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Book 1 of 2 Books
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WHY: To provide the public with access to information necessary to research Federal agency regulations which directly affect them. There will be no discussion of specific agency regulations.

WHEN: Tuesday, September 11, 2007
9:00 a.m.–Noon

WHERE: Office of the Federal Register
Conference Room, Suite 700
800 North Capitol Street, NW.
Washington, DC 20002

RESERVATIONS: (202) 741–6008

Contents

Federal Register

Vol. 72, No. 148

Thursday, August 2, 2007

Separate Parts In This Issue

Reader Aids
Consult the Reader Aids section at the end of this issue for phone numbers, online resources, finding aids, reminders, and notice of recently enacted public laws.

To subscribe to the Federal Register Table of Contents LISTSERV electronic mailing list, go to http://listserv.access.gpo.gov and select Online mailing list archives, FEDREGTOC-L, Join or leave the list (or change settings); then follow the instructions.

CFR PARTS AFFECTED IN THIS ISSUE

A cumulative list of the parts affected this month can be found in the Reader Aids section at the end of this issue.

9 CFR
Proposed Rules:
93.....42318
12 CFR
748.....42271
749.....42271
14 CFR
23.....42274
Proposed Rules:
39 (2 documents) 42326, 42328
17 CFR
171.....42276
18 CFR
33.....42277
Proposed Rules:
385.....42330
21 CFR
522.....42290
524.....42291
26 CFR
1.....42291
26.....42291
602.....42291
Proposed Rules:
1.....42335
26.....42340
32 CFR
229.....42298
33 CFR
117.....42306
165.....42307
40 CFR
Proposed Rules:
52 (3 documents) 42344, 42349, 42354
81.....42354
42 CFR
410.....42470
416.....42470
Proposed Rules:
410.....42628
411.....42628
414.....42628
416.....42628
419.....42628
482.....42628
485.....42628
45 CFR
Proposed Rules:
1626.....42363
46 CFR
67.....42310
48 CFR
202 (2 documents) 42313
204.....42313
205.....42315
210.....42313
213.....42313
215.....42313
219.....42313
225 (2 documents) 42315
252.....42315
Proposed Rules:
216.....42366
232.....42366
252 (2 documents) 42366, 42367
50 CFR
922.....42318
Proposed Rules:
679.....42369

Rules and Regulations

Federal Register
Vol. 72, No. 148
Thursday, August 2, 2007

NATIONAL CREDIT UNION ADMINISTRATION

12 CFR Parts 748 and 749

RIN 3133–AD24

Records Preservation Program and Appendices—Record Retention Guidelines; Catastrophic Act Preparedness Guidelines

AGENCY: National Credit Union Administration (NCUA).

ACTION: Final rule.

SUMMARY: NCUA is issuing a final rule to amend its regulations regarding a federally-insured credit union's obligation to maintain a records preservation program. The final rule clarifies the meaning of catastrophic act and the requirements for preserving vital records. The agency also provides a new Appendix B that offers guidelines for developing a program to prepare for a catastrophic act. NCUA believes the revised rule language and new appendix will facilitate the recovery of essential operations after a catastrophic act resulting in continued member confidence in the credit union system.

DATES: This rule is effective September 4, 2007.

FOR FURTHER INFORMATION CONTACT: Andrew Healey, Program Officer, Division of Supervision, Office of Examination and Insurance, at (703) 518–6360 or Linda K. Dent, Staff Attorney, Office of General Counsel, at (703) 518–6540.

SUPPLEMENTARY INFORMATION:

Background

On March 15, 2007, the NCUA Board (Board) requested comments on proposed amendments to parts 748 and 749 addressing catastrophic act events, vital records preservation, and vital member services restoration. The agency's previous experiences with catastrophic acts underscored the importance of preserving vital records and swiftly restoring vital member services. In particular, NCUA's review of events in the aftermath of hurricanes Katrina and Rita demonstrated the need for advance planning and preparation to respond to a catastrophic act successfully. In reviewing these experiences, the Board determined the most immediate issues for credit unions and their members concerned access to funds and account information, access to facilities, and locating and communicating with staff. The proposed amendments drew from these experiences to identify program elements the Board considered essential to restoring vital records and member services.

While many of these elements are covered in previous NCUA guidance issued to federally-insured credit unions on disaster recovery planning, the Board wants to ensure that credit unions are maintaining sufficient plans and safeguards to preserve vital records. The Board believes the regulatory changes are necessary to ensure credit unions establish certain minimum standards for preserving vital records. The Board also believes the recommendations and guidance offered, concerning restoring vital member services and development of a program to prepare for a catastrophic act, provide important information about maintaining member services and confidence in the credit union system if a catastrophic act occurs.

Summary of Comments

The Board received twelve comments on the proposed regulation: Four from natural person credit unions, one corporate credit union, two national trade associations, and five state trade associations. While all commenters generally supported the overall purpose of the proposed changes, about half of them offered recommendations on the definitions for catastrophic act, vital member services, and vital records, and the proposed new Appendix B to Part 749. Comments for these items were mixed and are discussed in further detail below.

Section 748.1(b). Catastrophic Act Report

The Board proposed to revise the definition of catastrophic act to include any event, natural or otherwise, causing an interruption in vital member services for more than two business days. Seven commenters recommended additional changes: Four commenters believe the definition should clarify what constitutes a business day; two commenters suggested including cross-references to relevant definitions in parts 748 and 749; and one commenter felt the definition of catastrophic act should focus only on whether a loss of vital member services has occurred without regard to whether physical damage has occurred.

Section 748.1(b) previously required a credit union to file a report when a catastrophic act caused physical damage to its facilities. The proposed rule retained this requirement but added that a catastrophic act would include an interruption in vital member services lasting for more than two consecutive business days, regardless of whether physical damage is present. In the final rule, the Board has substituted the word ''disaster'' for ''event'' and added the word ''causing'' before ''an interruption'' to address concerns that relatively minor events could be construed to trigger the need to file a report and, also, clarifying the causal link between a disaster and an interruption in vital member services. The Board believes these changes are consistent with the usual and customary meaning of the word catastrophe. These changes also reinforce the Board's view that the reporting requirement applies only to a disaster as opposed to a circumstance where physical damage or a business closing occurs but is not disaster-related.

The Board believes adding a definition of business day is unnecessary and could be cumbersome because the hours and days of operations vary significantly among credit unions. The word ''consecutive'' has been added to the regulation so the requirement to submit a report due to an interruption in vital member services caused by a disaster will be triggered when the interruption is ''projected to last more than two consecutive business days.'' Two consecutive business days means full consecutive days on which a credit union would normally be open for business. For example, if a credit union, normally operating Monday through Friday from 9 a.m. to 5 p.m., shuts early on Thursday because a hurricane has caused a loss of power,

the credit union must file a report only if it is unable to provide vital member services, through any of its delivery channels, by 9:00 am on Tuesday. Finally, as suggested in the comments, the Board also included a cross-reference to the definition of vital member services in part 749.

Part 749

Vital Member Services

Six commenters generally supported the proposed definition, while two of the commenters addressing this subject suggested including a clarification that vital member services can be provided by any means or delivery channel. The Board believes the additional clarification is unnecessary as the final rule does not restrict the manner in which vital member services are provided.

Vital Records

Eight commenters provided comments on the proposed definition: Four were in support of the proposed change and four recommended changes. Two of the recommendations, one from a national trade association and the other from a state trade association, expressed concern about the rule's impact on small, non-automated credit unions and recommended flexibility, or exemption, for such institutions. The Board is not persuaded an exemption for small credit unions is warranted; this is discussed below in the section on the Regulatory Flexibility Act.

Another recommendation suggested the Board include the general ledger as a vital record. This is unnecessary because the content of the general ledger is contained in the records designated as vital; the Board notes credit unions are free to classify additional records as vital if they choose.

As proposed, vital records is defined to include a ''list of share, deposit, and loan balances for each member's account as of the most recent business day,'' and another recommendation was that the phrase ''as of the most recent business day'' would be clearer if the word ''completed'' were added before ''business'' or the phrase ''day of normal operations'' was substituted for ''business day.'' To clarify, the Board has revised the phrase to read ''as of the close of the most recent business day.'' This means the credit union must have this record as of the close of the most recent day the credit union was open for business.

The Board is aware of some concern about the level of detail required in the records log, particularly where records may be stored in an electronic format and various individuals may be involved in scanning paper records for storage. This provision is re-worded slightly in the amendment but substantively unchanged from previous requirements; the Board believes recording this information is not unduly burdensome and ensures accountability for this important function. The log can take various forms, for example, a data processing system log. Where various persons may be involved in preparing records for storage, whether in an electronic format or otherwise, the log should identify who is responsible, as stated in the regulation, for ''sending the record to storage.''

Appendix B—Catastrophic Act Preparedness Guidelines

Nine commenters expressed an opinion on whether to include a new Appendix B in the regulation: Three supported including it and six recommended against it. Five of the six commenters that opposed including the appendix felt sufficient guidance already existed. One of these five, a national trade association, also expressed a concern that including the appendix and other recommendations in the regulation would cause examiners and credit union staff to misconstrue the guidance as being enforceable like a regulation. The sixth commenter felt it would be more appropriate to integrate the guidance into the regulation.

The Board has weighed the fact the guidance is available from other sources and the potential for confusion regarding enforceability of a regulation versus guidance. The Board believes the benefit to credit unions in having the guidance in proximity to the regulatory requirement will enhance access to the guidance and will facilitate compliance. The Board believes including specific words like ''recommended'' and ''guidance'' means, as a legal matter, that the guidance is just that—guidance—and is not enforceable as a regulation. These words clarify and minimize, to the extent linguistically possible, the potential for misinterpretation.

NCUA, as a matter of its supervisory obligation to protect the interests of credit union members and the National Credit Union Share Insurance Fund, offers guidance to help federally-insured credit unions meet their obligation to protect their operations. Federally-insured credit unions may choose to meet this obligation through other alternatives appropriate for their operations.

Regulatory Procedures

Regulatory Flexibility Act

The Regulatory Flexibility Act requires NCUA to prepare an analysis to describe any significant economic impact a proposed rule may have on a substantial number of small credit unions (those under $10 million in assets). This proposed rule modifies a preexisting requirement for federally-insured credit unions to file reports of catastrophic acts and to have a vital records preservation program. The requirement to maintain vital records as of the most recent business day versus the existing month-end requirement may pose some burden for non-automated credit unions. There are approximately 122 non-automated credit unions or approximately 3.3% of all small credit unions. The NCUA has determined and certifies that this proposed rule, if adopted, will not have a significant economic impact on a substantial number of small credit unions. Accordingly, the NCUA has determined that an RFA analysis is not required.

Paperwork Reduction Act

The changes involve information collection requirements. As required by the Paperwork Reduction Act of 1995 (44 U.S.C. 3507(d)), NCUA submitted a copy of the proposed rule as part of an information collection package to the Office of Management and Budget (OMB) for its review. OMB has approved this collection as a revision to an existing collection, OMB Control Number 3133–0032.

Executive Order 13132

Executive Order 13132 encourages independent regulatory agencies to consider the impact of their regulatory actions on state and local interests. In adherence to fundamental federalism principles, NCUA, an independent regulatory agency as defined in 44 U.S.C. 3502(5), voluntarily complies with the executive order. This proposed rule, if adopted, will not have substantial direct effects on the states, on the relationship between the national government and states, or on the distribution of power and responsibilities among the various levels of government. NCUA has determined the proposed rule does not constitute a policy that has federalism implications for purposes of the executive order.

Treasury and General Government Appropriations Act, 1999

NCUA has determined that the proposed rule will not affect family

well-being within the meaning of section 654 of the Treasury and General Appropriations Act, 1999, Public Law 105–277, 112 Stat. 2681 (1998).

List of Subjects

12 CFR Part 748

Credit Unions, Reporting and record keeping requirements.

12 CFR Part 749

Credit Unions, Reporting and record keeping requirements.

By the National Credit Union Administration Board on July 26, 2007.

Mary Rupp,

Secretary of the Board.

■ For the reasons set forth in the preamble, the Board amends 12 CFR parts 748 and 749 as set forth below.

■ Accordingly, NCUA amends 12 CFR parts 748 and 749 as follows:

PART 748—SECURITY PROGRAM, REPORT OF SUSPECTED CRIMES, SUSPICIOUS TRANSACTIONS, CATASTROPHIC ACTS AND BANK SECRECY ACT COMPLIANCE

■ 1. The authority citation for part 748 continues to read as follows:

Authority: 12 U.S.C. 1766(a) and 1786(q); 15 U.S.C. 6801 and 6805(b); 31 U.S.C. 5311 and 5318.

■ 2. Amend § 748.1 by revising the second sentence of paragraph (b) to read as follows:

§ 748.1 Filing of reports.

* * * * *

(b) * * * A catastrophic act is any disaster, natural or otherwise, resulting in physical destruction or damage to the credit union or causing an interruption in vital member services, as defined in § 749.1 of this chapter, projected to last more than two consecutive business days. * * *

* * * * *

PART 749—RECORDS PRESERVATION PROGRAM AND APPENDICES—RECORD RETENTION GUIDELINES; CATASTROPHIC ACT PREPAREDNESS GUIDELINES

■ 1. The authority citation for part 749 continues to read as follows:

Authority: 12 U.S.C. 1766, 1783 and 1789; 15 U.S.C. 7001(d).

■ 2. Amend part 749 by revising the part heading as set forth above.

■ 3. Revise § 749.0 to read as follows:

§ 749.0 Purpose and scope.

(a) This part describes the obligations of all federally-insured credit unions to maintain a records preservation program to identify, store and reconstruct vital records in the event that the credit union's records are destroyed and provides recommendations for restoring vital member services. All credit unions must have a written program that includes plans for safeguarding records and reconstructing vital records. To complement these plans, it is recommended a credit union develop a method for restoring vital member services in the event of a catastrophic act as defined in § 748.1(b) of this chapter. Additionally, the regulation establishes flexibility in the format credit unions may use for maintaining writings, records or information required by other NCUA regulations.

(b) Appendix A to this part provides guidance concerning the appropriate length of time credit unions should retain various types of operational records. Appendix B to this part also provides guidance for developing a program for responding to a catastrophic act to ensure duplicate vital records can be used for restoration of vital member services.

■ 4. Revise § 749.1 to read as follows:

§ 749.1 Definitions.

For purposes of this part:

Vital member services mean informational account inquiries, share withdrawals and deposits, and loan payments and disbursements.

Vital records refer to the following records:

(a) A list of share, deposit, and loan balances for each member's account as of the close of the most recent business day that:

(1) Shows each balance individually identified by a name or number;

(2) Lists multiple loans of one account separately; and

(3) Contains information sufficient to enable the credit union to locate each member, such as address and telephone number.

(b) A financial report, which lists all of the credit union's asset and liability accounts and bank reconcilements, current as of the most recent month-end.

(c) A list of the credit union's accounts at financial institutions, insurance policies, and investments along with related contact information, current as of the most recent month-end.

(d) Emergency contact information for employees, officials, regulatory offices, and vendors used to support vital records.

■ 5. Revise § 749.2 to read as follows:

§ 749.2 Vital records preservation program.

The board of directors of a credit union is responsible for establishing a vital records preservation program within 6 months after its insurance certificate is issued. The program must be in writing and contain procedures for maintaining duplicate vital records at a vital records center. The procedures must include: designated staff responsible for vital records preservation, a schedule for the storage and destruction of records, and a records preservation log detailing for each record stored, its name, storage location, storage date, and name of the person sending the record for storage. It is recommended credit unions include in these procedures a method for using duplicate records to restore vital member services in the event of catastrophic act. Credit unions which have some or all of their records maintained by an off-site data processor are considered to be in compliance for the storage of those records if the service agreement specifies the data processor safeguards against the simultaneous destruction of production and back-up information.

■ 6. Revise § 749.3 to read as follows:

§ 749.3 Vital records center.

A vital records center is defined as a storage facility, which may include another federally-insured credit union, at any location far enough from the credit union's offices to avoid the simultaneous loss of both sets of records in the event of a catastrophic act. A credit union must maintain or contract with a third party to maintain any equipment or software for its vital records center necessary to access records.

■ 7. Revise § 749.4 to read as follows:

§ 749.4 Format for vital records preservation.

Preserved records may be in any format that can be used to reconstruct the credit union's records. The format used must accurately reflect the information in the record, remain accessible to all persons entitled to access by statute, regulation or rule of law, and be capable of reproduction by transmission, printing, or otherwise.

■ 8. Revise § 749.5 to read as follows:

§ 749.5 Format for records required by other NCUA regulations.

Where NCUA regulations require credit unions to retain certain writings, records or information, credit unions may use any format that accurately reflects the information in the record, is accessible to all persons entitled to

access by statute, regulation or rule of law, and is capable of being reproduced by transmission, printing, or otherwise. The credit union must maintain the necessary equipment or software to permit an examiner to access the records during the examination process.

■ 9. Add new Appendix B to part 749 to read as follows:

Appendix B to Part 749—Catastrophic Act Preparedness Guidelines

Credit unions often look to NCUA for guidance on preparing for a catastrophic act. While NCUA has minimal regulation in this area,[1] as an aid to credit unions it is publishing this appendix of suggested guidelines. It is recommended that all credit unions develop a program to prepare for a catastrophic act. The program should be developed with oversight and approval of the board of directors. It is recommended the program address the following five elements:

(1) A business impact analysis to evaluate potential threats;

(2) A risk assessment to determine critical systems and necessary resources;

(3) A written plan addressing:

i. Persons with authority to enact the plan;

ii. Preservation and ability to restore vital records;

iii. A method for restoring vital member services through identification of alternate operating location(s) or mediums to provide services, such as telephone centers, shared service centers, agreements with other credit unions, or other appropriate methods;

iv. Communication methods for employees and members;

v. Notification of regulators as addressed in 12 CFR 748.1(b);

vi. Training and documentation of training to ensure all employees and volunteer officials are aware of procedures to follow in the event of destruction of vital records or loss of vital member services; and

vii. Testing procedures, including a means for documenting the testing results.

(4) Internal controls for reviewing the plan at least annually and for revising the plan as circumstances warrant, for example, to address changes in the credit union's operations; and

(5) Annual testing.

[FR Doc. E7–14851 Filed 8–1–07; 8:45 am]

BILLING CODE 7535–01–P

[1] See 12 CFR 748.1(b) concerning a FICU's reporting of any catastrophic act that occurs at its office to its regional director and 12 CFR 749.3 concerning the location of a FICU's vital records center to avoid the simultaneous loss of both sets of records in the event of disaster.

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 23

[Docket No. CE261; Special Conditions No. 23–201–SC]

Special Conditions: Centex Aerospace, Inc.; Cirrus Design Corporation Model SR22; Installation of a Full Authority Digital Engine Control (FADEC) Engine

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final special conditions; request for comments.

SUMMARY: These special conditions are issued for the Cirrus Design Corporation, Model SR22 airplane as modified by Centex Aerospace, Inc. This airplane as modified by Centex Aerospace, Inc. will have a novel or unusual design feature(s) associated with the installation of a full authority digital engine control (FADEC) engine. The applicable airworthiness regulations do not contain adequate or appropriate safety standards for this design feature. These special conditions contain the additional safety standards that the Administrator considers necessary to establish a level of safety equivalent to that established by the existing airworthiness standards.

DATES: The effective date of these special conditions is July 26, 2007.

Comments must be received on or before September 4, 2007.

ADDRESSES: Mail two copies of your comments to: Federal Aviation Administration, Regional Counsel, ACE–7, Attn: Rules Docket No. CE261, 901 Locust, Kansas City, MO 64106. You may deliver two copies to the Regional Counsel at the above address. Mark your comments: Docket No. CE261. You may inspect comments in the Rules Docket weekdays, except Federal holidays, between 7:30 a.m. and 4 p.m.

FOR FURTHER INFORMATION CONTACT: Peter L. Rouse, Federal Aviation Administration, Small Airplane Directorate, Aircraft Certification Service, 901 Locust, Room 301, Kansas City, MO 64106; telephone (816) 329–4135; facsimile (816) 329–4090.

SUPPLEMENTARY INFORMATION: The FAA has determined that notice and opportunity for prior public comment hereon are impracticable because these procedures would significantly delay issuance of the approval design and thus delivery of the affected aircraft. In addition, the substance of these special conditions has been subject to the public comment process in several prior instances with no substantive comments received. The FAA therefore finds that good cause exists for making these special conditions effective upon issuance.

Comments Invited

We invite interested people to take part in this rulemaking by sending written comments, data, or views. The most helpful comments reference a specific portion of the special conditions, explain the reason for any recommended change, and include supporting data. We ask that you send us two copies of written comments.

We will file in the docket all comments we receive, as well as a report summarizing each substantive public contact with FAA personnel about these special conditions. You can inspect the docket before and after the comment closing date. If you wish to review the docket in person, go to the address in the **ADDRESSES** section of this preamble between 7:30 a.m. and 4 p.m., Monday through Friday, except Federal holidays.

We will consider all comments we receive by the closing date for comments. We will consider comments filed late if it is possible to do so without incurring expense or delay. We may change these special conditions based on the comments we receive.

If you want us to let you know we received your comments on these special conditions, send us a pre-addressed, stamped postcard on which the docket number appears. We will stamp the date on the postcard and mail it back to you.

Background

On, March 15, 2004, Centex Aerospace, Inc. applied for a supplemental type certificate for the Cirrus Model SR22 to install a full authority digital engine control in the Cirrus Model SR22. CenTex Aerospace, Inc. plans to install a Teledyne Continental Motors model IOF–550–N engine in a Cirrus Design Corporation Model SR–22 airplane. This type certified engine, approved under FAA Type Certificate E3SO; Revision 7, dated February 4, 2002, incorporates Full Authority Digital Electronic Controls (FADEC) fuel and ignition control system. Even though the engine control system is certificated as part of the engine and does not interface or share data with any of the airplane systems, the installation of an engine with an electronic control system requires evaluation due to critical environmental effects and possible effects on or by other airplane systems. For example,

indirect effects of lightning, radio interference with other airplane electronic systems, shared engine and airplane data and power sources.

The Cirrus SR 22 is currently approved under Type Certificate No. A00009CH. The Cirrus SR–22 is a 3,400 pound single-engine, four-place, fixed-gear airplane powered by a 310 hp reciprocating engine. It has a conventional tractor configuration and utilizes composites for the structure. Some unique features of the SR–22 include sidestick controls and a ballistic recovery system, and a single combination throttle/propeller control lever.

The considerations for installation of digital electronic engine control systems were not envisaged and are not adequately addressed in 14 CFR part 23. The regulatory requirements in 14 CFR part 23 for evaluating the installation of complex systems, including electronic systems and critical environmental effects, are contained in § 23.1309. However, when § 23.1309 was developed, the use of highly airframe integrated electronic control systems for engines was not envisioned. Therefore, the § 23.1309 requirements were not applicable to systems certificated as part of the engine (reference § 23.1309(f)(1)). The parts of the system that are not certificated with the engine could be evaluated using the criteria of § 23.1309. However, the integral nature of systems such as these makes it unfeasible to evaluate the airplane portion of the system without including the engine portion of the system. Section 23.1309(f)(1) prevents complete evaluation of the installed airplane system since evaluation of the engine system's effects is not required.

Type Certification Basis

Under the provisions of § 21.101, Centex Aerospace, Inc. must show that the Cirrus Design Corporation Model SR22, as changed, continues to meet the applicable provisions of the regulations incorporated by reference in Type Certificate No. A00009CH, or the applicable regulations in effect on the date of application for the change. The regulations incorporated by reference in the type certificate are commonly referred to as the ''original type certification basis.'' The regulations incorporated by reference in Type Certificate No. A00009CH are as follows:

Model SR22: Part 23 of the Federal Aviation Regulations effective February 1, 1965, as amended by 23–1 through 23–53, except as follows:

23.301 through Amendment 47
23.855, 23.1326, 23.1359, not applicable
Federal Aviation Regulations 36 dated December 1, 1969, as amended by current amendment as of the date of type Certification.

Equivalent Safety Items:

Equivalent Levels of Safety finding (ACE–96–5) made per the provisions of 14 CFR part 23, § 23.221; Refer to FAA ELOS letter dated June 10, 1998 for models SR20, SR22.
Equivalent Levels of Safety finding (ACE–00–09) made per the provisions of 14 CFR part 23, §§ 23.1143(g) and 23.1147(b); Refer to FAA ELOS letter dated September 11, 2000, for model SR22.

Special Conditions:

23–ACE–88 for ballistic parachute
23–134–SC for protection of systems for High Intensity Radiated Fields (HIRF)
23–163–SC for inflatable restraint system

In addition, if the regulations incorporated by reference do not provide adequate standards regarding the change, the applicant must comply with certain regulations in effect on the date of application for the change.

If the Administrator finds that the applicable airworthiness regulations (i.e., 14 CFR part 23, § 23.1309) do not contain adequate or appropriate safety standards for the Model SR22 because of a novel or unusual design feature, special conditions are prescribed under the provisions of § 21.16.

The FAA issues special conditions, as defined in § 11.19, under § 11.38 and they become part of the type certification basis under § 21.101.

Special conditions are initially applicable to the model for which they are issued. Should the applicant apply for a supplemental type certificate to modify any other model included on the same type certificate to incorporate the same novel or unusual design feature, the special conditions would also apply to the other model.

Novel or Unusual Design Features

The Centex Aerospace, Inc. modified Cirrus Model SR22 will incorporate the following novel or unusual design features:

An engine that includes an electronic control system with Full Authority Digital Engine control (FADEC) capability.

Discussion

The regulatory requirements in 14 CFR part 23 for evaluating the installation of complex systems, including electronic systems and critical environmental effects, are contained in § 23.1309. However, when § 23.1309 was developed, the use of electronic control systems for engines were not envisioned. Therefore, the § 23.1309 requirements were not applicable to systems certificated as part of the engine (reference § 23.1309(f)(1)). Although the parts of the system that are not certificated with the engine could be evaluated using the criteria of § 23.1309, the integral nature of systems such as these makes it unfeasible to evaluate the airplane portion of the system without including the engine portion of the system. However, § 23.1309(f)(1) again prevents complete evaluation of the installed airplane system since evaluation of the engine system's effects is not required.

The Policy Statement; Installation of Electronic Engine Control for Reciprocating Engine, PS–ACE100–2004–10024, states:

> The current Small Airplane Directorate Standards Office policy on EEC installation in small airplanes, under § 23.1309, has been to issue two special conditions. The first special condition applies § 23.1309(a) through (e) to the propulsion system installation. The second special condition is protection of the EEC from exposure to HIRF. The evaluation should be limited to the interfaces of the engine/control system and verification that none of the assumptions made for part 33 certification of the engine are invalidated by the installation. The analysis should not extend into data submitted and approved as part of the engine certification program.

The Lightning and HIRF certification requirements for design and installation approval of electronic equipment are presented in 14 CFR part 23, § 23.1309, and Advisory Circular (AC) 23.1309–1C and AC 23–17A. However, a typical misinterpretation is that the concepts in AC 23.1309–1C can be applied to engine control systems to reduce the certification requirements for single engine airplanes.

The EEC is certified as part of the engine design certification, the certification requirements for engine control systems must be driven by 14 CFR part 33 and the two advisory circulars; AC 33.28–1 and AC 33.28–2. Both of those Advisory Circulars clearly state that electronic engine controls must provide the same level of safety as traditional mechanical engine controls. We believe the EEC systems have additional failure modes that were not present in purely mechanical engine controls. To ensure an equivalent level of safety, the FAA position has always been:

> EEC System with catastrophic and hazardous failure conditions, without an acceptable conventional engine control backup, lightning and HIRF protection levels are required to be certified to the levels for catastrophic failure conditions.

The environmental certification tests are normally conducted with the appropriate category and level of RTCA/DO–160. For HIRF, it is at the environment in the notice or category W of section 20 of RTCA/DO–160. For indirect effects of lightning, it is at the appropriate category and level for pin injection tests and multiple stroke and multiple burst tests of section 22 of RTCA/DO–160. When appropriate, engine certification data may be used when showing compliance with this requirement. However, the effects of the installation on this data must be addressed.

The applicant will comply with the following special condition:

The installation of the electronic engine control system must comply with the requirements of § 23.1309(a) through (e) at Amendment 23–49. The intent of this requirement is not to reevaluate the inherent hardware reliability of the control itself, but rather determine the effects, including environmental effects addressed in § 23.1309(e), on the airplane systems and engine control system when installing the control on the airplane. When appropriate, engine certification data may be used when showing compliance with this requirement; however, the effects of the installation on this data must be addressed.

With respect to compliance with § 23.1309(e), the levels required for compliance shall be at the levels for catastrophic failure conditions.

Applicability

As discussed above, these special conditions are applicable to the Cirrus Model SR22 as modified by Centex Aerospace, Inc. Should Centex Aerospace, Inc. apply at a later date for a supplemental type certificate to modify any other model included on Type Certificate No. A00009CH, to incorporate the same novel or unusual design feature, the special conditions would apply to that model as well.

Conclusion

This action affects only certain novel or unusual design features on one model of airplane. It is not a rule of general applicability and affects only the applicant who applied to the FAA for approval of these features on the airplane.

The substance of these special conditions has been subjected to the notice and comment period in several prior instances and has been derived without substantive change from those previously issued. It is unlikely that prior public comment would result in a significant change from the substance contained herein. Therefore, because a delay would significantly affect the certification of the airplane, which is imminent, the FAA has determined that prior public notice and comment are unnecessary and impracticable, and good cause exists for adopting these special conditions upon issuance. The FAA is requesting comments to allow interested persons to submit views that may not have been submitted in response to the prior opportunities for comment described above.

List of Subjects in 14 CFR Part 23

Aircraft, Aviation safety, Signs and symbols.

Citation

■ The authority citation for these special conditions is as follows:

Authority: 49 U.S.C. 106(g), 40113 and 44701; 14 CFR 21.16 and 21.101; and 14 CFR 11.38 and 11.19.

The Special Conditions

■ Accordingly, pursuant to the authority delegated to me by the Administrator, the following special conditions are issued as part of the type certification basis for the Cirrus Model SR22 airplanes as modified by Centex Aerospace, Inc.

1. Electronic Engine Control System

The installation of the electronic engine control system must comply with the requirements of § 23.1309(a) through (e) at Amendment 23–49. The intent of this requirement is not to reevaluate the inherent hardware reliability of the control itself, but rather determine the effects, including environmental effects addressed in § 23.1309(e), on the airplane systems and engine control system when installing the control on the airplane. When appropriate, engine certification data may be used when showing compliance with this requirement; however, the effects of the installation on this data must be addressed.

With respect to compliance with § 23.1309(e), the levels required for compliance shall be at the levels for catastrophic failure conditions.

Issued in Kansas City, Missouri on July 26, 2007.

James E. Jackson,

Acting Manager, Small Airplane Directorate, Aircraft Certification Service.

[FR Doc. E7–14933 Filed 8–1–07; 8:45 am]

BILLING CODE 4910–13–P

COMMODITY FUTURES TRADING COMMISSION

17 CFR Part 171

RIN 3038–AC43

Rules Relating To Review of National Futures Association Decisions in Disciplinary, Membership Denial, Registration and Member Responsibility Actions

AGENCY: Commodity Futures Trading Commission.

ACTION: Final Rule.

SUMMARY: The Commodity Futures Trading Commission (''Commission'' or ''CFTC'') hereby amends 17 CFR Part 171, by adding language to Commission Rule § 171.9(b) (manner of service), allowing for service by facsimile (''fax'') or by electronic means (''e-mail''), making either means of service effective upon receipt. The amendment will also indicate that parties who consent to accepting service of documents by electronic means or fax in the underlying NFA action also consent to accepting service by the same means in proceedings under Part 171.

DATES: August 2, 2007.

FOR FURTHER INFORMATION CONTACT: Thuy Dinh, Office of the General Counsel, Commodity Futures Trading Commission, Three Lafayette Centre, 1155 21st Street, NW., Washington, DC 20581. Telephone: (202) 418–5128.

SUPPLEMENTARY INFORMATION: On October 9, 1990, the Commission adopted Part 171 to establish standards and procedures for its review of decisions of registered futures associations such as the National Futures Association (''NFA'') in disciplinary actions, membership denial actions, registration actions and member responsibility actions. 55 FR 41061. From the time Part 171 was promulgated until now, Commission Rule 171.9(b) provides only for service by personal delivery (effective upon receipt) or service by mail (effective upon deposit). On May 22, 2007, the NFA asked the Commission to amend language to Rule 171.9(b), to allow service by fax and e-mail. In proposing the amendment, NFA cited three supporting arguments: (1) To avoid undue delay (due to cautionary procedures adopted in the post-September 11 climate, postal mail to U.S. government agencies is often delayed and thus is not as effective as it used to be prior to September 11); (2) to take advantage of technological means of service, which will be faster and less costly than the mails; (3) to

streamline procedures. NFA cites Commission Rules under 17 CFR Part 10, which allows for service of documents by fax in enforcement proceedings. In addition, it cites its own rules governing arbitration, compliance and disciplinary cases as allowing service by both fax and e-mail. Thus, NFA asserts, to allow service by fax and e-mail in Part 171 would make the process more efficient.

After reviewing NFA's proposed amended language and its justifications for the proposal, the Commission has decided to adopt NFA's request in its entirety. Amending the 17 CFR 171.9(b) to allow for service by fax and e-mail will(a) enhance the efficiency of proceedings under Part 171; and (b) comport with the various capabilities of today's changing world.

Related Matters

A. No Notice Is Required Under 5 U.S.C. 553

The Commission has determined that this amendment to Part 171 is exempt from the provisions of the Administrative Procedure Act, 5 U.S.C. 553, which generally require notice of proposed rulemaking and provide other opportunities for public participation. However, 5 U.S.C. 553 gives an agency discretion not to provide notice for ''rules of agency organization, procedure, or practice.'' Notice and public procedure are unnecessary in this case. The proposed amendment, if made effective immediately, will actually promote efficiency and facilitate the Commission's core mission. For the above reasons, the notice requirements under 5 U.S.C. 553 are inapplicable.

B. Regulatory Flexibility Act

The Regulatory Flexibility Act (''RFA''), 5 U.S.C. 601 *et seq.*, requires agencies with rulemaking authority to consider the impact those rules will have on small businesses. With respect to persons seeking Commission reviews of NFA adjudicatory decisions, the amendments will impose no additional regulatory burden. Commission review of NFA disciplinary and membership denial actions has been carried out pursuant to 17 CFR Part 171 since 1990. These amendments to 17 CFR 171.9(b) do not present any significant changes and will in fact ease the regulatory burden by providing more options, greater certainty and predictability concerning manners of service under Part 171. Accordingly, the Acting Chairman, on behalf of the Commission, hereby certifies, pursuant to 5 U.S.C. 605(b), that the amendments will not have a significant economic impact on a substantial number of small businesses.

C. Paperwork Reduction Act

The amendments to Part 171 rules do not impose a burden within the meaning and intent of the Paperwork Reduction Act of 1980, 44 U.S.C. 3501, *et seq.*

D. Cost-Benefit Analysis

Section 15(a) of the Commodity Exchange Act, 7 U.S.C. 19(a), requires the Commission to consider the costs and benefits of its action before issuing a new regulation. Section 15(a) further specifies that costs and benefits shall be evaluated in light of five broad areas of market and public concern: (1) Protection of market participants and the public; (2) efficiency, competitiveness, and financial integrity of futures markets; (3) price discovery; (4) sound risk management practices; and (5) other public interest considerations. Accordingly, the Commission can, in its discretion, give greater weight to any one of the five enumerated areas of concern and can, in its discretion, determine that notwithstanding its costs, a particular rule is necessary or appropriate to protect the public interest or to effectuate any of the provisions, or accomplish any of the purposes, of the Commodity Exchange Act.

The amendments to Part 171 will not create any significant change in the Commission's appellate process or impose new burdens or costs thereon. In fact, the amendments should enhance the protection of market participants and the public by making service more certain, faster and cheaper.

After considering these above factors, the Commission has determined to amend Part 171, as set forth below.

List of Subjects in 17 CFR Part 171

Administrative practice and procedure, Commodity exchanges, Commodity futures.

■ In consideration of the following, and pursuant to authority contained in the Commodity Exchange Act, the Commission hereby amends chapter I of title 17 of the Code of Federal Regulations to read as follows:

PART 171–RULES RELATING TO REVIEW OF NATIONAL FUTURES ASSOCIATION DECISIONS IN DISCIPLINARY, MEMBERSHIP DENIAL, REGISTRATION AND MEMBER RESPONSIBILITY ACTIONS

■ 1. The authority citation for Part 171 continues to read as follows:

Authority: 7 U.S.C. 4a, 12a, and 21.

■ 2. Section 171.9 is amended by revising paragraph (b) to read as follows:

§ 171.9 Service

* * * * *

(b) *Manner of Service:* Service may be made by personal delivery (effective upon receipt), mail (effective upon deposit), facsimile (effective upon receipt) or electronic mail (effective upon receipt). When service is effected by mail, the time within which the person served may respond thereto shall be increased by five days. Parties who consent to accepting service of documents by electronic means in the underlying NFA action also consent to accepting service by the same means in proceedings under this Part 171.

* * * * *

Issued in Washington, DC on the 26th of July 2007, by the Commission.

Eileen A. Donovan,

Acting Secretary of the Commission.

[FR Doc. E7–14922 Filed 8–1–07; 8:45 am]

BILLING CODE 6351–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

18 CFR Part 33

[Docket No. PL07–1–000]

FPA Section 203 Supplemental Policy Statement

Issued July 20, 2007.

AGENCY: Federal Energy Regulatory Commission, DOE.

ACTION: Policy statement.

SUMMARY: The Federal Energy Regulatory Commission is providing guidance regarding future implementation of section 203 of the Federal Power Act. In the Supplemental Policy Statement the Commission adopts policies and provides clarifications intended to continue the encouragement of beneficial utility industry investment while also providing for effective customer protections, including working in a complementary fashion with the states in protecting customers.

DATES: *Effective Date:* This Supplemental Policy Statement is effective July 20, 2007.

FOR FURTHER INFORMATION CONTACT: Carla Urquhart (Legal Information), Office of the General Counsel, Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426, (202) 502–8496.

Roshini Thayaparan (Legal Information), Office of the General Counsel, Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426, (202) 502–6857.

David Hunger (Technical Information), Office of Energy Markets and Reliability, Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426, (202) 502–8148.

Andrew P. Mosier, Jr. (Technical Information), Office of Energy Markets and Reliability, Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426, (202) 502–6274.

SUPPLEMENTARY INFORMATION:

Before Commissioners: Joseph T. Kelliher, Chairman; Suedeen G. Kelly, Marc Spitzer, Philip D. Moeller, and Jon Wellinghoff.

FPA Section 203 Supplemental Policy Statement

1. The Commission is issuing this Policy Statement as a supplement to the Commission's rulemakings issued in 2006 to implement provisions of the Energy Policy Act of 2005 [1] and also as a supplement to its 1996 Merger Policy Statement.[2] The 2006 rulemakings addressed amendments to the Commission's corporate review authority under section 203 of the Federal Power Act (FPA),[3] the repeal of the Public Utility Holding Company Act of 1935 [4] and the enactment of the Public Utility Holding Company Act of 2005.[5] Based on our experience in implementing the new laws thus far, and on the two technical conferences in which industry participants and state commissioners provided input on key issues, including the protection of captive customers against inappropriate cross-subsidization and the need to provide sufficient flexibility to encourage industry investment that benefits customers, the Commission finds that it is appropriate to provide guidance in this Policy Statement regarding future implementation of section 203. We clarify that this Policy Statement supplements, and does not replace, any part of the Commission's 1996 Merger Policy Statement.

2. This Policy Statement is one of three actions being taken based on the Commission's experience implementing amended FPA section 203 and PUHCA 2005, as well as the record from the Commission's December 7, 2006 and March 8, 2007 technical conferences regarding section 203 and PUHCA 2005. In addition, in separate orders, the Commission is concurrently issuing a Notice of Proposed Rulemaking proposing to grant a limited blanket authorization for certain dispositions of jurisdictional facilities under FPA section 203(a)(1) [6] and a Notice of Proposed Rulemaking proposing to codify restrictions on affiliate transactions between franchised public utilities with captive customers and their market-regulated power sales affiliates or non-utility affiliates.[7]

I. Background

3. In 1996, the Commission issued the 1996 Merger Policy Statement updating and clarifying the Commission's procedures, criteria and policies concerning public utility mergers under section 203 of the FPA.[8] The purpose of the 1996 Merger Policy Statement was to ensure that mergers are consistent with the public interest and to provide greater certainty and expedition in the Commission's analysis of merger applications. The 1996 Merger Policy Statement refined and modified the Commission's merger policy ''in light of dramatic and continuing changes in the electric power industry and corresponding changes in the regulation of that industry.'' [9]

4. In the 1996 Merger Policy Statement, the Commission set out the three factors it generally considers when analyzing whether a proposed section 203 transaction [10] is consistent with the public interest: effect on competition, effect on rates, and effect on regulation. In 2000, the Commission issued the Filing Requirements Rule,[11] which updated the filing requirements under 18 CFR Part 33 of the Commission's regulations for section 203 applications. Among other things, the Filing Requirements Rule codified the Commission's screening approach to quickly identify mergers that may raise horizontal competitive concerns, provided specific filing requirements consistent with Appendix A of the 1996 Merger Policy Statement, established guidelines for vertical competitive analysis, and set forth filing requirements for mergers that potentially raise vertical market power concerns. The revised filing requirements are in effect today, as recently modified (discussed below), and they assist the Commission in determining whether section 203 transactions are consistent with the public interest, provide more certainty to applicants regarding what showings must be made to satisfy the Commission's concerns under section 203, and expedite the Commission's review of such applications.

5. The scope of the Commission's section 203 review was expanded by EPAct 2005. Among other things, amended section 203: (1) Expands the Commission's review authority to include authority over certain holding company mergers and acquisitions, as well as certain public utility acquisitions of generating facilities; (2) requires that, prior to approving a disposition under section 203, the Commission must determine that the transaction would not result in inappropriate cross-subsidization of non-utility affiliates or encumbrance of utility assets; [12] and (3) imposes statutory deadlines for acting on

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[1] Pub. L. 109–58, 119 Stat. 594 (2005) (EPAct 2005).

[2] *Inquiry Concerning the Commission's Merger Policy Under the Federal Power Act: Policy Statement,* Order No. 592, 61 FR 68595 (Dec. 30, 1996), FERC Stats. & Regs. ¶ 31,044 (1996) (1996 Merger Policy Statement), *reconsideration denied,* Order No. 592–A, 62 FR 33341 (June 19, 1997), 79 FERC ¶ 61,321 (1997).

[3] 16 U.S.C. 824b (2000), amended by EPAct 2005, Pub. L. No. 109–58, 1289, 119 Stat. 594, 982–83 (2005). *See also Transactions Subject to FPA section 203,* Order No. 669, 71 FR 1348 (Jan. 6, 2006), FERC Stats. & Regs. ¶ 31,200 (2005), *order on reh'g,* Order No. 669–A, 71 FR 28422 (May 16, 2006), FERC Stats. & Regs. ¶ 31,214, order on reh'g, Order No. 669–B, 71 FR 42579 (July 27, 2006), FERC Stats. & Regs. ¶ 31,225 (2006).

[4] 16 U.S.C. 79a *et seq.* (PUHCA 1935).

[5] EPAct 2005, Pub. L. 109–58, 1261, *et seq.,* 119 Stat. 594, 972–78 (PUHCA 2005). *See also Repeal of the Public Utility Holding Company Act of 1935 and Enactment of the Public Utility Holding Company Act of 2005,* Order No. 667, 70 FR 75592 (Dec. 20, 2005), FERC Stats. & Regs. ¶ 31,197 (2005), *order on reh'g,* Order No. 667–A, 71 FR 28446 (May 16, 2006), FERC Stats. & Regs. ¶ 31,213, *order on reh'g,* Order No. 667–B, 71 FR 42750 (July 28, 2006), FERC Stats. & Regs. ¶ 31,224 (2006), *order on reh'g,* Order No. 667–C, 72 FR 8277 (Feb. 26, 2007), 118 FERC ¶ 61,133 (2007).

[6] *Blanket Authorization Under FPA Section 203,* 120 FERC ¶ 61,062 (2007) (issued in Docket No. RM07–21–000) (Blanket Authorization NOPR).

[7] *Cross-Subsidization Restrictions on Affiliate Transactions,* 120 FERC ¶ 61,061(2007) (issued in Docket No. RM07–15–000) (Affiliate Transactions NOPR).

[8] *Supra* note 2.

[9] 1996 Merger Policy Statement, FERC Stats. & Regs. ¶ 31,044, at 30,110.

[10] Although the Commission applies these factors to all section 203 transactions, not just mergers, the filing requirements and the level of detail required may differ. 1996 Merger Policy Statement, FERC States & Regs. ¶ 31,044, at 30,113 n.7. *See also* 18 CFR 2.26 (codifying the 1996 Merger Policy Statement).

[11] *Revised Filing Requirements Under Part 33 of the Commission's Regulations,* Order No. 642, 65 FR 70984 (Nov. 28, 2000), FERC Stats. & Regs. ¶ 31,111 (2000) (Filing Requirements Rule), *order on reh'g,* Order No. 642–A, 66 FR 16121 (Mar. 23, 2001), 94 FERC ¶ 61,289 (2001) (*codified* at 18 CFR Part 33).

[12] Section 203(a)(4) is not an absolute prohibition on the creoss-subsidization of a non-utility associate company or the pledge or encumbrance of utility assets for the benefit of an associate company. If the Commission determines that the cross-subsidization, pledge or encumbrance will be consistent with the public interest, such action may be permitted.

mergers and other jurisdictional transactions.

6. Through the Order No. 669 rulemaking proceeding, the Commission promulgated regulations adopting certain modifications to 18 CFR 2.26 and Part 33 to implement amended section 203. The Commission also provided blanket authorizations for certain transactions subject to section 203. These blanket authorizations were crafted to ensure that there is no harm to captive utility customers, but sought to accommodate investments in the electric utility industry by facilitating market liquidity. Some commenters in the rulemaking proceeding urged the Commission to grant additional blanket authorizations. Other commenters argued that the Commission should adopt additional generic rules to guard against inappropriate cross-subsidization associated with the mergers. Certain commenters argued that the Commission should modify its competitive analysis for mergers, which has been in place for 10 years. The Commission stated that it would reevaluate these and other issues at a future technical conference on the Commission's section 203 regulations as well as certain issues raised in the Order No. 667 rulemaking proceeding implementing PUHCA 2005.

7. On December 7, 2006, the Commission held a technical conference (December 7 Technical Conference) to discuss several of the issues that arose in the Order No. 667 and Order No. 669 rulemaking proceedings. The December 7 Technical Conference discussed a range of topics. The first panel discussed whether there are additional actions, under the FPA or the Natural Gas Act (NGA), that the Commission should take to supplement the protections against cross-subsidization that were implemented in the Order No. 667 and Order No. 669 rulemaking proceedings. The second panel discussed whether, and if so how, the Commission should modify its Cash Management Rule [13] in light of PUHCA 2005, and whether the Commission should codify specific safeguards that must be adopted for cash management programs and money pool agreements and transactions. The third panel discussed whether modifications to the specific exemptions, waivers and blanket authorizations set forth in the Order No. 667 and Order No. 669 rulemaking proceedings are warranted. Post-technical conference comments were accepted.

8. On March 8, 2007, the Commission held a second technical conference (March 8 Technical Conference) to discuss whether the Commission's section 203 policy should be revised and, in particular, whether the Commission's Appendix A merger analysis is sufficient to identify market power concerns in today's electric industry market environment. The first panel discussed whether the Appendix A analysis is appropriate to analyze a merger's effect on competition, given the changes that have occurred in the industry (*e.g.,* the development of Regional Transmission Organizations (RTOs)) and statutory changes (*e.g.,* as a result of the repeal of PUHCA 1935 and new authorities given to the Commission in EPAct 2005). The second panel assessed the factors the Commission uses in reviewing mergers and the coordination between the Commission and other agencies (including state commissions) with merger review responsibility.

II. Discussion

9. Based on the Commission's experiences thus far in implementing amended section 203, the input received through the Order No. 669 rulemaking proceeding, and the comments received in response to the December 7 and March 8 Technical Conferences, the Commission finds that additional clarification and guidance regarding our section 203 policy are warranted. The Commission will provide certain clarifications and guidance concerning: (1) The information that must be filed as part of section 203 applications for transactions that do not raise cross-subsidization concerns; (2) the types of applicant commitments and ring-fencing measures that, if offered, might address cross-subsidization concerns; [14] (3) the scope of blanket authorizations under sections 203(a)(1) and 203(a)(2); (4) what constitutes a disposition of control of jurisdictional facilities for purposes of section 203; and (5) the Commission's Appendix A analysis.

10. We note that amended section 203 and PUHCA 2005 did not become effective until February 2006. The Commission thus has had only 18 months' experience under the new laws. Therefore, we will continue to monitor the issues that arise under section 203, including cross-subsidization issues, and re-evaluate our regulatory approach as appropriate. The Commission's goals are to provide sufficient flexibility to adopt customer protections as needed, work in a complementary fashion with the states in protecting customers, appropriately address the need for regulatory certainty with respect to jurisdictional transactions, and address ways to allow beneficial utility industry investment that does not harm captive customers.[15]

A. The Commission's Cross-Subsidization Concerns and Exhibit M Requirements

11. At the December 7 Technical Conference, a number of commenters asserted that a vast majority of section 203 transactions pose no threat of cross-subsidization but nonetheless, the Commission's regulations require applicants to provide ''an explanation, with appropriate evidentiary support for such explanation * * * of how applicants are providing assurance * * * that the proposed transaction will not result in, at the time of the transaction or in the future, cross-subsidization of a non-utility associate company or pledge or encumbrance of utility assets for the benefit of an associate company * * *.'' [16]

[13] *Regulation of Cash Management Practices,* Order No. 634, 68 FR 40500 (July 8, 2003), FERC Stats. & Regs. ¶ 31,145, *revised,* Order No. 634–A, 68 FR 61993 (Oct. 31, 2003), FERC Stats. & Regs. ¶ 31,152 (2003) (Cash Management Rule).

[14] When ''cross-subsidization'' occurs, some of the costs of dealings between affiliated regulated and unregulated companies are borne by the regulated utility affiliate. The costs might be passed on to captive customers through the rates of the regulated affiliate. ''Ring-fencing'' employs various techniques to separate and protect the financial assets and ratings of the regulated utility from the business risks of other members of the holding company family, including bankruptcy of the parent or its affiliates. These techniques could preclude some types of transactions that involve cross-subsidization.

[15] As indicated below, the Commission does not propose actions on all of the issues raised by commenters. For example, the Commission is not proposing changes to its regulations that would require: (1) Codification of specific requirements for cash management programs and money pool agreements; (2) codification of additional information reporting requirements (through section 203 applications or through routine reporting requirements); or (3) additional, generic actions pursuant to the Commission's NGA authority. Based on the types of filings made since Order Nos. 667 and 669 became effective and the comments raised at the technical conferences, we do not believe further actions on these particular issues are warranted at this time. Moreover, we note that certain commenters recommended that the Commission provide a list on its website of all jurisdictional public utilities (including qualifying facilities and exempt wholesale generators), foreign utility companies, transmitting utilities, electric utilities, electric utility companies, and holding companies (as those terms are defined under EPAct 2005 and PUHCA 2005) for use by market participants in their regulatory compliance monitoring efforts and as they consider whether to acquire or hold the securities of companies, the acquisition or holding of which might or might not be subject to FPA section 203 or PUHCA 2005. While the Commission declines to rule on this issue in the context of a policy statement, it will explore the feasibility of making some of this information publicly available on its website.

[16] The explanation, to be provided as Exhibit M to a section 203 application, includes:

Continued

12. Several commenters argued that it is not clear how to provide the explanation required under Exhibit M for transactions in which cross-subsidization is not possible, is precluded by existing safeguards or is reduced to a very low possibility. Thus, they urged the Commission to establish criteria to identify ''safe harbors'' or classes of transactions that clearly do not raise cross-subsidization concerns. They contended that such an approach will enhance regulatory certainty by letting parties know up front that with these types of transactions, there is no risk of additional restrictions being imposed by the Commission.

13. The Commission's focus generally has been on preventing a transfer of benefits from a public utility's captive customers to shareholders of the public utility's holding company due to an intra-system transaction that involves electric power or energy, generation facilities, or non-power goods and services.[17] Concerns arise in a number of circumstances, including where a market-regulated affiliate (*e.g.,* a power seller with market-based rates) or a non-utility affiliate provides power or goods and services to a franchised public utility with captive customers, as well as the circumstance in which the franchised public utility with captive customers provides power or non-power goods and services to the market-regulated or non-utility affiliate. For instance, a franchised public utility with captive customers may purchase power from its marketing affiliate at a price above market or sell power to its marketing affiliate at below-market prices, thus transferring benefits from customers to shareholders of the holding company. Further, customers may be harmed if the franchised public utility purchases non-power goods and services from an affiliate at above-market prices or sells non-power goods and services to an affiliate at less than market value and seeks to recover the overcharges or the undercharges through rates for service to captive customers.[18] Concerns may also arise with respect to intra-corporate financing transactions that may encumber franchised public utility assets in favor of a market-regulated or non-utility affiliate. The Commission's regulatory concern with this particular form of cross-subsidization is with the potential adverse impact of the internal finance transaction on the rates of a franchised public utility with captive customers.

1. ''Safe Harbors'' for Meeting Exhibit M Requirements for Certain Transactions

14. Since the February 2006 effective date of the FPA section 203 amendments, the Commission has gained sufficient experience in implementing the cross-subsidization provision of FPA section 203(a)(4) to provide policy guidance on the cross-subsidization demonstration required by Exhibit M. As described above, there are many instances where cross-subsidization can occur, but our focus is on the specific requirements under section 203(a)(4) and the Order No. 669 rulemaking proceeding—inappropriate cross-subsidization of non-utility or market-regulated affiliates or the pledge or encumbrance of utility assets for the benefit of an associate company. The concern arises in a corporate structure that has at least one franchised public utility with captive customers and one or more non-utility affiliates or market-regulated utility affiliates (*i.e.,* utilities regulated on a market rather than a cost basis). These types of relationships provide opportunities for cross-subsidization in routine transactions between affiliates in addition to more significant transactions such as transfers of utility assets, encumbrance of utility assets, new affiliate contracts, and issuance of securities by affiliates (that usually receive more public scrutiny or regulatory attention).

15. Where these affiliate relationships do not exist, that is, where a transaction involves only market-regulated and/or non-utility affiliated entities or is a bona fide, arm's-length, bargained-for exchange, then the transaction is not likely to result in inappropriate cross-subsidization and the detailed explanation and evidentiary support required by Exhibit M may not be warranted.

16. Accordingly, for purposes of compliance with Exhibit M, the Commission will recognize three classes of transactions that are unlikely to raise the cross-subsidization concerns described in the Order No. 669 rulemaking proceeding. These, in effect, are ''safe harbors'' for meeting the section 203 cross-subsidization demonstration, absent concerns identified by the Commission or evidence from interveners that there is a cross-subsidy problem based on the particular circumstances presented.

17. The first class of transactions includes those transactions where the applicant shows that a franchised public utility with captive customers is not involved. If no captive customers are involved, then there is no potential for harm to customers. Therefore, compliance with Exhibit M could be a showing that no franchised public utility with captive customers [19] is involved in the transaction.

18. The second class of transactions includes those transactions that are subject to review by a state commission. The Commission, in the context of specific mergers or other corporate transactions, intends to defer to state commissions where the state adopts or has in place ring-fencing measures to protect customers against inappropriate cross-subsidization or the encumbrance of utility assets for the benefit of the ''unregulated'' affiliates. Therefore, compliance with Exhibit M could be satisfied with a showing that the proposed transaction complies with specific state regulatory protections against inappropriate cross-subsidization by captive customers. If a state does not have the authority to impose cross-subsidization protections, however, the transaction would not qualify for this safe harbor.

19. The third class of transactions are those involving only non-affiliates. Where a franchised public utility transacts only with nonaffiliated entities, the potential for inappropriate cross-subsidization of a non-utility associate company or the pledge or encumbrance of utility assets for the benefit of an associate company

''Disclosure of existing pledges and/or encumbrances of utility assets; and a detailed showing that the transaction will not result in: any transfer of facilities between a traditional public utility associate company that has captive customers or that owns or provides transmission service over jurisdictional transmission facilities, and an associate company; any new issuance of securities by a traditional public utility associate company that has captive customers or that owns or provides transmission service over jurisdictional transmission facilities, for the benefit of an associate company; any new pledge or encumbrance of assets of a traditional public utility associate company that has captive customers or that owns or provides transmission service over jurisdictional transmission facilities, for the benefit of an associate company; or any new affiliate contract between a non-utility associate company and a traditional public utility associate company that has captive customers or that owns or provides transmission service over jurisdictional transmission facilities, other than non-power goods and services agreements subject to review under sections 205 and 206 of the Federal Power Act; or if no such assurance can be provided, an explanation of how such cross-subsidization, pledge, or encumbrance will be consistent with the public interest.'' 18 CFR 33.2(j)(1)–(2).

[17] Order No. 669, FERC Stats. & Regs. ¶ 31,200 at P 147.

[18] *Transactions Subject to FPA Section 203,* 70 FR 58636 (Oct. 7, 2005) FERC Stats. & Regs. ¶ 32,589 at P 47 (2005. In the concurrent Affiliate Transactions NOPR, *supra* note 7, the Commission is proposing to extend the affiliate abuse restrictions to apply to all franchised public utilities with captive customers and their market-regulated power sales affiliates and non-utility affiliates.

[19] The Commission has defined ''captive customers,'' for purposes of FPA section 203, to mean ''any wholesale or retaile electric energy customers served under cost-based regulation.'' 18 CFR 33.1(b)(5).

generally is not present. Therefore, compliance with Exhibit M could be satisfied with a showing that a public utility transacts only with nonaffiliated entities. This category includes a transfer of assets between a public utility and non-affiliates, but does not include mergers with, or acquisitions of, public utilities.

20. After review of a section 203 application relying on any of these ''safe harbors,'' if the Commission finds that the applicant has failed to make a sufficient showing that it meets the criteria described above, then the application will be deemed to be deficient and a new Exhibit M will be required.

2. Other Means of Addressing Cross-Subsidization Concerns

21. Intra-corporate financing transactions may raise cross-subsidization concerns if the assets of a franchised public utility with captive customers are used to finance its market-regulated utility affiliates or non-utility affiliates or their activities. In the December 7 Technical Conference, several commenters noted that their states had implemented ring-fencing measures to mitigate potential risks of cross-subsidization but that many states had not. These commenters suggested that the Commission implement safeguards to mitigate risks in the absence of state regulation (although not necessarily on a generic basis, relying on the states where the state has already taken such measures). Most commenters urged the Commission to continue to review whether potential mergers required additional protections on a case-by-case basis. Representatives of the state commissions, including the Oregon Public Utility Commission, Wisconsin Public Service Commission and Missouri Public Service Commission, recommended that the Commission only act where there is a demonstrable gap in state authority. None supported adoption of federal, mandatory ring-fencing conditions. Some commenters did not oppose the establishment of guidelines on the kinds of protections that might be appropriate in different cases.[20]

22. American Public Power Association and the National Rural Electric Cooperative Association argued that the Commission adopt regulations with minimum cross-subsidization safeguards that would apply in all cases, and also provide an exhaustive menu of additional cross-subsidization safeguards, including ring-fencing measures, that applicants might propose or that the Commission might impose in appropriate cases. They proposed that the Commission codify its code of conduct requirements in the regulations and that these restrictions be made applicable to all traditional public utilities and their unregulated affiliates.

23. The Commission agrees that it is appropriate to codify in our regulations code of conduct affiliate restrictions to prevent cross-subsidization involving power and non-power goods and services transactions and to make those prophylactic restrictions applicable to all traditional (franchised) public utilities (not just public utilities seeking section 203 approval) and their transactions with power sellers as well as non-utility affiliates. Accordingly, contemporaneous with this Policy Statement, we are instituting a Notice of Proposed Rulemaking to do this. However, with respect to additional restrictions that may be appropriate for section 203 applicants, such as ring-fencing restrictions, the Commission does not believe it is necessary or appropriate to mandate generic one-size-fits-all protections for all section 203 applicants. Rather, the Commission will examine the facts and circumstances of each transaction and determine on a case-by-case basis whether additional protections against inappropriate cross-subsidization or encumbrances of utility assets are necessary. As noted above, part of our approach will involve review of whether state commissions have authority to impose cross-subsidy protections or have in place such protections. The Commission, as a general matter, intends to defer to state-adopted protections unless they can be shown to be inadequate to protect wholesale customers. This deference is appropriate because retail customers typically represent the vast majority of load served by a franchised public utility, and ring-fencing measures typically affect the entire corporation, thereby protecting both retail and wholesale customers. If it can be shown, however, that these measures are inadequate to protect wholesale customers in a given case, the Commission may adopt supplemental protections as appropriate. Finally, we emphasize that, consistent with section 203 and the Commission's regulations, all section 203 applicants must demonstrate that a proposed transaction will not result in inappropriate cross-subsidization of non-utility associate companies or the inappropriate pledge or encumbrance of utility assets for the benefit of an associate company, either through meeting one of the safe harbor demonstrations, proposing its own ring-fencing or other protections to prevent cross-subsidization, or demonstrating that there are no potential cross-subsidy issues associated with the proposed transaction.

24. With respect to guidance to applicants that do not make the ''safe harbor'' demonstration or do not demonstrate that cross-subsidy issues are not present, one way to make the demonstration required by Exhibit M would be to propose ring-fencing measures. For example, a ring-fencing structure related to internal corporate financings, *i.e.,* money pool or cash management transactions, could include some or all of the following elements depending on the circumstances: (1) The holding company participates in the money pool as a lender only and it does not borrow from the subsidiaries with captive customers; (2) where the holding company system includes more than one public utility, the money pool for subsidiaries with captive customers is separate from the money pool for all other subsidiaries; (3) all money pool transactions are short-term (one year or less), and payable on demand to the public utility; (4) the interest rate formula is set according to a known index and recognizes that internal and external funds may be loaned into the money pool; (5) loan transactions are made pro rata from those offering funds on the date of the transactions; (6) the formula for distributing interest income realized from the money pool to money pool members is publicly disclosed; and (7) the money pool administrator is required to maintain records of daily money pool transactions for examination by the Commission by transaction date, lender, borrower, amount, and interest rate(s).[21] We clarify that the forms of ring-fencing protections listed herein are simply examples of protections that the Commission would consider in evaluating proposed ring-fencing measures. Appropriate ring-fencing measures will depend on the facts presented and the specifics of an applicant's corporate structure and must be evaluated on a case-by-case basis. Further, as noted earlier, to the extent a state commission imposes specific ring-fencing measures, the Commission will defer to those measures absent evidence

[20] *See, e.g.,* Comments of Clifford M. Naeve, December 7 Technical Conference, Tr. 91–92; Comments of Joseph G. Sauvage, December 7 Technical Conference, Tr. 56–58.

[21] These ring-fencing measures are among those requirements typically approved by the Securities and Exchange Commission (SEC) and/or adopted by state commissions.

that additional measures are needed to protect wholesale customers.

25. The Commission also notes that if it approves a transaction under section 203 (with or without ring-fencing measures), the Commission retains authority under section 203(b) to later impose additional cross-subsidy protections or modify any previously approved measures. Further, irrespective of any link to the section 203 transaction, the Commission retains ongoing authority under section 206 of the FPA [22] to modify rates, contracts and practices that may result in inappropriate cross-subsidization or encumbrances of utility assets (and, if appropriate, to require new practices).

3. Future Case-Specific Informational Filings

26. Given that the Commission often issues its order in a section 203 proceeding before the state proceedings are completed, the Commission may grant authorization under section 203 before the relevant state commission issues an order specifying any state-required cross-subsidy or ring fencing protections. In such circumstances, as appropriate, the Commission in the context of individual section 203 authorizations will require applicants to file with the Commission a copy of any subsequent state orders. Such copy would be filed in the Commission's section 203 proceeding docket as an informational filing, and the applicant would also provide copies to the intervenors in the Commission's section 203 proceedings.

B. Blanket Authorizations Under Sections 203(a)(1) and 203(a)(2) and Clarifications Regarding Jurisdictional Transactions

27. Through the Order No. 669 rulemaking proceeding, the Commission granted certain blanket authorizations on a generic basis under section 203.[23] Participants at the December 7 Technical Conference addressed whether additional blanket authorizations were warranted. Specifically, commenters discussed under what circumstances the Commission should grant a blanket authorization under section 203(a)(1) (which applies to public utilities' dispositions of jurisdictional facilities) to parallel the Order No. 669 blanket authorizations under section 203(a)(2) (which, among other things, applies to holding companies' acquisitions of securities of public utilities with jurisdictional facilities). The section 203 blanket authorizations under Order No. 669 allow a holding company to acquire the voting securities of a transmitting utility, an electric utility company, or a holding company in a holding company system that includes a transmitting utility or an electric utility company, if, after the acquisition, the holding company will own less than 10 percent of the outstanding voting securities. What most commenters seek is a parallel blanket authorization under section 203(a)(1) for the public utilities in such transactions to ''dispose'' of their facilities to the holding company, *i.e.,* a blanket authorization for transactions that (1) involve or permit transfers (dispositions) of up to 10 percent of a public utility's voting stock, or (2) involve a transfer of up to 10 percent of the voting stock of a holding company that directly or indirectly owns or controls a public utility. Alternatively, they seek clarification that certain transactions are not jurisdictional.

28. Several commenters supported modification of the rules to grant such a parallel blanket authorization under 203(a)(1). In addition, Mirant Corporation (Mirant) argued that section 203(a)(1) should not apply at all to stock transactions in the secondary market involving the corporate parent. Mirant maintained that if the Commission continues to apply section 203(a)(1) to equity transfers of upstream ownership interests in public utilities that result in either a direct or indirect change in control over the underlying public utility, there would be a substantial and unnecessary overlap between sections 203(a)(1) and 203(a)(2). The Goldman Sachs Group, Inc. (Goldman) added that financial investors need certainty on whether particular transactions in the secondary market would require prior Commission approval under section 203(a)(1). Goldman also argued for a blanket authorization under section 203(a)(2) for the acquisition of voting securities by firms acting in a fiduciary capacity.

29. Edison Electric Institute (EEI) argued for a blanket authorization for internal corporate reorganizations under both sections 203(a)(1) and 203(a)(2) for transfer of assets from one non-traditional utility subsidiary, such as an exempt wholesale generator, to another non-traditional utility subsidiary.

30. The Financial Institutions Energy Group (FIEG) [24] requested that the Commission clarify that transactions that do not affect control do not, in fact, require approval under section 203(a)(1). Alternatively, FIEG argued that there are several types of transactions under which no change of control is involved and, therefore, the Commission should provide blanket authorizations under both section 203(a)(1) and section 203(a)(2). FIEG asserted that such transactions include: (1) Acquisitions of voting securities that would give the acquiring entity less than 10 percent ownership of outstanding voting securities; (2) acquisitions of up to 20 percent of the voting interests in a public utility where the acquirer is eligible to file with the SEC a Schedule 13G demonstrating no intent to exercise control over the entity whose securities are being acquired; (3) acquisitions involving securities held for lending, hedging, underwriting and/or fiduciary purposes. FIEG also argued that a blanket authorization should be granted for transactions in which a public utility or a holding company is acquiring or assigning a jurisdictional contract where the acquirer does not have captive customers and the contract does not convey control over the operation of a generation or transmission facility.

31. In support of its requests for clarification and expanded blanket authorizations, FIEG states that shares and other interests in public utilities are bought, sold and traded on a regular basis and that an active market for a public utility's shares is important to its ability to raise capital. FIEG explains that if a passive or non-controlling investor must seek prior Commission approval for transactions, the trading process is slowed, resulting in a less efficient market for the company's shares. According to FIEG, such inefficiencies chill participation in the industry and reduce needed market liquidity.

32. Several commenters also urged the Commission to provide greater clarity on what constitutes a passive investment for which no Commission authorization is required under section 203(a)(1).

33. The Commission agrees that greater industry investment and market liquidity are important goals. However, blanket authorizations under section 203 cannot be granted lightly, particularly generic authorizations. Because it is an *ex ante* determination as to the appropriateness of a category

[22] 16 U.S.C. 824e.

[23] 18 CFR 33.1(c)

[24] Members of FIEG include: Bank of America, N.A, Barclays Bank PLC, Bear Energy LP, Citigroup Energy Inc., Credit Suisse Energy LLC (a subsidiary of Credit Suisse), Deutche Bank AG, J. Aron & Company (a subsidiary of The Goldman Sachs Group), JPMorgan Chase & Co., Lehman Brothers Commodity Services Inc. (a subsidiary of Lehman Brothers Holding Inc.), Merrill Lynch Commodities, Inc., Morgan Stanley Capital Group Inc., Société Générale, and UBS Energy LLC (a subsidiary of UBS AG).

of transactions under section 203 and a counterparty is not yet identified, a blanket authorization can be granted only when the Commission can be assured that the statutory standards will be met, including ensuring that the interests of captive customers are safeguarded and that public utility assets are protected under all circumstances. It is under this paradigm that we provide the following guidance with respect to the section 203 blanket authorizations.

34. First, we will grant in part and deny in part requests for blanket authorizations under section 203(a)(1) to parallel those previously granted under section 203(a)(2). The Commission recognizes that, in some circumstances, the lack of a blanket authorization under section 203(a)(1) can lessen the practical effectiveness of the blanket authorizations previously granted under section 203(a)(2). Accordingly, in a Notice of Proposed Rulemaking issued contemporaneous with this Policy Statement, the Commission is proposing a limited blanket authorization under section 203(a)(1) under which a public utility would be ''pre-authorized'' to dispose of less than 10 percent of its securities to a public utility holding company but only if, after the disposition, the holding company and any associate or affiliated company in aggregate will own less than 10 percent of that public utility.[25] The Commission believes that this narrow blanket authorization will provide appropriate relief to investors and at the same time ensure that utility assets and captive customers are protected.

35. The Commission will continue to consider broader requests for blanket authorizations under section 203(a)(1) on a *case-specific* basis,[26] taking into account all other authorizations that have been granted and whether those authorizations, in conjunction with a blanket authorization under section 203(a)(1), would raise concerns. While the Commission, as discussed above, has determined that additional generic blanket authorizations for public utilities' dispositions of jurisdictional assets are not warranted at this time (other than the blanket authorizations discussed in the accompanying NOPR), we expect that in many circumstances individual blanket authorizations can be granted. Such an individual, situation-specific, *ex ante* blanket authorization will provide some of the certainty that is sought by the industry and investors. At the same time, this approach will allow the Commission to assess specific circumstances, to place time limits on blanket authorizations if appropriate (subject to possible renewal), to monitor industry activity, and to adapt the use of blanket authorizations over time as we gain further experience with financial institution investments in particular. Further, we do not rule out the possibility that groups of similarly situated holding companies, such as financial institutions, can make joint filings seeking common blanket authorizations under section 203(a)(1) or section 203(a)(2); however, they would need to clearly demonstrate on the record that there would be no adverse impact on captive customers or the public interest if the authorizations were granted.

36. In response to requests that the Commission clarify that secondary market transactions involving public utilities do not require approval under section 203(a)(1)(A) (which provides that a public utility may not sell, lease ''or otherwise dispose'' of the whole of its jurisdictional facilities or any part hereof without prior Commission approval), we so clarify. Secondary market transactions, for purposes of this discussion, are purchases or sales of the securities of a public utility or its upstream holding company by a third-party investor. Thus, such transactions do not include the securities' initial issuance or reacquisition by the issuer. Thousands of shares of the stock of a public utility or public utility holding company may be traded on a daily basis by non-public utility third parties, particularly if the stock is widely held and publicly traded. As noted by Mirant, EEI and members of FIEG in their comments, neither a public utility holding company nor a public utility subsidiary of the holding company are themselves parties to these transactions and they cannot know in advance what trading will occur or whether direct or indirect ''control'' over the public utility is being acquired. It would be virtually impossible in such circumstances for the public utility or holding company to know what is occurring before the fact and we do not interpret section 203(a)(1)(A) to be triggered for these secondary trades. Accordingly, neither public utilities nor public utility holding companies have an obligation to seek approval of a ''disposition'' of public utility jurisdictional facilities for such trades.[27]

37. In addition, we clarify that transactions that do not transfer control of a public utility do not fall within the ''or otherwise dispose'' language of section 203(a)(1)(A) and thus do not require approval under section 203(a)(1)(A) (assuming there is no sale or lease of the facilities). As indicated in our discussion of what constitutes a disposition of control for purposes of the Commission's section 203 analysis,[28] while the Commission cannot make an *ex ante* determination regarding what is control for purposes of the Commission's section 203 analysis absent facts of a specific case, the Commission is setting forth herein certain guidelines regarding what has been deemed to be (or not to be) control. This clarification addresses many of the concerns raised by commenters regarding acquisitions involving securities held for lending, hedging, underwriting and/or fiduciary purposes. If such transactions do not result in a transfer of control and there is no sale or lease of the facilities taking place, then section 203(a)(1)(A) is not triggered. This should assist applicants in determining the need for prior authorization under section 203.

38. With respect to the request for a generic blanket authorization for internal corporate reorganizations under both sections 203(a)(1) and 203(a)(2) for the transfer of assets from one non-traditional utility subsidiary [29] to another non-traditional utility subsidiary, the Commission cannot be certain of the impact of such transactions on utility affiliates on a generic basis and, therefore, will not grant a blanket authorization at this time. The Commission will consider case-specific blanket authorizations (with appropriate reporting requirements) on a case-by-case basis.

39. The Commission also denies the request for a generic blanket authorization under section 203(a)(2) for non-bank fiduciaries subject to the jurisdiction of the SEC. The Commission finds that we need further experience in this area before granting a blanket authorization on a generic basis. However, the Commission is willing to consider such requests on a holding company-specific basis or from similarly situated holding companies, such as similarly situated financial institutions. Any such applications would need to demonstrate in sufficient

[25] Blanket Authorization NOPR, *supra* note 6.

[26] Order No. 669–A, FERC Stats. & Regs. ¶ 31,214 at P 103; Order No. 669–B, FERC Stats. & Regs. ¶ 31,225 at P 43.

[27] If the acquirer of securities in the secondary market is a public utility holding company, however, it may have an obligation to file for approval under section 203(a)(2). If the acquirer is another public utility, it may also have to file under section 203(a)(1)(C) (no public utility may purchase securities of another public utility if over $10 million in value).

[28] *See infra* section II.C.

[29] For example, power marketers, exempt wholesale generators, or qualifying facilities.

detail that applicants would not be able to control public utilities and that there would be no adverse impact on captive customers or the public interest if the authorizations were granted. As discussed above with respect to section 203(a)(1) authorizations, this type of approach would allow the Commission to assess specific circumstances, to place time limits on blanket authorizations if appropriate (subject to possible renewal), to monitor industry activity, and to adapt the use of blanket authorizations over time as we gain further experience.

40. Certain participants to the technical conferences argue that a blanket authorization under section 203(a)(1) should be granted for transactions in which a public utility or a holding company is acquiring or disposing of a jurisdictional contract where the acquirer does not have captive customers and the contract does not convey control over the operation of a generation or transmission facility. These commenters argue that because acquisition of these contracts cannot create competitive or rate concerns, the Commission should grant blanket authorization under section 203(a)(1) for such transactions. Because the specific request for blanket authorization may present concerns where the transferor has captive customers, we seek comment in the Blanket Authorization NOPR on whether a generic blanket authorization under section 203(a)(1) is warranted for the acquisition or disposition of a jurisdictional contract where neither the acquirer nor transferor has captive customers and the contract does not convey control over the operation of a generation or transmission facility.

41. We also decline to grant a generic blanket authorization under sections 203(a)(1) and 203(a)(2) for acquisitions of up to 20 percent of the voting interests in a public utility where the acquirer is eligible to file with the SEC a Schedule 13G, which demonstrates no intent to exercise control over the entity whose securities are being acquired. While the Commission may consider eligibility to file a Schedule 13G with the SEC as part of an indication that an entity will not be able to assert control over a public utility, the Commission will not accept Schedule 13G eligibility as a definitive statement regarding control. The Commission will consider Schedule 13G eligibility as one factor in the analysis of whether an entity can assert control over a public utility.[30]

[30] *See, e.g., Capital Research and Management Company,* 116 FERC ¶ 61,267 (2006).

C. Disposition of ''Control'' of Jurisdictional Facilities

42. Several commenters have asked the Commission to provide guidance on what constitutes a disposition of ''control'' of jurisdictional facilities under section 203. Most recently, this request is being pressed by the investment community, which seeks further clarification regarding the scope of the Commission's regulatory authority, and greater regulatory certainty as to when section 203 review is required.

43. We will provide guidance here, but emphasize that the determination of whether there is a disposition of control must be based on all circumstances. In other words, the decision must be made on a fact-specific basis. As discussed further below, while our case law under section 201 provides guidance on the factors that may result in control, no single factor or factors necessarily results in control. The electric industry remains a dynamic, developing industry, and no bright-line standard will encompass all relevant factors and possibilities that may occur now or in the future.[31]

44. We note that much of the Commission's precedent in this area was developed based on concerns that there could be a jurisdictional void if the Commission did not interpret broadly what constitutes a disposition of ''control'' of public utility facilities under FPA section 203. The Commission was particularly concerned about the creation of holding companies and holding company acquisitions that could result in an indirect change of control of the jurisdictional facilities of public utilities, without Commission review. In EPAct 2005, however, Congress has filled any jurisdictional void involving public utility holding companies by amending section 203 to specifically give the Commission authority over certain holding company acquisitions and mergers involving FPA public utilities. Thus, the Commission's pre-EPAct 2005 precedent should be read with this context in mind.

1. Precedent Discussing Dispositions of Control

45. Section 203 requires prior Commission approval if a public utility seeks to sell, lease, or otherwise dispose of jurisdictional facilities. As previously noted, the Commission has interpreted the ''or otherwise dispose'' language of section 203(a)(1) to include transfers of ''control'' of jurisdictional facilities. Additionally, prior Commission approval is required for any public utility that seeks to directly or indirectly merge or consolidate the whole of its jurisdictional facilities, or any part thereof, with the facilities of another person, ''by any means whatsoever.'' [32] As interpreted by the Commission, the requirement to obtain the Commission's approval under the ''merge or consolidate'' clause depends on whether the public utility's facilities are subject to the jurisdiction of the Commission and whether the transaction directly or indirectly would result in a change of ''control'' of the facilities.[33]

46. In *Enova Corporation*, the Commission explained that the purpose of section 203 is to provide a mechanism for maintaining oversight of the facilities of public utilities and to prevent transfers of control over those facilities that would harm consumers or that would inhibit the Commission's ability to secure the maintenance of adequate service and the coordination in the public interest of jurisdictional facilities.[34] The Commission determined that it cannot definitively identify every combination of entities or disposition of assets that may trigger jurisdiction under section 203, since it cannot anticipate every type of restructuring that might occur. The Commission stressed that its concern was with changes in control, including direct or indirect mergers that affect jurisdictional facilities. It said that it must be flexible in responding to industry restructuring if it is to discharge its statutory responsibility ''to secure the maintenance of adequate service and the coordination in the public interest of facilities subject to the jurisdiction of the Commission.'' [35]

47. Noting in *Enova* that the FPA did not provide definitions for the terms ''dispose'' or ''control,'' the Commission stated that those terms should not be read narrowly because to do so would result in a jurisdictional void in which certain types of corporate transactions could escape Commission oversight. While section 203 applies to changes or transfers in the proprietary interests of

[31] *Market-Based Rates for Wholesale Sales of Electric Energy, Capacity and Ancillary Services by Public Utilities*, Order No. 697, 72 FR 39903 (July 20, 2007), FERC Stats. & Regs. ¶ 31,252, at P 174 (2007) (Market-Based Rate Final Rule).

[32] While the section 203(a)(1) requirements for obtaining Commission authorization do not use the word ''control'' in the statutory text, section 203(a)(4) provides that the Commission must approve a proposed ''disposition, consolidation, acquisition, or *change in control*'' (emphasis added) if the statutory criteria are met.

[33] *PDI Stoneman, Inc.*, 104 FERC ¶ 61,270, at P 13 (2003) (*PDI Stoneman*).

[34] *Enova Corporation*, 79 FERC ¶ 61,107, at 61,489 (1997) (*Enova*) (*citing* pre-EPAct 2005 section 203(b)).

[35] *Id.* at 61,496.

a public utility,[36] not all transactions under section 203 involve a change in control of a public utility. If no change in control results from the transaction, it is not likely to adversely affect competition, rates or regulation, or result in cross-subsidization.

48. Our guidance concerning what constitutes a disposition of control of jurisdictional facilities for purposes of section 203 requires a discussion of what constitutes control of a public utility since a public utility is a person that owns or operates jurisdictional facilities. In *Enova*, the Commission cited the definition of control that has been in its accounting regulations since 1937. Under that definition, control means:

> the possession, directly or indirectly, of the power to direct or cause the direction of management and policies of a company, whether such power is exercised through one or more intermediary companies, or alone, or in conjunction with, or pursuant to an agreement, and whether such power is established through a majority or minority ownership or voting of securities, common directors, officers, or stockholders, voting trusts, holding trusts, associated companies, contract or any other direct or indirect means.[37]

49. The Commission has also discussed certain elements of control in cases concerning whether an entity is a public utility under section 201.[38] In those cases, the Commission linked ''decision-making'' and ''dominion and control'' in determining whether an entity is a ''public utility.'' The Commission also noted that the reference to ''operates [jurisdictional] facilities'' in the definition of public utility in section 201(e) of the FPA refers ''to the person who has control and decision-making authority concerning the operation of facilities.'' [39]

50. In a case in which the Commission disclaimed jurisdiction under section 201(e) over financial institutions that took title to facilities as part of a leveraged lease transaction, the Commission based its decision that the lessor/owner was not a public utility under section 201 on the following factors (which it found in a previous but analogous situation): (1) The financial institutions that held legal title were not operating the facilities; (2) none of the parties taking title to the facilities were in the business of producing or selling electric power; and (3) all had a principal business other than that of a public utility.[40] As part of its finding that the lessor/owner did not operate the facility, the Commission interpreted the word ''operates'' as referring to the person who has control and decision-making authority concerning the operation of the facility, *i.e.*, *not* a person who merely performs specific services that are ordered and directed by another party.

51. We note that ''control'' has been found even where that control is not absolute or unfettered. In a case involving a complex holding company corporate structure, the Commission deemed an investment adviser subsidiary to be a public utility because of its participation in wholesale transactions. The Commission found that the investment adviser had control over the wholesale contracts to be executed under the power marketer's market-based rate schedule because the combination of the following three factors translated into control: (1) The sole discretion to enter into contracts; (2) the exclusive ownership of the intellectual property on which contracts will be based; and (3) the intention that the investment adviser will recommend the contracts into which the power marketer subsidiary would enter.[41]

52. The Commission cited its decisions in *Bechtel* and *Shaw* as providing guidance on whether a nominal manager of a generating company actually exercised sufficient control to be deemed the operator and, hence, a public utility.[42] Based in part on those cases, in *Beck*, the Commission found that a manager was a controlling entity where he: (1) Effectively governed the physical operation of the jurisdictional facility; and (2) effectively served as the decision-maker in the sales of wholesale power. While the application in that case described a series of companies, at least five contracts (all of which either directly affected or were negotiated by the manager), and a trustee in addition to the manager, the Commission concluded that the manager was the controlling entity because he had the substantive decision-making authority regarding the jurisdictional assets, the market-based rate tariff and a full requirements purchase agreement. The Commission made this finding even though some of the manager's actions were subject to the approval of the trustee in certain circumstances, *e.g.*, if the transaction exceeded $1 million in value.

53. More recently, in the Market-Based Rate Final Rule, in providing guidance on what contractual arrangements convey control over a public utility, we explained that we will consider the totality of circumstances and attach the presumption of control when an entity can affect the ability of capacity to reach the market. We further explained that our guiding principle is that an entity controls the facilities of another when it controls the decision-making over sales of electric energy, including discretion as to how and when power generated by these facilities will be sold.[43]

54. Investments in public utilities that do not convey control may in some cases be considered to be passive investments not subject to section 203(a)(1)(A) (unless there is a sale or lease of the facilities). The Commission has found an investment to be passive if, among other things, (1) the acquired interest does not give the acquiring entity authority to manage, direct or control the day-to-day wholesale power sales activities, or the transmission in interstate commerce activities, of the jurisdictional entity;[44] and (2) the acquired interest gives the acquiring entity only limited rights (*e.g.*, veto and/or consent rights necessary to protect its economic investment interests, where those rights will not affect the ability of the jurisdictional public utility to conduct jurisdictional activities);[45] and (3) the acquiring entity has a principal

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[36] *See Atlantic City Electric Company* v. *FERC*, 295 F.3d 1, 12 (D.C. Cir. 2002).

[37] *Enova*, 79 FERC at 61,492 (*citing* 18 CFR Part 101, Definitions 5.B). This definition is identical to that found in the current regulations. In addition, for purposes of its Standards of Conduct for Transmission Providers, the Commission states that ''control'' ''includes, but is not limited to, the possession, directly or indirectly and whether acting alone or in conjunction with others, of the authority to direct or cause the direction of the management or policies of a company.'' 18 CFR 358.3(c).

[38] Section 201(b)(1) describes the activities that are subject to the jurisdiction of the Commission: ''* * * the transmission of electric energy in interstate commerce and * * * the sale of electric energy at wholesale in interstate commerce * * *'' The section further describes the facilities that are jurisdictional: ''The Commission shall have jurisdiction over all facilities for such transmission or sale of electric energy, * * *'' with certain exceptions not relevant here. In section 201(e), the term ''public utility'' is defined as ''any person who owns or operates facilities subject to the jurisdiction of the Commission under this Part (other than facilities subject to such jurisdiction solely by reason of [certain specified FPA sections]).'' 16 U.S.C. 824, *amended by* EPAct 2005, Pub. L. 109–58, 1295.

[39] *Enova*, 79 FERC at 61,492 (citing *Bechtel Power Corp.*, 60 FERC ¶ 61,156 (1992) (*Bechtel Power*)).

[40] *Bechtel Power*, 60 FERC at 61,572 (*citing Pacific Power & Light Co.*, 3 FERC ¶ 61,119 (1978); *Public Service Company of New Mexico*, 29 FERC ¶ 61,387 (1984); *United Illuminating Company*, 29 FERC ¶ 61,270 (1984)).

[41] *D.E. Shaw Plasma Power, L.L.C.*, 102 FERC ¶ 61,265, at P 33 (2003) (*Shaw*).

[42] *R.W. Beck Plant Management, Ltd.*, 109 FERC ¶ 61,315 (2004) (*Beck*).

[43] Market-Based Rate Final Rule, FERC Stats. & Regs. ¶ 31,252 at P 176.

[44] *See Milford Power Company, LLC,* 118 FERC ¶ 61,093, at P 35 n.21 (2007).

[45] *See Shaw,* 102 FERC ¶ 61,265 at P 15.

business other than that of producing, selling, or transmitting electric power.[46]

55. We emphasize that the circumstances that convey control in section 203 analysis vary depending on a variety of factors, including the transaction structure, the nature of voting rights and/or contractual rights and obligations conveyed in the transaction. For example, in *PDI Stoneman,* the Commission considered the acquisition of facilities through three transactions, over approximately seven years, in which the applicant's resulting ownership shares at issue at the end of each of the three transactions went from one-third to two-thirds to 100 percent of the voting stock. The applicant claimed that control never vested until the third transaction because of a ''supermajority'' provision in the operating agreement that required approval by 80 percent of the voting stock for a range of decisions, including the sale of electricity from the plant. The Commission focused on the market-based rate schedule and concluded that the first transaction may have transferred control over that jurisdictional asset because, even with one-third of the voting stock, the applicant had the authority to influence all significant decisions, including the sale of power from the plant. Further, the Commission ruled that the material change in the proportion of interests after the second transaction resulted in a change of control.[47]

56. While the purpose of the above discussion is to provide guidance on what, based on past precedent, constitutes a change of control for purposes of section 203, the burden remains upon the entities involved in a proposed transaction to decide whether they need to obtain Commission authorization under section 203 to undertake a proposed transaction.

2. General Guideline Regarding What Is Not a Transfer of Control

57. Based on the industry's need for further guidance on what may or may not constitute a transfer of control of jurisdictional facilities under section 203, and for greater regulatory certainty in undertaking utility investments, the Commission's general policy in future cases will be to presume that a transfer of less than 10 percent of a public utility's holdings is not a transfer of control if: (1) After the transaction, the acquirer and its affiliates and associate companies, directly or indirectly, in aggregate will own less than 10 percent of such public utility; and (2) the facts and circumstances do not indicate that such companies would be able to directly or indirectly exercise a controlling influence over the management or policies of the public utility. The Commission will apply this policy on a case-by-case basis. Further, if holding companies or other acquirers believe that facts and circumstances prevent them from exercising control even if they own 10 percent or more of a public utility, they may seek to make such a demonstration to the Commission.

58. This 10 percent threshold is consistent with the definition of ''holding company'' under section 1262(8)(A) of PUHCA 2005 (at which point a company may be in control of a subsidiary public utility). It is also consistent with the blanket authorization granted under section 203(a)(2) in the Order No. 669 rulemaking proceeding, under which holding companies are pre-authorized to acquire up to 9.99 percent of voting securities of a public utility, as well as the proposed section 203(a)(1) blanket authorization in the contemporaneous Notice of Proposed Rulemaking.[48]

Further, the Commission has employed a rebuttable presumption in the context of its Standards of Conduct for Transmission Providers that ownership of 10 percent or more of voting interests creates a rebuttable presumption of control.[49]

D. The Commission's Appendix A Analysis

1. Appendix A Policy and Case History

59. The 1996 Merger Policy Statement uses an analytical screen (Appendix A analysis) to allow early identification of transactions that clearly do not raise competitive concerns.[50] As discussed below, the Commission does not believe modifications to its Appendix A analysis are warranted at this time. However, the Commission will provide certain clarifications in light of the concerns raised by commenters in the Order No. 669 rulemaking proceeding and the March 8 Technical Conference.

60. In horizontal mergers, if an applicant fails the Competitive Analysis Screen (one piece of the Appendix A analysis), the Commission's analysis focuses on the merger's effect on the merged firm's ability and incentive to withhold output in order to drive up the market price. The ability to withhold output depends on the amount of marginal capacity controlled by the merged firm, and the incentive to do so depends on the amount of infra-marginal capacity that could benefit from higher prices. For example, in a horizontal merger combining a company with significant baseload capacity with a company owning capacity on the margin under many season/load conditions, the theory of competitive harm would be that the combination of the ''ability'' assets with one company's existing ''incentive'' assets would increase the likelihood of the company exercising market power. Proper mitigation would address the harm to competition by reducing the merged firm's ''ability'' assets or its ''incentive'' assets through divestiture or some other method. In *Commonwealth Edison Company,* we discussed both the ability and the incentive of the merged firm to

[46] *See Metropolitan Life Insurance Company,* 113 FERC ¶ 61,300, at P 6 (2005).

[47] *PDI Stoneman,* 104 FERC ¶ 61,270 at P 15–17.

[48] Blanket Authorization NOPR, *supra* note 6. In *The Goldman Sachs Group, Inc.,* 114 FERC ¶ 61,118 (*Goldman*), *order on reh'g,* 115 FERC ¶ 61,303 (2006), the Commission held that, under section 203(a)(2), subsidiaries that are not themselves holding companies are not required to seek authorization from the Commission to purchase, acquire, or take ''covered'' securities. Covered securities relate to (1) acquisitions of securities worth more than $10 million, and (2) acquisitions of securities of a transmitting utility, an electric company, or a holding company in a holding company system that includes a transmitting utility, or an electric utility company. The Commission also held that subsidiaries' securities acquisitions are not attributable to the upstream holding company. Thus, the upstream holding company also is not required to seek section 203(a)(2) authorization for its subsidiaries' acquisitions. This does not mean that authorization may not be required under other provisions of section 203. For example, if a non-utility subsidiary acquires securities of a public utility, that public utility must obtain section 203(a)(1)(A) authorization if the transaction results in a transfer of control of facilities valued at more than $10 million. Further, if each of a number of non-utility subsidiaries acquires, for example, up to 9.99 percent of the same public utility (in order to avoid becoming a holding company and/or avoid a transfer of control to a single one of the subsidiaries), it is possible that the public utility disposition of securities to several companies under common control could, taken as a whole, result in a transfer of control. Finally, irrespective of the dollar amount of the transaction, an indirect merger or consolidation could occur and require approval under section 203(a)(1)(B). *Goldman,* 114 FERC ¶ 61,118 at P 13–15. Thus, while the Commission's policy as a general matter will be to presume that a transfer of control is not likely where ownership in a public utility is less than 10 percent, the burden is on the entities to file under section 203 if this threshold is met. The Commission will continue to review the facts and circumstances of transactions on a case-by-case basis.

[49] 18 CFR 358.3(c).

[50] As part of the screen analysis, applicants must define the relevant products sold by the merging entities, identify the customers and potential suppliers in the geographic markets that are likely to be affected by the proposed transaction, and measure the concentration in those markets. Using the Delivered Price Test to identify alternative competing suppliers, the concentration of potential suppliers included in the defined market is then measured by the Herfindahl-Hirschman Index (HHI) and used as a screen to determine which transactions clearly do not raise market power concerns. 1996 Merger Policy Statement, FERC Stats. & Regs. ¶ 31,044 at 30,119–20.

withhold output. We found that despite screen failures, the merger would not harm competition in the relevant wholesale markets and therefore did not require any mitigation:

> An examination of market supply conditions shows three reasons why a profitable withholding strategy by ComEd would be unlikely: (a) For most hours during the year, the supply curve is relatively flat, so withholding capacity would not significantly raise the market price; (b) for those hours during which it could successfully raise the market price, ComEd would have to forgo sales from its low-cost nuclear capacity; and (c) ComEd's only generation is nuclear which is difficult to ramp down or up so as to withhold output during the most profitable time periods.[51]

61. The Commission also examines the possibility of competitive harm in vertical mergers. In the first stage of the analysis, the Commission requires applicants to calculate the post-merger concentration in both the upstream and downstream markets to determine whether the upstream and downstream markets are highly concentrated, because highly concentrated upstream and downstream markets are necessary, but not sufficient, conditions for a vertical foreclosure strategy to be effective. If both of those necessary conditions are present, then the second stage of the analysis focuses on whether the merger creates or enhances the ability or incentive of the merged firm to exercise vertical market power through vertical foreclosure or raising rivals' costs.[52]

62. For example, in *AEP/CSW,* the Commission found—without relying solely on changes in HHI statistics—that the merger of two vertically integrated utilities with both transmission and generation assets would harm competition by enhancing the ability and incentive for the merged firm to use control of its transmission assets to frustrate competitors' access to relevant markets. The Commission therefore required that AEP turn over control of its transmission facilities to a Commission-approved Regional Transmission Operator and, in the interim, be subject to market monitoring by an independent entity and have an independent entity calculate and post the available transfer capacity on AEP's transmission system.[53]

63. We will continue to analyze mergers (both horizontal and vertical) and other section 203 applications by focusing on a transaction's effect on the company's ability and incentive to exercise market power, and thus harm competition. We expect applicants and intervenors to frame their arguments in this manner.

2. Issues Raised at the March 8 Technical Conference

a. The Role of HHIs in the Appendix A Analysis

64. Some commenters argued that the Commission was overly focused on the HHI statistic, which measures concentration, and asked that the Commission look at competitive effects of section 203 transactions that are not apparent from the assessment of concentration.[54]

65. In fact, as noted above, the Commission does look beyond the change in HHI in its analysis of the effect on competition in both horizontal and vertical mergers. The change in HHI serves as a screen to identify those transactions that could potentially harm competition. If the screen is failed, then, as discussed in paragraph 59 above, the Commission examines the factors that could affect competition in the relevant market. Specifically, in these circumstances the Commission typically considers a case-specific theory of competitive harm, which includes, but is not limited to, an analysis of the merged firm's ability and incentive to withhold output in order to drive up prices. Again, and as noted above, the Commission has discussed its consideration of such factors in cases such as *Commonwealth Edison Company.* Further, the Filing Requirements Rule requires applicants failing the screen to address market conditions beyond the change in HHI:

> The facts of each case (*e.g.*, market conditions, such as demand and supply elasticity, ease of entry and market rules, as well as technical conditions, such as the types of generation involved) determine whether the merger would harm competition. When there is a screen failure, applicants must provide evidence of relevant market conditions that indicate a lack of a competitive problem or they should propose mitigation.[55]

Moreover, even where an applicant passes the HHI screen, the Commission also considers intervenor theories of competitive harm.

b. Commission-Developed Computer Simulation Model

66. Some commenters stated that the Commission should develop and internally run its own computer simulation model, similar to what is done by the U.S. Department of Justice (DOJ) and the Federal Trade Commission (FTC). Dr. Frankena asserted that using a computer simulation model would be more reliable than our alleged practice of relying exclusively on applicants to perform the current Appendix A analysis. Mr. Hegedus advocated the use of regional models in concert with the process the Commission proposed in the market-based rate rulemaking proceeding and other proceedings involving market power issues. Dr. Moss suggested using an in-house model in a more limited way, as a consistency check on submissions rather than as a formal evaluative tool. Dr. Neifer stated that models are among the many types of evidence the DOJ considers in evaluating a merger. For example, the DOJ uses simple models that evaluate the costs and benefits of the merger as well as more complex ones that model a firm's decision to operate a generating unit in the markets at issue.

67. Other commenters argued that the costs for the Commission to develop and run its own computer simulation model would exceed any related benefits. Mr. Baliff argued that it would be difficult to use any model unless it were generally accepted, well known, and accessible to all so that applicants could know whether their proposed transactions passed muster. In addition, different models focus on different decisions—bidding decisions, supply decisions, pricing decisions—and some or all of these may be relevant. Mr. Hegedus argued that the Commission should develop regional models to analyze mergers based on the information available from its analyses of market-based rate authorizations and through its Office of Enforcement.

68. We will not develop and run our own computer simulation model in lieu of or in addition to the Delivered Price Test model that we already require applicants to perform as part of the Competitive Analysis Screen. While advocates of computer simulation models believe that such models would more accurately analyze the effect on competition, and some believe they will allow better coordination with other Commission programs involving market

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[51] *Commonwealth Edison Company,* 91 FERC ¶ 61,036, at 61,133 n.42 (2000).

[52] *See* Filing Requirements Rule, FERC Stats. & Regs. ¶ 31,111 at 31,910–11.

[53] *American Electric Power Company and Central and Southwest Corporation,* Opinion No. 442, 90 FERC ¶ 61,242, at 61,788–90 (*AEP/CSW*), *order on reh'g,* Opinion No. 442–A, 91 FERC ¶ 61,129 (2000), *appeal denied sub nom., Wabash Valley Power Association, Inc.* v. *FERC,* 268 F.3d 1105 (D.C. Cir. 2001).

[54] *See, e.g.,* Comments of Darren Bush, March 8 Technical Conference, Tr. 23; Comments of Mark Hegedus, March 8 Technical conference, Tr. 94–95; Comments of Diana Moss, March 8 Technical Conference, Tr. 101; Comments of Mark J. Niefer, March 8 Technical Conference, Tr. 108.

[55] Filing Requirements Rule, FERC Stats. & Regs. ¶ 31, 111 at 31, 897.

power issues, these advocates have not demonstrated how the Commission's use of an internal model would have altered any Commission determinations on previous section 203 applications. While the benefits of a Commission-internal computer simulation model have not been well-defined or quantified, we believe that the costs of such a modeling requirement in time and resources to applicants, intervenors, and Commission staff would be likely to exceed any benefits.

69. It also should be emphasized that those who advocate use of an internal modeling overlook important differences between Commission proceedings under section 203 and the processes used by the DOJ and the FTC to review mergers and acquisitions. The Commission's process of reviewing mergers and acquisitions under section 203 is a public one. An application is filed publicly, all interested parties have the ability to comment, and the Commission decides the case based on the public record. Our Appendix A analysis facilitates this public process by requiring the submission of a transparent market power study, using standardized assumptions and criteria, that is available for review and comment by all interested parties, including state commissions and customers, and, importantly, can be replicated by them in the limited time period available for public comment. Similarly, when mitigation measures are necessary in Commission proceedings, they are based on the public record and available for comment by all interested parties.

70. By contrast, the DOJ and the FTC use largely informal and non-public processes for reviewing transactions subject to their jurisdiction. Their meetings with applicants are not noticed to the public and are less formal in nature. This provides the DOJ and the FTC greater flexibility to use, among other things, internal modeling tools that may not be easily replicated or other methodological approaches that are stylized to an individual case. In DOJ and FTC proceedings, staff and applicants can engage in extensive informal communications to discuss and address data, methodological and other disputes that are associated with these more stylized approaches. Similarly, when mitigation is required, staff and applicants can design such mitigation measures in a non-public manner. In sum, these more informal processes, while entirely appropriate in the context of DOJ and FTC review of mergers and transactions, simply cannot be replicated by the Commission given the due process and other considerations relevant in proceedings under section 203 of the FPA.

71. We also note that some commenters urging the Commission to develop and run its own internal computer simulation model are mistakenly assuming that the current process is flawed because applicants can file merger impact studies using their own methodologies and assumptions. On the contrary, in the 1996 Merger Policy Statement, in the Filing Requirements Rule and in many subsequent orders interpreting those issuances, the Commission has carefully set forth the requirements of how the Commission's adopted study methodology, the Delivered Price Test, must be performed and what assumptions the Commission will accept as reasonable. If applicants fail to perform the studies according to the Commission's prescribed methodology, or their studies are based on faulty assumptions or use questionable data inputs, then those studies are required to be amended or supplemented with additional data.[56] In some cases the Commission has required that new studies be conducted which conform to the Commission's standards. Thus, contrary to the view of some commenters, neither the Commission nor intervenors are disadvantaged by our current policy of requiring applicants to perform the merger impact studies, nor is the Commission subject to manipulation by applicants who can allegedly game the studies to their own benefit. Studies which do not conform to the Commission's explicit requirements are either rejected or required to be revised until they do conform, and intervenors have opportunity in every merger proceeding to inform the Commission if they believe that something in the applicant's study is amiss.

72. Specifically, merger applicants must submit the model and all of the data inputs necessary for completing the Competitive Analysis Screen in any section 203 Application requiring a complete Appendix A analysis.[57] In those cases, Commission staff reviews the data supplied and runs the applicants' models to check the accuracy of the results and the sensitivity of the results to changes in the underlying assumptions. In addition, the models and input data are available to intervenors in the proceeding, who can also verify the accuracy of the results and perform sensitivity tests.

73. A complete Competitive Screen Analysis submission provides sufficient information to identify those transactions that may harm competition. The data submitted includes a valuable intermediate calculation: A supply curve of all the generators that can possibly serve the area, and whether those generators are dispatched given transmission constraints. Finding the supply curve requires an estimate of suppliers' generation costs, including fuel costs, operation and maintenance costs, heat rates, and emissions costs; competitive market prices; transmission prices; and transmission import constraints.[58] Whether the Commission grants the merger application with or without conditions, rejects it, or sets it for hearing, the Commission can determine whether the application presents any competitive issues because the current Competitive Analysis Screen is sufficiently precise to make such a determination.

74. In summary, there has been no showing that a Commission-internal computer simulation model is needed, both in light of these burdens as well as because the study that the Commission already requires applicants to perform is adequate to measure the potential for competitive harm associated with section 203 dispositions. And, as noted above, the Commission is diligent in ensuring that applicants conduct the Competitive Analysis Screen properly, including using reasonable assumptions and data inputs.

c. Adding Hart-Scott-Rodino Information to the Section 203 Record

75. Some commenters suggested that the Commission require applicants to file all materials submitted to the DOJ and the FTC in their Hart-Scott-Rodino (HSR) filings. Other commenters noted that such a filing would create confidentiality concerns due to the public nature of the Commission's section 203 proceedings. We also share those concerns. Unlike the DOJ and the FTC, who can keep any of the information confidential, our proceedings require a public record, and our decisions must be based on evidence that is available to the parties

[56] For example, in *Entergy Gulf States, Inc.,* Commission Staff was unable to verify the results of applicants' model performing the Competitive Analysis Screen, and sent the applicants a deficiency letter identifying the error in the input data and requiring the applicants to submit the corrected data. *Entergy Gulf States, Inc.,* Docket No. EC07–70–000, at 1 (Apr. 6, 2007) (unpublished deficiency letter).

[57] In cases involving a *de minimis* amount of generation being combined in the relevant geographic market, applicants are not required to perform a complete Appendix A analysis.

[58] *See* 1996 Merger Policy Statement, FERC Stats. & Regs. ¶ 31,044 at 30,130–33 (discussion of the delivered price test).

of record in the proceeding. We permit applicants to request confidentiality for certain documents and file a protective order to allow intervenors to view those documents. However, we cannot maintain the same degree of confidentiality as do the DOJ and the FTC.[59] The HSR filings often contain highly sensitive proprietary documents such as the companies' price forecasts, pricing analyses, and pricing decisions.[60] Access to such valuable commercial information could not only harm the merging companies, it could also harm competition in wholesale electricity markets by facilitating coordination by competitors, who would have a better understanding of each other's pricing strategies and competitive objectives.

d. Alternatives to Trial-Type Hearings

76. Some commenters suggested that the Commission use alternatives to trial-type evidentiary hearing procedures, including technical conferences and paper hearings with limited periods of discovery and additional data requests.

77. Given the statutory deadlines faced by the Commission on section 203 applications,[61] we believe that holding an evidentiary hearing generally will not be feasible, depending on the issues in dispute. Therefore, in cases that present complicated factual disputes, we will consider alternatives such as paper hearings with a limited period of discovery, so that we can develop a complete record.

e. Attribution of Generation Under Contract

78. Some commenters also requested clarification on how generation under contract should be attributed in the analysis of market concentration. Specifically, they asked whether the generation should be attributed to the party with operational control of the generation facility or to the party with the economic interest in the capacity.

79. The determination on whether a long-term generation contract should be attributed to the purchaser of power or the seller depends on the party with operational control, which depends upon the specific contract. Therefore, we have required that applicants file information about whether their long-term generation contracts confer operational control over generation resources to the purchaser. Our practice has been to attribute contracted capacity to the purchaser if such a contract confers operational control over the generation to the purchaser.[62] We will continue this practice, and require applicants to file purchase and sales data, including information on whether the terms and conditions of purchase contracts confer operational control over generation to the purchaser. However, if an applicant fails the Competitive Analysis Screen, we will consider arguments regarding the ability and incentive of the merged firm to exercise market power, and therefore consider the merged firm's contractual positions as well as its physical control of generation.

III. Information Collection Statement

80. The Office of Management and Budget's (OMB) regulations require that OMB approve certain information collection and data retention requirements imposed by agency rules.[63] In this supplemental policy statement, the Commission is providing guidance regarding future implementation of FPA section 203. The Commission is not imposing any additional information collection requirement upon the public. The Commission is not proposing any changes to its current regulations. Accordingly, there should be no impact on the current reporting burden associated with an individual section 203 application. The Commission also does not expect the total number of section 203 applications to be affected by this Supplemental Policy Statement. However, the Commission will submit for informational purposes only a copy of this Supplemental Policy Statement to OMB.

Burden Estimate: The Public Reporting and records retention burden for section 203 applications is as follows.

Title: FERC–519, ''Application Under the Federal Power Act, Section 203''.

Action: Revised Collection.

OMB Control No.: 1902–0082.

The applicant will not be penalized for failure to respond to this information collection unless the information collection displays a valid OMB control number or the Commission has provided justification as to why the control number should not be displayed.

Respondents: Businesses or other for profit.

Frequency of Responses: N/A.

Necessity of the Information: This Supplemental Policy Statement provides guidance regarding future implementation of FPA section 203. The Commission is not proposing any changes to its current regulations.

Internal Review: The Commission has conducted an internal review of the public reporting burden associated with the collection of information and assured itself, by means of internal review, that there is specific, objective support for its existing information burden estimate.

81. Interested persons may obtain information on the reporting requirements by contacting: Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC, 20426 [Attention: Michael Miller, Office of the Executive Director, Phone (202) 502–8415, fax (202) 273–0873, e-mail: *michael.miller@ferc.gov*]. Comments on the requirements of the Supplemental Policy Statement may also be sent to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, DC 20503 [Attention: Desk Officer for the Federal Energy Regulatory Commission, fax (202) 395–7285, e-mail *oira_submission@omb.eop.gov*].

IV. Environmental Analysis

82. The Commission is required to prepare an Environmental Assessment or an Environmental Impact Statement for any action that may have a significant adverse effect on the human environment.[64] The Commission has categorically excluded certain actions from this requirement as not having a significant effect on the human environment.[65] The Supplemental Policy Statement is categorically excluded as it addresses actions under section 203.[66] Accordingly, no environmental assessment is necessary and none has been prepared in this Supplemental Policy Statement.

[59] As Mark J. Niefer noted, ''the [Antitrust] Division [of the DOJ] is precluded from sharing much of the information it gathers to analyze a merger'' and ''[e]xcept in very limited circumstances, information provided to the Division * * * may not be disclosed to others without the consent of the producing party.'' Comments of Mark J. Niefer, March 8 Technical Conference, Tr. 106–07.

[60] *See* Federal Trade Commission, Introductory Guide III to the Premerger Notification Program, Model Request for Additional Information and Documentary Material (Second Request) (revised May 2007), available at *http://www.ftc.gov/bc/hsr/introguides/guide3.pdf*.

[61] Under revised section 203, the Commission must act within 180 days of a complete application, and with good cause may extend the deadline another 180 days. If not, the authorization is granted by law.

[62] *See* Filing Requirements Rule, FERC Stats. & Regs. ¶ 31,111 at 31,888.

[63] 5 CFR 1320.

[64] *Regulations Implementing the National Environmental Policy Act,* Order No. 486, 52 FR 47897 (Dec. 17, 1987), FERC Stats. & Regs., Regulations Preambles 1986–1990 ¶ 30,783 (1987).

[65] 18 CFR 380.4.

[66] *See* 18 CFR 380.4(a)(16).

V. Regulatory Flexibility Act Certification

83. The Regulatory Flexibility Act of 1980 (RFA)[67] requires agencies to prepare certain statements, descriptions and analyses of proposed rules that will have a significant economic impact on a substantial number of small entities.[68] However, the RFA does not define ''significant'' or ''substantial.'' Instead, the RFA leaves it up to an agency to determine the effect of its regulations on small entities.

84. Most filing companies regulated by the Commission do not fall within the RFA's definition of small entity.[69] Further, as noted above, the Supplemental Policy Statement does not propose any changes to the Commission's current regulations under section 203; therefore there is no change in how the Commission's regulations under section 203 affect small entities. Therefore, the Commission certifies that the Supplemental Policy Statement will not have a significant economic impact on a substantial number of small entities. As a result, no regulatory flexibility analysis is required.

VI. Document Availability

85. In addition to publishing the full text of this document in the **Federal Register**, the Commission provides all interested persons an opportunity to view and/or print the contents of this document via the Internet through the Commission's Home Page (*http://www.ferc.gov*) and in the Commission's Public Reference Room during normal business hours (8:30 a.m. to 5 p.m. Eastern time) at 888 First Street, NE., Room 2A, Washington DC 20426.

86. From the Commission's Home Page on the Internet, this information is available in the Commission's document management system, eLibrary. The full text of this document is available on eLibrary in PDF and Microsoft Word format for viewing, printing, and/or downloading. To access this document in eLibrary, type the docket number (excluding the last three digits of the docket number), in the docket number field.

87. User assistance is available for eLibrary and the Commission's website during normal business hours. For assistance, please contact FERC Online Support at (202) 502–6652 (toll-free at 1–866–208–3676) or e-mail at *ferconlinesupport@ferc.gov,* or the Public Reference Room at (202) 502–8371, TTY (202) 502–8659. E-mail the Public Reference Room at *public.referenceroom@ferc.gov.*

VII. Effective Date and Congressional Notification

88. This Supplemental Policy Statement is effective July 20, 2007. The Commission has determined that, consistent with the discussion above with regard to information collection and the RFA, this policy statement also is not a ''major rule'' as defined in section 351 of the Small Business Regulatory Enforcement Fairness Act of 1996. The Commission will submit this Supplemental Policy Statement to both houses of Congress and to the General Accounting Office.

List of Subjects in 18 CFR Part 33

Electric utilities, Reporting and recordkeeping requirements, Securities.

By the Commission.

Kimberly D. Bose,

Secretary.

[FR Doc. E7–14956 Filed 8–1–07; 8:45 am]

BILLING CODE 6717–01–P

[67] 5 U.S.C. 601–12.

[68] The RFA definition of ''small entity'' refers to the definition provided in the Small Business Act, which defines a ''small business concern'' as a business that is independently owned and operated and that is not dominant in its field of operation. 15 U.S.C. 632. The Small Business Size Standards component of the North American Industry Classification System defines a small electric utility as one that, including its affiliates, is primarily engaged in the generation, transmission, and/or distribution of electric energy for sale and whose total electric output for the preceding fiscal year did not exceed 4 million MWh. 13 CFR 121.201.

[69] 5 U.S.C. 601(3), citing to section 3 of the Small Business Act, 15 U.S.C. 632. Section 3 of the Small Business Act defines a ''small-business concern'' as a business which is independently owned and operated and which is not dominant in its field of operation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

21 CFR Part 522

Implantation or Injectable Dosage Form New Animal Drugs; Oxytetracycline Hydrochloride Injection

AGENCY: Food and Drug Administration, HHS.

ACTION: Final rule.

SUMMARY: The Food and Drug Administration (FDA) is amending the animal drug regulations to reflect approval of an abbreviated new animal drug application (ANADA) filed by Norbrook Laboratories, Ltd. The ANADA provides for use of an oxytetracycline hydrochloride injectable solution in beef cattle, beef calves, nonlactating dairy cattle, and dairy calves for the treatment of various bacterial diseases.

DATES: This rule is effective August 2, 2007.

FOR FURTHER INFORMATION CONTACT: John K. Harshman, Center for Veterinary Medicine (HFV–104), Food and Drug Administration, 7500 Standish Pl., Rockville, MD 20855, 301–827–0169, e-mail: *john.harshman@fda.hhs.gov*.

SUPPLEMENTARY INFORMATION: Norbrook Laboratories, Ltd., Station Works, Newry BT35 6JP, Northern Ireland, filed ANADA 200–452 that provides for use of OXYTET 10 (oxytetracycline hydrochloride) Injection in beef cattle, beef calves, nonlactating dairy cattle, and dairy calves for the treatment of various bacterial diseases. Norbrook Laboratories, Ltd.'s OXYTET 10 Injection is approved as a generic copy of Boehringer Ingelheim Vetmedica, Inc.'s, MEDAMYCIN Injectable approved under NADA 108–963. The ANADA is approved as of June 27, 2007, and the regulations are amended in 21 CFR 522.1662a to reflect the approval.

In accordance with the freedom of information provisions of 21 CFR part 20 and 21 CFR 514.11(e)(2)(ii), a summary of safety and effectiveness data and information submitted to support approval of this application may be seen in the Division of Dockets Management (HFA–305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852, between 9 a.m. and 4 p.m., Monday through Friday.

FDA has determined under 21 CFR 25.33(a)(1) that this action is of a type that does not individually or cumulatively have a significant effect on the human environment. Therefore, neither an environmental assessment nor an environmental impact statement is required.

This rule does not meet the definition of ''rule'' in 5 U.S.C. 804(3)(A) because it is a rule of ''particular applicability.'' Therefore, it is not subject to the congressional review requirements in 5 U.S.C. 801–808.

List of Subjects in 21 CFR Part 522

Animal drugs.

■ Therefore, under the Federal Food, Drug, and Cosmetic Act and under authority delegated to the Commissioner of Food and Drugs and redelegated to the Center for Veterinary Medicine, 21 CFR part 522 is amended as follows:

PART 522—IMPLANTATION OR INJECTABLE DOSAGE FORM NEW ANIMAL DRUGS

■ 1. The authority citation for 21 CFR part 522 continues to read as follows:

Authority: 21 U.S.C. 360b.

■ 2. Section 522.1662a is amended by revising paragraph (h)(2) to read as follows:

§ 522.1662a Oxytetracycline hydrochloride injection.

* * * * *

(h) * * *

(2) *Sponsors.* See No. 000010 in § 510.600(c) of this chapter for use of 50 and 100 milligrams per milliliter solution; and Nos. 055529 and 059130 in § 510.600(c) for use of 100 milligrams per milliliter solution.

* * * * *

Dated: July 17, 2007.

Stephen F. Sundlof,

Director, Center for Veterinary Medicine.

[FR Doc. E7–14950 Filed 8–1–07; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

21 CFR Part 524

Ophthalmic and Topical Dosage Form New Animal Drugs; Emodepside and Praziquantel

AGENCY: Food and Drug Administration, HHS.

ACTION: Final rule.

SUMMARY: The Food and Drug Administration (FDA) is amending the animal drug regulations to reflect approval of a new animal drug application (NADA) filed by Bayer HealthCare LLC. The NADA provides for veterinary prescription use of an emodepside and praziquantel topical solution on cats for the treatment and control of infections by several internal parasites.

DATES: This rule is effective August 2, 2007.

FOR FURTHER INFORMATION CONTACT: Melanie R. Berson, Center for Veterinary Medicine (HFV–110), Food and Drug Administration, 7500 Standish Pl., Rockville, MD 20855; 301–827–7540; e-mail: *melanie.berson@fda.hhs.gov*.

SUPPLEMENTARY INFORMATION: Bayer HealthCare LLC, Animal Health Division, P.O. Box 390, Shawnee Mission, KS 66201, filed NADA 141–275 that provides for veterinary prescription use of PROFENDER (emodepside and praziquantel) Topical Solution for the treatment and control of infections by several internal parasites of cats. The NADA is approved as of June 29, 2007, and the regulations are amended in 21 CFR part 524 by adding § 524.775 to reflect the approval.

In accordance with the freedom of information provisions of 21 CFR part 20 and 21 CFR 514.11(e)(2)(ii), a summary of safety and effectiveness data and information submitted to support approval of this application may be seen in the Division of Dockets Management (HFA–305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852, between 9 a.m. and 4 p.m., Monday through Friday.

Under section 512(c)(2)(F)(ii) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360b(c)(2)(F)(ii)), this approval qualifies for 3 years of marketing exclusivity beginning on the date of the approval.

The agency has determined under 21 CFR 25.33(d)(1) that this action is of a type that does not individually or cumulatively have a significant effect on the human environment. Therefore, neither an environmental assessment nor an environmental impact statement is required.

This rule does not meet the definition of ''rule'' in 5 U.S.C. 804(3)(A) because it is a rule of ''particular applicability.'' Therefore, it is not subject to the congressional review requirements in 5 U.S.C. 801–808.

List of Subjects in 21 CFR Part 524

Animal drugs.

■ Therefore, under the Federal Food, Drug, and Cosmetic Act and under authority delegated to the Commissioner of Food and Drugs and redelegated to the Center for Veterinary Medicine, 21 CFR part 524 is amended as follows:

PART 524—OPHTHALMIC AND TOPICAL DOSAGE FORM NEW ANIMAL DRUGS

■ 1. The authority citation for 21 CFR part 524 continues to read as follows:

Authority: 21 U.S.C. 360b.

■ 2. Add § 524.775 to read as follows:

§ 524.775 Emodepside and praziquantel.

(a) *Specifications.* Each milliliter of solution contains 21.4 milligrams (mg) emodepside and 85.7 mg praziquantel.

(b) *Sponsor.* See No. 000859 in § 510.600(c) of this chapter.

(c) *Conditions of use in cats*—(1) *Amount.* The recommended minimum dose is 1.36 mg/pound (lb) (3 mg/kilogram (kg)) emodepside and 5.45 mg/lb (12 mg/kg) praziquantel applied as a single topical dose.

(2) *Indications for use.* For the treatment and control of hookworm infections caused by *Ancylostoma tubaeforme* (adults, immature adults, and fourth stage larvae), roundworm infections caused by *Toxocara cati* (adults and fourth stage larvae), and tapeworm infections caused by *Dipylidium caninum* (adults) and *Taenia taeniaeformis* (adults).

(3) *Limitations.* Federal law restricts this drug to use by or on the order of a licensed veterinarian.

Dated: July 17, 2007.

Stephen F. Sundlof,

Director, Center for Veterinary Medicine.

[FR Doc. E7–14945 Filed 8–1–07; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Parts 1, 26, and 602

[TD 9348]

RIN 1545–BC50

Qualified Severance of a Trust for Generation-Skipping Transfer (GST) Tax Purposes

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final regulations.

SUMMARY: This document contains final regulations providing guidance regarding the qualified severance of a trust for generation-skipping transfer (GST) tax purposes under section 2642(a)(3) of the Internal Revenue Code (Code), which was added to the Code by the Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA). The regulations will affect trusts that are subject to the GST tax.

DATES: *Effective Date:* The regulations are effective August 2, 2007.

Applicability Date: For dates of applicability, see § 26.2642–6(k)(1) and § 26.2642–6(k)(2).

FOR FURTHER INFORMATION CONTACT: Mayer R. Samuels, (202) 622–3090 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Paperwork Reduction Act

The collection of information contained in these final regulations has been previously reviewed and approved by the Office of Management and Budget in accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3507(d)) under control number 1545–1902.

The collection of information in these final regulations is in § 26.2642–6(e). This information is requested by the IRS to identify whether a trust is exempt from the GST tax. This information is

required to determine whether the amount of tax has been calculated correctly. The respondents are trustees of trusts that are being severed.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid control number assigned by the Office of Management and Budget.

The estimated average annual burden per respondent/recordkeeper is .5 hours per respondent. Comments concerning the accuracy of this burden estimate should be sent to the Internal Revenue Service, Attn: IRS Reports Clearance Officer, SE:W:CAR:MP:T:T:SP, Washington, DC 20224 and the Office of Management and Budget, Attn: Desk Officer for the Department of the Treasury, Office of Information and Regulatory Affairs, Washington, DC 20503.

Books or records relating to this collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Background

Section 2642(a)(3) was added to the Internal Revenue Code by the Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA), Public Law 107–16 (115 Stat. 38 (2001)). Under section 2642(a)(3), if a trust is divided into two or more trusts in a ''qualified severance,'' the resulting trusts will be recognized as separate trusts for GST tax purposes. In many cases, a qualified severance of a trust will facilitate the most efficient and effective use of the transferor's GST tax exemption. The GST tax exemption is each person's lifetime exemption that may be allocated to a generation-skipping transfer. If the transfer is made in trust, allocation of the donor's GST tax exemption reduces the trust's inclusion ratio, which in turn determines the amount of GST tax imposed on any generation-skipping transfer made with regard to the trust.

On August 24, 2004, the IRS published in the **Federal Register** a notice of proposed rulemaking (REG–145987–03, 2004–39 IRB 519, 69 FR 51967), providing rules under section 2642(a)(3) regarding the qualified severance of a trust for GST tax purposes. The IRS received written and oral comments responding to the notice of proposed rulemaking. No public hearing was requested or held. After consideration of all the comments, the proposed regulations are adopted as amended by this Treasury decision, and the corresponding proposed regulations are removed. The comments and revisions to the proposed regulations are discussed below. In addition, additional proposed regulations are being issued contemporaneously with these final regulations in order to respond to certain comments that the Treasury Department and the IRS believe merit further consideration in proposed regulations.

Summary of Comments

The proposed regulations take the position that the severance rules contained in § 26.2654–1(b) of the regulations were superseded by the enactment of section 2642(a)(3), and therefore that § 26.2654–1(b) is no longer effective. However, many commentators noted that sections 2654(b) and 2642(a)(3) address different situations, and they suggested that section 2642(a)(3) was intended to supplement, rather than to replace, section 2654(b), and to thereby provide more flexibility in severing trusts for GST tax purposes. The commentators noted that section 2642(a)(3) qualified severances are effective prospectively from the date of severance and thus, that section only addresses severances that typically would occur after an irrevocable trust (whether inter vivos or testamentary) has been in existence for a period of time. In contrast, § 26.2654–1(b) addresses only severances of testamentary trusts and revocable inter vivos trusts included in the transferor's gross estate, and a severance satisfying § 26.2654–1(b) is effective retroactively to the date of death. Section 26.2654–1(b) provides for the recognition of severances of separate shares of such trusts, and of discretionary severances that, although not provided for in the governing instrument, are necessary to fully utilize available tax benefits (for example, the reverse qualified terminable interest property election under section 2652(a)(3)). To fulfill the purpose of these severances (generally, efficient utilization and allocation of the decedent's GST exemption), the severance must be effective retroactive to the date of death. Thus, section 2642(a)(3) and § 26.2654–1(b) address different circumstances.

In response to these comments, the final regulations do not supersede § 26.2654–1(b). Rather, § 26.2654–1(b) is retained, but, as explained hereafter, is proposed to be amended as described in a notice of proposed rulemaking issued contemporaneously with these final regulations. Subject to those proposed changes, § 26.2654–1(b) will continue to provide rules for mandatory and discretionary severances of trusts includible in the transferor's gross estate, effective retroactively to the transferor's date of death. The final regulations under § 26.2642–6 generally provide rules for the qualified severance of a trust (whether or not includible in the transferor's gross estate) if the severance will be effective only prospectively from the date of severance.

One commentator requested that the regulations provide that separate trusts, created as the result of a mandated division of a single trust that is effective under state law, be recognized prospectively as separate trusts for certain GST tax purposes, even if the severance does not satisfy the requirements of a qualified severance. This comment will be addressed in the proposed regulations under section 2642, issued contemporaneously with these final regulations.

One commentator requested that the regulations provide additional flexibility in severing a trust that has an inclusion ratio between zero and one. Specifically, the commentator requested that the final regulations permit the qualified severance of a trust into one or more separate resulting trusts, as long as one or more of the resulting trusts, in the aggregate, would receive a fractional share of the total value of the original trust's assets that equals the applicable fraction of the original trust. In such a qualified severance, the resulting trust or trusts receiving this fractional share would each have an inclusion ratio of zero, and each of the other resulting trusts would have an inclusion ratio of one. This comment will be addressed in the proposed regulations under section 2642, issued contemporaneously with these final regulations.

In response to comments, the final regulations continue to require that, in notifying the IRS of the severance of a trust, the words ''Qualified Severance'' should appear at the top of Form 706–GS(T), ''Generation-Skipping Transfer Tax Return for Terminations,'' but the use of red ink for that purpose is not required.

One commentator questioned the requirement in the proposed regulations that any non-pro rata funding of trusts resulting from a qualified severance must be based on the value of the trust assets as of the date of funding. The commentator pointed out that, in many cases, the funding of trusts resulting from a qualified severance will take place over a period of time, rather than on one specific date. Accordingly, under the final regulations, the non-pro rata funding of trusts resulting from a

qualified severance must be achieved by applying the appropriate fraction or percentage to the total value of the trust assets as of the ''date of severance.'' The term ''date of severance'' is defined as the date selected for determining the value of the trust assets (whether selected on a discretionary basis or by a court order), provided that funding is commenced immediately and occurs within a reasonable time before or after the selected date of severance. For this purpose, a reasonable time may differ depending upon the type of asset involved, but in no event may be more than 90 days.

Several commentators requested that the regulations address the severance of a trust that was irrevocable on September 25, 1985, but with respect to which an addition was made to the trust after September 25, 1985. For purposes of determining the inclusion ratio with respect to such a trust, § 26.2601–1(b)(1)(iv)(A) provides that the trust is deemed to consist of two portions, one portion not subject to GST tax (the non-chapter 13 portion) with an inclusion ratio of zero, and one portion subject to GST tax (the chapter 13 portion) with an inclusion ratio determined under section 2642. In response to these comments, the final regulations provide guidance regarding a qualified severance of the chapter 13 portion of these trusts.

The proposed regulations include a mandatory reporting requirement, without which a severance would not constitute a qualified severance. One commentator noted that, in some situations, it may be advantageous to sever a trust but to avoid qualification under section 2642(a)(3) as a qualified severance. The Treasury Department and the IRS believe that the qualified severance rules were not intended to be optional; that is, able to be employed or avoided depending upon the tax consequences of a particular severance. Therefore, under the final regulations, the reporting provisions do not constitute a requirement for qualified severance status, but each severance should be reported to ensure that the provisions of Chapter 13 of the Code may be properly applied with regard to the trusts.

One commentator noted that § 1.1001–1(h)(1) of the proposed regulations provides favorable income tax treatment only with respect to a qualified severance. The commentator requested that the regulations also address the income tax treatment of all other trust modifications and severances. The commentator noted that the failure to address, for example, the income tax consequences of severances that are not qualified severances for GST tax purposes implies that such severances are taxable events for income tax purposes. In response to these comments, the category of severances to which § 1.1001–1(h)(1) will apply has been broadened. No inference should be drawn with respect to the income tax consequences under section 1001 of any severance that is not described in § 1.1001–1(h)(1).

Commentators noted that some qualified severances may result in a taxable termination or taxable distribution, for example, if after the severance, one of the resulting trusts is a skip person. The final regulations clarify that, if the qualified severance itself results in a GST taxable event, the taxable event is treated as occurring immediately after the severance. As a result, if the resulting trust that is a skip person is also the trust that has a zero inclusion ratio after the severance, then no GST tax will result from the taxable event that is deemed to occur after the severance. An example was added illustrating this rule.

Finally, in response to comments, an example has been added addressing the qualified severance rules in the case of a trust where the beneficiary is granted a contingent testamentary general power of appointment that is dependent upon the trust's inclusion ratio.

Special Analyses

It has been determined that this Treasury decision is not a significant regulatory action as defined in Executive Order 12866. Therefore, a regulatory assessment is not required. It also has been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations. It is hereby certified that the collection of information in these regulations will not have a significant economic impact on a substantial number of small entities. This certification is based upon the fact that the collection of information imposed by this regulation is not significant as reflected in the estimated burden of information collection for, which is 0.5 hours per respondent, and that few trustees are likely to be small entities. Therefore, a Regulatory Flexibility Analysis under the Regulatory Flexibility Act (5 U.S.C. chapter 6) is not required.

Pursuant to section 7805(f) of the Code, the notice of proposed rulemaking preceding these regulations was submitted to the Small Business Administration for comment on their impact on small business.

Drafting Information

The principal author of these final regulations is Mayer R. Samuels, Office of the Associate Chief Counsel (Passthroughs and Special Industries), IRS. Other personnel from the IRS and the Treasury Department participated in their development.

List of Subjects

26 CFR Part 1

Income taxes, Reporting and recordkeeping requirements.

26 CFR Part 26

Estate taxes, Reporting and recordkeeping requirements.

26 CFR Part 602

Reporting and recordkeeping requirements.

Adoption of Amendments to the Regulations

■ Accordingly, 26 CFR parts 1, 26 and 602 are amended as follows:

PART 1—INCOME TAXES

■ **Paragraph 1**. The authority citation for part 1 continues to read in part as follows:

Authority: 26 U.S.C. 7805 * * *

■ **Par. 2**. In § 1.1001–1, paragraph (h) is added to read as follows:

§ 1.1001–1 Computation of gain or loss.

* * * * *

(h) *Severances of trusts*—(1) *In general.* The severance of a trust (including without limitation a severance that meets the requirements of § 26.2642–6 or of § 26.2654–1(b) of this chapter) is not an exchange of property for other property differing materially either in kind or in extent if—

(i) An applicable state statute or the governing instrument authorizes or directs the trustee to sever the trust; and

(ii) Any non-pro rata funding of the separate trusts resulting from the severance (including non-pro rata funding as described in § 26.2642–6(d)(4) or § 26.2654–1(b)(1)(ii)(C) of this chapter), whether mandatory or in the discretion of the trustee, is authorized by an applicable state statute or the governing instrument.

(2) *Effective/applicability date.* This paragraph (h) applies to severances occurring on or after August 2, 2007. Taxpayers may apply this paragraph (h) to severances occurring on or after August 24, 2004, and before August 2, 2007.

PART 26—GENERATION-SKIPPING TRANSFER TAX REGULATIONS UNDER THE TAX REFORM ACT OF 1986

■ **Par. 3**. The authority citation for part 26 is amended by adding an entry in numerical order to read, in part, as follows:

Authority: 26 U.S.C. 7805 * * *

Section 26.2642–6 also issued under 26 U.S.C. 2642. * * *

■ **Par. 4**. In § 26.2600–1, the table of contents is amended by adding entries for §§ 26.2642–6 and 26.2654–1(c) to read as follows:

§ 26.2600–1 Table of contents.

* * * * *

§ 26.2642–6 Qualified severance.

(a) In general.
(b) Qualified severance defined.
(c) Effective date of qualified severance.
(d) Requirements for a qualified severance.
(e) Reporting a qualified severance.
(f) Time for making a qualified severance.
(g) Trusts that were irrevocable on September 25, 1985.
(1) In general.
(2) Trusts in receipt of a post-September 25, 1985, addition.
(h) [Reserved]
(i) [Reserved]
(j) Examples.
(k) Effective date.
(1) In general.
(2) Transition rule.

* * * * *

§ 26.2654–1 Certain trusts treated as separate trusts.

* * * * *

(c) Cross reference.

* * * * *

■ **Par. 5**. Section 26.2642–6 is added to read as follows:

§ 26.2642–6 Qualified severance.

(a) *In general.* If a trust is divided in a qualified severance into two or more trusts, the separate trusts resulting from the severance will be treated as separate trusts for generation-skipping transfer (GST) tax purposes and the inclusion ratio of each new resulting trust may differ from the inclusion ratio of the original trust. Because the post-severance resulting trusts are treated as separate trusts for GST tax purposes, certain actions with respect to one resulting trust will generally have no GST tax impact with respect to the other resulting trust(s). For example, GST exemption allocated to one resulting trust will not impact on the inclusion ratio of the other resulting trust(s); a GST tax election made with respect to one resulting trust will not apply to the other resulting trust(s); the occurrence of a taxable distribution or termination with regard to a particular resulting trust will not have any GST tax impact on any other trust resulting from that severance. In general, the rules in this section are applicable only for purposes of the GST tax and are not applicable in determining, for example, whether the resulting trusts may file separate income tax returns or whether the severance may result in a gift subject to gift tax, may cause any trust to be included in the gross estate of a beneficiary, or may result in a realization of gain for purposes of section 1001. See § 1.1001–1(h) of this chapter for rules relating to whether a qualified severance will constitute an exchange of property for other property differing materially either in kind or in extent.

(b) *Qualified severance defined.* A qualified severance is a division of a trust (other than a division described in § 26.2654–1(b)) into two or more separate trusts that meets each of the requirements in paragraph (d) of this section.

(c) *Effective date of qualified severance.* A qualified severance is applicable as of the date of the severance, as defined in § 26.2642–6(d)(3), and the resulting trusts are treated as separate trusts for GST tax purposes as of that date.

(d) *Requirements for a qualified severance.* For purposes of this section, a qualified severance must satisfy each of the following requirements:

(1) The single trust is severed pursuant to the terms of the governing instrument, or pursuant to applicable local law.

(2) The severance is effective under local law.

(3) The date of severance is either the date selected by the trustee as of which the trust assets are to be valued in order to determine the funding of the resulting trusts, or the court-imposed date of funding in the case of an order of the local court with jurisdiction over the trust ordering the trustee to fund the resulting trusts on or as of a specific date. For a date to satisfy the definition in the preceding sentence, however, the funding must be commenced immediately upon, and funding must occur within a reasonable time (but in no event more than 90 days) after, the selected valuation date.

(4) The single trust (original trust) is severed on a fractional basis, such that each new trust (resulting trust) is funded with a fraction or percentage of the original trust, and the sum of those fractions or percentages is one or one hundred percent, respectively. For this purpose, the fraction or percentage may be determined by means of a formula (for example, that fraction of the trust the numerator of which is equal to the transferor's unused GST tax exemption, and the denominator of which is the fair market value of the original trust's assets on the date of severance). The severance of a trust based on a pecuniary amount does not satisfy this requirement. For example, the severance of a trust is not a qualified severance if the trust is divided into two trusts, with one trust to be funded with $1,500,000 and the other trust to be funded with the balance of the original trust's assets. With respect to the particular assets to be distributed to each resulting trust, each resulting trust may be funded with the appropriate fraction or percentage (pro rata portion) of each asset held by the original trust. Alternatively, the assets may be divided among the resulting trusts on a non pro rata basis, based on the fair market value of the assets on the date of severance. However, if funded on a non pro rata basis, each resulting trust must be funded by applying the appropriate fraction or percentage to the total fair market value of the trust assets as of the date of severance.

(5) The terms of the resulting trusts must provide, in the aggregate, for the same succession of interests of beneficiaries as are provided in the original trust. This requirement is satisfied if the beneficiaries of the separate resulting trusts and the interests of the beneficiaries with respect to the separate trusts, when the separate trusts are viewed collectively, are the same as the beneficiaries and their respective beneficial interests with respect to the original trust before severance. With respect to trusts from which discretionary distributions may be made to any one or more beneficiaries on a non-pro rata basis, this requirement is satisfied if—

(i) The terms of each of the resulting trusts are the same as the terms of the original trust (even though each permissible distributee of the original trust is not a beneficiary of all of the resulting trusts);

(ii) Each beneficiary's interest in the resulting trusts (collectively) equals the beneficiary's interest in the original trust, determined by the terms of the trust instrument or, if none, on a per-capita basis. For example, in the case of the severance of a discretionary trust established for the benefit of A, B, and C and their descendants with the remainder to be divided equally among those three families, this requirement is satisfied if the trust is divided into three separate trusts of equal value with one trust established for the benefit of A and A's descendants, one trust for the

benefit of B and B's descendants, and one trust for the benefit of C and C's descendants;

(iii) The severance does not shift a beneficial interest in the trust to any beneficiary in a lower generation (as determined under section 2651) than the person or persons who held the beneficial interest in the original trust; and

(iv) The severance does not extend the time for the vesting of any beneficial interest in the trust beyond the period provided for in (or applicable to) the original trust.

(6) In the case of a qualified severance of a trust with an inclusion ratio as defined in § 26.2642–1 of either one or zero, each trust resulting from the severance will have an inclusion ratio equal to the inclusion ratio of the original trust.

(7) In the case of a qualified severance occurring after GST tax exemption has been allocated to the trust (whether by an affirmative allocation, a deemed allocation, or an automatic allocation pursuant to the rules contained in section 2632), if the trust has an inclusion ratio as defined in § 26.2642–1 that is greater than zero and less than one, then the trust must be severed initially into two trusts. One resulting trust must receive that fractional share of the total value of the original trust as of the date of severance that is equal to the applicable fraction, as defined in § 26.2642–1(b) and (c), used to determine the inclusion ratio of the original trust immediately before the severance. The other resulting trust must receive that fractional share of the total value of the original trust as of the date of severance that is equal to the excess of one over the fractional share described in the preceding sentence. The trust receiving the fractional share equal to the applicable fraction shall have an inclusion ratio of zero, and the other trust shall have an inclusion ratio of one. If the applicable fraction with respect to the original trust is .50, then, with respect to the two equal trusts resulting from the severance, the Trustee may designate which of the resulting trusts will have an inclusion ratio of zero and which will have an inclusion ratio of one. Each separate trust resulting from the severance then may be further divided in accordance with the rules of this section. See paragraph (j), *Example 7* of this section.

(e) *Reporting a qualified severance*—(1) *In general.* A qualified severance is reported by filing Form 706–GS(T), ''Generation-Skipping Transfer Tax Return for Terminations,'' (or such other form as may be provided from time to time by the Internal Revenue Service (IRS) for the purpose of reporting a qualified severance). Unless otherwise provided in the applicable form or instructions, the IRS requests that the filer write ''Qualified Severance'' at the top of the form and attach a Notice of Qualified Severance (Notice). The return and attached Notice should be filed by April 15th of the year immediately following the year during which the severance occurred or by the last day of the period covered by an extension of time, if an extension of time is granted, to file such form.

(2) *Information concerning the original trust.* The Notice should provide, with respect to the original trust that was severed—

(i) The name of the transferor;

(ii) The name and date of creation of the original trust;

(iii) The tax identification number of the original trust; and

(iv) The inclusion ratio before the severance.

(3) *Information concerning each new trust.* The Notice should provide, with respect to each of the resulting trusts created by the severance—

(i) The name and tax identification number of the trust;

(ii) The date of severance (within the meaning of paragraph (c) of this section);

(iii) The fraction of the total assets of the original trust received by the resulting trust;

(iv) Other details explaining the basis for the funding of the resulting trust (a fraction of the total fair market value of the assets on the date of severance, or a fraction of each asset); and

(v) The inclusion ratio.

(f) *Time for making a qualified severance.* (1) A qualified severance of a trust may occur at any time prior to the termination of the trust. Thus, provided that the separate resulting trusts continue in existence after the severance, a qualified severance may occur either before or after—

(i) GST tax exemption has been allocated to the trust;

(ii) A taxable event has occurred with respect to the trust; or

(iii) An addition has been made to the trust.

(2) Because a qualified severance is effective as of the date of severance, a qualified severance has no effect on a taxable termination as defined in section 2612(a) or a taxable distribution as defined in section 2612(b) that occurred prior to the date of severance. A qualified severance shall be deemed to occur before a taxable termination or a taxable distribution that occurs by reason of the qualified severance. See paragraph (j) *Example 8* of this section.

(g) *Trusts that were irrevocable on September 25, 1985*—(1) *In general.* See § 26.2601–1(b)(4) for rules regarding severances and other actions with respect to trusts that were irrevocable on September 25, 1985.

(2) *Trusts in receipt of a post-September 25, 1985, addition.* A trust described in § 26.2601–1(b)(1)(iv)(A) that is deemed for GST tax purposes to consist of one separate share not subject to GST tax (the non-chapter 13 portion) with an inclusion ratio of zero, and one separate share subject to GST tax (the chapter 13 portion) with an inclusion ratio determined under section 2642, may be severed into two trusts in accordance with § 26.2654–1(a)(3). One resulting trust will hold the non-chapter 13 portion of the original trust (the non-chapter 13 trust) and will not be subject to GST tax, and the other resulting trust will hold the chapter 13 portion of the original trust (the chapter 13 trust) and will have the same inclusion ratio as the chapter 13 portion immediately prior to the severance. The chapter 13 trust may be further divided in a qualified severance in accordance with the rules of this section. The non-chapter 13 trust may be further divided in accordance with the rules of § 26.2601–1(b)(4).

(h) [Reserved].

(i) [Reserved].

(j) *Examples.* The rules of this section are illustrated by the following examples:

Example 1. Succession of interests. T dies in 2006. T's will establishes a testamentary trust (Trust) providing that income is to be paid to T's sister, S, for her life. On S's death, one-half of the corpus is to be paid to T's child, C (or to C's estate if C fails to survive S), and one-half of the corpus is to be paid to T's grandchild, GC (or to GC's estate if GC fails to survive S). On the Form 706, ''United States Estate (and Generation-Skipping Transfer) Tax Return,'' filed for T's estate, T's executor allocates all of T's available GST tax exemption to other transfers and trusts, such that Trust's inclusion ratio is 1. Subsequent to filing the Form 706 in 2007 and in accordance with applicable state law, the trustee divides Trust into two separate trusts, Trust 1 and Trust 2, with each trust receiving 50 percent of the value of the assets of the original trust as of the date of severance. Trust 1 provides that trust income is to be paid to S for life with remainder to C or C's estate, and Trust 2 provides that trust income is to be paid to S for life with remainder to GC or GC's estate. Because Trust 1 and Trust 2 provide for the same succession of interests in the aggregate as provided in the original trust, the severance constitutes a qualified severance, provided that all other requirements of section 2642(a)(3) and this section are satisfied.

Example 2. Succession of interests in discretionary trust. In 2006, T establishes Trust, an irrevocable trust providing that income may be paid from time to time in

such amounts as the trustee deems advisable to any one or more members of the group consisting of T's children (A and B) and their respective descendants. In addition, the trustee may distribute corpus to any trust beneficiary in such amounts as the trustee deems advisable. On the death of the last to die of A and B, the trust is to terminate and the corpus is to be distributed in two equal shares, one share to the then-living descendants of each child, per stirpes. T elects, under section 2632(c)(5), to not have the automatic allocation rules contained in section 2632(c) apply with respect to T's transfers to Trust, and T does not otherwise allocate GST tax exemption with respect to Trust. As a result, Trust has an inclusion ratio of one. In 2008, the trustee of Trust, pursuant to applicable state law, divides Trust into two equal but separate trusts, Trust 1 and Trust 2, each of which has terms identical to the terms of Trust except for the identity of the beneficiaries. Trust 1 and Trust 2 each has an inclusion ratio of one. Trust 1 provides that income is to be paid in such amounts as the trustee deems advisable to A and A's descendants. In addition, the trustee may distribute corpus to any trust beneficiary in such amounts as the trustee deems advisable. On the death of A, Trust 1 is to terminate and the corpus is to be distributed to the then-living descendants of A, per stirpes, but, if A dies with no living descendants, the principal will be added to Trust 2. Trust 2 contains identical provisions, except that B and B's descendants are the trust beneficiaries and, if B dies with no living descendants, the principal will be added to Trust 1. Trust 1 and Trust 2 in the aggregate provide for the same beneficiaries and the same succession of interests as provided in Trust, and the severance does not shift any beneficial interest to a beneficiary who occupies a lower generation than the person or persons who held the beneficial interest in Trust. Accordingly, the severance constitutes a qualified severance, provided that all other requirements of section 2642(a)(3) and this section are satisfied.

Example 3. Severance based on actuarial value of beneficial interests. In 2004, T establishes Trust, an irrevocable trust providing that income is to be paid to T's child C during C's lifetime. Upon C's death, Trust is to terminate and the assets of Trust are to be paid to GC, C's child, if living, or, if GC is not then living, to GC's estate. T properly elects, under section 2632(c)(5), to not have the automatic allocation rules contained in section 2632(c) apply with respect to T's transfers to Trust, and T does not otherwise allocate GST tax exemption with respect to Trust. Thus, Trust has an inclusion ratio of one. In 2008, the trustee of Trust, pursuant to applicable state law, divides Trust into two separate trusts, Trust 1 for the benefit of C (and on C's death to C's estate), and Trust 2 for the benefit of GC (and on GC's death to GC's estate). The document severing Trust directs that Trust 1 is to be funded with an amount equal to the actuarial value of C's interest in Trust prior to the severance, determined under section 7520 of the Internal Revenue Code. Similarly, Trust 2 is to be funded with an amount equal to the actuarial value of GC's interest in Trust prior to the severance, determined under section 7520. Trust 1 and Trust 2 do not provide for the same succession of interests as provided under the terms of the original trust. Therefore, the severance is not a qualified severance.

Example 4. Severance of a trust with a 50% inclusion ratio. On September 1, 2006, T transfers $100,000 to a trust for the benefit of T's grandchild, GC. On a timely filed Form 709, ''United States Gift (and Generation-Skipping Transfer) Tax Return,'' reporting the transfer, T allocates all of T's remaining GST tax exemption ($50,000) to the trust. As a result of the allocation, the applicable fraction with respect to the trust is .50 [$50,000 (the amount of GST tax exemption allocated to the trust) divided by $100,000 (the value of the property transferred to the trust)]. The inclusion ratio with respect to the trust is .50 [1 − .50]. In 2007, pursuant to authority granted under applicable state law, the trustee severs the trust into two trusts, Trust 1 and Trust 2, each of which is identical to the original trust and each of which receives a 50 percent fractional share of the total value of the original trust, valued as of the date of severance. Because the applicable fraction with respect to the original trust is .50 and the trust is severed into two equal trusts, the trustee may designate which resulting trust has an inclusion ratio of one, and which resulting trust has an inclusion ratio of zero. Accordingly, in the Notice of Qualified Severance reporting the severance, the trustee designates Trust 1 as having an inclusion ratio of zero, and Trust 2 as having an inclusion ratio of one. The severance constitutes a qualified severance, provided that all other requirements of section 2642(a)(3) and this section are satisfied.

Example 5. Funding of severed trusts on a non-pro rata basis. T's will establishes a testamentary trust (Trust) for the benefit of T's descendants, to be funded with T's stock in Corporation A and Corporation B, both publicly traded stocks. T dies on May 1, 2004, at which time the Corporation A stock included in T's gross estate has a fair market value of $100,000 and the stock of Corporation B included in T's gross estate has a fair market value of $200,000. On a timely filed Form 706, T's executor allocates all of T's remaining GST tax exemption ($270,000) to Trust. As a result of the allocation, the applicable fraction with respect to Trust is .90 [$270,000 (the amount of GST tax exemption allocated to the trust) divided by $300,000 (the value of the property transferred to the trust)]. The inclusion ratio with respect to Trust is .10 [1 − .90]. On August 1, 2008, in accordance with applicable local law, the trustee executes a document severing Trust into two trusts, Trust 1 and Trust 2, each of which is identical to Trust. The instrument designates August 3, 2008, as the date of severance (within the meaning of paragraph (d)(3) of this section). The terms of the instrument severing Trust provide that Trust 1 is to be funded on a non-pro rata basis with assets having a fair market value on the date of severance equal to 90% of the value of Trust's assets on that date, and Trust 2 is to be funded with assets having a fair market value on the date of severance equal to 10% of the value of Trust's assets on that date. On August 3, 2008, the value of the Trust assets totals $500,000, consisting of Corporation A stock worth $450,000 and Corporation B stock worth $50,000. On August 4, 2008, the trustee takes all action necessary to transfer all of the Corporation A stock to Trust 1 and to transfer all of the Corporation B stock to Trust 2. On August 6, 2008, the stock transfers are completed and the stock is received by the appropriate resulting trust. Accordingly, Trust 1 is funded with assets having a value equal to 90% of the value of Trust as of the date of severance, August 3, 2008, and Trust 2 is funded with assets having a value equal to 10% of the value of Trust as of the date of severance. Therefore, the severance constitutes a qualified severance, provided that all other requirements of section 2642(a)(3) and this section are satisfied. Trust 1 will have an inclusion ratio of zero and Trust 2 will have an inclusion ratio of one.

Example 6. [Reserved].

Example 7. Statutory qualified severance. T dies on October 1, 2004. T's will establishes a testamentary trust (Trust) to be funded with $1,000,000. Trust income is to be paid to T's child, S, for S's life. The trustee may also distribute trust corpus from time to time, in equal or unequal shares, for the benefit of any one or more members of the group consisting of S and T's three grandchildren (GC1, GC2, and GC3). On S's death, Trust is to terminate and the assets are to be divided equally among GC1, GC2, and GC3 (or their respective then-living descendants, per stirpes). On a timely filed Form 706, T's executor allocates all of T's remaining GST tax exemption ($300,000) to Trust. As a result of the allocation, the applicable fraction with respect to the trust is .30 [$300,000 (the amount of GST tax exemption allocated to the trust) divided by $1,000,000 (the value of the property transferred to the trust)]. The inclusion ratio with respect to the trust is .70 [1 − .30]. On June 1, 2007, the trustee determines that it is in the best interest of the beneficiaries to sever Trust to provide a separate trust for each of T's three grandchildren and their respective families. The trustee severs Trust into two trusts, Trust 1 and Trust 2, each with terms and beneficiaries identical to Trust and thus each providing that trust income is to be paid to S for life, trust principal may be distributed for the benefit of any or all members of the group consisting of S and T's grandchildren, and, on S's death, the trust is to terminate and the assets are to be divided equally among GC1, GC2, and GC3 (or their respective then-living descendants, per stirpes). The instrument severing Trust provides that Trust 1 is to receive 30% of Trust's assets and Trust 2 is to receive 70% of Trust's assets. Further, each such trust is to be funded with a pro rata portion of each asset held in Trust. The trustee then severs Trust 1 into three equal trusts, Trust GC1, Trust GC2, and Trust GC3. Each trust is named for a grandchild of T and provides that trust income is to be paid to S for life, trust principal may be distributed for the benefit of S and T's grandchild for whom

the trust is named, and, on S's death, the trust is to terminate and the trust proceeds distributed to the respective grandchild for whom the trust is named. If that grandchild has predeceased the termination date, the trust proceeds are to be distributed to that grandchild's then-living descendants, per stirpes, or, if none, then equally to the other two trusts resulting from the severance of Trust 1. Each such resulting trust is to be funded with a pro rata portion of each Trust 1 asset. The trustee also severs Trust 2 in a similar manner, into Trust GC1(2), Trust GC2(2), and Trust GC3(2). The severance of Trust into Trust 1 and Trust 2, the severance of Trust 1 into Trust GC1, Trust GC2, Trust GC3, and the severance of Trust 2 into Trust GC1(2), Trust GC2(2) and Trust GC3(2), constitute qualified severances, provided that all other requirements of section 2642(a)(3) and this section are satisfied with respect to each severance. Trust GC1, Trust GC2, Trust GC3 will each have an inclusion ratio of zero and Trust GC1(2), Trust GC2(2), and Trust GC3(2) will each have an inclusion ratio of one.

Example 8. Qualified severance deemed to precede a taxable termination. In 2004, T establishes an inter vivos irrevocable trust (Trust) for a term of 10 years providing that Trust income is to be paid annually in equal shares to T's child C and T's grandchild GC (the child of another then-living child of T). If either C or GC dies prior to the expiration of the 10-year term, the deceased beneficiary's share of Trust's income is to be paid to that beneficiary's then-living descendants, per stirpes, for the balance of the trust term. At the expiration of the 10-year trust term, the corpus is to be distributed equally to C and GC; if either C or GC is not then living, then such decedent's share is to be distributed instead to such decedent's then-living descendants, per stirpes. T allocates T's GST tax exemption to Trust such that Trust's applicable fraction is .50 and Trust's inclusion ratio is .50 [1 − .50]. In 2006, pursuant to applicable state law, the trustee severs the trust into two equal trusts, Trust 1 and Trust 2. The instrument severing Trust provides that Trust 1 is to receive 50% of the Trust assets, and Trust 2 is to receive 50% of Trust's assets. Both resulting trusts are identical to Trust, except that each has different beneficiaries: C and C's descendants are designated as the beneficiaries of Trust 1, and GC and GC's descendants are designated as the beneficiaries of Trust 2. The severance constitutes a qualified severance, provided all other requirements of section 2642(a)(3) and this section are satisfied. Because the applicable fraction with respect to Trust is .50 and Trust was severed into two equal trusts, the trustee may designate which resulting trust has an inclusion ratio of one, and which has an inclusion ratio of zero. Accordingly, in the Notice of Qualified Severance reporting the severance, the trustee designates Trust 1 as having an inclusion ratio of one, and Trust 2 as having an inclusion ratio of zero. Because Trust 2 is a skip person under section 2613, the severance of Trust resulting in the distribution of 50% of Trust's corpus to Trust 2 would constitute a taxable termination or distribution (as described in section 2612(a)) of that 50% of Trust for GST tax purposes, but for the rule that a qualified severance is deemed to precede a taxable termination that is caused by the qualified severance. Thus, no GST tax will be due with regard to the creation and funding of Trust 2 because the inclusion ratio of Trust 2 is zero.

Example 9. [Reserved].

Example 10. Beneficiary's interest dependent on inclusion ratio. On August 8, 2006, T transfers $1,000,000 to Trust and timely allocates $400,000 of T's remaining GST tax exemption to Trust. As a result of the allocation, the applicable fraction with respect to Trust is .40 [$400,000 divided by $1,000,000] and Trust's inclusion ratio is .60 [1 − .40]. Trust provides that all income of Trust will be paid annually to C, T's child, for life. On C's death, the corpus is to pass in accordance with C's exercise of a testamentary limited power to appoint the corpus of Trust to C's lineal descendants. However, Trust provides that if, at the time of C's death, Trust's inclusion ratio is greater than zero, then C may also appoint that fraction of the trust corpus equal to the inclusion ratio to the creditors of C's estate. On May 3, 2008, pursuant to authority granted under applicable state law, the trustee severs Trust into two trusts. Trust 1 is funded with 40% of Trust's assets, and Trust 2 is funded with 60% of Trust's assets in accordance with the requirements of this section. Both Trust 1 and Trust 2 provide that all income of Trust will be paid annually to C during C's life. On C's death, Trust 1 corpus is to pass in accordance with C's exercise of a testamentary limited power to appoint the corpus to C's lineal descendants. Trust 2 is to pass in accordance with C's exercise of a testamentary power to appoint the corpus of Trust to C's lineal descendants and to the creditors of C's estate. The severance constitutes a qualified severance, provided that all other requirements of section 2642(a)(3) and this section are satisfied. No additional contribution or allocation of GST tax exemption is made to either Trust 1 or Trust 2 prior to C's death. Accordingly, the inclusion ratio with respect to Trust 1 is zero. The inclusion ratio with respect to Trust 2 is one until C's death, at which time C will become the transferor of Trust 2 for GST tax purposes. (Some or all of C's GST tax exemption may be allocated to Trust 2 upon C's death.)

Example 11. Date of severance. Trust is an irrevocable trust that has both skip person and non-skip person beneficiaries. Trust holds two parcels of real estate, Property A and Property B, stock in Company X, a publicly traded company, and cash. On June 16, 2008, the local court with jurisdiction over Trust issues an order, pursuant to the trustee's petition authorized under state law, severing Trust into two resulting trusts of equal value, Trust 1 and Trust 2. The court order directs that Property A will be distributed to Trust 1 and Property B will be distributed to Trust 2, and that an appropriate amount of stock and cash will be distributed to each trust such that the total value of property distributed to each trust as of the date of severance will be equal. The court order does not mandate a particular date of funding. Trustee receives notice of the court order on June 24, and selects July 16, 2008, as the date of severance. On June 26, 2008, Trustee commences the process of transferring title to Property A and Property B to the appropriate resulting trust(s), which process is completed on July 8, 2008. Also on June 26, the Trustee hires a professional appraiser to value Property A and Property B as of the date of severance and receives the appraisal report on Friday, October 3, 2008. On Monday, October 6, 2008, Trustee commences the process of transferring to Trust 1 and Trust 2 the appropriate amount of Company X stock valued as of July 16, 2008, and that transfer (as well as the transfer of Trust's cash) is completed by October 9, 2008. Under the facts presented, the funding of Trust 1 and Trust 2 occurred within 90 days of the date of severance selected by the trustee, and within a reasonable time after the date of severance taking into account the nature of the assets involved and the need to obtain an appraisal. Accordingly, the date of severance for purposes of this section is July 16, 2008, the resulting trusts are to be funded based on the value of the original trust assets as of that date, and the severance is a qualified severance assuming that all other requirements of section 2642(a)(3) and this section are met. (However, if Trust had contained only marketable securities and cash, then in order to satisfy the reasonable time requirement, the stock transfer would have to have been commenced, and generally completed, immediately after the date of severance, and the cash distribution would have to have been made at the same time.)

(k) *Effective/applicability date*—(1) *In general.* This section applies to severances occurring on or after August 2, 2007.

(2) *Transition rule.* In the case of a qualified severance occurring after December 31, 2000, and before August 2, 2007, taxpayers may rely on any reasonable interpretation of section 2642(a)(3) as long as reasonable notice concerning the qualified severance and identification of the trusts involved has been given to the IRS. For this purpose, the proposed regulations (69 FR 51967) are treated as a reasonable interpretation of the statute. For purposes of the reporting provisions of § 26.2642–6(e), notice to the IRS should be mailed by the due date of the gift tax return (including extensions granted) for gifts made during the year in which the severance occurred. If no gift tax return is filed, notice to the IRS should be mailed by April 15th of the year immediately following the year during which the severance occurred. For severances occurring between December 31, 2000, and January 1, 2007, notification should be mailed to the IRS as soon as reasonably practicable after August 2, 2007, if sufficient notice has not already been given.

■ **Par. 6**. Section 26.2654–1 is amended by adding paragraphs (b)(4) *Example 3* and (c) to read as follows:

§ 26.2654–1 Certain trusts treated as separate trusts.

* * * * *

(b) * * *

(4) *Examples.* * * *

Example 3. Formula severance. T's will establishes a testamentary marital trust (Trust) that meets the requirements of qualified terminable interest property (QTIP) if an election under section 2056(b)(7) is made. Trust provides that all trust income is to be paid to T's spouse for life. On the spouse's death, the trust corpus is to be held in further trust for the benefit of T's then-living descendants. On T's date of death in January of 2004, T's unused GST tax exemption is $1,200,000, and T's will includes $200,000 of bequests to T's grandchildren. Prior to the due date for filing the Form 706, ''United States Estate (and Generation-Skipping Transfer) Tax Return,'' for T's estate, T's executor, pursuant to applicable state law, divides Trust into two separate trusts, Trust 1 and Trust 2. Trust 1 is to be funded with that fraction of the Trust assets, the numerator of which is $1,000,000, and the denominator of which is the value of the Trust assets as finally determined for federal estate tax purposes. Trust 2 is to be funded with that fraction of the Trust assets, the numerator of which is the excess of the Trust assets over $1,000,000, and the denominator of which is the value of the Trust assets as finally determined for federal estate tax purposes. On the Form 706 filed for the estate, T's executor makes a QTIP election under section 2056(b)(7) with respect to Trust 1 and Trust 2 and a ''reverse'' QTIP election under section 2652(a)(3) with respect to Trust 1. Further, T's executor allocates $200,000 of T's available GST tax exemption to the bequests to T's grandchildren, and the balance of T's exemption ($1,000,000) to Trust 1. If the requirements of paragraph (b) of this section are otherwise satisfied, Trust 1 and Trust 2 are recognized as separate trusts for GST tax purposes. Accordingly, the ''reverse'' QTIP election and allocation of GST tax exemption with respect to Trust 1 are recognized and effective for generation-skipping transfer tax purposes.

(c) *Cross reference.* For rules applicable to the qualified severance of trusts (whether or not includible in the transferor's gross estate), see § 26.2642–6.

PART 602—OMB CONTROL NUMBERS UNDER THE PAPERWORK REDUCTION ACT

■ **Par. 7**. The authority citation for part 602 continues to read as follows:

Authority: 26 U.S.C. 7805.

■ **Par. 8**. In § 602.101, paragraph (b) is amended by adding entries in numerical order to the table to read as follows:

§ 602.101 OMB Control numbers.

* * * * *

(b) * * *

CFR part or section where identified and described	Current OMB Control No.
* * * * *	
1.1001–1	1545–1902
* * * * *	
26.2642–6	1545–1902
* * * * *	
26.2654–1	1545–1902
* * * * *	

Linda E. Stiff,

Acting Deputy Commissioner for Services and Enforcement.

Approved: July 24, 2007.

Eric Solomon,

Assistant Secretary of the Treasury (Tax Policy).

[FR Doc. E7–14852 Filed 8–1–07; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF DEFENSE

Office of the Secretary

32 CFR Part 229

Protection of Archaeological Resources: Uniform Regulations

AGENCY: Department of Defense.

ACTION: Final rule.

SUMMARY: This rule reinstates 32 CFR part 229, ''Protection of Archaeological Resources: Uniform Regulations,'' which was inadvertently removed by the Department of Defense in 2006. Except for certain formatting updates, the requirements in this document are consistent with those removed in 2006.

DATES: *Effective Date:* This rule is effective August 2, 2007.

FOR FURTHER INFORMATION CONTACT: Ms. Maureen Sullivan, OSD, 703 604 5419, *Maureen.sullivan@osd.mil.*

SUPPLEMENTARY INFORMATION: On Friday, March 10, 2006 (71 FR 12280), the Department of Defense removed 32 CFR part 229. This was done because the corresponding DoD issuance, DoD Directive 4710.1, was canceled and removed from the DoD Directives System. The current corresponding issuance is DoD Instruction 4715.3, Environmental Conservation Program, issued May 3, 1996.

List of Subjects in 32 CFR Part 229

Administrative practice and procedure, Historic preservation, Indians—lands, Penalties, Public lands, Reporting and recordkeeping requirements.

■ Accordingly, subchapter M of title 32 of the Code of Federal Regulations, is amended to add part 229 to read as follows:

PART 229—PROTECTION OF ARCHAEOLOGICAL RESOURCES: UNIFORM REGULATIONS

Sec.

Note: The information collection and reporting requirements in this part were approved by the Office of Management and Budget under control number 1024–0037.

Authority: Pub. L. 96–95, 93 Stat. 721, as amended, 102 Stat. 2983 (16 U.S.C. 470aa–mm) Sec. 10(a). Related Authority: Pub. L. 59–209, 34 Stat. 225 (16 U.S.C. 432, 433); Pub. L. 86–523, 74 Stat. 220, 221 (16 U.S.C. 469), as amended, 88 Stat. 174 (1974); Pub. L. 89–665, 80 Stat. 915 (16 U.S.C. 470a–t), as amended, 84 Stat. 204 (1970), 87 Stat. 139 (1973), 90 Stat. 1320 (1976), 92 Stat. 3467 (1978), 94 Stat. 2987 (1980); Pub. L. 95–341, 92 Stat. 469 (42 U.S.C. 1996).

§ 229.1 Purpose.

(a) The regulations in this part implement provisions of the Archaeological Resources Protection Act of 1979, as amended (16 U.S.C. 470aa–mm) by establishing the uniform definitions, standards, and procedures to be followed by all Federal land managers in providing protection for archaeological resources, located on public lands and Indian lands of the United States. These regulations enable Federal land managers to protect archaeological resources, taking into consideration provisions of the American Indian Religious Freedom Act

(92 Stat. 469; 42 U.S.C. 1996), through permits authorizing excavation and/or removal of archaeological resources, through civil penalties for unauthorized excavation and/or removal, through provisions for the preservation of archaeological resource collections and data, and through provisions for ensuring confidentiality of information about archaeological resources when disclosure would threaten the archaeological resources.

(b) The regulations in this part do not impose any new restrictions on activities permitted under other laws, authorities, and regulations relating to mining, mineral leasing, reclamation, and other multiple uses of the public lands.

§ 229.2 Authority.

(a) The regulations in this part are promulgated pursuant to section 10(a) of the Archaeological Resources Protection Act of 1979 (16 U.S.C. 470ii), which requires that the Secretaries of the Interior, Agriculture and Defense and the Chairman of the Board of the Tennessee Valley Authority jointly develop uniform rules and regulations for carrying out the purposes of the Act.

(b) In addition to the regulations in this part, section 10(b) of the Act (16 U.S.C. 470ii) provides that each Federal land manager shall promulgate such rules and regulations, consistent with the uniform rules and regulations in this part, as may be necessary for carrying out the purposes of the Act.

§ 229.3 Definitions.

As used for purposes of this part:

(a) *Archaeological resource* means any material remains of human life or activities which are at least 100 years of age, and which are of archaeological interest.

(1) *Of archaeological interest* means capable of providing scientific or humanistic understandings of past human behavior, cultural adaptation, and related topics through the application of scientific or scholarly techniques such as controlled observation, contextual measurement, controlled collection, analysis, interpretation and explanation.

(2) *Material remains* means physical evidence of human habitation, occupation, use, or activity, including the site, location, or context in which such evidence is situated.

(3) The following classes of material remains (and illustrative examples), if they are at least 100 years of age, are of archaeological interest and shall be considered archaeological resources unless determined otherwise pursuant to paragraph (a)(4) or (a)(5) of this section:

(i) Surface or subsurface structures, shelters, facilities, or features (including, but not limited to, domestic structures, storage structures, cooking structures, ceremonial structures, artificial mounds, earthworks, fortifications, canals, reservoirs, horticultural/agricultural gardens or fields, bedrock mortars or grinding surfaces, rock alignments, cairns, trails, borrow pits, cooking pits, refuse pits, burial pits or graves, hearths, kilns, post molds, wall trenches, middens);

(ii) Surface or subsurface artifact concentrations or scatters;

(iii) Whole or fragmentary tools, implements, containers, weapons and weapon projectiles, clothing, and ornaments (including, but not limited to, pottery and other ceramics, cordage, basketry and other weaving, bottles and other glassware, bone, ivory, shell, metal, wood, hide, feathers, pigments, and flaked, ground, or pecked stone);

(iv) By-products, waste products, or debris resulting from manufacture or use of human-made or natural materials;

(v) Organic waste (including, but not limited to, vegetal and animal remains, coprolites);

(vi) Human remains (including, but not limited to, bone, teeth, mummified flesh, burials, cremations);

(vii) Rock carvings, rock paintings, intaglios and other works of artistic or symbolic representation;

(viii) Rockshelters and caves or portions thereof containing any of the above material remains;

(ix) All portions of shipwrecks (including, but not limited to, armaments, apparel, tackle, cargo);

(x) Any portion or piece of any of the foregoing.

(4) The following material remains shall not be considered of archaeological interest, and shall not be considered to be archaeological resources for purposes of the Act and this part, unless found in a direct physical relationship with archaeological resources as defined in this section:

(i) Paleontological remains;

(ii) Coins, bullets, and unworked minerals and rocks.

(5) The Federal land manager may determine that certain material remains, in specified areas under the Federal land manager's jurisdiction, and under specified circumstances, are not or are no longer of archaeological interest and are not to be considered archaeological resources under this part. Any determination made pursuant to this subparagraph shall be documented. Such determination shall in no way affect the Federal land manager's obligations under other applicable laws or regulations.

(6) For the disposition following lawful removal or excavations of Native American human remains and ''cultural items'', as defined by the Native American Graves Protection and Repatriation Act (NAGPRA; Pub. L. 101–601; 104 Stat. 3050; 25 U.S.C. 3001–13), the Federal land manager is referred to NAGPRA and its implementing regulations.

(b) *Arrowhead* means any projectile point which appears to have been designed for use with an arrow.

(c) *Federal land manager* means:

(1) With respect to any public lands, the secretary of the department, or the head of any other agency or instrumentality of the United States, having primary management authority over such lands, including persons to whom such management authority has been officially delegated;

(2) In the case of Indian lands, or any public lands with respect to which no department, agency or instrumentality has primary management authority, such term means the Secretary of the Interior;

(3) The Secretary of the Interior, when the head of any other agency or instrumentality has, pursuant to section 3(2) of the Act and with the consent of the Secretary of the Interior, delegated to the Secretary of the Interior the responsibilities (in whole or in part) in this part.

(d) *Public lands* means:

(1) Lands which are owned and administered by the United States as part of the national park system, the national wildlife refuge system, or the national forest system; and

(2) All other lands the fee title to which is held by the United States, except lands on the Outer Continental Shelf, lands under the jurisdiction of the Smithsonian Institution, and Indian lands.

(e) *Indian lands* means lands of Indian tribes, or Indian individuals, which are either held in trust by the United States or subject to a restriction against alienation imposed by the United States, except for subsurface interests not owned or controlled by an Indian tribe or Indian individual.

(f) *Indian tribe as defined in the Act* means any Indian tribe, band, nation, or other organized group or community, including any Alaska village or regional or village corporation as defined in, or established pursuant to, the Alaska Native Claims Settlement Act (85 Stat. 688). In order to clarify this statutory definition for purposes of this part, ''Indian tribe'' means:

(1) Any tribal entity which is included in the annual list of recognized tribes published in the **Federal Register** by the Secretary of the Interior pursuant to 25 CFR part 54;

(2) Any other tribal entity acknowledged by the Secretary of the Interior pursuant to 25 CFR part 54 since the most recent publication of the annual list; and

(3) Any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688), and any Alaska Native village or tribe which is recognized by the Secretary of the Interior as eligible for services provided by the Bureau of Indian Affairs.

(g) *Person* means an individual, corporation, partnership, trust, institution, association, or any other private entity, or any officer, employee, agent, department, or instrumentality of the United States, or of any Indian tribe, or of any State or political subdivision thereof.

(h) *State* means any of the fifty states, the District of Columbia, Puerto Rico, Guam, and the Virgin Islands.

(i) *Act* means the Archaeological Resources Protection Act of 1979 (16 U.S.C. 470aa–mm).

§ 229.4 Prohibited acts and criminal penalties.

(a) Under section 6(a) of the Act, no person may excavate, remove, damage, or otherwise alter or deface, or attempt to excavate, remove, damage, or otherwise alter or deface any archaeological resource located on public lands or Indian lands unless such activity is pursuant to a permit issued under § 229.8 or exempted by § 229.5(b) of this part.

(b) No person may sell, purchase, exchange, transport, or receive any archaeological resource, if such resource was excavated or removed in violation of:

(1) The prohibitions contained in paragraph (a) of this section; or

(2) Any provision, rule, regulation, ordinance, or permit in effect under any other provision of Federal law.

(c) Under section (d) of the Act, any person who knowingly violates or counsels, procures, solicits, or employs any other person to violate any prohibition contained in section 6 (a), (b), or (c) of the Act will, upon conviction, be fined not more than $10,000.00 or imprisoned not more than one year, or both: provided, however, that if the commercial or archaeological value of the archaeological resources involved and the cost of restoration and repair of such resources exceeds the sum of $500.00, such person will be fined not more than $20,000.00 or imprisoned not more than two years, or both. In the case of a second or subsequent such violation upon conviction such person will be fined not more than $100,000.00, or imprisoned not more than 5 years, or both.

§ 229.5 Permit requirements and exceptions.

(a) Any person proposing to excavate and/or remove archaeological resources from public lands or Indian lands, and to carry out activities associated with such excavation and/or removal, shall apply to the Federal land manager for a permit for the proposed work, and shall not begin the proposed work until a permit has been issued. The Federal land manager may issue a permit to any qualified person, subject to appropriate terms and conditions, provided that the person applying for a permit meets conditions in § 229.8(a) of this part.

(b) Exceptions:

(1) No permit shall be required under this part for any person conducting activities on the public lands under other permits, leases, licenses, or entitlements for use, when those activities are exclusively for purposes other than the excavation and/or removal of archaeological resources, even though those activities might incidentally result in the disturbance of archaeological resources. General earth-moving excavation conducted under a permit or other authorization shall not be construed to mean excavation and/or removal as used in this part. This exception does not, however, affect the Federal land manager's responsibility to comply with other authorities which protect archaeological resources prior to approving permits, leases, licenses, or entitlements for use; any excavation and/or removal of archaeological resources required for compliance with those authorities shall be conducted in accordance with the permit requirements of this part.

(2) No permit shall be required under this part for any person collecting for private purposes any rock, coin, bullet, or mineral which is not an archaeological resource as defined in this part, provided that such collecting does not result in disturbance of any archaeological resource.

(3) No permit shall be required under this part or under section 3 of the Act of June 8, 1906 (16 U.S.C. 432), for the excavation or removal by any Indian tribe or member thereof of any archaeological resource located on Indian lands of such Indian tribe, except that in the absence of tribal law regulating the excavation or removal or archaeological resources on Indian lands, an individual tribal member shall be required to obtain a permit under this part;

(4) No permit shall be required under this part for any person to carry out any archaeological activity authorized by a permit issued under section 3 of the Act of June 8, 1906 (16 U.S.C. 432), before the enactment of the Archaeological Resources Protection Act of 1979. Such permit shall remain in effect according to its terms and conditions until expiration.

(5) No permit shall be required under section 3 of the Act of June 8, 1906 (16 U.S.C. 432) for any archaeological work for which a permit is issued under this part.

(c) Persons carrying out official agency duties under the Federal land manager's direction, associated with the management of archaeological resources, need not follow the permit application procedures of § 229.6. However, the Federal land manager shall insure that provisions of § 229.8 and § 229.9 have been met by other documented means, and that any official duties which might result in harm to or destruction of any Indian tribal religious or cultural site, as determined by the Federal land manager, have been the subject of consideration under § 229.7.

(d) Upon the written request of the Governor of any State, on behalf of the State or its educational institutions, the Federal land manager shall issue a permit, subject to the provisions of §§ 229.5(b)(5), 229.7, 229.8(a)(3), (4), (5), (6), and (7), 229.9, 229.10, 229.12, and 229.13(a) to such Governor or to such designee as the Governor deems qualified to carry out the intent of the Act, for purposes of conducting archaeological research, excavating and/or removing archaeological resources, and safeguarding and preserving any materials and data collected in a university, museum, or other scientific or educational institution approved by the Federal land manager.

(e) Under other statutory, regulatory, or administrative authorities governing the use of public lands and Indian lands, authorizations may be required for activities which do not require a permit under this part. Any person wishing to conduct on public lands or Indian lands any activities related to but believed to fall outside the scope of this part should consult with the Federal land manager, for the purpose of determining whether any authorization is required, prior to beginning such activities.

§ 229.6 Application for permits and information collection.

(a) Any person may apply to the appropriate Federal land manager for a permit to excavate and/or remove archaeological resources from public lands or Indian lands and to carry out activities associated with such excavation and/or removal.

(b) Each application for a permit shall include:

(1) The nature and extent of the work proposed, including how and why it is proposed to be conducted, proposed time of performance, locational maps, and proposed outlet for public written dissemination of the results.

(2) The name and address of the individual(s) proposed to be responsible for conducting the work, institutional affiliation, if any, and evidence of education, training, and experience in accord with the minimal qualifications listed in § 229.8(a).

(3) The name and address of the individual(s), if different from the individual(s) named in paragraph (b)(2) of this section, proposed to be responsible for carrying out the terms and conditions of the permit.

(4) Evidence of the applicant's ability to initiate, conduct, and complete the proposed work, including evidence of logistical support and laboratory facilities.

(5) Where the application is for the excavation and/or removal of archaeological resources on public lands, the names of the university, museum, or other scientific or educational institution in which the applicant proposes to store all collections, and copies of records, data, photographs, and other documents derived from the proposed work. Applicants shall submit written certification, signed by an authorized official of the institution, of willingness to assume curatorial responsibility for the collections, records, data, photographs and other documents and to safeguard and preserve these materials as property of the United States.

(6) Where the application is for the excavation and/or removal of archaeological resources on Indian lands, the name of the university, museum, or other scientific or educational institution in which the applicant proposes to store copies of records, data, photographs, and other documents derived from the proposed work, and all collections in the event the Indian owners do not wish to take custody or otherwise dispose of the archaeological resources. Applicants shall submit written certification, signed by an authorized official of the institution, or willingness to assume curatorial responsibility for the collections, if applicable, and/or the records, data, photographs, and other documents derived from the proposed work.

(c) The Federal land manager may require additional information, pertinent to land management responsibilities, to be included in the application for permit and shall so inform the applicant.

(d) *Paperwork Reduction Act.* The information collection requirement contained in this section of these regulations has been approved by the Office of Management and Budget under 44 U.S.C. 3501 *et seq.* and assigned clearance number 1024–0037. The purpose of the information collection is to meet statutory and administrative requirements in the public interest. The information will be used to assist Federal land managers in determining that applicants for permits are qualified, that the work proposed would further archaeological knowledge, that archaeological resources and associated records and data will be properly preserved, and that the permitted activity would not conflict with the management of the public lands involved. Response to the information requirement is necessary in order for an applicant to obtain a benefit.

§ 229.7 Notification to Indian tribes of possible harm to, or destruction of, sites on public lands having religious or cultural importance.

(a) If the issuance of a permit under this part may result in harm to, or destruction of, any Indian tribal religious or cultural site on public lands, as determined by the Federal land manager, at least 30 days before issuing such a permit the Federal land manager shall notify any Indian tribe which may consider the site as having religious or cultural importance. Such notice shall not be deemed a disclosure to the public for purposes of section 9 of the Act.

(1) Notice by the Federal land manager to any Indian tribe shall be sent to the chief executive officer or other designated official of the tribe. Indian tribes are encouraged to designate a tribal official to be the focal point for any notification and discussion between the tribe and the Federal land manager.

(2) The Federal land manager may provide notice to any other Native American group that is known by the Federal land manager to consider sites potentially affected as being of religious or cultural importance.

(3) Upon request during the 30-day period, the Federal land manager may meet with official representatives of any Indian tribe or group to discuss their interests, including ways to avoid or mitigate potential harm or destruction such as excluding sites from the permit area. Any mitigation measures which are adopted shall be incorporated into the terms and conditions of the permit under § 229.9.

(4) When the Federal land manager determines that a permit applied for under this part must be issued immediately because of an imminent threat of loss or destruction of an archaeological resource, the Federal land manager shall so notify the appropriate tribe.

(b)(1) In order to identify sites of religious or cultural importance, the Federal land manager shall seek to identify all Indian tribes having aboriginal or historic ties to the lands under the Federal land manager's jurisdiction and seek to determine, from the chief executive officer or other designated official of any such tribe, the location and nature of specific sites of religious or cultural importance so that such information may be on file for land management purposes. Information on sites eligible for or included in the National Register of Historic Places may be withheld from public disclosure pursuant to section 304 of the Act of October 15, 1966, as amended (16 U.S.C. 470w–3).

(2) If the Federal land manager becomes aware of a Native American group that is not an Indian tribe as defined in this part but has aboriginal or historic ties to public lands under the Federal land manager's jurisdiction, the Federal land manager may seek to communicate with official representatives of that group to obtain information on sites they may consider to be of religious or cultural importance.

(3) The Federal land manager may enter into agreement with any Indian tribe or other Native American group for determining locations for which such tribe or group wishes to receive notice under this section.

(4) The Federal land manager should also seek to determine, in consultation with official representatives of Indian tribes or other Native American groups, what circumstances should be the subject of special notification to the tribe or group after a permit has been issued. Circumstances calling for notification might include the discovery of human remains. When circumstances for special notification have been determined by the Federal land manager, the Federal land manager will include a requirement in the terms and conditions of permits, under § 229.9(c), for permittees to notify the Federal land

manager immediately upon the occurrence of such circumstances. Following the permittee's notification, the Federal land manager will notify and consult with the tribe or group as appropriate. In cases involving Native American human remains and other ''cultural items'', as defined by NAGPRA, the Federal land manager is referred to NAGPRA and its implementing

§ 229.8 Issuance of permits.

(a) The Federal land manager may issue a permit, for a specified period of time appropriate to the work to be conducted, upon determining that:

(1) The applicant is appropriately qualified, as evidenced by training, education, and/or experience, and possesses demonstrable competence in archaeological theory and methods, and in collecting, handling, analyzing, evaluating, and reporting archaeological data, relative to the type and scope of the work proposed, and also meets the following minimum qualifications:

(i) A graduate degree in anthropology or archaeology, or equivalent training and experience;

(ii) The demonstrated ability to plan, equip, staff, organize, and supervise activity of the type and scope proposed;

(iii) The demonstrated ability to carry research to completion, as evidenced by timely completion of theses, research reports, or similar documents;

(iv) Completion of at least 16 months of professional experience and/or specialized training in archaeological field, laboratory, or library research, administration, or management, including at least 4 months experience and/or specialized training in the kind of activity the individual proposes to conduct under authority of a permit; and

(v) Applicants proposing to engage in historical archaeology should have had at least one year of experience in research concerning archaeological resources of the historic period. Applicants proposing to engage in prehistoric archaeology should have had at least one year of experience in research concerning archaeological resources of the prehistoric period.

(2) The proposed work is to be undertaken for the purpose of furthering archaeological knowledge in the public interest, which may include but need not be limited to, scientific or scholarly research, and preservation of archaeological data;

(3) The proposed work, including time, scope, location, and purpose, is not inconsistent with any management plan or established policy, objectives, or requirements applicable to the management of the public lands concerned;

(4) Where the proposed work consists of archaeological survey and/or data recovery undertaken in accordance with other approved uses of the public lands or Indian lands, and the proposed work has been agreed to in writing by the Federal land manager pursuant to section 106 of the National Historic Preservation Act (16 U.S.C. 470f), paragraphs (a) (2) and (a) (3) shall be deemed satisfied by the prior approval.

(5) Written consent has been obtained, for work proposed on Indian lands, from the Indian landowner and the Indian tribe having jurisdiction over such lands;

(6) Evidence is submitted to the Federal land manager that any university, museum, or other scientific or educational institution proposed in the application as the repository possesses adequate curatorial capability for safeguarding and preserving the archaeological resources and all associated records; and

(7) The applicant has certified that, not later than 90 days after the date the final report is submitted to the Federal land manager, the following will be delivered to the appropriate official of the approved university, museum, or other scientific or educational institution, which shall be named in the permit:

(i) All artifacts, samples, collections, and copies of records, data, photographs, and other documents resulting from work conducted under the requested permit where the permit is for the excavation and/or removal of archaeological resources from public lands.

(ii) All artifacts, samples and collections resulting from work under the requested permit for which the custody or disposition is not undertaken by the Indian owners, and copies of records, data, photographs, and other documents resulting from work conducted under the requested permit, where the permit is for the excavation and/or removal of archaeological resources from Indian lands.

(b) When the area of the proposed work would cross jurisdictional boundaries, so that permit applications must be submitted to more than one Federal land manager, the Federal land manager shall coordinate the review and evaluation of applications and the issuance of permits.

§ 229.9 Terms and conditions of permits.

(a) In all permits issued, the Federal land manager shall specify:

(1) The nature and extent of work allowed and required under the permit, including the time, duration, scope, location, and purpose of the work;

(2) The name of the individual(s) responsible for conducting the work and, if different, the name of the individual(s) responsible for carrying out the terms and conditions of the permit;

(3) The name of any university, museum, or other scientific or educational institutions in which any collected materials and data shall be deposited; and

(4) Reporting requirements.

(b) The Federal land manager may specify such terms and conditions as deemed necessary, consistent with this part, to protect public safety and other values and/or resources, to secure work areas, to safeguard other legitimate land uses, and to limit activities incidental to work authorized under a permit.

(c) The Federal land manager shall include in permits issued for archaeological work on Indian lands such terms and conditions as may be requested by the Indian landowner and the Indian tribe having jurisdiction over the lands, and for archaeological work on public lands shall include such terms and conditions as may have been developed pursuant to § 229.7.

(d) Initiation of work or other activities under the authority of a permit signifies the permittee's acceptance of the terms and conditions of the permit.

(e) The permittee shall not be released from requirements of a permit until all outstanding obligations have been satisfied, whether or not the term of the permit has expired.

(f) The permittee may request that the Federal land manager extend or modify a permit.

(g) The permittee's performance under any permit issued for a period greater than 1 year shall be subject to review by the Federal land manager, at least annually.

§ 229.10 Suspension and revocation of permits.

(a) *Suspension or revocation for cause.* (1) The Federal land manager may suspend a permit issued pursuant to this part upon determining that the permittee has failed to meet any of the terms and conditions of the permit or has violated any prohibition of the Act or § 229.4. The Federal land manager shall provide written notice to the permittee of the suspension, the cause thereof, and the requirements which must be met before the suspension will be removed.

(2) The Federal land manager may revoke a permit upon assessment of a civil penalty under § 229.15 upon the permittee's conviction under section 6

of the Act, or upon determining that the permittee has failed after notice under this section to correct the situation which led to suspension of the permit.

(b) *Suspension or revocation for management purposes.* The Federal land manager may suspend or revoke a permit, without liability to the United States, its agents, or employees, when continuation of work under the permit would be in conflict with management requirements not in effect when the permit was issued. The Federal land manager shall provide written notice to the permittee stating the nature of and basis for the suspension or revocation.

§ 229.11 Appeals relating to permits.

Any affected person may appeal permit issuance, denial of permit issuance, suspension, revocation, and terms and conditions of a permit through existing administrative appeal procedures, or through procedures which may be established by the Federal land manager pursuant to section 10(b) of the Act and this part.

§ 229.12 Relationship to section 106 of the National Historic Preservation Act.

Issuance of a permit in accordance with the Act and this part does not constitute an undertaking requiring compliance with section 106 of the Act of October 15, 1966 (16 U.S.C. 470f). However, the mere issuance of such a permit does not excuse the Federal land manager from compliance with section 106 where otherwise required.

§ 229.13 Custody of archaeological resources.

(a) Archaeological resources excavated or removed from the public lands remain the property of the United States.

(b) Archaeological resources excavated or removed from Indian lands remain the property of the Indian or Indian tribe having rights of ownership over such resources.

(c) The Secretary of the Interior may promulgate regulations providing for the exchange of archaeological resources among suitable universities, museums, or other scientific or educational institutions, for the ultimate disposition of archaeological resources, and for standards by which archaeological resources shall be preserved and maintained, when such resources have been excavated or removed from public lands and Indian lands.

(d) In the absence of regulations referenced in paragraph (c) of this section, the Federal land manager may provide for the exchange of archaeological resources among suitable universities, museums, or other scientific or educational institutions, when such resources have been excavated or removed from public lands under the authority of a permit issued by the Federal land manager.

(e) Notwithstanding the provisions of paragraphs (a) through (d) of this section, the Federal land manager will follow the procedures required by NAGPRA and its implementing regulations for determining the disposition of Native American human remains and other ''cultural items'', as defined by NAGPRA, that have been excavated, removed, or discovered on public lands.

§ 229.14 Determination of archaeological or commercial value and cost of restoration and repair.

(a) *Archaeological value.* For purposes of this part, the archaeological value of any archaeological resource involved in a violation of the prohibitions in § 229.4 of this part or conditions of a permit issued pursuant to this part shall be the value of the information associated with the archaeological resource. This value shall be appraised in terms of the costs of the retrieval of the scientific information which would have been obtainable prior to the violation. These costs may include, but need not be limited to, the cost of preparing a research design, conducting field work, carrying out laboratory analysis, and preparing reports as would be necessary to realize the information potential.

(b) *Commercial value.* For purposes of this part, the commercial value of any archaeological resource involved in a violation of the prohibitions in § 229.4 of this part or conditions of a permit issued pursuant to this part shall be its fair market value. Where the violation has resulted in damage to the archaeological resource, the fair market value should be determined using the condition of the archaeological resource prior to the violation, to the extent that its prior condition can be ascertained.

(c) *Cost of restoration and repair.* For purposes of this part, the cost of restoration and repair of archaeological resources damaged as a result of a violation of prohibitions or conditions pursuant to this part, shall be the sum of the costs already incurred for emergency restoration or repair work, plus those costs projected to be necessary to complete restoration and repair, which may include, but need not be limited to, the costs of the following:

(1) Reconstruction of the archaeological resource;

(2) Stabilization of the archaeological resource;

(3) Ground contour reconstruction and surface stabilization;

(4) Research necessary to carry out reconstruction or stabilization;

(5) Physical barriers or other protective devices, necessitated by the disturbance of the archaeological resource, to protect it from further disturbance;

(6) Examination and analysis of the archaeological resource including recording remaining archaeological information, where necessitated by disturbance, in order to salvage remaining values which cannot be otherwise conserved;

(7) Reinterment of human remains in accordance with religious custom and State, local, or tribal law, where appropriate, as determined by the Federal land manager.

(8) Preparation of reports relating to any of the above activities.

§ 229.15 Assessment of civil penalties.

(a) The Federal land manager may assess a civil penalty against any person who has violated any prohibition contained in § 229.4 or who has violated any term or condition included in a permit issued in accordance with the Act and this part.

(b) *Notice of violation.* The Federal land manager shall serve a notice of violation upon any person believed to be subject to a civil penalty, either in person or by registered or certified mail (return receipt requested). The Federal land manager shall include in the notice:

(1) A concise statement of the facts believed to show a violation;

(2) A specific reference to the provision(s) of this part or to a permit issued pursuant to this part allegedly violated;

(3) The amount of penalty proposed to be assessed, including any initial proposal to mitigate or remit where appropriate, or a statement that notice of a proposed penalty amount will be served after the damages associated with the alleged violation have been ascertained;

(4) Notification of the right to file a petition for relief pursuant to paragraph (d) of this section, or to await the Federal land manager's notice of assessment, and to request a hearing in accordance with paragraph (g) of this section. The notice shall also inform the person of the right to seek judicial review of any final administrative decision assessing a civil penalty.

(c) The person served with a notice of violation shall have 45 calendar days from the date of its service (or the date of service of a proposed penalty amount,

if later) in which to respond. During this time the person may:

(1) Seek informal discussions with the Federal land manager;

(2) File a petition for relief in accordance with paragraph (d) of this section;

(3) Take no action and await the Federal land manager's notice of assessment;

(4) Accept in writing or by payment the proposed penalty, or any mitigation or remission offered in the notice. Acceptance of the proposed penalty or mitigation or remission shall be deemed a waiver of the notice of assessment and of the right to request a hearing under paragraph (g) of this section.

(d) *Petition for relief.* The person served with a notice of violation may request that no penalty be assessed or that the amount be reduced, by filing a petition for relief with the Federal land manager within 45 calendar days of the date of service of the notice of violation (or of a proposed penalty amount, if later). The petition shall be in writing and signed by the person served with the notice of violation. If the person is a corporation, the petition must be signed by an officer authorized to sign such documents. The petition shall set forth in full the legal or factual basis for the requested relief.

(e) *Assessment of penalty.* (1) The Federal land manager shall assess a civil penalty upon expiration of the period for filing a petition for relief, upon completion of review of any petition filed, or upon completion of informal discussions, whichever is later.

(2) The Federal land manager shall take into consideration all available information, including information provided pursuant to paragraphs (c) and (d) of this section or furnished upon further request by the Federal land manager.

(3) If the facts warrant a conclusion that no violation has occurred, the Federal land manager shall so notify the person served with a notice of violation, and no penalty shall be assessed. (4) Where the facts warrant a conclusion that a violation has occurred, the Federal land manager shall determine a penalty amount in accordance with § 229.16.

(f) *Notice of assessment.* The Federal land manager shall notify the person served with a notice of violation of the penalty amount assessed by serving a written notice of assessment, either in person or by registered or certified mail (return receipt requested). The Federal land manager shall include in the notice of assessment:

(1) The facts and conclusions from which it was determined that a violation did occur;

(2) The basis in § 229.16 for determining the penalty amount assessed and/or any offer to mitigate or remit the penalty; and

(3) Notification of the right to request a hearing, including the procedures to be followed, and to seek judicial review of any final administrative decision assessing a civil penalty.

(g) *Hearings.* (1) Except where the right to request a hearing is deemed to have been waived as provided in paragraph (c)(4) of this section, the person served with a notice of assessment may file a written request for a hearing with the adjudicatory body specified in the notice. The person shall enclose with the request for hearing a copy of the notice of assessment, and shall deliver the request as specified in the notice of assessment, personally or by registered or certified mail (return receipt requested).

(2) Failure to deliver a written request for a hearing within 45 days of the date of service of the notice of assessment shall be deemed a waiver of the right to a hearing.

(3) Any hearing conducted pursuant to this section shall be held in accordance with 5 U.S.C. 554. In any such hearing, the amount of civil penalty assessed shall be determined in accordance with this part, and shall not be limited by the amount assessed by the Federal land manager under paragraph (f) of this section or any offer of mitigation or remission made by the Federal land manager.

(h) *Final administrative decision.* (1) Where the person served with a notice of violation has accepted the penalty pursuant to paragraph (c)(4) of this section, the notice of violation shall constitute the final administrative decision;

(2) Where the person served with a notice of assessment has not filed a timely request for a hearing pursuant to paragraph (g)(1) of this section, the notice of assessment shall constitute the final administrative decision;

(3) Where the person served with a notice of assessment has filed a timely request for a hearing pursuant to paragraph (g)(1) of this section, the decision resulting from the hearing or any applicable administrative appeal therefrom shall constitute the final administrative decision.

(i) *Payment of penalty.* (1) The person assessed a civil penalty shall have 45 calendar days from the date of issuance of the final administrative decision in which to make full payment of the penalty assessed, unless a timely request for appeal has been filed with a U.S. District Court as provided in section 7(b)(1) of the Act.

(2) Upon failure to pay the penalty, the Federal land manager may request the Attorney General to institute a civil action to collect the penalty in a U.S. District Court for any district in which the person assessed a civil penalty is found, resides, or transacts business. Where the Federal land manager is not represented by the Attorney General, a civil action may be initiated directly by the Federal land manager.

(j) *Other remedies not waived.* Assessment of a penalty under this section shall not be deemed a waiver of the right to pursue other available legal or administrative remedies.

§ 229.16 Civil penalty amounts.

(a) *Maximum amount of penalty.* (1) Where the person being assessed a civil penalty has not committed any previous violation of any prohibition in § 229.4 or of any term or condition included in a permit issued pursuant to this part, the maximum amount of the penalty shall be the full cost of restoration and repair of archaeological resources damaged plus the archaeological or commercial value of archaeological resources destroyed or not recovered.

(2) Where the person being assessed a civil penalty has committed any previous violation of any prohibition in § 229.4 or of any term or condition included in a permit issued pursuant to this part, the maximum amount of the penalty shall be double the cost of restoration and repair plus double the archaeological or commercial value of archaeological resources destroyed or not recovered.

(3) Violations limited to the removal of arrowheads located on the surface of the ground shall not be subject to the penalties prescribed in this section.

(b) *Determination of penalty amount, mitigation, and remission.* The Federal land manager may assess a penalty amount less than the maximum amount of penalty and may offer to mitigate or remit the penalty.

(1) Determination of the penalty amount and/or a proposal to mitigate or remit the penalty may be based upon any of the following factors:

(i) Agreement by the person being assessed a civil penalty to return to the Federal land manager archaeological resources removed from public lands or Indian lands;

(ii) Agreement by the person being assessed a civil penalty to assist the Federal land manager in activity to preserve, restore, or otherwise contribute to the protection and study of

archaeological resources on public lands or Indian lands;

(iii) Agreement by the person being assessed a civil penalty to provide information which will assist in the detection, prevention, or prosecution of violations of the Act or this part;

(iv) Demonstration of hardship or inability to pay, provided that this factor shall only be considered when the person being assessed a civil penalty has not been found to have previously violated the regulations in this part;

(v) Determination that the person being assessed a civil penalty did not willfully commit the violation;

(vi) Determination that the proposed penalty would constitute excessive punishment under the circumstances;

(vii) Determination of other mitigating circumstances appropriate to consideration in reaching a fair and expeditious assessment.

(2) When the penalty is for a violation on Indian lands, the Federal land manager shall consult with and consider the interests of the Indian landowner and the Indian tribe having jurisdiction over the Indian lands prior to proposing to mitigate or remit the penalty.

(3) When the penalty is for a violation which may have had an effect on a known Indian tribal religious or cultural site on public lands, the Federal land manager should consult with and consider the interests of the affected tribe(s) prior to proposing to mitigate or remit the penalty.

§ 229.17 Other penalties and rewards.

(a) Section 6 of the Act contains criminal prohibitions and provisions for criminal penalties. Section 8(b) of the Act provides that archaeological resources, vehicles, or equipment involved in a violation may be subject to forfeiture.

(b) Section 8(a) of the Act provides for rewards to be made to persons who furnish information which leads to conviction for a criminal violation or to assessment of a civil penalty. The Federal land manager may certify to the Secretary of the Treasury that a person is eligible to receive payment. Officers and employees of Federal, State, or local government who furnish information or render service in the performance of their official duties, and persons who have provided information under § 229.16(b)(1)(iii) shall not be certified eligible to receive payment of rewards.

(c) In cases involving Indian lands, all civil penalty monies and any item forfeited under the provisions of this section shall be transferred to the appropriate Indian or Indian tribe.

§ 229.18 Confidentiality of archaeological resource information.

(a) The Federal land manager shall not make available to the public, under subchapter II of chapter 5 of title 5 of the U.S. Code or any other provision of law, information concerning the nature and location of any archaeological resource, with the following exceptions:

(1) The Federal land manager may make information available, provided that the disclosure will further the purposes of the Act and this part, or the Act of June 27, 1960, as amended (16 U.S.C. 469–469c), without risking harm to the archaeological resource or to the site in which it is located.

(2) The Federal land manager shall make information available, when the Governor of any State has submitted to the Federal land manager a written request for information, concerning the archaeological resources within the requesting Governor's State, provided that the request includes:

(i) The specific archaeological resource or area about which information is sought;

(ii) The purpose for which the information is sought; and

(iii) The Governor's written commitment to adequately protect the confidentiality of the information.

(b) [Reserved]

§ 229.19 Report.

(a) Each Federal land manager, when requested by the Secretary of the Interior, will submit such information as is necessary to enable the Secretary to comply with section 13 of the Act and comprehensively report on activities carried out under provisions of the Act.

(b) The Secretary of the Interior will include in the annual comprehensive report, submitted to the Committee on Interior and Insular Affairs of the United States House of Representatives and to the Committee on Energy and Natural Resources of the United States Senate under section 13 of the Act, information on public awareness programs submitted by each Federal land manager under § 229.20(b). Such submittal will fulfill the Federal land manager's responsibility under section 10(c) of the Act to report on public awareness programs.

(c) The comprehensive report by the Secretary of the Interior also will include information on the activities carried out under section 14 of the Act. Each Federal land manager, when requested by the Secretary, will submit any available information on surveys and schedules and suspected violations in order to enable the Secretary to summarize in the comprehensive report actions taken pursuant to section 14 of the Act.

§ 229.20 Public awareness programs.

(a) Each Federal land manager will establish a program to increase public awareness of the need to protect important archaeological resources located on public and Indian lands. Educational activities required by section 10(c) of the Act should be incorporated into other current agency public education and interpretation programs where appropriate.

(b) Each Federal land manager annually will submit to the Secretary of the Interior the relevant information on public awareness activities required by section 10(c) of the Act for inclusion in the comprehensive report on activities required by section 13 of the Act.

§ 229.21 Surveys and schedules.

(a) The Secretaries of the Interior, Agriculture, and Defense and the Chairman of the Board of the Tennessee Valley Authority will develop plans for surveying lands under each agency's control to determine the nature and extent of archaeological resources pursuant to section 14(a) of the Act. Such activities should be consistent with Federal agency planning policies and other historic preservation program responsibilities required by 16 U.S.C. 470 *et seq.* Survey plans prepared under this section will be designed to comply with the purpose of the Act regarding the protection of archaeological resources.

(b) The Secretaries of the Interior, Agriculture, and Defense and the Chairman of the Tennessee Valley Authority will prepare schedules for surveying lands under each agency's control that are likely to contain the most scientifically valuable archaeological resources pursuant to section 14(b) of the Act. Such schedules will be developed based on objectives and information identified in survey plans described in paragraph (a) of this section and implemented systematically to cover areas where the most scientifically valuable archaeological resources are likely to exist.

(c) Guidance for the activities undertaken as part of paragraphs (a) through (b) of this section is provided by the Secretary of the Interior's Standards and Guidelines for Archeology and Historic Preservation.

(d) Other Federal land managing agencies are encouraged to develop plans for surveying lands under their jurisdictions and prepare schedules for surveying to improve protection and management of archaeological resources.

(e) The Secretaries of the Interior, Agriculture, and Defense and the Chairman of the Tennessee Valley Authority will develop a system for documenting and reporting suspected violations of the various provisions of the Act. This system will reference a set of procedures for use by officers, employees, or agents of Federal agencies to assist them in recognizing violations, documenting relevant evidence, and reporting assembled information to the appropriate authorities. Methods employed to document and report such violations should be compatible with existing agency reporting systems for documenting violations of other appropriate Federal statutes and regulations. Summary information to be included in the Secretary's comprehensive report will be based upon the system developed by each Federal land manager for documenting suspected violations.

Dated: July 25, 2007.

L.M. Bynum,

Alternate OSD Federal Register Liaison Officer, DoD.

[FR Doc. E7–14811 Filed 8–1–07; 8:45 am]

BILLING CODE 5001–06–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 117

[CGD05–07–025]

RIN 1625–AA09

Drawbridge Operation Regulations; Wicomico River (North Prong), Salisbury, MD

AGENCY: Coast Guard, DHS.

ACTION: Final rule.

SUMMARY: The Coast Guard is changing the drawbridge operation regulations of two Maryland Department of Transportation (MDOT) bridges: The Main Street and U.S. 50 Bridges, at mile 22.4, across Wicomico River (North Prong) in Salisbury, MD. This final rule will allow the bridges to open on signal if four hours advance notice is given and eliminate the continual attendance of draw tender services while still providing the reasonable needs of navigation.

DATES: This rule is effective September 4, 2007.

ADDRESSES: Comments and material received from the public, as well as documents indicated in this preamble as being available in the docket, are part of docket CGD05–07–025 and are available for inspection or copying at Commander (dpb), Fifth Coast Guard District, Federal Building, 1st Floor, 431 Crawford Street, Portsmouth, VA 23704–5004 between 8 a.m. and 4 p.m., Monday through Friday, except Federal holidays. The Fifth Coast Guard District maintains the public docket for this rulemaking.

FOR FURTHER INFORMATION CONTACT: Waverly W. Gregory, Jr., Bridge Administrator, Fifth Coast Guard District, at (757) 398–6222.

SUPPLEMENTARY INFORMATION:

Regulatory History

On April 5, 2007, we published a notice of proposed rulemaking (NPRM) entitled ''Drawbridge Operation Regulations; Wicomico River (North Prong), Salisbury, MD'' in the **Federal Register** (72 FR 16752). We received no comments on the proposed rule. No public meeting was requested, and none was held.

Background and Purpose

The State Highway Administration (SHA), a division under MDOT, is responsible for the operation of both the Main Street and U.S. 50 Bridges, at mile 22.4, across Wicomico River in Salisbury. SHA requested advance notification for vessel openings and a reduction in draw tender services due to the infrequency of requests for vessel openings of the drawbridges.

The Main Street and U.S. 50 Bridges have vertical clearances of four feet, above mean high water, in the closed-to-navigation position. The existing operating regulations for these drawbridges are set out in 33 CFR § 117.579, which requires the draws to open on signal, except from 7 a.m. to 9 a.m., from 12 noon to 1 p.m. and from 4 p.m. to 6 p.m., the draw need not be opened for the passage of vessels, except for tugs with tows, if at least three hours of advance notice is given, and the reason for passage through the bridges during a closure period is due to delay caused by inclement weather or other emergency or unforeseen circumstances.

Bridge opening data supplied by SHA revealed a significant decrease in yearly openings. In the past three years from 2004 to 2006, the bridges opened for vessels 522, 282 and 157 times, respectively. Due to the infrequency of requests for vessel openings of the drawbridges, SHA requested to change the current operating regulations by requiring the draw spans to open on signal if at least four hours notice is given year-round by calling the contact telephone number at (410) 430–7561.

Discussion of Comments and Changes

The Coast Guard did not receive any comments on the NPRM. Therefore, no changes were made to the final rule.

Discussion of Rule

The Coast Guard is amending 33 CFR 117.579, which governs the Main Street and U.S. 50 Bridges, by revising the paragraph to read that the draws shall open on signal if at least four hours notice is given by calling the telephone contact number at (410) 430–7461. Under this revision, there will no longer be closure periods. All vessels will be required to provide at least four hours notice.

Regulatory Evaluation

This rule is not a ''significant regulatory action'' under section 3(f) of Executive Order 12866, Regulatory Planning and Review, and does not require an assessment of potential costs and benefits under section 6(a)(3) of that Order. The Office of Management and Budget has not reviewed it under that Order. It is not ''significant'' under the regulatory policies and procedures of the Department of Homeland Security (DHS).

This conclusion is based on the fact that these changes have only a minimal impact on maritime traffic transiting the bridges. Mariners will no longer have to wait for closure periods to end, which will allow them to plan their trips without requiring a stop, so long as the four hour notice is provided. ″

Small Entities

Under the Regulatory Flexibility Act (5 U.S.C. 601–612), we have considered whether this rule would have a significant economic impact on a substantial number of small entities. The term ''small entities'' comprises small businesses, not-for-profit organizations that are independently owned and operated and are not dominant in their fields, and governmental jurisdictions with populations of less than 50,000.

The Coast Guard certifies under 5 U.S.C. 605(b) that this rule would not have a significant economic impact on a substantial number of small entities.

This conclusion is based on the fact the rule would not have a significant economic impact on a substantial number of small entities because the rule relieves restrictions to the movement of navigation, as mariners will no longer have to wait for closure periods to end, which will allow them to plan their trips without requiring a stop, so long as the four hour notice is provided.

Assistance for Small Entities

Under section 213(a) of the Small Business Regulatory Enforcement Fairness Act of 1996 (Pub. L. 104–121), we want to assist small entities in understanding this rule so that they can better evaluate its effects on them and participate in the rulemaking process. No assistance was requested from any small entity.

Collection of Information

This rule calls for no new collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520.).

Federalism

A rule has implications for federalism under Executive Order 13132, Federalism, if it has a substantial direct effect on State or local governments and would either preempt State law or impose a substantial direct cost of compliance on them. We have analyzed this rule under that Order and have determined that it does not have implications for federalism.

Unfunded Mandates Reform Act

The Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1531–1538) requires Federal agencies to assess the effects of their discretionary regulatory actions. In particular, the Act addresses actions that may result in the expenditure by a State, local, or tribal government, in the aggregate, or by the private sector of $100,000,000 or more in any one year. Though this rule will not result in such an expenditure, we do discuss the effects of this rule elsewhere in this preamble.

Taking of Private Property

This rule will not effect a taking of private property or otherwise have taking implications under Executive Order 12630, Governmental Actions and Interference with Constitutionally Protected Property Rights.

Civil Justice Reform

This rule meets applicable standards in sections 3(a) and 3(b)(2) of Executive Order 12988, Civil Justice Reform, to minimize litigation, eliminates ambiguity, and reduce burden.

Protection of Children

We have analyzed this rule under Executive Order 13045, Protection of Children from Environmental Health Risks and Safety Risks. This rule is not an economically significant rule and would not create an environmental risk to health or risk to safety that might disproportionately affect children.

Indian Tribal Governments

This rule does not have tribal implications under Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, because it would not have a substantial direct effect on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes.

Energy Effects

We have analyzed this rule under Executive Order 13211, Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use. We have determined that it is not a ''significant energy action'' under that order because it is not a ''significant regulatory action'' under Executive Order 12866 and is not likely to have a significant adverse effect on the supply, distribution, or use of energy. The Administrator of the Office of Information and Regulatory Affairs has not designated it as a significant energy action. Therefore, it does not require a Statement of Energy Effects under Executive Order 13211.

Technical Standards

The National Technology Transfer and Advancement Act (NTTAA) (15 U.S.C. 272 note) directs agencies to use voluntary consensus standards in their regulatory activities unless the agency provides Congress, through the Office of Management and Budget, with an explanation of why using these standards would be inconsistent with applicable law or otherwise impractical. Voluntary consensus standards are technical standards (e.g., specifications of materials, performance, design, or operation; test methods; sampling procedures; and related management systems practices) that are developed or adopted by voluntary consensus standards bodies.

This rule does not use technical standards. Therefore, we did not consider the use of voluntary consensus standards.

Environment

We have analyzed this rule under Commandant Instruction M16475.1D and Department of Homeland Security Management Directive 5100.1, which guide the Coast Guard in complying with the National Environmental Policy Act of 1969 (NEPA) (42 U.S.C. 4321–4370f), and have concluded that there are no factors in this case that would limit the use of a categorical exclusion under section 2.B.2 of the Instruction. Therefore, this rule is categorically excluded, under figure 2–1, paragraph (32)(e) of the Instruction, from further environmental documentation because it has been determined that the promulgation of operating regulations for drawbridges are categorically excluded.

List of Subjects in 33 CFR Part 117

Bridges.

■ For the reasons discussed in the preamble, the Coast Guard amends 33 CFR part 117 as follows:

PART 117—DRAWBRIDGE OPERATION REGULATIONS

■ 1. The authority citation for part 117 continues to read as follows:

Authority: 33 U.S.C. 499; Department of Homeland Security Delegation No. 0170.1; 33 CFR 1.05–1(g); section 117.255 also issued under the authority of Pub. L. 102–587, 106 Stat. 5039.

■ 2. Revise § 117.579 to read as follows:

§ 117.579 Wicomico River (North Prong).

The draws of the Main Street and U.S. 50 bridges, mile 22.4, Salisbury, Maryland shall open on signal if at least four hours notice is given by calling the telephone contact number at (410) 430–7461.

Dated: July 24, 2007.

Fred M. Rosa, Jr.,

Rear Admiral, United States Coast Guard, Commander, Fifth Coast Guard District.

[FR Doc. E7–14936 Filed 8–1–07; 8:45 am]

BILLING CODE 4910–15–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 165

[Docket No. COTP North Carolina CGD05–07–071]

RIN 1625–AA00

Safety Zone for Marine Events; New River, Jacksonville, NC

AGENCY: Coast Guard, DHS.

ACTION: Temporary final rule.

SUMMARY: The Coast Guard is establishing a temporary Safety Zone during the ''National Night Out'', an event to be held August 7, 2007 on the New River, Jacksonville, North Carolina. This safety zone is necessary to provide for the safety of life on navigable waters during the event. This action is intended to temporarily restrict vessel traffic in the New River to accommodate a Helicopter Search and Rescue demonstration and a fireworks display.

DATES: This rule is effective from 5:30 p.m. to 10 p.m. on August 7, 2007.

ADDRESSES: Documents indicated in this preamble as being available in the docket are part of docket CGD05–07–071 and are available for inspection or copying at Commander (dpi), Fifth Coast Guard District, 431 Crawford Street, Portsmouth, Virginia 23704–5004, between 9 a.m. and 2 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: D. M. Sens, Project Manager, Inspections and Investigations Branch, at (757) 398–6204.

SUPPLEMENTARY INFORMATION:

Regulatory Information

We did not publish a notice of proposed rulemaking (NPRM) for this regulation. Under 5 U.S.C. 553(b)(B), the Coast Guard finds that good cause exists for not publishing an NPRM. Publishing an NPRM would be impracticable and contrary to public interest because immediate action is needed to minimize potential danger to the public during the event. The necessary information to determine whether the marine event poses a threat to persons and vessels was not provided to the Coast Guard in sufficient time to publish an NPRM. The potential dangers posed by the helicopter demonstration and pyrotechnic fireworks display, make a safety zone necessary to provide for the safety of spectator craft and other vessels transiting the event area. The Coast Guard will issue a broadcast notice to mariners to advise mariners of the restriction and on scene Coast Guard and local law enforcement vessels will also provide notice to mariners.

Under 5 U.S.C. 553(d)(3) and for the same reasons, the Coast Guard finds that good cause exists for making this rule effective less than 30 days after publication in the **Federal Register**. Delaying the effective date would be contrary to the public interest, because immediate action is needed to ensure the safety of the event participants, spectator craft and other vessels transiting the event area. Advance notifications will be made to users of the New River, via marine information broadcasts, local notice to mariners, commercial radio stations and area newspapers.

Background and Purpose

On August 7, 2007, the Jacksonville Police Department will sponsor the ''National Night Out'' Helicopter Search and Rescue (SAR) demonstration and fireworks display. These events will take place on the New River near position 34°44′45″ N 077°26′18″ W. The Helicopter SAR Demonstration will consist of a basket hoist from a Coast Guard small boat. The fireworks display will be launched from shore and will have a fallout area over the waters of the New River. The safety zone is necessary to safe guard the SAR demonstration team as well as the spectator fleet expected by the sponsor. Due to the need for vessel control during these events, vessel traffic will be temporarily restricted to provide for the safety of SAR demonstration team, spectators and transiting vessels.

Discussion of Rule

The Coast Guard is establishing a safety zone on specified waters of the New River, Jacksonville, North Carolina. The regulated area includes all waters within a 300 yard radius of position 34°44′45″ N 077°26′18″ W or approximately one half nautical mile south of the Hwy 17 bridge, Jacksonville, North Carolina. The safety zone will be in effect from 5:30 p.m. to 10 p.m. on August 7, 2007. The effect will be to restrict general navigation in the regulated area during the SAR demonstration and the fireworks display. Except for persons or vessels authorized by the Coast Guard Patrol Commander, no person or vessel may enter or remain in the regulated area during the enforcement period. The Patrol Commander will notify the public of specific enforcement times by Marine Radio Safety Broadcast. These regulations are needed to control vessel traffic during the event to enhance the safety of participants, spectators and transiting vessels.

Regulatory Evaluation

This rule is not a ''significant regulatory action'' under section 3(f) of Executive Order 12866, Regulatory Planning and Review, and does not require an assessment of potential costs and benefits under section 6(a)(3) of that Order. The Office of Management and Budget has not reviewed it under that Order.

Although this regulation restricts vessel traffic from transiting the New River, near Jacksonville, North Carolina during the event, the effect of this regulation will not be significant due to the limited duration that the safety zone will be in effect and the extensive advance notifications that will be made to the maritime community via marine information broadcasts and area newspapers so mariners can adjust their plans accordingly.

Small Entities

Under the Regulatory Flexibility Act (5 U.S.C. 601–612), we have considered whether this rule would have a significant economic impact on a substantial number of small entities. The term ''small entities'' comprises small businesses, not-for-profit organizations that are independently owned and operated and are not dominant in their fields, and governmental jurisdictions with populations of less than 50,000.

The Coast Guard certifies under 5 U.S.C. 605(b) that this rule will not have a significant economic impact on a substantial number of small entities. This rule will affect the following entities, some of which may be small entities: The owners or operators of vessels intending to transit the New River, near Jacksonville, North Carolina during the event.

This rule will not have a significant economic impact on a substantial number of small entities for the following reasons. This rule will be in effect for only a short period, from 5:30 p.m. to 10 p.m. on August 7, 2007. Before the enforcement period, we will issue maritime advisories so mariners can adjust their plans accordingly.

Assistance for Small Entities

Under section 213(a) of the Small Business Regulatory Enforcement Fairness Act of 1996 (Pub. L. 104–121), we want to assist small entities in understanding this proposed rule so that they can better evaluate its effects on them and participate in the rulemaking. If the rule would affect your small business, organization, or governmental jurisdiction and you have questions concerning its provisions or options for compliance, please contact the address listed under **ADDRESSES**.

Small businesses may send comments on the actions of Federal employees who enforce, or otherwise determine compliance with, Federal regulations to the Small Business and Agriculture Regulatory Enforcement Ombudsman and the Regional Small Business Regulatory Fairness Boards. The Ombudsman evaluates these actions annually and rates each agency's responsiveness to small business. If you wish to comment on actions by employees of the Coast Guard, call 1–888–REG–FAIR (1–888–734–3247). The Coast Guard will not retaliate against small entities that question or complain about this rule or any policy or action of the Coast Guard.

Collection of Information

This rule calls for no new collection of information under the Paperwork

Reduction Act of 1995 (44 U.S.C. 3501–3520).

Federalism

A rule has implications for federalism under Executive Order 13132, Federalism, if it has a substantial direct effect on State or local governments and would either preempt State law or impose a substantial direct cost of compliance on them. We have analyzed this rule under that Order and have determined that it does not have implications for federalism.

Unfunded Mandates Reform Act

The Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1531–1538) requires Federal agencies to assess the effects of their discretionary regulatory actions. In particular, the Act addresses actions that may result in the expenditure by a State, local, or tribal government, in the aggregate, or by the private sector of $100,000,000 or more in any one year. Though this rule will not result in such an expenditure, we do discuss the effects of this rule elsewhere in this preamble.

Taking of Private Property

This rule will not effect a taking of private property or otherwise have taking implications under Executive Order 12630, Governmental Actions and Interference with Constitutionally Protected Property Rights.

Civil Justice Reform

This rule meets applicable standards in sections 3(a) and 3(b)(2) of Executive Order 12988, Civil Justice Reform, to minimize litigation, eliminate ambiguity, and reduce burden.

Protection of Children

We have analyzed this rule under Executive Order 13045, Protection of Children from Environmental Health Risks and Safety Risks. This rule is not an economically significant rule and does not create an environmental risk to health or risk to safety that may disproportionately affect children.

Indian Tribal Governments

This rule does not have tribal implications under Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, because it does not have a substantial direct effect on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes.

Energy Effects

We have analyzed this rule under Executive Order 13211, Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use. We have determined that it is not a ''significant energy action'' under that order because it is not a ''significant regulatory action'' under Executive Order 12866 and is not likely to have a significant adverse effect on the supply, distribution, or use of energy. The Administrator of the Office of Information and Regulatory Affairs has not designated it as a significant energy action. Therefore, it does not require a Statement of Energy Effects under Executive Order 13211.

Technical Standards

The National Technology Transfer and Advancement Act (NTTAA) (15 U.S.C. 272 note) directs agencies to use voluntary consensus standards in their regulatory activities unless the agency provides Congress, through the Office of Management and Budget, with an explanation of why using these standards would be inconsistent with applicable law or otherwise impractical. Voluntary consensus standards are technical standards (e.g., specifications of materials, performance, design, or operation; test methods; sampling procedures; and related management systems practices) that are developed or adopted by voluntary consensus standards bodies.

This rule does not use technical standards. Therefore, we did not consider the use of voluntary consensus standards.

Environment

We have analyzed this rule under Commandant Instruction M16475.lD and Department of Homeland Security Management Directive 5100.1, which guide the Coast Guard in complying with the National Environmental Policy Act of 1969 (NEPA) (42 U.S.C. 4321–4370f), and have concluded that there are no factors in this case that would limit the use of a categorical exclusion under section 2.B.2 of the Instruction. Therefore, this rule is categorically excluded, under figure 2–1, paragraph (34)(g), of the Instruction, from further environmental documentation.

A final ''Environmental Analysis Check List'' and a final ''Categorical Exclusion Determination'' will be available in the docket where indicated under **ADDRESSES**.

List of Subjects in 33 CFR Part 165

Harbors, Marine safety, Navigation (water), Reporting and recordkeeping requirements, Security measures, Waterways.

■ For the reasons discussed in the preamble, the Coast Guard amends 33 CFR part 165 as follows:

PART 165—REGULATED NAVIGATION AREAS AND LIMITED ACCESS AREAS

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

Authority: 33 U.S.C. 1226, 1231; 46 U.S.C. Chapter 701; 50 U.S.C. 191, 195; 33 CFR 1.05–1(g), 6.04–1, 6.04–6 and 160.5; Pub. L. 107–295, 116 Stat. 2064; Department of Homeland Security Delegation No. 0170.1.

■ 2. Add temporary § 165.T05–071 to read as follows:

§ 165.T05–071 Safety zone; New River, approximate one half mile south of the HWY 17 Bridge, south of Jacksonville, North Carolina.

(a) *Regulated area.* The regulated area includes all waters within a 300 yard radius of position 34°44′45″ North 077°26′18″ West, approximately one half nautical mile south of the HWY 17 bridge, Jacksonville, North Carolina. All coordinates reference Datum NAD 1983.

(b) *Definitions. Coast Guard Patrol Commander* means a commissioned, warrant, or petty officer of the Coast Guard who has been designated by the Commander, Coast Guard Sector North Carolina.

(2) *Official Patrol* means any vessel assigned or approved by Commander, Coast Guard Sector North Carolina with a commissioned, warrant, or petty officer on board and displaying a Coast Guard ensign.

(c) *Safety Zone regulations.* (1) Except for persons or vessels authorized by the Coast Guard Patrol Commander, no person or vessel may enter or remain in the regulated area.

(2) The operator of any vessel in the regulated area shall: (i) Stop the vessel immediately when directed to do so by any Official Patrol.

(ii) Proceed as directed by any official patrol.

(d) *Enforcement period.* This section will be enforced from 5:30 p.m. to 10 p.m. on August 7, 2007.

Dated: July 9, 2007.

William D. Lee,

Captain of the Port, Coast Guard Sector North Carolina.

[FR Doc. E7–14939 Filed 8–1–07; 8:45 am]

BILLING CODE 4910–15–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

46 CFR Part 67

[USCG–2007–28098]

RIN 1625–AB18

Vessel Documentation; Recording of Instruments

AGENCY: Coast Guard, DHS.

ACTION: Direct final rule; request for comments.

SUMMARY: By this direct final rule, the Coast Guard is amending the vessel documentation regulations to eliminate the requirement to provide certain original documents to the National Vessel Documentation Center (NVDC) for recording, and to eliminate the additional fee for filing by facsimile. We are undertaking this rulemaking to conform our business practices with similar functions provided by other governmental entities and to allow our customers to avail themselves of better service through electronic filing. This rulemaking is expected to improve efficiency at the NVDC and permit the use of improved information collection technology.

DATES: This rule is effective October 31, 2007, unless an adverse comment, or notice of intent to submit an adverse comment, reaches the Docket Management Facility on or before October 1, 2007. If an adverse comment, or notice of intent to submit an adverse comment, is received, we will withdraw this direct final rule and publish a timely notice of withdrawal in the **Federal Register**.

ADDRESSES: You may submit comments identified by Coast Guard docket number USCG–2007–28098 to the Docket Management Facility at the U.S. Department of Transportation. To avoid duplication, please use only one of the following methods:

(1) *Web Site: http://dms.dot.gov.*

(2) *Mail:* Docket Management Facility (M–30), U.S. Department of Transportation, West Building, Ground Floor, Room W12–140, 1200 New Jersey Avenue, SE., Washington, DC 20590.

(3) *Fax:* 202–493–2251.

(4) *Delivery:* Room W12–140 on the Ground Floor of the West Building, 1200 New Jersey Avenue, SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The telephone number is 202–366–9329.

(5) *Federal eRulemaking Portal: http://www.regulations.gov.*

FOR FURTHER INFORMATION CONTACT: If you have questions on this rule, call Mr. Thomas L. Willis, Director, National Vessel Documentation Center, U.S. Coast Guard, telephone 304–271–2506. If you have questions on viewing or submitting material to the docket, call Renee V. Wright, Program Manager, Docket Operations, telephone 202–366–9826.

SUPPLEMENTARY INFORMATION:

Submitting comments: If you submit a comment, please include your name and address, identify the docket number for this rulemaking (USCG–2007–28098), indicate the specific section of this document to which each comment applies, and give the reason for each comment. You may submit your comments and material by electronic means, mail, fax, or delivery to the Docket Management Facility at the address under **ADDRESSES**; but please submit your comments and material by only one means. If you submit them by mail or delivery, submit them in an unbound format, no larger than 8½ by 11 inches, suitable for copying and electronic filing. If you submit them by mail and would like to know that they reached the Facility, please enclose a stamped, self-addressed postcard or envelope. We will consider all comments and material received during the comment period. We may change this rule in view of them.

Viewing comments and documents: To view comments, as well as documents mentioned in this preamble as being available in the docket, go to *http://dms.dot.gov* at any time, click on ''Simple Search,'' enter the last five digits of the docket number for this rulemaking, and click on ''Search.'' You may also visit the Docket Management Facility in Room W12–140 on the ground floor of the DOT West Building, 1200 New Jersey Avenue, SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

Privacy Act: Anyone can search the electronic form of all comments received into any of our dockets by the name of the individual submitting the comment (or signing the comment, if submitted on behalf of an association, business, labor union, etc.). You may review the Department of Transportation's Privacy Act Statement in the **Federal Register** published on April 11, 2000 (65 FR 19477), or you may visit *http://dms.dot.gov.*

Regulatory Information

We are publishing a direct final rule under 33 CFR 1.05–55 because we do not expect an adverse comment. If no adverse comment or notice of intent to submit an adverse comment is received by October 1, 2007, this rule will become effective as stated in the **DATES** section. In that case, approximately 30 days before the effective date, we will publish a document in the **Federal Register** stating that no adverse comment was received and confirming that this rule will become effective as scheduled. However, if we receive an adverse comment or notice of intent to submit an adverse comment, we will publish a document in the **Federal Register** announcing the withdrawal of all or part of this direct final rule. If an adverse comment applies only to part of this rule (e.g., to an amendment, a paragraph, or a section) and it is possible to remove that part without defeating the purpose of this rule, we may adopt, as final, those parts of this rule on which no adverse comment was received. We will withdraw the part of this rule that was the subject of an adverse comment. If we decide to proceed with a rulemaking following receipt of an adverse comment, we will publish a separate notice of proposed rulemaking (NPRM) and provide a new opportunity for comment.

A comment is considered ''adverse'' if the comment explains why this rule or a part of this rule would be inappropriate, including a challenge to its underlying premise or approach, or would be ineffective or unacceptable without a change.

Background and Purpose

We are undertaking this rulemaking to conform our business practices with similar functions provided by other governmental entities and to allow our customers to avail themselves of better service through electronic filing. It will also permit implementation of the Electronic Signature Act in maritime financial transactions. In addition, we are eliminating the need for multiple copies of instruments to conform to changing business practices within the Coast Guard.

The Coast Guard records bills of sale, mortgages, and related instruments in accordance with the provisions of Chapter 313 of Title 46 of the U.S. Code. This is similar to service provided by county registries of deeds for real estate. However, unlike county registries, the Coast Guard requires the submission of an originally signed instrument accompanied by one or more copies. In addition, it has kept originally signed instruments and returned the copy or copies after annotating them with information about the recording.

In 1982, the Coast Guard promulgated a rule which required original instruments to be provided (47 FR

27490, June 24, 1982). The Coast Guard reaffirmed that rule in 1993, following codification of the Ship Mortgage Act (58 FR 60256, November 15, 1993). The Coast Guard's practice and regulation was further buttressed in 1996 when Congress enacted section 305 of Public Law 104–324 providing clear authority to accept instruments by electronic means, but requiring submission of the originals within ten days of the electronic filing. However, after enactment of the Electronic Signatures in Global and National Commerce Act, Public Law 106–229, Congress in 2002 amended section 31321((a)(4) of Title 46, U.S. Code, by repealing the requirement to present original instruments within ten days following electronic filing (Pub. L. 107–295, section 420). (See also, 15 U.S.C. 7031 encouraging the use of electronic signatures and the elimination of paper-based obstacles to electronic transactions.)

In 2006, the Coast Guard began scanning all instruments into an electronic data base from which copies may be printed. Providing a copy from the data base rather than annotating a copy provided by the submitter is a better business practice for two primary reasons. First, it is no longer necessary to track copies of paperwork through the office. More importantly, however, it ensures that the copy returned to the submitter is a true copy of what appears in the electronic data base and not something that merely appears to be a true copy.

Discussion of Rule

Section 67.209 is amended to eliminate the need to submit originally signed instruments plus a copy. Section 67.219 is amended to eliminate the need to submit original instruments after filing by facsimile. Section 67.218 is a new section providing procedures for filing by submitting the instrument in Portable Document Filing, commonly referred to as ''pdf''. The fee for filing by facsimile is deleted. Instruments may be submitted to the National Vessel Documentation Center for filing by e-mailing them as .pdf attachments to *NVDC.pdf.filing@uscg.mil.*

Regulatory Evaluation

This rule is not a ''significant regulatory action'' under section 3(f) of Executive Order 12866 and does not require an assessment of potential costs and benefits under section 6(a)(3) of that Order. The Office of Management and Budget has not reviewed it under that Order. We expect the economic impact of this rule to be so minimal that a full Regulatory Evaluation is unnecessary.

There are no new costs or requirements associated with this rule. Although persons filing instruments need send only a single copy, the savings are insignificant.

Small Entities

Under the Regulatory Flexibility Act (5 U.S.C. 601–612), we have considered whether this rule would have a significant economic impact on a substantial number of small entities. The term ''small entities'' comprises small businesses, not-for-profit organizations that are independently owned and operated and are not dominant in their fields, and governmental jurisdictions with populations of less than 50,000.

This rule will affect the following small entities: Small businesses, individuals, nonprofit organizations, and municipal governments currently owning documented vessels or seeking to document vessels in the future; brokers, attorneys, and law offices providing vessel documentation services; small shipbuilders building vessels which are subsequently documented; boat dealers selling vessels of at least five (5) net tons in size; and lending institutions engaging in preferred mortgage financing.

The changes in this rulemaking are procedural and administrative in nature. The changes are technical amendments which the affected small entities should have little difficulty understanding or adopting into their business practices. Moreover, there are no new reporting, recordkeeping or other requirements for compliance.

Therefore, the Coast Guard certifies under 5 U.S.C. 605(b) that this rule will not have a significant economic impact on a substantial number of small entities. If, however, you think that your business qualifies as a small entity and that this proposal will have a significant impact on your business, please submit a comment [see ''**ADDRESSES**''] explaining why you think your business qualifies and in what way and to what degree this rulemaking will economically affect your business. Comments submitted in response to this finding will be evaluated under the criteria in the ''Regulatory Information'' section of this preamble.

Assistance for Small Entities

Under section 213(a) of the Small Business Regulatory Enforcement Fairness Act of 1996 (Pub. L. 104–121), we want to assist small entities in understanding this rule so that they can better evaluate its effects on them and participate in the rulemaking. If the rule will affect your small business, organization, or governmental jurisdiction and you have questions concerning its provisions or options for compliance, please consult Mr. Thomas L. Willis, Director of the National Vessel Documentation Center, 792 TJ Jackson Drive, Falling Waters, WV 25419, telephone 304 271–2400. The Coast Guard will not retaliate against small entities that question or complain about this rule or any policy or action of the Coast Guard.

Collection of Information

This rule calls for no new collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520). Additionally, the Coast Guard estimates this rule will result in no change to the information collection burden associated with the existing collection of information entitled, ''Vessel Documentation,'' Office of Management and Budget Control Number 1625–0027, which expires on January 31, 2010.

Federalism

A rule has implications for federalism under Executive Order 13132, Federalism, if the rule has a substantial direct effect on State or local governments and would either preempt State law or impose a substantial direct cost of compliance on them. We have analyzed this rule under that Order and have determined that it does not have implications for federalism.

Unfunded Mandates Reform Act

The Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1531–1538) requires Federal agencies to assess the effects of their discretionary regulatory actions. In particular, the Act addresses actions that may result in the expenditure by a State, local, or tribal government, in the aggregate, or by the private sector of $100,000,000 or more in any one year. Though this rule will not result in such an expenditure, we do discuss the effects of this rule elsewhere in this preamble.

Taking of Private Property

This rule will not effect a taking of private property or otherwise have taking implications under Executive Order 12630, Governmental Actions and Interference with Constitutionally Protected Property Rights.

Civil Justice Reform

This rule meets applicable standards in sections 3(a) and 3(b)(2) of Executive Order 12988, Civil Justice Reform, to minimize litigation, eliminate ambiguity, and reduce burden.

Protection of Children

We have analyzed this rule under Executive Order 13045, Protection of Children from Environmental Health Risks and Safety Risks. This rule is not an economically significant rule and does not create an environmental risk to health or risk to safety that may disproportionately affect children.

Indian Tribal Governments

This rule does not have tribal implications under Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, because it does not have a substantial direct effect on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes.

Energy Effects

We have analyzed this rule under Executive Order 13211, Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use. We have determined that it is not a ''significant energy action'' under that order because it is not a ''significant regulatory action'' under Executive Order 12866 and is not likely to have a significant adverse effect on the supply, distribution, or use of energy. The Administrator of the Office of Information and Regulatory Affairs has not designated it as a significant energy action. Therefore, it does not require a Statement of Energy Effects under Executive Order 13211.

Technical Standards

The National Technology Transfer and Advancement Act (NTTAA) (15 U.S.C. 272 note) directs agencies to use voluntary consensus standards in their regulatory activities unless the agency provides Congress, through the Office of Management and Budget, with an explanation of why using these standards would be inconsistent with applicable law or otherwise impractical. Voluntary consensus standards are technical standards (e.g., specifications of materials, performance, design, or operation; test methods; sampling procedures; and related management systems practices) that are developed or adopted by voluntary consensus standards bodies.

This rule does not use technical standards. Therefore, we did not consider the use of voluntary consensus standards.

Environment

We have analyzed this rule under Commandant Instruction M16475.lD, which guides the Coast Guard in complying with the National Environmental Policy Act of 1969 (NEPA)(42 U.S.C. 4321–4370f), and have concluded that there are no factors in this case that would limit the use of a categorical exclusion under section 2.B.2 of the Instruction. Therefore, this rule is categorically excluded, under figure 2–1, paragraph (34)(d), of the Instruction from further environmental documentation. These regulations concern the documentation of vessels. Under figure 2–1, paragraph (34)(d), of the Instruction, an ''Environmental Analysis Check List'' and a ''Categorical Exclusion Determination'' are not required for this rule.

List of Subjects in 46 CFR Part 67

Reporting and recordkeeping requirements, Vessels.

■ For the reasons discussed in the preamble, the Coast Guard amends 46 CFR part 67 as follows:

Title 46—Shipping

PART 67—DOCUMENTATION OF VESSELS

■ 1. The authority citation for part 67 continues to read as follows:

Authority: 14 U.S.C. 1664; 31 U.S.C. 9701; 42 U.S.C. 9118; 46 U.S.C. 2103, 2107, 2110, 12106, 12120, 12122; 46 U.S.C. app. 841a, 876; Department of Homeland Delegation No. 0170.1.

■ 2. Revise § 67.209 to read as follows:

§ 67.209 No original instrument requirement.

A copy of the original signed and acknowledged instrument must be presented. The original instrument itself may be presented but is not required. The copy may be delivered to the National Vessel Documentation Center or transmitted by facsimile or in portable document format (.pdf) in accordance with the procedures in §§ 67.218 and 67.219 of this part. Signatures may be affixed manually or digitally.

■ 3. Add new § 67.218 to subpart O to read as follows:

§ 67.218 Optional filing of instruments in portable document format as attachments to electronic mail.

(a) Any instrument identified as eligible for filing and recording under § 67.200 may be submitted in portable document format (.pdf) as an attachment to electronic mail (e-mail) for filing at the National Vessel Documentation Center. The e-mail address to be used for instrument filing may be obtained from the National Vessel Documentation Center Web site. If the instrument submitted for filing in .pdf format pertains to a vessel that is not a currently documented vessel, a completed Application for Initial Issue, Exchange, or Replacement Certificate of Documentation, or Return to Documentation (form CG–1258) or a letter application for deletion from documentation must already be on file with the National Vessel Documentation Center or must be submitted in .pdf format with the instrument being submitted in .pdf format for filing.

(b) All instruments submitted for filing in .pdf format must be clearly legible, be submitted from 8½ inch by 11 inch paper in not less than 10-point type size, and submitted as an attachment to e-mail.

(c) The e-mail required by paragraph (b) should indicate:

(1) The name, address, telephone number, and e-mail address of the person submitting the instrument for filing in .pdf format;

(2) The number of pages submitted for filing in .pdf format; and

(3) The name of the vessel, official number or hull identification number of the vessel(s), and the name(s) of the owner(s) of the vessel(s) to which the instrument relates.

(d) The filing of any instrument submitted for filing in .pdf format is terminated and the instrument will be returned to the submitter if the instrument is subject to termination for any cause under § 67.217(a).

■ 4. Revise § 67.219 to read as follows:

§ 67.219 Optional filing of instruments by facsimile.

(a) Any instrument identified as eligible for filing and recording under § 67.200 may be submitted for filing to the National Vessel Documentation Center by facsimile at (304) 271–2405. If the instrument submitted by facsimile for filing pertains to a vessel that is not a currently documented vessel, a completed Application for Initial Issue, Exchange, or Replacement Certificate of Documentation, or Return to Documentation (form CG–1258) or a letter application for deletion from documentation must already be on file with the National Vessel Documentation Center or must be submitted by facsimile with the instrument being submitted by facsimile for filing.

(b) All instruments submitted by facsimile for filing must be clearly legible, be submitted from 81/2 inch by 11 inch paper in not less than 10-point type size, and accompanied by a cover sheet.

(c) The cover sheet required by paragraph (b) should indicate:

(1) The name, address, telephone number, and facsimile telephone number of the person submitting the instrument by facsimile;

(2) The number of pages submitted by facsimile; and

(3) The name of the vessel, official number or hull identification number of the vessel(s), and the name(s) of the owner(s) of the vessel(s) to which the instrument relates.

(d) The filing of any instrument submitted by facsimile is terminated and the instrument will be returned to the submitter if the instrument is subject to termination for any cause under § 67.217(a).

§ 67.540 [Removed]

■ 5. Remove § 67.540.

§ 67.550 [Amended]

■ 6. Amend § 67.550 by removing from Table 67.550–Fees, the entry reading: ''Facsimile submission handling Subpart O 2.00 [1].''

Dated: July 26, 2007.

J.G. Lantz,

Acting Assistant Commandant For Prevention, U.S. Coast Guard.

[FR Doc. E7–14938 Filed 8–1–07; 8:45 am]

BILLING CODE 4910–15–P

DEPARTMENT OF DEFENSE

Defense Acquisition Regulations System

48 CFR Parts 202 and 204

Defense Federal Acquisition Regulation Supplement; Technical Amendments

AGENCY: Defense Acquisition Regulations System, Department of Defense (DoD).

ACTION: Final rule.

SUMMARY: DoD is making technical amendments to the Defense Federal Acquisition Regulation Supplement (DFARS) to update organization names, office symbols, and an Internet address.

DATES: *Effective Date:* August 2, 2007.

FOR FURTHER INFORMATION CONTACT: Ms. Michele Peterson, Defense Acquisition Regulations System, OUSD(AT&L)DPAP(DARS), IMD 3C132, 3062 Defense Pentagon, Washington, DC 20301–3062. Telephone (703) 602–0311; facsimile (703) 602–7887.

SUPPLEMENTARY INFORMATION: This final rule amends DFARS text as follows:

• *Section 202.101.* Updates the lists of Army and Defense Logistics Agency contracting activities.

• *Section 204.7005.* Updates the Internet address for DoD order code assignment listings, and updates the office symbol for the Air Force order code monitor.

List of Subjects in 48 CFR Parts 202 and 204

Government procurement.

Michele P. Peterson,

Editor, Defense Acquisition Regulations System.

■ Therefore, 48 CFR Parts 202 and 204 are amended as follows:

PART 202—DEFINITIONS OF WORDS AND TERMS

■ 1. The authority citation for 48 CFR Parts 202 and 204 continues to read as follows:

Authority: 41 U.S.C. 421 and 48 CFR Chapter 1.

■ 2. Section 202.101 is amended in the definition of ''Contracting activity'' as follows:

■ a. By revising the list with the heading ''ARMY''; and

■ b. Under the heading ''DEFENSE LOGISTICS AGENCY'', by removing ''Office of the Deputy Director, Logistics Operations'' and adding in its place ''Acquisition Management Directorate''. The revised list reads as follows:

202.101 Definitions.

* * * * *

Army

Headquarters, U.S. Army Contracting Agency Joint Contracting Command—Iraq/Afghanistan
National Guard Bureau
Program Executive Office for Simulation, Training, and Instrumentation
U.S. Army Aviation and Missile Command
U.S. Army Communications-Electronics Command
U.S. Army Corps of Engineers
U.S. Army Intelligence and Security Command
U.S. Army Joint Munitions and Lethality Life Cycle Management Command
U.S. Army Materiel Command, Office of Command Contracting
U.S. Army Medical Command
U.S. Army Medical Research and Materiel Command
U.S. Army Military Surface Deployment and Distribution Command
U.S. Army Research, Development, and Engineering Command
U.S. Army Space and Missile Defense Command
U.S. Army Sustainment Command
U.S. Army Tank-Automotive and Armaments Command

* * * * *

PART 204—ADMINISTRATIVE MATTERS

§ 204.7005 [Amended]

■ 3. Section 204.7005 is amended as follows:

■ a. In paragraph (c), by removing ''Air Force: SAF/AQCX'' and adding in its place ''Air Force: SAF/AQCI''; and

■ b. In paragraph (d) by removing ''*http://www.acq.osd.mil/dpap/dfars/ordercode.htm*'' and adding in its place ''*http://www.acq.osd.mil/dpap/dars/ordercodes/index.htm*''.

[FR Doc. E7–14897 Filed 8–1–07; 8:45 am]

BILLING CODE 5001–08–P

DEPARTMENT OF DEFENSE

Defense Acquisition Regulations System

48 CFR Parts 202, 210, 213, 215, and 219

RIN 0750–AF36

Defense Federal Acquisition Regulation Supplement; Limitations on Tiered Evaluation of Offers (DFARS Case 2006–D009)

AGENCY: Defense Acquisition Regulations System, Department of Defense (DoD).

ACTION: Final rule.

SUMMARY: DoD has adopted as final, with changes, an interim rule amending the Defense Federal Acquisition Regulation Supplement (DFARS) to implement Section 816 of the National Defense Authorization Act for Fiscal Year 2006. Section 816 requires DoD to prescribe guidance on the use of tiered evaluation of offers for contracts and for task or delivery orders under contracts.

DATES: *Effective Date:* August 2, 2007.

FOR FURTHER INFORMATION CONTACT: Ms. Deborah Tronic, Defense Acquisition Regulations System, OUSD(AT&L)DPAP(DARS), IMD 3C132, 3062 Defense Pentagon, Washington, DC 20301–3062. Telephone (703) 602–0289; facsimile (703) 602–7887. Please cite DFARS Case 2006–D009.

SUPPLEMENTARY INFORMATION:

A. Background

DoD published an interim rule at 71 FR 53042 on September 8, 2006, to implement Section 816 of the National Defense Authorization Act for Fiscal Year 2006 (Pub. L. 109–163). Section

816 requires DoD to prescribe guidance on the use of tiered evaluation of offers for contracts and for task or delivery orders under contracts. The guidance must include a prohibition on the use of tiered evaluation of offers unless the contracting officer (1) has conducted market research in accordance with Part 10 of the Federal Acquisition Regulation (FAR); (2) is unable, after conducting market research, to determine whether or not a sufficient number of qualified small businesses are available to justify limiting competition for the contract or order; and (3) includes in the contract file a written explanation of why the contracting officer was unable to make the determination.

Four sources submitted comments on the interim rule. A discussion of the comments is provided below. In addition to the changes addressed in the DoD response to Comment 1, the final rule revises section 213.106–1–70 to provide a cross-reference to section 215.203–70, instead of duplicating the text found in that section.

1. *Comment:* The rule failed to include an explicit prohibition.

DoD Response: While DoD believes that stating the actions that the contracting officer must take before using tiered evaluation is an implied prohibition, the final rule contains amendments at 215.203–70 to explicitly prohibit the contracting officer from using tiered evaluation unless those actions have been taken.

2. *Comment:* Defining the technique of tiered evaluation in the DFARS legitimizes the use of tiered evaluation.

DoD Response: The statute does not completely prohibit the use of tiered evaluation; it requires that certain actions be taken before this technique may be used. To permit an understanding of the statutory requirements, the technique must first be defined.

3. *Comment:* FAR Part 10 already requires the market research required by the statute, and no additional research is necessary.

DoD Response: DoD agrees that the FAR already requires agencies to conduct market research appropriate to the circumstances before soliciting offers for acquisitions in excess of the simplified acquisition threshold and, when necessary and cost-effective, below the simplified acquisition threshold. However, DoD believes the additional language in DFARS Part 210 is appropriate to reinforce the statutory requirement for market research before conducting a tiered evaluation of offers.

4. *Comment:* The phrase ''appropriate to the circumstances'' at DFARS 210.001(a)(i), with regard to requirements for conducting market research, should be deleted. Although the phrase is consistent with the FAR, it is not in the statute being implemented and creates ambiguity.

DoD Response: The text at DFARS 210.001 is consistent with both the statute and FAR Part 10. The statute prohibits the use of tiered evaluation of offers unless, among other things, the contracting officer has conducted market research in accordance with Part 10 of the FAR. The implementing DFARS language reflects the policy in FAR Part 10, requiring the conduct of market research ''appropriate to the circumstances.'' The DFARS language recognizes that there are many ways to conduct market research, and that the methods employed should be those that will be effective for the particular acquisition.

5. *Comment:* The rule states that the tiered evaluation of offers order of precedence shall be consistent with FAR Part 19. However, FAR Part 19 does not provide an ''order of precedence'' among the various small business goals.

DoD Response: FAR Part 19 does not specifically state an order of precedence. However, it does provide direction on the circumstances under which acquisitions may or must be set aside for various categories of small businesses. For example, FAR 19.1305 states that the contracting officer must consider HUBZone set-asides for acquisitions at a certain dollar level before considering small business set-asides. DoD believes that, in establishing an order of precedence in a tiered evaluation of offers, that order of precedence must be consistent with the direction in FAR Part 19.

6. *Comment:* Guidance to the contracting officer can be addressed in the Procedures, Guidance, and Information (PGI), consistent with the law.

DoD Response: PGI guidance to supplement this rule is considered unnecessary at this time.

7. *Comment:* The rule should include coverage stating that a large business involved in an 8(a) mentor-protege agreement shall not offer itself as a large business in competition against the 8(a) mentor-protege agreement. In a recent cascading set-aside, a large business offered itself as a large entity, as a subcontractor to a small business, and as a mentor in an 8(a) mentor-protege joint venture.

DoD Response: The issue of a mentor firm competing against a protege firm is not specific to tiered evaluation of offers. Therefore, the final rule contains no change relating to this comment.

This rule was not subject to Office of Management and Budget review under Executive Order 12866, dated September 30, 1993.

B. Regulatory Flexibility Act

DoD certifies that this final rule will not have a significant economic impact on a substantial number of small entities within the meaning of the Regulatory Flexibility Act, 5 U.S.C. 601, *et seq.*, because the rule relates to market research and documentation requirements performed by the Government.

C. Paperwork Reduction Act

The Paperwork Reduction Act does not apply, because the rule does not impose any information collection requirements that require the approval of the Office of Management and Budget under 44 U.S.C. 3501, *et seq.*

List of Subjects in 48 CFR Parts 202, 210, 213, 215, and 219

Government procurement.

Michele P. Peterson,

Editor, Defense Acquisition Regulations System.

■ Accordingly, the interim rule amending 48 CFR parts 202, 210, 213, 215, and 219, which was published at 71 FR 53042 on September 8, 2006, is adopted as a final rule with the following changes:

■ 1. The authority citation for 48 CFR parts 202, 210, 213, 215, and 219 continues to read as follows:

Authority: 41 U.S.C. 421 and 48 CFR Chapter 1.

PART 213—SIMPLIFIED ACQUISITION PROCEDURES

■ 2. Section 213.106–1–70 is revised to read as follows:

213.106–1–70 Soliciting competition—tiered evaluation of offers.

See limitations on the use of tiered evaluation of offers at 215.203–70.

PART 215—CONTRACTING BY NEGOTIATION

■ 3. Section 215.203–70 is amended by revising paragraph (c) introductory text, paragraph (c)(1) introductory text, and paragraph (c)(2) to read as follows:

215.203–70 Requests for proposals—tiered evaluation of offers.

* * * * *

(c) The contracting officer is prohibited from issuing a solicitation with a tiered evaluation of offers unless—

(1) The contracting officer conducts market research, in accordance with

FAR Part 10 and Part 210, to determine—

* * * * *

(2) If the contracting officer cannot determine whether the criteria in paragraph (c)(1) of this section are met, the contracting officer includes a written explanation in the contract file as to why such a determination could not be made (Section 816 of Public Law 109–163).

[FR Doc. E7–14906 Filed 8–1–07; 8:45 am]

BILLING CODE 5001–08–P

DEPARTMENT OF DEFENSE

Defense Acquisition Regulations System

48 CFR Parts 205 and 225

RIN 0750–AF33

Defense Federal Acquisition Regulation Supplement; Berry Amendment Notification Requirement (DFARS Case 2006–D006)

AGENCY: Defense Acquisition Regulations System, Department of Defense (DoD).

ACTION: Final rule.

SUMMARY: DoD has adopted as final, without change, an interim rule amending the Defense Federal Acquisition Regulation Supplement (DFARS) to implement Section 833(a) of the National Defense Authorization Act for Fiscal Year 2006. Section 833(a) requires the posting of a notice on the FedBizOpps Internet site, when certain exceptions to domestic source requirements apply to an acquisition.

DATES: *Effective Date:* August 2, 2007.

FOR FURTHER INFORMATION CONTACT: Ms. Amy Williams, Defense Acquisition Regulations System, OUSD(AT&L)DPAP(DARS), IMD 3C132, 3062 Defense Pentagon, Washington, DC 20301–3062. Telephone (703) 602–0328; facsimile (703) 602–7887. Please cite DFARS Case 2006–D006.

SUPPLEMENTARY INFORMATION:

A. Background

DoD published an interim rule at 71 FR 58536 on October 4, 2006, to implement Section 833(a) of the National Defense Authorization Act for Fiscal Year 2006 (Pub. L. 109–163). Section 833(a) amended 10 U.S.C. 2533a to add a requirement for the posting of a notice on the FedBizOpps Internet site, within 7 days after award of a contract exceeding the simplified acquisition threshold, for the acquisition of (1) certain clothing, fiber, yarn, or fabric items, when DoD has determined that adequate domestic items are not available; or (2) chemical warfare protective clothing, when an exception to domestic source requirements applies because the acquisition furthers an agreement with a qualifying country.

One source submitted comments on the interim rule, as discussed below.

Comments: The respondent strongly supported the initiative to insert transparency into the process of waiving domestic source requirements. Although the law allows posting within 7 days after contract award, the respondent encouraged a more immediate notice to industry, preferably before contract award. The respondent also suggested that there should be a permanent posting of current domestic nonavailability determinations, so that industry (especially a company just entering the contracting arena) would have information regarding the materials or components for which a waiver has been granted. The respondent recommended that this information be available in an easily accessible and permanent location to permit better compliance with domestic source requirements.

DoD Response: When drafting the interim rule, DoD determined that the least burdensome approach for posting the notice would be to make it part of the synopsis that is published after contract award in accordance with FAR 5.301. Therefore, the final rule continues to provide for posting of the notice within 7 days after contract award, consistent with the statutory provisions. A listing of current domestic nonavailability determinations is available on the Defense Procurement and Acquisition Policy Web site, at *http://www.acq.osd.mil/dpap/paic/dnad.htm.*

This rule was not subject to Office of Management and Budget review under Executive Order 12866, dated September 30, 1993.

B. Regulatory Flexibility Act

DoD certifies that this final rule will not have a significant economic impact on a substantial number of small entities within the meaning of the Regulatory Flexibility Act, 5 U.S.C. 601, *et seq.*, because the rule relates to a notification requirement that is performed by the Government.

C. Paperwork Reduction Act

The Paperwork Reduction Act does not apply, because the rule does not impose any information collection requirements that require the approval of the Office of Management and Budget under 44 U.S.C. 3501, *et seq.*

List of Subjects in 48 CFR Parts 205 and 225

Government procurement.

Michele P. Peterson,

Editor, Defense Acquisition Regulations System.

Interim Rule Adopted as Final Without Change

■ Accordingly, the interim rule amending 48 CFR Parts 205 and 225, which was published at 71 FR 58536 on October 4, 2006, is adopted as a final rule without change.

[FR Doc. E7–14904 Filed 8–1–07; 8:45 am]

BILLING CODE 5001–08–P

DEPARTMENT OF DEFENSE

Defense Acquisition Regulations System

48 CFR Parts 225 and 252

RIN 0750–AF54

Defense Federal Acquisition Regulation Supplement; Berry Amendment Restrictions—Clothing Materials and Components Covered (DFARS Case 2006–D031)

AGENCY: Defense Acquisition Regulations System, Department of Defense (DoD).

ACTION: Final rule.

SUMMARY: DoD has adopted as final, without change, an interim rule amending the Defense Federal Acquisition Regulation Supplement (DFARS) to implement Section 833(b) of the National Defense Authorization Act for Fiscal Year 2006. Section 833(b) expands the foreign source restrictions applicable to the acquisition of clothing to also include clothing materials and components, other than sensors, electronics, or other items added to, and not normally associated with, clothing and the materials and components thereof.

DATES: *Effective Date:* August 2, 2007.

FOR FURTHER INFORMATION CONTACT: Ms. Amy Williams, Defense Acquisition Regulations System, OUSD(AT&L)DPAP(DARS), IMD 3C132, 3062 Defense Pentagon, Washington, DC 20301–3062. Telephone (703) 602–0328; facsimile (703) 602–7887. Please cite DFARS Case 2006–D031.

SUPPLEMENTARY INFORMATION:

A. Background

DoD published an interim rule at 72 FR 2637 on January 22, 2007, to implement Section 833(b) of the National Defense Authorization Act for Fiscal Year 2006 (Public Law 109–163). Section 833(b) amended 10 U.S.C. 2533a (the Berry Amendment) to expand the foreign source restrictions applicable to the acquisition of clothing to also include clothing materials and components, other than sensors, electronics, or other items added to, and not normally associated with, clothing and the materials and components thereof.

DoD received no comments on the interim rule. Therefore, DoD has adopted the interim rule as a final rule without change.

This rule was not subject to Office of Management and Budget review under Executive Order 12866, dated September 30, 1993.

B. Regulatory Flexibility Act

DoD has prepared a final regulatory flexibility analysis consistent with 5 U.S.C. 604. A copy of the analysis may be obtained from the point of contact specified herein. The analysis is summarized as follows:

The objective of the rule is to provide for the acquisition of clothing, and clothing materials and components, from domestic sources in accordance with statutory requirements. The rule applies to entities interested in receiving DoD contracts or subcontracts for the acquisition of clothing. Based on data collected through the DoD contract action reporting system, DoD awarded 6,072 contract actions relating to the acquisition of clothing items during fiscal year 2005. These actions had a total dollar value of $1.868 billion and involved 1,110 contractors. Of these actions, 4,087 totaling $.81 billion involved 906 contractors that were small business concerns. This rule may have a positive impact on small businesses that manufacture clothing materials and components, by reducing foreign competition. However, the rule could have a negative impact on small businesses that have been using foreign components in the manufacture of clothing products.

C. Paperwork Reduction Act

The Paperwork Reduction Act does not apply, because the rule does not impose any information collection requirements that require the approval of the Office of Management and Budget under 44 U.S.C. 3501, *et seq.*

List of Subjects in 48 CFR Parts 225 and 252

Government procurement.

Michele P. Peterson,

Editor, Defense Acquisition Regulations System.

Interim Rule Adopted as Final Without Change

■ Accordingly, the interim rule amending 48 CFR Parts 225 and 252, which was published at 72 FR 2637 on January 22, 2007, is adopted as a final rule without change.

[FR Doc. E7–14898 Filed 8–1–07; 8:45 am]

BILLING CODE 5001–08–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

15 CFR Part 922

[Docket No. 0612242956–7411–02]

RIN 0648–AT18

Establishment of Marine Reserves and a Marine Conservation Area Within the Channel Islands National Marine Sanctuary; Correction

AGENCY: National Marine Sanctuary Program (NMSP), National Ocean Service (NOS), National Oceanic and Atmospheric Administration (NOAA), Department of Commerce (DOC).

ACTION: Final rule; correction.

SUMMARY: NOAA published a final rule on May 24, 2007 that established marine reserves and a marine conservation area in the Channel Islands Natioal Marine Sanctuary. That document contained a few clerical and printing errors. This document corrects and clarifies those three errors.

DATES: Pursuant to section 304(b) of the National Marine Sanctuaries Act, the final rule published on May 24, 2007 and the revised terms of designation shall take effect and become final after the close of a review period of 45 days of continuous session of Congress, that began on May 24, 2007. This correction only makes three non-substantive corrections and clarifications to that rule and does not change the calculation of the effective date. Announcement of the effective date of the final rule will be published in the **Federal Register** at a later date.

FOR FURTHER INFORMATION CONTACT: Sean Hastings, (805) 884–1472; e-mail: *Sean.Hastings@noaa.gov.*

SUPPLEMENTARY INFORMATION: NOAA published a document in the **Federal Register** on May 24, 2007 (72 FR 29208) establishing marine reserves and a marine conservation area in the Channel Islands National Marine Sanctuary. There was a printing error that requires clarification and two clerical errors that are being corrected by this document as described below.

Clarification of Changes to the Designation Document

The printing error affected the way in which the changes to the original designation document were portrayed to the reader. They did not, however, affect the substance of the actual revision. The following clarifies for the reader the changes that were made to the designation document by the May 24, 2007 **Federal Register** notice. In this notice, certain conventions have been used to highlight the revisions that were made via the preamble to the May 24, 2007 rule. New language is shown inside boldfaced arrows while language that was deleted is set off with bold-faced brackets:

Beginning of Revised Designation Document

Preamble

Under the authority of the Marine Protection, Research and Sanctuaries Act of 1972, Pub. L. 92–532, (the Act) the waters surrounding the northern Channel Islands and Santa Barbara Island are hereby designated a Marine Sanctuary for the purposes of preserving and protecting this unique and fragile ecological community.

Article 1. Effect of Designation

Within the area designated as the Channel Islands National Marine Sanctuary (the Sanctuary), described in Article 2, the Act authorizes the promulgation of such regulations as are reasonable and necessary to protect the values of the Sanctuary. Article 4 of this Designation lists those activities which may require regulation, but the listing of any activity does not by itself prohibit or restrict it. Restrictions or prohibitions may be accomplished only through regulation, and additional activities may be regulated only by amending Article 4.

Article 2. Description of the Area

The Sanctuary consists of an area of the waters off the coast of California, of approximately [1252.5] >1,128< square nautical miles [(nm)] >(nmi)< adjacent to the northern Channel Islands and Santa Barbara Island seaward to a distance of [6nm] >approximately 6

nmi<. The precise boundaries are defined by regulation.

Article 3. Characteristics of the Area That Give it Particular Value

The Sanctuary is located in an area of upwelling and in a transition zone between the cold waters of the California Current and the warmer Southern California Countercurrent. Consequently, the Sanctuary contains an exceptionally rich and diverse biota, including 30 species of marine mammals and several endangered species of marine mammals and sea birds. The Sanctuary will provide recreational experiences and scientific research opportunities and generally will have special value as an ecological, recreational, and esthetic resource.

Article 4. Scope of Regulation

Section 1. Activities Subject to Regulation

In order to protect the distinctive values of the Sanctuary, the following activities may be regulated within the Sanctuary to the extent necessary to ensure the protection and preservation of its marine features and the ecological, recreational, and esthetic value of the area:

a. Hydrocarbon operations

b. Discharging or depositing any substance

c. Dredging or alteration of, or construction on, the seabed

d. Navigation of vessels except fishing vessels or vessels [travelling] >traveling< within a Vessel Traffic Separation Scheme or Port Access Route designated by the Coast Guard outside of 1 nmi from any island

e. Disturbing marine mammals or birds by overflights below 1000 feet

f. Removing or otherwise deliberately harming cultural or historical resources

>g. Within a marine reserve, marine park, or marine conservation area, harvesting, removing, taking, injuring, destroying, possessing, collecting, moving, or causing the loss of any Sanctuary resource, including living or dead organisms or historical resources, or attempting any of these activities

h. Within a marine reserve, marine park, or marine conservation area, possessing fishing gear<

Section 2. Consistency With International Law

The regulations governing the activities listed in Section 1 of this article will apply to foreign flag vessels and persons not citizens of the United States only to the extent consistent with recognized principles of international law including treaties and international agreements to which the United States is signatory.

Section 3. Emergency Regulations

Where essential to prevent immediate, serious and irreversible damage to the ecosystem of the area, activities other than those listed in Section 1 may be regulated within the limits of the Act on an emergency basis for an interim period not to exceed 120 days, during which an appropriate amendment of this article would be proposed in accordance with the procedures specified in Article 6.

Article 5. Relation to Other Regulatory Programs

Section 1. Fishing

The regulation of fishing is not authorized under Article 4>, except within portions of the Sanctuary designated as marine reserves, marine parks, or marine conservation areas established pursuant to the goals and objectives of the Sanctuary and within the scope of the State of California's Final Environmental Document ''Marine Protected Areas in NOAA's Channel Islands National Marine Sanctuary'' (California Department of Fish and Game, October 2002), certified by the California Fish and Game Commission<. However, fishing vessels may be regulated with respect to discharges in accordance with Article 4, Section 1, paragraph (b) and aircraft conducting kelp bed surveys below 1000 feet can be regulated in accordance with Article 4, Section 1, paragraph (e). All regulatory programs pertaining to fishing, including particularly regulations promulgated under the California Fish and Game Code and Fishery Management Plans promulgated under the Fishery Conservation and Management Act of 1976, 16 U.S.C. 1801 et seq., shall remain in effect. All permits, licenses and other authorizations issued pursuant thereto shall be valid within the Sanctuary unless authorizing any activity prohibited by any regulation implementing Article 4. Fishing as used in this article and in Article 4 includes kelp harvesting.

Section 2. Defense Activities

The regulation of those activities listed in Article 4 shall not prohibit any activity conducted by the Department of Defense that is essential for national defense or because of emergency. Such activities shall be consistent with the regulations to the maximum extent practicable.

Section 3. Other Programs

All applicable regulatory programs shall remain in effect and all permits, licenses and other authorizations issued pursuant thereto shall be valid within the Sanctuary unless authorizing any activity prohibited by any regulation implementing Article 4. The Sanctuary regulations shall set forth any necessary certification procedures.

Article 6. Alterations to This Designation

This Designation can be altered only in accordance with the same procedures by which it has been made, including public hearings, consultation with interested federal and state agencies and the Pacific Regional Fishery Management Council, and approval by the President of the United States.

End of Revised Designation Document

Corrections

In FR Doc. E7–10096 (published on May 24, 2007) make the following corrections:

■ 1. Amend instruction number eight (page 29233) to read: ''Add Appendix B and Appendix C to subpart G to read as follows:''

■ 2. Amend the heading for Appendix C to read: ''Appendix C to Subpart G of Part 922—Marine Conservation Area Boundary''

Dated: July 26, 2007.

Elizabeth R. Scheffler,

Chief Financial Officer, Chief Administrator Officer, National Ocean Service.

[FR Doc. 07–3754 Filed 8–1–07; 8:45 am]

BILLING CODE 3510–NK–M

Proposed Rules

Federal Register
Vol. 72, No. 148
Thursday, August 2, 2007

This section of the FEDERAL REGISTER contains notices to the public of the proposed issuance of rules and regulations. The purpose of these notices is to give interested persons an opportunity to participate in the rule making prior to the adoption of the final rules.

DEPARTMENT OF AGRICULTURE

Animal and Plant Health Inspection Service

9 CFR Part 93

[Docket No. APHIS–2006–0164]

RIN 0579–AC35

Temporary Importation of Horses; Noncompetitive Entertainment Horses From Countries Affected With Contagious Equine Metritis

AGENCY: Animal and Plant Health Inspection Service, USDA.

ACTION: Proposed rule.

SUMMARY: We are proposing to amend the regulations to allow noncompetitive entertainment horses from countries affected with contagious equine metritis to be temporarily imported into the United States under certain conditions. The regulations currently provide for the temporary importation of horses from countries affected with contagious equine metritis to compete in specified events. In recent years it has become evident that similar provisions are needed for noncompetitive entertainment horses. This action would allow the temporary importation of horses into the United States solely for public exhibition and entertainment purposes while continuing to protect against the introduction and dissemination of contagious equine metritis.

DATES: We will consider all comments that we receive on or before October 1, 2007.

ADDRESSES: You may submit comments by either of the following methods:

- *Federal eRulemaking Portal:* Go to *http://www.regulations.gov,* select ''Animal and Plant Health Inspection Service'' from the agency drop-down menu, then click ''Submit.'' In the Docket ID column, select APHIS–2006–0164 to submit or view public comments and to view supporting and related materials available electronically. Information on using Regulations.gov, including instructions for accessing documents, submitting comments, and viewing the docket after the close of the comment period, is available through the site's ''User Tips'' link.
- *Postal Mail/Commercial Delivery:* Please send four copies of your comment (an original and three copies) to Docket No. APHIS–2006–0164, Regulatory Analysis and Development, PPD, APHIS, Station 3A–03.8, 4700 River Road Unit 118, Riverdale, MD 20737–1238. Please state that your comment refers to Docket No. APHIS–2006–0164.

Reading Room: You may read any comments that we receive on this docket in our reading room. The reading room is located in room 1141 of the USDA South Building, 14th Street and Independence Avenue SW., Washington, DC. Normal reading room hours are 8 a.m. to 4:30 p.m., Monday through Friday, except holidays. To be sure someone is there to help you, please call (202) 690–2817 before coming.

Other Information: Additional information about APHIS and its programs is available on the Internet at *http://www.aphis.usda.gov.*

FOR FURTHER INFORMATION CONTACT: Dr. Ellen M. Buck, Veterinary Medical Officer, Import/Export Animals, National Center for Import and Export, VS, APHIS, 4700 River Road Unit 39, Riverdale, MD 20737–1231; (301) 734–8364.

SUPPLEMENTARY INFORMATION:

Background

The regulations in 9 CFR part 93 (referred to below as the regulations) prohibit or restrict the importation of certain animals into the United States to prevent the introduction of communicable diseases of livestock and poultry. Subpart C—Horses, §§ 93.300 through 92.326 of the regulations, pertains to the importation of horses into the United States.

Section 93.301 of the regulations contains specific provisions for the quarantine and testing of horses from regions affected with contagious equine metritis (CEM), a highly contagious bacterial venereal disease that affects breeding and fertility. This section also identifies regions where CEM exists and regions that trade horses freely with those where CEM exists without testing for CEM.

To prevent the introduction of CEM into the United States, § 93.301(c)(1) prohibits the importation of horses into the United States from listed regions unless the horses are imported in accordance with certain requirements. To be eligible for importation, the horses must fall into one of the following categories:

- Wild (non-domesticated) species of equidae if captured in the wild or imported from a zoo or other facility where it would be unlikely that the animal would come in contact with domesticated horses used for breeding;
- Geldings;
- Weanlings or yearlings whose age is certified on the import health certificate required under § 93.314(a);
- Horses imported in accordance with conditions prescribed by the Administrator as provided in § 93.301(a);
- Spanish Pure Breed horses imported for permanent entry from Spain or thoroughbred horses imported for permanent entry from France, Germany, Ireland, or the United Kingdom as provided in § 93.301(d);
- Stallions or mares over 731 days of age imported for permanent entry as provided in § 93.301(e);
- Horses over 731 days of age imported into the United States for no more than 90 days to compete in specified events as provided in § 93.301(f); and
- U.S. horses returning to the United States as provided in § 93.301(g).

The Animal and Plant Health Inspection Service (APHIS) has used the provisions in § 93.301(f), relating to the temporary importation of horses for competition, to allow the temporary importation of noncompetitive entertainment horses into the United States. Several performance horse groups have asked APHIS to extend the 90-day limit provided for in § 93.301(f) so that they may exhibit and show their horses in the United States for longer periods of time. In addition, the United States Animal Health Association has recommended that APHIS amend the regulations to establish a category for noncompetitive entertainment horses.

APHIS has conducted a risk assessment to evaluate the risk of allowing the extended importation of noncompetitive entertainment horses

from countries affected by CEM without requiring CEM testing, and the risk of the U.S. Department of Agriculture (USDA) losing track of these horses during extended importation. The risk assessment, titled ''Assessment of the Risk of Introduction of Contagious Equine Metritis (CEM) through the Extended Importation of Noncompetitive Entertainment Horses from CEM-affected countries,'' may be viewed on the Regulations.gov Web site (see **ADDRESSES** at the beginning of this document for instructions for accessing Regulations.gov). Copies of the risk assessment may be obtained by calling or writing to the person listed under **FOR FURTHER INFORMATION CONTACT**.

The risk assessment concluded that the risk posed by allowing the extended importation of noncompetitive entertainment horses from CEM-affected countries would be extremely low, with the application of the restrictions described in this proposed rule. In addition, the risk assessment concluded that the risk of USDA losing track of the animals was extremely low due to the extensive supervision and involvement of APHIS personnel and the accredited veterinarian.

Accordingly, we are proposing to amend the regulations in § 93.301 to establish conditions under which noncompetitive entertainment horses from CEM-affected regions may be imported into the United States for longer than 90 days solely for public exhibition and entertainment purposes. Because the conditions would be very similar to the conditions in § 93.301(f), which provides for the temporary importation of horses to compete in specified events, we would amend § 93.301(f) to apply to both types of imported horses. We would also amend the regulations pertaining to import permits in § 93.304 to require the submission of additional information with the application for an import permit.

As with horses imported for competition, we are proposing to provide two primary safeguards against the horses transmitting CEM while in the United States. First, a representative of APHIS would monitor the horses whenever they are not in transit in the United States. Second, we would require stringent measures to ensure that the horses are kept apart from other horses, except when performing or being exhibited or exercised. Because CEM is a venereal disease transmitted by sexual contact, there is virtually no risk that a horse will transmit the disease through casual contact with other horses during a performance, exhibition, or exercise.

Import Permit and Health Certificate

In addition to the current requirements in § 93.304(a) for an import permit, we are proposing that the owner or importer would have to supply the following information to APHIS with the application for the permit:

- The individual identifying information for all horses to be imported;
- The permanent electronic identification of each horse to be imported, if applicable;
- Photographs (head and lateral views) of each horse that are sufficient to identify the horse on an electronic medium approved by APHIS;
- The proposed total length of stay in the United States;
- A description of the shows or events in which the horse would perform while in the United States;
- The names and locations of the venues in which the horse would perform while in the United States, and the dates the horse would perform at each venue;
- The names and locations of the premises on which the horse would be kept while in the United States, and the dates the horse would be kept on each premises;
- The methods and routes by which the horse would be transported while in the United States;
- A written plan for handling sick or injured horses that includes the name, address, and phone number of each accredited veterinarian who would provide veterinary services in the United States; the name, address, and phone number of medical facilities to be used to diagnose or treat sick or injured horses while in the United States; and a plan to return sick or injured horses to performance condition; and
- An application for a trust fund or escrow account agreement with APHIS.

This information would allow APHIS to monitor the location of the horse while it is in the United States and to confirm compliance with the required isolation and handling procedures to ensure that the horse does not transmit CEM to any other horse while in this country.

Given the potential for long stays in the United States for noncompetitive entertainment horses, APHIS must have current information about the horses and their itinerary in order to effectively monitor the horses for compliance with the regulations. Therefore, we would require that while in the United States, the owner or importer apply for and obtain from APHIS an import permit each year prior to the anniversary date of the horse's arrival in the United States. This would ensure that APHIS has current information about the horses and their itinerary for monitoring purposes.

As with horses imported for competition, we would require that, at the time of importation, each horse be accompanied by an import permit in accordance with § 93.304 and a health certificate in accordance with § 93.314. However, we would also require the health certificates for noncompetitive entertainment horses to certify that cultures negative for CEM have been collected from each horse on three separate occasions within a 7-day period, with the last set of specimens collected within 30 days of exportation. This would help to ensure that horses infected with CEM do not enter this country and jeopardize the health of the U.S. horse population.

Restrictions Following Arrival in the United States

We are proposing to allow horses over 731 days of age to be imported into the United States solely for noncompetitive public exhibition and entertainment purposes. Such horses would be allowed to remain in the United States indefinitely as long as the conditions in the regulations are met. While in the United States, the horse would be prohibited from entering competitions and would have to be regularly used in performances or exhibitions, unless sick or injured. A horse that is no longer performing or being exhibited would be required to be exported or made eligible for permanent entry. In addition, a noncompetitive entertainment horse would have to be kept with the other horses listed on the import permit, unless otherwise approved by an APHIS representative. We expect that such approvals would be granted for diagnosis or treatment of a medical condition, pre-export isolation, or quarantine for permanent entry.

As with horses imported for competition, we would require a noncompetitive entertainment horse to be moved according to the itinerary and methods of transport specified in the import permit. However, we are proposing to allow horses imported for competition and noncompetitive entertainment horses to be moved for diagnosis or treatment of a medical condition with the prior approval of an APHIS representative. APHIS has always allowed such movements; however, we are proposing to add that provision to the regulations to make it clear to the public.

We are proposing that, while in the United States, the horse would be monitored by an accredited veterinarian

or APHIS representative to ensure that the horse is moved according to the itinerary and methods specified in the import permit, kept separated from other horses not listed on the import permit, and not used for breeding purposes (including artificial insemination or semen collection) or has any other sexual contact with other horses. The horse could not be kept on a breeding premises.

We would require that the horse be kept in a pasture or stall separate from other horses not listed on the import permit, except when actually performing or being exhibited or exercised. The stall in which the horse is kept would have to be separated from other stalls containing horses that are not listed on the import permit, either by an empty stall, by an open area across which horses cannot touch each other, or by a solid wall that is at least 8 feet (2.4 meters) high. The premises on which the horse is kept would have to be approved in writing by an APHIS representative.

As noted above, we would require that the horse not be used for breeding purposes or have any other sexual contact with other horses. However, in contrast to horses imported for competition, we would allow a noncompetitive entertainment horse to undergo genital examinations necessary for diagnosis or treatment of a medical condition with the prior approval of an APHIS representative. This provision would allow the horse to receive appropriate medical care during its extended stay in the country.

We are also proposing to apply the transportation and cleaning and disinfection requirements for horses imported for competition that are contained in the current regulations to noncompetitive entertainment horses. Thus, we would require that, while the horse is in transit, it would have to be moved either in an aircraft or a sealed van or trailer and, except in situations where the horse's life is in danger, only an APHIS representative would be permitted to break the seal on a van or trailer used to move the horse. Additionally, we would require that after the horse is transported anywhere in the United States, any vehicle in which the horse was transported would have to be cleaned and disinfected in the presence of an APHIS representative, according to the procedures for cleaning and disinfection specified in 9 CFR 71.7 through 71.12 of the regulations. We would also require that, in most instances, the cleaning and disinfection would have to be done before the vehicle is moved from the place where the horse is unloaded. However, in cases where there are inadequate facilities or equipment for cleaning and disinfection at the place where the horse is unloaded, the Administrator would have the discretion to allow the vehicle to be moved to another location for cleaning and disinfection, when the move would not pose a disease risk to other horses in the United States.

Change in Itinerary

We are proposing that if the owner or importer wishes to change the horse's itinerary or the methods by which the horse is transported from those specified in the import permit, the owner or importer would have to make the request for change in writing to the Administrator. Such requests would have to be submitted at least 15 days before the proposed date of any change. We propose that this provision would also apply to horses imported for competition. This would ensure that APHIS has enough time to process the request, including inspecting any new premises, and to arrange for the required monitoring before the date of the proposed change. The change in itinerary or means of transport would not be permitted without the written approval of the Administrator, who would have the discretion to grant the request for change when he or she determines that granting the request would not endanger other horses in the United States, and that sufficient APHIS personnel would be available to provide the services requested by the owner or importer.

Permanent Entry

We are proposing that noncompetitive entertainment stallions or mares over 731 days of age would be eligible to remain in the United States if the horse meets the provisions for permanent entry in the current regulations. Specifically, the horse's owner or importer would have to: (1) Apply for and receive a new import permit from APHIS that specifies that the stallion or mare would be moved to an approved State; and (2) transport the stallion or mare in a sealed vehicle that has been cleaned and disinfected to an approved facility in an approved State where it is quarantined under State or Federal supervision until the stallion or mare has met the testing and treatment requirements of § 93.301(e)(3) or (e)(5).

Cancellation of Import Permit

We are proposing to apply to noncompetitive entertainment horses the provisions relating to the cancellation of an import permit and the appeals process that currently appear in the regulations pertaining to horses imported for competition. Specifically, we are proposing that if the provisions described in this proposed rule are not met, the Administrator would cancel the import permit that allows the importation of the horse into the United States and that allows the horse to stay in this country. If the cancellation is oral, the decision and the reason for cancellation of the permit would be confirmed in writing as promptly as circumstances allow. The owner or importer would be able to appeal the cancellation of the permit in writing to the Administrator within 10 days after receiving either oral or written notification of the cancellation, whichever is earlier. If the appeal is sent by mail, it would have to be postmarked within 10 days after the owner or importer receives the notification of cancellation. The appeal would have to include all of the facts and reasons upon which the person relies to show that the import permit was wrongfully canceled. If there is a conflict as to any material fact, a hearing would be held to resolve the conflict. These provisions would satisfy due process requirements pertaining to the cancellation of an import permit.

We are also proposing that, except in those cases where an appeal is in process, any person whose import permit is canceled would have to move his or her horse out of the United States within 10 days after receiving an oral or written notice of cancellation, whichever is earlier. The horse would not be permitted to perform or be exhibited from the date the owner or importer receives the notice of cancellation until the horse is moved out of the United States or until resolution of an appeal in favor of the owner or importer. Except when being exercised, the horse would have to be kept in a stall that is separated from other stalls containing horses that are not listed on the import permit, either by an empty stall, an open area across which horses cannot touch each other, or a solid wall that is at least 8 feet (2.4 meters) high.

Until the horse is removed from the United States or an appeal is resolved in favor of the owner or importer, the horse would have to be kept, at the expense of the owner or importer, either on the premises at which the horse is located when the notice of cancellation is received or, if the horse is in transit when the notice of cancellation is received, on the premises at which it is next scheduled to perform or be exhibited. However, in cases where the owners of the premises do not permit the horse to stay on those premises, or

when the Administrator determines that keeping the horse at the premises would pose a disease risk to other horses in the United States, the horse would have to be kept, at the expense of the owner or importer, on an alternative premises approved by the Administrator.

Trust Fund Agreement and Cost of Government-Provided Services

We are proposing to require that noncompetitive entertainment horses be imported and maintained in the United States in accordance with a trust fund agreement executed by the horse's owner or importer. The current regulations already require that a trust fund agreement be executed for horses imported into the United States to compete in specified events. We would extend these provisions to noncompetitive entertainment horses to ensure that the government is reimbursed for the services it provides.

Under the trust fund agreement, the owner or importer would have to deposit with APHIS an amount equal to the estimated cost, including travel, subsistence, administrative expenses, and incidental expenses, as determined by APHIS, for an APHIS representative to: (1) Inspect the premises at which the horse would perform or be exhibited; (2) conduct the required monitoring of the horse at the premises at which it competes; and (3) supervise cleaning and disinfecting the means of conveyance in which the horses travels while in the United States. The estimated costs would be based on the following factors:

- Number of hours needed for an APHIS representative to conduct the required inspection and monitoring;
- For services provided during regular business hours (8 a.m. to 4:30 p.m., Monday through Saturday, except holidays), the average salary, per hour, for an APHIS representative;
- For services provided outside regular business hours, the applicable rate for overtime, night differential, or Sunday or holiday pay, based on the average salary, per hour, for an APHIS representative;
- Number of miles from the premises at which the horse competes, performs, or is exhibited to the APHIS office or facility that is monitoring the activities;
- Government rate per mile for automobile travel or, if appropriate, cost of other means of transportation between the premises at which the horse competes, performs, or is exhibited and the APHIS office or facility;
- Number of trips between the premises at which the horse competes, performs, or is exhibited and the APHIS office or facility that APHIS representatives are required to make in order to conduct the required inspection and monitoring;
- Number of days the APHIS representative conducting the inspection and monitoring must be in ''travel status;''
- Applicable government per diem rate; and
- Cost of related administrative support services.

During the horse's stay in the United States, if we determine that the amount deposited would not fully cover the services we are scheduled to provide during the remainder of the horse's stay, we would issue a bill for the difference to the horse's owner or importer. The horse's owner or importer would have to pay amounts billed within 14 days after receiving the bill. If the bill is not paid within that time, we would cease to perform the services provided for in this proposed rule until the bill is paid. The Administrator would inform the owner or importer of the cessation of services orally or in writing. If the notice is oral, it would be confirmed in writing as soon as circumstances permit, along with the reasons for it.

In such a case, the horse would have to be kept, at the expense of the owner or importer and until the bill is paid, either on the premises at which the horse is located when the notice of cessation of services is received or, if the horse is in transit when the notice of cessation is received, on the premises at which it is next scheduled to perform or be exhibited according to the import permit. The horse would have to be kept in a stall that is separated from other stalls containing horses that are not listed on the import permit either by an empty stall, an open area across which horses cannot touch each other, or a solid wall that is at least 8 feet (2.4 meters) high. In cases where the owners of the premises where the horse would be expected to stay do not permit the horse to be kept on those premises, or when the Administrator determines that keeping the horse on the premises would pose a disease risk to other horses in the United States, the horse would have to be kept, at the expense of the owner or importer, on an alternative premises approved by the Administrator. Until the bill is paid, the horse would not be permitted to perform or be exhibited. Any amount deposited in excess of the cost to APHIS of providing the services required would be refunded to the owner or importer.

Miscellaneous

In this document, we are also updating the name of the breed association in Spain that is specifically approved by the U.S. Department of Agriculture to provide factual, current information regarding the activities of Spanish Pure Breed horses for the purposes of § 93.301(d). The current regulations identify the breed association in Spain as ''Jefatura de Cria Caballar Registro Matricula.'' The Spanish Government has notified APHIS that the name of the breed association has been changed to ''Asociacion Nacional de Criadores de Caballos de Pura Raza Espanola.''

Executive Order 12866 and Regulatory Flexibility Act

This proposed rule has been reviewed under Executive Order 12866. The rule has been determined to be not significant for the purposes of Executive Order 12866 and, therefore, has not been reviewed by the Office of Management and Budget.

Currently, § 93.301(f) provides that mares and stallions over 731 days old from CEM-affected countries may be temporarily imported into the United States to compete in specified events for no longer than 90 days without meeting CEM quarantine and testing requirements that would otherwise apply to such horses. These same provisions have been used to authorize the temporary importation of noncompetitive entertainment horses. Several performance horse groups have requested that APHIS extend the 90-day limit so that they may exhibit and show their horses in the United States for longer periods.

We are proposing to amend the regulations to establish conditions under which noncompetitive entertainment horses (stallions and mares) over 731 days of age from CEM-affected countries could remain in the United States for longer than 90 days for public exhibition and entertainment purposes without undergoing the CEM quarantine and testing prescribed in the regulations.

The horse industry plays an important role in the U.S. economy. There were 542,223 farms with 3.644 million horses valued at $9.9 billion in the U.S. in 2002.[1] According to a recent study done for the American Horse Council, the number and value of horses are much larger than those reported in the 2002 Census of Agriculture: 2 million people owning 9.2 million horses with direct

[1] 2002 Census of Agriculture (NASS).

value of about $39 billion.[2] Both sets of data underscore the importance of the equine industry. In addition, other agricultural and non-agricultural sectors are dependent on the horse industry for their economic activity. Horses are a highly valued asset, especially those with a specific pedigree.

Horses also play an important role in U.S. international trade. The value of U.S. horse exports ($449 million) was more than the combined export value of cattle, hogs and sheep and goats ($65 million) between 2003 and 2005.[3]

The United States imported a total of 31,198 horses in 2005. Nearly 67 percent of horses imported were from Canada and 7.6 percent were from Mexico. Of the total imports, 25,564 were from non-CEM countries and the remaining 5,634 were from CEM countries. The proportion of horse imports that are pure breeding horses is small. Of the above total, 2,341 were purebred breeding horses. Only 340 purebred breeding horses were imported from CEM countries.[4] However, horses supplied by CEM-affected countries are generally highly valued. In 2005, for example, the average value of purebred breeding horses imported from CEM-affected regions was $41,220, whereas the average value of purebred breeding horses imported from countries not affected by CEM was $17,180.

Although the disease does not result in death, CEM can be economically costly. The direct consequence may include the closing of breeding operations, production losses as a result of abortion, and costs of disease control. A CEM outbreak would result in the quarantine of affected horse farms, temporary cessation of breeding operations, and restriction of both intrastate and interstate movement. For some breeders, this could mean the loss of thousands or even millions of dollars in stud fees and breeding losses. Other consequences include trade restrictions that may be imposed by international trading partners.

The noncompetitive entertainment horses that would be affected by this rule would not be allowed to have direct contact with horses outside those listed on their permit and could not be used for breeding purposes at any time while in the United States, including breeding with horses in the same show. Additionally, these horses may not undergo any genital examinations (unless required for diagnosis and treatment of a medical condition with prior approval of an APHIS representative), semen collection, or artificial insemination. Furthermore, since these are very specialized performance animals, domestic breeders would not be affected if this rule were to increase the amount of time the imported horses are in the United States.

Horses arriving in the United States from abroad are quarantined at a USDA Animal Import Center, generally for 3 days. Horses temporarily imported are required to exit the United States and be readmitted, following quarantine and testing, every 90 days. Each entry after 90 days is considered a new entry into the United States. The USDA charges a minimum of $810 for the 3-day quarantine. In addition to this facility charge, user fees of $80 are paid for blood testing, resulting in a total quarantine and testing cost per horse of $890. The proposed rule would allow imported performance horses to stay in the U.S. longer than 90 days without their owners having again to pay USDA import quarantine and testing costs. This is a saving that accrues to the importing entities and is likely to counterbalance their costs associated with supervisory activities of APHIS and/or an accredited veterinarian.

The number of entities and horses expected to be directly affected by this rule is not large. We anticipate that between 1 and 10 performing groups varying in size from 5 to 40 horses (or a total of between 5 and 400 horses) would utilize the proposed exception each year. Given that there are over a million domestic show horses, even the upper quantity represents a very small fraction of the total supply (0.04 percent).

The Small Business Administration (SBA) has established guidelines for determining which types of firms are to be considered small under the Regulatory Flexibility Act. This rule may affect operations such as zoological parks (North American Industry Classification System [NAICS] code 712130), and animal performances including circuses, carnivals, and amusement parks (NAICS code 711190). SBA classifies these operations as small entities if their annual receipts are not more than $6.5 million. Of the approximately 850 such establishments, about 12.5 percent are considered to be large. The subset of these entities that temporarily import noncompetitive entertainment horses from CEM countries would benefit from the forgone costs of having the horses exit and reenter the United States every 90 days. On the other hand, they would bear the cost of supervisory activities by APHIS and/or an accredited veterinarian. The overall impact is expected to be insignificant, given the relatively small number of noncompetitive entertainment horses imported from CEM countries. Other operations that may remotely be affected are domestic suppliers of similar horses (NAICS code 112920). According to the 2002 Census of Agriculture, that year there were 542,223 horse farms with 3,644,278 horses in the United States, of which 124,596 farms sold 470,423 horses that had a total value of over $1.13 billion.[5] An unknown share of these farms supply show horses that could be comparable to the noncompetitive entertainment horses imported temporarily from CEM affected countries. SBA classifies horse farms as small entities if their annual receipts are not more than $750,000;[6] over 99 percent are considered to be small.

Entities that may be affected by the rule are principally small businesses, but the impact of the rule is not expected to be significant. Because the pool of noncompetitive entertainment horses that are temporarily imported is a small fraction of the total number of show horses in the United States, any effects of the proposed rule for U.S. entities would be very small.

Under these circumstances, the Administrator of the Animal and Plant Health Inspection Service has determined that this action would not have a significant economic impact on a substantial number of small entities.

Executive Order 12988

This proposed rule has been reviewed under Executive Order 12988, Civil Justice Reform. If this proposed rule is adopted: (1) All State and local laws and regulations that are inconsistent with this rule will be preempted; (2) no retroactive effect will be given to this rule; and (3) administrative proceedings will not be required before parties may file suit in court challenging this rule.

[2] Deloitte Consulting LLP for American Horse Council, National Economic Impact of the U.S. Horse Industry, 2005.

[3] Global Trade Information Services (GTIS), World Trade Atlas.

[4] Id.

[5] As stated above, the census total is much less than the total reported by the American Horse Council Foundation. According to that report, there were 9,222,847 horses in 2005 (Deloitte Consulting LLP, National Economic Impact of the U.S. Horse Industry). Of this total, 9 percent were racing, 30 percent showing, 42 percent recreation and 19 percent other (*http://www.horsecouncil.org/statistics.htm*).

[6] SBA, Small Business Size Standards matched to North American Industry Classification System, Effective July 31, 2006; and U.S. Census Bureau, 2002 Economic Census: Manufacturing-Industries Series, Wholesale Trade-Subject Series and Transportation and Warehousing-Subject Series, Issued August, 2006.

Paperwork Reduction Act

In accordance with section 3507(d) of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*), the information collection or recordkeeping requirements included in this proposed rule have been submitted for approval to the Office of Management and Budget (OMB). Please send written comments to the Office of Information and Regulatory Affairs, OMB, Attention: Desk Officer for APHIS, Washington, DC 20503. Please state that your comments refer to Docket No. APHIS–2006–0164. Please send a copy of your comments to: (1) Docket No. APHIS–2006–0164, Regulatory Analysis and Development, PPD, APHIS, Station 3A–03.8, 4700 River Road Unit 118, Riverdale, MD 20737–1238, and (2) Clearance Officer, OCIO, USDA, room 404–W, 14th Street and Independence Avenue, SW., Washington, DC 20250. A comment to OMB is best assured of having its full effect if OMB receives it within 30 days of publication of this proposed rule.

We are proposing to amend the regulations to allow noncompetitive entertainment horses from countries affected with CEM to be temporarily imported into the United States under conditions very similar to the conditions in § 93.301(f), which provides for the temporary importation of horses to compete in specified events. In addition, we are proposing to require the submission of additional information with the application for an import permit.

We are soliciting comments from the public (as well as affected agencies) concerning our proposed information collection and recordkeeping requirements. These comments will help us:

(1) Evaluate whether the proposed information collection is necessary for the proper performance of our agency's functions, including whether the information will have practical utility;

(2) Evaluate the accuracy of our estimate of the burden of the proposed information collection, including the validity of the methodology and assumptions used;

(3) Enhance the quality, utility, and clarity of the information to be collected; and

(4) Minimize the burden of the information collection on those who are to respond (such as through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology; e.g., permitting electronic submission of responses).

Estimate of burden: Public reporting burden for this collection of information is estimated to average 1.4 hours per response.

Respondents: Importers of noncompetitive entertainment horses.

Estimated annual number of respondents: 15.

Estimated annual number of responses per respondent: 1.333333333.

Estimated annual number of responses: 20.

Estimated total annual burden on respondents: 28 hours. (Due to averaging, the total annual burden hours may not equal the product of the annual number of responses multiplied by the reporting burden per response.)

Copies of this information collection can be obtained from Mrs. Celeste Sickles, APHIS' Information Collection Coordinator, at (301) 734–7477.

E-Government Act Compliance

The Animal and Plant Health Inspection Service is committed to compliance with the E-Government Act to promote the use of the Internet and other information technologies, to provide increased opportunities for citizen access to Government information and services, and for other purposes. For information pertinent to E-Government Act compliance related to this proposed rule, please contact Mrs. Celeste Sickles, APHIS' Information Collection Coordinator, at (301) 734–7477.

List of Subjects in 9 CFR Part 93

Animal diseases, Imports, Livestock, Poultry and poultry products, Quarantine, Reporting and recordkeeping requirements.

Accordingly, we propose to amend 9 CFR part 93 as follows:

PART 93—IMPORTATION OF CERTAIN ANIMALS, BIRDS, FISH, AND POULTRY, AND CERTAIN ANIMAL, BIRD, AND POULTRY PRODUCTS; REQUIREMENTS FOR MEANS OF CONVEYANCE AND SHIPPING CONTAINERS

1. The authority citation for part 93 continues to read as follows:

Authority: 7 U.S.C. 1622 and 8301–8317; 21 U.S.C. 136 and 136a; 31 U.S.C. 9701; 7 CFR 2.22, 2.80, and 371.4.

2. Section 93.301 is amended as follows:

a. In paragraph (c)(2)(vii), by removing the words ''paragraph (f)'' and adding the words ''paragraph (f)(1)'' in their place, and by removing the word ''and'' at the end of the sentence.

b. By redesignating paragraph (c)(2)(viii) as paragraph (c)(2)(ix) and adding a new paragraph (c)(2)(viii) to read as set forth below.

c. In footnote 6, by removing the words ''Jefatura de Cria Caballar Registro Matricula for Spain'' and adding the words ''Asociacion National de Criadores de Caballos de Pura Raza Espanola for Spain'' in their place.

d. By revising paragraph (f) to read as set forth below.

§ 93.301 General prohibitions; exceptions.

* * * * *

(c) * * *

(2) * * *

(viii) Horses over 731 days of age imported into the United States for noncompetitive public exhibition and entertainment purposes if the horses meet the requirements of paragraph (f)(2) of this section; and

* * * * *

(f) *Special provisions for temporary importation for competition or entertainment purposes.* (1) Horses over 731 days of age may be imported into the United States for no more than 90 days to compete in specified events provided that the conditions in paragraphs (f)(3) through (f)(12) of this section are met.

(2) Horses over 731 days of age may be temporarily imported into the United States solely for noncompetitive public exhibition and entertainment purposes provided that the conditions in paragraphs (f)(3) through (f)(12) of this section are met.

(3) At the time of importation, each horse must be accompanied by an import permit in accordance with § 93.304 and a health certificate issued in accordance with § 93.314. For horses imported in accordance with paragraph (f)(2) of this section, the health certificate must also certify that cultures negative for CEM were obtained from sets of specimens collected on three separate occasions within a 7-day period from the mucosal surfaces of the clitoral fossa and the clitoral sinuses of any female horses and from the surfaces of the prepuce, the urethral sinus, and the fossa glandis, including the diverticulum of the fossa glandis, of any male horses. For both female and male horses, the sets of specimens must be collected on days 1, 4, and 7 of the 7-day period, and the last of these sets of specimens must be collected within 30 days of exportation. All specimens required by this paragraph must be collected by a licensed veterinarian who either is, or is acting in the presence of, the veterinarian signing the certificate.

(4) Following the horse's arrival in the United States:

(i) A horse imported in accordance with paragraph (f)(1) of this section may remain in the United States for not more

than 90 days, except as provided in paragraph (f)(9) of this section.

(ii) A horse imported in accordance with paragraph (f)(2) of this section may remain in the United States indefinitely, except as provided in paragraph (f)(9) of this section, as long as the conditions of paragraphs (f)(3) through (f)(12) of this section are met and the horse's owner or importer applies for and obtains from APHIS an import permit, as provided for in § 93.304, each year prior to the anniversary date of the horse's arrival in the United States.

(5) While the horse is in the United States, the following conditions must be met:

(i) A horse imported in accordance with paragraph (f)(2) of this section:

(A) Must not be entered in competitions.

(B) Must be regularly used in performances or exhibitions, unless sick or injured. A horse that is no longer performing or being exhibited must be exported or made eligible for permanent entry in accordance with paragraph (f)(9) of this section.

(C) Must be kept with the other horses listed on the import permit, unless otherwise approved by an APHIS representative.

(ii) Except as provided in paragraph (f)(5)(viii) of this section, the horse must be moved according to the itinerary and methods of transport specified in the import permit provided for in § 93.304.

(iii) The horse must be monitored by an accredited veterinarian or APHIS representative to ensure that the provisions of paragraphs (f)(5)(ii), (f)(5)(vi), and (f)(5)(vii) of this section are met. If the monitoring is performed by an accredited veterinarian, the Veterinarian in Charge will ensure that the accredited veterinarian is familiar with the requirements of this section and spot checks will be conducted by an APHIS representative to ensure that the requirements of this section are being met. If an APHIS representative finds that requirements are not being met, the Administrator may require that all remaining monitoring be conducted by APHIS representatives to ensure compliance.

(iv) Except when in transit, the horse must be kept on a premises that has been approved by an APHIS representative. For horses imported in accordance with paragraph (f)(1) of this section, such approval may be oral or in writing. If the approval is oral, it will be confirmed in writing by the Administrator as soon as circumstances permit. For horses imported in accordance with paragraph (f)(2) of this section, the approval will be in writing. To receive approval, the premises:

(A) Must not be a breeding premises; and

(B) Must be or contain a building in which the horse can be kept in a stall that is separated from other stalls that contain horses that are not listed on the import permit, either by an empty stall, by an open area across which horses cannot touch each other, or by a solid wall that is at least 8 feet (2.4 meters) high.

(v) While in transit, the horse must be moved in either an aircraft or a sealed van or trailer. If the horse is moved in a sealed van or trailer, the seal may be broken only by an APHIS representative at the horse's destination, except in situations where the horse's life is in danger.

(vi) Except when actually competing, performing, or being exhibited or exercised, the horse must be kept in a pasture approved by APHIS or in a stall that is separated from other stalls containing horses that are not listed on the import permit, either by an empty stall, by an open area across which horses cannot touch each other, or by a solid wall that is at least 8 feet (2.4 meters) high.

(vii) The horse may not be used for breeding purposes (including artificial insemination or semen collection) and may not have any other sexual contact with other horses. The horse may not undergo any genital examinations, except that a horse imported in accordance with paragraph (f)(2) of this section may undergo genital examinations for diagnosis or treatment of a medical condition with the prior approval of an APHIS representative.

(viii) The horse may be moved for diagnosis or treatment of a medical condition with the prior approval of an APHIS representative.

(ix) After the horse is transported anywhere in the United States, any vehicle in which the horse was transported must be cleaned and disinfected in the presence of an APHIS representative, according to the procedures specified in §§ 71.7 through 71.12 of this chapter, before any other horse is transported in the vehicle.

(x) The cleaning and disinfection specified in paragraph (f)(5)(ix) of this section must be completed before the vehicle is moved from the place where the horse is unloaded. In those cases where the facilities or equipment for cleaning and disinfection are inadequate at the place where the horse is unloaded, the Administrator may allow the vehicle to be moved to another location for cleaning and disinfection when the move will not pose a disease risk to other horses in the United States.

(xi) The owner or importer of the horse must comply with any other provisions of this part applicable to him or her.

(6) If the owner or importer wishes to change the horse's itinerary or the methods by which the horse is transported from that which he or she specified in the application for the import permit, the owner or importer must make the request for change in writing to the Administrator. Requests for change must be submitted to APHIS no less than 15 days before the proposed date of the change. Requests should be sent to the Administrator, c/o Import-Export Animals Staff, VS, APHIS, 4700 River Road Unit 39, Riverdale, MD 20737–1231. The change in itinerary or method of transport may not be made without the written approval of the Administrator, who may grant the request for change when he or she determines that granting the request will not endanger other horses in the United States and that sufficient APHIS personnel are available to provide the services required by the owner or importer.

(7) The Administrator may cancel, orally or in writing, the import permit provided for under § 93.304 whenever the Administrator finds that the owner or importer of the horse has not complied with the provisions of paragraphs (f)(3) through (f)(6) of this section or any conditions imposed under those provisions. If the cancellation is oral, the Administrator will confirm the cancellation and the reasons for the cancellation in writing as soon as circumstances permit. Any person whose import permit is cancelled may appeal the decision in writing to the Administrator within 10 days after receiving oral or written notification of the cancellation, whichever is earlier. If the appeal is sent by mail, it must be postmarked within 10 days after the owner or importer receives oral or written notification of the cancellation, whichever is earlier. The appeal must include all of the facts and reasons upon which the person relies to show that the import permit was wrongfully cancelled. The Administrator will grant or deny the appeal in writing as promptly as circumstances permit, stating the reason for his or her decision. If there is a conflict as to any material fact, a hearing will be held to resolve the conflict. Rules of practice concerning the hearing will be adopted by the Administrator.

(8) Except in those cases where an appeal is in process, any person whose import permit is cancelled must move the horse identified in the import permit out of the United States within 10 days

after receiving oral or written notification of cancellation, whichever is earlier. The horse is not permitted to enter competition, perform, or be exhibited from the date the owner or importer receives the notice of cancellation until the horse is moved out of the United States or until resolution of an appeal in favor of the owner or importer. Except when being exercised, the horse must be kept, at the expense of the owner or importer, in a stall on the premises where the horse is located when the notice of cancellation is received or, if the horse is in transit when the notice of cancellation is received, on the premises where it is next scheduled to compete, perform, or be exhibited according to the import permit. The stall in which the horse is kept must be separated from other stalls containing horses that are not listed on the import permit, either by an empty stall, by an open area across which horses cannot touch each other, or a by solid wall that is at least 8 feet (2.4 meters) high. In cases where the owners of the above specified premises do not permit the horse to be kept on those premises, or when the Administrator determines that keeping the horse on the above specified premises will pose a disease risk to horses in the United States, the horse must be kept, at the expense of the owner or importer, on an alternative premises approved by the Administrator.

(9) Stallions or mares over 731 days of age that are imported in accordance with paragraphs (f)(1) or (f)(2) of this section may be eligible to remain in the United States if the following is completed:

(i) Following completion of the itinerary specified in the import permit provided for in § 93.304, the horse's owner or importer applies for and receives a new import permit that specifies that the stallion or mare will be moved to an approved State listed in paragraph (h)(6) or (h)(7) of this section; and

(ii) The stallion or mare is transported in a sealed vehicle that has been cleaned and disinfected to an approved facility in an approved State where it is quarantined under State or Federal supervision until the stallion or mare has met the testing and treatment requirements of paragraph (e)(3) or (e)(5) of this section.

(10) All costs and charges associated with the supervision and maintenance of a horse imported under paragraphs (f)(1) or (f)(2) of this section will be borne by the horse's owner or importer. The costs associated with the supervision and maintenance of the horse by an APHIS representative at his or her usual places of duty will be reimbursed by the horse's owner or importer through user fees payable under part 130 of this chapter.

(11) In the event that an APHIS representative must be temporarily detailed from his or her usual place of duty in connection with the supervision and maintenance of a horse imported under this paragraph (f), the owner or importer of the horse must execute a trust fund agreement with APHIS to reimburse all expenses (including travel costs, salary, per diem or subsistence, administrative expenses, and incidental expenses) incurred by the Department in connection with the temporary detail. Under the trust fund agreement, the horse's owner or importer must deposit with APHIS an amount equal to the estimated cost, as determined by APHIS, for the APHIS representative to inspect the premises at which the horse will compete, perform, or be exhibited; to conduct the monitoring required by paragraph (f)(5)(iii) of this section; and to supervise the cleaning and disinfection required by paragraph (f)(5)(ix) of this section. The estimated costs will be based on the following factors:

(i) Number of hours needed for an APHIS representative to conduct the required inspection and monitoring;

(ii) For services provided during regular business hours (8 a.m. to 4:30 p.m., Monday through Saturday, except holidays), the average salary, per hour, for an APHIS representative;

(iii) For services provided outside regular business hours, the applicable rate for overtime, night differential, or Sunday or holiday pay, based on the average salary, per hour, for an APHIS representative;

(iv) Number of miles from the premises at which the horse competes, performs, or is exhibited to the APHIS office or facility that is monitoring the activities;

(v) Government rate per mile for automobile travel or, if appropriate, cost of other means of transportation between the premises at which the horse competes, performs, or is exhibited and the APHIS office or facility;

(vi) Number of trips between the premises at which the horse competes, performs, or is exhibited and the APHIS office or facility that APHIS representatives are required to make in order to conduct the required inspection and monitoring;

(vii) Number of days the APHIS representative conducting the inspection and monitoring must be in ''travel status;''

(viii) Applicable government per diem rate; and

(ix) Cost of related administrative support services.

(12) If a trust fund agreement with APHIS has been executed by the owner or importer of a horse in accordance with paragraph (f)(11) of this section and APHIS determines, during the horse's stay in the United States, that the amount deposited will be insufficient to cover the services APHIS is scheduled to provide during the remainder of the horse's stay, APHIS will issue to the horse's owner or importer a bill to restore the deposited amount to a level sufficient to cover the estimated cost to APHIS for the remainder of the horse's stay in the United States. The horse's owner or importer must pay the amount billed within 14 days after receiving the bill. If the bill is not paid within 14 days after its receipt, APHIS will cease to perform the services provided for in paragraph (f)(5) of this section until the bill is paid. The Administrator will inform the owner or importer of the cessation of services orally or in writing. If the notice of cessation is oral, the Administrator will confirm, in writing, the notice of cessation and the reason for the cessation of services as soon as circumstances permit. In such a case, the horse must be kept, at the expense of the owner or importer and until the bill is paid, in a stall either on the premises at which the horse is located when the notice of cessation of services is received or, if the horse is in transit when the notice of cessation of services is received, on the premises at which it is next scheduled to compete, perform, or be exhibited according to the import permit. The stall in which the horse is kept must be separated from other stalls containing horses that are not listed on the import permit either by an empty stall, an open area across which horses cannot touch each other, or a solid wall that is at least 8 feet (2.4 meters) high. In cases where the owners of the premises where the horse would be kept following a cessation of services do not permit the horse to be kept on those premises, or when the Administrator determines that keeping the horse on the premises will pose a disease risk to other horses in the United States, the horse must be kept, at the expense of the owner or importer, on an alternative premises approved by the Administrator. Until the bill is paid, the horse is not permitted to enter competition, perform, or be exhibited. Any amount deposited in excess of the costs to APHIS to provide the required

services will be refunded to the horse's owner or importer.

* * * * *

3. Section 93.304 is amended as follows:

a. In paragraph (a)(1)(ii), by removing the citation ''§ 93.301(f)'' and adding the citation ''§ 93.301(f)(1)'' in its place.

b. By redesignating paragraph (a)(1)(iii) as paragraph (a)(1)(iv) and adding a new paragraph (a)(1)(iii) to read as set forth below.

§ 93.304 Import permits for horses from regions affected with CEM and for horse specimens for diagnostic purposes; reservation fees for space at quarantine facilities maintained by APHIS.

(a) *Application for permit; reservation required.* (1) * * *

(iii) Horses intended for importation under § 93.301(f)(2) must meet the permit requirements of paragraph (a)(1)(i) of this section. Additionally, for horses intended for importation under § 93.301(f)(2), the horse's owner or importer must include the following information with the application for permit that is required by paragraph (a)(1)(i) of this section:

(A) The individual identifying information required in paragraph (a)(1)(i) of this section for all horses to be imported.

(B) The permanent electronic identification of each horse to be imported, if applicable. In the event that a horse has permanent electronic identification, the horse must be accompanied by a compatible reader.

(C) Photographs (head and lateral views) that are sufficient to identify each horse on an electronic medium approved by APHIS.

(D) The proposed total length of stay in the United States.

(E) A description of the shows or events in which the horse will perform while in the United States.

(F) The names, dates, and locations of the venues in which the horse will perform while in the United States.

(G) The names and locations of the premises on which the horse will be kept while in the United States, and the dates the horse will be kept on each premises.

(H) The methods and routes by which the horse will be transported while in the United States.

(I) A written plan for handling sick or injured horses that includes:

(*1*) The name, address, and phone number of each accredited veterinarian who will provide veterinary services in the United States;

(*2*) The name, address, and phone number of medical facilities to be used to diagnose or treat sick or injured horses while in the United States; and

(*3*) A plan to return sick or injured horses to performance condition.

(J) An application for a trust fund or escrow account agreement with APHIS in accordance with § 93.301(f)(11).

* * * * *

Done in Washington, DC, this 27th day of July 2007.

Kevin Shea,

Acting Administrator, Animal and Plant Health Inspection Service.

[FR Doc. E7–14994 Filed 8–1–07; 8:45 am]

BILLING CODE 3410–34–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2007–28854; Directorate Identifier 2007–NM–109–AD]

RIN 2120–AA64

Airworthiness Directives; Boeing Model 777–200, –200LR, –300, and –300ER Series Airplanes

AGENCY: Federal Aviation Administration (FAA), Department of Transportation (DOT).

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: The FAA proposes to adopt a new airworthiness directive (AD) for all Boeing Model 777–200, –200LR, –300, and –300ER series airplanes. This proposed AD would require doing initial and repetitive inspections for cracking of the elevator actuator fittings, and replacing any cracked fitting with a new fitting. This proposed AD results from a report that a cracked left elevator actuator fitting was found on a Model 777 airplane. We are proposing this AD to detect and correct a cracked actuator fitting, which could detach from the elevator and lead to an unrestrained elevator and an unacceptable flutter condition, which could result in loss of airplane control.

DATES: We must receive comments on this proposed AD by September 17, 2007.

ADDRESSES: Use one of the following addresses to submit comments on this proposed AD.

- DOT Docket Web site: Go to *http://dms.dot.gov* and follow the instructions for sending your comments electronically.
- Government-wide rulemaking Web site: Go to *http://www.regulations.gov* and follow the instructions for sending your comments electronically.
- Mail: U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue, SE., Washington, DC 20590.
- Fax: (202) 493–2251.
- Hand Delivery: Room W12–140 on the ground floor of the West Building, 1200 New Jersey Avenue, SE., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

Contact Boeing Commercial Airplanes, P.O. Box 3707, Seattle, Washington 98124–2207, for the service information identified in this proposed AD.

FOR FURTHER INFORMATION CONTACT: Gary Oltman, Aerospace Engineer, Airframe Branch, ANM–120S, FAA, Seattle Aircraft Certification Office, 1601 Lind Avenue, SW., Renton, Washington 98057–3356; telephone (425) 917–6443; fax (425) 917–6590.

SUPPLEMENTARY INFORMATION:

Comments Invited

We invite you to submit any relevant written data, views, or arguments regarding this proposed AD. Send your comments to an address listed in the **ADDRESSES** section. Include the docket number ''FAA–2007–28854; Directorate Identifier 2007–NM–109–AD'' at the beginning of your comments. We specifically invite comments on the overall regulatory, economic, environmental, and energy aspects of the proposed AD. We will consider all comments received by the closing date and may amend the proposed AD in light of those comments.

We will post all comments we receive, without change, to *http://dms.dot.gov*, including any personal information you provide. We will also post a report summarizing each substantive verbal contact with FAA personnel concerning this proposed AD. Using the search function of that Web site, anyone can find and read the comments in any of our dockets, including the name of the individual who sent the comment (or signed the comment on behalf of an association, business, labor union, etc.). You may review DOT's complete Privacy Act Statement in the **Federal Register** published on April 11, 2000 (65 FR 19477–78), or you may visit *http://dms.dot.gov*.

Examining the Docket

You may examine the AD docket on the Internet at *http://dms.dot.gov*, or in person at the Docket Operations office between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The Docket Operations office (telephone (800) 647–5527) is located on the

ground floor of the West Building at the DOT street address stated in the **ADDRESSES** section. Comments will be available in the AD docket shortly after the Docket Management System receives them.

Discussion

We have received a report indicating that a cracked left elevator actuator fitting was found on a Model 777 airplane with 17,346 total flight hours and 14,043 total flight cycles. The crack extended through the lower inboard flange of the fitting and into the vertical flange. Analysis by Boeing indicates that this crack resulted from fatigue due to higher than anticipated stress levels in the fitting flanges. Cracked elevator actuator fittings could lack adequate residual strength to react to design flight loads and become detached from the elevator. This condition, if not corrected, could allow a cracked actuator fitting to detach from the elevator and lead to an unrestrained elevator and an unacceptable flutter condition, which could result in loss of airplane control.

Relevant Service Information

We have reviewed Boeing Alert Service Bulletin 777–55A0015, dated April 19, 2007. The service bulletin describes procedures for doing an initial dye penetrant or high-frequency eddy current (HFEC) inspection to detect cracking of the elevator actuator fittings; repetitive dye penetrant, HFEC, or detailed inspections of the fittings thereafter; and replacing any cracked fitting with a new fitting having the same part number or an approved optional part number. Compliance times for the initial inspections, depending upon airplane condition, are:

- For airplanes having 14,000 total flight-cycles or more as of the date on the service bulletin, within 90 days after the date on the service bulletin;
- For airplanes having 10,000 total flight-cycles or more, but less than 14,000 total flight-cycles, as of the date on the service bulletin, within 12 months after the date on the service bulletin or within 90 days after the airplane reaches 14,000 total flight-cycles, whichever occurs first; or
- For airplanes having less than 10,000 total flight-cycles as of the date on the service bulletin, before the accumulation of 10,000 total flight cycles or within 12 months after the date on the service bulletin, whichever occurs first.

The next inspection, depending upon the type of initial inspection, is to be done at 1,000 or 1,200 flight cycles after the initial inspection, and repetitive inspections thereafter are to be done at intervals not to exceed 350 to 1,200 flight cycles. Any fitting found cracked during any inspection must be replaced before further flight. Any replacement fitting must receive an initial inspection before the accumulation of 10,000 total flight cycles after the replacement date, and repetitive inspections thereafter as described in this paragraph.

FAA's Determination and Requirements of the Proposed AD

We have evaluated all pertinent information and identified an unsafe condition that is likely to exist or develop on other airplanes of this same type design. For this reason, we are proposing this AD, which would require accomplishing the actions specified in the service information described previously.

Interim Action

We consider this proposed AD interim action. The manufacturer is currently developing a modification that will address the unsafe condition identified in this AD. Once this modification is developed, approved, and available, we might consider additional rulemaking.

Costs of Compliance

There are about 619 airplanes of the affected design in the worldwide fleet. This proposed AD would affect about 138 airplanes of U.S. registry. The proposed inspections would take about 4 work hours per airplane, per inspection cycle, at an average labor rate of $80 per work hour. Based on these figures, the estimated cost of the proposed AD for U.S. operators is $44,160, or $320 per airplane, per inspection cycle.

Authority for This Rulemaking

Title 49 of the United States Code specifies the FAA's authority to issue rules on aviation safety. Subtitle I, Section 106, describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the Agency's authority.

We are issuing this rulemaking under the authority described in Subtitle VII, Part A, Subpart III, Section 44701, ''General requirements.'' Under that section, Congress charges the FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this rulemaking action.

Regulatory Findings

We have determined that this proposed AD would not have federalism implications under Executive Order 13132. This proposed AD would not have a substantial direct effect on the States, on the relationship between the national Government and the States, or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify that the proposed regulation:

1. Is not a ''significant regulatory action'' under Executive Order 12866;

2. Is not a ''significant rule'' under the DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and

3. Will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

We prepared a regulatory evaluation of the estimated costs to comply with this proposed AD and placed it in the AD docket. See the **ADDRESSES** section for a location to examine the regulatory evaluation.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Safety.

The Proposed Amendment

Accordingly, under the authority delegated to me by the Administrator, the FAA proposes to amend 14 CFR part 39 as follows:

PART 39—AIRWORTHINESS DIRECTIVES

1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

2. The Federal Aviation Administration (FAA) amends § 39.13 by adding the following new airworthiness directive (AD):

Boeing: Docket No. FAA–2007–28854; Directorate Identifier 2007–NM–109–AD.

Comments Due Date

(a) The FAA must receive comments on this AD action by September 17, 2007.

Affected ADs

(b) None.

Applicability

(c) This AD applies to all Boeing Model 777–200, –200LR, –300, and –300ER series airplanes, certificated in any category.

Unsafe Condition

(d) This AD results from a report that a cracked left elevator actuator fitting was found on a Model 777 airplane. We are issuing this AD to detect and correct a cracked actuator fitting, which could detach from the elevator and lead to an unrestrained elevator and an unacceptable flutter condition, which could result in loss of airplane control.

Compliance

(e) You are responsible for having the actions required by this AD performed within the compliance times specified, unless the actions have already been done.

Inspections

(f) At the applicable time specified in paragraph 1.E. ''Compliance'' of Boeing Alert Service Bulletin 777–55A0015, dated April 19, 2007, do an initial dye penetrant or high-frequency eddy current (HFEC) inspection for cracking of the elevator actuator fittings, and, thereafter, do repetitive dye penetrant, HFEC, or detailed inspections at the applicable times specified in paragraph 1.E. ''Compliance.'' Before further flight, replace any fitting found to be cracked during any inspection required by this AD with a new fitting having the same part number, or an optional part number as identified in the service bulletin. Thereafter, do initial and repetitive inspections of the replacement fitting as described in paragraph 1.E. of the service bulletin. Do all inspections and actions described in this paragraph in accordance with the Accomplishment Instructions of the alert service bulletin; except, where the service bulletin specifies a compliance time after the date on the service bulletin, this AD requires compliance within the specified compliance time after the effective date of this AD.

Alternative Methods of Compliance (AMOCs)

(g)(1) The Manager, Seattle Aircraft Certification Office (ACO), FAA, has the authority to approve AMOCs for this AD, if requested in accordance with the procedures found in 14 CFR 39.19.

(2) To request a different method of compliance or a different compliance time for this AD, follow the procedures in 14 CFR 39.19. Before using any approved AMOC on any airplane to which the AMOC applies, notify your appropriate principal inspector (PI) in the FAA Flight Standards District Office (FSDO), or lacking a PI, your local FSDO.

(3) An AMOC that provides an acceptable level of safety may be used for any repair required by this AD, if it is approved by an Authorized Representative for the Boeing Commercial Airplanes Delegation Option Authorization Organization who has been authorized by the Manager, Seattle ACO, to make those findings. For a repair method to be approved, the repair must meet the certification basis of the airplane, and the approval must specifically refer to this AD.

Issued in Renton, Washington, on July 25, 2007.

Stephen P. Boyd,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. E7–15025 Filed 8–1–07; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2007–28855; Directorate Identifier 2007–NM–098–AD]

RIN 2120–AA64

Airworthiness Directives; EMBRAER Model EMB–120, –120ER, –120FC, –120QC, and –120RT Airplanes

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: We propose to adopt a new airworthiness directive (AD) for the products listed above. This proposed AD results from mandatory continuing airworthiness information (MCAI) originated by an aviation authority of another country to identify and correct an unsafe condition on an aviation product. The MCAI describes the unsafe condition as:

Icing tunnel tests on an EMB–120 wing section, conducted under a joint Embraer–NASA–(National Aeronautics and Space Administration) FAA–CTA (Centro Técnico Aeroespacial) research program well after the EMB–120( ) was type-certificated, have shown that stick shaker to stick pusher speed margins may drop below the minimum required by the applicable regulations in certain icing conditions. Although flight tests have shown that the aircraft handling qualities are not adversely affected, these reduced speed margins may significantly increase crew workload in certain flight phases.

The unsafe condition is reduced ability of the flightcrew to maintain the safe flight and landing of the airplane. The proposed AD would require actions that are intended to address the unsafe condition described in the MCAI.

DATES: We must receive comments on this proposed AD by September 4, 2007.

ADDRESSES: You may send comments by any of the following methods:

- DOT Docket Web Site: Go to *http://dms.dot.gov* and follow the instructions for sending your comments electronically.
- Fax: (202) 493–2251.
- Mail: U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue, SE., Washington, DC 20590.
- Hand Delivery: Room W12–140 on the ground floor of the West Building, 1200 New Jersey Avenue SE., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.
- Federal eRulemaking Portal: *http://www.regulations.gov*. Follow the instructions for submitting comments.

Examining the AD Docket

You may examine the AD docket on the Internet at *http://dms.dot.gov*; or in person at the Docket Operations office between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The AD docket contains this proposed AD, the regulatory evaluation, any comments received and other information. The street address for the Docket Operations office (telephone (800) 647–5527) is in the **ADDRESSES** section. Comments will be available in the AD docket shortly after receipt.

FOR FURTHER INFORMATION CONTACT: Dan Rodina, Aerospace Engineer, International Branch, ANM–116, FAA, Transport Airplane Directorate, 1601 Lind Avenue SW., Renton, Washington 98057–3356; telephone (425) 227–2125; fax (425) 227–1149.

SUPPLEMENTARY INFORMATION:

Streamlined Issuance of AD

The FAA is implementing a new process for streamlining the issuance of ADs related to MCAI. This streamlined process will allow us to adopt MCAI safety requirements in a more efficient manner and will reduce safety risks to the public. This process continues to follow all FAA AD issuance processes to meet legal, economic, Administrative Procedure Act, and **Federal Register** requirements. We also continue to meet our technical decision-making responsibilities to identify and correct unsafe conditions on U.S.-certificated products.

This proposed AD references the MCAI and related service information that we considered in forming the engineering basis to correct the unsafe condition. The proposed AD contains text copied from the MCAI and for this reason might not follow our plain language principles.

Comments Invited

We invite you to send any written relevant data, views, or arguments about this proposed AD. Send your comments to an address listed under the **ADDRESSES** section. Include ''Docket No. FAA–2007–28855; Directorate Identifier 2007–NM–098–AD'' at the beginning of

your comments. We specifically invite comments on the overall regulatory, economic, environmental, and energy aspects of this proposed AD. We will consider all comments received by the closing date and may amend this proposed AD based on those comments.

We will post all comments we receive, without change, to *http://dms.dot.gov*, including any personal information you provide. We will also post a report summarizing each substantive verbal contact we receive about this proposed AD.

Discussion

The Agência Nacional de Aviaçãao Civil (ANAC), which is the airworthiness authority for Brazil, has issued Brazilian Airworthiness Directive 2007–03–03, effective April 10, 2007 (referred to after this as ''the MCAI''), to correct an unsafe condition for the specified products. The MCAI states:

> Icing tunnel tests on an EMB–120 wing section, conducted under a joint Embraer–NASA—(National Aeronautics and Space Administration) FAA–CTA (Centro Técnico Aeroespacial) research program well after the EMB–120( ) was type-certificated, have shown that stick shaker to stick pusher speed margins may drop below the minimum required by the applicable regulations in certain icing conditions. Although flight tests have shown that the aircraft handling qualities are not adversely affected, these reduced speed margins may significantly increase crew workload in certain flight phases.

The unsafe condition is reduced ability of the flightcrew to maintain the safe flight and landing of the airplane. The corrective action includes modification of certain electrical wiring and installation of a new Stall Warning Computer. You may obtain further information by examining the MCAI in the AD docket.

Relevant Service Information

EMBRAER has issued Service Bulletins 120–27–0091, Change 02, dated September 29, 2003; and 120–27–0092, Revision 01, dated December 29, 2006. The actions described in this service information are intended to correct the unsafe condition identified in the MCAI.

FAA's Determination and Requirements of This Proposed AD

This product has been approved by the aviation authority of another country, and is approved for operation in the United States. Pursuant to our bilateral agreement with the State of Design Authority, we have been notified of the unsafe condition described in the MCAI and service information referenced above. We are proposing this AD because we evaluated all pertinent information and determined an unsafe condition exists and is likely to exist or develop on other products of the same type design.

Differences Between This AD and the MCAI or Service Information

We have reviewed the MCAI and related service information and, in general, agree with their substance. But we might have found it necessary to use different words from those in the MCAI to ensure the AD is clear for U.S. operators and is enforceable. In making these changes, we do not intend to differ substantively from the information provided in the MCAI and related service information.

We might also have proposed different actions in this AD from those in the MCAI in order to follow FAA policies. Any such differences are highlighted in a NOTE within the proposed AD.

Costs of Compliance

Based on the service information, we estimate that this proposed AD would affect about 107 products of U.S. registry. We also estimate that it would take about 58 work-hours per product to comply with the basic requirements of this proposed AD. The average labor rate is $80 per work-hour. Required parts would cost up to $2,000 per product, depending on airplane configuration. Where the service information lists required parts costs that are covered under warranty, we have assumed that there will be no charge for these costs. As we do not control warranty coverage for affected parties, some parties may incur costs higher than estimated here. Based on these figures, we estimate the cost of the proposed AD on U.S. operators to be up to $710,480, or $6,640 per product.

Authority for This Rulemaking

Title 49 of the United States Code specifies the FAA's authority to issue rules on aviation safety. Subtitle I, section 106, describes the authority of the FAA Administrator. ''Subtitle VII: Aviation Programs,'' describes in more detail the scope of the Agency's authority.

We are issuing this rulemaking under the authority described in ''Subtitle VII, Part A, Subpart III, Section 44701: General requirements.'' Under that section, Congress charges the FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this rulemaking action.

Regulatory Findings

We determined that this proposed AD would not have federalism implications under Executive Order 13132. This proposed AD would not have a substantial direct effect on the States, on the relationship between the national Government and the States, or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify this proposed regulation:

1. Is not a ''significant regulatory action'' under Executive Order 12866;

2. Is not a ''significant rule'' under the DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and

3. Will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

We prepared a regulatory evaluation of the estimated costs to comply with this proposed AD and placed it in the AD docket.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Safety.

The Proposed Amendment

Accordingly, under the authority delegated to me by the Administrator, the FAA proposes to amend 14 CFR part 39 as follows:

PART 39—AIRWORTHINESS DIRECTIVES

1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

2. The FAA amends § 39.13 by adding the following new AD:

Empresa Brasileira de Aeronautica S.A. (EMBRAER): Docket No. FAA–2007–28855; Directorate Identifier 2007–NM–098–AD.

Comments Due Date

(a) We must receive comments by September 4, 2007.

Affected ADs

(b) None.

Applicability

(c) This AD applies to all EMBRAER Model EMB–120, –120ER, –120FC, –120QC, and –120RT airplanes; certificated in any category.

Subject

(d) Air Transport Association (ATA) of America Code 27: Flight controls.

Reason

(e) The mandatory continuing airworthiness information (MCAI) states:

Icing tunnel tests on an EMB–120 wing section, conducted under a joint Embraer–NASA—(National Aeronautics and Space Administration) FAA–CTA (Centro Técnico Aeroespacial) research program well after the EMB–120( ) was type-certificated, have shown that stick shaker to stick pusher speed margins may drop below the minimum required by the applicable regulations in certain icing conditions. Although flight tests have shown that the aircraft handling qualities are not adversely affected, these reduced speed margins may significantly increase crew workload in certain flight phases.

The unsafe condition is reduced ability of the flightcrew to maintain the safe flight and landing of the airplane. The corrective action includes modification of certain electrical wiring and installation of a new Stall Warning Computer.

Actions and Compliance

(f) Within 36 months after the effective date of this AD, unless already done, do the following actions.

(1) Replace the current Stall Warning Computers with new improved ones in accordance with detailed instructions and procedures described in the Embraer Service Bulletin 120–27–0092, Revision 01, dated December 29, 2006.

(2) Before installing the improved Stall Warning Computers, accomplish the detailed instructions and procedures described in the Embraer Service Bulletin 120–27–0091, Change 02, dated September 29, 2003.

(3) As of 36 months after the effective date of this AD, no person may install a Stall Warning Computer; part number C–81806–1 or –2, Mod. A, or C–81806–3, on any airplane.

FAA AD Differences

Note: This AD differs from the MCAI and/or service information as follows: No differences.

Other FAA AD Provisions

(g) The following provisions also apply to this AD:

(1) *Alternative Methods of Compliance (AMOCs):* The Manager, International Branch, ANM–116, FAA, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19. Send information to ATTN: Dan Rodina, Aerospace Engineer, 1601 Lind Avenue, SW., Renton, Washington 98057–3356; telephone (425) 227–2125; fax (425) 227–1149. Before using any approved AMOC on any airplane to which the AMOC applies, notify your appropriate principal inspector (PI) in the FAA Flight Standards District Office (FSDO), or lacking a PI, your local FSDO.

(2) *Airworthy Product:* For any requirement in this AD to obtain corrective actions from a manufacturer or other source, use these actions if they are FAA-approved. Corrective actions are considered FAA-approved if they are approved by the State of Design Authority (or their delegated agent). You are required to assure the product is airworthy before it is returned to service.

(3) *Reporting Requirements:* For any reporting requirement in this AD, under the provisions of the Paperwork Reduction Act, the Office of Management and Budget (OMB) has approved the information collection requirements and has assigned OMB Control Number 2120–0056.

Related Information

(h) Refer to MCAI Brazilian Airworthiness Directive 2007–03–03, effective April 10, 2007; and Embraer Service Bulletins 120–27–0091, Change 02, dated September 29, 2003; and 120–27–0092, Revision 01, dated December 29, 2006; for related information.

Issued in Renton, Washington, on July 25, 2007.

Stephen P. Boyd,

Acting Manager,Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. E7–15026 Filed 8–1–07; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

18 CFR Part 385

[Docket No. RM07–16–000]

Filing Via the Internet

July 23, 2007.

AGENCY: Federal Energy Regulatory Commission, Department of Energy.

ACTION: Notice of proposed rulemaking.

SUMMARY: The Commission is proposing to amend its regulations to implement the latest version of its eFiling system. The upgraded system will permit most documents filed with the Commission to be submitted via the Internet. This will include, among other things, large documents such as maps and some confidential documents.

DATES: Comments are due October 1, 2007.

ADDRESSES: You may submit comments, identified by docket number by any of the following methods:

- *Agency Web Site: http://ferc.gov/docs-filing/efiling.asp*. Documents created electronically using word processing software should be filed in native applications or print-to-PDF format and not in a scanned format.
- *Mail/Hand Delivery:* Commenters unable to file comments electronically must mail or hand deliver an original and 14 copies of their comments to: Federal Energy Regulatory Commission, Secretary of the Commission, 888 First Street, NE., Washington, DC 20426.

Instructions: For detailed instructions on submitting comments and additional information on the rulemaking process, see the Comment Procedures Section of this document.

FOR FURTHER INFORMATION CONTACT: Wilbur Miller, 888 First Street, NE., Washington, DC 20426, telephone: (202) 502–8953, e-mail: *wtmiller@ferc.gov*.

SUPPLEMENTARY INFORMATION:

I. Background

1. On September 21, 2000, the Commission issued Order No. 619, which implemented the use of the Internet for submission of documents to the Commission for filing.[1] Such submissions were limited to categories of documents specified by the Secretary of the Commission, with the intention of gradually expanding the range of eligible documents.[2] The eFiling system plays an important role in the Commission's efforts to comply with the Government Paperwork Elimination Act, which requires that agencies provide the option to submit information electronically, when practicable, as a substitute for paper.[3] The Commission also has established a system of electronic registration, or eRegistration, which is required for users of its eFiling system and other specified activities.[4] Filing via the Internet is optional for eligible documents.[5] The eFiling system now is receiving approximately one third of all documents filed at the Commission. The system is accessible through the Commission's Web site at *http://www.ferc.gov/docs-filing/efiling.asp*.

2. The Commission is proposing to implement, in late 2007, eFiling 7.0, which will significantly expand the capabilities of the system. As part of this implementation, the Commission proposes to expand the range of documents that may be filed via the Internet to include all filings, with specified exceptions. Most notably, it will be possible for regulated entities to make complex filings in their entireties in electronic format.[6] The Commission

[1] *Electronic Filing of Documents*, Order No. 619, 65 FR 57088 (Sept. 21, 2000), FERC Stats. & Regs. ¶ 31,107 (2000).

[2] *See* Rule 2003(c) of the Commission's Rules of Practice and Procedure, 18 CFR 385.2003(c).

[3] Pub. L. 105–277, Sec. 1702–1704 (1998); *see* OMB Circular A–130 Para 8.a.1(k).

[4] 18 CFR 390.1 & 390.2.

[5] Rule 2001(a) of the Commission's Rules of Practice and Procedure, 18 CFR 385.2001(a).

[6] The process for making tariff filings by the electric, gas, and oil industries is being addressed in *Electronic Tariff Filings*, Docket No. RM01–5–000. *See Electronic Tariff Filings*, Notice of Proposed Rulemaking, 69 FR 43929 (July 23, 2004),

also proposes to implement other changes and technical enhancements, and is seeking comments on the advisability of these changes and the best methods of implementing them.

II. Discussion

A. Eligible Documents

3. Under the Commission's regulations, only ''qualified documents'' may be filed via the Internet, and the Secretary is authorized to specify which documents are qualified.[7] A list of qualified documents is published on the Commission's web site. Currently, there are over forty categories of qualified documents.[8] The Secretary also is authorized to issue filing instructions.[9]

4. To implement eFiling 7.0, the Commission proposes to revise its regulations to permit users to submit via the Internet all documents filed in Commission proceedings pursuant to Chapter I of Title 18 of the Code of Federal Regulations, with specified exceptions. As before, the Secretary will specify the documents that may be submitted to the eFiling system, but now the Secretary would list exceptions rather than eligible documents. The Secretary would continue to issue filing instructions for allowable file formats, electronic document formats and electronic filings having multiple components. However, where specific regulations require that a filing include particular content, those regulations will continue to apply. Similarly, where specific regulations or other instructions contain requirements applicable to electronic documents, such as allowable file formats,[10] those instructions also will continue to apply. The Commission invites comment on the proposals described below and generally on which documents should be accepted through the eFiling system.

5. The Commission proposes to revise Rule 2003(c) of the its Rules of Practice and Procedure [11] to provide specifically that all documents may be filed via the Internet unless excluded by the Secretary. It is not necessary, however, to revise the regulations to allow the Secretary to issue instructions regarding allowable file formats and other aspects of eFiling, as that authority is already included in Rule 2003(c)(2). Although they will not be the subject of revisions to the regulations, this notice of proposed rulemaking seeks comment on issues such as appropriate file formats and the filing of paper copies of oversized documents. Matters such as file formats and filing instructions would be contained in the instructions to be issued by the Secretary rather than being covered by regulations.

6. There are several types of filings that the Commission anticipates will not be made initially through eFiling 7.0. Electronic filing of tariffs, tariff revisions and rate change applications is the subject of a separate rulemaking.[12] Certain forms will not be accepted through eFiling. For example, the following forms are currently, and would continue to be, submitted through eForms: FERC Form No.1, FERC Form No. 2, FERC Form No. 2–A, FERC Form No. 3–Q, FERC Form No. 6, FERC Form No. 6–Q, Form 60, Form 714, and Electric Quarterly Reports.[13] Requests for extensions of time to file these forms, however, would be submitted through eFiling.

7. Finally, the Commission proposes to begin accepting, through eFiling, documents for which participants request confidential treatment pursuant to the Commission's regulations,[14] including critical energy infrastructure information (CEII).[15] Although the Commission proposes to begin accepting confidential documents with the eFiling 7.0 release, it does not propose to accept documents that are subject to protective order. There likely will be separate file uploads for Public, Confidential, and CEII files. Filers also will be able to revise security designations—for example, move a file from Confidential to Public. Filers will be able to load multiple files under each security class or they may upload .zip files containing numerous files if the files all have the same security class. The Commission will create separate accession numbers for the files uploaded under each security class and pass the files under each accession number to eLibrary with the appropriate security designation. This mirrors the current process for paper filings containing non-public material.

8. In some cases, the Commission will require paper copies of filings although it will also be possible to submit the documents through eFiling 7.0. This paper back-up will apply most notably to oversized documents such as maps, diagrams and drawings. Due to the size of standard monitors and other hardware and software limitations, it is impractical at this time for Commission staff to review such documents in electronic form. The Commission therefore anticipates that it will continue to need paper copies of most documents that are larger than 8.5 x 11 inches. As the Commission upgrades its resources, it expects to be able to reduce or eliminate the requirement for paper copies. The Commission also is considering whether to require paper copies of long documents, such as those exceeding 500 pages. The instructions posted by the Secretary will include directions specifying whether, and how many, paper copies of electronically filed documents are required. Appendix A contains examples of some documents that participants will be able to file via the Internet, but for which the Commission will also require paper copies.

B. File Formats

9. The acceptance through eFiling 7.0 of documents that are not in standard word processing formats will present some issues involving file formats. As noted above, the Commission has issued instructions regarding file formats for specific documents in some regulations. In addition, staff has provided instructions in specific instances. Those requirements will continue to apply. The Secretary will specify formats in filing instructions that will apply in all other cases. The need for specific formatting may arise in connection with oversized documents, spreadsheets and other documents that contain data, to ensure that the documents will be in formats that users can reasonably be expected to find accessible.

10. The Secretary has already issued instructions specifying acceptable file formats for filings submitted on CD–ROM, DVD and other electronic media. These can be found at *http://www.ferc.gov/help/submission-guide/electronic-media/acceptable.asp*. The Commission anticipates that these instructions will be updated concurrent with eFiling 7.0 and will apply to documents submitted through the eFiling system via the Internet. The Commission is required to establish standards for the creation, use, preservation, and disposition of

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FERC Stats. & Regs. ¶ 32,575 (July 8, 2004); *Notice of Additional Proposals and Procedures*, 70 FR 40941 (July 15, 2005), FERC Stats. & Regs. ¶ 35,551 (July 6, 2005). The Commission allows Open Access Transmission Tariffs (OATTs) and revisions to be eFiled as described at *http://www.ferc.gov/help/filing-guide/file-OATT.asp*.

[7] Rule 2003(c), 18 CFR 385.2003(c).

[8] *See http://www.ferc.gov/docs-filing/efiling/docs-efiled.asp*.

[9] Rule 2003(c)(1)(ii), 18 CFR 385.2003(c)(1)(ii); *see http://www.ferc.gov/docs-filing/efiling/user-guide.asp*.

[10] *E.g., http://www.ferc.gov/industries/electric/gen-info/qual-fac/completing.asp* (Form 556 for Qualifying Facilities).

[11] 18 CFR 385.2003(c).

[12] *See Electronic Tariff Filings*, Docket No. RM01–5–000, FERC Statutes and Regulations ¶ 35,551 (2005).

[13] FERC Form 1–F is currently not included in eForms, so it could be efiled. The same is true with OATTs, as explained in footnote 6.

[14] 18 CFR 388.112.

[15] 18 CFR 388.113.

electronic records to retain them in a usable format until their authorized disposition dates. The Commission therefore invites comment on the current instructions, particularly on the question whether they provide adequate accessibility and accuracy. Based on guidance from the National Archives and Records Administration (NARA), the Commission is considering accepting exclusively waveform audio (.wav) format files for audio content and either audio-video interleave (.avi) or quicktime (.mov) format files for video content except where specific regulations contain requirements for other file formats. Also, the Commission intends to enforce, to the extent it is technically able to do so, the instructions issued with the eFiling 7.0 system rather than rely on voluntary compliance. We also plan to continue to improve our technical ability to enforce the instructions. For example, when the Commission has a technical solution for reliably and rapidly detecting a password-protected document, it will prevent the uploading of that document through eFiling.

11. In some instances, the Commission may issue more detailed instructions requiring particular document formats in connection with specific types of filings. For example, the Commission's regulations set out required exhibits for applications under section 7 of the Natural Gas Act,[16] such as articles of incorporation and a statement showing state authorization to do business,[17] as well as various types of data.[18] The Commission anticipates that the Secretary will issue instructions specifying required formats for many exhibits that must be included in section 7 applications. For documents such as Articles of Incorporation, it is likely that PDF versions would be required. For documents containing data, the Secretary likely will specify that they shall be filed in native spreadsheet application.[19]

12. Another formatting issue concerns the presentation of filed documents in eLibrary. In the original conception of e-Library, the Commission would convert filings in native application to PDF and to Text.[20] This is intended to make filings accessible to the public in an open format without the need for purchasing proprietary software. As eFiling has increased and more complex documents have been filed, the conversion tools used by the Commission have not always been able to produce accurate renditions of filed documents. The degree of reliability decreases as the complexity of the electronic files increases and the costs of staff intervention to ensure reliability are prohibitive. For example, electronic spread sheets commonly contain multiple worksheets, with each worksheet containing many potential paper pages of data in many different formats. The conversion tools however frequently convert only the first worksheet.

13. The Commission therefore is considering whether to discontinue creating PDF and Text versions of submitted documents and post only the electronic files as filed with the Commission, although it intends to continue providing PDF versions of its own issuances. We are requesting comments on the effect this would have on public accessibility to the files. Discontinuing the conversion to open formats could require users to purchase proprietary software. There would also be some inconvenience to participants in Commission proceedings when they are citing to page numbers, as the vast majority of filers do not use paragraph numbers. The Commission requests comments on this proposal.

14. Should the Commission discontinue the practice of creating PDF versions of submissions, it could implement several measures. It could require that all word processing filings be made in open file formats, such as text, html, rtf, or possibly PDF. Open source file types would be the most easily accessible to all users. Alternatively, the Commission could permit filings in open file formats as well as in certain Microsoft Office formats. The Commission notes that Microsoft provides a free viewer that can be downloaded and used to view these files. Alternatively, the Commission could require that documents created with proprietary software be filed in the proprietary software along with an open source format to ensure that all viewers are able to download and read that document. Such filings would duplicate the current Commission practice of scanning all filings to create PDF formats.

15. Spreadsheets may be even more complicated because spreadsheet conversions do not retain formulas and may be difficult for the public to use. Thus, while spreadsheets need to be filed in native application, the Commission could require the filer to provide a PDF or open source file that could be used, at least, to obtain the numbers presented in the spreadsheet. The Commission invites comment on these alternatives, as well as on the possibility of discontinuing the Commission's practice of creating PDF and Text versions.

16. As a related issue, the Commission seeks input on whether the Secretary should require that documents created electronically by the filer using word processing software be filed in native applications or print-to-PDF format and not in a scanned format. The Commission has found that many ordinary text documents are being scanned and then converted to PDF formats. This removes the advantages of the native application, most notably the ability to search the text of the document and to copy and paste. It is unclear what advantage is derived from the submission of scanned PDF versions in such instances.[21] The Commission's regulations regarding signatures are intended to allow participants to submit pleadings, sworn statements and the like without the need for physical signatures or notarization,[22] which in turn should eliminate the need for scanned versions to ensure authenticity. The Commission understands that, in some situations, a scanned, non-searchable document is the only reasonable alternative. For instance, a filer may possess an exhibit only in hard copy and therefore cannot submit it in text-searchable form. The Commission would allow for such situations.

C. Documentless Intervention

17. As part of eFiling 7.0, the Commission is proposing to permit documentless intervention. This proposal will permit users to intervene in Commission proceedings via the Internet through an online form or web interface, without actually uploading a document to serve as the motion or

[16] 18 CFR 157.14.

[17] 18 CFR 157.14(1)–(2) (Exhibits A and B).

[18] *E.g.*, 18 CFR 157.14(11) (Exhibit I—Market Data), (13) (Exhibit K—Cost of Facilities).

[19] The Commission anticipates that spreadsheet files in native application would be required for Exhibit K and the data portions of Exhibits I, L, and N through P of Section 157.14.

[20] *See* Electronic Filing of the Application for Authorization for the Issuance of Securities or the Assumption of Liabilities, 70 FR 35372 (June 20, 2005), FERC Stats. & Regs. Regulations Preambles 2001–2005 ¶ 31,188 at p. 6 (May 27, 2005); Electronic Filing of Documents, 65 FR 57088 (September 21, 2000), FERC Stats. & Regs. Regulations Preambles July 1996–December 2000 ¶ 31,107, at 31,820 (September 14, 2000).

[21] Many courts prohibit or discourage the filing of scanned PDF documents. *E.g.*, *http://www.txs.uscourts.gov/attorneys/cmecf/dcfaq.htm*; *http://www.utd.uscourts.gov/documents/utahdraftadminproc.pdf*; *http://www.med.uscourts.gov/ecf/adminprocedures.htm*.

[22] *See* Rule 2005(b)(3) of the Commission's Rules of Practice and Procedure, 18 CFR 385.2005(b)(3) (permitting declaration under oath pursuant to 28 U.S.C. 1746); Rule 2005(c) of the Commission's Rules of Practice and Procedure, 18 CFR 385.2005(c) (in electronic documents, typed characters suffice as signature).

notice.[23] This change would not, however, affect in any way the issue of whether a participant is entitled to intervene. The Commission does not propose revising any regulation in connection with this proposed change. Instructions relating to this proposal would be issued by the Secretary.[24] The Commission invites comment on the proposal as described below.

18. The current online system allows the entry of only the docket number, the party or parties, and at least one registered contact for each party. If a person who has not eRegistered attempts to file a motion/notice to intervene with the Commission online, the system will prompt the user first to eRegister.[25] Under the current system the user must then attach a document that contains the basis for intervention. The proposed change to online filing of interventions will add a section for the user to enter the basis for intervention directly into the system without attaching a separate document.[26] The system would allow users to submit online only motions/notices of intervention and would require that users file protests, substantive comments and other matters besides the intervention as separate documents using the existing eFiling process.

19. As a part of the proposed change regarding interventions, the Commission will issue a confirmation via electronic mail for receipt of each motion/notice of intervention that it receives online. This confirmation will identify the information submitted by the filer, including the filing date and time. The Commission will also create a placeholder document in eLibrary that will specify the date and time the filing was submitted, the docket number, the name of the applicant in the docket, the name of the intervening party(ies), contact information for the intervening party, and the basis for intervening. Anyone eSubscribed to the docket will receive an eSubscription e-mail with a link to the ''document'' that the Commission created and added to eLibrary on behalf of the submitter. This placeholder document will also be stamped with the Commission's standard watermark. The intervening party(ies), as identified, will be added to the service list for the specified docket. Where intervention is late or is opposed on other grounds, the party(ies) attempting to intervene would be removed from the service list if and when intervention was denied.

D. Quick Comment

20. As part of eFiling 7.0, the Commission is proposing to create a ''quick comment'' feature that will operate in a manner similar to documentless intervention by allowing users to submit comments without uploading documents. The Commission believes that this feature will be particularly helpful to individuals who do not participate routinely in Commission proceedings and wish to make brief comments in certain proceedings, such as users impacted by a single project. To submit a documentless, or quick, comment the user will first fill out a form with name and e-mail address, and send this information to FERC. If the e-mail address provided is valid, an e-mail will be sent to the user, which will include a link to the quick comment form. The form will be pre-filled with the contact information captured during the prior step. The user will be required to input a docket number for the proceeding to which the comment will apply. At this time, the Commission anticipates that the quick comment feature will be available only for P (Hydropower Project), PF (Pre-Filing NEPA activities for proposed gas pipelines), and CP (Certificates for Interstate Natural Gas Pipelines) proceedings. After the user has identified the docket(s), he or she would enter a comment in the text box by typing or copying and pasting. Once the information is submitted to the Commission, a PDF document will be created and added to eLibrary, where it will be searchable in the same manner as all other documents in the system. As with documentless intervention, the Commission does not propose to revise any regulation in connection with this proposed change. Instructions relating to quick comment would be issued by the Secretary.[27] The Commission invites comments on this proposal.

E. Filing Deadlines for Documents Submitted Via the Internet

21. In connection with the conversion to eFiling 7.0, the Commission seeks comment on the advisability of extending hours for filing online to allow Internet filers to make submissions until midnight Eastern Standard or Daylight Savings Time. For example, a document filed via the Internet would be considered received by the Commission on the date of filing as long as the last byte of information is received by midnight Eastern Standard or Daylight Savings Time on that date.[28] Currently, both Internet and paper filings must be received by the close of business, *i.e.*, 5 p.m., to be considered to have been filed on that date. Otherwise, the document is considered to have been filed on the next business day.[29]

22. Paper filings must be received by close of business because there must be staff available to stamp the date and time of receipt. However, internet submissions have no such limitation because the eFiling system records the date and time of the submission separately from the actual file date. The Commission is interested in receiving public comments on the effect of bifurcated filing deadlines.

F. Technical Conference

23. Commission staff may conduct one or more technical conferences to discuss issues relating to electronic file format and electronic document standards. Any conference will be held prior to the deadline for filing comments on this proposal and will be separately noticed.

III. Information Collection Statement

24. Office of Management and Budget (OMB) regulations require OMB to approve certain information collection requirements imposed by agency rule.[30] This Final Rule does not contain any information collection requirements and compliance with the OMB regulations is thus not required.

IV. Environmental Analysis

25. The Commission is required to prepare an Environmental Assessment or an Environmental Impact Statement for any action that may have a significant adverse effect on the human environment.[31] Issuance of this Final Rule does not represent a major federal action having a significant adverse effect on the quality of the human environment under the Commission's regulations implementing the National Environmental Policy Act. Part 380 of the Commission's regulations lists exemptions to the requirement to draft an Environmental Analysis or

[23] *See* Rule 214 of the Commission's Rules of Practice and Procedure, 18 CFR 385.214.

[24] 24 *See* Rule 2003 of the Commission's Rules of Practice and Procedure, 18 CFR 385.2003 (Secretary's authority for issuing instructions for filings made via the Internet).

[25] Rule 2010 requires persons eligible to receive service under that rule to eRegister pursuant to 18 C.F.R. 390.1. A person may eRegister through the FERC Online page at *http://www.ferc.gov/docs-filing/ferconline.asp.*

[26] *See* 18 CFR 385.214(3)(b), setting forth the acceptable bases for intervention.

[27] *See* Rule 2003.

[28] *See* Rule 2003(c)(3).

[29] Rule 2001(a)(2) of the Commission's Rules of Practice and Procedure, 18 CFR 385.2001(a)(2).

[30] 5 CFR 1320.12

[31] Order No. 486, Regulations Implementing the National Environmental Policy Act, 52 FR 47897 (Dec. 17, 1987), FERC Stats. & Regs., Regulations Preambles 1986–1990 ¶ 30,783 (1987).

Environmental Impact Statement. Included is an exemption for procedural, ministerial or internal administrative actions.[32] This rulemaking is exempt under that provision.

V. Regulatory Flexibility Act Certification

26. The Regulatory Flexibility Act of 1980 (RFA) [33] generally requires a description and analysis of final rules that will have significant economic impact on a substantial number of small entities. This Final Rule concerns procedural matters and is expected to increase the ease and convenience of filing. The Commission certifies that it will not have a significant economic impact upon participants in Commission proceedings. An analysis under the RFA is not required.

VI. Comment Procedures

27. The Commission invites interested persons to submit comments on the matters and issues proposed in this notice to be adopted, including any related matters or alternative proposals that commenters may wish to discuss. Comments are due October 1, 2007. Comments must refer to Docket No. RM07–16–000, and must include the commenter's name, the organization he/she represents, if applicable, and his/her address in the comments.

28. The Commission encourages comments to be filed electronically via the eFiling link on the Commission's Web site at *http://ferc.gov/docs-filing/efiling.asp.* The Commission accepts most standard word processing formats. Documents created electronically using word processing software should be filed in native applications or print-to-PDF format and not in a scanned format. Commenters filing electronically do not need to make paper filings. It is not necessary to serve copies of rulemaking comments on other commenters.

29. Commenters that are not able to file comments electronically must send an original and 14 copies of their comments to: Federal Energy Regulatory Commission, Secretary of the Commission, 888 First Street, NE., Washington, DC 20426.

30. All comments will be placed in the Commission's public files and may be viewed, printed, or downloaded remotely as described in the Document Availability section below.

VII. Document Availability

31. In addition to publishing the full text of this document in the **Federal Register**, the Commission provides all interested persons an opportunity to view and/or print the contents of this document via the Internet through FERC's Home Page (*http://www.ferc.gov*) and in FERC's Public Reference Room during normal business hours (8:30 a.m. to 5 p.m. Eastern time) at 888 First Street, NE., Room 2A, Washington, DC 20426.

32. From FERC's Home Page on the Internet, this information is available on eLibrary. The full text of this document is available on eLibrary in PDF and Microsoft Word format for viewing, printing, and/or downloading. To access this document in eLibrary, type the docket number excluding the last three digits of this document in the docket number field.

33. User assistance is available for eLibrary and the FERC's website during normal business hours from our Help line at (202) 502–8222 or the Public Reference Room at (202) 502–8371 Press 0, TTY (202) 502–8659. E-mail the Public Reference Room at *public.referenceroom@ferc.gov.*

List of Subjects in 18 CFR Part 385

Administrative practice and procedure, Electric utilities, Penalties, Pipelines, Reporting and recordkeeping requirements.

By direction of the Commission.

Kimberly D. Bose,

Secretary.

In consideration of the foregoing, the Commission proposes to amend part 385, Chapter I, Title 18, *Code of Federal Regulations,* as follows.

PART 385—RULES OF PRACTICE AND PROCEDURE

1. The authority citation for part 385 continues to read as follows:

Authority: 5 U.S.C. 551–557; 15 U.S.C. 717–717z, 3301–3432; 16 U.S.C. 791a–825v, 2601–2645; 28 U.S.C. 2461; 31 U.S.C. 3701, 9701; 42 U.S.C. 7101–7352, 16441, 16451–16463; 49 U.S.C. 60502; 49 App. U.S.C. 1–85 (1988).

2. Section 385.2001 is amended by revising paragraph (a)(1)(iii) to read as follows:

§ 385.2001 Filings (Rule 2001).

(a) * * *

(1) * * *

(iii) By filing via the Internet pursuant to Rule 2003 through the links provided at *http://www.ferc.gov.*

* * * * *

3. Section 385.2003 is amended by revising paragraph (c) to read as follows:

§ 385.2003 Specifications (Rule 2003).

* * * * *

(c) *Filing via the Internet.* (1) All documents filed under this Chapter may be filed via the Internet except those listed by the Secretary. Except as otherwise specifically provided in this Chapter, filing via the Internet is in lieu of other methods of filing. Internet filings must be made in accordance with instructions issued by the Secretary and made available online at *http://www.ferc.gov.* Provisions of this chapter or directions from the Commission containing requirements as to the content and format of specific types of filings remain applicable.

(2) The Secretary will make available on the Commission's web site a list of document types that may not be filed via the Internet, as well as instructions pertaining to allowable electronic file and document formats, the filing of complex documents, whether paper copies are required, and procedural guidelines.

(3) For purposes of statutes or regulations governing timeliness, a document filed via the Internet will be deemed to have been received by the Commission at the time the last byte of the document is received by the Commission.

* * * * *

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

APPENDIX A

(Partial list of eFiling-eligible documents for which paper copies may be required.)

Environmental and Electric Transmission Filings

- USGS 7.5 minute topographic maps.
- National Wetland Inventory maps.
- Alignment sheets.
- Aerial photographs.
- Major waterbody crossing plans and HDD (horizontal directional drill) diagrams.
- Drawings/figures showing project boundaries, footprints, building locations, etc.
- Drawings of valve and piping details at compressor stations, meter stations and pipeline interconnections.

Liquefied Natural Gas (LNG)

- Engineering diagrams and plot plans.
- Process flow diagrams.
- Detailed piping and instrumentation diagrams (PSID's).
- Equipment/tank detailed drawings of LNG storage tanks and process equipment.
- Hazard detection and control location diagrams/plot plans.

Pipeline Engineering

- Flow diagrams required under Exhibits G and G–1 (18 CFR 157.14).

Storage

- Isopach, isobaric, structural, and stratigraphic maps.

[32] 18 CFR 380.4(1) and (5).

[33] 5 U.S.C. 601–612.

- Well logs.

[FR Doc. E7–14724 Filed 8–1–07; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 1

[REG–155929–06]

RIN 1545–BG31

Payout Requirements for Type III Supporting Organizations That Are Not Functionally Integrated

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Advance notice of proposed rulemaking.

SUMMARY: This document describes rules that the Treasury Department and the IRS anticipate proposing, in a notice of proposed rulemaking, regarding the payout requirements for Type III supporting organizations that are not functionally integrated, the criteria for determining whether a Type III supporting organization is functionally integrated, the modified requirements for Type III supporting organizations that are organized as trusts, and the requirements regarding the type of information a Type III supporting organization must provide to its supported organization(s) to demonstrate that it is responsive to its supported organization(s). Sections 1241 and 1243 of the Pension Protection Act of 2006 amended the law with respect to Type III supporting organizations prompting a need to revise the Treasury Regulations regarding the four matters mentioned above. These new requirements and criteria would apply to Type III supporting organizations as defined under sections 509(a)(3)(B)(iii) and 4943(f)(5) of the Internal Revenue Code (Code). This document also invites comments from the public regarding the proposed payout requirement and the proposed criteria for qualifying as functionally integrated. All materials submitted will be available for public inspection and copying.

DATES: Written or electronic comments must be submitted by October 31, 2007.

ADDRESSES: Send submissions to: CC:PA:LPD:PR (REG–155929–06), room 5203, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044. Submissions may be hand-delivered Monday through Friday between the hours of 8 a.m. and 4 p.m. to CC:PA:LPD:PR (REG–155929–06), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW., Washington, DC, or sent electronically via the Federal eRulemaking Portal at *http://www.regulations.gov/* (IRS REG–155929–06).

FOR FURTHER INFORMATION CONTACT: Concerning submissions, Richard A. Hurst at (202) 622–2949 (TDD Telephone) and his e-mail address is *Richard.A.Hurst@irscounsel.treas.gov;* concerning the proposed rules, Philip T. Hackney or Michael B. Blumenfeld at (202) 622–6070 (not toll-free numbers).

SUPPLEMENTARY INFORMATION:

Background

The Pension Protection Act of 2006, Public Law 109–280, 120 Stat. 780 (2006) (PPA), amended the requirements that an organization exempt from tax under section 501(c)(3) of the Code must meet to qualify as a Type III supporting organization under section 509(a)(3) of the Code. This advanced notice of proposed rulemaking describes the rules that the Treasury Department and the IRS expect to propose to implement the new qualification requirements for Type III supporting organizations enacted by Congress and solicits comments from the public.

Public Charities Versus Private Foundations

Under section 509(a), an organization described in section 501(c)(3) is a private foundation unless it meets the requirements of section 509(a)(1), (2), (3), or (4). Organizations described in section 501(c)(3) that meet the requirements of section 509(a)(1), (2), (3), or (4) are referred to as public charities.

Private foundations, which are generally divided into two categories, operating and non-operating, depending on the type of activity in which the foundation engages, are subject to a different set of requirements than those applicable to public charities. Sections 4940 through 4948 impose various restrictions and excise taxes on private foundations along with their disqualified persons and foundation managers, that are generally not applicable to public charities. Furthermore, more stringent deduction limitations apply to contributions made to private non-operating foundations than apply to contributions to public charities. For example, under section 170(b)(1)(A), an individual who makes a cash contribution to a public charity may deduct up to fifty percent of his or her contribution base (a modified adjusted gross income amount) in the year of his or her contribution, while the same contribution to a private non-operating foundation would be limited to thirty percent of the individual's contribution base under section 170(b)(1)(B). In addition, deductions for contributions of certain appreciated property to a private non-operating foundation are limited to the contributor's basis in the property under section 170(e)(1)(A), while the same contribution to a public charity could result in a deduction based on the property's fair market value under section 170(e)(1)(B)(ii).

Supporting Organizations

Public charities that meet the requirements of section 509(a)(3) are known as supporting organizations. To be classified as a supporting organization, an organization must satisfy an organizational test, an operational test, a relationship test, and a disqualified person control test. The organizational and operational tests require that the organization be organized and at all times thereafter operated exclusively for the benefit of, to perform the functions of, or to conduct the purposes of one or more publicly supported organizations described in section 509(a)(1) or (2). The relationship test requires that the organization be operated, supervised, or controlled by or in connection with one or more publicly supported organizations. Finally, the disqualified person control test requires that the organization not be controlled directly or indirectly by certain disqualified persons.

Relationship Test

Treasury Regulation (Treas. Reg.) § 1.509(a)–4(f)(2) sets forth three structural or operational relationships a supporting organization is permitted to have with its supported organization(s). Each supporting organization must have one of the three types of relationships with the organization(s) it supports to be a supporting organization described in section 509(a)(3) of the Code. The purpose of the relationship requirement is to ensure that a supporting organization has a sufficiently close tie to one or more publicly supported organizations such that the supporting organization will be accountable to a broader public constituency.

A supporting organization that is operated, supervised or controlled by one or more publicly supported organizations is commonly known as a Type I supporting organization. The relationship a Type I supporting organization has with its supported

organization(s) is comparable to that of a parent-subsidiary relationship. A supporting organization supervised or controlled in connection with one or more publicly supported organizations is commonly known as a Type II supporting organization. The relationship a Type II supporting organization has with its supported organization(s) is comparable to a brother-sister corporate relationship. A supporting organization that is operated in connection with one or more publicly supported organizations is commonly known as a Type III supporting organization.

Qualification Requirements for Type III Supporting Organizations Prior to Enactment of the Pension Protection Act

In general, Treas. Reg. § 1.509(a)–4(i)(1) requires an organization to meet a ''responsiveness test'' and an ''integral part test'' to satisfy the relationship requirement for a Type III supporting organization.

Responsiveness Test: General Rule. Treas. Reg. § 1.509(a)–4(i)(2)(i) provides that an organization is ''considered to meet the 'responsiveness test' if the organization is responsive to the needs or demands of'' its publicly supported organizations. Treas. Reg. § 1.509(a)–4(i)(2)(ii) provides that a supporting organization may demonstrate responsiveness to its publicly supported organization(s) if: (1)(a) One or more of its officers, directors, or trustees are elected or appointed by the officers, directors, trustees, or membership of its publicly supported organization(s), (b) one or more members of the governing bodies of its publicly supported organization(s) are also officers, directors, or trustees of, or hold other important offices in, the supporting organization, or (c) the officers, directors, or trustees of the supporting organization maintain a close, continuous working relationship with the officers, directors, or trustees of its publicly supported organization(s); and (2) by reason of such arrangement, the officers, directors, or trustees of its publicly supported organization(s) have a significant voice in the investment policies of the supporting organization, the timing and the manner of making grants, the selection of the grant recipients by the supporting organization, and otherwise directing the use of the income or assets of the supporting organization.

In addition, with respect to an organization that was supporting a publicly supported organization before November 20, 1970, Treas. Reg. § 1.509(a)–4(i)(1)(ii) provides that additional facts and circumstances, such as a historic and continuing relationship between the supporting organization and its supported organization(s), may be taken into account, in addition to the factors described in the general responsiveness test above, to establish compliance with the responsiveness test.

Responsiveness Test: Charitable Trusts. Before enactment of the PPA, one way of satisfying the responsiveness test, under Treas. Reg. § 1.509(a)–4(i)(2)(iii), required that (1) the supporting organization be a charitable trust under state law, (2) each publicly supported organization that the trust supports be named as a beneficiary under the charitable trust's governing instrument, and (3) each beneficiary organization have the power to enforce the trust and compel an accounting under State law. As described below, this method of satisfying the responsiveness test was effectively removed by the PPA.

Integral Part Test. Treas. Reg. § 1.509(a)–4(i)(3)(i) provides that a supporting organization is required to establish that ''it maintains a significant involvement in the operations of one or more publicly supported organizations and such publicly supported organizations are in turn dependent upon the supporting organization for the type of support which it provides.'' Treas. Reg. § 1.509(a)–4(i)(3)(ii) and (iii) sets forth two alternative ways to meet the integral part test. The first method is typically referred to as the ''but for'' test. In this advance notice of proposed rulemaking, the second method of meeting the integral part test will be referred to as the ''attentiveness'' test.

Integral Part Test, Alternative I: the ''but for'' test. Under Treas. Reg. § 1.509(a)–4(i)(3)(ii) the ''but for'' test is satisfied if ''the activities engaged in [by the supporting organization] for or on behalf of the publicly supported organizations are activities to perform the functions of, or to carry out the purposes of, such organizations, and, but for the involvement of the supporting organization, would normally be engaged in by the publicly supported organizations themselves.''

Integral Part Test, Alternative II: the ''attentiveness'' test. The ''attentiveness'' test, under Treas. Reg. § 1.509(a)–4(i)(3)(iii), requires a supporting organization to (1) make payments of substantially all of its income to or for the use of one or more publicly supported organizations, (2) provide enough support to one or more publicly supported organizations to insure the attentiveness of such organizations to the operations of the supporting organization, and (3) pay a substantial amount of the total support of the supporting organization to those publicly supported organizations that meet the attentiveness requirement. Rev. Rul. 76–208, 1976–1 CB 161, (see § 601.601(d)(2) of this chapter), provides that the phrase ''substantially all of its income'' in Treas. Reg. § 1.509(a)–4(i)(3)(iii) means at least 85 percent of its adjusted net income.

PPA Amendments to Qualification Requirements for Type III Supporting Organizations

The PPA amended the qualification requirements for Type III supporting organizations, modifying both the integral part test and the responsiveness test.

Sections 1241 and 1243 of the PPA enacted Code sections 509(d) and 4943(f)(5). These provisions define the term Type III supporting organization and distinguish between functionally integrated and non-functionally integrated Type III supporting organizations. These two new categories appear to reflect the distinction drawn in the Treasury Regulations between those organizations that meet the integral part test by meeting the ''but for'' test and those that meet the integral part test by meeting the ''attentiveness'' test.

In conformity with existing Treasury Regulations, new section 4943(f)(5)(A) defines a Type III supporting organization as a supporting organization that is operated in connection with one or more section 509(a)(1) or (2) organizations. New section 4943(f)(5)(B) defines a functionally integrated Type III supporting organization as a Type III supporting organization that is not required under regulations established by the Secretary to make payments to supported organizations due to the activities of the organization related to performing the functions of, or carrying out the purposes of, such supported organizations. Although this language appears similar to the ''but for'' prong of the integral part test, the Staff of the Joint Committee on Taxation in its technical explanation of the provision notes that there is ''concern that the current regulatory standards for satisfying the integral part test not by reason of a payout [i.e., the existing ''but for'' test] are not sufficiently stringent to ensure that there is a sufficient nexus between the supporting and supported organizations.'' See Staff of the Joint Committee on Taxation, Technical Explanation of H.R. 4, the ''Pension Protection of 2006,'' as Passed by the House on July 28, 2006, and as Considered by the Senate on August 3,

2006 (JCX–38–06) at 360 n. 571, August 3, 2006 (Technical Explanation). In particular, the Technical Explanation states that in revising the Type III supporting organization regulations the Secretary ''shall strengthen the standard for qualification as [a Type III supporting] organization that is not required to pay out.'' *Id.*

Section 1241(d)(1) of the PPA directed the Secretary to promulgate new regulations on the payments required by Type III supporting organizations that are not functionally integrated. Section 1241(d)(1) of the PPA provides that such regulations shall require non-functionally integrated Type III supporting organizations to make distributions of a ''percentage of either income or assets to supported organizations (defined in new section 509(f)(3) of [the] Code) in order to ensure that a significant amount is paid'' to their supported organizations. The Technical Explanation notes that there is concern that merely requiring a Type III supporting organization to pay out substantially all of its net income (as under the ''attentiveness'' prong of the integral part test) does not necessarily result in significant distributions to publicly supported organizations relative to the value of the assets held by the Type III supporting organization and ''as compared to amounts paid out by nonoperating private foundations.'' See Technical Explanation at 360 n. 571.

Section 1241(c) of the PPA modified the responsiveness test as it applies to charitable trusts. Effectively, section 1241(c) provides that having each organization that the trust supports be a publicly supported organization named as a beneficiary under the trust's governing instrument and establishing that each beneficiary organization has the power to enforce the trust and compel an accounting is no longer sufficient to satisfy the responsiveness test as provided in Treas. Reg. § 1.509(a)–4(i)(2)(iii). The Technical Explanation states that a Type III supporting organization organized as a trust must now ''establish to the satisfaction of the Secretary, that it has a close and continuous relationship with the supported organization such that the trust is responsive to the needs or demands of the supported organization.'' Technical Explanation at 362. Under section 1241(e)(2)(A) of the PPA, trusts that operated in connection with a publicly supported organization on August 17, 2006, have until August 17, 2007 to satisfy the modified responsiveness test under Treas. Reg. 1.509(a)–4(i)(2)(ii). For other trusts, the provision was effective on August 17, 2006.

Finally, section 1241(b) added section 509(f)(1)(A), which contains another requirement for Type III supporting organizations. The provision requires a Type III supporting organization to provide each of its supported organizations with ''such information as the Secretary may require to ensure that such organization is responsive to the needs or demands of the supported organization.''

As described in this advanced notice of proposed rulemaking, the Treasury Department and the IRS intend to propose regulations that provide (1) the payout requirements for Type III supporting organizations that are not functionally integrated, (2) the criteria for determining whether a Type III supporting organization is functionally integrated, (3) the modified responsiveness test for Type III supporting organizations that are organized as charitable trusts, and (4) the type of information a Type III supporting organization will be required to provide to its supported organization(s) to demonstrate that it is responsive.

Explanation of Provisions

Summary of Proposed Criteria for Qualifying as a Type III Supporting Organization

The Treasury Department and the IRS expect that all Type III supporting organizations will be required to meet the responsiveness test under Treas. Reg. § 1.509(a)–4(i)(2)(ii). In addition, it is expected that Type III supporting organizations that are functionally integrated will be required to meet: (A) The ''but for'' test in existing Treas. Reg. § 1.509(a)–4(i)(3)(ii); (B) an expenditure test that will resemble the qualifying distributions test for private operating foundations; and (C) an assets test that will resemble the alternative assets test for private operating foundations. Finally, it is expected that a Type III supporting organization that is not functionally integrated will be required to meet a payout requirement equal to the qualified distribution requirement of a private non-operating foundation. In addition, there will be a limit on the number of publicly supported organizations a non-functionally integrated Type III supporting organization may support. These proposed criteria for qualifying as a Type III supporting organization will replace the integral part test in the existing regulations. These provisions are explained in more detail below.

Definition of Functionally Integrated Type III Supporting Organization and the Applicability of Private Operating Foundation Rules

Private operating foundations under section 4942(j)(3) share strong similarities with Type III functionally integrated supporting organizations under section 4943(f)(5)(B) in that both are expected to be directly engaged in the active conduct of charitable activities rather than only making grants to, or for the use of, charitable organizations. The Code and Treasury Regulations provide extensive rules used to determine whether a private foundation is a private operating foundation. See section 4942(j)(3) and Treas. Reg. § 53.4942(b). The Treasury Department and the IRS believe that these rules provide a useful model for developing standards to determine whether a Type III supporting organization is functionally integrated, and that adoption of similar rules under section 4943(f)(5)(B) will further the Congressional purpose articulated in the Technical Explanation of strengthening the nexus between a functionally integrated Type III supporting organization and the publicly supported organization(s) it supports.

To qualify as a private operating foundation under section 4942(j)(3), an organization must satisfy a qualifying distributions test and one of three alternative tests described below. Under the qualifying distributions test, a private operating foundation must make qualifying distributions ''directly for the active conduct of the activities constituting the purpose or function for which it is organized and operated,'' equal to substantially all (at least 85 percent) of the lesser of its adjusted net income or its minimum investment return. Under section 4942(e)(1), the minimum investment return is equal to 5 percent of the excess of (A) the aggregate fair market value of all the foundation's assets other than those used (or held for use) directly in carrying out the organization's exempt purpose over (B) the acquisition indebtedness with respect to such assets. Under Treas. Reg. § 53.4942(b)–1(b)(1), a qualifying distribution directly for the active conduct of activities constituting the foundation's exempt purpose is a distribution that is used by the foundation itself to carry out its exempt activities rather than paid to other organizations to help them carry out their exempt activities.

In addition, a private operating foundation must meet one of three alternative tests: An assets test, an endowment test or a support test. The

assets test, under section 4942(j)(3)(B)(i) and Treas. Reg. § 53.4942(b)–2(a), requires that substantially more than half (at least 65 percent) of the assets of an operating foundation must be devoted directly to the private operating foundation's exempt purpose activities, or to functionally related businesses (see section 4942(j)(4)), or both, or are stock of a corporation controlled by, and substantially all (at least 85 percent) of the assets of which are devoted to, the foundation. The endowment test, under Treas. Reg. § 53.4942(b)–2(b), requires a foundation to make qualifying distributions directly for the active conduct of its exempt activities in an amount not less than two thirds of its minimum investment return. The support test, under Treas. Reg. § 53.4942(b)–2(c), is satisfied if substantially all (85 percent) of a foundation's support (other than gross investment income) is normally received from the general public and from five or more exempt organizations that are not related to each other or the recipient foundation, if the foundation does not normally receive more than 25 percent of its support from any one such exempt organization; and if the foundation does not normally receive more than 50 percent of its support from gross investment income.

Description of the Proposed Functionally Integrated Test

The Treasury Department and the IRS anticipate that the proposed regulations will define the term functionally integrated Type III supporting organization as a Type III supporting organization that meets: (A) The ''but for'' test in existing Treas. Reg. § 1.509(a)–4(i)(3)(ii); (B) an expenditure test consistent with section 4942(j)(3)(A); and (C) an assets test consistent with section 4942(j)(3)(B)(i). It is expected that the expenditure test will require a functionally integrated Type III supporting organization to use substantially all of the lesser of (a) its adjusted net income or (b) five percent of the aggregate fair market value of all its assets (other than assets that are used, or held for use, directly in supporting the charitable programs of the supported organizations) directly for the active conduct of activities that directly further the exempt purposes of the organizations it supports. The assets test will require the organization to devote at least 65 percent of the aggregate fair market value of all its assets directly for the active conduct of activities that directly further the exempt purposes of the organizations it supports. The Treasury Department and the IRS believe that requiring functionally integrated Type III supporting organizations to satisfy the expenditure and assets tests, in addition to the ''but for'' test, will be stronger than the existing integral part test and ensure a sufficient nexus between a supporting organization and the organization(s) it supports. These tests also will ensure that a sufficient amount is being dedicated directly to the active conduct of activities that further the exempt purposes of publicly supported organizations.

The term ''adjusted net income'' is expected to have substantially the same meaning as that term has in section 4942(f) and Treas. Reg. § 53.4942(a)–2(d). The valuation of assets is expected to be determined in a manner similar to the rules under section 4942(e)(2) and Treas. Reg. § 53.4942(a)–2(c)(4).

The Treasury Department and the IRS also intend that certain Type III supporting organizations that oversee or facilitate the operation of an integrated system that includes one or more charities and that may be unable to satisfy the ''direct active conduct'' and ''directly further'' requirements of the expenditure and assets tests, such as certain hospital systems, will be classified as functionally integrated in the proposed regulations if they satisfy the existing ''but for'' test.

The proposed regulations will not permit a functionally integrated Type III supporting organization to qualify as functionally integrated by using the endowment or support tests that are available to private operating foundations as alternatives to the proposed assets test. Because the endowment test is similar to the expenditure test, the Treasury Department and the IRS believe that the endowment test would not provide sufficient additional assurances of a tight nexus between a functionally integrated supporting organization and its supported organizations. Furthermore the support test, which focuses on sources of support received by a private foundation rather than on its activities, appears to be inapplicable to the functionally integrated concept. By requiring at least 65 percent of the value of all assets of each functionally integrated supporting organization to be devoted directly for the active conduct of the activities of its supported organizations, the proposed assets test is intended to ensure that the connection between the supporting and supported organizations is significant.

Payout Requirement for Type III Supporting Organizations That Are Not Functionally Integrated

In establishing a payout requirement for non-functionally integrated Type III supporting organizations, the Treasury Department and the IRS expect to follow the framework of the existing section 4942 qualifying distribution regulations applicable to private non-operating foundations. Private non-operating foundations have operated under these qualifying distribution regulations for many years. The Treasury Department and the IRS believe these rules are appropriate for Type III grant-making organizations, and would further the Congressional purpose articulated in the Technical Explanation of ensuring that, as compared to amounts paid out by private non-operating foundations, significant amounts are being paid to supported organizations even if the supporting organization's assets produce little or no income.

A private non-operating foundation is required under section 4942 to make certain qualifying distributions or pay an excise tax. A private non-operating foundation is generally liable for this excise tax under section 4942(a) and (b) if it does not make qualifying distributions each year equal to its minimum investment return. The minimum investment return is five percent of the aggregate fair market value of all the foundation's assets other than those used (or held for use) directly in carrying out the organization's exempt purpose over the acquisition indebtedness with respect to such assets. Qualifying distributions under section 4942(g) are generally those distributions (including reasonable and necessary administrative expenses) paid to accomplish charitable purposes.

Description of the Proposed Payout Rule

The Treasury Department and the IRS anticipate that the proposed regulations will (A) require a non-functionally integrated Type III supporting organization to meet a payout requirement and (B) limit the number of publicly supported organizations a non-functionally integrated Type III supporting organization may support.

The payout requirement will call for a Type III supporting organization that is not functionally integrated to distribute annually to or for the use of its supported organizations an amount equal to at least five percent of the aggregate fair market value of all its assets (other than assets that are used, or held for use, directly in supporting the charitable programs of its supported organizations). Additionally, the

Treasury Department and the IRS are concerned that a supporting organization's relationship with and accountability to its supported organizations is diminished as the number of its supported organizations increases. Accordingly, except for organizations in existence on or before the date the regulations are proposed, it is expected that the proposed regulations will also provide that non-functionally integrated Type III supporting organizations will be limited to supporting no more than five publicly supported organizations. An organization in existence on or prior to the date regulations are proposed may support more than five supported organizations only if the organization distributes at least 85 percent of its total required payout amount to, or for the use of, publicly supported organizations to which the supporting organization is responsive pursuant to Treas. Reg. § 1.509(a)–4(i)(2)(ii). The anticipated proposed payout rules are intended to ensure that a non-functionally integrated Type III supporting organization has a tight nexus with its supported organization(s).

The Treasury Department and the IRS recognize that requiring an existing Type III supporting organization that supports more than five supported organizations to provide 85 percent of its total required payout to those supported organizations to which it is responsive may affect existing donee relationships. The Treasury Department and the IRS solicit comments on whether transitional rules are needed with respect to this proposed limitation regarding distributions to supported organizations.

The valuation of assets for purposes of the payout requirement is expected to be determined in a manner similar to that under section 4942(e)(2) and Treas. Reg. § 53.4942(a)–2(c)(4). The proposed distribution rules will be similar to the distribution rules under section 4942. It is expected that amounts paid by an organization to accomplish the exempt purposes of its supported organizations will be considered as distributed to or for the use of its supported organization(s).

Responsiveness Test

Except as explained below with respect to charitable trusts, the Treasury Department and the IRS do not expect to modify the responsiveness test. Thus, all Type III supporting organizations will be expected to meet the responsiveness test under Treas. Reg. § 1.509(a)–4(i)(2)(ii). Accordingly, a Type III supporting organization will be expected to demonstrate the necessary relationship between its officers, directors or trustees and those of its supported organization(s), and further show that this relationship results in the officers, directors or trustees of its supported organization(s) having a significant voice in the operations of the supporting organization.

Responsiveness Test for Charitable Trusts

Consistent with section 1241(c) of the PPA, discussed in the Background section above, the proposed regulations will provide that charitable trusts must satisfy the responsiveness test under Treas. Reg. § 1.509(a)–4(i)(2)(ii). Thus, for instance, a trust would be expected to show that its trustees have a close, continuous working relationship with the officers, directors, or trustees of the publicly supported organization(s) it supports and that through such relationship the officers, directors or trustees of its publicly supported organization(s) have a significant voice in the operations of the supporting organization. Comments are requested with respect to potential transition relief given that the statute directs that this modified test apply as of August 17, 2007 to trusts already in existence on the date of enactment of the PPA.

Requirement To Provide Supported Organizations With Information Regarding Responsiveness

The proposed regulations will provide rules for the form, content and timing of the information Type III supporting organizations are required to provide their supported organization(s) under section 509(f)(1)(A). The Treasury Department and the IRS solicit comments as to what information the Secretary should require a Type III supporting organization to provide to each of its supported organizations to ensure that such supporting organization is responsive to the needs or demands of its supported organization(s).

Consequences for Failing To Satisfy the Proposed Tests

The proposed regulations will clarify that an organization that would otherwise be classified as a Type III supporting organization, but either does not establish that it is functionally integrated or does not satisfy the payout requirement for non-functionally integrated organizations in a taxable year, will be classified as a private foundation for such taxable year and all subsequent taxable years until it terminates its private foundation status under section 507. The Treasury Department and the IRS solicit comments on how the requirements for a private foundation termination under section 507 should apply in these circumstances.

Transitional Issues

Implementation of the new qualification requirements for Type III supporting organizations enacted in the PPA will raise transitional issues for certain organizations. For instance, an organization that currently qualifies as a Type III supporting organization by meeting the attentiveness prong of the integral part test might be prohibited by its current governing instrument from distributing capital or corpus, thus preventing it from being able to satisfy the new payout requirement for non-functionally integrated Type III supporting organizations without a change to such instrument. The Treasury Department and the IRS invite comments regarding potential transition rules for supporting organizations in existence as of the date of enactment of the PPA that will provide such organizations a reasonable opportunity to amend their governing instruments or make other changes to comply with the law as amended by the PPA.

Proposed Effective Date

Except as otherwise noted, the Treasury Department and the IRS anticipate that these new proposed rules for Type III supporting organizations would apply to taxable years with respect to each organization beginning after the date these rules are published in the **Federal Register** as final or temporary regulations.

Request for Comments

Before the notice of proposed rulemaking is issued, consideration will be given to any written comments (a signed original and eight (8) copies) or electronic comments that are submitted timely to the IRS. All comments will be available for public inspection and copying.

Drafting Information

The principal authors of this advance notice of proposed rulemaking are Philip T. Hackney and Michael B. Blumenfeld, Office of the Chief Counsel (Tax-exempt and Government Entities), however, other personnel from the IRS and the Treasury Department participated in its development.

Kevin M. Brown,

Deputy Commissioner for Services and Enforcement.

[FR Doc. E7–14925 Filed 8–1–07; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 26

[REG–128843–05]

RIN 1545–BE70

Severance of a Trust for Generation-Skipping Transfer (GST) Tax Purposes II

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of proposed rulemaking.

SUMMARY: These proposed regulations provide guidance regarding the generation-skipping transfer (GST) tax consequences of the severance of trusts in a manner that is effective under state law, but that does not meet the requirements of a qualified severance under section 2642(a)(3) of the Internal Revenue Code. These proposed regulations also provide guidance regarding the GST tax consequences of a qualified severance of a trust with an inclusion ratio between zero and one into more than two resulting trusts. These proposed regulations also provide special funding rules applicable to the non pro rata division of certain assets between or among resulting trusts. The regulations will affect trusts that are subject to the GST tax.

DATES: Written or electronic comments and requests for a public hearing must be received by October 31, 2007.

ADDRESSES: Send submissions to: CC:PA:LPD:PR (REG–128843–05), room 5203, Internal Revenue Service, PO Box 7604, Ben Franklin Station, Washington, DC 20044. Submissions may be hand-delivered Monday through Friday between the hours of 8 a.m. and 4 p.m. to: CC:PA:LPD:PR (REG–128843–05), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW., Washington, DC, or sent electronically, via the Federal eRulemaking Portal at *http://www.regulations.gov* (IRS REG–128843–05).

FOR FURTHER INFORMATION CONTACT: Mayer R. Samuels, (202) 622–3090 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Background

On August 24, 2004, proposed regulations under section 2642(a)(3) regarding qualified severances were published in the **Federal Register** (REG–145987–03, 2004–39 IRB 519, 69 FR 51967). Final regulations were published on August 2, 2007. The Treasury Department and the IRS determined that certain comments received in response to the proposed regulations under section 2642(a)(3) should be addressed in a separate notice of proposed rulemaking, instead of in the final regulations published on August 2, 2007. Accordingly, this notice of proposed rulemaking proposes additional changes to the regulations in response to those comments.

Section 2642(a)(3) was added to the Internal Revenue Code (Code) by the Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA), Public Law 107–16 (115 Stat. 38 (2001)). Under section 2642(a)(3), if a trust is divided into two or more trusts in a ''qualified severance,'' the trusts resulting from the severance (resulting trusts), which may have different inclusion ratios, will be recognized as separate trusts for GST tax purposes. Once the resulting trusts are recognized as separate trusts, the transferor's lifetime GST tax exemption may be allocated separately to either trust. In addition, whether or not a GST taxable event occurs is determined separately for each resulting trust.

One commentator with respect to the notice of proposed rulemaking under section 2642(a)(3) suggested that those regulations should expressly address the GST tax consequences of dividing a trust in a manner that does not satisfy the regulatory requirements of a qualified severance, but nonetheless is effective to create separate trusts under applicable state law. Specifically, the commentator requested that the regulations be amended to provide that the separate trusts created as the result of a trust's division that is effective under state law, but that does not qualify as a qualified severance, will be respected prospectively as separate trusts for GST tax purposes, but that the inclusion ratio of each of the resulting trusts will be the same as the inclusion ratio of the original trust immediately before its severance.

As noted by a commentator, however, such a result would require an amendment to the existing regulations under section 2654. Generally, section 2654(b)(2) provides that ''substantially separate and independent shares'' of different beneficiaries in a trust will be treated as separate trusts for GST tax purposes. Section 26.2654–1(a)(1)(i) provides that, for purposes of section 2654(b)(2), the term ''substantially separate and independent shares'' generally has the same meaning as provided in § 1.663(c)(3). However, these regulations further provide that a portion of a trust is not a separate share ''unless such share exists from and at all times after creation of the trust.''

Section 26.2654–1(a)(5), *Example 8,* illustrates this rule. In *Example 8,* T creates a discretionary trust with discretionary power in the trustee to distribute income and principal among T's children and grandchildren. The trust agreement directs that, when T's youngest child reaches age 21, the trust be divided into separate shares, with one such share for each child of T; the income from a particular share is to be paid to T's child (for whom that share was created) for life, with the remainder from that share to be distributed to that child's own children. The example concludes that the separate shares that come into existence when the youngest child reaches age 21 are not recognized as separate trusts for GST tax purposes because the separate shares did not constitute separate and independent shares of a single trust at all times from the date of creation of the original trust, as required by § 26.2654–1(a)(1). Thus, any allocation of GST tax exemption to the original trust, or to any of the separate shares after the division, will apply with respect to the entire trust. The example provides that the result would be the same if the original trust was divided into separate trusts rather than separate shares.

Another commentator with respect to the notice of proposed rulemaking under section 2642(a)(3) requested that the regulations provide additional flexibility in severing a trust that has an inclusion ratio between zero and one. Generally, the final regulations apply section 2642(a)(3)(B)(ii) by requiring that the trust first be severed into two identical trusts, one of which would then have an inclusion ratio of zero and the other an inclusion ratio of one. The final regulations confirm that either or both of these trusts may then be further severed into a trust for the benefit of the skip person(s) and a trust for the benefit of the non-skip person(s). However, under this two-step procedure, one of the resulting trusts for the benefit of skip persons would have an inclusion ratio of one, and one of the trusts for the benefit of the non-skip persons would have an inclusion ratio of zero. The commentator requested that the regulations allow severances in a manner that would permit a more effective utilization of the exemption.

The Treasury Department and the IRS believe that each of these suggestions merits further consideration in a new notice of proposed rulemaking. In addition, the new proposed regulations clarify the rules in the final regulations regarding the funding of resulting trusts.

Explanation of Provisions

The proposed regulations amend the regulations under § 26.2642–6 to provide that trusts resulting from a severance that does not meet the requirements of a qualified severance nevertheless will be treated, after the severance, as separate trusts for GST tax purposes, provided that the resulting trusts are recognized as separate trusts under applicable state law. Because the severance is not a qualified severance, each such resulting trust will have the same inclusion ratio immediately after the severance as the original trust immediately before the severance. Nevertheless, GST tax exemption allocated after the severance may be separately allocated to one or more of the resulting trusts and the trusts will otherwise be treated as separate trusts for GST tax purposes. An example of a nonqualified severance is added to the regulations.

The proposed regulations also revise § 26.2654–1(a)(1)(i) and (a)(5), *Example 8*.

In addition, pursuant to the authority granted in section 2642(a)(3)(B)(iii), these proposed regulations provide for an additional type of qualified severance. Specifically, the proposed regulations provide that a trust with an inclusion ratio between zero and one may be severed in a qualified severance into more than two resulting trusts. One or more of the resulting trusts in the aggregate must receive that fractional share of the total value of the original trust as of the date of severance that is equal to the applicable fraction used to determine the inclusion ratio of the original trust immediately before the severance. The trust or trusts receiving such fractional share shall have an inclusion ratio of zero, and each of the other resulting trust or trusts shall have an inclusion ratio of one. Further, the trustee may designate the beneficiary of each separate resulting trust, provided that the designation results in each beneficiary having the same beneficial interest (within the meaning of § 26.2642–6(d)(5)) after the severance as that beneficiary had in the original trust corpus. Guidance illustrating the application of this rule is included in § 26.2642–6(d)(7)(ii) and *Example 9* of § 26.2642–6(j) of these proposed regulations.

Finally, these proposed regulations clarify a provision of the final regulations issued contemporaneously with these proposed regulations. Specifically, § 26.2642–6(d)(4) requires that each resulting trust be funded with a fraction or percentage of the entire trust and that, although particular assets may be divided among the resulting trusts on a non pro rata basis based on the fair market value of the assets on the date of severance, the sum of those fractions or percentages must be one or one hundred percent, respectively. Thus, if the resulting trusts are funded on a non pro rata basis, the sum of the values distributed to the resulting trusts must equal the fair market value of the trust being severed. These proposed regulations clarify that no discounts or other reductions from the value of an asset owned by the original trust, arising by reason of the division of the original trust's interest in the asset between or among the resulting trusts, are permitted in funding the resulting trusts. Instead, solely for funding purposes, each resulting trust's interest in the stock of a closely held corporation, partnership interest, or other single asset must be valued by multiplying the fair market value of the asset held in the original trust as of the date of severance by the fractional or percentage interest in that asset being distributed to that resulting trust. This clarification is proposed to be effective with respect to severances occurring on or after the date these proposed regulations are published in the **Federal Register**.

Special Analyses

It has been determined that this notice of proposed rulemaking is not a significant regulatory action as defined in Executive Order 12866. Therefore, a regulatory assessment is not required. It also has been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) applies only to § 26.2642–6(d)(7)(ii) of these regulations. It is hereby certified that this provision will not have a significant economic impact on a substantial number of small entities. Accordingly, a Regulatory Flexibility Analysis is not required. This provision directly affects individuals, not entities. Because the remaining sections of these regulations do not impose on small entities a collection of information requirement, the Regulatory Flexibility Act (5 U.S.C. chapter 6) does not apply. Pursuant to section 7805(f) of the Code, this notice of proposed rulemaking will be submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

Comments and Requests for Public Hearing

Before these proposed regulations are adopted as final regulations, consideration will be given to any written (a signed original and eight (8) copies) or electronic comments that are submitted timely to the IRS. The IRS and Treasury Department request comments on the substance of the proposed regulations, as well as on the clarity of the proposed rules and how they may be made easier to understand. All comments will be available for public inspection and copying. A public hearing will be scheduled if requested in writing by any person that timely submits written comments. If a public hearing is scheduled, notice of the date, time, and place for the public hearing will be published in the **Federal Register**.

Drafting Information

The principal author of these proposed regulations is Mayer R. Samuels, Office of the Associate Chief Counsel (Passthroughs and Special Industries), IRS. Other personnel from the IRS and the Treasury Department participated in their development.

List of Subjects in 26 CFR Part 26

Estate taxes, Reporting and recordkeeping requirements.

Proposed Amendments to the Regulations

Accordingly, 26 CFR part 26 is proposed to be amended as follows:

PART 26—GENERATION-SKIPPING TRANSFER TAX REGULATIONS UNDER THE TAX REFORM ACT OF 1986

Paragraph 1. The authority citation for part 26 continues to read in part as follows:

Authority: 26 U.S.C. 7805 * * *

Par. 2. In § 26.2600–1, the table of contents is amended by adding the entry for § 26.2642–6(h) to read as follows:

§ 26.2600–1 Table of contents.

* * * * *

§ 26.2642–6 Qualified severance.

* * * * *

(h) Treatment of trusts resulting from a severance that is not a qualified severance.

* * * * *

Par. 3. Section 26.2642–6 is amended as follows:

1. Paragraphs (d)(4) and (d)(7) are revised.

2. Paragraph (h) is added.

3. Paragraph (j) *Examples 6, 9, 12* and *13* are added.

4. Paragraph (k)(1) is revised.

The additions and revisions read as follows:

§ 26.2642–6 Qualified severance.

* * * * *

(d) * * *

(4) The single trust (original trust) is severed on a fractional basis, such that each new trust (resulting trust) is funded with a fraction or percentage of the original trust, and the sum of those fractions or percentages is one or one hundred percent, respectively. For this purpose, the fraction or percentage may be determined by means of a formula (for example, that fraction of the trust the numerator of which is equal to the transferor's unused GST tax exemption, and the denominator of which is the fair market value of the original trust's assets on the date of severance). The severance of a trust based on a pecuniary amount does not satisfy this requirement. For example, the severance of a trust is not a qualified severance if the trust is divided into two trusts, with one trust to be funded with $1,500,000 and the other trust to be funded with the balance of the original trust's assets. With respect to the particular assets to be distributed to each resulting trust, each resulting trust may be funded with the appropriate fraction or percentage (pro rata portion) of each asset held by the original trust. Alternatively, the assets may be divided among the resulting trusts on a non-pro rata basis, based on the fair market value of the assets on the date of severance. However, if a resulting trust is funded on a non-pro rata basis, each asset received by a resulting trust must be valued, solely for funding purposes, by multiplying the fair market value of the asset held in the original trust as of the date of severance by the fraction or percentage of that asset received by that resulting trust. Thus, the assets must be valued without taking into account any discount or premium arising from the severance, for example, any valuation discounts that might arise because the resulting trust receives less than the entire interest held by the original trust. See paragraph (j), *Example 6* of this section.

* * * * *

(7) In the case of a qualified severance occurring after GST tax exemption has been allocated to the trust (whether by an affirmative allocation, a deemed allocation, or an automatic allocation pursuant to the rules contained in section 2632), if the trust has an inclusion ratio as defined in § 26.2642–1 that is greater than zero and less than one, then either paragraph (d)(7)(i) or (ii) of this section must be satisfied.

(i) The trust is severed initially into only two resulting trusts. One resulting trust must receive that fractional share of the total value of the original trust as of the date of severance that is equal to the applicable fraction, as defined in § 26.2642–1(b) and (c), used to determine the inclusion ratio of the original trust immediately before the severance. The other resulting trust must receive that fractional share of the total value of the original trust as of the date of severance that is equal to the excess of one over the fractional share described in the preceding sentence. The trust receiving the fractional share equal to the applicable fraction shall have an inclusion ratio of zero, and the other trust shall have an inclusion ratio of one. If the applicable fraction with respect to the original trust is .50, then, with respect to the two equal trusts resulting from the severance, the Trustee may designate which of the resulting trusts will have an inclusion ratio of zero and which will have an inclusion ratio of one. Each separate trust resulting from the severance then may be further divided in accordance with the rules of this section. See paragraph (j), *Example 7* of this section.

(ii) The trust is severed initially into more than two resulting trusts. One or more of the resulting trusts in the aggregate must receive that fractional share of the total value of the original trust as of the date of severance that is equal to the applicable fraction used to determine the inclusion ratio of the original trust immediately before the severance. The trust or trusts receiving such fractional share shall have an inclusion ratio of zero, and each of the other resulting trust or trusts shall have an inclusion ratio of one. (If, however, two or more of the resulting trusts each receives the fractional share of the total value of the original trust equal to the applicable fraction, the trustee may designate which of those resulting trusts will have an inclusion ratio of zero and which will have an inclusion ratio of one.) The resulting trust or trusts with an inclusion ratio of one must receive in the aggregate that fractional share of the total value of the original trust as of the date of severance that is equal to the excess of one over the fractional share described in the second sentence of this paragraph. See paragraph (j), *Example 9* of this section.

* * * * *

(h) *Treatment of trusts resulting from a severance that is not a qualified severance.* Trusts resulting from a severance (other than a severance under § 26.2654–1) that does not meet the requirements of a qualified severance under paragraph (b) of this section will be treated, after the date of severance, as separate trusts for purposes of the generation-skipping transfer (GST) tax, provided that the trusts resulting from such severance are recognized as separate trusts under applicable state law. The post-severance treatment of the resulting trusts as separate trusts for GST tax purposes generally permits the allocation of GST tax exemption, the making of various elections permitted for GST tax purposes, and the occurrence of a taxable distribution or termination with regard to a particular resulting trust, with no GST tax impact on any other trust resulting from that severance. Each trust resulting from a severance described in this paragraph, however, will have the same inclusion ratio immediately after the severance as that of the original trust immediately before the severance. (See § 26.2654–1 for the inclusion ratio of each trust resulting from a severance described in that section.)

* * * * *

(j) * * *

Example 6. Funding of severed trusts on a non-pro rata basis. T's will establishes an irrevocable trust, Trust, for the benefit of T's descendants. As a result of the allocation of GST tax exemption, the applicable fraction with respect to Trust is .60 and Trust's inclusion ratio is .40 [1–.60]. Pursuant to authority granted under applicable state law, on August 1, 2008, the trustee executes a document severing Trust into two trusts, Trust 1 and Trust 2, each of which is identical to Trust. The instrument of severance provides that the severance is intended to qualify as a qualified severance within the meaning of section 2642(a)(3) and designates August 3, 2008, as the date of severance (within the meaning of paragraph (d)(3) of this section). The instrument further provides that Trust 1 and Trust 2 are to be funded on a non-pro rata basis with Trust 1 funded with assets having a fair market value on the date of severance equal to 40% of the value of Trust's assets on that date and Trust 2 funded with assets having a fair market value equal to 60% of the value of Trust's assets on that date. The fair market value of the assets used to fund each trust is to be determined in compliance with the requirements of paragraph (d)(4) of this section. On August 3, 2008, the fair market value of the Trust assets totals $4,000,000, consisting of 52% of the outstanding common stock in Company, a closely-held corporation, valued at $3,000,000 and $1,000,000 in cash and marketable securities. Trustee proposes to divide the Company stock equally between Trust 1 and Trust 2, and thus transfer 26% of the Company stock to Trust 1 and 26% of the stock to Trust 2. In addition, the appropriate amount of cash and marketable securities will be distributed to each trust. In accordance with paragraph (d)(4) of this section, for funding purposes, the interest in the Company stock distributed to each trust is valued as a pro rata portion of the value of the 52% interest in Company held by Trust before severance, without taking into account, for example, any valuation discount that might otherwise apply in valuing the noncontrolling interest

distributed to each resulting trust. Accordingly, for funding purposes, each 26% interest in Company stock distributed to Trust 1 and Trust 2 is valued at $1,500,000 (.5 × $3,000,000). Therefore, Trust 1, which is to be funded with $1,600,000 (.40 × $4,000,000), receives $100,000 in cash and marketable securities valued as of August 3, 2008, in addition to the Company stock, and Trust 2, which is to be funded with $2,400,000 (.60 × $4,000,000), receives $900,000 in cash and marketable securities in addition to the Company stock. Therefore, the severance is a qualified severance, provided that all other requirements of section 2642(a)(3) and this section are satisfied.

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Example 9. Regulatory qualified severance. In 2004, T establishes an inter vivos irrevocable trust (Trust) providing that Trust income is to be paid annually in equal shares to T's children, A and B, for 10 years. If either (or both) dies prior to the expiration of the 10-year term, the deceased child's share of trust income is to be paid to the child's then living descendants, per stirpes, for the balance of the trust term. At the expiration of the 10-year trust term, the corpus is to be distributed equally to A and B; if A and B (or either or them) is not then living, then such decedent's share is to be distributed instead to such decedent's then living descendants, per stirpes. T allocates GST tax exemption to Trust such that Trust's applicable fraction is .25 and its inclusion ratio is .75. In 2006, pursuant to applicable state law, the trustee severs the trust into three trusts: Trust 1, Trust 2, and Trust 3. The instrument severing Trust provides that Trust 1 is to receive 50% of Trust's assets, Trust 2 is to receive 25% of Trust's assets, and Trust 3 is to receive 25% of Trust's assets. All three resulting trusts are identical to Trust, except that each has different beneficiaries: A and A's issue are designated as the beneficiaries of Trust 1, and B and B's issue are designated as the beneficiaries of Trust 2 and Trust 3. The severance constitutes a qualified severance, provided that all other requirements of section 2642(a)(3) and this section are satisfied. Trust 1 will have an inclusion ratio of 1. Because both Trust 2 and Trust 3 have each received the fractional share of Trust's assets equal to Trust's applicable fraction of .25, trustee designates that Trust 2 will have an inclusion ratio of one and that Trust 3 will have an inclusion ratio of zero.

* * * * *

Example 12. Mandatory severance that does not qualify as a qualified severance. In 1996, T creates an irrevocable inter vivos trust (Trust) that provides the trustee with the discretionary power to distribute income or corpus from time to time to one or more of T's children and grandchildren. Trust provides that, when T's youngest child reaches age 30, Trust is to be divided equally into separate trusts (resulting trusts), with one resulting trust for each child of T who is then living, and one resulting trust for each child of T who is then deceased and who has then living descendants. The income from a child's resulting trust will be paid to that child during the child's life, with the remainder passing to such child's descendants (grandchildren and younger generation descendants of T). On a timely filed Form 709, ''United States Gift (and Generation-Skipping Transfer) Tax Return,'' reporting the transfer, T allocates all of T's remaining GST tax exemption to Trust. As a result of the allocation, the applicable fraction with respect to Trust is .20, so Trust's inclusion ratio is .80 [1 –.20]. T's youngest child reaches age 30 in 2008. (No additional gifts are made through 2008 and Trust's inclusion ratio does not change.) In accordance with Trust's terms, Trust is divided in 2008 into three separate trusts (Trust 1, Trust 2, and Trust 3), one trust for each of T's three children, each of whom is then living. Trust 1, Trust 2, and Trust 3 are each recognized as a separate trust under applicable state law. With the consent of all interested parties, each resulting trust is funded with assets different from the assets distributed to the other two resulting trusts in a manner that does not meet the requirements of paragraph (d)(3) of this section. As a result, the severance does not satisfy the requirements of a qualified severance under this section. Under paragraph (h) of this section, however, Trust 1, Trust 2, and Trust 3 are each recognized as a separate trust for GST tax purposes prospectively from the date of severance, because the severance was effective to create three separate trusts under applicable state law. Therefore, after the severance, if T becomes entitled to any additional GST tax exemption pursuant to subsequent changes in applicable Federal tax law, T may allocate that additional GST tax exemption to any one or more of these three resulting trusts. Because the severance is not a qualified severance, however, the inclusion ratio of each of the three new trusts immediately after the severance will be .80, the same as Trust's inclusion ratio immediately before the severance.

Example 13. Other severance that does not qualify as a qualified severance. In 2004, T establishes an irrevocable inter vivos trust (Trust) providing that Trust income is to be paid to T's children, A and B, in equal shares for their joint lives. Upon the death of the first to die of A and B, all Trust income will be paid to the survivor of A and B. At the death of the survivor, the corpus is to be distributed in equal shares to T's grandchildren, W and X (with any then-deceased grandchild's share being paid in accordance with that grandchild's testamentary general power of appointment). W is A's child and X is B's child. T elects under section 2632(c)(5) not to have the automatic allocation rules contained in section 2632(c) apply with respect to T's transfers to Trust, and T does not otherwise allocate GST tax exemption to Trust. In 2006, the trustee of Trust, as permitted by applicable state law, divides Trust into two separate trusts, Trust 1 and Trust 2. Trust 1 provides that trust income is to be paid to A for life and, on A's death, the remainder is to be distributed to W (or pursuant to W's testamentary general power of appointment). Trust 2 provides that trust income is to be paid to B for life and, on B's death, the remainder is to be distributed to X (or pursuant to X's testamentary general power of appointment). Because Trust 1 and Trust 2 do not provide A and B with the contingent survivor income interests that were provided to A and B under the terms of Trust, Trust 1 and Trust 2 do not provide for the same succession of interests in the aggregate as provided by Trust. Therefore, the severance does not satisfy the requirements of this section and is not a qualified severance. However, under paragraph (h) of this section, provided that Trust 1 and Trust 2 are recognized as separate trusts under applicable state law, Trust 1 and Trust 2 will be recognized as separate trusts for GST tax purposes, prospectively from the date of the severance. Trust 1 and Trust 2 each have the same inclusion ratio immediately after the severance as Trust's inclusion ratio immediately before the severance.

(k) * * *

(1) *In general.* Except as otherwise provided, this section applies to severances occurring on or after August 2, 2007. Paragraph (d)(7)(ii), paragraph (h), and *Examples 9, 12,* and *13* of paragraph (j) of this section apply to severances occurring on or after [DATE THIS DOCUMENT IS PUBLISHED IN THE **Federal Register** AS FINAL REGULATIONS]. Paragraph (d)(4) and *Example 6* of paragraph (j) apply to severances occurring on or after August 2, 2007.

Par. 4. Section 26.2654–1 is amended as follows:

1. Paragraph (a)(1)(i) is revised.

2. A new paragraph (a)(1)(iii) is added.

3. In paragraph (a)(5), *Example 8* is revised.

The additions and revisions read as follows:

§ 26.2654–1 Certain trusts treated as separate trusts.

(a) *Single trust treated as separate trusts*—(1) *Substantially separate and independent shares*—(i) *In general.* If a single trust consists solely of substantially separate and independent shares for different beneficiaries, the share attributable to each beneficiary (or group of beneficiaries) is treated as a separate trust for purposes of chapter 13. The phrase ''substantially separate and independent shares'' generally has the same meaning as provided in § 1.663(c)–3 of this chapter. However, except as provided in paragraph (a)(1)(iii) of this section, a portion of a trust is not a separate share unless such share exists from and at all times after the creation of the trust. For purposes of this paragraph (a)(1), a trust is treated as created at the date of death of the grantor if the trust is includible in its entirety in the grantor's gross estate for Federal estate tax purposes. Further, treatment of a single trust as separate trusts under this paragraph (a)(1) does

not permit treatment of those portions as separate trusts for purposes of filing returns and payment of tax or for purposes of computing any other tax imposed under the Internal Revenue Code. Also, additions to, and distributions from, such trusts are allocated pro rata among the separate trusts, unless the governing instrument expressly provides otherwise. See § 26.2642–6 and paragraph (b) of this section regarding the treatment, for purposes of chapter 13, of separate trusts resulting from the actual severance of a single trust.

* * * * *

(iii) *Mandatory severances.* For purposes of this section, if the governing instrument of a trust requires the division or severance of a single trust into separate trusts upon the future occurrence of a particular event not within the discretion of the trustee or any other person, and if the trusts resulting from such a division or severance are recognized as separate trusts under applicable state law, then each resulting trust is treated as a separate trust for purposes of chapter 13. For this purpose, the rules of paragraph (b)(1)(ii)(C) of this section apply with respect to the severance and funding of the trusts. Similarly, if the governing instrument requires the division of a single trust into separate shares under the circumstances described in this paragraph, each such resulting share is treated as a separate trust for purposes of chapter 13. The post-severance treatment of the resulting trusts or shares as separate trusts for GST tax purposes generally permits the allocation of GST tax exemption, the making of various elections permitted for GST tax purposes, and the occurrence of a taxable distribution or termination with regard to a particular resulting trust or share, with no GST tax impact on any other trust or share resulting from that severance. The treatment of a single trust as separate trusts under this paragraph (a)(1), however, does not permit treatment of those portions as separate trusts for purposes of filing returns and payment of tax or for purposes of computing any other tax imposed under the Internal Revenue Code. Also, additions to, and distributions from, such trusts are allocated pro rata among the separate trusts, unless the governing instrument expressly provides otherwise. Each separate share and each trust resulting from a mandatory division or severance described in this paragraph will have the same inclusion ratio immediately after the severance as that of the original trust immediately before the division or severance.

* * * * *

(5) * * *

Example 8. Subsequent mandatory division into separate trusts. T creates an irrevocable trust that provides the trustee with the discretionary power to distribute income or corpus to T's children and grandchildren. The trust provides that, when T's youngest child reaches age 21, the trust will be divided into separate shares, one share for each child of T. The income from a respective child's share will be paid to the child during the child's life, with the remainder passing on the child's death to such child's children (grandchildren of T). The separate shares that come into existence when the youngest child reaches age 21 will be recognized as of that date as separate trusts for purposes of Chapter 13. Any allocation of GST tax exemption to the trust after T's youngest child reaches age 21 may be made to any one or more of the separate shares. The result would be the same if the trust instrument provided that the trust was to be divided into separate trusts when T's youngest child reached age 21, provided that the severance and funding of the separate trusts meets the requirements of this section.

* * * * *

Linda E. Stiff,

Acting Deputy Commissioner for Services and Enforcement.

[FR Doc. E7–14850 Filed 8–1–07; 8:45 am]

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ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA–R04–OAR–2007–0360–200717; FRL–8449–2]

Approval of Implementation Plans of Florida: Clean Air Interstate Rule

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: EPA is proposing to approve a revision to the Florida State Implementation Plan (SIP) submitted on March 16, 2007. This revision addresses the requirements of EPA's Clean Air Interstate Rule (CAIR), promulgated on May 12, 2005, and subsequently revised on April 28, 2006, and December 13, 2006. EPA is proposing to determine that the SIP revision fully implements the CAIR requirements for Florida. Therefore, as a consequence of the SIP approval, EPA will also withdraw the CAIR Federal Implementation Plans (CAIR FIPs) concerning sulfur dioxide (SO_2), nitrogen oxides (NO_X) annual, and NO_X ozone season emissions for Florida. The CAIR FIPs for all States in the CAIR region were promulgated on April 28, 2006, and subsequently revised on December 13, 2006.

CAIR requires States to reduce emissions of SO_2 and NO_X that significantly contribute to nonattainment of, and interfere with maintenance of, the national ambient air quality standards (NAAQS) for fine particulates and/or ozone in any downwind state. CAIR establishes State budgets for SO_2 and NO_X and requires States to submit SIP revisions that implement these budgets in States that EPA concluded did contribute to nonattainment in downwind states. States have the flexibility to choose which control measures to adopt to achieve the budgets, including participating in the EPA-administered cap-and-trade programs. In the SIP revision that EPA is proposing to approve, Florida would meet CAIR requirements by participating in the EPA-administered cap-and-trade programs addressing SO_2, NO_X annual, and NO_X ozone season emissions.

DATES: Comments must be received on or before September 4, 2007.

ADDRESSES: Submit your comments, identified by Docket ID No. EPA–R04–OAR–2007–0360 by one of the following methods:

1. *http://www.regulations.gov:* Follow the on-line instructions for submitting comments.

2. *E-mail: harder.stacy@epa.gov.*

3. *Fax:* 404–562–9019.

4. *Mail:* ''EPA–R04–OAR–2007–0360,'' Regulatory Development Section, Air Planning Branch, Air, Pesticides and Toxics Management Division, U.S. Environmental Protection Agency, Region 4, 61 Forsyth Street, SW., Atlanta, Georgia 30303–8960.

5. *Hand Delivery or Courier:* Stacy Harder, Regulatory Development Section, Air Planning Branch, Air, Pesticides and Toxics Management Division, U.S. Environmental Protection Agency, Region 4, 61 Forsyth Street, SW., Atlanta, Georgia 30303–8960. Such deliveries are only accepted during the Regional Office's normal hours of operation. The Regional Office's official hours of business are Monday through Friday, 8:30 a.m. to 4:30 p.m., excluding federal holidays.

Instructions: Direct your comments to Docket ID No. ''EPA–R04–OAR–2007–0360.'' EPA's policy is that all comments received will be included in the public docket without change and may be made available online at *http://www.regulations.gov*, including any personal information provided, unless the comment includes information claimed to be Confidential

Business Information (CBI) or other information whose disclosure is restricted by statute. Do not submit through *http://www.regulations.gov* or e-mail, information that you consider to be CBI or otherwise protected. The *http://www.regulations.gov* Web site is an ''anonymous access'' system, which means EPA will not know your identity or contact information, unless you provide it in the body of your comment. If you send an e-mail comment directly to EPA without going through *http://www.regulations.gov*, your e-mail address will be automatically captured and included as part of the comment that is placed in the public docket and made available on the Internet. If you submit an electronic comment, EPA recommends that you include your name and other contact information in the body of your comment and with any disk or CD–ROM you submit. If EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment. Electronic files should avoid the use of special characters and any form of encryption and should be free of any defects or viruses. For additional information about EPA's public docket visit the EPA Docket Center homepage at *http://www.epa.gov/epahome/dockets.htm.*

Docket: All documents in the electronic docket are listed in the *http://www.regulations.gov* index. Although listed in the index, some information is not publicly available, i.e., CBI or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, is not placed on the Internet and will be publicly available only in hard copy form. Publicly available docket materials are available either electronically in *http://www.regulations.gov* or in hard copy at the Regulatory Development Section, Air Planning Branch, Air, Pesticides and Toxics Management Division, U.S. Environmental Protection Agency, Region 4, 61 Forsyth Street, SW., Atlanta, Georgia 30303–8960. EPA requests that if at all possible, you contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section to schedule your inspection. The Regional Office's official hours of business are Monday through Friday, 8:30 to 4:30, excluding federal holidays.

FOR FURTHER INFORMATION CONTACT: If you have questions concerning this proposal, please contact Ms. Stacy Harder, Regulatory Development Section, Air Planning Branch, Air, Pesticides and Toxics Management Division, U.S. Environmental Protection Agency, Region 4, 61 Forsyth Street, SW., Atlanta, Georgia 30303–8960. The telephone number is (404) 562–9042. Ms. Harder can also be reached via electronic mail at *harder.stacy@epa.gov.*

SUPPLEMENTARY INFORMATION:

Table of Contents

I. What Action Is EPA Proposing To Take?

EPA is proposing to approve a revision to Florida's SIP, submitted on March 16, 2007. In its SIP revision, Florida would meet CAIR requirements by requiring certain electric generating units (EGUs) to participate in the EPA-administered State CAIR cap-and-trade programs addressing SO_2, NO_X annual, and NO_X ozone season emissions. EPA is proposing to determine that the SIP, as revised, will meet the applicable requirements of CAIR. Any final action approving the SIP will be taken by the Regional Administrator for Region 4. As a consequence of the SIP approval, the Administrator of EPA will also issue a final rule to withdraw the FIPs concerning SO_2, NO_X annual, and NO_X ozone season emissions for Florida. This action will delete and reserve 40 CFR 52.540 and 40 CFR 52.541. The withdrawal of the CAIR FIPs for Florida is a conforming amendment that must be made once the SIP is approved because EPA's authority to issue the FIPs was premised on a deficiency in the SIP for Florida. Once the SIP is fully approved, EPA no longer has authority for the FIPs. Thus, EPA will not have the option of maintaining the FIPs following the full SIP approval. Accordingly, EPA does not intend to offer an opportunity for a public hearing or an additional opportunity for written public comment on the withdrawal of the FIPs.

II. What Is the Regulatory History of the CAIR and the CAIR FIPs?

The CAIR was published by EPA on May 12, 2005 (70 FR 25162). In this rule, EPA determined that 28 States and the District of Columbia contribute significantly to nonattainment and interfere with maintenance of the NAAQS for fine particles ($PM_{2.5}$) and/or 8-hour ozone in downwind States in the eastern part of the country. As a result, EPA required those upwind States to revise their SIPs to include control measures that reduce emissions of SO_2, which is a precursor to $PM_{2.5}$ formation, and/or NO_X, which is a precursor to both ozone and $PM_{2.5}$ formation. For jurisdictions that contribute significantly to downwind $PM_{2.5}$ nonattainment, CAIR sets annual State-wide emission reduction requirements (i.e., budgets) for SO_2 and annual State-wide emission reduction requirements for NO_X. Similarly, for jurisdictions that contribute significantly to 8-hour ozone nonattainment, CAIR sets State-wide emission reduction requirements for NO_X for the ozone season (May 1st to September 30th). Under CAIR, States may implement these reduction requirements by participating in the EPA-administered cap-and-trade programs or by adopting any other control measures.

CAIR explains to subject States what must be included in SIPs to address the requirements of section 110(a)(2)(D) of the Clean Air Act (CAA) with regard to interstate transport with respect to the 8-hour ozone and $PM_{2.5}$ NAAQS. EPA made national findings, effective on May 25, 2005, that the States had failed to submit SIPs meeting the requirements of section 110(a)(2)(D). The SIPs were due in July 2000, three years after the promulgation of the 8-hour ozone and $PM_{2.5}$ NAAQS. These findings started a two-year clock for EPA to promulgate a FIP to address the requirements of section 110(a)(2)(D). Under CAA section 110(c)(1), EPA may issue a FIP anytime after such findings are made and must do so within two years, unless a SIP revision correcting the deficiency is approved by EPA before the FIP is promulgated.

On April 28, 2006, EPA promulgated FIPs for all States covered by CAIR in order to ensure the emissions reductions required by CAIR are achieved on schedule. Each CAIR State is subject to the FIPs until the State fully adopts, and EPA approves, a SIP revision meeting the requirements of CAIR. The CAIR FIPs require EGUs to participate in the EPA-administered CAIR SO_2, NO_X annual, and NO_X ozone season trading programs, as appropriate. The CAIR FIP SO_2, NO_X annual, and NO_X ozone season trading programs impose essentially the same requirements as, and are integrated with, the respective CAIR SIP trading programs. The

integration of the FIP and SIP trading programs means that these trading programs will work together to create effectively a single trading program for each regulated pollutant (SO_2, NO_X annual, and NO_X ozone season) in all States covered by the CAIR FIP or SIP trading program for that pollutant. The CAIR FIPs also allow States to submit abbreviated SIP revisions that, if approved by EPA, will automatically replace or supplement certain CAIR FIP provisions (e.g., the methodology for allocating NO_X allowances to sources in the State), while the CAIR FIP remains in place for all other provisions.

On April 28, 2006, EPA published two additional CAIR-related final rules that added the States of Delaware and New Jersey to the list of States subject to CAIR for $PM_{2.5}$ and announced EPA's final decisions on reconsideration of five issues, without making any substantive changes to the CAIR requirements.

III. What Are the General Requirements of CAIR and the CAIR FIPs?

CAIR establishes State-wide emission budgets for SO_2 and NO_X and is to be implemented in two phases. The first phase of NO_X reductions starts in 2009 and continues through 2014, while the first phase of SO_2 reductions starts in 2010 and continues through 2014. The second phase of reductions for both NO_X and SO_2 starts in 2015 and continues thereafter. CAIR requires States to implement the budgets by either: (1) Requiring EGUs to participate in the EPA-administered cap-and-trade programs; or (2) adopting other control measures of the State's choosing and demonstrating that such control measures will result in compliance with the applicable State SO_2 and NO_X budgets.

The May 12, 2005, and April 28, 2006, CAIR rules provide model rules that States must adopt (with certain limited changes, if desired) if they want to participate in the EPA-administered trading programs.

With two exceptions, only States that choose to meet the requirements of CAIR through methods that exclusively regulate EGUs are allowed to participate in the EPA-administered trading programs. One exception is for States that adopt the opt-in provisions of the model rules to allow non-EGUs individually to opt into the EPA-administered trading programs. The other exception is for States that include all non-EGUs from their NO_X SIP Call trading programs in their CAIR NO_X ozone season trading programs.

IV. What Are the Types of CAIR SIP Submittals?

States have the flexibility to choose the type of control measures they will use to meet the requirements of CAIR. EPA anticipates that most States will choose to meet the CAIR requirements by selecting an option that requires EGUs to participate in the EPA-administered CAIR cap-and-trade programs. For such States, EPA has provided two approaches for submitting and obtaining approval for CAIR SIP revisions. States may submit full SIP revisions that adopt the model CAIR cap-and-trade rules. If approved, these SIP revisions will fully replace the CAIR FIPs. Alternatively, States may submit abbreviated SIP revisions. These SIP revisions will not replace the CAIR FIPs; however, the CAIR FIPs provide that, when approved, the provisions in these abbreviated SIP revisions will be used instead of or in conjunction with, as appropriate, the corresponding provisions of the CAIR FIPs (e.g., the NO_X allowance allocation methodology).

A State submitting a full SIP revision may either adopt regulations that are substantively identical to the model rules or incorporate by reference the model rules. CAIR provides that States may only make limited changes to the model rules if the States want to participate in the EPA-administered trading programs. A full SIP revision may change the model rules, only by altering their applicability and allowance allocation provisions to:

1. Include NO_X SIP Call trading sources that are not EGUs under CAIR in the CAIR NO_X ozone season trading program;

2. Provide for State allocation of NO_X annual or ozone season allowances using a methodology chosen by the State;

3. Provide for State allocation of NO_X annual allowances from the compliance supplement pool (CSP) using the State's choice of allowed, alternative methodologies; or

4. Allow units that are not otherwise CAIR units to opt individually into the CAIR SO_2, NO_X annual, or NO_X ozone season trading programs under the opt-in provisions in the model rules.

An approved CAIR full SIP revision addressing EGUs' SO_2, NO_X annual, or NO_X ozone season emissions will replace the CAIR FIP for that State for the respective EGU emissions.

V. Analysis of Florida's CAIR SIP Submittal

A. State Budgets for Allowance Allocations

The CAIR NO_X annual and ozone season budgets were developed from historical heat input data for EGUs. Using these data, EPA calculated annual and ozone season regional heat input values, which were multiplied by 0.15 pounds per million British thermal units (lb/mmBtu), for phase 1, and 0.125 lb/mmBtu, for phase 2, to obtain regional NO_X budgets for 2009–2014 and for 2015 and thereafter, respectively. EPA derived the State NO_X annual and ozone season budgets from the regional budgets using State heat input data adjusted by fuel factors.

The CAIR State SO_2 budgets were derived by discounting the tonnage of emissions authorized by annual allowance allocations under the Acid Rain Program under title IV of the CAA. Under CAIR, each allowance allocated in the Acid Rain Program for the years in phase 1 of CAIR (2010 through 2014) authorizes 0.5 ton of SO_2 emissions in the CAIR trading program, and each Acid Rain Program allowance allocated for the years in phase 2 of CAIR (2015 and thereafter) authorizes 0.35 ton of SO_2 emissions in the CAIR trading program.

In this action, EPA is proposing approval of Florida's SIP revision that adopts the budgets established for the State in CAIR, i.e., 99,445 (2009–2014) and 82,871 (2015–thereafter) tons for NO_X annual emissions, 47,912 (2009–2014) and 39,926 (2015–thereafter) tons for NO_X ozone season emissions, and 253,450 (2010–2014) and 177,415 (2015–thereafter) tons for SO_2 emissions. Florida's SIP revision sets these budgets as the total amounts of allowances available for allocation for each year under the EPA-administered cap-and-trade programs.

Florida has committed to revising the definitions of ''permitting authority'' and ''State'' in its CAIR rules in order to ensure that allowances issued by all States with approved rules providing for participation in the respective EPA-administered cap-and-trade programs are fungible and can be traded and used by all sources in all these States, as intended. EPA discovered after review of other States' rules, but after Florida had adopted its CAIR rules, that there was an issue related to these definitions when they are revised to refer only to a specific State.

In Florida's rules for CAIR, the EPA model trading rules were revised to limit all references to ''permitting authority'' to refer to the Florida

Department of Environmental Protection. Similarly, references to ''State'' were limited to refer to Florida. These changes are acceptable in most, but not all, instances under the current model rules. In certain definitions in the model rules incorporated by Florida (i.e., ''allocate'' or ''allocation,'' ''CAIR NO_X allowance,'' ''CAIR SO_2 allowance,'' and ''CAIR NO_X Ozone Season allowance''), it is important that the term ''permitting authority'' cover permitting authorities in all States that choose to participate in the respective EPA-administered trading programs and that the term ''State'' cover all such States. This is necessary to ensure that all allowances issued in each EPA-administered trading program are fungible and can be traded and used for compliance with the allowance-holding requirement in any State in the program.

On May 24, 2007, EPA participated in a teleconference with Florida and outlined necessary definition revisions. EPA received a letter from Florida dated June 22, 2007, and a supplemental electronic mail submission on July 11, 2007, that provide a commitment to make these rule revisions in its CAIR rules in early 2008. Specifically, in the June 22, 2007, letter and supplemental submission on July 11, 2007, Florida commits to revising section 62–296.470(1) of Florida's rule to state that: the limitation of the ''permitting authority'' definition only to Florida does not apply when this term is used in the definitions of '''allocate' or 'allocation','' ''CAIR NO_X allowance,'' ''CAIR SO_2 allowance,'' and ''CAIR NO_X Ozone Season allowance;'' and the limitation of the ''State'' definition only to Florida does not apply when the term is used in the definitions of ''CAIR NO_X allowance,'' ''CAIR SO_2 allowance,'' and ''CAIR NO_X Ozone Season allowance.''

B. CAIR Cap-and-Trade Programs

The CAIR NO_X annual and ozone-season model trading rules both largely mirror the structure of the NO_X SIP Call model trading rule in 40 CFR part 96, subparts A through I. While the provisions of the NO_X annual and ozone-season model rules are similar, there are some differences. For example, the NO_X annual model rule (but not the NO_X ozone season model rule) provides for a CSP, which is discussed below and under which allowances may be awarded for early reductions of NO_X annual emissions. As a further example, the NO_X ozone season model rule reflects the fact that the CAIR NO_X ozone season trading program replaces the NO_X SIP Call trading program after the 2008 ozone season and is coordinated with the NO_X SIP Call program. The NO_X ozone season model rule provides incentives for early emissions reductions by allowing banked, pre-2009 NO_X SIP Call allowances to be used for compliance in the CAIR NO_X ozone-season trading program. In addition, States have the option of continuing to meet their NO_X SIP Call requirement by participating in the CAIR NO_X ozone season trading program and including all their NO_X SIP Call trading sources in that program.

The provisions of the CAIR SO_2 model rule are also similar to the provisions of the NO_X annual and ozone season model rules. However, the SO_2 model rule is coordinated with the ongoing Acid Rain SO_2 cap-and-trade program under CAA title IV. The SO_2 model rule uses the title IV allowances for compliance, with each allowance allocated for 2010–2014 authorizing only 0.5 ton of emissions and each allowance allocated for 2015 and thereafter authorizing only 0.35 ton of emissions. Banked title IV allowances allocated for years before 2010 can be used at any time in the CAIR SO_2 cap-and-trade program, with each such allowance authorizing 1 ton of emissions. Title IV allowances are to be freely transferable among sources covered by the Acid Rain Program and sources covered by the CAIR SO_2 cap-and-trade program.

EPA also used the CAIR model trading rules as the basis for the trading programs in the CAIR FIPs. The CAIR FIP trading rules are virtually identical to the CAIR model trading rules, with changes made to account for federal rather than state implementation. The CAIR model SO_2, NO_X annual, and NO_X ozone season trading rules and the respective CAIR FIP trading rules are designed to work together as integrated SO_2, NO_X annual, and NO_X ozone season trading programs.

In the SIP revision, Florida chooses to implement its CAIR budgets by requiring EGUs to participate in EPA-administered cap-and-trade programs for SO_2, NO_X annual, and NO_X ozone season emissions. Florida has adopted a full SIP revision that adopts, with certain allowed changes discussed below, the CAIR model cap-and-trade rules for SO_2, NO_X annual, and NO_X ozone season emissions.

C. Applicability Provisions for Non-EGU NO_X SIP Call Sources

In general, the CAIR model trading rules apply to any stationary, fossil-fuel-fired boiler or stationary, fossil-fuel-fired combustion turbine serving at any time, since the later of November 15, 1990, or the start-up of the unit's combustion chamber, a generator with nameplate capacity of more than 25 MWe producing electricity for sale.

States have the option of bringing in, for the CAIR NO_X ozone season program only, those units in the State's NO_X SIP Call trading program that are not EGUs as defined under CAIR. EPA advises States exercising this option to add the applicability provisions in the State's NO_X SIP Call trading rule for non-EGUs to the applicability provisions in 40 CFR 96.304 in order to include in the CAIR NO_X ozone season trading program all units required to be in the State's NO_X SIP Call trading program that are not already included under 40 CFR 96.304. Under this option, the CAIR NO_X ozone season program must cover all large industrial boilers and combustion turbines, as well as any small EGUs (i.e. units serving a generator with a nameplate capacity of 25 MWe or less) that the State currently requires to be in the NO_X SIP Call trading program.

Because Florida was not included in the NO_X SIP Call trading program, Florida did not have an option of expanding the applicability provisions of the CAIR NO_X ozone season trading program.

D. NO_X Allowance Allocations

Under the NO_X allowance allocation methodology in the CAIR model trading rules and in the CAIR FIP, NO_X annual and ozone season allowances are allocated to units that have operated for five years, based on heat input data from a three-year period that are adjusted for fuel type by using fuel factors of 1.0 for coal, 0.6 for oil, and 0.4 for other fuels. The CAIR model trading rules and the CAIR FIP also provide a new unit set-aside from which units without five years of operation are allocated allowances based on the units' prior year emissions.

States may establish in their SIP submissions a different NO_X allowance allocation methodology that will be used to allocate allowances to sources in the States, if certain requirements are met concerning the timing of submission of units' allocations to the Administrator for recordation and the total amount of allowances allocated for each control period. In adopting alternative NO_X allowance allocation methodologies, States have flexibility with regard to:

1. The cost to recipients of the allowances, which may be distributed for free or auctioned;

2. The frequency of allocations;

3. The basis for allocating allowances, which may be distributed, for example, based on historical heat input or electric and thermal output; and

4. The use of allowance set-asides and, if used, their size.

Florida has chosen to replace the provisions of the CAIR NO_X annual model trading rule concerning the allocation of NO_X annual allowances with its own methodology. Florida has chosen to distribute NO_X annual allowances based upon a methodology that is similar, but not identical, to that in the CAIR model trading rule for existing and new units. Under Florida's rule and the CAIR model rule, existing units are allocated NO_X allowances in proportion to their ''fuel-adjusted control period heat input'' during the baseline period. However, in addition to the fuel adjustment factors used to calculate adjusted heat input in the CAIR model rule, Florida has also developed a separate 150% fuel factor for existing biomass-fired units that use best available control technology (BACT). Further, in Florida's rule, as in the CAIR model rule, new units are allocated NO_X allowances in proportion to their ''converted control period heat input.'' However, unlike the CAIR model rule, Florida's rule categorizes new units as those commencing operation on or after January 1, 2007, (rather than January 1, 2001), and establishes a new unit set set-aside of five percent for all control years (rather than five percent through 2014 and three percent thereafter). Moreover, under Florida's rule, allocations are scheduled to be made in 2006, 2009, and every three years thereafter, with three-year blocks of allocations being made generally four years in advance. Florida's rule also limits the number of years for which permanently retired units are allocated allowances after retirement.

Florida has chosen to replace the provisions of the CAIR NO_X ozone season model trading rule concerning allowance allocations with its own methodology. Florida has chosen to distribute NO_X ozone season allowances based upon the same allowance allocation methodology described above for NO_X annual allowances.

E. Allocation of NO_X Allowances From Compliance Supplement Pool

The CAIR rule establishes a CSP to provide an incentive for early reductions in NO_X annual emissions. The CSP consists of 200,000 CAIR NO_X annual allowances of vintage 2009 for the entire CAIR region, and a State's share of the CSP is based upon the projected magnitude of the emission reductions required by CAIR in that State. States may distribute CSP allowances, one allowance for each ton of early reduction, to sources that make NO_X reductions during 2007 or 2008 beyond what is required by any applicable State or Federal emission limitation. States also may distribute CSP allowances based upon a demonstration of need for an extension of the 2009 deadline for implementing emission controls.

The CAIR annual NO_X model trading rule establishes specific methodologies for allocations of CSP allowances. States may choose an allowed, alternative CSP allocation methodology to be used to allocate CSP allowances to sources in the States.

Florida has not chosen to modify the provisions of the CAIR NO_X annual model trading rule concerning the allocation of allowances from the CSP. Florida has chosen to distribute CSP allowances using an allocation methodology that is the same as EPA's model rule. The CSP is an additional 8,335 annual NO_X allowances given to the State for 2009, and there is no CSP for ozone-season allowances.

F. Individual Opt-In Units

The opt-in provisions of the CAIR SIP model trading rules allow certain non-EGUs (i.e., boilers, combustion turbines, and other stationary fossil-fuel-fired devices) that do not meet the applicability criteria for a CAIR trading program to participate voluntarily in (i.e., opt into) the CAIR trading program. A non-EGU may opt into one or more of the CAIR trading programs. In order to qualify to opt into a CAIR trading program, a unit must vent all emissions through a stack and be able to meet monitoring, recordkeeping, and recording requirements of 40 CFR part 75. The owners and operators seeking to opt a unit into a CAIR trading program must apply for a CAIR opt-in permit. If the unit is issued a CAIR opt-in permit, the unit becomes a CAIR unit, is allocated allowances, and must meet the same allowance-holding and emissions monitoring and reporting requirements as other units subject to the CAIR trading program. The opt-in provisions provide for two methodologies for allocating allowances for opt-in units, one methodology that applies to opt-in units in general and a second methodology that allocates allowances only to opt-in units that the owners and operators intend to repower before January 1, 2015.

States have several options concerning the opt-in provisions. States may adopt the CAIR opt-in provisions entirely or may adopt them but exclude one of the methodologies for allocating allowances. States may also decline to adopt the opt-in provisions at all.

Florida has chosen not to allow non-EGUs meeting certain requirements to opt into the CAIR NO_X annual trading program.

Florida has chosen not to allow non-EGUs meeting certain requirements to opt into the CAIR NO_X ozone season trading program.

Florida has chosen not to allow certain non-EGUs to opt into the CAIR SO_2 trading program.

VI. Proposed Actions

EPA is proposing to approve Florida's full CAIR SIP revision submitted on March 16, 2007. Under this SIP revision, Florida is choosing to participate in the EPA-administered cap-and-trade programs for SO_2, NO_X annual, and NO_X ozone season emissions. The SIP revision (revised as discussed above) meets the applicable requirements in 40 CFR 51.123(o) and (aa), with regard to NO_X annual and NO_X ozone season emissions, and 40 CFR 51.124(o), with regard to SO_2 emissions. Further, Florida has agreed to make the technical corrections to certain definitions as discussed above. Therefore, EPA is proposing to determine that the SIP, as revised, will meet the requirements of CAIR. As a consequence of the SIP approval, the Administrator of EPA will also issue, without providing an opportunity for a public hearing or an additional opportunity for written public comment, a final rule to withdraw the CAIR FIPs concerning SO_2, NO_X annual, NO_X ozone season emissions for Florida. This action will delete and reserve 40 CFR 52.540 and 40 CFR 52.541.

VII. Statutory and Executive Order Reviews

Under Executive Order 12866 (58 FR 51735, October 4, 1993), this action is not a ''significant regulatory action'' and therefore is not subject to review by the Office of Management and Budget. For this reason, this action is also not subject to Executive Order 13211, ''Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use'' (66 FR 28355, May 22, 2001). This action merely proposes to approve State law as meeting Federal requirements and would impose no additional requirements beyond those imposed by State law. Accordingly, the Administrator certifies that this proposed rule would not have a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*). Because this action proposes to approve pre-existing requirements under State law and would not impose any additional

enforceable duty beyond that required by State law, it does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4).

This proposal also does not have tribal implications because it would not have a substantial direct effect on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes, as specified by Executive Order 13175 (65 FR 67249, November 9, 2000). This proposed action also does not have Federalism implications because it would not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government, as specified in Executive Order 13132 (64 FR 43255, August 10, 1999). This action merely proposes to approve a State rule implementing a Federal standard and will result, as a consequence of that approval, in the Administrator's withdrawal of the CAIR FIP. It does not alter the relationship or the distribution of power and responsibilities established in the CAA. This proposed rule also is not subject to Executive Order 13045 ''Protection of Children from Environmental Health Risks and Safety Risks'' (62 FR 19885, April 23, 1997), because it would approve a State rule implementing a Federal Standard.

In reviewing SIP submissions, EPA's role is to approve State choices, provided that they meet the criteria of the CAA. In this context, in the absence of a prior existing requirement for the State to use voluntary consensus standards (VCS), EPA has no authority to disapprove a SIP submission for failure to use VCS. It would thus be inconsistent with applicable law for EPA, when it reviews a SIP submission, to use VCS in place of a SIP submission that otherwise satisfies the provisions of the CAA. Thus, the requirements of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) do not apply. This proposed rule would not impose an information collection burden under the provisions of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Electric utilities, Intergovernmental relations, Nitrogen oxides, Ozone, Particulate matter, Reporting and recordkeeping requirements, Sulfur dioxide.

Authority: 42 U.S.C. 7401 *et seq.*

Dated: July 25, 2007.

J.I. Palmer, Jr.,

Regional Administrator, Region 4.

[FR Doc. E7–14981 Filed 8–1–07; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA–R04–OAR–2007–0251–200719; FRL–8449–3]

Approval of Implementation Plans of Georgia: Clean Air Interstate Rule

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: EPA is proposing to approve a revision to the Georgia State Implementation Plan (SIP) submitted on March 28, 2007. This revision addresses the requirements of EPA's Clean Air Interstate Rule (CAIR), promulgated on May 12, 2005, and subsequently revised on April 28, 2006, and December 13, 2006. EPA is proposing to determine that the SIP revision fully implements the CAIR requirements for Georgia. Therefore, as a consequence of the SIP approval, EPA will also withdraw the CAIR Federal Implementation Plans (CAIR FIPs) concerning sulfur dioxide (SO_2) and nitrogen oxides (NO_X) annual emissions for Georgia. The CAIR FIPs for all States in the CAIR region were promulgated on April 28, 2006, and subsequently revised on December 13, 2006.

CAIR requires States to reduce emissions of SO_2 and NO_X that significantly contribute to nonattainment of, and interfere with maintenance of, the national ambient air quality standards (NAAQS) for fine particulates and/or ozone in any downwind state. CAIR establishes State budgets for SO_2 and NO_X and requires States to submit SIP revisions that implement these budgets in States that EPA concluded did contribute to nonattainment in downwind states. States have the flexibility to choose which control measures to adopt to achieve the budgets, including participating in the EPA-administered cap-and-trade programs. In the SIP revision that EPA is proposing to approve, Georgia would meet CAIR requirements by participating in the EPA-administered cap-and-trade programs addressing SO_2 and NO_X annual emissions.

DATES: Comments must be received on or before September 4, 2007.

ADDRESSES: Submit your comments, identified by Docket ID No. EPA–R04–OAR–2007–0251, by one of the following methods:

1. *http://www.regulations.gov*: Follow the online instructions for submitting comments.
2. *E-mail: harder.stacy@epa.gov*.
3. *Fax:* 404–562–9019.
4. *Mail:* ''EPA–R04–OAR–2007–0251,'' Regulatory Development Section, Air Planning Branch, Air, Pesticides and Toxics Management Division, U.S. Environmental Protection Agency, Region 4, 61 Forsyth Street, SW., Atlanta, Georgia 30303–8960.
5. *Hand Delivery or Courier:* Stacy Harder, Regulatory Development Section, Air Planning Branch, Air, Pesticides and Toxics Management Division, U.S. Environmental Protection Agency, Region 4, 61 Forsyth Street, SW., Atlanta, Georgia 30303–8960. Such deliveries are only accepted during the Regional Office's normal hours of operation. The Regional Office's official hours of business are Monday through Friday, 8:30 a.m. to 4:30 p.m., excluding federal holidays.

Instructions: Direct your comments to Docket ID No. ''EPA–R04–OAR–2007–0251.'' EPA's policy is that all comments received will be included in the public docket without change and may be made available online at *http://www.regulations.gov*, including any personal information provided, unless the comment includes information claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Do not submit through *http://www.regulations.gov* or e-mail, information that you consider to be CBI or otherwise protected. The *http://www.regulations.gov* website is an ''anonymous access'' system, which means EPA will not know your identity or contact information, unless you provide it in the body of your comment. If you send an e-mail comment directly to EPA without going through *http://www.regulations.gov*, your e-mail address will be automatically captured and included as part of the comment that is placed in the public docket and made available on the Internet. If you submit an electronic comment, EPA recommends that you include your name and other contact information in the body of your comment and with any disk or CD–ROM you submit. If EPA cannot read your comment due to technical difficulties and cannot contact

you for clarification, EPA may not be able to consider your comment. Electronic files should avoid the use of special characters and any form of encryption and should be free of any defects or viruses. For additional information about EPA's public docket visit the EPA Docket Center homepage at *http://www.epa.gov/epahome/dockets.htm.*

Docket: All documents in the electronic docket are listed in the *http://www.regulations.gov* index. Although listed in the index, some information is not publicly available, i.e., CBI or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, is not placed on the Internet and will be publicly available only in hard copy form. Publicly available docket materials are available either electronically in *http://www.regulations.gov* or in hard copy at the Regulatory Development Section, Air Planning Branch, Air, Pesticides and Toxics Management Division, U.S. Environmental Protection Agency, Region 4, 61 Forsyth Street, SW., Atlanta, Georgia 30303–8960. EPA requests that if at all possible, you contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section to schedule your inspection. The Regional Office's official hours of business are Monday through Friday, 8:30 a.m. to 4:30 p.m., excluding federal holidays.

FOR FURTHER INFORMATION CONTACT: If you have questions concerning this proposal, please contact Ms. Stacy Harder, Regulatory Development Section, Air Planning Branch, Air, Pesticides and Toxics Management Division, U.S. Environmental Protection Agency, Region 4, 61 Forsyth Street, SW., Atlanta, Georgia 30303–8960. The telephone number is (404) 562–9042. Ms. Harder can also be reached via electronic mail at *harder.stacy@epa.gov.*

SUPPLEMENTARY INFORMATION:

Table of Contents

I. What Action Is EPA Proposing to Take?

EPA is proposing to approve a revision to Georgia's SIP, submitted on March 28, 2007. In its SIP revision, Georgia would meet CAIR requirements by requiring certain electric generating units (EGUs) to participate in the EPA-administered State CAIR cap-and-trade programs addressing SO_2 and NO_X annual emissions. EPA is proposing to determine that the SIP, as revised, will meet the applicable requirements of CAIR. Any final action approving the SIP will be taken by the Regional Administrator for Region 4. As a consequence of the SIP approval, the Administrator of EPA will also issue a final rule to withdraw the FIPs concerning SO_2 and NO_X annual emissions for Georgia. This action will delete and reserve 40 CFR 52.584 and 40 CFR 52.585. The withdrawal of the CAIR FIPs for Georgia is a conforming amendment that must be made once the SIP is approved because EPA's authority to issue the FIPs was premised on a deficiency in the SIP for Georgia. Once the SIP is fully approved, EPA no longer has authority for the FIPs. Thus, EPA will not have the option of maintaining the FIPs following the full SIP approval. Accordingly, EPA does not intend to offer an opportunity for a public hearing or an additional opportunity for written public comment on the withdrawal of the FIPs.

II. What Is the Regulatory History of the CAIR and the CAIR FIPs?

CAIR was published by EPA on May 12, 2005 (70 FR 25162). In this rule, EPA determined that 28 States and the District of Columbia contribute significantly to nonattainment and interfere with maintenance of the NAAQS for fine particles ($PM_{2.5}$) and/or 8-hour ozone in downwind States in the eastern part of the country. As a result, EPA required those upwind States to revise their SIPs to include control measures that reduce emissions of SO_2, which is a precursor to $PM_{2.5}$ formation, and/or NO_X, which is a precursor to both ozone and $PM_{2.5}$ formation. For jurisdictions that contribute significantly to downwind $PM_{2.5}$ nonattainment, CAIR sets annual State-wide emission reduction requirements (i.e., budgets) for SO_2 and annual State-wide emission reduction requirements for NO_X. Similarly, for jurisdictions that contribute significantly to 8-hour ozone nonattainment, CAIR sets State-wide emission reduction requirements for NO_X for the ozone season (May 1st to September 30th). Under CAIR, States may implement these reduction requirements by participating in the EPA-administered cap-and-trade programs or by adopting any other control measures.

CAIR explains to subject States what must be included in SIPs to address the requirements of section 110(a)(2)(D) of the Clean Air Act (CAA) with regard to interstate transport with respect to the 8-hour ozone and $PM_{2.5}$ NAAQS. EPA made national findings, effective on May 25, 2005, that the States had failed to submit SIPs meeting the requirements of section 110(a)(2)(D). The SIPs were due in July 2000, three years after the promulgation of the 8-hour ozone and $PM_{2.5}$ NAAQS. These findings started a two-year clock for EPA to promulgate a FIP to address the requirements of section 110(a)(2)(D). Under CAA section 110(c)(1), EPA may issue a FIP anytime after such findings are made and must do so within two years, unless a SIP revision correcting the deficiency is approved by EPA before the FIP is promulgated.

On April 28, 2006, EPA promulgated FIPs for all States covered by CAIR in order to ensure the emissions reductions required by CAIR are achieved on schedule. Each CAIR State is subject to the FIPs until the State fully adopts, and EPA approves, a SIP revision meeting the requirements of CAIR. The CAIR FIPs require EGUs to participate in the EPA-administered CAIR SO_2, NO_X annual, and NO_X ozone season trading programs, as appropriate. The CAIR FIP SO_2, NO_X annual, and NO_X ozone season trading programs impose essentially the same requirements as, and are integrated with, the respective CAIR SIP trading programs. The integration of the FIP and SIP trading programs means that these trading programs will work together to create effectively a single trading program for each regulated pollutant (SO_2, NO_X annual, and NO_X ozone season) in all States covered by the CAIR FIP or SIP trading program for that pollutant. The CAIR FIPs also allow States to submit abbreviated SIP revisions that, if approved by EPA, will automatically replace or supplement certain CAIR FIP provisions (e.g., the methodology for allocating NO_X allowances to sources in the State), while the CAIR FIP remains in place for all other provisions.

On April 28, 2006, EPA published two additional CAIR-related final rules that added the States of Delaware and New Jersey to the list of States subject to CAIR for $PM_{2.5}$ and announced EPA's final decisions on reconsideration of five issues, without making any substantive changes to the CAIR requirements.

III. What are the General Requirements of CAIR and the CAIR FIPs?

CAIR establishes State-wide emission budgets for SO_2 and NO_X and is to be implemented in two phases. The first phase of NO_X reductions starts in 2009 and continues through 2014, while the first phase of SO_2 reductions starts in 2010 and continues through 2014. The second phase of reductions for both NO_X and SO_2 starts in 2015 and continues thereafter. CAIR requires States to implement the budgets by either: (1) Requiring EGUs to participate in the EPA-administered cap-and-trade programs; or (2) adopting other control measures of the State's choosing and demonstrating that such control measures will result in compliance with the applicable State SO_2 and NO_X budgets.

The May 12, 2005, and April 28, 2006, CAIR rules provide model rules that States must adopt (with certain limited changes, if desired) if they want to participate in the EPA-administered trading programs.

With two exceptions, only States that choose to meet the requirements of CAIR through methods that exclusively regulate EGUs are allowed to participate in the EPA-administered trading programs. One exception is for States that adopt the opt-in provisions of the model rules to allow non-EGUs individually to opt into the EPA-administered trading programs. The other exception is for States that include all non-EGUs from their NO_X SIP Call trading programs in their CAIR NO_X ozone season trading programs.

IV. What are the Types of CAIR SIP Submittals?

States have the flexibility to choose the type of control measures they will use to meet the requirements of CAIR. EPA anticipates that most States will choose to meet the CAIR requirements by selecting an option that requires EGUs to participate in the EPA-administered CAIR cap-and-trade programs. For such States, EPA has provided two approaches for submitting and obtaining approval for CAIR SIP revisions. States may submit full SIP revisions that adopt the model CAIR cap-and-trade rules. If approved, these SIP revisions will fully replace the CAIR FIPs. Alternatively, States may submit abbreviated SIP revisions. These SIP revisions will not replace the CAIR FIPs; however, the CAIR FIPs provide that, when approved, the provisions in these abbreviated SIP revisions will be used instead of or in conjunction with, as appropriate, the corresponding provisions of the CAIR FIPs (e.g., the NO_X allowance allocation methodology).

A State submitting a full SIP revision may either adopt regulations that are substantively identical to the model rules or incorporate by reference the model rules. CAIR provides that States may only make limited changes to the model rules, if the States want to participate in the EPA-administered trading programs. A full SIP revision may change the model rules only by altering their applicability and allowance allocation provisions to:

1. Include NO_X SIP Call trading sources that are not EGUs under CAIR in the CAIR NO_X ozone season trading program;

2. Provide for State allocation of NO_X annual or ozone season allowances using a methodology chosen by the State;

3. Provide for State allocation of NO_X annual allowances from the compliance supplement pool (CSP) using the State's choice of allowed, alternative methodologies; or

4. Allow units that are not otherwise CAIR units to opt individually into the CAIR SO_2, NO_X annual, or NO_X ozone season trading programs under the opt-in provisions in the model rules.

An approved CAIR full SIP revision addressing EGUs' SO_2, NO_X annual, or NO_X ozone season emissions will replace the CAIR FIP for that State for the respective EGU emissions.

V. Analysis of Georgia's CAIR SIP Submittal

A. State Budgets for Allowance Allocations

The CAIR NO_X annual and ozone season budgets were developed from historical heat input data for EGUs. Using these data, EPA calculated annual and ozone season regional heat input values, which were multiplied by 0.15 pounds per million British thermal units (0.15lb/mmBtu), for phase 1, and 0.125 lb/mmBtu, for phase 2, to obtain regional NO_X budgets for 2009–2014 and for 2015 and thereafter, respectively. EPA derived the State NO_X annual and ozone season budgets from the regional budgets using State heat input data adjusted by fuel factors.

The CAIR State SO_2 budgets were derived by discounting the tonnage of emissions authorized by annual allowance allocations under the Acid Rain Program under title IV of the CAA. Under CAIR, each allowance allocated in the Acid Rain Program for the years in phase 1 of CAIR (2010 through 2014) authorizes 0.5 ton of SO_2 emissions in the CAIR trading program, and each Acid Rain Program allowance allocated for the years in phase 2 of CAIR (2015 and thereafter) authorizes 0.35 ton of SO_2 emissions in the CAIR trading program.

In this action, EPA is proposing approval of Georgia's SIP revision that adopts the budgets established for the State in CAIR, i.e., 66,321 (2009–2014) and 55,268 (2015–thereafter) tons for NO_X annual emissions, and 213,057 (2010–2014) and 149,140 (2015–thereafter) tons for SO_2 emissions. Georgia's SIP revision sets these budgets as the total amounts of allowances available for allocation for each year under the EPA-administered cap-and-trade programs.

B. CAIR Cap-and-Trade Programs

The CAIR NO_X annual and ozone-season model trading rules both largely mirror the structure of the NO_X SIP Call model trading rule in 40 CFR part 96, subparts A through I. While the provisions of the NO_X annual and ozone-season model rules are similar, there are some differences. For example, the NO_X annual model rule (but not the NO_X ozone season model rule) provides for a CSP, which is discussed below and under which allowances may be awarded for early reductions of NO_X annual emissions. As a further example, the NO_X ozone season model rule reflects the fact that the CAIR NO_X ozone season trading program replaces the NO_X SIP Call trading program after the 2008 ozone season and is coordinated with the NO_X SIP Call program. The NO_X ozone season model rule provides incentives for early emissions reductions by allowing banked, pre-2009 NO_X SIP Call allowances to be used for compliance in the CAIR NO_X ozone-season trading program. In addition, States have the option of continuing to meet their NO_X SIP Call requirement by participating in the CAIR NO_X ozone season trading program and including all their NO_X SIP Call trading sources in that program.

The provisions of the CAIR SO_2 model rule are also similar to the provisions of the NO_X annual and ozone season model rules. However, the SO_2 model rule is coordinated with the ongoing Acid Rain SO_2 cap-and-trade program under CAA title IV. The SO_2 model rule uses the title IV allowances for compliance, with each allowance allocated for 2010–2014 authorizing only 0.50 ton of emissions and each allowance allocated for 2015 and thereafter authorizing only 0.35 ton of emissions. Banked title IV allowances allocated for years before 2010 can be used at any time in the CAIR SO_2 cap-and-trade program, with each such allowance authorizing one ton of

emissions. Title IV allowances are to be freely transferable among sources covered by the Acid Rain Program and sources covered by the CAIR SO_2 cap-and-trade program.

EPA also used the CAIR model trading rules as the basis for the trading programs in the CAIR FIPs. The CAIR FIP trading rules are virtually identical to the CAIR model trading rules, with changes made to account for federal rather than state implementation. The CAIR model SO_2, NO_X annual, and NO_X ozone season trading rules and the respective CAIR FIP trading rules are designed to work together as integrated SO_2, NO_X annual, and NO_X ozone season trading programs.

In the SIP revision, Georgia chooses to implement its CAIR budgets by requiring EGUs to participate in EPA-administered cap-and-trade programs for SO_2 and NO_X annual emissions. Georgia has adopted a full SIP revision that adopts, with certain allowed changes discussed below, the CAIR model cap-and-trade rules for SO_2, and NO_X annual emissions.

C. Applicability Provisions for Non-EGU NO_X SIP Call Sources

In general, the CAIR model trading rules apply to any stationary, fossil-fuel-fired boiler or stationary, fossil-fuel-fired combustion turbine serving at any time, since the later of November 15, 1990, or the start-up of the unit's combustion chamber, a generator with nameplate capacity of more than 25 MWe producing electricity for sale.

States have the option of bringing in, for the CAIR NO_X ozone season program only, those units in the State's NO_X SIP Call trading program that are not EGUs as defined under CAIR. EPA advises States exercising this option to add the applicability provisions in the State's NO_X SIP Call trading rule for non-EGUs to the applicability provisions in 40 CFR 96.304 in order to include in the CAIR NO_X ozone season trading program all units required to be in the State's NO_X SIP Call trading program that are not already included under 40 CFR 96.304. Under this option, the CAIR NO_X ozone season program must cover all large industrial boilers and combustion turbines, as well as any small EGUs (i.e. units serving a generator with a nameplate capacity of 25 MWe or less) that the State currently requires to be in the NO_X SIP Call trading program.

Because Georgia is not subject to the CAIR NO_X ozone season requirements, Georgia will not participate in the CAIR NO_X ozone season trading program and therefore did not have an option of expanding the applicability provisions of the CAIR NO_X ozone season trading program to include all non-EGUs in the State's NO_X SIP Call trading program.

D. NO_X Allowance Allocations

Under the NO_X allowance allocation methodology in the CAIR model trading rules and in the CAIR FIP, NO_X annual and ozone season allowances are allocated to units that have operated for five years, based on heat input data from a three-year period that are adjusted for fuel type by using fuel factors of 1.0 for coal, 0.6 for oil, and 0.4 for other fuels. The CAIR model trading rules and the CAIR FIP also provide a new unit set-aside from which units without five years of operation are allocated allowances based on the units' prior year emissions.

States may establish in their SIP submissions a different NO_X allowance allocation methodology that will be used to allocate allowances to sources in the States, if certain requirements are met concerning the timing of submission of units' allocations to the Administrator for recordation and the total amount of allowances allocated for each control period. In adopting alternative NO_X allowance allocation methodologies, States have flexibility with regard to:

1. The cost to recipients of the allowances, which may be distributed for free or auctioned;
2. The frequency of allocations;
3. The basis for allocating allowances, which may be distributed, for example, based on historical heat input or electric and thermal output; and
4. The use of allowance set-asides and, if used, their size.

Georgia has chosen to replace the provisions of the CAIR NO_X annual model trading rule concerning the allocation of NO_X annual allowances with its own methodology. Georgia has chosen to distribute NO_X annual allowances based upon allocation methods for both existing and new units. Georgia defines an existing unit as one that commences operation prior to January 1, 2006, rather than 2001 as in EPA's model rule. Georgia defines new sources as those that have commenced operation on or after January 1, 2006, and do not yet have a baseline heat input. Under Georgia's cap and trade program, allowances will be allocated to EGUs in an amount no greater than the NO_X budget established in EPA's model rule. Allocations are based on the highest annual amount of heat input during a baseline period, using heat input figures that are fuel-adjusted as set forth in EPA's model rule. Allowances are initially allocated for 2010 through 2011 and are allocated on a year-by-year basis, about three years in advance, for 2012 and each subsequent year. The baseline period for initial allocations is 2001–2005, and will be updated annually for subsequent allocations. For years 2010 and thereafter, 97 percent of the budget will be allocated to existing sources, with the remaining three percent allocated to new sources. A new-unit set aside will be established for each control period, and will be allocated CAIR NO_X allowances equal to 1,990 and 1,658 for control periods 2009–2014, and 2015 and thereafter, respectively.

However, the new-unit set aside provisions in Georgia's rule contain certain cross-citation errors and, for example (in Rule 391–3–1.02(12)(f)(3)(iii)), inadvertently fail to reference the provisions establishing the size of the new-unit set aside. Further, the allowance recordation provisions in Georgia's rule contain certain citation errors and establish deadlines for the EPA Administrator's recordation of the allowance allocations in the allowance tracking system that are inconsistent with the allocation schedule established in Georgia's rule. While the allocation schedule requires allocations to be made about three years in advance, the recordation schedule (in Rule 391–3–1–.02(g)(1)(i) and (ii)) does not require allocations to be recorded in advance at all. Georgia indicated in its response to comments in its CAIR SIP rulemaking that the State will revise the rule to correct all of these errors. *See* Responses to Comments Received During the Public Comment Period Regarding Proposed Revisions to Air Quality Rules, Chapter 391–3–1 at C.–10 through C–11 (February 12, 2007). Moreover, EPA interprets Georgia's existing rule to limit total annual allocations to new units to the amount of the allowances in the applicable new-unit set aside and intends to record allowances in a manner consistent with the allocation schedule.

E. Allocation of NO_X Allowances From Compliance Supplement Pool

The CAIR rule establishes a CSP to provide an incentive for early reductions in NO_X annual emissions. The CSP consists of 200,000 CAIR NO_X annual allowances of vintage 2009 for the entire CAIR region, and a State's share of the CSP is based upon the projected magnitude of the emission reductions required by CAIR in that State. States may distribute CSP allowances, one allowance for each ton of early reduction, to sources that make NO_X reductions during 2007 or 2008 beyond what is required by any applicable State or Federal emission limitation. States also may distribute

CSP allowances based upon a demonstration of need for an extension of the 2009 deadline for implementing emission controls.

The CAIR annual NO_X model trading rule establishes specific methodologies for allocations of CSP allowances. States may choose an allowed, alternative CSP allocation methodology to be used to allocate CSP allowances to sources in the States.

Georgia has not chosen to modify the provisions of the CAIR NO_X annual model trading rule concerning the allocation of allowances from the CSP. Georgia has chosen to distribute CSP allowances using an allocation methodology that is the same as EPA's model rule. The CSP provides up to 12,397 CAIR NO_X annual allowances to be allocated by the State for 2009.

F. Individual Opt-In Units

The opt-in provisions of the CAIR SIP model trading rules allow certain non-EGUs (i.e., boilers, combustion turbines, and other stationary fossil-fuel-fired devices) that do not meet the applicability criteria for a CAIR trading program to participate voluntarily in (i.e., opt into) the CAIR trading program. A non-EGU may opt into one or more of the CAIR trading programs. In order to qualify to opt into a CAIR trading program, a unit must vent all emissions through a stack and be able to meet monitoring, recordkeeping, and recording requirements of 40 CFR part 75. The owners and operators seeking to opt a unit into a CAIR trading program must apply for a CAIR opt-in permit. If the unit is issued a CAIR opt-in permit, the unit becomes a CAIR unit, is allocated allowances, and must meet the same allowance-holding and emissions monitoring and reporting requirements as other units subject to the CAIR trading program. The opt-in provisions provide for two methodologies for allocating allowances for opt-in units, one methodology that applies to opt-in units in general and a second methodology that allocates allowances only to opt-in units that the owners and operators intend to repower before January 1, 2015.

States have several options concerning the opt-in provisions. States may adopt the CAIR opt-in provisions entirely or may adopt them but exclude one of the methodologies for allocating allowances. States may also decline to adopt the opt-in provisions at all.

Georgia has chosen not to allow non-EGUs meeting certain requirements to opt into the CAIR NO_X annual trading program.

Georgia has chosen not to allow certain non-EGUs to opt into the CAIR SO_2 trading program.

VI. Proposed Actions

EPA is proposing to approve Georgia's full CAIR SIP revision submitted on March 28, 2007. Under this SIP revision, Georgia is choosing to participate in the EPA-administered cap-and-trade programs for SO_2 and NO_X annual emissions. The SIP revision (interpreted by EPA as discussed above) meets the applicable requirements in 40 CFR 51.123(o) and (aa), with regard to NO_X annual emissions, and 40 CFR 51.124(o), with regard to SO_2 emissions. Further, Georgia has agreed to make the technical corrections discussed above to clarify the allowance allocation procedures and make the allowance recordation procedures consistent with the allocation procedures. Therefore, EPA is proposing to determine that the SIP, as revised, will meet the requirements of CAIR. As a consequence of the SIP approval, the Administrator of EPA will also issue, without providing an opportunity for a public hearing or an additional opportunity for written public comment, a final rule to withdraw the CAIR FIPs concerning SO_2 and NO_X annual emissions for Georgia. This action will delete and reserve 40 CFR 52.584 and 40 CFR 52.585.

VII. Statutory and Executive Order Reviews

Under Executive Order 12866 (58 FR 51735, October 4, 1993), this action is not a ''significant regulatory action'' and therefore is not subject to review by the Office of Management and Budget. For this reason, this action is also not subject to Executive Order 13211, ''Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use'' (66 FR 28355, May 22, 2001). This action merely proposes to approve State law as meeting Federal requirements and would impose no additional requirements beyond those imposed by State law. Accordingly, the Administrator certifies that this proposed rule would not have a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*). Because this action proposes to approve pre-existing requirements under State law and would not impose any additional enforceable duty beyond that required by State law, it does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4).

This proposal also does not have tribal implications because it would not have a substantial direct effect on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes, as specified by Executive Order 13175 (65 FR 67249, November 9, 2000). This proposed action also does not have Federalism implications because it would not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government, as specified in Executive Order 13132 (64 FR 43255, August 10, 1999). This action merely proposes to approve a State rule implementing a Federal standard and will result, as a consequence of that approval, in the Administrator's withdrawal of the CAIR FIP. It does not alter the relationship or the distribution of power and responsibilities established in the CAA. This proposed rule also is not subject to Executive Order 13045 ''Protection of Children from Environmental Health Risks and Safety Risks'' (62 FR 19885, April 23, 1997), because it would approve a State rule implementing a Federal Standard.

In reviewing SIP submissions, EPA's role is to approve State choices, provided that they meet the criteria of the CAA. In this context, in the absence of a prior existing requirement for the State to use voluntary consensus standards (VCS), EPA has no authority to disapprove a SIP submission for failure to use VCS. It would thus be inconsistent with applicable law for EPA, when it reviews a SIP submission, to use VCS in place of a SIP submission that otherwise satisfies the provisions of the CAA. Thus, the requirements of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) do not apply. This proposed rule would not impose an information collection burden under the provisions of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Electric utilities, Intergovernmental relations, Nitrogen oxides, Ozone, Particulate matter, Reporting and recordkeeping requirements, Sulfur dioxide.

Authority: 42 U.S.C. 7401 *et seq.*

Dated: July 25, 2007.

J.I. Palmer, Jr.,

Regional Administrator, Region 4.

[FR Doc. E7–15055 Filed 8–1–07; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Parts 52 and 81

[EPA–R04–OAR–2007–0548–200728; FRL–8449–4]

Approval and Promulgation of Implementation Plans and Designations of Areas for Air Quality Planning Purposes; Georgia: Redesignation of the Macon 8-Hour Ozone Nonattainment Area to Attainment for Ozone

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: On June 15, 2007, the State of Georgia, through the Georgia Environmental Protection Division (EPD), submitted a request to redesignate the Macon 8-hour ozone nonattainment area to attainment for the 8-hour ozone National Ambient Air Quality Standard (NAAQS); and to approve a State Implementation Plan (SIP) revision containing a maintenance plan for the Macon Area. The Macon 8-hour ozone area is comprised of Bibb County, and a portion of Monroe County located in middle Georgia (hereafter referred to as the ''Macon Area''). In this action, EPA is proposing to approve Georgia's 8-hour ozone redesignation request for the Macon Area. Additionally, EPA is proposing to approve the 8-hour ozone maintenance plan for the Macon Area, including the regional motor vehicle emissions budgets (MVEBs) for nitrogen oxides (NO_X) and volatile organic compounds (VOCs). This proposed approval of Georgia's redesignation request is based on EPA's determination that Georgia has demonstrated that the Macon Area has met the criteria for redesignation to attainment specified in the Clean Air Act (CAA), including the determination that the entire Macon 8-hour ozone nonattainment area has attained the 8-hour ozone standard. In this action, EPA is also describing the status of its transportation conformity adequacy determination for the new regional MVEBs for 2020 that are contained in the 8-hour ozone maintenance plan for the Macon Area.

DATES: Comments must be received on or before September 4, 2007.

ADDRESSES: Submit your comments, identified by Docket ID No. EPA–R04–OAR–2007–0548, by one of the following methods:

(a) *http://www.regulations.gov:* Follow the on-line instructions for submitting comments.

(b) *E-mail: Harder.Stacy@epa.gov.*

(c) *Fax:* (404) 562–9019.

(d) *Mail:* EPA–R04–OAR–2007–0548, Regulatory Development Section, Air Planning Branch, Air, Pesticides and Toxics Management Division, U.S. Environmental Protection Agency, Region 4, 61 Forsyth Street, SW., Atlanta, Georgia 30303–8960.

(e) *Hand Delivery or Courier:* Stacy Harder, Regulatory Development Section, Air Planning Branch, Air, Pesticides and Toxics Management Division, U.S. Environmental Protection Agency, Region 4, 61 Forsyth Street, SW., Atlanta, Georgia 30303–8960. Such deliveries are only accepted during the Regional Office's normal hours of operation. The Regional Office's official hours of business are Monday through Friday, 8:30 a.m. to 4:30 p.m., excluding Federal holidays.

Instructions: Direct your comments to Docket ID No. EPA–R04–OAR–2007–0548. EPA's policy is that all comments received will be included in the public docket without change and may be made available online at *http://www.regulations.gov*, including any personal information provided, unless the comment includes information claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Do not submit through *http://www.regulations.gov* or e-mail, information that you consider to be CBI or otherwise protected. The *http://www.regulations.gov* Web site is an ''anonymous access'' system, which means EPA will not know your identity or contact information unless you provide it in the body of your comment. If you send an e-mail comment directly to EPA without going through *http://www.regulations.gov*, your e-mail address will be automatically captured and included as part of the comment that is placed in the public docket and made available on the Internet. If you submit an electronic comment, EPA recommends that you include your name and other contact information in the body of your comment and with any disk or CD–ROM you submit. If EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment. Electronic files should avoid the use of special characters, any form of encryption, and be free of any defects or viruses. For additional information about EPA's public docket visit the EPA Docket Center homepage at *http://www.epa.gov/epahome/dockets.htm.*

Docket: All documents in the electronic docket are listed in the *http://www.regulations.gov* index. Although listed in the index, some information is not publicly available, i.e., CBI or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, is not placed on the Internet and will be publicly available only in hard copy form. Publicly available docket materials are available either electronically in *http://www.regulations.gov* or in hard copy at the Regulatory Development Section, Air Planning Branch, Air, Pesticides and Toxics Management Division, U.S. Environmental Protection Agency, Region 4, 61 Forsyth Street, SW., Atlanta, Georgia 30303–8960. EPA requests that if at all possible, you contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section to schedule your inspection. The Regional Office's official hours of business are Monday through Friday, 8:30 a.m. to 4:30 p.m., excluding Federal holidays.

FOR FURTHER INFORMATION CONTACT: Ms. Stacy Harder of the Regulatory Development Section at the Air Planning Branch, Air, Pesticides and Toxics Management Division, U.S. Environmental Protection Agency, Region 4, 61 Forsyth Street, SW., Atlanta, Georgia 30303–8960. Ms. Harder's telephone number is (404) 562–9042. She can also be reached via electronic mail at *harder.stacy@epa.gov.*

SUPPLEMENTARY INFORMATION:

Table of Contents

I. What Proposed Actions Is EPA Taking?

EPA is proposing to take three related actions which are summarized below and described in greater detail throughout this notice of proposed

rulemaking: (1) To redesignate the Macon Area to attainment for the 8-hour ozone NAAQS; (2) to approve Georgia's 8-hour ozone maintenance plan into the Georgia SIP, including the associated MVEBs; and (3) to notify the public of the status of EPA's adequacy determination for the Macon Area MVEBs.

First, EPA is proposing to determine that the Macon Area has attained the 8-hour ozone standard, and that the Macon Area has met the requirements for redesignation under section 107(d)(3)(E) of the CAA. EPA is now proposing to approve a request to change the legal designation of the Macon Area from nonattainment to attainment for the 8-hour ozone NAAQS.

Second, EPA is proposing to approve Georgia's 8-hour ozone maintenance plan for the Macon Area (such approval being one of the CAA criteria for redesignation to attainment status). The maintenance plan is designed to help keep the Macon Area in attainment for the 8-hour ozone NAAQS through 2020. Consistent with the CAA, the maintenance plan that EPA is proposing to approve today also includes 2020 regional MVEBs for NO_X and VOCs. Therefore, EPA is proposing to approve into the Georgia SIP the 2020 regional MVEBs that are included as part of Georgia's maintenance plan. These regional MVEBs apply to the entire Macon Area.

Third, EPA is notifying the public of the status of EPA's adequacy process for the newly-established 2020 MVEBs for the Macon Area. The adequacy comment period for the Macon Area's 2020 MVEBs began on June 21, 2007, with EPA's posting of the availability of this submittal on EPA's Adequacy Web site (*http://www.epa.gov/otaq/stateresources/transconf/currsips.htm*). The adequacy comment period for these MVEBs closed on July 23, 2007. No adverse comments were received on this submittal during the adequacy public comment period. Please see section VIII of this rulemaking for further explanation of this process, and for more details on the MVEBs.

Today's notice of proposed rulemaking is in response to Georgia's June 15, 2007, SIP submittal. The June 15, 2007, submittal requested redesignation of the Macon Area, and included a SIP revision addressing the specific issues summarized above, and the necessary elements for redesignation described in section 107(d)(3)(E) of the CAA.

II. What Is the Background for EPA's Proposed Actions?

Ground-level ozone is not emitted directly by sources. Rather, emissions of NO_X and VOCs react in the presence of sunlight to form ground-level ozone. NO_X and VOCs are referred to as precursors of ozone. The CAA establishes a process for air quality management through the NAAQS.

On July 18, 1997, EPA promulgated a revised 8-hour ozone standard of 0.08 parts per million (ppm). This new standard is more stringent than the previous 1-hour ozone standard. Under EPA regulations at 40 CFR part 50, the 8-hour ozone standard is attained when the 3-year average of the annual fourth highest daily maximum 8-hour average ambient air quality ozone concentration is less than or equal to 0.08 ppm (i.e., 0.084 ppm when rounding is considered). (See, 69 FR 23857 (April 30, 2004) for further information.) Ambient air quality monitoring data for the 3-year period must meet a data completeness requirement. The ambient air quality monitoring data completeness requirement is met when the average percent of days with valid ambient monitoring data is greater than 90 percent, and no single year has less than 75 percent data completeness as determined in Appendix I of part 50. Specifically, section 2.3 of 40 CFR part 50, Appendix I, ''Comparisons with the Primary and Secondary Ozone Standards'' states:

> ''The primary and secondary ozone ambient air quality standards are met at an ambient air quality monitoring site when the 3-year average of the annual fourth-highest daily maximum 8-hour average ozone concentration is less than or equal to 0.08 ppm. The number of significant figures in the level of the standard dictates the rounding convention for comparing the computed 3-year average annual fourth-highest daily maximum 8-hour average ozone concentration with the level of the standard. The third decimal place of the computed value is rounded, with values equal to or greater than 5 rounding up. Thus, a computed 3-year average ozone concentration of 0.085 ppm is the smallest value that is greater than 0.08 ppm.''

The CAA required EPA to designate as nonattainment any area that was violating the 8-hour ozone NAAQS based on the three most recent years of ambient air quality data. The Macon 8-hour ozone nonattainment area was designated using 2001–2003 ambient air quality data. The **Federal Register** document making these designations was signed on April 15, 2004, and published on April 30, 2004 (69 FR 23857). The CAA contains two sets of provisions—subpart 1 and subpart 2—that address planning and control requirements for ozone nonattainment areas. (Both are found in title I, part D.) Subpart 1 (which EPA refers to as ''basic'' nonattainment) contains general, less prescriptive, requirements for nonattainment areas for any pollutant—including ozone—governed by a NAAQS. Subpart 2 (which EPA refers to as ''classified'' nonattainment) provides more specific requirements for certain ozone nonattainment areas. Some 8-hour ozone nonattainment areas are subject only to the provisions of subpart 1. Other 8-hour ozone nonattainment areas are also subject to the provisions of subpart 2. Under EPA's Phase 1 8-hour ozone implementation rule (69 FR 23857) (Phase 1 Rule), signed on April 15, 2004, and published April 30, 2004, an area was classified under subpart 2 based on its 8-hour ozone design value (i.e., the 3-year average of the annual fourth-highest daily maximum 8-hour average ozone concentrations), if it had a 1-hour design value at or above 0.121 ppm (the lowest 1-hour design value in Table 1 of subpart 2). All other areas are covered under subpart 1, based upon their 8-hour ambient air quality design values.

On April 30, 2004, EPA designated the Macon Area as a ''basic'' 8-hour ozone nonattainment area (see, 69 FR 23857, April 30, 2004). On June 15, 2007, when Georgia submitted its final redesignation request, the Macon Area was classified under subpart 1 of the CAA, and was obligated to meet only the subpart 1 requirements.

Various aspects of EPA's Phase 1 8-hour ozone implementation rule were challenged in court. On December 22, 2006, the U.S. Court of Appeals for the District of Columbia Circuit (DC Circuit Court) vacated EPA's Phase 1 Implementation Rule for the 8-hour Ozone Standard (69 FR 23951, April 30, 2004). *South Coast Air Quality Management Dist. (SCAQMD)* v. *EPA,* 472 F.3d 882 (DC Cir. 2006). On June 8, 2007, in response to several petitions for rehearing, the DC Circuit Court clarified that the Phase 1 Rule was vacated only with regard to those parts of the Rule that had been successfully challenged. Therefore, the Phase 1 Rule provisions related to classifications for areas currently classified under subpart 2 of title I, part D of the CAA as 8-hour nonattainment areas, the 8-hour attainment dates and the timing for emissions reductions needed for attainment of the 8-hour ozone NAAQS remain effective. The June 8th decision left intact the Court's rejection of EPA's reasons for implementing the 8-hour standard in certain nonattainment areas

under subpart 1 in lieu of subpart 2. By limiting the vacatur, the Court let stand EPA's revocation of the 1-hour standard and those anti-backsliding provisions of the Phase 1 Rule that had not been successfully challenged. The June 8th decision reaffirmed the December 22, 2006, decision that EPA had improperly failed to retain measures required for 1-hour nonattainment areas under the anti-backsliding provisions of the regulations: (1) Nonattainment area New Source Review (NSR) requirements based on an area's 1-hour nonattainment classification; (2) Section 185 penalty fees for 1-hour severe or extreme nonattainment areas; and (3) measures to be implemented pursuant to section 172(c)(9) or 182(c)(9) of the CAA, on the contingency of an area not making reasonable further progress toward attainment of the 1-hour NAAQS, or for failure to attain that NAAQS. The June 8th decision clarified that the Court's reference to conformity requirements for anti-backsliding purposes was limited to requiring the continued use of 1-hour motor vehicle emissions budgets until 8-hour budgets were available for 8-hour conformity determinations, which is already required under EPA's conformity regulations. The Court thus clarified that 1-hour conformity determinations are not required for anti-backsliding purposes.

This section sets forth EPA's views on the potential effect of the Court's rulings on this proposed redesignation action. For the reasons set forth below, EPA does not believe that the Court's rulings alter any requirements relevant to this redesignation action so as to preclude redesignation, and do not prevent EPA from proposing or ultimately finalizing this redesignation. EPA believes that the Court's December 22, 2006, and June 8, 2007, decisions impose no impediment to moving forward with redesignation of the Macon Area to attainment. Even in light of the Court's decisions, redesignation is appropriate under the relevant redesignation provisions of the CAA and long-standing policies regarding redesignation requests.

With respect to the 8-hour standard, the Court's ruling rejected EPA's reasons for classifying areas under subpart 1 for the 8-hour standard, and remanded that matter to the Agency. Consequently, it is possible that this Area could, during a remand to EPA, be reclassified under subpart 2. Although any future decision by EPA to classify this area under subpart 2 might trigger additional future requirements for the area, EPA believes that this does not mean that redesignation of the area cannot now go forward. This belief is based upon (1) EPA's long-standing policy of evaluating redesignation requests in accordance with the requirements due at the time the request is submitted; and (2) consideration of the inequity of applying retroactively any requirements that might in the future be applied.

First, at the time the redesignation request was submitted, the Macon Area was classified under subpart 1 and was obligated to meet only subpart 1 requirements. Under EPA's long-standing interpretation of section 107(d)(3)(E) of the CAA to qualify for redesignation, states requesting redesignation to attainment must meet only the relevant SIP requirements that came due prior to the submittal of a complete redesignation request. September 4, 1992, Calcagni Memorandum (''Procedures for Processing Requests to Redesignate Areas to Attainment,'' Memorandum from John Calcagni, Director, Air Quality Management Division). See also, Michael Shapiro Memorandum, September 17, 1993, and 60 FR 12459, 12465–66 (March 7, 1995) (Redesignation of Detroit-Ann Arbor, Michigan). See, *Sierra Club* v. *EPA,* 375 F.3d 537 (7th Cir. 2004), which upheld this interpretation. See, *e.g.* also, 68 FR 25418, 25424, 25427 (May 12, 2003) (redesignation of St. Louis, Missouri).

Moreover, it would be inequitable to retroactively apply any new SIP requirements that were not applicable at the time the request was submitted. The DC Circuit Court has recognized the inequity in such retroactive rulemaking, (See, *Sierra Club* v. *Whitman,* 285 F.3d 63 (DC Cir. 2002)), in which the Court upheld a district court's ruling refusing to make retroactive an EPA determination of nonattainment that was past the statutory due date. Such a determination would have resulted in the imposition of additional requirements on the area. The Court stated, ''Although EPA failed to make the nonattainment determination within the statutory time frame, Sierra Club's proposed solution only makes the situation worse. Retroactive relief would likely impose large costs on the States, which would face fines and suits for not implementing air pollution prevention plans in 1997, even though they were not on notice at the time.'' *Id.* at 68. Similarly, with regard to Georgia's redesignation request, it would be unfair to penalize the Macon Area by applying to it for purposes of redesignation, additional SIP requirements under subpart 2 that were not in effect at the time it submitted its redesignation request.

As noted earlier, in 2005, the ambient ozone data for the Macon Area indicated no further violations of the 8-hour ozone NAAQS, using data from the 3-year period of 2003–2005 to demonstrate attainment. As a result, on June 15, 2007, Georgia requested redesignation of the Macon Area to attainment for the 8-hour ozone NAAQS. The redesignation request included three years of complete, quality-assured ambient air quality data for the ozone seasons (March 1st until October 31st) of 2003–2005, indicating that the 8-hour ozone NAAQS has been achieved for the entire Macon Area. Under the CAA, nonattainment areas may be redesignated to attainment if sufficient, complete, quality-assured data is available for the Administrator to determine that the area has attained the standard and the area meets the other CAA redesignation requirements in section 107(d)(3)(E).

III. What Are the Criteria for Redesignation?

The CAA provides the requirements for redesignating a nonattainment area to attainment. Specifically, section 107(d)(3)(E) of the CAA allows for redesignation providing that: (1) The Administrator determines that the area has attained the applicable NAAQS; (2) the Administrator has fully approved the applicable implementation plan for the area under section 110(k); (3) the Administrator determines that the improvement in air quality is due to permanent and enforceable reductions in emissions resulting from implementation of the applicable SIP and applicable Federal air pollutant control regulations and other permanent and enforceable reductions; (4) the Administrator has fully approved a maintenance plan for the area as meeting the requirements of section 175A; and, (5) the state containing such area has met all requirements applicable to the area under section 110 and part D of the CAA.

EPA provided guidance on redesignation in the General Preamble for the Implementation of Title I of the CAA Amendments of 1990, on April 16, 1992 (57 FR 13498), and supplemented this guidance on April 28, 1992 (57 FR 18070). EPA has provided further guidance on processing redesignation requests in the following documents:

1. ''Ozone and Carbon Monoxide Design Value Calculations,'' Memorandum from Bill Laxton, Director, Technical Support Division, June 18, 1990;

2. ''Maintenance Plans for Redesignation of Ozone and Carbon Monoxide Nonattainment Areas,'' Memorandum from G. T. Helms, Chief, Ozone/Carbon Monoxide Programs Branch, April 30, 1992;

3. ''Contingency Measures for Ozone and Carbon Monoxide (CO) Redesignations,'' Memorandum from G. T. Helms, Chief, Ozone/Carbon Monoxide Programs Branch, June 1, 1992;

4. ''Procedures for Processing Requests to Redesignate Areas to Attainment,'' Memorandum from John Calcagni, Director, Air Quality Management Division, September 4, 1992 (hereafter referred to as the ''Calcagni Memorandum'');

5. ''State Implementation Plan (SIP) Actions Submitted in Response to Clean Air Act (ACT) Deadlines,'' Memorandum from John Calcagni, Director, Air Quality Management Division, October 28, 1992;

6. ''Technical Support Documents (TSD's) for Redesignation of Ozone and Carbon Monoxide (CO) Nonattainment Areas,'' Memorandum from G. T. Helms, Chief, Ozone/Carbon Monoxide Programs Branch, August 17, 1993;

7. ''State Implementation Plan (SIP) Requirements for Areas Submitting Requests for Redesignation to Attainment of the Ozone and Carbon Monoxide (CO) National Ambient Air Quality Standards (NAAQS) On or After November 15, 1992,'' Memorandum from Michael H. Shapiro, Acting Assistant Administrator for Air and Radiation, September 17, 1993;

8. ''Use of Actual Emissions in Maintenance Demonstrations for Ozone and CO Nonattainment Areas,'' Memorandum from D. Kent Berry, Acting Director, Air Quality Management Division, November 30, 1993;

9. ''Part D New Source Review (Part D NSR) Requirements for Areas Requesting Redesignation to Attainment,'' Memorandum from Mary D. Nichols, Assistant Administrator for Air and Radiation, October 14, 1994; and

10. ''Reasonable Further Progress, Attainment Demonstration, and Related Requirements for Ozone Nonattainment Areas Meeting the Ozone National Ambient Air Quality Standard,'' Memorandum from John S. Seitz, Director, Office of Air Quality Planning and Standards, May 10, 1995.

IV. Why Is EPA Proposing These Actions?

On June 15, 2007, Georgia requested redesignation of the Macon 8-hour ozone nonattainment area to attainment for the 8-hour ozone standard. EPA's evaluation indicates that Georgia has demonstrated that the Macon Area has attained the standard and has met the requirements for redesignation set forth in section 107(d)(3)(E) of the CAA. EPA is also announcing the status of its adequacy determination for the 2020 regional MVEBs, which is relevant to the requested redesignation.

V. What Is the Effect of EPA's Proposed Actions?

EPA's proposed actions establish the basis upon which EPA may take final action on the issues being proposed for approval today. Approval of Georgia's redesignation request would change the official designation of the Macon Area for the 8-hour ozone NAAQS found at 40 CFR part 81. Approval of Georgia's request would also incorporate into the Georgia SIP, a plan for the Macon Area for maintaining the 8-hour ozone NAAQS in the area through 2020. This maintenance plan includes contingency measures to remedy future violations of the 8-hour ozone NAAQS. The maintenance plan also establishes regional MVEBs for the year 2020 of 7.8744 tpd for VOCs and 14.7712 tpd for NO_X, for the Macon Area. Approval of Georgia's maintenance plan would also result in approval of the regional MVEBs. Additionally, EPA is notifying the public of the status of its adequacy determination for the 2020 regional MVEBs, pursuant to 40 CFR 93.118(f)(1).

VI. What Is EPA's Analysis of the Request?

EPA is proposing to make the determination that the Macon Area has attained the 8-hour ozone standard, and that all other redesignation criteria have been met for the Macon Area. The basis for EPA's determination for the area is discussed in greater detail below.

Criteria (1)—The Macon Area Has Attained the 8-hour Ozone NAAQS

EPA is proposing to determine that the Macon Area has attained the 8-hour ozone NAAQS. For ozone, an area may be considered to be attaining the 8-hour ozone NAAQS if there are no violations, as determined in accordance with 40 CFR 50.10 and Appendix I of part 50, based on three complete, consecutive calendar years of quality-assured air quality monitoring data. To attain this standard, the 3-year average of the fourth-highest daily maximum 8-hour average ozone concentrations measured at each monitor within an area over each year must not exceed 0.08 ppm. Based on the rounding convention described in 40 CFR part 50, Appendix I, the standard is attained if the design value is 0.084 ppm or below. The data must be collected and quality-assured in accordance with 40 CFR part 58, and recorded in the EPA Air Quality System (AQS). The monitors generally should have remained at the same location for the duration of the monitoring period required for demonstrating attainment.

EPA reviewed ozone monitoring data from the ambient ozone monitoring station in the Macon Area for the ozone season from 2003–2005. This data has been quality assured and is recorded in AQS. The fourth high average for 2003, 2004, and 2005, and the 3-year average of these values (i.e., design values), are summarized in Table 1 below. The 2006 data continues to demonstrate attainment.

TABLE 1.—ANNUAL 4TH MAX HIGH AND DESIGN VALUE CONCENTRATION FOR 8-HOUR OZONE FOR THE MACON AREA

(In parts per million)

Site name	4th Highest value (ppm)				3-year average	
	2003	2004	2005	2006	2003–2005	2004–2006
Macon SE	0.081	0.086	0.082	0.077	0.083	0.082

As discussed above, the design value for an area is the highest design value recorded at any monitor in the area. Therefore, the design value for the Macon Area is (0.083) ppm, which meets the standard as described above. As discussed in more detail below, Georgia has committed to continue monitoring in this area in accordance with 40 CFR part 58. The data submitted by Georgia provides an adequate demonstration that the Macon Area has attained the 8-hour ozone NAAQS.

Criteria (2)—Georgia Has a Fully Approved SIP Under Section 110(k) for the Macon Area and Criteria (5)—Has Met All Applicable Requirements Under Section 110 and Part D of the CAA

Below is a summary of how these two criteria were met.

EPA has determined that Georgia has met all applicable SIP requirements for the Macon Area under section 110 of the CAA (general SIP requirements). EPA has also determined that the Georgia SIP satisfies the criterion that it meet applicable SIP requirements under part D of title I of the CAA (requirements specific to subpart 1 basic 8-hour ozone nonattainment areas) in accordance with section 107(d)(3)(E)(v). In addition, EPA has determined that the SIP is fully approved with respect to all applicable requirements in accordance with section 107(d)(3)(E)(ii). In making these determinations, EPA ascertained which requirements are applicable to the area and that if applicable, they are fully approved under section 110(k). SIPs must be fully approved only with respect to applicable requirements.

a. The Macon Area has met all applicable requirements under section 110 and part D of the CAA.

The September 4, 1992, Calcagni Memorandum (see ''Procedures for Processing Requests to Redesignate Areas to Attainment,'' Memorandum from John Calcagni, Director, Air Quality Management Division, September 4, 1992) describes EPA's interpretation of section 107(d)(3)(E). Under this interpretation, to qualify for redesignation, states requesting redesignation to attainment must meet only the relevant CAA requirements that come due prior to the submittal of a complete redesignation request. See also, Michael Shapiro Memorandum, (''SIP Requirements for Areas Submitting Requests for Redesignation to Attainment of the Ozone and Carbon Monoxide NAAQS On or After November 15, 1992,'' September 17, 1993), and 60 FR 12459, 12465–66 (March 7, 1995) (redesignation of Detroit-Ann Arbor, Michigan). Applicable requirements of the CAA that come due subsequent to the area's submittal of a complete redesignation request remain applicable until a redesignation is approved, but are not required as a prerequisite to redesignation. See, section 175A(c) of the CAA; *Sierra Club,* 375 F.3d 537 (7th Cir. 2004); see also, 68 FR 25424, 25427 (May 12, 2003) (redesignation of St. Louis, Missouri).

General SIP requirements. Section 110(a)(2) of title I of the CAA delineates the general requirements for a SIP, which include enforceable emissions limitations and other control measures, means, or techniques, provisions for the establishment and operation of appropriate devices necessary to collect data on ambient air quality, and programs to enforce the limitations. General SIP elements and requirements are delineated in section 110(a)(2) of title I, part A of the CAA. These requirements include, but are not limited to, the following: Submittal of a SIP that has been adopted by the state after reasonable public notice and hearing; provisions for establishment and operation of appropriate procedures needed to monitor ambient air quality; implementation of a source permit program; provisions for the implementation of part C requirements (Prevention of Significant Deterioration (PSD)) and provisions for the implementation of part D requirements (NSR permit programs); provisions for air pollution modeling; and provisions for public and local agency participation in planning and emission control rule development.

Section 110(a)(2)(D) requires that SIPs contain certain measures to prevent sources in a state from significantly contributing to air quality problems in another state. To implement this provision, EPA has required certain states to establish programs to address the transport of air pollutants (NO_X SIP Call, Clean Air Interstate Rule (CAIR)). EPA has also found, generally, that states have not submitted SIPs under section 110(a)(1) to meet the interstate transport requirements of section 110(a)(2)(D)(i). However, the section 110(a)(2)(D) requirements for a state are not linked with a particular nonattainment area's designation and classification in that state. EPA believes that the requirements linked with a particular nonattainment area's designation and classifications are the relevant measures to evaluate in reviewing a redesignation request. The transport SIP submittal requirements, where applicable, continue to apply to a state regardless of the designation of any one particular area in the state. Thus, we do not believe that the CAA's interstate transport requirements should be construed to be applicable requirements for purposes of redesignation.

In addition, EPA believes that the other section 110 elements not connected with nonattainment plan submissions and not linked with an area's attainment status are not applicable requirements for purposes of redesignation. The area will still be subject to these requirements after the area is redesignated. The section 110 and part D requirements, which are linked with a particular area's designation and classification, are the relevant measures to evaluate in reviewing a redesignation request. This approach is consistent with EPA's existing policy on applicability (i.e., for redesignations) of conformity and oxygenated fuels requirements, as well as with section 184 ozone transport requirements. See, Reading, Pennsylvania, proposed and final rulemakings (61 FR 53174–53176, October 10, 1996), (62 FR 24826, May 7, 1997); Cleveland-Akron-Loraine, Ohio, final rulemaking (61 FR 20458, May 7, 1996); and Tampa, Florida, final rulemaking at (60 FR 62748, December 7, 1995). See also, the discussion on this issue in the Cincinnati, Ohio redesignation (65 FR 37890, June 19, 2000), and in the Pittsburgh, Pennsylvania redesignation (66 FR 50399, October 19, 2001).

EPA believes that section 110 elements not linked to the area's nonattainment status are not applicable for purposes of redesignation. Any section 110 requirements that are linked to the part D requirements for 8-hour ozone nonattainment areas are not yet due, since, as explained below, no part D requirements for 8-hour standard became due prior to submission of the redesignation request. Therefore, as discussed above, for purposes of redesignation, they are both not considered applicable requirements. Nonetheless, EPA notes it has previously approved provisions in the Georgia SIP addressing section 110 elements under the 1-hour ozone NAAQS (70 FR 34660, June 15, 2005). EPA believes that the section 110 SIP approved for the 1-hour ozone NAAQS is also sufficient to meet the requirements under the 8-hour ozone NAAQS (as well as satisfying the issues raised by the D.C. Circuit Court in the *SCAQMD* case).

Part D requirements. EPA has also determined that the Georgia SIP meets applicable SIP requirements under part D of the CAA since no requirements became due prior to the submission of the area's redesignation request. Sections 172–176 of the CAA, found in subpart 1 of part D, set forth the basic nonattainment requirements applicable to all nonattainment areas.

Section 182 of the CAA, found in subpart 2 of part D, establishes additional specific requirements depending on the area's nonattainment classification. Subpart 2 is not applicable to the Macon Area.

Part D, subpart 1 applicable SIP requirements. For purposes of evaluating this redesignation request,

the applicable part D, subpart 1 SIP requirements for all nonattainment areas are contained in sections 172(c)(1)–(9). A thorough discussion of the requirements contained in section 172 can be found in the General Preamble for Implementation of title I (57 FR 13498). No requirements applicable for purposes of redesignation under part D became due prior to the submission of the redesignation request, and therefore none are applicable to the area for purposes of redesignation. For example, the requirements for an attainment demonstration that meets the requirements of section 172(c)(1) are not yet applicable, nor are the requirements for Reasonably Achievable Control Technology (RACT) and Reasonably Available Control Measures (RACM) (section 172(c)(1)), reasonable further progress (RFP) (section 172(c)(2)), and contingency measures (section 172(c)(9)).

In addition to the fact that no part D requirements applicable for purposes of redesignation became due prior to submission of the redesignation request and therefore are not applicable, EPA believes it is reasonable to interpret the conformity and NSR requirements as not requiring approval prior to redesignation.

Section 176 Conformity Requirements. Section 176(c) of the CAA requires states to establish criteria and procedures to ensure that Federally supported or funded projects conform to the air quality planning goals in the applicable SIP. The requirement to determine conformity applies to transportation plans, programs and projects developed, funded or approved under title 23 of the United States Code (U.S.C.) and the Federal Transit Act (transportation conformity) as well as to all other Federally supported or funded projects (general conformity). State conformity revisions must be consistent with Federal conformity regulations relating to consultation, enforcement and enforceability that the CAA required the EPA to promulgate.

EPA believes it is reasonable to interpret the conformity SIP requirements as not applying for purposes of evaluating the redesignation request under section 107(d) because state conformity rules are still required after redesignation and Federal conformity rules apply where state rules have not been approved. See, *Wall*, 265 F.3d 426 ((upholding this interpretation). See also, 60 FR 62748 (December 7, 1995, Tampa, Florida.)

EPA has also determined that areas being redesignated need not comply with the requirement that a NSR program be approved prior to redesignation, provided that the area demonstrates maintenance of the standard without a part D NSR program in effect since PSD requirements will apply after redesignation. The rationale for this view is described in a memorandum from Mary Nichols, Assistant Administrator for Air and Radiation, dated October 14, 1994, entitled ''Part D New Source Review (Part D NSR) Requirements for Areas Requesting Redesignation to Attainment.'' Georgia has demonstrated that the area will be able to maintain the standard without a part D NSR program in effect, and therefore, Georgia need not have a fully approved part D NSR program prior to approval of the redesignation request. Georgia's PSD program will become effective in the Macon Area upon redesignation to attainment. See, rulemakings for Detroit, Michigan (60 FR 12467–12468, March 7, 1995); Cleveland-Akron-Lorraine, Ohio (61 FR 20458, 20469–70, May 7, 1996); Louisville, Kentucky (66 FR 53665, October 23, 2001); Grand Rapids, Michigan (61 FR 31834–31837, June 21, 1996). Thus, the Macon Area has satisfied all applicable requirements for purposes of redesignation under section 110 and part D of the CAA.

b. The area has a fully approved applicable SIP under section 110(k) of the CAA.

EPA has fully approved the applicable Georgia SIP for the Macon Area (including Bibb and a portion of Monroe County) under section 110(k) of the CAA for all requirements applicable for purposes of redesignation. EPA may rely on prior SIP approvals in approving a redesignation request, see Calcagni Memorandum at p. 3; *Southwestern Pennsylvania Growth Alliance* v. *Browner,* 144 F.3d 984, 989–90 (6th Cir. 1998); *Wall*, 265 F.3d 426, plus any additional measures it may approve in conjunction with a redesignation action. See, 68 FR 25426 (May 12, 2003) and citations therein. Following passage of the CAA of 1970, Georgia has adopted and submitted, and EPA has fully approved at various times, provisions addressing the various 1-hour ozone standard SIP elements applicable in Macon, Georgia (70 FR 34660, June 15, 2005).

As indicated above, EPA believes that the section 110 elements not connected with nonattainment plan submissions and not linked to the area's nonattainment status are not applicable requirements for purposes of redesignation. EPA also believes that since the part D requirements applicable for purposes of redesignation did not become due prior to submission of the redesignation request, they also are therefore not applicable requirements for purposes of redesignation.

Criteria (3)—The Air Quality Improvement in the Macon Area Is Due to Permanent and Enforceable Reductions in Emissions Resulting From Implementation of the SIP and Applicable Federal Air Pollution Control Regulations and Other Permanent and Enforceable Reductions

EPA believes that Georgia has demonstrated that the observed air quality improvement in the Macon Area is due to permanent and enforceable reductions in emissions resulting from implementation of the SIP, Federal measures, and other state adopted measures. Additionally, new emissions control programs for fuels and motor vehicles will help ensure a continued decrease in emissions throughout the region.

TABLE 2.—MACON AREA EMISSION REDUCTIONS PROGRAMS

Onboard Refueling Vapor Recovery for Light-Duty Vehicles.
Architectural and Industrial Maintenance Coatings.
Automobile Refinishing.
The National Emission Standards for Hazardous Air Pollutants (NESHAP); the majority of which are also VOCs.
Phase II Acid Rain Program for NO_X.
Tier 2 Motor Vehicle Emissions Standards and Gasoline Sulfur Control Requirements.
Regional NO_X SIP Call.

Notably, no credit specific emission reduction is being claimed in the SIP for the NO_X SIP Call reductions although this program has resulted in measurable emissions reductions.

Criteria (4)—The Area Has a Fully Approved Maintenance Plan Pursuant to Section 175A of the CAA

In its request to redesignate the Macon Area to attainment, EPD submitted a SIP revision to provide for the maintenance of the 8-hour ozone NAAQS for at least 10 years after the effective date of redesignation to attainment.

a. What is required in a maintenance plan?

Section 175A of the CAA sets forth the elements of a maintenance plan for areas seeking redesignation from nonattainment to attainment. Under section 175A, the plan must demonstrate continued attainment of the applicable NAAQS for at least 10 years after the Administrator approves a redesignation to attainment. Eight years after the redesignation, the State of Georgia must submit a revised

maintenance plan which demonstrates that attainment will continue to be maintained for the 10 years following the initial 10-year period. To address the possibility of future NAAQS violations, the maintenance plan must contain such contingency measures, with a schedule for implementation as EPA deems necessary to assure prompt correction of any future 8-hour ozone violations. Section 175A of the CAA sets forth the elements of a maintenance plan for areas seeking redesignation from nonattainment to attainment. The Calcagni Memorandum provides additional guidance on the content of a maintenance plan. The Calcagni Memorandum explains that an ozone maintenance plan should address five requirements: the attainment emissions inventory, maintenance demonstration, monitoring, verification of continued attainment, and a contingency plan. As is discussed more fully below, Georgia's maintenance plan includes all the necessary components and is approvable as part of the redesignation request.

b. Attainment Emissions Inventory

Georgia selected 2005 as ''the attainment year'' for the Macon Area for the purposes of demonstrating attainment of the 8-hour ozone NAAQS. This attainment inventory identifies the level of emissions in the area which is sufficient to attain the 8-hour ozone standard. Georgia began development of this attainment inventory by first developing a baseline emissions inventory for the Macon Area. The year 2003 was chosen as the base year for developing a comprehensive ozone precursor emissions inventory for which projected emissions could be developed for 2005, 2008, 2011, 2014, 2017, and 2020. Non-road mobile emissions estimates were based on the EPA's NONROAD2005 model. On-road mobile source emissions were calculated using EPA's MOBILE6.2 emission factors model. The 2005 VOCs and NO_X emissions, as well as the emissions for other years, for the Macon Area were developed consistent with EPA guidance, and are summarized in Tables 3 and 4 in the following subsection.

c. Maintenance Demonstration

The June 15, 2007, final submittal includes a maintenance plan for the Macon Area. This demonstration:

(i) Shows compliance and maintenance of the 8-hour ozone standard by providing information to support the demonstration that current and future emissions of VOCs and NO_X remain at or below attainment year 2005 emissions levels. The year 2005 was chosen as the attainment year because it is one of the most recent three years (i.e., 2003, 2004, and 2005) for which the Macon Area has clean air quality data for the 8-hour ozone standard.

(ii) Uses 2005 as the attainment year and includes future emission inventory projections for 2005, 2008, 2011, 2014, 2017, and 2020.

(iii) Identifies an ''out year,'' at least 10 years after the time necessary for EPA to review and approve the maintenance plan. Per 40 CFR part 93, MVEBs were established for the last year (2020) of the maintenance plan. See, section VII below.

(iv) Provides the following actual and projected emissions inventories for the Macon nonattainment Area. See, Tables 3 and 4.

TABLE 3.—MACON AREA EMISSIONS OF VOCS

[Tons per summer day]

Source category	2003	2005	2008	2011	2014	2017	2020
Non-EGU	5.4752	4.9767	4.2290	4.1672	4.4484	4.7295	4.8890
EGU	1.0197	0.9818	0.9249	0.9060	0.9060	0.9060	0.9060
Area	16.7094	16.6437	16.5452	17.1532	18.1145	19.0758	19.1643
Mobile*	16.1605	14.7602	12.6598	10.5215	8.3645	6.6906	5.2581
Nonroad	4.5063	4.4556	4.3797	4.1626	3.8751	3.5875	3.1884
Total	43.8711	41.8180	38.7385	36.9105	35.7084	34.9894	33.4058
Safety Margin**	N/A	2.0531	5.1326	6.9606	8.1627	8.8817	10.4653

*Calculated using MOBILE 6.2.
**After assigning 2.6163 TPD of the 2020 VOCs safety margin to the MVEB, the revised 2020 safety margin will be 7.8490 TPD.

TABLE 4.—MACON AREA NO_X EMISSIONS

[Tons per summer day]

Source category	2003	2005	2008	2011	2014	2017	2020
Non-EGU	5.9471	5.6213	5.1325	5.0792	5.2435	5.4079	5.5590
EGU	74.9781	67.7887	57.0046	53.4099	53.4099	53.4099	53.4099
Area	1.5008	1.5136	1.5328	1.5641	1.6013	1.6385	1.6609
Mobile*	18.4512	16.8661	14.4883	11.8974	9.2000	7.2225	5.6051
Nonroad	4.1467	3.9555	3.6687	3.3229	2.9475	2.5722	2.1246
Total	105.0239	95.7452	81.8270	75.2734	72.4022	70.2509	68.3595
Safety Margin**	N/A	9.2787	23.1969	29.7505	32.6217	34.7730	36.6644

*Calculated using MOBILE 6.2.
**After assigning 9.1661 TPD of the 2020 NO_X safety margin to the MVEB, the revised 2020 safety margin will be 27.4983 TPD.

A safety margin is the difference between the attainment level of emissions (from all sources) and the projected level of emissions (from all sources) in the maintenance plan. The attainment level of emissions is the

level of emissions during one of the years in which the area met the NAAQS. Georgia has decided to allocate a portion of the available safety margin to the regional 2020 MVEBs for NO_X and VOCs for the Macon Area, and has calculated the safety margin in its submittal. See, Tables 3 and 4 above. This allocation and the resulting available safety margin for the Macon Area are discussed further in section VII of this rulemaking.

d. Monitoring Network

There are currently two monitors measuring ozone in the Macon Area. Only one of the monitors was in place during the 2003–2005 monitoring period. The second monitor was installed and began collecting data for the 2005 ozone season. Georgia has committed in the maintenance plan to continue operation of these monitors in compliance with 40 CFR part 58, and has addressed the requirement for monitoring.

e. Verification of Continued Attainment

Georgia has the legal authority to enforce and implement the requirements of the ozone maintenance plan for the Macon Area. This includes the authority to adopt, implement and enforce any subsequent emissions control contingency measures determined to be necessary to correct future ozone attainment problems.

Georgia will track the progress of the maintenance plan by performing future reviews of actual emissions for the area using the latest emissions factors, models and methodologies. For these periodic inventories Georgia will review the assumptions made for the purpose of the maintenance demonstration concerning projected growth of activity levels. If any of these assumptions appear to have changed substantially, Georgia will re-project emissions.

f. Contingency Plan

The contingency plan provisions are designed to promptly correct a violation of the NAAQS that occurs after redesignation. Section 175A of the CAA requires that a maintenance plan include such contingency measures as EPA deems necessary to assure that the state will promptly correct a violation of the NAAQS that occurs after redesignation. The maintenance plan should identify the contingency measures to be adopted, a schedule and procedure for adoption and implementation, and a time limit for action by the state. A state should also identify specific indicators to be used to determine when the contingency measures need to be implemented. The maintenance plan must include a requirement that a state will implement all measures with respect to control of the pollutant that were contained in the SIP before redesignation of the area to attainment in accordance with section 175A(d).

In the June 15, 2007, submittal, Georgia affirms that all programs instituted by the State and EPA will remain enforceable, and that sources are prohibited from reducing emissions controls following the redesignation of the Macon Area. In the submittal, if there is a measured violation of the 8-hour ozone NAAQS in the Macon Area, contingency measures would be adopted and implemented as expeditiously as possible, but no later than eighteen to twenty four months after the triggering event. The proposed schedule for these actions would be as follows:

- Six months to perform a comprehensive analysis;
- Three months to identify potential sources for reductions;
- Three months to identify applicable control measures;
- Three months to initiate a stakeholder process;
- Three months to draft SIP regulations; and
- Six months to initiate the rulemaking process. This step would include the time required to hold a public comment period, hearing, and board adoption, and submit the final plans to EPA. This process may be initiated simultaneous with drafting the regulations.

Georgia will consider one or more of the following contingency measures to re-attain the standard.

- RACM for all sources of NO_X
- RACT for all existing point sources of NO_X
- Expansion of RACM/RACT to area(s) of transport within the State
- Mobile Source Measures
- Additional NO_X reduction measures yet to be identified

EPA has concluded that the maintenance plan adequately addresses the five basic components of a maintenance plan: attainment inventory, maintenance demonstration, monitoring network, verification of continued attainment, and a contingency plan. The maintenance plan SIP revision submitted by Georgia for the Macon Area meets the requirements of section 175A of the CAA and is approvable.

VII. What Are the Proposed Regional MVEBs for the Macon Area?

Under the CAA, states are required to submit, at various times, control strategy SIPs and maintenance plans in ozone areas. These control strategy SIPs (reasonable further progress SIPs and attainment demonstration SIPs etc.) and maintenance plans create MVEBs for criteria pollutants and/or their precursors to address pollution from cars and trucks. Per 40 CFR part 93, an MVEB is established for the last year of the maintenance plan. The MVEB is the portion of the total allowable emissions in the maintenance demonstration that is allocated to highway and transit vehicle use and emissions. See, 40 CFR 93.101. The MVEB serves as a ceiling on emissions from an area's planned transportation system. The MVEB concept is further explained in the preamble to the November 24, 1993, transportation conformity rule (58 FR 62188). The preamble also describes how to establish the MVEB in the SIP and revise the MVEB.

Georgia, after interagency consultation with the transportation partners for the Macon Area, has elected to develop regional MVEBs for NO_X and VOCs for this entire area. Georgia is developing these MVEBs, as required, for the last year of its maintenance plan (2020). The MVEBs reflect the total on-road emissions for 2020, plus an allocation from the available VOCs and NO_X safety margin. Under 40 CFR 93.101, the term safety margin is the difference between the attainment level (from all sources) and the projected level of emissions (from all sources) in the maintenance plan. The safety margin can be allocated to the transportation sector; however, the total emissions must remain below the attainment level. These MVEBs and allocation from the safety margin were developed in consultation with the transportation partners and were added to account for uncertainties in population growth, changes in model VMT and new emission factor models. The regional MVEBs for the Macon Area are defined in Table 5, below.

TABLE 5.—MACON AREA MVEBS

[Tons per day]

	2020*
NO_X	14.7712
VOCs	7.8744

*Includes an allocation for the available NO_X and VOCs safety margins.

As mentioned above, Georgia has chosen to allocate a portion of the available safety margin to the 2020 MVEBs. This allocation is 9.1661 tpd for NO_X and 2.6163 tpd for VOCs. The 2020 regional MVEBs are derived as follows for NO_X: (5.6051 tpd for total mobile

emissions) + (9.1661 tpd from available safety margin) = 14.7712 tpd; and for VOCs: (5.2581 tpd for total mobile emissions) + (2.6163 tpd from available safety margin) = 7.8744 tpd. Thus, the remaining safety margin in 2020 is 27.4983 tpd for NO_X and 7.8490 tpd for VOCs.

Through this rulemaking, EPA is proposing to approve the 2020 regional MVEBs for NO_X and VOCs for the Macon Area because EPA has determined that the Area maintains the 8-hour ozone standard with the emissions at the levels of the budgets. As mentioned above, these MVEBs are regional MVEBs for the entire Macon Area. Once the new regional MVEBs for the Macon Area (the subject of this rulemaking) are approved or found adequate (whichever is done first), they must be used for future conformity determinations. As is discussed in greater detail below, EPA is also announcing the status of its adequacy determination for the proposed 2020 MVEBs for the Macon Area pursuant to 40 CFR 93.118(f)(1).

VIII. What Is the Status of EPA's Adequacy Determination for MVEBs for the Year 2020 for the Macon Area?

Under section 176(c) of the CAA, new transportation projects, such as the construction of new highways, must ''conform'' to (i.e., be consistent with) the part of the State's air quality plan that addresses pollution from cars and trucks. ''Conformity'' to the SIP means that transportation activities will not cause new air quality violations, worsen existing violations, or delay timely attainment of the NAAQS. If a transportation plan does not ''conform,'' most new projects that would expand the capacity of roadways cannot go forward. Regulations at 40 CFR part 93 set forth EPA policy, criteria, and procedures for demonstrating and assuring conformity of such transportation activities to a SIP. The regional emissions analysis is one, but not the only, requirement for implementing transportation conformity. Transportation conformity is a requirement for nonattainment and maintenance areas. Maintenance areas are areas that were previously nonattainment for a particular NAAQS but have since been redesignated to attainment with a maintenance plan for that NAAQS.

When reviewing submitted ''control strategy'' SIPs or maintenance plans containing MVEBs, EPA must affirmatively find the MVEB contained therein ''adequate'' for use in determining transportation conformity. Once EPA affirmatively finds the submitted MVEB is adequate for transportation conformity purposes, that MVEB can be used by state and Federal agencies in determining whether proposed transportation projects ''conform'' to the SIP as required by section 176(c) of the Clean Air Act.

EPA's substantive criteria for determining ''adequacy'' of an MVEB are set out in 40 CFR 93.118(e)(4). The process for determining ''adequacy'' consists of three basic steps: public notification of a SIP submission, a public comment period, and EPA's adequacy finding. This process for determining the adequacy of submitted SIP MVEBs was initially outlined in EPA's May 14, 1999, guidance, ''Conformity Guidance on Implementation of March 2, 1999, Conformity Court Decision.'' This guidance was finalized in the Transportation Conformity Rule Amendments for the ''New 8-Hour Ozone and $PM_{2.5}$ National Ambient Air Quality Standards and Miscellaneous Revisions for Existing Areas; Transportation Conformity Rule Amendments—Response to Court Decision and Additional Rule Change,'' on July 1, 2004 (69 FR 40004). EPA follows this guidance and rulemaking in making its adequacy determinations.

Georgia's maintenance plan submission contained new regional MVEBs for VOCs and NO_X for the Macon Area for the year 2020. The availability of the Georgia SIP submission with the Macon MVEBs was available for public comment on EPA's adequacy Web site on June 21, 2007, at: *http://www.epa.gov/otaq/stateresources/transconf/currsips.htm.* The EPA public comment period on adequacy of the 2020 regional MVEBs for the Macon Area closed on July 23, 2007. EPA did not receive any comments or requests for the submittal.

EPA intends to make its determination of the adequacy of the 2020 MVEBs for the Macon Area for transportation conformity purposes in the final rulemaking on the redesignation of the Macon Area. If EPA finds the 2020 MVEBs adequate and approves these MVEBs in the final rulemaking action, the new MVEBs must be used for future transportation conformity determinations. The new 2020 MVEBs, if found adequate and approved in the final rulemaking, will be effective on the date of publication of EPA's final rulemaking in the **Federal Register**. For required regional emissions analysis years that involve the year 2019 or before, the area will continue to use the interagency consultation group for this area to determine the appropriate interim test to use to demonstrate conformity. For required regional emissions analysis years that involve 2020 or beyond, the applicable budgets will be the new 2020 MVEBs. The 2020 MVEBs are defined in section VII of this rulemaking.

IX. Proposed Actions on the Redesignation Request and the Maintenance Plan SIP Revision Including Proposed Approval of the 2020 MVEBs

EPA is now proposing to make the determination that the Macon Area has met the criteria for redesignation from nonattainment to attainment for the 8-hour ozone NAAQS. Further, EPA is proposing to approve Georgia's redesignation request for the Macon Area. After evaluating Georgia's SIP submittal requesting redesignation, EPA has determined that it meets the redesignation criteria set forth in section 107(d)(3)(E) of the CAA. EPA believes that the redesignation request and monitoring data demonstrate that the Macon Area has attained, and will continue to maintain the 8-hour ozone standard.

EPA is also proposing to approve the June 15, 2007, SIP revision containing Georgia's 8-hour ozone maintenance plan for the Macon Area. The maintenance plan includes regional MVEBs for 2020 for NO_X and VOCs, among other requirements. EPA is proposing to approve the 2020 MVEBs for the Macon Area, because the maintenance plan demonstrates that expected emissions for all other source categories will continue to maintain the 8-hour ozone standard.

Further, as part of today's action, EPA is describing the status of its adequacy determination for the 2020 MVEBs in accordance with 40 CFR 93.118(f)(1). Within 24 months from the effective date of EPA's adequacy finding for the MVEBs, or the publication date for the final rule for this action, the transportation partners will need to demonstrate conformity to these new MVEBs pursuant to 40 CFR 93.104(e) as effectively amended by section 172(c)(2)(E) of the CAA as added by the Safe, Accountable, Flexible, Efficient Transportation Equity Act—A Legacy for Users (SAFETEA–LU), which was signed into law on August 10, 2005.

X. Statutory and Executive Order Reviews

Under Executive Order 12866 (58 FR 51735, October 4, 1993), this proposed action is not a ''significant regulatory action'' and therefore is not subject to review by the Office of Management and Budget. For this reason, this action is also not subject to Executive Order

13211, ''Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use'' (66 FR 28355, May 22, 2001). This proposed action merely proposes to approve state law as meeting Federal requirements and imposes no additional requirements beyond those imposed by state law. Redesignation of an area to attainment under section 107(d)(3)(e) of the CAA does not impose any new requirements on small entities. Redesignation is an action that affects the status of a geographical area and does not impose any new regulatory requirements on sources. Accordingly, the Administrator certifies that this proposed rule will not have a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*). Because this rule proposes to approve pre-existing requirements under state law and does not impose any additional enforceable duty beyond that required by state law, it does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4).

This proposed rule also does not have tribal implications because it will not have a substantial direct effect on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes, as specified by Executive Order 13175 (65 FR 67249, November 9, 2000). This action also does not have Federalism implications because it does not have substantial direct effects on the states, on the relationship between the national government and the states, or on the distribution of power and responsibilities among the various levels of government, as specified in Executive Order 13132 (64 FR 43255, August 10, 1999). This action merely affects the status of a geographical area, does not impose any new requirements on sources, or allow a state to avoid adopting or implementing other requirements and does not alter the relationship or the distribution of power and responsibilities established in the CAA. This proposed rule also is not subject to Executive Order 13045 ''Protection of Children from Environmental Health Risks and Safety Risks'' (62 FR 19885, April 23, 1997); because it is not economically significant and because the Agency does not have reason to believe that the rule concerns an environmental health risk or safety risk that may disproportionately affect children.

In reviewing SIP submissions, EPA's role is to approve state choices, provided that they meet the criteria of the CAA. In this context, in the absence of a prior existing requirement for the State to use voluntary consensus standards (VCS), EPA has no authority to disapprove a SIP submission for failure to use VCS. It would thus be inconsistent with applicable law for EPA, when it reviews a SIP submission; to use VCS in place of a SIP submission that otherwise satisfies the provisions of the CAA. Redesignation is an action that affects the status of a geographical area but does not impose any new requirements on sources. Thus, the requirements of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) do not apply. This proposed rule does not impose an information collection burden under the provisions of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

List of Subjects

40 CFR Part 52

Environmental protection, Air pollution control, Intergovernmental relations, Nitrogen dioxide, Ozone, Reporting and recordkeeping requirements, Volatile organic compounds.

40 CFR Part 81

Environmental protection, Air pollution control, National parks, Wilderness areas.

Authority: 42 U.S.C. 7401 *et seq.*

Dated: July 25, 2007.

J.I. Palmer, Jr.,

Regional Administrator, Region 4.

[FR Doc. E7–14983 Filed 8–1–07; 8:45 am]

BILLING CODE 6560–50–P

LEGAL SERVICES CORPORATION

45 CFR Part 1626

Restrictions on Legal Assistance to Aliens

AGENCY: Legal Services Corporation.

ACTION: Termination of Rulemaking and Notice of Proposed Rulemaking.

SUMMARY: LSC is terminating a rulemaking it initiated in 2001 to consider broad revisions to its regulation on restrictions on legal assistance. Contemporaneously, LSC is initiating a new rulemaking to consider a proposal of limited scope to amend section 1626.10(a) of this regulation to permit LSC grant recipients to provide legal assistance to otherwise financially eligible citizens of the Federated States of Micronesia, the Republic of the Marshall Islands and the Republic of Palau legally residing in the United States.

DATES: The open rulemaking published on September 10, 2001 (66 FR 46977) is terminated as of August 2, 2007. Comments on this NPRM are due on September 4, 2007.

ADDRESSES: Written comments on the NPRM may be submitted by mail, fax or e-mail to Mattie Cohan, Senior Assistant General Counsel, Office of Legal Affairs, Legal Services Corporation, 3333 K Street, NW., Washington, DC 20007; 202–295–1624 (ph); 202–337–6519 (fax); *mcohan@lsc.gov.*

FOR FURTHER INFORMATION CONTACT: Mattie Cohan, Senior Assistant General Counsel, 202–295–1624 (ph); *mcohan@lsc.gov.*

SUPPLEMENTARY INFORMATION:

Termination of Open Rulemaking

The LSC Board of Directors identified 45 CFR Part 1626 as an appropriate subject for rulemaking on January 27, 2001. On June 30, 2001, the LSC President and the Chair of the Operations and Regulations Committee made a determination to proceed with the initiation of a Negotiated Rulemaking to consider amendments to Part 1626. In accordance with the LSC Rulemaking Protocol, LSC published a notice in the **Federal Register** formally soliciting suggestions for appointment to the Negotiated Rulemaking Working Group from the regulated community, its clients, advocates, the organized bar and other interested parties (66 FR 46977, September 10, 2001). After receiving submissions of interest, a Working Group was appointed. Each organization which timely requested to participate was appointed to the Working Group. The Working Group met three times without coming to consensus on several issues. Subsequently, work on the 2001 rulemaking was deferred in 2003 by the previous Board of Directors pending the appointment and confirmation of the present Board. No further action on the rulemaking has been taken since that time.

During the past several years as LSC has considered its rulemaking agenda, neither Management nor recipients have suggested reinitiating work on this broad rulemaking. As such, LSC is of the opinion that consideration of broad revision of Part 1626 is no longer necessary or appropriate. Accordingly, with the publication of this notice LSC is terminating the open rulemaking.

New Notice of Proposed Rulemaking

LSC-funded legal services providers are permitted to provide legal assistance only to citizens of the United States and aliens upon whom eligibility has been expressly conferred by statute. LSC regulations at 45 CFR Part 1626 implement the various existing statutory authorities and set forth the eligibility standards based on citizenship and eligible alien status. Since 1996 Part 1626 has limited the eligibility of citizens of the Republic of the Marshall Islands (''RMI'') and the Federated States of Micronesia (''FSM'') and the Republic of Palau to services provided in those respective nations (unless the applicant is otherwise eligible under Part 1626). In connection with LSC's development of a 2007 Rulemaking Agenda, the Legal Aid Society of Hawai'i (LASH) and Legal Aid of Arkansas (LAA) have both requested that LSC engage in rulemaking to change the section 1626.10(a) to provide for the eligibility of citizens of RMI, FSM and Palau legally residing in the United States for legal assistance from LSC-funded programs.

LSC agrees that there is sufficient reason and authority for LSC to amend its regulation in this regard. To that end, the Operations and Regulations Committee of the LSC Board of Directors considered a Draft NPRM and the Board of Directors approved this NPRM for publication and comment at their respective meetings on July 28, 2007.

History of FAS Eligibility for Legal Assistance From LSC-Funded Programs

At the time of the creation of LSC in 1974, the countries that are now the sovereign nations of the Republic of the Marshall Islands (''RMI''), the Federated States of Micronesia (''FSM''), and the Republic of Palau were possessions of the United States, known as the Trust Territories of the Pacific Islands (''the Trust Territories''). The LSC Act defined the Trust Territories as a ''State'' for the purposes of the Act. The Act thus conferred eligibility for LSC-funded legal services to Trust Territory residents to the same extent provided to residents of any other State of the United States. Section 1002(8) of the LSC Act, 42 U.S.C. 2996a(8).

In 1983, Congress placed the first statutory restrictions on representation of aliens on LSC recipients in LSC's appropriations bill for that year, Public Law 97–377. That law provided that none of the funds appropriated could be expended to provide legal assistance for or on behalf of any alien unless the alien was a resident of the U.S. and otherwise met certain statutorily specified criteria. On its face, this language would have appeared to imply that all non-U.S. citizens, including residents of RMI, FSM and Palau would be subject to these restrictions, notwithstanding their eligibility under the LSC Act. To deal with this problem, LSC included a ''special eligibility section'' (§ 1626.10) in the implementing regulations on representation of aliens, 45 CFR part 1626, to exempt residents of the Trust Territory from the alien restrictions imposed by Congress.

In 1986 the trust governing the relationship between the U.S. and the Trust Territories was terminated. At that time the former Trust Territories were recognized as independent nations and a new relationship with RMI, FSM and Palau was created by the signing of two Compacts of Free Association, one with RMI and FSM and the other with Palau. The Compact with RMI and FSM contemplates the provision of certain services and programs of the U.S. to those nations. Specifically, section 224 of the Compact of Free Association with RMI and FSM provides that:

> The Government of the United States and the Government of the Marshall Islands or the Federated States of Micronesia may agree from time to time to the extension of additional United States grant assistance, services and programs as provided by the laws of the United States, to the Marshall Islands or the Federated States of Micronesia, respectively.

The Compact of Free Association Act of 1985 (''CFA Act'') (Pub. L. 99–239, codified at 48 U.S.C. 1901 *et seq.*), which implemented the Compact, provides express authority for the provision of LSC-funded legal services. Specifically, section 105(h)(1)(A) of the CFA Act provides that:

> * * * pursuant to section 224 of the Compact the programs and services of the [Legal Services Corporation] shall be made available to the Federated States of Micronesia and to the Marshall Islands.

The implementing act for the Compact with Palau makes section 105 of the CFA Act applicable to the Republic of Palau. 48 U.S.C. 1932(b).[1]

After the signing of the respective Compacts and the corresponding implementing statutes, the FAS remained covered by the special eligibility section of Part 1626, notwithstanding their change in legal status vis-à-vis their relationship with the United States. In 1989 that section of the regulation was amended to make the section more precise in light of the termination of the trust. Under this version of the rule, the special eligibility section provided:

> (a) *Micronesia.* The alien restriction stated in the appropriations acts is not applicable to the legal services program in the following Pacific island entities:
> (1) Commonwealth of the Northern Marianas;
> (2) Republic of Palau;
> (3) Federated States of Micronesia;
> (4) Republic of the Marshall Islands
> All citizens of these entities are eligible to receive legal assistance, provided they are otherwise eligible under the [LSC] Act.

54 FR 18812 (April 29, 1989). The preamble to the Final Rule adopting this language explained that this change was intended to ''restate[] congressional intent that residents of these political entities be eligible to be clients of a legal services program.'' Id. at 18110. The special eligibility section addressing the FAS remained as set forth above until 1996.

As a result of new statutory restrictions contained in the LSC FY 1996 appropriations legislation (Pub. L. 104–134), additional changes to Part 1626 were made in 1996. Although the statutory amendments did not address this issue, § 1626.10(a) was again revised, this time in response to comments from the LSC Office of Inspector General (OIG). As explained in the preamble to the 1996 Final Rule:

> The OIG suggested that both the prior rule and the interim rule dealt with the question of special eligibility incorrectly and urged that the final rule refer only to the legal services programs serving people who were citizens of those jurisdictions. The effect of this change would be to make financially eligible citizens of the Federated States of Micronesia, the Republic of the Marshall Islands and the Republic of Palau only eligible for legal services from the recipients serving those areas * * *. They would not be eligible for services from any other recipients unless they also came within one of the categories of eligible aliens listed in section 1626.5 * * *.

62 FR 19413 (April 21, 1997). The OIG's comments were based upon its interpretation of the CFA Act that the language of the CFA Act provides authority for the provision of services within those nations, but does not expressly confer individual eligibility for services to the citizens of those nations without reference to where the service is to be provided. The Board considered the matter, agreed with the OIG analysis, and revised § 1626.10(a) as follows.

> This part [1626] is not applicable to recipients providing services in the Commonwealth of the Northern Mariana Islands, the Republic of Palau, the Federated

[1] RMI, FSM and Palau are collectively referred to as the ''Freely Associated States'' or ''FAS.'' This designation will be used throughout the remainder of the supplementary information section.

States of Micronesia, or the Republic of the Marshall Islands.

62 FR 19413 (April 21, 1997); 45 CFR 1626.10(a). Thus, since 1996 otherwise financially eligible residents of the FAS seeking assistance from legal services providers in the United States may only receive such assistance if they meet the alien eligibility requirements of § 1626.5.

Alternative Interpretation of the Compact Act

During the last session of Congress, legislation was passed in the Senate by unanimous consent on September 29, 2006, which would have definitively clarified the issue by clearly stating that LSC services were to be available to the citizens of the FAS. Specifically, section 5 of S.1830, provided:

SEC. 5. AVAILABILITY OF LEGAL SERVICES.

Section 105(f)(1)(C) of the Compact of Free Association Amendments Act of 2003 (48 U.S.C. 1921d(f)(1)(C)) is amended by inserting before the period at the end the following: '', which shall also continue to be available to the citizens of the Federated States of Micronesia, the Republic of Palau, and the Republic of the Marshall Islands who legally reside in the United States (including territories and possessions)''.

The report accompanying S.1830 explained that:

Section 5 clarifies that section 105(f)(1)(C) of the CFAAA is intended to continue eligibility for the programs and services of the Legal Services Corporation for FSM and RMI migrants who legally reside in the United States. Legal Services Corporation eligibility was extended by the first Compact Act in 1986 (Pub. L. 99–239), but in 1996, without any further action by Congress, the Legal Services Corporation, by rule, terminated the eligibility of FSM and RMI migrants. Section 104(e) of the original Compact Act, and of the CFAAA, state that it is 'not the intent of Congress to cause any adverse consequences for an affected area,' which are defined as Hawaii, Guam, the CNMI, and American Samoa. The Legal Services Corporation is one of those programs which had assisted local communities, in both the 'affected areas' and in the mainland U.S., in responding to the impacts and needs of FSM and RMI citizens who were residing in U.S. communities. This section would restore eligibility as it existed from 1986 to 1996.

Similar legislation was introduced in the House, but was not acted on during the course of the 109th Congress. Accordingly, there was no final legislation enacted into law on this subject in the last Congress. More recently, on January 12, 2007, S. 283, the Compact of Free Association Amendments Act was introduced in the Senate. On February 15, 2007, the bill was reported out of the Senate Committee on Energy and Natural Resources, accompanied by a written report. The operative language of the bill and report dealing with the availability of legal assistance from LSC recipients to citizens of the FAS, regardless of where they are obtaining those services, is the same as in last year's Senate bill (quoted above). A similar bill, H.R. 2705, has also been introduced in the House. As of the publication of this notice, both of the bills are still pending.

In addition, LSC received a letter dated June 1, 2007, from David Cohen, Deputy Assistant Secretary for Insular Affairs at the Department of Interior. In his letter, Deputy Assistant Secretary Cohen stated:

I can assure you that it is consistent with Federal policy under the Compacts and the [implementing] public laws * * * to allow FAS citizens lawfully resident in the United States to receive LSC services. * * * We are not aware of any intention to permit the extension of LSC benefits to FAS citizens in the FAS but to prevent the extension of those benefits to FAS citizens during their lawful residence in the United States.

Subsequently, representatives of LSC met with the Deputy Assistant Secretary, several members of his staff and an attorney from the Department of State. They reiterated their understanding of the Compact and the CFA Act. In particular, they explained that the United States and the FAS countries negotiated the Compacts as essentially an aid package and that the Departments of Interior and State, as well as the FAS nations themselves, consider the extension of benefits to the FAS to include the extension of benefits to FAS citizens, regardless of where those citizens are lawfully residing (in the FAS or the United States). As an example, they noted that the CFA Act extends the Pell Grant (educational grants) program to the FAS and that the grants are provided to FAS citizens regardless of whether they are attending institutions of higher education in the FAS or in the United States. Similarly, FAS citizens are eligible for Job Corps services being provided in the United States.

In light of the above, it would appear that LSC's interpretation of the CFA Act, while permissible, was not the only permissible reading and perhaps, in hindsight, not the best available reading. Moreover, LSC appears to be within its legal authority under the law to amend § 1626.10 to permit FAS citizens to receive legal assistance anywhere LSC services are provided without requiring independent eligibility under Part 1626.

Need for Amendment of the Regulation—FAS Citizens in the United States

When LSC was created in 1974, there were probably no more than a few thousand Micronesians living in Guam and Hawai'i, and a scattering in the continental United States. Even when the first Compact was negotiated in 1986, there were probably still less than ten thousand Micronesians living within U.S. territory, still mostly in Guam and Honolulu. However, when the Compact was renegotiated and extended in 2002 it was then known that the migration pattern was showing greatly increased numbers in the continental United States. According to the Embassy of FSM there are, in addition to the traditionally high populations of Micronesians in Guam and Hawai'i, at least 30,000 to 40,000 FSM citizens living or going to school in the continental U.S. Further, LAA has noted in its request to LSC for rulemaking on this issue that there are also 6,000 to 10,000 Marshallese living in Northwest Arkansas alone.

Thus, while there was relatively little demand for legal services among FAS citizens in the United States in 1996, the increased migration of FAS citizens to the United States has significantly increased the potential demand for legal services among members of that community. The inability of financially eligible FAS citizens in the U.S. to access legal services from LSC programs assistance is a growing problem for the U.S. FAS community. LASH, for example, has noted that that FAS citizens working in Hawai'i are more likely to be victims of unscrupulous employers because they believe that such citizens have little recourse to legal services to protect their employment rights.

Proposed Amendment of Section 1626.10(a)

LSC is proposing to amend section 1626.10(a) to redesignate the existing language in paragraph (a) as paragraph (a)(1) and to add a new paragraph (a)(2) to read as follows: ''All citizens of the Republic of Palau, the Federated States of Micronesia, and the Republic of the Marshall Islands residing in the United States are eligible to receive legal assistance provided that are they otherwise eligible under the Act.'' This language makes explicit that FAS citizens are eligible under Part 1626 for legal assistance and is consistent with the other eligibility provision in section 1626.10 addressing the eligibility of Canadian-born American Indians at least 50% Indians by blood, members of

the Texas Band of Kickapoo and foreign nationals seeing assistance pursuant to the Hague Convention. 45 CFR 1626.10(b); 1626.10(c); and 1626.10(d). The ''otherwise eligible'' language is meant to refer to financial eligibility (for the provision of LSC-funded legal assistance'') and to the permissibility of the legal assistance provided under applicable law and regulation.

List of Subjects in 45 CFR Part 1626

Aliens, Grant programs—law, Legal services, Migrant labor, Reporting and recordkeeping requirements.

For reasons set forth above, and under the authority of 42 U.S.C. 2996g(e), LSC proposes to amend 45 CFR Part 1626 as follows:

PART 1626—Restrictions on Legal Assistance to Aliens

1. The authority citation for part 1626 continues to read as follows:

Authority: Pub. L. 104–208, 110 Stat 1321; Pub L. 104–134, 110 Stat. 3009.

2. Amend § 1626.10 by revising paragraph (a) to read as follows:

§ 1626.10 Special eligibility questions.

(a)(1) This part is not applicable to recipients providing services in the Commonwealth of the Northern Mariana Islands, the Republic of Palau, the Federated States of Micronesia, or the Republic of the Marshall Islands.

(2) All citizens of the Republic of Palau, the Federated States of Micronesia, and the Republic of the Marshall Islands residing in the United States are eligible to receive legal assistance provided that are they otherwise eligible under the Act.

* * * * *

Victor M. Fortuno,

Vice President and General Counsel.

[FR Doc. E7–15043 Filed 8–1–07; 8:45 am]

BILLING CODE 7050–01–P

DEPARTMENT OF DEFENSE

Defense Acquisition Regulations System

48 CFR Parts 216, 232, and 252

RIN 0750–AF71

Defense Federal Acquisition Regulation Supplement; Payments on Cost-Reimbursement Contracts for Services (DFARS Case 2006–D066)

AGENCY: Defense Acquisition Regulations System, Department of Defense (DoD).

ACTION: Proposed rule with request for comments.

SUMMARY: DoD is proposing to amend the Defense Federal Acquisition Regulation Supplement (DFARS) to provide for interim payments under cost-reimbursement contracts for services within 30 days, instead of the current DoD policy of making payments within 14 days. The change will not apply to small business concerns.

DATES: Comments on the proposed rule should be submitted in writing to the address shown below on or before October 1, 2007, to be considered in the formation of the final rule.

ADDRESSES: You may submit comments, identified by DFARS Case 2006–D066, using any of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.
- *E-mail: dfars@osd.mil.* Include DFARS Case 2006–D066 in the subject line of the message.
- *Fax:* (703) 602–7887.
- *Mail:* Defense Acquisition Regulations System, Attn: Mr. John McPherson, OUSD(AT&L)DPAP(CPF), IMD 3C132, 3062 Defense Pentagon, Washington, DC 20301–3062.
- *Hand Delivery/Courier:* Defense Acquisition Regulations System, Crystal Square 4, Suite 200A, 241 18th Street, Arlington, VA 22202–3402.

Comments received generally will be posted without change to *http://www.regulations.gov,* including any personal information provided.

FOR FURTHER INFORMATION CONTACT: Mr. John McPherson, (703) 602–0296.

SUPPLEMENTARY INFORMATION:

A. Background

DFARS 232.906 presently provides for interim payments on cost-reimbursement contracts for services within 14 days after receipt of a proper payment request. The proposed rule would revise this policy to provide for payment to other than small business concerns within 30 days. The proposed change will allow DoD to better cash manage payments without having a significant impact on small business concerns. The proposed change is consistent with the policies of other Government agencies, which do not pay in 14 days. These payments are subject to the Prompt Payment Act.

This proposed rule was not subject to Office of Management and Budget review under Executive Order 12866, dated September 30, 1993.

B. Regulatory Flexibility Act

DoD does not expect this proposed rule to have a significant economic impact on a substantial number of small entities within the meaning of the Regulatory Flexibility Act, 5 U.S.C. 601, *et seq.*, because the proposed rule makes no change to payment procedures for small business concerns. Therefore, DoD has not performed an initial regulatory flexibility analysis. DoD invites comments from small businesses and other interested parties. DoD also will consider comments from small entities concerning the affected DFARS subparts in accordance with 5 U.S.C. 610. Such comments should be submitted separately and should cite DFARS Case 2006–D066.

C. Paperwork Reduction Act

The Paperwork Reduction Act does not apply, because the proposed rule does not impose any information collection requirements that require the approval of the Office of Management and Budget under 44 U.S.C. 3501, *et seq.*

List of Subjects in 48 CFR Parts 216, 232, and 252

Government procurement.

Michele P. Peterson,

Editor, Defense Acquisition Regulations System.

Therefore, DoD proposes to amend 48 CFR Parts 216, 232, and 252 as follows:

1. The authority citation for 48 CFR Parts 216, 232, and 252 continues to read as follows:

Authority: 41 U.S.C. 421 and 48 CFR Chapter 1.

PART 216—TYPES OF CONTRACTS

2. Section 216.307 is added to read as follows:

216.307 Contract clauses.

(a)(i) The following apply to interim payments on cost-reimbursement contracts for services:

(A) For contracts with other than small business concerns, insert the standard due date of the ''30th'' day in paragraph (a)(3) of the clause at FAR 52.216–7.

(B) For contracts with small business concerns, insert the ''14th'' day in paragraph (a)(3) of the clause at FAR 52.216–7.

(ii) For interim payments on cost-reimbursement contracts for other than services, insert the ''14th'' day in paragraph (a)(3) of the clause at FAR 52.216–7.

PART 232—CONTRACT FINANCING

3. Section 232.906 is revised to read as follows:

232.906 Making payments.

(a)(i) The restrictions of FAR 32.906 prohibiting early payment do not apply to interim payments made to small business concerns. However, contractors shall not be entitled to interest penalties if the Government fails to make early payment.

(ii) It is DoD policy to make payments within 14 days for cost-reimbursement contracts for services with small business concerns.

4. Section 232.908 is added to read as follows:

232.908 Contract clauses.

(c)(3) For cost-reimbursement contracts for services with small business concerns, use the clause at 252.232–7XXX, Payments on Cost-Reimbursement Contracts for Services with Small Business Concerns, instead of Alternate I of the clause at FAR 52.232–25.

PART 252—SOLICITATION PROVISIONS AND CONTRACT CLAUSES

5. Section 252.232–7XXX is added to read as follows:

252.232–7XXX Payments on Cost-Reimbursement Contracts for Services with Small Business Concerns.

As prescribed in 232.908(c)(3), use the following clause:

PAYMENTS ON COST-REIMBURSEMENT CONTRACTS FOR SERVICES WITH SMALL BUSINESS CONCERNS (XXX 2007)

(a) Paragraphs (a)(2), (a)(3), (a)(4)(ii), (a)(4)(iii), and (a)(5)(i) of the Allowable Cost and Payment clause (FAR 52.216–7) do not apply to this contract.

(b) Although accelerated payments may be made in 14 days in accordance with section 232.906(a)(ii) of the Defense Federal Acquisition Regulation Supplement, for purposes of computing late payment interest penalties that may apply, the due date for payment is the 30th day after the designated billing office receives a proper payment request.

(c) The Contractor shall submit requests for interim payments in accordance with paragraph (a) of FAR 52.216–7, Allowable Cost and Payment. If the payment request does not comply with contract requirements, it will be returned within 7 days after the date the designated billing office received the request.

(End of clause)

[FR Doc. E7–14921 Filed 8–1–07; 8:45 am]

BILLING CODE 5001–08–P

DEPARTMENT OF DEFENSE

Defense Acquisition Regulations System

48 CFR Part 252

RIN 0750–AF73

Defense Federal Acquisition Regulation Supplement; Item Identification and Valuation Clause Update (DFARS Case 2007–D007)

AGENCY: Defense Acquisition Regulations System, Department of Defense (DoD).

ACTION: Proposed rule with request for comments.

SUMMARY: DoD is proposing to amend the Defense Federal Acquisition Regulation Supplement (DFARS) to update and clarify requirements for unique identification and valuation of items delivered under DoD contracts. The proposed rule revises the applicable contract clause to reflect the current requirements.

DATES: Comments on the proposed rule should be submitted in writing to the address shown below on or before October 1, 2007, to be considered in the formation of the final rule.

ADDRESSES: You may submit comments, identified by DFARS Case 2007–D007, using any of the following methods:

Federal eRulemaking Portal: http://www.regulations.gov. Follow the instructions for submitting comments.

E-mail: dfars@osd.mil. Include DFARS Case 2007–D007 in the subject line of the message.

Fax: (703) 602–7887.

Mail: Defense Acquisition Regulations System, Attn: Mr. Gary Delaney, OUSD(AT&L)DPAP(DARS), IMD 3C132, 3062 Defense Pentagon, Washington, DC 20301–3062.

Hand Delivery/Courier: Defense Acquisition Regulations System, Crystal Square 4, Suite 200A, 241 18th Street, Arlington, VA 22202–3402.

Comments received generally will be posted without change to *http://www.regulations.gov,* including any personal information provided.

FOR FURTHER INFORMATION CONTACT: Mr. Gary Delaney, (703) 602–8384.

SUPPLEMENTARY INFORMATION:

A. Background

The contract clause at DFARS 252.211–7003, Item Identification and Valuation, requires unique identification for all delivered items for which the Government's unit acquisition cost is $5,000 or more, and for other items designated by the Government. In addition, the clause requires identification of the Government's unit acquisition cost for all delivered items, and provides instructions to contractors regarding the identification and valuation processes.

This proposed rule revises the clause at DFARS 252.211–7003 to update and clarify instructions for the identification and valuation processes. The changes include: Updating of references to standards and other documents; clarification of the definition of unique item identifier; specifically addressing the DoD recognized unique identification equivalent, where applicable; clarification of data submission requirements for end items and embedded items; and clarification of requirements for inclusion of the clause in subcontracts.

This proposed rule was not subject to Office of Management and Budget review under Executive Order 12866, dated September 30, 1993.

B. Regulatory Flexibility Act

DoD does not expect this proposed rule to have a significant economic impact on a substantial number of small entities within the meaning of the Regulatory Flexibility Act, 5 U.S.C. 601, *et seq.*, because the proposed rule does not significantly change existing requirements relating to the identification and valuation of items delivered under DoD contracts. Therefore, DoD has not performed an initial regulatory flexibility analysis. DoD invites comments from small businesses and other interested parties. DoD also will consider comments from small entities concerning the affected DFARS subpart in accordance with 5 U.S.C. 610. Such comments should be submitted separately and should cite DFARS Case 2007–D007.

C. Paperwork Reduction Act

The Paperwork Reduction Act does not apply, because the proposed rule does not impose any information collection requirements that require the approval of the Office of Management and Budget under 44 U.S.C. 3501, *et seq.*

List of Subjects in 48 CFR Part 252

Government procurement.

Michele P. Peterson,

Editor, Defense Acquisition Regulations System.

Therefore, DoD proposes to amend 48 CFR Part 252 as follows:

PART 252—SOLICITATION PROVISIONS AND CONTRACT CLAUSES

1. The authority citation for 48 CFR Part 252 continues to read as follows:

Authority: 41 U.S.C. 421 and 48 CFR Chapter 1.

2. Section 252.211–7003 is amended as follows:

a. By revising the clause date;

b. In paragraph (a), by revising the definitions of ''Issuing agency'' and ''Unique item identifier''; and

c. By revising paragraphs (c) through (g) to read as follows:

252.211–7003 Item Identification and Valuation.

* * * * *

Item Identification and Valuation (XXX 2007)

(a) * * *

Issuing agency means an organization responsible for assigning a non-repeatable identifier to an enterprise (i.e., Dun & Bradstreet's Data Universal Numbering System (DUNS) Number, GS1 Company Prefix, or Defense Logistics Information System (DLIS) Commercial and Government Entity (CAGE) Code).

* * * * *

Unique item identifier means a set of data elements marked on items that is globally unique and unambiguous. The term includes a concatenated unique item identifier or a DoD recognized unique identification equivalent.

* * * * *

(c) *Unique item identifier.*

(1) The Contractor shall provide a unique item identifier for—(i) All delivered items for which the Government's unit acquisition cost is $5,000 or more;

(ii) The following items for which the Government's unit acquisition cost is less than $5,000:

Contract line, subline, or exhibit line item number	Item description

(iii) Subassemblies, components, and parts embedded within delivered items as specified in Attachment Number _.

(2) The unique item identifier and the component data elements of the DoD unique item identification shall not change over the life of the item.

(3) *Data syntax and semantics of unique item identifiers.* The Contractor shall ensure that—

(i) The encoded data elements (except issuing agency code) of the unique item identifier are marked on the item using one of the following three types of data qualifiers, as determined by the Contractor:

(A) Application Identifiers (AIs) (Format Indicator 05 of ISO/IEC International Standard 15434), in accordance with ISO/IEC International Standard 15418, Information Technology—EAN/UCC Application Identifiers and Fact Data Identifiers and Maintenance and ANSI MH 10.8.2 Data Identifier and Application Identifier Standard.

(B) Data Identifiers (DIs) (Format Indicator 06 of ISO/IEC International Standard 15434), in accordance with ISO/IEC International Standard 15418, Information Technology—EAN/UCC Application Identifiers and Fact Data Identifiers and Maintenance and ANSI MH 10.8.2 Data Identifier and Application Identifier Standard.

(C) Text Element Identifiers (TEIs) (Format Indicator 12 of ISO/IEC International Standard 15434), in accordance with the Air Transport Association Common Support Data Dictionary; and

(ii) The encoded data elements of the unique item identifier conform to the transfer structure, syntax, and coding of messages and data formats specified for Format Indicators 05, 06, and 12 in ISO/IEC International Standard 15434, Information Technology—Transfer Syntax for High Capacity Automatic Data Capture Media.

(4) *Unique item identifier.*

(i) The Contractor shall—(A) Determine whether to—(1) Serialize within the enterprise identifier;

(2) Serialize within the part, lot, or batch number; or

(3) Use a DoD recognized unique identification equivalent; and

(B) Place the data elements of the unique item identifier (enterprise identifier; serial number; DoD recognized unique identification equivalent; and for serialization within the part, lot, or batch number only: original part, lot, or batch number) on items requiring marking by paragraph (c)(1) of this clause, based on the criteria provided in the version of MIL–STD–130, Identification Marking of U.S. Military Property, cited in the contract Schedule.

(ii) The issuing agency code—

(A) Shall not be placed on the item; and

(B) Shall be derived from the data qualifier for the enterprise identifier.

(d) For each item that requires unique item identification under paragraph (c)(1)(i) or (ii) of this clause, in addition to the information provided as part of the Material Inspection and Receiving Report specified elsewhere in this contract, the Contractor shall report at the time of delivery, either as part of, or associated with, the Material Inspection and Receiving Report, the following information:

(1) Unique item identifier.

(2) Unique item identifier type.

(3) Issuing agency code (if concatenated unique item identifier is used).

(4) Enterprise identifier (if concatenated unique item identifier is used).

(5) Original part number (if there is serialization within the original part number).

(6) Lot or batch number (if there is serialization within the lot or batch number).

(7) Current part number (optional and only if not the same as the original part number).

(8) Current part number effective date (optional and only if current part number is used).

(9) Serial number (if concatenated unique item identifier is used).

(10) Government's unit acquisition cost.

(11) Unit of measure.

(e) For embedded subassemblies, components, and parts that require DoD unique item identification under paragraph (c)(1)(iii) of this clause, the Contractor shall report as part of, or

associated with, the Material Inspection and Receiving Report specified elsewhere in this contract, the following information:

(1) Unique item identifier of the parent item under paragraph (c)(1) of this clause that contains the embedded subassembly, component, or part.

(2) Unique item identifier of the embedded subassembly, component, or part.

(3) Unique item identifier type.**

(4) Issuing agency code (if concatenated unique item identifier is used).**

(5) Enterprise identifier (if concatenated unique item identifier is used).**

(6) Original part number (if there is serialization within the original part number).**

(7) Lot or batch number (if there is serialization within the lot or batch number).**

(8) Current part number (optional and only if not the same as the original part number).**

(9) Current part number effective date (optional and only if current part number is used).**

(10) Serial number (if concatenated unique item identifier is used).**

(11) Description.

** Once per item.

(f) The Contractor shall submit the information required by paragraphs (d) and (e) of this clause in accordance with the data submission procedures at *http://www.acq.osd.mil/dpap/UID/DataSubmission.htm.*

(g) *Subcontracts.* If the Contractor acquires by subcontract, any item(s) for which unique item identification is required in accordance with paragraph (c)(1) of this clause, the Contractor shall include this clause, including this paragraph (g), in the applicable subcontract(s).

* * * * *

[FR Doc. E7–14896 Filed 8–1–07; 8:45 am]

BILLING CODE 5001–08–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 679

[I.D. 013006I]

RIN 0648–AU93

Fisheries of the Exclusive Economic Zone Off Alaska; Groundfish, Crab, Salmon, and Scallop Fisheries of the Bering Sea and Aleutian Islands Management Area and Gulf of Alaska, Essential Fish Habitat Rule Correction

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice of reopening of a comment period.

SUMMARY: On June 19, 2007, NMFS published a proposed rule in the **Federal Register** to correct certain provisions of a June 28, 2006, essential fish habitat (EFH) rule for Alaska fisheries. The comment period deadline for written comments for the proposed rule was June 19, 2007. NMFS is reopening the comment period on this proposed rule because the E-mail account listed in the proposed rule for the submission of comments was in error and did not accept comments as intended. The proposed rule would clarify that portions of EFH management areas in the vicinity of the Aleutian Islands are located in State of Alaska waters. The proposed action also would apply EFH vessel monitoring system and closure requirements to federally permitted vessels operating in State of Alaska waters adjacent to the Gulf of Alaska (GOA) and Aleutian Islands subarea. This action is necessary to ensure federally permitted vessels operating in State of Alaska waters comply with EFH protection measures.

DATES: Written comments must be received by September 4, 2007.

ADDRESSES: Send comments to Sue Salveson, Assistant Regional Administrator, Sustainable Fisheries Division, Alaska Region, NMFS, Attn: Records Officer. Comments may be submitted by:

- Mail: P.O. Box 21668, Juneau, AK 99802;
- Hand delivery: 709 West 9th Street, Room 420A, Juneau, AK;
- Fax: 907–586–7557;
- E-mail: *VMS-PR–0648–AU93@noaa.gov*. Include in the subject line the following document identifier: ''VMS PR.'' E-mail comments, with or without attachments, are limited to 5 megabytes; or
- Webform at the Federal eRulemaking Portal: *http://www.regulations.gov*. Follow the instructions at that site for submitting comments.

FOR FURTHER INFORMATION CONTACT: Melanie Brown, 907–586–7228 or e-mail at *melanie.brown@noaa.gov*.

SUPPLEMENTARY INFORMATION: The proposed rule was published in the **Federal Register** on June 19, 2007 (72 FR 33732). Additional information on the proposed management measures are described in the proposed rule.

Dated: July 30, 2007.

Emily H. Menashes,

Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. E7–15045 Filed 8–1–07; 8:45 am]

BILLING CODE 3510–22–S

Notices

Federal Register
Vol. 72, No. 148
Thursday, August 2, 2007

This section of the FEDERAL REGISTER contains documents other than rules or proposed rules that are applicable to the public. Notices of hearings and investigations, committee meetings, agency decisions and rulings, delegations of authority, filing of petitions and applications and agency statements of organization and functions are examples of documents appearing in this section.

DEPARTMENT OF AGRICULTURE

Submission for OMB Review; Comment Request

July 30, 2007.

The Department of Agriculture has submitted the following information collection requirement(s) to OMB for review and clearance under the Paperwork Reduction Act of 1995, Public Law 104–13. Comments regarding (a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; (b) the accuracy of the agency's estimate of burden including the validity of the methodology and assumptions used; (c) ways to enhance the quality, utility and clarity of the information to be collected; (d) ways to minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology should be addressed to: Desk Officer for Agriculture, Office of Information and Regulatory Affairs, Office of Management and Budget (OMB), *OIRA_Submission@OMB.EOP.GOV* or fax (202) 395–5806 and to Departmental Clearance Office, USDA, OCIO, Mail Stop 7602, Washington, DC 20250–7602. Comments regarding these information collections are best assured of having their full effect if received within 30 days of this notification. Copies of the submission(s) may be obtained by calling (202) 720–8958.

An agency may not conduct or sponsor a collection of information unless the collection of information displays a currently valid OMB control number and the agency informs potential persons who are to respond to the collection of information that such persons are not required to respond to the collection of information unless it displays a currently valid OMB control number.

Animal and Plant Health Inspection Service,

Title: Blood and Tissue Collection at Slaughtering Establishments

OMB Control Number: 0579–0212

Summary of Collection: Title 21, U.S.C. 117, Animal Industry Act of 1884, authorizes the Secretary to prevent, control and eliminate domestic diseases such as brucellosis and chronic wasting disease, as well as to take action to prevent and to manage exotic diseases such as foot-and-mouth disease, rinderpest, and other foreign animal diseases. Regulations in 9 CFR, subchapter C, part 71, provide for the collection of blood and tissue samples from livestock (horses, cattle, bison, captive cervids, sheep and goats, swine, and other farmed animals) and poultry at slaughter. Disease surveillance plays an important role in the APHIS mission of protecting the health of the U.S. livestock and poultry population, and testing animals for disease is an important surveillance tool. The Animal and Plant Health Inspection Service (APHIS) will collect information using VS form 10–4 and 10–4A, Specimen Submission Form and Supplemental Sheet and VS form 10–5, Facility Inspection Report.

Need and Use of the Information: APHIS will collect information to identify specimens (blood and tissue) submitted for laboratory analysis and to identify the individual animal from which the specimen was taken as well as the animal's herd or flock; the type of specimen submitted, and the purpose for submitting the specimen. Without the information contained on the form, personnel at the National Veterinary Services Laboratories or other Federal laboratories would have no way of identifying or processing the specimens being sent to them for analysis.

Description of Respondents: Business or other for-profit.

Number of Respondents: 155.

Frequency of Responses: Reporting: On occasion.

Total Burden Hours: 4,209.

Ruth Brown,

Departmental Information Collection Clearance Officer.

[FR Doc. E7–15010 Filed 8–1–07; 8:45 am]

BILLING CODE 3410–34–P

DEPARTMENT OF AGRICULTURE

Animal and Plant Health Inspection Service

[Docket No. APHIS–2007–0083]

Notice of Request for Extension of Approval of an Information Collection; Virus-Serum-Toxin Act and Regulations

AGENCY: Animal and Plant Health Inspection Service, USDA.

ACTION: Extension of approval of an information collection; comment request.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, this notice announces the Animal and Plant Health Inspection Service's intention to request an extension of approval of an information collection associated with the Virus-Serum-Toxin Act and regulations.

DATES: We will consider all comments that we receive on or October 1, 2007.

ADDRESSES: You may submit comments by either of the following methods: *Federal eRulemaking Portal:* Go to *http://www.regulations.gov,* select ''Animal and Plant Health Inspection Service'' from the agency drop-down menu, then click ''Submit.'' In the Docket ID column, select APHIS–2007–0083 to submit or view public comments and to view supporting and related materials available electronically. Information on using Regulations.gov, including instructions for accessing documents, submitting comments, and viewing the docket after the close of the comment period, is available through the site's ''User Tips'' link.

Postal Mail/Commercial Delivery: Please send four copies of your comment (an original and three copies) to Docket No. APHIS–2007–0083, Regulatory Analysis and Development, PPD, APHIS, Station 3A–03.8, 4700 River Road Unit 118, Riverdale, MD 20737–1238. Please state that your comment refers to Docket No. APHIS–2007–0083.

Reading Room: You may read any comments that we receive on this docket in our reading room. The reading room is located in room 1141 of the USDA South Building, 14th Street and Independence Avenue SW., Washington, DC. Normal reading room

hours are 8 a.m. to 4:30 p.m., Monday through Friday, except holidays. To be sure someone is there to help you, please call (202) 690–2817 before coming.

Other Information: Additional information about APHIS and its programs is available on the Internet at *http://www.aphis.usda.gov.*

FOR FURTHER INFORMATION CONTACT: For information on the Virus-Serum-Toxin Act and regulations, contact Dr. Albert Morgan, Section Leader, Operational Support Staff, Center for Veterinary Biologics, VS, APHIS, 4700 River Road Unit 148, Riverdale MD 20737, (301) 734–8245. For copies of more detailed information on the information collection, contact Mrs. Celeste Sickles, APHIS' Information Collection Coordinator, at (301) 734–7477.

SUPPLEMENTARY INFORMATION:

Title: Virus-Serum-Toxin Act and Regulations.

OMB Number: 0579–0013.

Type of Request: Extension of approval of an information collection.

Abstract: The Animal and Plant Health Inspection Service (APHIS) of the U.S. Department of Agriculture is responsible for ensuring that veterinary biological products are pure, safe, potent, and effective. This program is conducted under the Virus-Serum-Toxin Act (21 U.S.C. 151 *et seq.*) and the regulations in 9 CFR, chapter I, subchapter E. Veterinary biological products are defined as all viruses, serums, toxins (excluding substances that are selectively toxic to microorganisms, e.g., antibiotics), or analogous products at any stage of production, shipment, distribution, or sale, which are intended for use in the treatment of animals and which act primarily through the direct stimulation, supplementation, enhancement, or modulation of the immune system or immune response. The term ''biological products'' includes, but is not limited to, vaccines, bacterins, allergens, antibodies, antitoxins, toxoids, immunostimulants, certain cytokines, antigenic or immunizing components of live organisms, and diagnostic components that are of natural or synthetic origin or that are derived from synthesizing or altering various substances or components of substances, such as microorganisms, genes or genetic sequences, carbohydrates, proteins, antigens, allergens, or antibodies.

To accomplish its mission, APHIS issues licenses to qualified establishments that produce biological products and issues permits to importers of such products. We also enforce requirements concerning production, packaging, labeling, and shipping of these products and set standards for the testing of these products.

Fulfilling this responsibility requires us to use certain information collection activities such as establishment license applications, product license applications, product import permit applications, product and test report forms, and field study summaries. This information helps us to ensure that biological products used in the United States are pure, safe, potent, and effective. If we did not collect this information, we would be unable to carry out this mission.

We are asking the Office of Management and Budget (OMB) to approve our use of these information collection activities for an additional 3 years.

The purpose of this notice is to solicit comments from the public (as well as affected agencies) concerning these information collection activities. These comments will help us:

(1) Evaluate whether the collection of information is necessary for the proper performance of the functions of the Agency, including whether the information will have practical utility;

(2) Evaluate the accuracy of our estimate of the burden of the information collection, including the validity of the methodology and assumptions used;

(3) Enhance the quality, utility, and clarity of the information to be collected; and

(4) Minimize the burden of the information collection on those who are to respond, through use, as appropriate, of automated, electronic, mechanical, and other collection technologies; e.g., permitting electronic submission of responses.

Estimate of burden: The public reporting burden for this collection of information is estimated to average 4.337559606 hours per response.

Respondents: U.S. importers, exporters, and shippers of veterinary biological products; State veterinary authorities; and operators of establishments that produce or test veterinary biological products or that engage in product research and development.

Estimated Annual Number of Respondents: 500.

Estimated Annual Number of Responses per Respondent: 43.452.

Estimated Annual Number of Responses: 21,726.

Estimated Total Annual Burden on Respondents: 94,237.82 hours. (Due to averaging, the total annual burden hours may not equal the product of the annual number of responses multiplied by the reporting burden per response.)

All responses to this notice will be summarized and included in the request for OMB approval. All comments will also become a matter of public record.

Done in Washington, DC, this 27th day of August 2007.

Kevin Shea,

Acting Administrator, Animal and Plant Health Inspection Service.

[FR Doc. E7–14988 Filed 8–1–07; 8:45 am]

BILLING CODE 3410–34–P

DEPARTMENT OF AGRICULTURE

Animal and Plant Health Inspection Service

[Docket No. APHIS–2007–0076]

Notice of Request for Extension of Approval of an Information Collection; Importation of Tomatoes From Spain, Chile, France, Morocco, and Western Sahara

AGENCY: Animal and Plant Health Inspection Service, USDA.

ACTION: Extension of approval of an information collection; comment request.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, this notice announces the Animal and Plant Health Inspection Service's intention to request an extension of approval of an information collection associated with our regulations governing the importation of tomatoes from Spain, Chile, France, Morocco, and Western Sahara.

DATES: We will consider all comments that we receive on or before October 1, 2007.

ADDRESSES: You may submit comments by either of the following methods:

Federal eRulemaking Portal: Go to *http://www.regulations.gov,* select ''Animal and Plant Health Inspection Service'' from the agency drop-down menu, then click ''Submit.'' In the Docket ID column, select APHIS–2007–0076 to submit or view public comments and to view supporting and related materials available electronically. Information on using *http://www.Regulations.gov,* including instructions for accessing documents, submitting comments, and viewing the docket after the close of the comment period, is available through the site's ''User Tips'' link.

Postal Mail/Commercial Delivery: Please send four copies of your comment (an original and three copies)

to Docket No. APHIS–2007–0076, Regulatory Analysis and Development, PPD, APHIS, Station 3A–03.8, 4700 River Road, Unit 118, Riverdale, MD 20737–1238. Please state that your comment refers to Docket No. APHIS–2007–0076.

Reading Room: You may read any comments that we receive on this docket in our reading room. The reading room is located in room 1141 of the USDA South Building, 14th Street and Independence Avenue, SW., Washington, DC. Normal reading room hours are 8 a.m. to 4:30 p.m., Monday through Friday, except holidays. To be sure someone is there to help you, please call (202) 690–2817 before coming.

Other Information: Additional information about APHIS and its programs is available on the Internet at *http://www.aphis.usda.gov.*

FOR FURTHER INFORMATION CONTACT: For information regarding foreign quarantine regulations, contact Ms. Sharon Porsche, Import Specialist, Commodity Import Analysis and Operations, PPQ, APHIS, 4700 River Road Unit 133, Riverdale, MD 20737–1236; (301) 734–5281. For copies of more detailed information on the information collection, contact Mrs. Celeste Sickles, APHIS* Information Collection Coordinator, at (301) 734–7477.

SUPPLEMENTARY INFORMATION:

Title: Importation of Tomatoes from Spain, Chile, France, Morocco, and Western Sahara.

OMB Number: 0579–0131.

Type of Request: Extension of Approval of an Information Collection.

Abstract: The Plant Protection Act (PPA, 7 U.S.C. 7701 *et seq.*) authorizes the Secretary of Agriculture to restrict the importation, entry, or interstate movement of plants, plant products, and other articles to prevent the introduction of plant pests, including fruit flies, into the United States or their dissemination within the United States. Regulations authorized by the PPA concerning the importation of fruits and vegetables into the United States from certain parts of the world are contained in ''Subpart—Fruits and Vegetables'' (7 CFR 319.56 through 319.56–46).

The regulations in 319.56–28 allow tomatoes from Spain, Chile, France, Morocco, and Western Sahara to be imported into the United States subject to certain conditions designed to protect the tomatoes from infestation by the Mediterranean fruit fly (Medfly). Allowing tomatoes to be imported necessitates the use of certain information collection activities, including completing phytosanitary inspection certificates and maintaining records regarding trap placement and Medfly captures. The information we collect serves as the supporting documentation needed to confirm that the tomatoes meet the conditions set forth in the regulations.

We are asking the Office of Management and Budget (OMB) to approve our use of this information collection activity for an additional 3 years.

The purpose of this notice is to solicit comments from the public (as well as affected agencies) concerning our information collection. These comments will help us:

(1) Evaluate whether the collection of information is necessary for the proper performance of the functions of the Agency, including whether the information will have practical utility;

(2) Evaluate the accuracy of our estimate of the burden of the collection of information, including the validity of the methodology and assumptions used;

(3) Enhance the quality, utility, and clarity of the information to be collected; and

(4) Minimize the burden of the collection of information on those who are to respond, through use, as appropriate, of automated, electronic, mechanical, and other collection technologies; e.g., permitting electronic submission of responses.

Estimate of Burden: The public reporting burden for this collection of information is estimated to average 0.6960 hour per response.

Respondents: Importers, foreign officials, shippers.

Estimated Annual Number of Respondents: 34.

Estimated Annual Number of Responses Per Respondent: 72.

Estimated Annual Number of Responses: 2,448.

Estimated Total Annual Burden on Respondents: 1,704 hours. (Due to averaging, the total annual burden hours may not equal the product of the annual number of responses multiplied by the reporting burden per response.)

All responses to this notice will be summarized and included in the request for OMB approval. All comments will also become a matter of public record.

Done in Washington, DC, this 27th day of July 2007.

Kevin Shea,

Acting Administrator, Animal and Plant Health Inspection Service.

[FR Doc. E7–15008 Filed 8–1–07; 8:45 am]

BILLING CODE 3410–34–P

DEPARTMENT OF AGRICULTURE

Animal and Plant Health Inspection Service

[Docket No. APHIS–2007–0077]

Notice of Request for Extension of Approval of an Information Collection; Black Stem Rust; Identification Requirements for Addition of Rust-Resistant Varieties

AGENCY: Animal and Plant Health Inspection Service, USDA.

ACTION: Extension of Approval of an Information Collection; Comment Request.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, this notice announces the Animal and Plant Health Inspection Service's intention to request an extension of approval of an information collection associated with the black stem rust quarantine and regulations.

DATES: We will consider all comments that we receive on or before October 1, 2007.

ADDRESSES: You may submit comments by either of the following methods:

Federal eRulemaking Portal: Go to *http://www.regulations.gov*, select ''Animal and Plant Health Inspection Service'' from the agency drop-down menu, then click ''Submit.'' In the Docket ID column, select APHIS–2007–0077 to submit or view public comments and to view supporting and related materials available electronically. Information on using Regulations.gov, including instructions for accessing documents, submitting comments, and viewing the docket after the close of the comment period, is available through the site's ''User Tips'' link.

Postal Mail/Commercial Delivery: Please send four copies of your comment (an original and three copies) to Docket No. APHIS–2007–0077, Regulatory Analysis and Development, PPD, APHIS, Station 3A–03.8, 4700 River Road, Unit 118, Riverdale, MD 20737–1238. Please state that your comment refers to Docket No. APHIS–2007–0077.

Reading Room: You may read any comments that we receive on this docket in our reading room. The reading room is located in room 1141 of the USDA South Building, 14th Street and Independence Avenue SW., Washington, DC. Normal reading room hours are 8 a.m. to 4:30 p.m., Monday through Friday, except holidays. To be sure someone is there to help you,

please call (202) 690–2817 before coming.

Other Information: Additional information about APHIS and its programs is available on the Internet at *http://www.aphis.usda.gov.*

FOR FURTHER INFORMATION CONTACT: For information regarding regulations for the black stem rust quarantine and regulations, contact Dr. Vedpal S. Malik, Agriculturist, Emergency and Domestic Programs, PPQ, APHIS, 4700 River Road Unit 134, Riverdale MD 20737; (301) 734–6774. For copies of more detailed information on the information collection, contact Mrs. Celeste Sickles, APHIS' Information Collection Coordinator, at (301) 734–7477.

SUPPLEMENTARY INFORMATION:

Title: Black Stem Rust; Identification Requirements for Addition of Rust-Resistant Varieties.

OMB Number: 0579–0186.

Type of Request: Extension of approval of an information collection.

Abstract: The Plant Protection Act (7 U.S.C. 7701 *et seq.*) authorizes the Secretary of Agriculture to prohibit or restrict the importation, entry, or interstate movement of plants and plant products to prevent the introduction of plant pests into the United States or their dissemination within the United States.

Black stem rust is one of the most destructive plant diseases of small grains that is known to exist in the United States. The disease is caused by a fungus that reduces the quality and yield of infected wheat, oat, barley, and rye crops by robbing host plants of food and water. In addition to infecting small grains, the fungus lives on a variety of alternate host plants that are species of the genera *Berberis*, *Mahoberberis*, and *Mahonia.* The fungus is spread from host to host by wind-borne spores.

The black stem rust quarantine and regulations, contained in 7 CFR 301.38 through 301.38–8 (referred to below as the regulations), quarantine the conterminous 48 States and the District of Columbia and govern the interstate movement of certain plants of the genera *Berberis*, *Mahoberberis*, and *Mahonia*, known as barberry plants. The species of these plants are categorized as either rust-resistant or rust-susceptible. Rust-resistant plants do not pose a risk of spreading black stem rust or of contributing to the development of new races of the rust; rust-susceptible plants do pose such risks.

Persons who request the Animal and Plant Health Inspection Service to add a variety to the list of rust-resistant barberry varieties in the regulations must provide the Agency with a description of the variety, including a written description and color pictures that can be used by State nursery inspectors to clearly identify the variety and distinguish it from other varieties. This requirement helps to ensure that State plant inspectors can clearly determine whether plants moving into or through their States are rust-resistant varieties listed in 7 CFR 301.38–2.

We are asking the Office of Management and Budget (OMB) to approve our use of these information collection activities for an additional 3 years.

The purpose of this notice is to solicit comments from the public (as well as affected agencies) concerning our information collection activity. APHIS needs this outside input to help accomplish the following:

(1) Evaluate whether the collection of information is necessary for the proper performance of the functions of the Agency, including whether the information will have practical utility;

(2) Evaluate the accuracy of our estimate of the burden of the information collection, including the validity of the methodology and assumptions used;

(3) Enhance the quality, utility, and clarity of the information to be collected; and

(4) Minimize the burden of the information collection on those who are to respond, through use, as appropriate, of automated, electronic, mechanical, and other collection technologies, *e.g.*, permitting electronic submission of responses.

Estimate of Burden: The public reporting burden for this collection of information is estimated to average 4 hours per response.

Respondents: Nurseries.

Estimated Annual Number of Respondents : 4.

Estimated Annual Number of Responses per Respondent: 2.

Estimated Annual Number of Responses: 8.

Estimated Total Annual Burden on Respondents: 32 hours. (Due to averaging, the total annual burden hours may not equal the product of the annual number of responses multiplied by the reporting burden per response.)

All responses to this notice will be summarized and included in the request for OMB approval. All comments will also become a matter of public record.

Done in Washington, DC, this 27th day of July 2007.

Kevin Shea,

Acting Administrator, Animal and Plant Health Inspection Service.

[FR Doc. E7–15009 Filed 8–1–07; 8:45 am]

BILLING CODE 3410–34–P

DEPARTMENT OF AGRICULTURE

Animal and Plant Health Inspection Service

[Docket No. APHIS–2006–0195]

Monsanto Company; Determination of Nonregulated Status for Soybean Genetically Engineered for Glyphosate Herbicide Tolerance

AGENCY: Animal and Plant Health Inspection Service, USDA.

ACTION: Notice.

SUMMARY: We are advising the public of our determination that a soybean line developed by the Monsanto Company, designated as transformation event MON 89788, which has been genetically engineered for tolerance to the herbicide glyphosate, is no longer considered a regulated article under our regulations governing the introduction of certain genetically engineered organisms. Our determination is based on our evaluation of data submitted by the Monsanto Company in its petition for a determination of nonregulated status, our analysis of other scientific data, and comments received from the public in response to a previous notice announcing the availability of the petition for nonregulated status and an environmental assessment. This notice also announces the availability of our written determination and finding of no significant impact.

DATES: *Effective Date:* July 23, 2007.

ADDRESSES: You may read the petition, environmental assessment, determination, finding of no significant impact, the comments we received on our previous notice, and our responses to those comments in our reading room. The reading room is located in room 1141 of the USDA South Building, 14th Street and Independence Avenue, SW., Washington, DC. Normal reading room hours are 8 a.m. to 4:30 p.m., Monday through Friday, except holidays. To be sure someone is there to help you, please call (202) 690–2817 before coming. To view those documents on the Internet, go to *http://www.regulations.gov,* click on the ''Advanced Search'' tab, and select ''Docket Search.'' In the Docket ID field, enter APHIS–2006–0195, then click ''Submit.'' Clicking on the Docket ID link in the search results page will produce a list of all documents in the docket.

FOR FURTHER INFORMATION CONTACT: Dr. Virgil Meier, Biotechnology Regulatory Services, APHIS, 4700 River Road, Unit 147, Riverdale, MD 20737–1236; (301) 734–3363. To obtain copies of the

petition, environmental assessment, or the finding of no significant impact, contact Ms. Cynthia Eck at (301) 734–0667; *cynthia.a.eck@aphis.usda.gov.* Those documents may also be viewed on the Internet at *http://www.aphis.usda.gov/brs/aphisdocs/06_17801p.pdf* and *http://www.aphis.usda.gov/brs/aphisdocs/06_17801p_ea.pdf*.

SUPPLEMENTARY INFORMATION:

Background

The regulations in 7 CFR part 340, ''Introduction of Organisms and Products Altered or Produced Through Genetic Engineering Which Are Plant Pests or Which There Is Reason to Believe Are Plant Pests,'' regulate, among other things, the introduction (importation, interstate movement, or release into the environment) of organisms and products altered or produced through genetic engineering that are plant pests or that there is reason to believe are plant pests. Such genetically engineered organisms and products are considered ''regulated articles.''

The regulations in § 340.6(a) provide that any person may submit a petition to the Animal and Plant Health Inspection Service (APHIS) seeking a determination that an article should not be regulated under 7 CFR part 340. Paragraphs (b) and (c) of § 340.6 describe the form that a petition for a determination of nonregulated status must take and the information that must be included in the petition.

On June 27, 2006, APHIS received a petition seeking a determination of nonregulated status (APHIS Petition Number 06–178–01p) from Monsanto Company of St. Louis, MO (Monsanto), for soybean (*Glycine max* L.) designated as transformation event MON 89788, which has been genetically engineered for tolerance to the herbicide glyphosate, stating that soybean line MON 89788 does not present a plant pest risk and, therefore, should not be a regulated article under APHIS' regulations in 7 CFR part 340.

As described in the petition, MON 89788 soybean plants have been genetically engineered to express a 5-enolpyruvylshikimate-3-phosphate synthase protein from *Agrobacterium* sp. strain CP4 (CP4 EPSPS), which confers tolerance to the herbicide glyphosate. Expression of the added gene is controlled, in part, by gene sequences derived from *Arabidopsis thaliana* and the plant pathogen figwort mosaic virus. The *Agrobacterium tumefaciens* transformation method was used to transfer the added genetic material into the recipient parental soybean line A3244.

MON 89788 soybean plants have been considered regulated articles under the regulations in 7 CFR part 340 because they contain gene sequences from plant pathogens. MON 89788 soybean plants have been field tested in the United States since 2001 under notifications authorized by APHIS. In the process of reviewing the notifications for field trials of the subject soybean plants, APHIS determined that the vectors and other elements were disarmed and that field trials, which were conducted under conditions of reproductive and physical confinement or isolation, would not present a risk of plant pest introduction or dissemination.

In a notice [1] published in the **Federal Register** on February 5, 2007 (72 FR 5261–5263, Docket No. APHIS–2006–0195), APHIS announced the availability of Monsanto's petition and the associated environmental assessment (EA). APHIS solicited comments on whether the subject soybean would present a plant pest risk for 60 days ending April 6, 2007. APHIS received 23 comments during the comment period, with 12 comments submitted in support of the conclusions drawn in the EA and 11 opposed. APHIS' responses to these comments can be found in an attachment to the finding of no significant impact.

Determination

Based on APHIS' analysis of field, greenhouse, and laboratory data submitted by Monsanto, references provided in the petition, other relevant information described in the EA, and comments provided by the public, APHIS has determined that Monsanto's soybean line, designated as MON 89788, will not pose a plant pest risk for the following reasons: (1) Gene introgression from MON 89788 soybean into its sexually compatible relatives in the United States and its territories is extremely unlikely and consequently the potential impact of introgression is not foreseeable; (2) the subgenus *Glycine max,* on which MON 89788 is based, is not considered to be a weed and does not persist in unmanaged ecosystems; (3) it does not pose a risk to non-target organisms, including beneficial organisms and threatened or endangered species, because the CP4 EPSPS protein is not known to have any toxic properties and has minimal potential to be a food allergen; (4) MON 89788 exhibits no traits that should cause increased weediness, and that its unconfined cultivation should not lead to increased weediness of other sexually compatible relatives (of which there are none in the United States); (5) if MON 89788 were to be grown commercially, the effect on agricultural practices from introducing MON 89788 into the environment should be no different than for the previously deregulated Roundup Ready 40–3–2 soybean line expressing the same CP4 EPSPS protein from *Agrobacterium* sp. Strain CP4, with which APHIS has over 10 years of experience; (6) APHIS does not expect MON 89788 to have any impacts on the development of herbicide resistant weeds or a cumulative impact in combination with other glyphosate tolerant crops; (7) there should be no significant impact from the stacking of herbicide resistant traits; (8) if MON 89788 were to be grown commercially, the potential impact on organic farming should not change from the current situation where close to 90 percent of soybeans produced are Roundup Ready and organic farmers or other farmers who choose not to plant or sell Roundup Ready soybean or other transgenic soybeans will still be able to purchase and grow nontransgenic soybeans and will be able to coexist with biotech soybean producers as they do now; (9) APHIS' analysis of data on agronomic performance, disease and insect susceptibility, and compositional profiles of MON 89788 and its non-genetically engineered counterpart indicates no significant differences between the two that would be expected to cause either a direct or indirect plant pest effect on raw or processed plant commodities from the deregulation of MON 89788; (10) APHIS has reviewed field performance data submitted by the petitioner, and these data indicate that the engineered plant is not different in any fitness characteristics from its parent that might cause MON 89788 to become invasive; and (11) none of the alternatives proposed in the EA are expected to have significant human health or environmental effects.

National Environmental Policy Act

To provide the public with documentation of APHIS' review and analysis of any potential environmental impacts associated with the determination of nonregulated status for MON 89788, an EA was prepared. The EA was prepared in accordance with (1) The National Environmental Policy Act of 1969 (NEPA), as amended (42 U.S.C. 4321 *et seq.*), (2) regulations of the Council on Environmental Quality for implementing the procedural provisions

[1] To view the notice, the EA, and the comments we received, go to *http://www.regulations.gov/fdmspublic/component/main?main=DocketDetail&d=APHIS–2006–0195.*

of NEPA (40 CFR parts 1500–1508), (3) USDA regulations implementing NEPA (7 CFR part 1b), and (4) APHIS' NEPA Implementing Procedures (7 CFR part 372). Based on that EA, APHIS has reached a finding of no significant impact with regard to the determination that Monsanto soybean line MON 89788 and lines developed from it are no longer regulated articles under its regulations in 7 CFR part 340. Copies of the EA and finding of no significant impact are available as indicated in the **ADDRESSES** and **FOR FURTHER INFORMATION CONTACT** sections of this notice.

Authority: 7 U.S.C. 7701–7772 and 7781–7786; 31 U.S.C. 9701; 7 CFR 2.22, 2.80, and 371.3.

Done in Washington, DC, this 27th day of July 2007.

Kevin Shea,

Acting Administrator, Animal and Plant Health Inspection Service.

[FR Doc. E7–15001 Filed 8–1–07; 8:45 am]

BILLING CODE 3410–34–P

DEPARTMENT OF AGRICULTURE

Animal and Plant Health Inspection Service

[Docket No. APHIS–2007–0106]

Secretary's Advisory Committee on Foreign Animal and Poultry Diseases; Meeting

AGENCY: Animal and Plant Health Inspection Service, USDA.

ACTION: Notice of meeting.

SUMMARY: Pursuant to the Federal Advisory Committee Act (5 U.S.C. App. II), we are giving notice of a meeting of the Secretary's Advisory Committee on Foreign Animal and Poultry Diseases.

DATES: A session open to the public will be held on August 21, 2007, from 8 a.m. to 5 p.m.

ADDRESSES: The meeting will be held in the Jamie L. Whitten Federal Building, 12th Street and Jefferson Drive, SW., Washington, DC, in room 107A.

FOR FURTHER INFORMATION CONTACT: Dr. Bethany O'Brien, Acting Director Interagency Coordination, National Center for Animal Health Emergency Management, VS, APHIS, 4700 River Road, Unit 41, Riverdale, MD 20737; (301) 734–0825.

SUPPLEMENTARY INFORMATION: The Secretary's Advisory Committee on Foreign Animal and Poultry Diseases (the Committee) advises the Secretary of Agriculture on actions necessary to prevent the introduction of foreign diseases of livestock and poultry into the United States. In addition, the Committee advises the Secretary on contingency planning and on maintaining a state of preparedness to deal with these diseases, if introduced.

The meeting will focus on the U.S. animal health emergency management system and on the foreign animal disease situation worldwide and its relevance to the United States. The session will be open to the public. However, due to time constraints, the public will not be allowed to participate in the Committee's discussions.

You may obtain an agenda for the meeting by contacting Dr. Bethany O'Brien at the address listed under **FOR FURTHER INFORMATION CONTACT**. Written statements on meeting topics may be filed with the Committee before or after the meeting by sending them to the person listed under **FOR FURTHER INFORMATION CONTACT**. Written statements may also be filed at the meeting. Please refer to Docket No. APHIS–2007–0106 when submitting your statements.

Upon entering the Whitten Building, visitors should inform security personnel that they are attending the Advisory Committee meeting on Foreign Animal and Poultry Diseases. Photo identification is required. Visitor badges must be worn at all times while inside the building.

Done in Washington, DC, this 27th day of July 2007.

Kevin Shea,

Acting Administrator, Animal and Plant Health Inspection Service.

[FR Doc. E7–14987 Filed 8–1–07; 8:45 am]

BILLING CODE 3410–34–P

DEPARTMENT OF AGRICULTURE

Food Safety and Inspection Service

[Docket No. FSIS–2007–0027]

National Advisory Committee on Meat and Poultry Inspection

AGENCY: Food Safety and Inspection Service, USDA.

ACTION: Notice of public meeting.

SUMMARY: Pursuant to the Federal Advisory Committee Act, 5 U.S.C. App., the National Advisory Committee on Meat and Poultry Inspection (NACMPI) will hold a public meeting on August 8–9, 2007, to review and discuss the following issues: (1) Data Collection and Analysis at the Food Safety and Inspection Service (FSIS): Standard Operating Procedures, (2) Linking FSIS Activities to its Public Health Goals, and (3) Pilot Project to Explore Mechanisms for Sharing Industry Data with FSIS.

The first issue, Data Collection and Analysis at FSIS: Standard Operating Procedures, will be presented to the entire Committee for discussion during the morning session on August 8, 2007. The other two issues will be presented to the entire Committee in the afternoon session. The committee will then divide into two subcommittees. These subcommittees will meet in the afternoon of August 8, 2007, to discuss the issues Linking FSIS Activities to its Public Health Goals and Pilot Project to Explore Mechanisms for Sharing Industry Data with FSIS. Each subcommittee will provide a report of their comments and recommendations to the full committee on the morning of August 9, 2007.

DATES: The full Committee will hold a public meeting on Wednesday, August 8, and Thursday, August 9, 2007, from 8:30 a.m. to 2 p.m. Subcommittees will hold open meetings on Wednesday, August 8, 2007, from 2 p.m. to 6 p.m.

ADDRESSES: All Committee meetings will take place at George Mason University, 3401 N. Fairfax Drive, Arlington, VA 22201. A meeting agenda is available on the Internet at the NACMPI Web site, *http://www.fsis.usda.gov/about_fsis/nacmpi/index.asp.* The NACMPI meeting agenda, together with information and resource materials on public health-based inspection, is also available on the Internet at, *http://www.fsis.usda.gov/Regulations_&_Policies/Risk_Based_Inspection/index.asp.* FSIS welcomes comments on the topics to be discussed at the NACMPI public meeting. Comments may be submitted by any of the following methods:

Electronic mail: NACMPI@fsis.usda.gov.

Mail, including floppy disks or CD–ROMs: Send to National Advisory Committee on Meat and Poultry Inspection, United States Department of Agriculture, Food Safety and Inspection Service, 14th & Independence Avenue, SW., Mail Drop 405 Aerospace, Washington, DC 20250.

Hand- or courier-delivered items: Deliver to Loraine Cannon at 901 D Street SW., Washington, DC. To deliver these items, the building security guard must first call (202) 690–6520.

Facsimile: Send to Loraine Cannon, (202) 690–6519. All submissions received must include the Agency name and docket number FSIS–2007–0027.

FOR FURTHER INFORMATION CONTACT: Robert Tynan for technical information at (202) 720–3884, or e-mail *robert.tynan@fsis.usda.gov* and Loraine Cannon for meeting information at (202)

690–6647, Fax (202) 690–6519, or e-mail *NACMPI@fsis.usda.gov.* Persons requiring a sign language interpreter or other special accommodations should notify Loraine Cannon at the numbers above or by e-mail.

SUPPLEMENTARY INFORMATION:

Background

The NACMPI provides advice and recommendations to the Secretary of Agriculture pertaining to the Federal and State meat and poultry inspection programs, pursuant to sections 7(c), 24, 205, 301(a)(3), 301(a)(4), and 301(c) of the Federal Meat Inspection Act [21 U.S.C. 607(c), 624, 645, 661(a)(3), 661(a)(4), and 661(c)] and sections 5(a)(3), 5(a)(4), 5(c), 8(b), and 11(e) of the Poultry Products Inspection Act [21 U.S.C. 454(a)(3), 454(a)(4), 454(c), 457(b), and 460(e)].

The Administrator of FSIS is the chairperson of the Committee. Membership of the Committee is drawn from representatives of consumer groups; producers, processors, and marketers from the meat, poultry and egg product industries; State and local government officials; and academia. The current members of the NACMPI are: Ms. Kibbe M. Conti, Northern Plains Nutrition Consulting, Rapid City, SD; Mr. Brian R. Covington, Keystone Foods LLC, West Conshohocken, PA; Dr. Catherine N. Cutter, Pennsylvania State University, University Park, PA; Dr. James S. Dickson, Iowa State University, Ames, IA; Mr. Kevin M. Elfering, Minnesota Department of Agriculture, St. Paul, MN; Mr. Mike W. Finnegan, Montana Meat & Poultry Inspection Bureau, Helena, MT; Ms. Carol Tucker Foreman, Consumer Federation of America, Chevy Chase, MD; Dr. Andrea L. Grondahl, North Dakota Department of Agriculture, Bismarck, ND; Dr. Joseph J. Harris, Southwest Meat Association, Bryan, TX; Dr. Craig W. Henry, Food Products Association, Washington, DC; Ms. Cheryl D. Jones, Morehouse School of Medicine, Atlanta, GA; Mr. Michael E. Kowalcyk, DunnhumbyUSA LLC, Cincinnati, OH; Dr. Shelton E. Murinda, California State Polytechnic University, Pomona, CA; Dr. Edna Negron-Bravo, University of Puerto Rico, Mayaguez, PR; Dr. Michael L. Rybolt, National Turkey Federation, Washington, DC; Mr. Mark P. Schad, Schad Meats, Inc., Cincinnati, OH; and Dr. Stanley A. Stromberg, Oklahoma Department of Agriculture, Food, and Forestry, Oklahoma City, OK.

The Committee has subcommittees to deliberate on specific issues and make recommendations to the whole Committee. The Committee makes recommendations to the Secretary of Agriculture.

All interested parties are welcome to attend the Meetings and to submit written comments and suggestions concerning issues the Committee will review and discuss. The comments and the official transcript of the meeting, when they become available, will be kept in the FSIS Docket Room, U.S. Department of Agriculture, Food Safety and Inspection Service, 300 12th Street, SW., Room 102, Cotton Annex, Washington, DC 20250, and posted on the Agency's NACMPI Web site, *http://www.fsis.usda.gov/about_fsis/nacmpi/index.asp.*

Members of the public will be required to register before entering the meeting.

Additional Public Notification

Public awareness of all segments of rulemaking and policy development is important. Consequently, in an effort to ensure that minorities, women, and persons with disabilities are aware of this notice, FSIS will announce it on-line through the FSIS Web page located at *http://www.fsis.usda.gov/regulations/2007 Notices Index/*. FSIS will also make copies of this **Federal Register** publication available through the FSIS Constituent Update, which is used to provide information regarding FSIS policies, procedures, regulations, **Federal Register** notices, FSIS public meetings, and other types of information that could affect or would be of interest to constituents and stakeholders. The Update is communicated via Listserv, a free electronic mail subscription service for industry, trade and farm groups, consumer interest groups, allied health professionals, and other individuals who have asked to be included. The Update is available on the FSIS Web page. Through the Listserv and Web page, FSIS is able to provide information to a much broader and more diverse audience. In addition, FSIS offers an e-mail subscription service which provides automatic and customized access to selected food safety news and information. This service is available at *http://www.fsis.usda.gov/news and events/email subscription/*. Options range from recalls to export information to regulations, directives and notices. Customers can add or delete subscriptions themselves and have the option to password protect their account.

Done in Washington, DC on July 24, 2007.

Alfred V. Almanza,

Administrator.

[FR Doc. 07–3783 Filed 7–30–07; 4:29 pm]

BILLING CODE 3410–DM–M

DEPARTMENT OF AGRICULTURE

Forest Service

Colville National Forest; Washington; Republic Ranger Station Excess Residence Sale

AGENCY: Forest Service, USDA.

ACTION: Notice of intent to prepare an environmental impact statement.

SUMMARY: The Colville National Forest, USDA Forest Service, will prepare an EIS (environmental impact statement) on a proposal to sell a 0.4-acre parcel of land with a residential building, located on the Republic Ranger District administrative compound, within the City of Republic, Ferry County Washington. The parcel and Building are no longer needed to meet public service of Forest Service mission requirements. The Forest Service Facility Realignment and Enhancement Act of 2005 authorized the Secretary of Agriculture to sell administrative sites that are no longer needed for National Forest System purposes. Project implementation is scheduled for Fiscal Year 2008. This project is not associated with the proposed Secure Rural Schools Land Sale Initiative. The Colville National Forest invites written comments and suggestions on the scope of the analysis. The agency will give notice of the full environmental analysis and decision-making process so interested and affected people may participate and contribute to the final decision.

DATES: Comments concerning the scope of the analysis must be received by August 31, 2007. The draft environmental impact statement is expected in November 2007 and the final environmental impact statement is expected in January 2008.

ADDRESSES: Send written comments to Rick Brazell, Forest Supervisor, Colville National Forest, 765 South Main, Colville, WA 99114 (phone 509–684–7000). Comments may be submitted electronically to *comments-pacificnorthwest-colville@fs.fed.us.* Comments may also be sent by fax to (509) 775–7401. Include your name and mailing address with your comments so documents pertaining to this project may be mailed to you.

FOR FURTHER INFORMATION CONTACT: Ed Shaw, Reality Specialist, Colville

National Forest, 765 South Main, Colville, WA 99114 (phone 509–684–7129), or Jim Parker, EIS Project Leader, Republic Ranger District, 650 East Delaware, Republic WA 99166 (phone 509–775–7462).

SUPPLEMENTARY INFORMATION:

Purpose and Need for Action

One of the key findings of the Colville National Forest Facilities Master Plan is that the Colville National Forest maintains more facility space than it needs to perform its mission. The Colville National Forest needs to remove unneeded buildings from the Forest's facility inventory in order to eliminate the cost of maintaining unneeded facilities.

Proposed Action

The proposed action is to sell 0.4 acres of land with a residential building, located on the Republic Ranger District administrative compound, located in Republic, Ferry County, Washington. The property legal description is: A portion of the SW¼NW¼ Section 6, T36N, R33E, WM. The site is located within the city limits of Republic, Washington. The land was acquired by the Forest Service in 1934.

The site has one residential building. The mineral estate would be reserved by the government. Water and sewer are provided by a community system.

This property may be sold directly to an identified purchaser or may be sold under competitive bidding procedures. The method of sale will be determined at a later date. If the property is offered for sale under competitive bidding procedures, an Invitation for Bid will provide specific information, including a minimum bid price, the scheduled starting date for bidding, approximate bid closing date, requirements and instructions for bidding, payment and other closing procedures. An Offer to Sell will be released after all environmental studies and other required analysis ar completed and a final decision to sell the property is made.

Responsible Official

The Responsible Official is Rick Brazell, Forest Supervisor, Colville National Forest, 765 South Main, Colville, WA 99114.

Nature of Decision To Be Made

The Responsible Official will decide whether or not to proceed with sale of Republic Ranger Station residence and property, including any outstanding interests or conditions to be conveyed. The decision and rationale for the decision will be documented in the Record of Decision, which will be subject to Forest Service Appeal Regulations (36 CFR Part 215).

Scoping Process

The scoping process will identify and clarify issues, identify key issues to be analyzed in depth, explore alternatives based on themes derived from key issues recognized during the scoping process, and identify potential environmental effects associated with the proposed action. A No Action alternative will be considered.

Preliminary Issues

Only one key issue was identified in preliminary project assessment: The National Historic Preservation Act of 1966, Revised, requires that Federal agencies evaluate properties for historic significance under Section 106. The residential structure has been found eligible to the NHRP (National Register of Historic Places), with the Washington State Historic Preservation Office concurring on this finding. Conveyance of the property from Federal ownership will be an adverse effect because of NRHP eligibility based on the following criteria: The property may represent a significant contribution to the American history (Criterion A), is associated with the lives of significant persons in our past (Criterion B), displays distinctive characteristics of type or period (Criterion C), or may be likely to yield information important to history (Criterion D). The NRHP eligibility for the structure is based on a national significance of context in association with the Depression-era Civilian Conservation Corps. Eligibility is also based on national and regional significance of context associated with distinctive architectural characteristics. The property also contains a deposit of prehistoric lithic material which would also be eligible for listing on the NRHP; however, the Forest Service intends to conduct a data recovery excavation of the site. Data will be professionally recorded, and artifacts recovered will be curated at an approved curation facility.

Comment Requested

This notice of intent initiates the scoping process which guides the development of the environmental impact statement. The Forest Service is seeking information, comments, and assistance from other agencies, organizations, Indian Tribes, and individuals who may be interested in or affected by the Proposed Action. This input will be used in preparation of the Draft EIS. Your comments are appreciated throughout the analysis process.

Early Notice of Importance of Public Participation in Subsequent Environmental Review: A draft environmental impact statement will be prepared for comment. The comment period on the draft environmental impact statement will be 45 days from the date the Environmental Protection Agency publishes the notice of availability in the **Federal Register.**

The Forest Service believes, at this early stage, it is important to give reviewers notice of several court rulings related to public participation in the environmental review process. First, reviewers of draft environmental impact statements must structure their participation in the environmental review of the proposal so that it is meaningful and alerts an agency to the reviewer's position and contentions. *Vermont Yankee Nuclear Power Corp.* v. *NRDC,* 435 U.S. 519, 553 (1978). Also, environmental objections that could be raised at the draft environmental impact statement stage but that are not raised until after completion of the final environmental impact statement may be waived or dismissed by the courts. *City of Angoon* v. *Hodel,* 803 F.2d 1016, 1022 (9th Cir. 1986) and *Wisconsin Heritages, Inc.* v. *Harris,* 490 F. Supp. 1334, 1338 (E.D. Wis. 1980). Because of these court rulings, it is very important that those interested in this proposed action participate by the close of the 45-day comment period so that substantive comments and objections are made available to the Forest Service at a time when it can meaningfully consider them and respond to them in the final environmental impact statement.

To assist the Forest Service in identifying and considering issues and concerns on the proposed action, comments on the draft environmental impact statement should be as specific as possible. It is also helpful if comments refer to specific pages or chapters of the draft statement. Comments may also address the adequacy of the draft environmental impact statement or the merits of the alternatives formulated and discussed in the statement. Reviewers may wish to refer to the Council on Environmental Quality Regulations for implementing the procedural provisions of the National Environmental Policy Act at 40 CFR 1503.3 in addressing these points.

Comments received, including the names and addresses of those who comment, will be considered part of the public record on this proposal and will be available for public inspection.

(Authority: 40 CFR 1501.7 and 1508.22; Forest Service Handbook 1909.15, Section 21)

Dated: July 26, 2007.

Rick Brazell,

Forest Supervisor.

[FR Doc. 07–3771 Filed 8–1–07; 8:45 am]

BILLING CODE 3410–11–M

DEPARTMENT OF AGRICULTURE

Forest Service

Glenn/Colusa County Resource Advisory Committee

AGENCY: Forest Service, USDA.

ACTION: Notice of meeting.

SUMMARY: The Glenn/Colusa County Resource Advisory Committee (RAC) will meet in Willows, California. Agenda items covered include: (1) Introductions, (2) Approve Minutes, (3) Public Comment, (4) Project Proposals/Action, (5) General Discussion, (6) Next Agenda.

DATES: The meeting will be held on August 13, 2007, from 1:30 p.m. and end at approximately 4:30 p.m.

ADDRESSES: The meeting will be held at the Mendocino National Forest Supervisor's Office, 825 N. Humboldt Ave., Willows, CA 95988. Individuals who wish to speak or propose agenda items send their names and proposals to Eduardo Olmedo, DFO, 825 N. Humboldt Ave., Willows, CA 95988.

FOR FURTHER INFORMATION CONTACT: Bobbin Gaddini, Committee Coordinator, USDA, Mendocino National Forest, Grindstone Ranger District, P.O. Box 164, Elk Creek, CA 95939. (530) 968–1815; e-mail *ggaddini@fs.fed.us.*

SUPPLEMENTARY INFORMATION: The meeting will be open to the public. Committee discussion is limited to Forest Service staff and Committee members. However, persons who wish to bring matters to the attention of the Committee will file written statements with the Committee staff before or after the meeting. Public input sessions are provided and individuals who made written requests by August 10, 2007 have the opportunity to address the committee at those sessions.

Dated: July 25, 2007.

Eduardo Olmedo,

Designated Federal Official.

[FR Doc. 07–3765 Filed 8–1–07; 8:45 am]

BILLING CODE 3410–11–M

DEPARTMENT OF AGRICULTURE

Forest Service

Siskiyou Resource Advisory Committee; Notice of Meeting

AGENCY: USDA Forest Service.

ACTION: Notice of Meeting; Siskiyou Resource Advisory Committee (RAC).

SUMMARY: The Siskiyou Resource Advisory Committee will meet on Thursday, August 30, 2007 to recommend Title II projects for fiscal year 2008 under the Secure Rural Schools and Community Self Determination Act of 2000. The meeting will be held at the Chetco Community Public Library, Large Community Meeting Room at 405 Alder Street, Brookings, Oregon. It begins at 10 a.m., ends at 2:30 p.m.; the open public comments begin at 11 a.m. and ends at 11:30 a.m. Written comments may be submitted prior to the meeting and delivered to Designated Federal Official, Scott Conroy at the Rogue River-Siskiyou National Forest, P.O. Box 520, Medford, Oregon 97501.

FOR FURTHER INFORMATION CONTACT: Rogue River-Siskiyou National Forest Public Affairs Officer Patty Burel at telephone: (541) 858-2211, e-mail: *pburel@fs.fed.us*, or USDA Forest Service, P.O. Box 520, 333 West 8th Street, Medford, OR, 97501.

Dated: July 26, 2007.

Cassius M. Cash,

Acting Forest Supervisor, Rogue River-Siskiyou National Forest.

[FR Doc. 07–3772 Filed 8–1–07; 8:45 am]

BILLING CODE 3410–11–M

DEPARTMENT OF AGRICULTURE

Forest Service

[FSM 2350]

Continental Divide National Scenic Trail

AGENCY: Forest Service, USDA.

ACTION: Notice of extension of public comment period for Proposed Continental Divide National Scenic Trail (CDNST) Directives.

SUMMARY: The Northern, Rocky Mountain, Southwestern, and Intermountain Regions of the USDA Forest Service are extending the public comment period through October 12, 2007, for the proposed directives for the planning, development, and management of the CDNST. The notice of proposed directives was first published in **Federal Register** Notice Vol. 72, No. 112, on Tuesday, June 12, 2007. After considering comments, the USDA Forest Service proposes to issue a supplemental directive for each Region. The directives would also amend the CDNST Comprehensive Plan of 1985.

Policy direction is needed to clarify the nature and purposes of the CDNST and to align the CDNST planning with USDA Forest Service land management planning processes. The directives would have no effect on the ground until site-specific planning decisions are completed, with additional opportunity for public involvement. Additional information regarding this proposed directive can be found on the Internet at: *http://www.fs.fed.us/cdt.*

DATES: Comments are requested and must be submitted on or before October 12, 2007.

FOR FURTHER INFORMATION CONTACT: Greg Warren, CDNST Administrator, (303) 275–5054.

Written comments concerning this proposal are to be sent to US Forest Service, Attn: CDNST, 740 Simms St, Golden, CO 80401–4720; or via e-mail *cdnst@fs.fed.us.*

All comments, including names and addresses, when provided, will be placed in the record and will be available for public inspection and copying. The public may inspect comments received in the office of the Director of Recreation, Heritage, and Wilderness Resources, USDA Forest Service, Rocky Mountain Regional Office, 740 Simms Street, Golden, CO 80401, on business days between the hours 8:30 a.m. and 4 p.m. Those wishing to inspect comments are encouraged to call ahead at (303) 275–5200 to facilitate entry into the building.

SUPPLEMENTARY INFORMATION:

Background

The USDA Forest Service provides internal direction to field units through its Directives System, consisting of the USDA Forest Service Manuals (FSM) and USDA Forest Service Handbooks (FSH). Directives provide guidance to field units in implementing programs established by statute and regulation. USDA Forest Service directives establish agency policies for delegations of authority, consistent definitions of terms, clear and consistent interpretation of regulatory language, and standard processes.

The USDA Forest Service is requesting comment on policy that promotes the nature and purposes of the CDNST as depicted in the CDNST Study Report and Final Environment Statement. In addition, the directives

recommend land management planning integration and management direction for the CDNST, and amends the CDNST Comprehensive Plan of 1985.

The Continental Divide National Scenic Trail is administered by the Secretary of Agriculture in consultation with the Secretary of the Interior. The Regional Forester of the Rocky Mountain Region is the lead Forest Service official coordinating matters concerning the study, planning, and operation of the CDT.

The issuance of timely direction for the planning and management of the CDNST is important due to the extensive nature of ongoing land management planning and project planning assessments along the trail corridor throughout these four Regions of the USDA Forest Service. These assessments need to provide for the integrated management of the CDNST designated area. Additional information regarding this proposed directive can be found on the Internet at *http://www.fs.fed.us/cdt.*

Because the agency plans to propose additional revisions to USDA Forest Service Manual 2300, chapter 50, proposed directives are issued for comments at this time. The current Forest Service Manual can be found on the Internet at: *http://www.fs.fed.us/im/directives/fsm/2300/2350.doc.*

The proposed directives for the four Regions are as follows:

Digest

2353.42(4)(5)—Adds policy direction for the Continental Divide National Scenic Trail.

2353.43(1–11) Planning and Development of the Continental Divide National Scenic Trail (CDNST)—Adds planning and development direction for the CDNST.

2353.44(1–8) Management of the Continental Divide National Scenic Trail (CDNST)—Adds management direction for the CDNST.

2353.4—Administration of National Scenic and National Historic Trails

2353.42—Policy

4. The nature and purposes of the Continental Divide National Scenic Trail are to provide for high quality, scenic, primitive hiking and horseback-riding, non-motorized recreational experiences and to conserve natural, historic, and cultural resources along the Continental Divide.

5. The policy, development, and management direction in this directive amends and supersedes the purpose depiction, management policy, and direction contained in the ''Continental Divide National Scenic Trail Comprehensive Plan'' of 1985.

2353.43—National Scenic and Historic Trail System Development

Planning and Development of the Continental Divide National Scenic Trail (CDNST)

1. Land Management Planning (FSM 1921) is to provide for the nature and purposes of theCDNST congressionally designated area, and address the Comprehensive Plan programmatic requirements of the National Trails System Act, as amended (Title 16, United States Code, section 1244(f) (16 U.S.C. 1244(f)):

a. Identify CDNST desired conditions,

b. Establish CDNST objectives,

c. Establish CDNST management guidelines,

d. Establish monitoring programs to evaluate the condition of the CDNST in the land management planning area, and

e. Where the CDNST travel route is outside the congressionally established wilderness delineate a special area or management area for the trail corridor.

2. For each land management plan area that encompasses the CDNST, a management plan should be completed to address the site-specific requirements of the National Trails System Act, as amended (16 U.S.C. 1244(f)):

a. Identify and display the located CDNST travel route,

b. Identify the significant natural, historical, and cultural resources to be preserved along the CDNST corridor,

c. Identify the carrying capacity for the trail that reflects the nature and purposes of the CDNST,

d. Provide for CDNST development, signing, and maintenance programs,

e. Establish monitoring programs to evaluate the condition of each CDNST segment as related to the nature and purposes of the CDNST, and

f. Where applicable, protect high potential segments until such time that the CDNST is located and delineated as a special area or management area (FMS 2353.43, Planning and Development of the CDNST (1)(e)).

3. The Scenery Management System (FSM 2382) should be followed when developing land management plans. The foreground zone from the CDNST travel route should be a primary consideration in delineating a CDNST special area or management area.

4. Use the Recreation Opportunity Spectrum (ROS) system to delineate, define and integrate CDNST recreational opportunities in land management planning (FSM 2311.1). The CDNST should be located in Primitive and Semi-Primitive Non-Motorized ROS settings where available in the land management planning area, while recognizing that the CDNST will intermittently traverse through more developed areas, and across designated motor vehicle use routes (Subpart B—Designation of Roads, Trails, and Areas for Motor Vehicle Use, part 212 Travel Management, of Title 36 Code of the Code of Federal Regulations (36 CFR part 212 subpart B)), in order to provide for a continuous travel route between Canada and Mexico along the Continental Divide.

5. A new segment of the CDNST travel route should only be constructed if current National Forest System trails cannot be managed, maintained, and reconstructed to provide for the nature and purposes of the CDNST.

6. A CDNST trail segment (16 U.S.C. 1246(c)) is not to be designated for motor vehicle use (36 CFR part 212 subpart B) by the general public, unless such use is consistent with FSM 2353.44, Management of the CDNST (5).

7. A CDNST segment may only be located on a road (16 U.S.C. 1244(5)) where the following conditions are met:

a. The road is primitive in nature and offers a recreation experiences not materially different in quality than that extended by a bona fide hiking and equestrian trail,

b. An affirmative determination has been made that motor vehicle use would not substantially interfere with the nature and purposes of the CDNST, and

c. Motor vehicle use does not constitute a safety hazard to hikers-pedestrians and equestrians.

8. Locating the CDNST in wilderness on a National Forest System trail, and marking the travel route at trail junctions with the CDNST marker brand, is consistent with the Wilderness Act (Title 16, United States Code, sections 1131(a) and 1133(b)).

9. The CDNST should be located on a permanent easement where the trail crosses private land (FSM 5460.3).

10. The CDNST should be designed following the Pack-and-Saddle Trail Class 2 or 3 design parameters when constructed or reconstructed (FSH 2309.18). However, a CDNST segment may be designed following the Hiker-Pedestrian Trail Class 1, 2, or 3 design parameters where there exists a substantial safety or resource concern, or the overall management direction for the land management plan area only provides for Hiker-Pedestrian use.

2353.44—Management of National Scenic and National Historic Trails

Management of the Continental Divide National Scenic Trail (CDNST)

1. Scenery should be managed following the Scenery Management System (FSM 2380). The CDNST is a concern level 1 travel route, and scenic integrity objective is to be high or very high.

2. Use the Recreation Opportunity Spectrum (ROS) system (FSM 2311.1) in the management of the CDNST corridor. The CDNST is to be managed primarily for Primitive and Semi-Primitive Non-Motorized ROS conditions and experiences.

3. The CDNST should be managed for both Pack-and-Saddle and Hiker-Pedestrian uses (FSH 2309.18). However, where the trail design parameters reflect only Hiker-Pedestrian use, the managed use should be only Hiker-Pedestrian.

4. Motor vehicle use may be allowed on a trail segment of the CDNST (Title 16 United States Code, section 1246(c) (16 U.S.C. 1246(c)):

a. If necessary to meet emergencies,

b. To enable adjacent landowners or land users to have reasonable access to their lands or where there are existing valid rights, and

c. On a designated motor vehicle use route (36 CFR part 212 subpart B) that crosses the CDNST where an affirmative determination has been made that such use would not substantially interfere with the nature and purposes of the CDNST.

d. In addition to one of the above three situations being met, motor vehicle use must also be allowed by the overall management direction for the land management plan area.

e. Motor vehicle use is also allowed on a trail segment if such use is consistent with FSM 2353.44, Management of the CDNST (5).

5. Motor vehicle use shall be allowed on a trail segment of the CDNST where the following conditions are met (16 U.S.C. 1246(c)):

a. An affirmative determination has been made that motor vehicle use would not substantially interfere with the nature and purposes of the CDNST, and

b. Motor vehicle use was allowed by administrative regulations on a National Forest System travel route that was developed prior to November 10, 1978, which is the time of designation of the CDNST by Public Law 95–625.

c. In addition to both of the above two situations being met, motor vehicle use must also be allowed by the overall management direction for the land management plan area.

d. Motor vehicle use may also be allowed on a trail segment if such use is consistent with FSM 2353.44, Management of the CDNST (4).

6. Where motor vehicle use is allowed on a road segment (16 U.S.C. 1244(5)) or trail segment (16 U.S.C. 1246(c)) of the CDNST, consider establishing motor vehicle use prohibitions and restrictions (part 261–Prohibitions, of Title 36 Code of Federal Regulations (36 CFR part 261)) to mitigate the effects of such use on the nature and purposes of the CDNST. Management practices and actions that would promote or result in increased motor vehicle use ont he CDNST should not occur.

7. Bicycle (mountain bike) use may only be allowed on a trail segment of the CDNST where the following conditions are met (16 U.S.C. 1246(c)):

a. An affirmative determination has been made that bicycle use would not substantially interfere with the nature and purposes of the CDNST, and

b. Bicycles must also be allowed by the overall management direction for the land management plan area.

8. Where bicycle (mountain bike) use is allowed on the CDNST, consider establishing bicycle use prohibitions and restrictions (36 CFR part 261) to mitigate the effects of such use on the nature and purposes of the CDNST. Management practices and actions that would promote or result in increased bicycle use on the CDNST should not occur.

Regulatory Certifications

Environmental Impact

The directives would provide policy and procedural guidance to agency officials implementing the National Trails System Act. CDNST management decisions implementing the directives would include appropriate site-specific environmental analysis and public involvement. The directives would have no effect on the ground until site-specific planning decisions are completed, with opportunity for public involvement. Section 31b of USDA Forest Service Handbook 1909.15 (57 FR 43180, September 18, 1992) excludes from documentation in an environmental assessment or environmental impact statement ''rules, regulations, or policies to establish Service-wide administrative procedures, program processes, or instructions.'' The agency's conclusion is that the directives fall within this category of actions and that no extraordinary circumstances exist which would require preparation of an environmental assessment or environmental impact statement.

Regulatory Impact

The directives have been reviewed under USDA procedures and Executive Order (E.O.) 12866 on regulatory planning and review. The directives would not have an annual effect of $100 million or more on the economy, nor would it adversely affect productivity, competition, jobs, the environment, public health and safety, or State and local governments. The directives would not interfere with any action taken or planned by another agency, nor would they raise new legal or policy issues. Finally, the directives would not alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of beneficiaries of such programs. Accordingly, the directives are not subject to OMB review under E.O. 12866.

Regulatory Flexibility Act Analysis

The directives have been considered in light of the Regulatory Flexibility Act (5 U.S.C. 602 *et seq.*). The directives would not have any effect on small entities as defined by the Regulatory Flexibility Act. The directives would not directly affect small businesses, small organizations, and small governmental jurisdictions. Therefore, the agency has determined that the directives would not have a significant economic impact on a substantial number of small entities pursuant to the Regulatory Flexibility Act because the directives would not impose record-keeping requirements on them; the directives would not affect their competitive position in relation to large entities; and it would not affect their cash flow, liquidity, or ability to remain in the market.

No Takings Implications

The directives have been analyzed in accordance with the principles and criteria contained in E.O. 12630. It has been determined that the directives would not pose the risk of a taking of private property.

Federalism and Consultation and Coordination With Indian Tribal Governments

The agency has considered the directives under the requirements of E.O. 13132 on federalism, and has determined that the directives conform with the federalism principles set out in this E.O.; would not impose any compliance costs on the States; and would not have substantial direct effects on the States, the relationship between the Federal government and the States, or the distribution of power and responsibilities among the various

levels of government. Therefore, the agency has determined that no further assessment of federalism implications is necessary.

Moreover, the directives would not have Tribal implications as defined by E.O. 13175, Consultation and Coordination With Indian Tribal Governments, and therefore advance consultation with Tribes is not required.

Energy Effects

The directives have been reviewed under E.O. 13211 of May 18, 2001, Actions Concerning Regulations That Significantly Affect the Energy Supply. It has been determined that the directives would not constitute a significant energy action as defined in the E.O.

Unfunded Mandates

Pursuant to Title II of the Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1531–1538), which the President signed into law on March 22, 1995, the agency has assessed the effects of the directives on State, local, and Tribal governments and the private sector. The directives would not compel the expenditure of $100 million or more by an State, local, or Tribal government or anyone in the private sector. Therefore, a statement under section 202 of the act is not required.

Controlling Paperwork Burdens on the Public

These directives do not contain any record-keeping or reporting requirements or other information collection requirements as defined in 5 CFR part 1320 that are not already required by law or not already approved for use. Accordingly, the review provisions of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*) and its implementing regulations at 5 CFR part 1320 do not apply.

Dated: July 26, 2007.

Richard Stem,

Deputy Regional Forester.

[FR Doc. 07–3770 Filed 8–1–07; 8:45 am]

BILLING CODE 3410–11–M

DEPARTMENT OF AGRICULTURE

Rural Utilities Service

Information Collection Activity; Comment Request

AGENCY: Rural Utilities Service, USDA.

ACTION: Notice and request for comments.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35, as amended), the Rural Utilities Service, an agency delivering the United States Department of Agriculture's (USDA) Rural Development Utilities Programs, hereinafter referred to as Rural Development and/or Agency, invites comments on this information collection for which the Agency intends to request approval from the Office of Management and Budget (OMB).

DATES: Comments on this notice must be received by October 1, 2007.

FOR FURTHER INFORMATION CONTACT: Michele L. Brooks, Acting Director, Program Development & Regulatory Analysis, Rural Utilities Service, USDA, 1400 Independence Ave., SW., STOP 1522, Room 5159 South Building, Washington, DC 20250–1522. Telephone: (202) 720–0736. FAX: (202) 720–4120.

SUPPLEMENTARY INFORMATION:

Title: 7 CFR Part 1753, Telecommunications System Construction Policies and Procedures.

OMB Control Number: 0572–0059.

Type of Request: Revision of a currently approved collection package.

Abstract: In order to facilitate the programmatic interest of the RE Act, and, in order to assure that loans made or guaranteed by the Agency are adequately secured, the Agency, as a secured lender, has established certain forms for materials, equipment and construction of electric and telecommunications systems. The use of standard forms, construction contracts, and procurement procedures helps assure the Agency that appropriate standards and specifications are maintained, the Agency's loan security is not adversely affected; and the loan and loan guarantee funds are used effectively and for the intended purposes.

Over the past year and a half, the Agency has undertaken a comprehensive review of its Telecommunications Program contracts. The purpose of this undertaking is to improve customer service to the Agency's rural borrowers with a more efficient and effective means to complete a contract transaction as well as improve the internal efficiency of processing contracts.

Estimate of Burden: Public reporting burden for this collection of information is estimated to average 2 hours per response.

Respondents: Business or other for-profit and non-profit institutions.

Estimated Number of Respondents: 513.

Estimated Number of Responses per Respondent: 10.

Estimate Total Annual Burden on Respondents: 10,592 hours.

Copies of this information collection can be obtained from MaryPat Daskal, Program Development and Regulatory Analysis, USDA Rural Development at (202) 720–7853. Comments are invited on (a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; (b) the accuracy of the agency's estimate of burden including the validity of the methodology and assumption used; (c) ways to enhance the quality, utility and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques on other forms of information technology.

All responses to this notice will be summarized and included in the request for OMB approval. All comments will also become a matter of public record.

James M. Andrew,

Administrator, Rural Utilities Service.

[FR Doc. E7–14974 Filed 8–1–07; 8:45 am]

BILLING CODE 3410–15–P

COMMISSION ON CIVIL RIGHTS

Agenda and Notice of Public Meeting of the Illinois Advisory Committee

Notice is hereby given, pursuant to the provisions of the rules and regulations of the U.S. Commission on Civil Rights (Commission), and the Federal Advisory Committee Act (FACA), that a briefing meeting of the Illinois Advisory Committee to the Commission will convene at 10 a.m. and adjourn at 4 p.m. on August 17, 2007, at the Dirksen Federal Building, Courtroom 1719, 219 S. Dearborn St., Chicago, IL 60604. The purpose of the meeting is to gather data regarding the enforcement of prohibitions against religious discrimination in prisons. The agenda will include panels of presenters knowledgeable of the topic, including prisoners' rights advocates; state, county, and federal prison officials; clergy who serve the religious needs of inmates; and legal scholars.

Members of the public are entitled to submit written comments; the comments must be received in the regional office by August 24, 2007. The address is 55 West Monroe Street, Suite 410, Chicago, IL 60603. Persons wishing to email their comments, or to present

their comments verbally at the meeting, or who desire additional information should contact Carolyn Allen, Administrative Assistant, (312) 353–8311, TDD/TTY (312) 353–8362, or by email: *callen@usccr.gov.*

Hearing-impaired persons who will attend the meeting and require the services of a sign language interpreter should contact the Regional Office at least ten (10) working days before the scheduled date of the meeting.

Records generated from this meeting may be inspected and reproduced at the Midwestern Regional Office, as they become available, both before and after the meeting. Persons interested in the work of this advisory committee are advised to go to the Commission's website, *http://www.usccr.gov,* or to contact the Midwestern Regional Office at the above email or street address.

The meeting will be conducted pursuant to the provisions of the rules and regulations of the Commission and FACA.

Dated in Washington, DC, July 30, 2007.

Ivy Davis,

Acting Chief, Regional Programs Coordination Unit.

[FR Doc. E7–15028 Filed 8–1–07; 8:45 am]

BILLING CODE 6335–02–P

DEPARTMENT OF COMMERCE

Foreign-Trade Zones Board

[T–3–2007]

Foreign-Trade Zone 7—Mayaguez, PR; Temporary/Interim Manufacturing Authority Merck Sharpe & Dohme Quimica De Puerto Rico Inc. (Pharmaceutical Manufacturing); Notice of Approval

On May 10, 2007, the Executive Secretary of the Foreign-Trade Zones (FTZ) Board filed an application submitted by the Puerto Rico Industrial Development Company, grantee of FTZ 7, requesting temporary/interim manufacturing (T/IM) authority on behalf of Merck Sharpe & Dohme Quimica De Puerto Rico, Inc., within FTZ 7, at the MOVA Pharmaceutical Corporation pharmaceutical manufacturing facility located in Caguas, Puerto Rico.

The application was processed in accordance with T/IM procedures, as authorized by FTZ Board Orders 1347 (69 FR 52587, 8/30/04) and 1480 (71 FR 55422, 9/22/06), including notice in the **Federal Register** inviting public comment (72 FR 27801, 5/17/07). The FTZ staff examiner reviewed the application and determined that it meets the criteria for approval under T/IM procedures. Pursuant to the authority delegated to the FTZ Board Executive Secretary in Board Orders 1347 and 1480 the application was approved, effective July 23, 2007, until July 23, 2009, subject to the FTZ Act and the Board's regulations, including Section 400.28.

Dated: July 23, 2007.

Andrew McGilvray,

Executive Secretary.

[FR Doc. E7–15030 Filed 8–1–07; 8:45 am]

BILLING CODE 3510–DS–P

DEPARTMENT OF COMMERCE

International Trade Administration

Antidumping or Countervailing Duty Order, Finding, or Suspended Investigation; Advance Notification of Sunset Reviews

AGENCY: Import Administration, International Trade Administration, Department of Commerce.

ACTION: Notice of upcoming Sunset Reviews.

Background

Every five years, pursuant to section 751(c) of the Tariff Act of 1930, as amended, the Department of Commerce (''the Department'') and the International Trade Commission automatically initiate and conduct a review to determine whether revocation of a countervailing or antidumping duty order or termination of an investigation suspended under section 704 or 734 would be likely to lead to continuation or recurrence of dumping or a counteravailable subsidy (as the case may be) and of material injury.

Upcoming Sunset Reviews for September 2007

The following Sunset Reviews are scheduled for initiation in September 2007 and will appear in that month's Notice of Initiation of Five-Year Sunset Reviews.

	Department contact
Antidumping Duty Proceeding	
Carbon and Certain Alloy Steel Wire Rod from Brazil (A–351–832)	Brandon Farlander (202) 482–0182.
Carbon and Certain Alloy Steel Wire Rod from Canada (A–122–840)	Brandon Farlander (202) 482–0182.
Carbon and Certain Alloy Steel Wire Rod from Mexico (A–201–830)	Brandon Farlander (202) 482–0182.
Carbon and Certain Alloy Steel Wire Rod from Trinidad and Tobago (A–274–804)	Brandon Farlander (202) 482–0182.
Carbon and Certain Alloy Steel Wire Rod from Ukraine (A–823–812)	Brandon Farlander (202) 482–0182.
Carbon and Certain Alloy Steel Wire Rod from Indonesia (A–560–815)	Brandon Farlander (202) 482–0182.
Carbon and Certain Alloy Steel Wire Rod from Moldova (A–841–805)	Brandon Farlander (202) 482–0182.
Countervailing Duty Proceedings	
Carbon and Certain Alloy Steel Wire Rod from Brazil (C–351–833)	Brandon Farlander (202) 482–0182.

Suspended Investigations

No Sunset Reviews of suspended investigations are scheduled for initiation in September 2007.

The Department's procedures for the conduct of Sunset Reviews are set forth in 19 CFR 351.218. Guidance on methodological or analytical issues relevant to the Department's conduct of Sunset Reviews is set forth in the Department's Policy Bulletin 98.3—Policies Regarding the Conduct of Five-Year (''Sunset'') Reviews of Antidumping and Countervailing Duty Orders; Policy Bulletin, 63 FR 18871 (April 16, 1998). The Notice of Initiation of Five-Year (''Sunset'') Reviews provides further information regarding what is required of all parties to participate in Sunset Reviews.

Pursuant to 19 CFR 351.103(c), the Department will maintain and make available a service list for these proceedings. To facilitate the timely preparation of the service list(s), it is requested that those seeking recognition as interested parties to a proceeding

contact the Department in writing within 15 days of the publication of the Notice of Initiation.

Please note that if the Department receives a Notice of Intent to Participate from a member of the domestic industry within 15 days of the date of initiation, the review will continue. Thereafter, any interested party wishing to participate in the Sunset Review must provide substantive comments in response to the notice of initiation no later than 30 days after the date of initiation.

This notice is not required by statute but is published as a service to the international trading community.

Dated: July 23, 2007.

Stephen J. Claeys,

Deputy Assistant Secretary for Import Administration.

[FR Doc. 07–3767 Filed 8–01–07; 8:45 am]

BILLING CODE 3510–DS–M

DEPARTMENT OF COMMERCE

International Trade Administration

Antidumping or Countervailing Duty Order, Finding, or Suspended Investigation; Opportunity to Request Administrative Review

AGENCY: Import Administration, International Trade Administration, Department of Commerce.

FOR FURTHER INFORMATION CONTACT: Sheila E. Forbes, Office of AD/CVD Operations, Customs Unit, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue, NW., Washington, DC 20230, telephone: (202) 482–4697.

Background

Each year during the anniversary month of the publication of an antidumping or countervailing duty order, finding, or suspension of investigation, an interested party, as defined in section 771(9) of the Tariff Act of 1930, as amended, may request, in accordance with section 351.213 (2002) of the Department of Commerce (the Department) Regulations, that the Department conduct an administrative review of that antidumping or countervailing duty order, finding, or suspended investigation.

Opportunity to Request a Review: Not later than the last day of August 2007,[1] interested parties may request administrative review of the following orders, findings, or suspended investigations, with anniversary dates in August for the following periods:

	Period
Antidumping Duty Proceeding	
Germany:	
Corrosion-Resistant Carbon Steel Flat Products, A–428–815	8/1/06–7/31/07
Seamless Line and Pressure Pipe, A–428–820	8/1/06–7/31/07
Italy:	
Granular Polytetrafluoroethylene Resin, A–475–703	8/1/06–7/31/07
Japan:	
Brass Sheet & Strip, A–588–704	8/1/06–7/31/07
Granular Polytetrafluoroethylene Resin, A–588–707	8/1/06–7/31/07
Tin Mill Products, A–588–854	8/1/06–7/31/07
Malaysia:	
Polyethylene Retail Carrier Bags, A–557–813	8/1/06–7/31/07
Mexico:	
Gray Portland Cement and Cement Clinker, A–201–802	8/1/06–7/31/07
Republic Of Korea:	
Corrosion-Resistant Carbon Steel Flat Products, A–580–816	8/1/06–7/31/07
Romania:	
Carbon and Alloy Seamless Standard, Line, and Pressure Pipe (Under 4½ Inches), A–485–805	8/1/06–7/31/07
Thailand:	
Polyethylene Retail Carrier Bags, A–549–821	8/1/06–7/31/07
The People's Republic of China:	
Floor Standing Metal-Top Ironing Tables and Parts Thereof, A–570–888	8/1/06–7/31/07
Petroleum Wax Candles, A–570–504	8/1/06–7/31/07
Polyethylene Retail Carrier Bags, A–570–886	8/1/06–7/31/07
Sulfanilic Acid, A–570–815	8/1/06–7/31/07
Tetrahydrofurfuryl Alcohol, A–570–887	8/1/06–7/31/07
Vietnam:	
Frozen Fish Fillets, A–552–801	8/1/06–7/31/07
Countervailing Duty Proceedings	
Italy:	
Oil Country Tubular Goods, C–475–817	1/1/06–7/24/06
Republic of Korea:	
Corrosion-Resistant Carbon Steel Plate, C–580–818	1/1/06–12/31/06
Dynamic Random Access Memory Semiconductors, C–580–851	1/1/06–12/31/06
Stainless Steel Sheet and Strip in Coils, C–580–835	1/1/06–12/31/06

Suspension Agreements

None.

In accordance with section 351.213(b) of the regulations, an interested party as defined by section 771(9) of the Act may request in writing that the Secretary conduct an administrative review. For both antidumping and countervailing duty reviews, the interested party must specify the individual producers or exporters covered by an antidumping finding or an antidumping or

[1] Or the next business day, if the deadline falls on a weekend, federal holiday or any other day when the Department is closed.

countervailing duty order or suspension agreement for which it is requesting a review, and the requesting party must state why it desires the Secretary to review those particular producers or exporters.[2] If the interested party intends for the Secretary to review sales of merchandise by an exporter (or a producer if that producer also exports merchandise from other suppliers) which were produced in more than one country of origin and each country of origin is subject to a separate order, then the interested party must state specifically, on an order-by-order basis, which exporter(s) the request is intended to cover.

As explained in *Antidumping and Countervailing Duty Proceedings: Assessment of Antidumping Duties*, 68 FR 23954 (May 6, 2003), the Department has clarified its practice with respect to the collection of final antidumping duties on imports of merchandise where intermediate firms are involved. The public should be aware of this clarification in determining whether to request an administrative review of merchandise subject to antidumping findings and orders. See also the Import Administration Web site at *http://ia.ita.doc.gov.*

Six copies of the request should be submitted to the Assistant Secretary for Import Administration, International Trade Administration, Room 1870, U.S. Department of Commerce, 14th Street & Constitution Avenue, NW., Washington, DC 20230. The Department also asks parties to serve a copy of their requests to the Office of Antidumping/Countervailing Operations, Attention: Sheila Forbes, in room 3065 of the main Commerce Building. Further, in accordance with section 351.303(f)(l)(i) of the regulations, a copy of each request must be served on every party on the Department's service list.

The Department will publish in the **Federal Register** a notice of ''Initiation of Administrative Review of Antidumping or Countervailing Duty Order, Finding, or Suspended Investigation'' for requests received by the last day of August 2007. If the Department does not receive, by the last day of August 2007, a request for review of entries covered by an order, finding, or suspended investigation listed in this notice and for the period identified above, the Department will instruct the U.S. Customs and Border Protection to assess antidumping or countervailing duties on those entries at a rate equal to the cash deposit of (or bond for) estimated antidumping or countervailing duties required on those entries at the time of entry, or withdrawal from warehouse, for consumption and to continue to collect the cash deposit previously ordered.

This notice is not required by statute but is published as a service to the international trading community.

Dated: July 23, 2007.

Stephen J. Claeys,

Deputy Assistant Secretary, for Import Administration.

[FR Doc. E7–14948 Filed 8–1–07; 8:45 am]

BILLING CODE 3510–DS–P

[2] If the review request involves a non-market economy and the parties subject to the review request do not qualify for separate rates, all other exporters of subject merchandise from the non-market economy country who do not have a separate rate will be covered by the review as part of the single entity of which the named firms are a part.

DEPARTMENT OF COMMERCE

International Trade Administration

[A–357–812, A–570–863, C–357–813]

Continuation of Antidumping Duty Orders on Honey From Argentina and the People's Republic of China, and Continuation of Countervailing Duty Order on Honey From Argentina

AGENCY: Import Administration, International Trade Administration, Department of Commerce.

SUMMARY: As a result of the determinations by the Department of Commerce (the Department) and the International Trade Commission (the Commission) that revocation of the antidumping duty (AD) orders on honey from Argentina and the People's Republic of China (PRC) would likely lead to continuation or recurrence of dumping; that revocation of the countervailing duty (CVD) order on honey from Argentina would likely lead to continuation or recurrence of a countervailable subsidy; and, that revocation of these AD and CVD orders would likely lead to a continuation or recurrence of material injury to an industry in the United States, the Department is publishing this notice of continuation of these AD and CVD orders.

DATES: *Effective Date:* August 2, 2007.

FOR FURTHER INFORMATION CONTACT: Deborah Scott (AD orders), Elfi Blum (CVD order), or Dana Mermelstein, AD/CVD Operations, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Ave., NW., Washington, DC 20230; telephone: (202) 482–2657, (202) 482–0197, or (202) 482–1391, respectively.

SUPPLEMENTARY INFORMATION:

Background

On November 1, 2006, the Department initiated and the Commission instituted sunset reviews of the AD orders on honey from Argentina and the PRC and the CVD order on honey from Argentina, pursuant to sections 751(c) and 752 of the Tariff Act of 1930, as amended (the Act), respectively. *See Initiation of Five-Year (''Sunset'') Reviews,* 71 FR 64242 (November 1, 2006) and *Honey From Argentina and China,* 71 FR 64292 (November 1, 2006). As a result of its reviews, the Department found that revocation of the AD orders would likely lead to a continuation or recurrence of dumping, and that revocation of the CVD order would likely lead to continuation or recurrence of subsidization, and notified the Commission of the dumping margins and the countervailable subsidy rates likely to prevail if the orders were revoked. *See Honey From Argentina and the People's Republic of China; Final Results of the Expedited Five-Year (''Sunset'') Reviews of Antidumping Duty Orders,* 72 FR 10150 (March 7, 2007), and *Honey from Argentina: Final Results of Full Sunset Review of the Countervailing Duty Order,* 72 FR 32078 (June 11, 2007).

On June 14, 2007, the Commission determined that revocation of the AD orders on honey from Argentina and the PRC and the CVD order on honey from Argentina would be likely to lead to continuation or recurrence of material injury to an industry in the United States within a reasonably foreseeable time. *See Honey from Argentina and China,* 72 FR 39445 (July 18, 2007), and USITC Publication 3929 (June 2007) (Inv. Nos. 701–TA–402 and 731–TA–892 and 893 (Review)).

Scope of the AD Orders

For purposes of these orders, the products covered are natural honey, artificial honey containing more than 50 percent natural honey by weight, preparations of natural honey containing more than 50 percent natural honey by weight, and flavored honey. The subject merchandise includes all grades and colors of honey whether in liquid, creamed, comb, cut comb, or chunk form, and whether packaged for retail or in bulk form.

The merchandise covered by these orders is currently classifiable under subheadings 0409.00.00, 1702.90.90, and 2106.90.99 of the *Harmonized Tariff Schedule of the United States* (HTSUS). Although the HTSUS subheadings are provided for convenience and customs purposes, the Department's written description of the

merchandise under this order is dispositive.

Scope of the CVD Order

The merchandise subject to this order is natural honey, artificial honey containing more than 50 percent natural honey by weight, preparations of natural honey containing more than 50 percent natural honey by weight, and flavored honey. The subject merchandise includes all grades and colors of honey whether in liquid, creamed, combs, cut comb, or chunk form, and whether packaged for retail or in bulk form.

The merchandise subject to this order is currently classifiable under subheadings 0409.00.00, 1702.90.90, and 2106.90.99 of the HTSUS. Although the HTSUS subheadings are provided for convenience and customs purposes, the Department's written description of the merchandise covered by this order is dispositive.

Determination

As a result of the determinations by the Department and the Commission that revocation of these AD and CVD orders would be likely to lead to continuation or recurrence of dumping or a countervailable subsidy and continuation or recurrence of material injury to an industry in the United States, pursuant to section 751(d)(2) of the Act, the Department hereby orders the continuation of the AD orders on honey from Argentina and the PRC and the CVD order on honey from Argentina.

U.S. Customs and Border Protection will continue to collect cash deposits at the rates in effect at the time of entry for all imports of subject merchandise. The effective date of continuation of these orders is the date of publication in the **Federal Register** of this notice of continuation. Pursuant to section 751(c)(2) of the Act, the Department intends to initiate the next five-year review of these orders not later than 30 days prior to the fifth anniversary of the effective date of continuation.

This notice also serves as the only reminder to parties subject to administrative protective order (APO) of their responsibility concerning the return/destruction or conversion to judicial protective order of proprietary information disclosed under APO in accordance with 19 CFR 351.305(a)(3). Failure to comply is a violation of the APO which may be subject to sanctions.

These five-year (''Sunset'') reviews and this continuation notice are in accordance with section 751(c) of the Act. This notice is published pursuant to 777(i) of the Act.

Dated: July 24, 2007.

David M. Spooner,

Assistant Secretary, for Import Administration.

[FR Doc. E7–14918 Filed 8–1–07; 8:45 am]

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DEPARTMENT OF COMMERCE

International Trade Administration

[A–428–801]

Ball Bearings and Parts Thereof from Germany: Notice of Court Decision Not in Harmony

AGENCY: Import Administration, International Trade Administration, Department of Commerce.

SUMMARY: On June 29, 2007, the United States Court of International Trade affirmed the Department of Commerce's redetermination on remand of the final results of the administrative review of the antidumping duty order on ball bearings and parts thereof from Germany. See *Paul Mueller Industrie GmbH & Co. v. United States*, Court No. 04–00522, slip op. 07–100 (CIT 2007) (*Paul Mueller*). The Department is now issuing this notice of court decision not in harmony with the Department's determination.

EFFECTIVE DATE: August 2, 2007.

FOR FURTHER INFORMATION CONTACT: David Dirstine or Richard Rimlinger, AD/CVD Operations, Office 5, Import Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue, NW, Washington, DC 20230; telephone: (202) 482–4033 or (202) 482–4477, respectively.

SUPPLEMENTARY INFORMATION:

Background

On September 15, 2004, the Department of Commerce (the Department) published the final results of the administrative review of the antidumping duty order on ball bearings and parts thereof from Germany for the period May 1, 2002, through April 30, 2003. See *Antifriction Bearings and Parts Thereof From France, Germany, Italy, Japan, Singapore, and the United Kingdom: Final Results of Antidumping Duty Administrative Reviews, Rescission of Administrative Reviews in Part, and Determination To Revoke Order in Part*, 69 FR 55574 (September 15, 2004) (*Final Results*). The *Final Results* were amended in *Ball Bearings and Parts Thereof from Germany; Amended Final Results of Antidumping Duty Administrative Review*, 69 FR 63507 (November 2, 2004) (*Amended Final Results*). Paul Mueller Industrie GmbH (Paul Mueller) and Timken US Corporation (Timken) filed lawsuits challenging the *Final Results* as amended by the *Amended Final Results*. The Department requested a voluntary remand on two issues. On May 26, 2006, the United States Court of International Trade (CIT) granted the Department's request and ordered the Department to address two items: (1) correct a ministerial error involving a billing adjustment reported by Paul Mueller for one home–market transaction and to recalculate its antidumping margin accordingly; (2) explain its treatment of Paul Mueller's inventory carrying costs.

In accordance with the CIT's remand order in *Paul Mueller v. United States*, 435 F. Supp. 2d at 1241, 1246–1247 (CIT 2006), the Department filed its redetermination on remand of the final results (remand results) on September 13, 2006. In its redetermination, the Department corrected the ministerial error and made a change to its treatment of the inventory carrying costs to ensure that home–market and U.S. inventory carrying costs were calculated on a consistent basis. On June 29, 2007, the CIT affirmed the Department's remand results. The CIT's decision was not made publicly available until July 17, 2007, when the Court entered its judgment. See *Paul Mueller*, slip op. 07–100.

Decision Not in Harmony

By affirming the remand results, the CIT recognized that the Department had made a ministerial error in its calculation of a billing adjustment for Paul Mueller and that its initial calculations of inventory carrying costs for Paul Mueller's home–market and U.S. inventory carrying costs were not made on a consistent basis.

The changes to our calculations with respect to Paul Mueller resulted in a change in the weighted–average margin for ball bearings and parts thereof from 0.44 percent to 0.46 percent for the period of review. Accordingly, absent an appeal or, if appealed, upon a final and conclusive court decision in this action, we will amend our final results of this review to reflect the recalculation of the margin for Paul Mueller.

Suspension of Liquidation

The United States Court of Appeals for Federal Circuit (CAFC) held that the Department must publish notice of a decision of the CIT or the CAFC which is not in harmony with the Department's determination. See *The Timken Company v. United States*, 893 F.2d 337, 341 (CAFC 1990). Publication of this notice fulfills that obligation. The CAFC also held that, in such a case, the

Department must suspend liquidation until there is a ''conclusive'' decision in the action. *Id.* Therefore, the Department must suspend liquidation pending the expiration of the period to appeal the CIT's June 29, 2007, decision or, if appealed, pending a final and conclusive court decision.

Because entries of ball bearings and parts thereof from Germany produced and exported to the United States by Paul Mueller are currently being suspended pursuant to the court's injunction order in effect, the Department does not need to order U.S. Customs and Border Protection to suspend liquidation of affected entries. The Department will not order the lifting of the suspension of liquidation on entries of ball bearings and parts thereof made during the review period before a court decision in this lawsuit becomes final and conclusive.

We are issuing and publishing this notice in accordance with section 516A(c)(1) of the Tariff Act of 1930, as amended.

Dated: July 24, 2007.

David M. Spooner,

Assistant Secretary for Import Administration.

[FR Doc. E7–15031 Filed 8–1–07; 8:45 am]

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DEPARTMENT OF COMMERCE

International Trade Administration

[A–570–846]

Brake Rotors From the People's Republic of China: Final Results of Antidumping Duty Administrative and New Shipper Reviews and Partial Rescission of the 2005–2006 Administrative Review

AGENCY: Import Administration, International Trade Administration, Department of Commerce.

SUMMARY: On February 15, 2007, the Department of Commerce (''Department'') published *Brake Rotors From the People's Republic of China: Preliminary Results of the 2005 2006 Administrative and New Shipper Reviews and Partial Rescission of the 2005 2006 Administrative Review*, 72 FR 7405 (February 15, 2007) (''*Preliminary Results*''). The period of review (''POR'') is April 1, 2005, through March 31, 2006. The administrative review covers three mandatory respondents and 12 separate–rate respondents. The new shipper review covers one new shipper.

We invited interested parties to comment on our *Preliminary Results*. Based on our analysis of the comments received, we made certain changes to our calculations. The final dumping margins for the administrative and new shipper reviews are listed in the ''Final Results of the Reviews'' section, below.

EFFECTIVE DATE: August 2, 2007.

FOR FURTHER INFORMATION CONTACT: Jennifer Moats for Longkou Haimeng Machinery Co., Ltd. and Qingdao Golrich Autoparts Co., Ltd., or Frances Veith for Yantai Winhere Auto–Part Manufacturing Co., Ltd. and Qingdao Meita Automotive, AD/CVD Operations, Office 8, Import Administration, International Trade Administration, U.S. Department of Commerce, 1401 Constitution Avenue, NW, Washington, DC 20230; telephone: 202–482–5047 and 202–482–4295, respectively.

SUPPLEMENTARY INFORMATION:

Background

On February 15, 2007, the Department published the Preliminary Results of the administrative and new shipper reviews of the antidumping duty order on brake rotors from the People's Republic of China (''PRC'').

On March 6, 2007, the Department issued a letter to all interested parties granting a 28-day extension of time to submit publicly available information to value the factors of production for the final results of these reviews and postponed the briefing schedule pending the Department's release of the Shandong Huanri Group General Co., Laizhou Huanri Automobile Parts Co., Ltd, and Shandong Huanri Group Co., Ltd. (collectively, ''Huanri'') verification report.

From March 20 through March 22, 2007, the Department conducted a verification of Huanri and released its verification report of Huanri on May 4, 2007.[1] On May 9, 2007, the Department issued a memorandum stating that it would revise the surrogate value for steel strap to include Indian import data from Ukraine for February and March 2006 for the final results.[2] *See* ''Surrogate Value'' section below. On May 10, 2007, the Department revised the deadline for submission of case and rebuttal briefs to May 21 and May 29, 2007, respectively. On May 15, 2007, in response to a request filed by the Coalition for the Preservation of American Brake Drum and Rotor Aftermarket Manufacturers (''the petitioner''), the Department extended the deadline for submission of rebuttal briefs until June 5, 2007. On May 21, 2007, the Department received case briefs from Laizhou Auto Brake Equipment Company (''LABEC''), Yantai Winhere Auto–Part Manufacturing Co., Ltd. (''Winhere''), Longkou Haimeng Machinery Co., Ltd. (''Haimeng''), Laizhou Luqi Machinery Co., Ltd. (''Luqi''), Laizhou Hongda Auto Replacement Co., Ltd. (''Hongda''), Qindgdao Meita Automotive Industry Co., Ltd. (''Meita'') (collectively, ''the Trade Pacific respondents''), and the petitioner. On May 21, 2007, the Department placed the supporting documentation regarding the Department's calculation of the surrogate wage rate used in respondents' margin calculations on the record of these reviews.[3] On June 5, 2007, we received rebuttal briefs from the petitioner and the Trade Pacific respondents.

On June 11, 2007, the Department published a notice extending the time limit for the completion of the final results of these reviews until July 31, 2007. *See Brake Rotors from the People's Republic of China: Extension of Time Limit for the Final Results of the 2005–2006 Administrative and New Shipper Reviews*, 72 FR 32071 (June 11, 2007).

We conducted these reviews in accordance with sections 751 and 777(i)(1) of the Tariff Act of 1930, as amended (''the Act''), and sections 19 CFR 351.213 and 19 CFR 351.221 of the agency's regulations.

Period of Review

The POR is April 1, 2005, through March 31, 2006.

Scope of the Order

The products covered by this order are brake rotors made of gray cast iron, whether finished, semifinished, or unfinished, ranging in diameter from 8 to 16 inches (20.32 to 40.64 centimeters) and in weight from 8 to 45 pounds (3.63

[1] *See* Memorandum from Eugene Degnan, Senior International Trade Compliance Analyst, AD/CVD Operations, Office 8, and Paul Stolz, International Trade Compliance Analyst, AD/CVD Operations, Office 8, through Robert Bolling, Program Manager, AD/CVD Operations, Office 8 and Wendy J. Frankel, Director, AD/CVD Operations, Office 8, to the File entitled, ''Antidumping Duty Administrative Review of Brake Rotors from the People's Republic of China: Verification of Section A and Quantity and Value Response of Shandong Huanri Group Co., Ltd., Laizhou Huanri Automobile Parts Co., Ltd., and Shandong Huanri Group General Co.,'' dated May 4, 2007 (''*Huanri Verification Report*'').

[2] *See* Memorandum from Ann Fornaro, International Trade Compliance Analyst, to the File entitled, ''2005-2006 Antidumping Duty Administrative and New Shipper Reviews of Brake Rotors from the People's Republic of China - Surrogate Value Change for Final Results,'' dated May 9, 2007 (''*Surrogate Value Change Memo*'').

[3] *See* Memorandum from Ann Fornaro, International Trade Compliance Analyst, to the File entitled, ''2005-2006 Antidumping Duty Administrative Review of Brake Rotors from the People's Republic of China - Expected Wages of Selected Non-Market Economy Countries,'' dated May 21, 2007.

to 20.41 kilograms). The size parameters (weight and dimension) of the brake rotors limit their use to the following types of motor vehicles: automobiles, all–terrain vehicles, vans and recreational vehicles under ''one ton and a half,'' and light trucks designated as ''one ton and a half.''

Finished brake rotors are those that are ready for sale and installation without any further operations. Semi–finished rotors are those on which the surface is not entirely smooth, and have undergone some drilling. Unfinished rotors are those which have undergone some grinding or turning.

These brake rotors are for motor vehicles, and do not contain in the casting a logo of an original equipment manufacturer (''OEM'') which produces vehicles sold in the United States. (*e.g.*, General Motors, Ford, Chrysler, Honda, Toyota, Volvo). Brake rotors covered in this order are not certified by OEM producers of vehicles sold in the United States. The scope also includes composite brake rotors that are made of gray cast iron, which contain a steel plate, but otherwise meet the above criteria. Excluded from the scope of this order are brake rotors made of gray cast iron, whether finished, semifinished, or unfinished, with a diameter less than 8 inches or greater than 16 inches (less than 20.32 centimeters or greater than 40.64 centimeters) and a weight less than 8 pounds or greater than 45 pounds (less than 3.63 kilograms or greater than 20.41 kilograms).[4]

Brake rotors are currently classifiable under subheadings 8708.39.5010, 8708.39.5030, and 8708.30.5030 of the *Harmonized Tariff Schedule of the United States* (''HTSUS'').[5] Although the HTSUS subheadings are provided for convenience and customs purposes, the written description of the scope of this order is dispositive.

Analysis of Comments Received

All issues raised in the case and rebuttal briefs filed by parties in these reviews are addressed in the Memorandum from Stephen J. Claeys, Deputy Assistant Secretary for Import Administration, to David M. Spooner, Assistant Secretary for Import Administration, ''Issues and Decision Memorandum for the 2005–2006 Administrative and New Shipper Reviews of Brake Rotors From the People's Republic of China,'' dated July 27, 2007 (''*Issues and Decision Memo*''), which is hereby adopted by this notice. A list of the issues that parties raised and to which we responded in the *Issues and Decision Memo* follows as an appendix to this notice. The *Issues and Decision Memo* is a public document which is on file in the Central Records Unit (''CRU'') in room B–099 of the main Department building, and is also accessible on the Web at <http://ia.ita.doc.gov/frn/>. The paper copy and electronic version of the *Issues and Decision Memo* are identical in content.

Verification

In the *Preliminary Results*, we stated that we intended to verify the information reported to the Department by Huanri in its separate–rate application.[6] From March 20 through March 22, 2007, the Department conducted a verification of Huanri at Huanri's headquarters in Panjia Village, Laizhou, China. We used standard verification procedures, including on–site inspection of the company's facilities and examination of relevant sales and financial records to verify Section A, and quantity and value information submitted by Huanri on the record of the administrative review. The Department issued the results of the verification on May 4, 2007. For further details on the verification, *see* the *Huanri Verification Report*.

Partial Rescission of Administrative Review

In the *Preliminary Results*, the Department issued a notice of intent to rescind the administrative review with respect to Hongfa Machinery (Dalian) Co., Ltd. (''Hongfa''), Laizhou Wally Automobile Co., Ltd. (''Wally''), Xianghe Xumingyuan Auto Parts Co. (''Xumingyuan''), China National Automotive Industry Import & Export Corporation (''CAIEC''), Shandong Laizhou CAPCO Industry (''CAPCO''), Laizhou Luyuan Automobile Fittings Co. (''Luyuan''), and Shenyang Honbase Machinery Co., Ltd. (''Honbase''), in accordance with 19 CFR 351.213(d)(3), because we found no evidence that any of these companies made shipments of subject merchandise to the United States during the POR. *See Preliminary Results*, 72 FR at 7409. The Department received no comments on this issue, and we did not receive any further information since the issuance of the *Preliminary Results* that provides a basis for reconsideration of this determination. Therefore, the Department is rescinding this administrative review with respect to Hongfa, Wally, Xumingyuan, CAIEC, CAPCO, Luyuan, and Honbase.

Separate Rates

In our *Preliminary Results*, we determined that Qingdao Rotec Auto Parts Co., Ltd. (''Rotec'') and Xiangfen Hengtai Brake System Co., Ltd. (''Hengtai'') did not qualify for a separate rate and, therefore, are deemed to be included in the PRC–wide entity, and subject to the PRC–wide rate. *See Preliminary Results*, 72 FR at 7410. The Department received no comments on this issue, and we did not receive any further information since the issuance of the *Preliminary Results* that provides a basis for reconsideration of these determinations for the final results. We also determined that the three mandatory (*i.e.*, Haimeng, Meita, and Winhere) and 12 separate–rate respondents (*i.e.*, non–selected respondents)[7] met the criteria for the assignment of a separate rate. Based on the results of Huanri's verification and the Department's careful consideration of comments placed on the record by parties, we have determined that Huanri is eligible for a separate rate in the final results of the administrative review. *See Issues and Decision Memo* at Comment 11.

The PRC–Wide Rate and Use of Facts Otherwise Available

In the *Preliminary Results*, we determined that the PRC–wide entity (including Hengtai and Rotec) received copies of the Department's questionnaire but did not respond and, therefore, failed to cooperate to the best of their ability in the administrative

[4] On January 17, 2007, the Department determined the brake rotors produced by Federal-Mogul and certified by the Ford Motor Company to be excluded from the scope of the order. *See* Memorandum from Blanche Ziv, Program Manager, AD/CVD Operations, Office 8, through Wendy J. Frankel, Office Director, AD/CVD Operations, Office 8, to Stephen J. Claeys, Deputy Assistant Secretary for Import Administration, entitled, ''Scope Ruling of the Antidumping Duty Order on Brake Rotors from the People's Republic of China; Federal-Mogul Corporation,'' dated January 17, 2007.

[5] As of January 1, 2005, the HTS classification for brake rotors (discs) changed from 8708.39.5010 to 8708.39.5030. As of January 1, 2007, the HTS classification for brake rotors (discs) changed from 8708.39.5030 to 8708.30.5030. *See Harmonized Tariff Schedule of the United States (2005)*, available at <www.usitc.gov>. *See also* Memorandum from Ann Fornaro, International Trade Compliance Analyst, through Blanche Ziv, Program Manager, to the File entitled, ''Brake Rotors from the People's Republic of China: Change in HTS Code for Subject Merchandise,'' dated February 6, 2007.

[6] *See Preliminary Results*, 72 FR at 7408.

[7] The non-selected respondents are as follows: China National Industrial Machinery Import & Export Corporation (''CNIM''), LABEC, Qingdao Gren Co. (''Gren''), Zibo Luzhou Automobile Parts Co., Ltd. (''ZLAP''), Hongda, Longkou TLC Machinery Co., Ltd. (''Longkou TLC''), Zibo Golden Harvest Machinery Limited Company (''ZGOLD''), Luqi, Shenyang Yinghao Machinery Co., Longkou Jinzheng Machinery Co. (''Jinzheng''), Shanxi Zhongding Auto Parts Co., Ltd. (''SZAP''), and Huanri.

review. *See Preliminary Results*, 72 FR at 7410–12. Accordingly, we determined that the use of facts otherwise available in reaching our determination is appropriate pursuant to sections 776(a)(2)(A) and (B) of the Act, and that the use of an adverse inference in selecting from the facts available is appropriate pursuant to section 776(b) of the Act. *See Preliminary Results*, 72 FR at 7410. In accordance with section 776(b)(1) of the Act, as adverse facts available, we assigned to the PRC–entity (including Hengtai and Rotec) the PRC–wide rate of 43.32 percent. For detailed information on the Department's corroboration of this rate, *see Preliminary Results*, 72 FR at 7411, and Memorandum from Ann Fornaro, International Trade Analyst, through Blanche Ziv, Program Manager, AD/CVD Enforcement Office 8, and Wendy J. Frankel, Office Director, AD/CVD Enforcement Office 8, to the File, entitled, ''Corroboration of the PRC–Wide Adverse Facts–Available Rate,'' dated February 9, 2007.

Changes Since the Preliminary Results

Based on our analysis of comments received from interested parties and information on the record of these reviews, we made changes to the margin calculations as noted below.

For the final results, we have corrected the calculation of freight values for Golrich's carton and steel buckle inputs by multiplying the distance from the domestic supplier to the factory by the surrogate value for truck freight, instead of adding those two values. For further details, *see* the *Issues and Decision Memo* at Comment 13, and Memorandum from Ann Fornaro, International Trade Analyst, through Blanche Ziv, Program Manager, AD/CVD Operations Office 8, to the File, entitled, ''Analysis for the Final Results of the 2005–2006 New Shipper Review of the Antidumping Duty Order on Brake Rotors from the People's Republic of China: Qingdao Golrich Autoparts Co., Ltd.,'' dated July 27, 2007 (''*Golrich Analysis Memo*'').

For further details on company–specific calculations, *see* the company–specific analysis memoranda.[8]

We have made certain changes to the financial ratio calculations for the final results. For further details, *see* the *Issues and Decision Memo* at Comment 3.

We determined that we inadvertently excluded Ukraine import data for February and March 2006 in the calculation of the surrogate value for steel strap in the *Preliminary Results*. Therefore, we recalculated the surrogate value for steel strap to include the Ukraine data for those two months for the final results.[9] For further information on the calculation of this value, *see* Memorandum from Ann Fornaro, Trade Compliance Analyst, through Blanche Ziv, Program Manager, AD/CVD Operations Office 8, to the File entitled, ''2005–2006 Administration and New Shipper Reviews of the Antidumping Duty Order of Brake Rotors from the People's Republic of China Surrogate Values for the Final Results,'' dated July 27, 2007 (''*Final Surrogate Value Memo*'').

We have also made changes to the surrogate values for cartons. For further details, see the *Issues and Decision Memo* at Comment 9 and *Final Surrogate Value Memo*.

Final Results of the Reviews

We determine that the following final dumping margins exist for the period April 1, 2005, through March 31, 2006:

Individually Reviewed Exporters 2005–2006 Administrative Review	Weighted–Average Percent Margin
Longkou Haimeng Machinery Co., Ltd.	4.22
Yantai Winhere Auto–Part Manufacturing Co., Ltd.	0.03 (*de minimis*)
Qingdao Meita Automotive Industry Co., Ltd.	0.00

Separate–Rate Applicant Exporters 2005–2006 Administrative Review	Weighted–Average Percent Margin
China National Industrial Machinery I & E Co.[10]	4.22
Laizhou Auto Brake Equipment Co., Ltd.	4.22
Qingdao Gren (Group) Co.[11]	4.22
Zibo Luzhou Automobile Parts Co., Ltd.	4.22
Laizhou Hongda Auto Replacement Parts Co., Ltd.	4.22
Longkou TLC Machinery Co., Ltd.	4.22
Zibo Golden Harvest Machinery Limited Company	4.22
Laizhou City Luqi Machinery Co., Ltd.	4.22
Shenyang Yinghao Machinery Co.	4.22
Longkou Jinzheng Machinery Co., Ltd.	4.22
Shanxi Zhongding Auto Parts Co., Ltd.	4.22
Shandong Huanri Group Co., Ltd.	4.22

[10] This company is also known as China National Industrial Machinery Import & Export Corporation.
[11] This company is also known as Qingdao Gren Co. and Gren Group (Qingdao) Co.

2005–2006 New Shipper Review	Weighted–Average Percent Margin
Qingdao Golrich Autoparts Co., Ltd.	0.00

[8] Memorandum from Jennifer Moats, Senior International Trade Analyst, through Blanche Ziv, Program Manager, AD/CVD Operations Office 8, to the File, entitled, ''Analysis for the Final Results of the 2005-2006 Administrative Review of the Antidumping Duty Order on Brake Rotors from the People's Republic of China: Longkou Haimeng Machinery Co., Ltd.,'' dated July 27, 2007; Memorandum from Frances Veith, International Trade Compliance Analyst, through Blanche Ziv, Program Manager, AD/CVD Operations Office 8, to the File, entitled, ''Analysis for the Final Results of the 2005-2006 Antidumping Duty Administrative Review of Brake Rotors from the People's Republic of China: Qingdao Meita Automotive Industry Co., Ltd.,'' dated July 27, 2007; Memorandum from Frances Veith, International Trade Compliance Analyst, through Blanche Ziv, Program Manager, AD/CVD Operations Office 8, to the File, entitled, ''Analysis for the Final Results of the 2005-2006 Antidumping Duty Administrative Review of Brake Rotors from the People's Republic of China: Yantai Winhere Auto-Part Manufacturing Co., Ltd.,'' dated July 27, 2007; and the *Golrich Analysis Memo*.

[9] *See Surrogate Value Change Memo*.

PRC–Wide Rate	Margin (Percent)
PRC–Wide Rate*	43.32

*This includes Rotec and Hengtai.

The Department will disclose calculations performed for the final results to the parties within five days of the date of publication of this notice in accordance with 19 CFR 351.224(b).

Assessment Rates

The Department has determined, and U.S. Customs and Border Protection (''CBP'') shall assess, antidumping duties on all appropriate entries covered by these reviews. The Department intends to issue assessment instructions to CBP 15 days after the publication date of the final results of the reviews. In accordance with 19 CFR 351.212(b)(1), for Winhere, Meita, Haimeng, and Golrich, we calculated an exporter/importer (or customer)-specific assessment rate for the merchandise subject to these reviews. Where the respondent has reported reliable entered values, we calculated importer (or customer)-specific *ad valorem* rates by aggregating the dumping margins calculated for all U.S. sales to each importer (or customer) and dividing this amount by the total entered value of the sales to each importer (or customer). *See* 19 CFR 351.212(b)(1). Where an importer (or customer)-specific *ad valorem* rate is greater than *de minimis*, we will apply the assessment rate to the entered value of the importer's/customer's entries during the review period. *See* 19 CFR 351.212(b)(1). Where we do not have entered values for all U.S. sales, we calculated a per–unit assessment rate by aggregating the antidumping duties due for all U.S. sales to each importer (or customer) and dividing this amount by the total quantity sold to that importer (or customer). *See* 19 CFR 351.212(b)(1). To determine whether the duty assessment rates are *de minimis*, in accordance with the requirement set forth in 19 CFR 351.106(c)(2), we calculated importer (or customer)-specific *ad valorem* ratios based on the estimated entered value. Where an importer (or customer)-specific *ad valorem* rate is zero or *de minimis*, we will instruct CBP to liquidate appropriate entries without regard to antidumping duties. *See* 19 CFR 351.106(c)(2).

For the companies receiving a separate rate that were not selected for individual review (*i.e.*, CNIM, LABEC, Gren, ZLAP, Hongda, Longkou TLC, ZGOLD, Luqi, Shenyang Yinghao Machinery Co., Jinzheng, SZAP, and Huanri), we will calculate an assessment rate based on the weighted average of the cash deposit rates calculated for the companies selected for individual review excluding any that are zero, *de minimis*, or based entirely on AFA pursuant to section 735(c)(5)(B) of the Act.

Cash–Deposit Requirements

The following cash deposit rates will be effective upon publication of this notice of final results for all shipments of subject merchandise from Golrich entered or withdrawn from warehouse, for consumption on or after publication date: (1) zero cash deposit will be required for subject merchandise manufactured and exported by Golrich;[12] and (2) for subject merchandise exported by Golrich but not manufactured by Golrich, the cash deposit rate will be the PRC–wide rate of 43.32 percent.

The following cash deposit requirements will be effective upon publication of this notice of final results for all shipments of brake rotors from the PRC entered, or withdrawn from warehouse, for consumption on or after the publication date, as provided by section 751(a)(1) of the Act: (1) the cash deposit rates for CNIM, LABEC, GREN, Winhere, Haimeng, ZLAP, Hongda, Meita, TLC, ZGOLD, Luqi Yinghao, Longkou Jinzheng, Zhongding and Huanri will be the company–specific rate indicated above (except that if a rate is *de minimis*, *i.e.*, less than 0.50 percent, zero cash deposit will be required); (2) the cash deposit rate for previously investigated or reviewed PRC and non–PRC exporters who received a separate rate in a prior segment of the proceeding (which were not reviewed in this segment of the proceeding) will continue to be the rate assigned in that segment of the proceeding; (3) the cash deposit rate for all PRC exporters of subject merchandise that have not been found to be entitled to a separate rate (including Rotec and Hengtai) will be the PRC–wide rate of 43.32 percent; and (4) the cash deposit rate for all non–PRC exporters of subject merchandise which have not received their own rate will be the rate applicable to the PRC exporter that supplied that non–PRC exporter. These requirements shall remain in effect until further notice.

Notification to Interested Parties

This notice serves as a final reminder to importers of their responsibility under 19 CFR 351.402(f)(2) to file a certificate regarding the reimbursement of antidumping duties prior to liquidation of the relevant entries during this review period. Pursuant to 19 CFR 351.402(f)(3), failure to comply with this requirement could result in the Secretary's presumption that reimbursement of antidumping duties occurred and the subsequent assessment of doubled antidumping duties.

This notice also serves as a reminder to parties subject to administrative protective order (''APO'') of their responsibility concerning the disposition of proprietary information disclosed under APO, in accordance with 19 CFR 351.305 and as explained in the APO itself. Timely written notification of the return/destruction of APO materials or conversion to judicial protective order is hereby requested. Failure to comply with the regulations and the terms of an APO is a sanctionable violation.

This notice of final results of the administrative and new shipper reviews is issued and published in accordance with sections 751(a)(1) and 777(i)(1) of the Act.

Dated: July 27, 2007.

David M. Spooner,

Assistant Secretary for Import Administration.

Appendix

List of Comments and Issues in the Issues and Decisions Memorandum

Comment 1 Valuation of Pig Iron
Comment 2 Selection of Financial Statements
Comment 3 Financial Ratios: Calculation of Factory Overhead, Selling, General, and Administrative Expenses and Profit
Comment 4 Revocation Eligibility of Non–selected Respondents
Comment 5 Cash Deposit Rates of Non–selected Respondents

[12] Due to an inadvertent typographical error, we incorrectly stated Golrich's cash deposit rate as ''2.15 percent'' instead of 0.78 percent in the *Preliminary Results*. See *Preliminary Results*, 72 FR at 7416. *See also* the Memorandum from Ann Fornaro, Trade Compliance Analyst through Blanche Ziv, Program Manager, AD/CVD Operations, Office 8, and Wendy J. Frankel, Office Director, AD/CVD Operations, Office 8, to the File, entitled, ''2005-2006 Antidumping Duty Administrative and New Shipper Reviews of Brake Rotors from the People's Republic of China (''PRC''),'' dated February 13, 2007.

Comment 6 Voluntary Responses of Non–selected Respondents
Comment 7 Incorporation of Zeroing for Mandatory Respondents
Comment 8 Incorporation of Zeroing for Non–selected Respondents
Comment 9 Valuation of Cartons
Comment 10 Rescission of Review: Shanxi Zhongding
Comment 11 Separate Rate: Huanri Group
Comment 12 Respondent Selection Methodology
Comment 13 Clerical Error Freight Expenses for Golrich's Buckles and Cartons
Comment 14 Clerical Error Valuation of Steel Strap

[FR Doc. E7–15037 Filed 8–1–07; 8:45 am]

BILLING CODE 3510–DS–S

DEPARTMENT OF COMMERCE

International Trade Administration

[A–570–831]

Fresh Garlic From the People's Republic of China: Extension of Time Limit for the Preliminary Results of the 12th Administrative Review

AGENCY: Import Administration, International Trade Administration, Department of Commerce

DATES: *Effective Date:* August 2, 2007,

FOR FURTHER INFORMATION CONTACT: Julia Hancock or Matthew Renkey, AD/CVD Operations, Office 9, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue, NW., Washington, DC 20230; telephone: (202) 482–1394 and (202) 482–2312, respectively.

Background

On December 27, 2006, the Department of Commerce (''Department'') published a notice of initiation of an administrative review of fresh garlic from the People's Republic of China (''PRC''), covering the period November 1, 2005, through October 31, 2006. *See Notice of Initiation of Antidumping and Countervailing Duty Administrative Reviews and Requests for Revocation in Part,* 71 FR 77720 (December 27, 2006). On April 11, 2007, after receiving quantity and value and separate rate responses, the Department selected the mandatory respondents for this review. Between May 14, 2007, and June 11, 2007, the Department received the initial section A, C and D questionnaire responses from the mandatory respondents. The preliminary results of this administrative review are currently due on August 2, 2007.

Extension of Time Limit for the Preliminary Results

The Department determines that completion of the preliminary results of this review within the statutory time period is not practicable, given the extraordinarily complicated nature of the proceeding. The 12th administrative review covers 19 companies (three mandatory respondents and 16 separate rate respondents), requiring the Department to gather and analyze a significant amount of information pertaining to each company's corporate structure and ownership, sales practices, and manufacturing methods. The Department requires more time within which to complete its analysis. Furthermore, this review involves the extraordinarily complicated intermediate input methodology issue. Lastly, the Department requires additional time to analyze the questionnaire responses and to issue supplemental questionnaires.

Therefore, given the number and complexity of issues in this case, and in accordance with section 751(a)(3)(A) of the Tariff Act of 1930, as amended (''the Act''), we are extending the time period for issuing the preliminary results of review by 120 days until November 30, 2007. The final results continue to be due 120 days after the publication of the preliminary results.

This notice is published pursuant to section 751(a)(3)(A) of the Act and 19 CFR 351.213(h)(2).

Dated: July 23, 2007.

Stephen J. Claeys,

Deputy Assistant Secretary for Import Administration.

[FR Doc. E7–14919 Filed 8–1–07; 8:45 am]

BILLING CODE 3510–DS–P

DEPARTMENT OF COMMERCE

International Trade Administration

[A–549–812]

Furfuryl Alcohol from Thailand: Preliminary Results of the 2005–2006 Antidumping Duty Administrative Review

AGENCY: Import Administration, International Trade Administration, Department of Commerce.

SUMMARY: The Department of Commence is conducting an administrative review of the antidumping duty order on furfuryl alcohol from Thailand. The period of review is July 1, 2005, through May 3, 2006. This review covers imports of furfuryl alcohol from one producer/exporter.

We preliminarily determine that sales of subject merchandise have not been made at less than normal value. If these preliminary results are adopted in our final results, we will instruct U.S. Customs and Border Protection to liquidate entries of furfuryl alcohol from Indorama Chemicals (Thailand) Ltd. without regard to antidumping duties. We invite interested parties to comment on these preliminary results. We will issue the final results not later than 120 days from the date of publication of this notice.

DATES: *Effective Date:* August 2, 2007.

FOR FURTHER INFORMATION CONTACT: Damian Felton or Brandon Farlander, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue, NW., Washington, DC 20230; telephone: (202) 482–0133 and (202) 482–0182, respectively.

SUPPLEMENTARY INFORMATION:

Background

On July 25, 1995, the Department published an antidumping duty order on furfuryl alcohol from Thailand. *See Furfuryl Alcohol from Thailand: Notice of Amended Final Antidumping Duty Determinant and Order,* 60 FR 38035 (July 25, 1995). On July 3, 2006, the Department published its *Antidumping or Countervailing Duty Order, Finding, or Suspended Investigation; Opportunity to Request Administrative Review,* 71 FR 37890 (July 3, 2006). On July 28, 2006, Penn Specialty Chemicals, Inc. (''petitioner'') requested that the Department conduct an administrative review of Indorama Chemicals (Thailand), Ltd. (''IRCT''), a producer and exporter of furfuryl alcohol from Thailand. In accordance with 19 CFR 351.221(b)(1), we published a notice of initiation of this antidumping duty administrative review on August 30, 2006. *See Notice of Initiation of Antidumping and Countervailing Duty Administrative Reviews,* 71 FR 51573 (August 30, 2006) (''*Furfuryl Alcohol Initiation*'').

An antidumping duty questionnaire was sent to IRCT on September 6, 2006. We received timely responses to the questionnaire from IRCT on September 27, 2006, and October 27, 2006. On April 3, 2007, in accordance with section 751(a)(3)(A) of the Tariff Act of 1930, as amended (''the Act''), we published a notice extending the time limit for the completion of the preliminary results in this case by 120 days (*i.e.,* until no later than July 31, 2007). *See Furfuryl Alcohol from*

Thailand: Notice of Extension for Time Limit for Preliminary Results of the 2005–2006 Antidumping Administrative Review, 72 FR 15863 (April 3, 2007).

We issued a supplemental questionnaire regarding IRCT's responses to sections A, B, and C of the Department's original questionnaire on May 3, 2007, and received a timely response from IRCT on May 25, 2007. We issued an additional supplemental questionnaire on June 18, 2007, and received a timely response to the second supplemental questionnaire on June 22, 2007.

Period of Review

The period of review (''POR'') covers July 1, 2005, through May 3, 2006.[1]

Scope of the Order

The merchandise covered by this order is furfuryl alcohol ($C_4H_3OCH_2OH$). Furfuryl alcohol is a primary alcohol, and is colorless or pale yellow in appearance. It is used in the manufacture of resins and as a wetting agent and solvent for coating resins, nitrocellulose, cellulose acetate, and other soluble dyes.

The product subject to this order is classifiable under subheading 2932.13.00 of the Harmonized Tariff Schedule of the United States (HTSUS). Although the HTSUS subheading is provided for convenience and customs purposes, our written description of the scope of this proceeding is dispositive.

Fair Value Comparisons

To determine whether sales of furfuryl alcohol by IRCT to the United States were made at less than normal value (''NV''), we compared the export price (''EP'') to NV, as described in the ''Export Price'' and ''Normal Value'' sections of this notice, below.

Pursuant to section 777A(d)(2) of the Act, we compared the EPs of individual U.S. transactions to the weighted-average sales prices of the foreign like product, where there were sales made in the ordinary course of trade, as discussed in the ''Normal Value'' section of this notice.

Product Comparisons

In accordance with section 771(16) of the Act, we considered all products produced by IRCT covered by the description in the ''Scope of the Order'' section, above, to be foreign like products for purposes of determining appropriate product comparisons to U.S. sales. In making product comparisons, consistent with the *Notice of Final Determination of Sales at Less Than Fair Value: Furfuryl Alcohol from Thailand: Final Determination of Sales at Less Than Fair Value,* 60 FR 22557 (May 8, 1995) and *Furfuryl Alcohol from Thailand: Notice of Amended Final Antidumping Duty Determination and Order,* 60 FR 38035 (July 25, 1995) (collectively ''LTFV Final''), we matched foreign like products based on the physical characteristics reported by IRCT.

Export Price

We calculated EP in accordance with section 772(a) of the Act because the merchandise was sold to the first unaffiliated purchaser in the United States prior to importation by the exporter or producer and constructed export price methodology was not otherwise warranted. We based EP on the packed delivered, freight-on-board, cash-in-freight, or the delivery-duty paid price to unaffiliated purchasers in the United States. We made deductions from the starting price for movement expenses in accordance with section 772(c)(2)(A) of the Act. These deductions included foreign inland freight, country of manufacture inland insurance, brokerage and handling, international freight, and marine insurance. We also made adjustments to the starting price for duty drawback in accordance with section 772(c)(1)(B) of the Act.

It is normally the Department's practice to confirm that the duty drawback adjustment claimed by the respondent meets the Department's two-pronged criteria for determining whether the duty drawback adjustment is appropriate. *See Rajinder Pipes, Ltd.* v. *United States*, 70 F. Supp. 2d 1350, 1358 (CIT 1999); *see also Notice of Final Determination of Sales at Less Than Fair Value: Light-Walled Rectangular Pipe and Tube from Turkey*, 69 FR 53675 (September 2, 2004) and accompanying Issues and Decision Memorandum at Comment 1; and *Notice of Final Determination of Sales at Less Than Fair Value and Final Determination of Critical Circumstances: Diamond Sawblades and Parts Thereof from the Republic of Korea*, 71 FR 29310 (May 22, 2006) and accompanying Issues and Decision Memorandum at Comment 49. We have determined that only one of the reported inputs used in the projection of furfuryl alcohol meets the two-pronged criteria. Therefore, we made an adjustment to the starting price for duty drawback to account for import duties paid on the importation of a single input used in the production of the subject merchandise. for an in-depth explanation of these changes, *see* Memorandum from Case Analyst to File, ''Preliminary Results Calculation Memorandum for Indorama Chemicals (Thailand) Ltd.,'' (''*Prelim Calc Memo*'') dated July 25, 2007, available in the Department's CRU.

Normal Value

A. Home Market Viability

In order to determine whether there was a sufficient volume of sales in the home market to serve as a viable basis for calculating NV, we compared the volume of IRCT's home market sales of the foreign like product to the volume of its U.S. sales of the subject merchandise, in accordance with section 773(a)(1)(C)(ii) of the Act. Because IRCT's aggregate volume of home market sales of the foreign like product was greater than five percent of its aggregate volume of U.S. sales for the subject merchandise, we determined that the home market was viable.

Level of Trade

Section 773(a)(1)(B)(i) of the Act states that, to the extent practicable, the Department will calculate NV based on sales at the same level of trade (''LOT'') as the EP. Sales are made at different LOTs if they are made at different marketing stages (or their equivalent). *See* 19 CFR 351.412(c)(2). Substantial differences in selling activities are a necessary, but not sufficient, condition for determining that there is a difference in the stages of marketing. *Id.*; *see also Notice of Final Determination of Sales at Less Than Fair Value: Certain Cut-to-Length Carbon Steel Plate From South Africa.* 62 FR 61731, 61732 (November 19, 1997). In order to determine whether the comparison sales were at different stages in the marketing process than the U.S. sales, we reviewed the distribution system in each market (*i.e.*, the ''chain of distribution''),[2] including selling functions,[3] class of customer (''customer

[1] On August 30, 2006, the Department published a notice of initiation for this administrative review covering the period July 1, 2005 through June 30, 2006. *See Furfuryl Alcohol Initiation.* However, since the initiation, the Department has revoked this order effective May 4, 2006. *See Furfuryl Alcohol from Thailand; Final Results of the Second Sunset Review of the Antidumping Duty Order and Revocation of the Order*, 72 FR 9729 (March 5, 2006). Therefore, the revised POR is now July 1, 2005 through May 3, 2006.

[2] The marketing process in the United States and comparison market begins with the producer and extends to the sale to the final user or consumer. The chain of distribution between the two may have many or few links, and the respondent's sales occur somewhere along this chain.

[3] Selling functions associated with a particular chain of distribution helps us to evaluate the level(s) of trade in a particular market. For purposes of these preliminary results, we have organized the common selling functions into four major categories: sales process and marketing support,

Continued

category''), and the level of selling expenses for each sale.

Pursuant to section 773(a)(1)(B)(i) of the Act, in identifying levels of trade for EP and comparison market sales, we consider the starting prices before any adjustments. *See Micron Technology, Inc.* v. *United States, et. al.*, 243 F. 3d 1301, 1314–1315 (Fed. Cir. 2001) (affirming this methodology).

When the Department is unable to match U.S. EP sales to sales of the foreign like product in the comparison market at the same LOT as the EP, the Department may compare the U.S. sale to sales at a different LOT in the comparison market. In comparing EP sales to a different LOT in the comparison market, where available data make it practical, we make a LOT adjustment under section 773(a)(7)(A) of the Act.

IRCT reported one LOT in the home market and one LOT in the U.S. market. IRCT reported making sales only to end-users in the home market. In the United States, IRCT reported that it made sales only to a trading company. We examined the information IRCT reported regarding its marketing process for making the reported comparison market and U.S. sales, including the type and level of selling activities performed and customer categories. Specifically, we considered the extent to which the sales process, freight services, warehouse/inventory maintenance, and warranty services varied with respect to the different customer categories (*i.e.*, distributors and end-users). Based on our analysis, we found that the single LOT in the United States is identical to the single LOT in the comparison market. Thus, we preliminarily find that a LOT adjustment for IRCT is not warranted.

C. Calculation of Normal Value Based on Comparison Market Prices

We calculated NV based on the delivered prices to unaffiliated customers. In accordance with section 773(a)(6)(b)(ii) of the Act, we made deductions for inland freight and inland insurance. Furthermore, where appropriate, we made adjustments for differences in circumstances of sale (''COS'') in accordance with section 773(a)(6)(c)(iii) of the Act and 19 CFR 351.410 by deducting direct selling expenses incurred on comparison market sales (credit expenses), and adding U.S. direct selling expenses (credit expenses). We deducted inventory carrying costs incurred on comparison market sales, and added U.S. inventory carrying cost. We deducted home market packing costs and added U.S. packing costs in accordance with section 773(a)(6)(A) and (B) of the Act.

Preliminary Results of the Review

We preliminarily find that the following dumping margin exists for the period July 1, 2005, through May 3, 2006.

Manufacturer/Exporter	Weighted-Average Margin (Percentage)
Indorama Chemicals (Thailand) Ltd.	*0.39

*This is a *de minimis* rate.

Assessment Rates

Upon completion of this administrative review, the Department will determine, and U.S. Customs and Border Protection (''CBP'') shall assess, antidumping duties on all appropriate entries. Pursuant to 19 CFR 351.212(b), the Department calculates an assessment rate for each importer (or customer) of the subject merchandise. Upon issuance of the final results of this administrative review, if any importer (or customer)-specific assessment rates calculated in the final results are above *de minimis* (*i.e.*, at or above 0.5 percent), the Department will issue appraisement instructions directly to CBP to assess antidumping duties on appropriate entries. Pursuant to 19 CFR 351.106(c)(2), we will instruct CBP to liquidate without regard to antidumping duties any entries for which the assessment rate is *de minimis* (*i.e.*, less than 0.50 percent).

The Department intends to issue appropriate assessment instructions directly to CBP 15 days after the date of publication of the final results of this administrative review.

Cash Deposit Rates

On March 5, 2006, pursuant to section 751(d)(2) of the Act and 19 CFR 351.222(i)(1)(ii), the Department revoked the antidumping duty order on furfuryl alcohol from Thailand (*see Furfuryl Alcohol from Thailand; Final Results of the Second Sunset Review of the Antidumping Duty Order and Revocation of the Order,* 72 FR 9729 (March 5, 2006)). The effective date of the revocation is May 4, 2007. As a result of this action, we do not intend to issue cash deposit instructions.

Public Comment

Any interested party may request a hearing within 30 days of publication of this notice. *See* 19 CFR 351.310(c). A hearing, if requested, will be 44 days after the publication of this notice, or the first business day thereafter. Issues raised in the hearing will be limited to those raised in the case and rebuttal briefs. Interested parties may submit case briefs and/or written comments no later than 30 days after the date of publication of these preliminary results. *See* 19 CFR 351.309(c)(ii). Rebuttal briefs and rebuttals to written comments, limited to issues raised in such briefs or comments, may be filed no later than five days after submission of case briefs. *See* 19 CFR 351.309(d). Parties who submit arguments are requested to submit with the argument (1) A statement of the issue, (2) a brief summary of the argument, and (3) a table of authorities.

The Department will issue the final results of this administrative review, including the results of its analysis of issues raised in any such written briefs or hearing, no later than 120 days after publication of these preliminary results.

Notification to Interested Parties

This notice also serves as a preliminary reminder to importers of their responsibility under 19 CFR 351.402(f) to file a certificate regarding the reimbursement of antidumping duties prior to liquidation of the relevant entries during this review period. Failure to comply with this requirement could result in the Secretary's presumption that reimbursement of antidumping duties occurred and the subsequent assessment of double antidumping duties.

We are issuing and publishing these results in accordance with sections 751(a)(1) and 777(i)(1) of the Act.

Dated: July 25, 2007.

David M. Spooner,

Assistant Secretary for Import Administration.

[FR Doc. 07–3764 Filed 8–1–07; 8:45 am]

BILLING CODE 3510–DS–M

freight and delivery, inventory and warehousing, and quality assurance/warranty services.

DEPARTMENT OF COMMERCE

International Trade Administration

[A–570–891]

Hand Trucks and Certain Parts Thereof From the People's Republic of China: Initiation of New Shipper Review

AGENCY: Import Administration, International Trade Administration, Department of Commerce

DATES: *Effective Date:* August 2, 2007.

SUMMARY: The Department of Commerce (the ''Department'') has determined that the request for a new shipper review of

the antidumping duty order on hand trucks and certain parts thereof (''Hand Trucks'') from the People's Republic of China (''PRC''), received July 2, 2007, meets the statutory and regulatory requirements for initiation. The period of review (''POR'') of this new shipper review is December 1, 2006, through May 31, 2007.

FOR FURTHER INFORMATION CONTACT: Matthew Quigley or Robert Bolling, AD/CVD Operations, Office 8, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue, NW., Washington, DC 20230; telephone: (202) 482–4551 or (202) 482–3434, respectively.

SUPPLEMENTARY INFORMATION:

Background

The notice announcing the antidumping duty order on hand trucks from the PRC was published on December 2, 2004. *See Antidumping Duty Order: Hand Trucks and Certain Parts Thereof From the People's Republic of China,* 69 FR 70122 (December 2, 2004). On July 2, 2007, we received a new shipper review request from New-Tec Integration (Xiamen) Co., Ltd. (''New-Tec''). New-Tec certified that it is both the producer and exporter of the subject merchandise upon which the respective request for a new shipper review is based.

Pursuant to section 751(a)(2)(B)(i)(I) of the Tariff Act of 1930, as amended (the ''Act''), and 19 CFR 351.214(b)(2)(i), New-Tec certified that it did not export hand trucks to the United States during the period of investigation (''POI''). In addition, pursuant to section 751(a)(2)(B)(i)(II) of the Act and 19 CFR 351.214(b)(2)(iii)(A), New-Tec certified that, since the initiation of the investigation, it has never been affiliated with any exporter or producer who exported hand trucks to the United States during the POI, including those not individually examined during the investigation. As required by 19 CFR 351.214(b)(2)(iii)(B), New-Tec also certified that its export activities were not controlled by the central government of the PRC.

In addition to the certifications described above, New-Tec submitted documentation establishing the following: (1) The date on which it first shipped hand trucks for export to the United States; (2) the volume of its first shipment; and (3) the date of its first sale to an unaffiliated customer in the United States.

Initiation of New Shipper Review

Pursuant to section 751(a)(2)(B) of the Act and 19 CFR 351.214(d)(1), we find that the request submitted by New-Tec meets the threshold requirements for initiation of a new shipper review for shipments of hand trucks from the PRC produced and exported by New-Tec.

The POR is December 1, 2006, through May 31, 2007. *See* 19 CFR 351.214(g)(1)(i)(B). We intend to issue preliminary results of this review no later than 180 days from the date of initiation, and final results no later than 90 days from the date the preliminary results are issued. *See* section 751(a)(2)(B)(iv) of the Act.

It is the Department's usual practice, in cases involving non-market economies, to require that a company seeking to establish eligibility for an antidumping duty rate separate from the country-wide rate provide evidence of *de jure* and *de facto* absence of government control over the company's export activities. Accordingly, we will issue a questionnaire to New-Tec, including a separate-rate section. The review will proceed if the response provides sufficient indication that New-Tec is not subject to either *de jure* or *de facto* government control with respect to its exports of hand trucks. However, if New-Tec does not demonstrate its eligibility for a separate rate, it will be deemed not separate from other companies that exported during the POI, and its new shipper review will be rescinded.

On August 17, 2006, the Pension Protection Act of 2006 (H.R. 4) was signed into law. Section 1632 of H.R. 4 temporarily suspends the authority of the Department to instruct U.S. Customs and Border Protection to collect a bond or other security in lieu of a cash deposit in a new shipper review. Therefore, the posting of a bond or other security under section 751(a)(2)(B)(iii) of the Act in lieu of a cash deposit is not available in this case. Importers of hand trucks produced by and exported by New-Tec must continue to post cash deposits of estimated antidumping duties on each entry of subject merchandise (*i.e.*, hand trucks) at the PRC-wide entity rate of 383.6 percent.

Interested parties that need access to proprietary information in this new shipper review should submit applications for disclosure under administrative protective order in accordance with 19 CFR 351.305 and 351.306.

This initiation and notice are in accordance with section 751(a)(2)(B) of the Act and 19 CFR 351.214 and 351.221(c)(1)(i).

Dated: July 26, 2007.

Stephen J. Claeys,

Deputy Assistant Secretary for Import Administration.

[FR Doc. E7–14923 Filed 8–1–07; 8:45 am]

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DEPARTMENT OF COMMERCE

International Trade Administration

[A–533–823, A–834–807, A–307–820]

Silicomanganese from India, Kazakhstan, and Venezuela: Final Results of Expedited Five-year (''Sunset'') Reviews of the Antidumping Duty Orders

AGENCY: Import Administration, International Trade Administration, Department of Commerce.

SUMMARY: On April 2, 2007, the Department of Commerce (''the Department'') published in the **Federal Register** the notice of initiation of the first five-year sunset reviews of the antidumping duty orders on silicomanganese from India, Kazakhstan, and Venezuela, pursuant to section 751(c) of the Tariff Act of 1930, as amended (''the Act''). *See Initiation of Five-year (''Sunset'') Reviews*, 72 FR 15652 (April 2, 2007) (''*Notice of Initiation*''). On the basis of notices of intent to participate and adequate substantive responses filed on behalf of domestic interested parties, and inadequate responses from respondent interested parties, the Department has conducted expedited sunset reviews of these orders pursuant to section 751(c)(3)(B) of the Act and 19 CFR 351.218(e)(1)(ii)(C). As a result of these sunset reviews, the Department finds that revocation of the antidumping duty orders is likely to lead to continuation or recurrence of dumping at the levels indicated in the ''Final Results of Review'' section of this notice.

EFFECTIVE DATE: August 2, 2007.

FOR FURTHER INFORMATION CONTACT: Martha Douthit or Dara Iserson, AD/CVD Operations, Office 6, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Ave., NW., Washington, DC. 20230; telephone: (202) 482–5050, or (202) 482–4052, respectively.

SUPPLEMENTARY INFORMATION:

Background

The antidumping duty orders on silicomanganese from India, Kazakhstan, and Venezuela were published in the **Federal Register** on May 23, 2002. *See Notice of Amended*

Final Determination of Sales at Less than Fair Value and Antidumping Duty Orders: Silicomanganese from India, Kazakhstan, and Venezuela, 67 FR 36149 (May 23, 2002). On April 2, 2007, the Department initiated the first sunset reviews of the antidumping duty orders on silicomanganese from India, Kazakhstan, and Venezuela, pursuant to section 751(c) of the Act. *See Notice of Initiation*. The Department received notices of intent to participate from Felman Production Inc. (''Felman''), Eramet Marietta Inc. (''Eramet'') (collectively ''domestic interested parties''), within the deadline specified in 19 CFR 351.218(d)(1)(i). Domestic interested parties claimed interested party status under section 771(9)(C) of the Act as producers of the subject merchandise.

On May 1 and May 2, 2007, the Department received substantive responses from domestic interested parties Felman and Eramet, respectively, within the deadline specified in 19 CFR 351.218(d)(3)(i). On May 8, 2007, the Department received a timely substantive response from Nava Bharat Ventures Limited (''Nava Bharat''), a respondent interested party from India.[1] Nava Bharat claimed interested party status under section 771(9)(A) of the Act as a producer/exporter of subject merchandise. On May 22, 2007, the Department determined that Nava Bharat did not provide an adequate response to the *Notice of Initiation* in accordance with 19 CFR 351.218(e)(1)(ii)(A) because its shipments accounted for less than 50 percent of exports of subject merchandise to the United States over the five calendar years preceding the initiation of this review. Pursuant to 19 CFR 351.218(e)(1)(ii)(C)(1), on the same day, the Department notified the International Trade Commission (''ITC'') of its adequacy determination. *See Memorandum to Barbara E. Tillman from the Sunset Team, Sunset Review of the Antidumping Duty Order on Silicomanganese from India: Adequacy Determination*, dated May 22, 2007. The Department, therefore, has conducted expedited sunset reviews of the antidumping duty orders pursuant to section 751(c)(3)(B) of the Act.

Scope of the Orders

For purposes of these orders, the products covered are all forms, sizes and compositions of silicomanganese, except low–carbon silicomanganese, including silicomanganese briquettes, fines and slag. Silicomanganese is a ferroalloy composed principally of manganese, silicon and iron, and normally contains much smaller proportions of minor elements, such as carbon, phosphorous and sulfur. Silicomanganese is sometimes referred to as ferrosilicon manganese. Silicomanganese is used primarily in steel production as a source of both silicon and manganese. Silicomanganese generally contains by weight not less than 4 percent iron, more than 30 percent manganese, more than 8 percent silicon and not more than 3 percent phosphorous. Silicomanganese is properly classifiable under subheading 7202.30.0000 of the Harmonized Tariff Schedule of the United States (HTSUS). Some silicomanganese may also be classified under HTSUS subheading 7202.99.5040.

The low–carbon silicomanganese excluded from this scope is a ferro alloy with the following chemical specifications: minimum 55 percent manganese, minimum 27 percent silicon, minimum 4 percent iron, maximum 0.10 percent phosphorus, maximum 0.10 percent carbon and maximum 0.05 percent sulfur. Low–carbon silicomanganese is used in the manufacture of stainless steel and special carbon steel grades, such as motor lamination grade steel, requiring a very low carbon content. It is sometimes referred to as ferromanganese–silicon. Low–carbon silicomanganese is classifiable under HTSUS subheading 7202.99.5040. This scope covers all silicomanganese, regardless of its tariff classification. Although the HTSUS subheadings are provided for convenience and customs purposes, our written description of the scope remains dispositive.

Analysis of Comments Received

All issues raised in the substantive responses by parties to these sunset reviews are addressed in the *Issues and Decision Memorandum for the Expedited Sunset Reviews of the Antidumping Duty Orders of Silicomanganese from India, Kazakhstan, and Venezuela; Final Results from Stephen J. Claeys, Deputy Assistant Secretary for Import Administration, to David M. Spooner, Assistant Secretary for Import Administration*, dated concurrently with this notice (''*Decision Memo*''), which is hereby adopted in this notice. The issues discussed in the *Decision Memo* include the likelihood of continuation or recurrence of dumping and the rate likely to prevail if the orders were revoked. Parties can find a complete discussion of all issues raised in these sunset reviews and the corresponding recommendation in this public memorandum which is on file in B–099, the Central Records Unit, of the main Commerce building. In addition, a complete version of the Decision Memo can be accessed directly on the Department's Web page at *http://ia.ita.doc.gov/frn*. The paper copy and electronic version of the *Decision Memo* are identical in content.

Final Results of Reviews

The Department determines that revocation of the antidumping duty orders on silicomanganese from India, Kazakhstan, and Venezuela would be likely to lead to continuation or recurrence of dumping at the following duty rates:

Manufacturers/Exporters/Producers	Weighted–Average Margin (percent)
India.	
Nava Bharat	15.32
Universal Ferro and Allied Chemicals, Ltd.	20.53
All Others Rate	17.74
Kazakhstan.	
Alloy 2000, S.A.	247.88
Kazakhstan–Wide Rate	247.88
Venezuela.	
Hornos Eléctricos de Venezuela, S.A.	
All Others Rate	24.62

International Trade Commission (ITC) Notification

In accordance with section 752(c)(3) of the Act, we will notify the ITC of the final results of this expedited sunset review.

Notification Regarding Administrative Protective Order

This notice also serves as the only reminder to parties subject to administrative protective orders (APO) of their responsibility concerning the return or destruction of proprietary information disclosed under APO in accordance with 19 CFR 351.305. Timely notification of the return or destruction of APO materials or conversion to judicial protective orders is hereby requested. Failure to comply with the regulations and terms of an APO is a violation which is subject to sanction.

We are issuing and publishing this determination and notice in accordance with sections 751(c), 752, and 777(i) of the Act.

[1] Nava Bharat received an extension to May 8, 2007, to submit its substantive response.

Dated: July 25, 2007.

David M. Spooner,

Assistant Secretary for Import Administration.

[FR Doc. E7–14947 Filed 8–1–07; 8:45 am]

BILLING CODE 3510–DS–S

DEPARTMENT OF COMMERCE

International Trade Administration

A–469–805

Stainless Steel Bar from Spain: Final Results of Antidumping Duty Administrative Review

AGENCY: Import Administration, International Trade Administration, Department of Commerce.

SUMMARY: On March 28, 2007, the Department of Commerce published the preliminary results of the 2005/2006 administrative review of the antidumping duty order on stainless steel bar from Spain. We gave interested parties an opportunity to comment on the preliminary results. Based on our analysis of the comments received we did not make changes for the final results. The final weighted–average dumping margin for a single respondent is listed below in the ''Final Results of the Review'' section of this notice.

EFFECTIVE DATE: August 2, 2007.

FOR FURTHER INFORMATION CONTACT: Dmitry Vladamirov or Minoo Hatten, AD/CVD Operations, Office 5, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue, NW., Washington, DC 20230; telephone: (202) 482–0665 and (202) 482–1690, respectively.

SUPPLEMENTARY INFORMATION:

Background

On March 28, 2007, the Department of Commerce (the Department) published *Stainless Steel Bar from Spain: Preliminary Results of Antidumping Duty Administrative Review*, 72 FR 14522 (March 28, 2007) (*Preliminary Results*) in the **Federal Register**. The period of review is March 1, 2005, through February 28, 2006.

We invited parties to comment on the Preliminary Results. On April 27, 2007, we received a case brief from the respondent, Sidenor Industrial SL (Sidenor). On May 7, 2007, Carpenter Technology Corporation, Valbruna Slater Stainless, Inc., and Electralloy Corporation, a Division of G.O. Carlson, Inc. (collectively, the domestic interested parties), filed a rebuttal brief. At the request of Sidenor, we held a hearing on May 16, 2007.

We have conducted this review in accordance with section 751(a) of the Tariff Act of 1930, as amended (the Act).

Scope of Order

The product covered by this order is stainless steel bar (SSB). SSB means articles of stainless steel in straight lengths that have been either hot–rolled, forged, turned, cold–drawn, cold–rolled or otherwise cold–finished, or ground, having a uniform solid cross section along their whole length in the shape of circles, segments of circles, ovals, rectangles (including squares), triangles, hexagons, octagons or other convex polygons. SSB includes cold–finished SSBs that are turned or ground in straight lengths, whether produced from hot–rolled bar or from straightened and cut rod or wire, and reinforcing bars that have indentations, ribs, grooves, or other deformations produced during the rolling process.

Except as specified above, the term does not include stainless steel semi–finished products, cut length flat–rolled products (*i.e.*, cut length rolled products which if less than 4.75 mm in thickness have a width measuring at least 10 times the thickness, or if 4.75 mm or more in thickness having a width which exceeds 150 mm and measures at least twice the thickness), wire (i.e., cold–formed products in coils, of any uniform solid cross section along their whole length, which do not conform to the definition of flat–rolled products), and angles, shapes and sections.

The SSB subject to this order is currently classifiable under subheadings 7222.10.0005, 7222.10.0050, 7222.20.0005, 7222.20.0045, 7222.20.0075, and 7222.30.0000 of the Harmonized Tariff Schedule of the United States (HTSUS). Although the HTSUS subheadings are provided for convenience and customs purposes, our written description of the scope of this order is dispositive.

Analysis of Comments Received

All comments raised in the case and rebuttal briefs by parties in this review of the antidumping duty order on stainless steel bar from Spain are addressed in the ''Issues and Decision Memorandum'' from Stephen J. Claeys, Deputy Assistant Secretary, to David M. Spooner, Assistant Secretary, dated July 26, 2007 (Decision Memorandum), which is hereby adopted by this notice. The Decision Memorandum, which is a public document, is on file in the Central Records Unit, main Commerce building, Room B–099, and is accessible on the Web at http://ia.ita.doc.gov/frn/index.html. The paper copy and electronic version of the Decision Memorandum are identical in content.

Changes Since The Preliminary Results

With respect to Sidenor, in the *Preliminary Results*, we determined that the use of adverse facts available is appropriate as the basis for the weighted–average dumping margin. For these final results of review, we have continued to rely on the use of adverse facts available in establishing the weighted–average dumping margin for Sidenor for the period of review. Therefore, there were no changes since the *Preliminary Results*.

Use of Adverse Facts Available

In accordance with section 776(b) of the Act, we determine that the use of adverse facts available as the basis for the weighted–average dumping margin is appropriate for Sidenor. As explained in the *Preliminary Results* and in the Memorandum from Mark Todd to Neal Halper, entitled ''Use of Adverse Facts Available for the Preliminary Determination,'' dated March 22, 2007 (AFA Memo), we determined that the cost–of-production (COP) questionnaire responses submitted by Sidenor are incomplete and cannot be used to calculate an accurate dumping margin for Sidenor. Specifically, as a result of the serious deficiencies that we identified and that Sidenor failed repeatedly to address with respect to its reporting of the COP information, we are unable to determine adequately whether the reported COP information reflects, reasonably and accurately, the costs incurred by Sidenor to produce the merchandise under consideration. Without this information, we cannot calculate an accurate dumping margin for this company.

Therefore, as a consequence of the requested necessary information being absent from the record, we find that our reliance on facts otherwise available is warranted pursuant to section 776(a)(1) of the Act. Furthermore, we find that Sidenor has withheld requested information, failed to provide such information in the form and manner required, impeded the conduct of this review, and reported information that could not be verified. As such, pursuant to sections 776(a)(2)(A), (B), (C), and (D) of the Act, we find that the use of facts available for the final results is warranted. For a detailed discussion, please refer to the AFA Memo. See also the Decision Memorandum for a complete discussion of this issue.In addition, we find that Sidenor did not act to the best of its ability in reporting the COP information. Despite our repeated requests for information and

our generous provisions of extensions of due dates to respond, in some instances Sidenor continued to refrain from providing certain requested information regarding its reported costs; in other instances it provided confusing and sometimes contradictory information; yet in other instances it de–emphasized the significance or downplayed the necessity of our repeated requests for certain critical information by claiming that we had been ''misinterpreting'' or ''misunderstanding'' its COP response. See, *e.g.*, Sidenor's January 24, 2007, third supplemental Section D questionnaire response at pages 1, 5, and 6. Therefore, we find that Sidenor has failed to cooperate to the best of its ability because Sidenor failed consistently to address certain critical elements for which we sought clarification or explanation in order to alleviate our concerns regarding the accuracy and reliability of Sidenor's reporting of its COP information. Accordingly, for these final results we find that, in selecting from among the facts otherwise available, an adverse inference is warranted. See the AFA Memo and the Decision Memorandum for a complete discussion of this issue.

As total adverse facts available, we have applied the highest rate determined in the less–than-fair–value investigation, which is 62.85 percent. See *Notice of Final Determination of Sales at Less Than Fair Value: Stainless Steel Bar From Spain*, 59 FR 66931 (December 28, 1994). Furthermore, as required by section 776(c) of the Act, we corroborated this margin with respect to Sidenor, to the extent practicable. For a detailed explanation of how we corroborated this margin, see the *Preliminary Results*. See also the Decision Memorandum for a complete discussion of this issue.

Final Results of the Review

As a result of our review, we determine a dumping margin of 62.85 percent for Sidenor for the period March 1, 2005, through February 28, 2006.

Assessment Rates

The Department will determine and U.S. Customs and Border Protection (CBP) shall assess antidumping duties on all appropriate entries, in accordance with 19 CFR 351.212(b). Because we are relying on total adverse facts available to establish Sidenor's dumping margin, we will instruct CBP to apply a dumping margin of 62.85 percent to all entries of subject merchandise during the period of review produced and/or exported by Sidenor. The Department intends to issue instructions to CBP 15 days after the date of publication of these final results of review.

Cash–Deposit Requirements

The following deposit requirements will be effective upon publication of this notice of final results of administrative review for all shipments of the subject merchandise entered, or withdrawn from warehouse, for consumption on or after the date of publication, consistent with section 751(a)(1) of the Act: (1) the cash–deposit rate for Sidenor will be 62.85 percent; (2) for previously investigated companies not listed above, the cash–deposit rate will continue to be the company–specific rate published for the most recent period; (3) if the exporter is not a firm covered in this review, a previous review, or the original less–than-fair–value (LTFV) investigation but the manufacturer is, the cash–deposit rate will be the rate established for the most recent period for the manufacturer of the merchandise; (4) the cash–deposit rate for all other manufacturers or exporters will continue to be 25.77 percent, which is the ''all others'' rate established in the LTFV investigation. See *Amended Final Determination and Antidumping Duty Order: Stainless Steel Bar From Spain*, 60 FR 11656 (March 2, 1995). These deposit requirements shall remain in effect until further notice.

Notification

This notice serves as a reminder to importers of their responsibility under 19 CFR 351.402(f) to file a certificate regarding the reimbursement of antidumping duties prior to liquidation of the relevant entries during this review period. Failure to comply with this requirement could result in the Department's presumption that reimbursement of antidumping duties occurred and the subsequent assessment of doubled antidumping duties.

This notice also serves as a reminder to parties subject to administrative protective order (APO) of their responsibility concerning the disposition of proprietary information disclosed under APO in accordance with 19 CFR 351.305(a)(3). Timely notification of the return or destruction of APO materials or conversion to judicial protective order is hereby requested. Failure to comply with the regulations and the terms of an APO is a sanctionable violation.

We are issuing and publishing these results in accordance with sections 751(a)(1) and 777(i) of the Act.

Dated: July 26, 2007.

David M. Spooner,

Assistant Secretary for Import Administration.

[FR Doc. E7–15039 Filed 8–1–07; 8:45 am]

Billing Code: 3510–DS–S

DEPARTMENT OF COMMERCE

International Trade Administration

[A–570–890]

Wooden Bedroom Furniture From The People's Republic of China: Notice of Partial Rescission of Antidumping Duty Administrative Review

AGENCY: Import Administration, International Trade Administration, Department of Commerce.

SUMMARY: On March 7, 2007, the Department of Commerce (''the Department'') initiated the second administrative review of the antidumping duty order on wooden bedroom furniture from the People's Republic of China (''PRC'') covering the period January 1, 2006, through December 31, 2006. *See Notice of Initiation of Administrative Review of the Antidumping Duty Order on Wooden Bedroom Furniture from the People's Republic of China,* 72 FR 10159 (March 7, 2007) (''*Initiation Notice*'').[1] Between March 7 and June 6, 2007, several parties withdrew their requests for review. Therefore, the Department is rescinding the administrative review of sales of wooden bedroom furniture with respect to the entities for whom all review requests have been withdrawn.

DATES: *Effective Date:* August 2, 2007.

FOR FURTHER INFORMATION CONTACT: Robert Bolling, AD/CVD Operations, Office 8, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue, NW., Washington, DC 20230; telephone: (202) 482–3434

SUPPLEMENTARY INFORMATION:

Background

On January 4, 2005, the Department published in the **Federal Register** the antidumping duty order on wooden bedroom furniture from the PRC. *See Notice of Amended Final Determination of Sales at Less Than Fair Value and Antidumping Duty Order: Wooden Bedroom Furniture from the People's*

[1] On May 30, 2007, the Department published a subsequent notice clarifying that Country Roots Furniture Inc. was omitted from the Initiation Notice. *See Initiation of Antidumping and Countervailing Duty Administrative Reviews and Request for Revocation in Part,* 72 FR 29968, 29969 n. 5 (May 30, 2007).

Republic of China, 70 FR 329 (January 4, 2005). On January 3, 2007, the Department published a notice of opportunity to request an administrative review of the antidumping duty order on wooden bedroom furniture from the PRC for the period January 1, 2006, through December 31, 2006. *See Antidumping or Countervailing Duty Order, Finding, or Suspended Investigation: Opportunity to Request Administrative Review,* 72 FR 99 (January 3, 2007).

The Department received multiple timely requests for review and on March 7, 2007, in accordance with section 751(a) of Tariff Act of 1930, as amended (''the Act''), published in the **Federal Register** a notice of the initiation of the antidumping duty administrative review of wooden bedroom furniture from the PRC for the 2006 period of review. *See Initiation Notice.*

Partial Rescission of Review

Pursuant to 19 CFR 351.213(d)(1), the Department will rescind an administrative review, in whole or in part, if a party that requested a review withdraws the request within 90 days of the date of publication of the notice of initiation. In response to a timely filed extension request from Petitioners to extend the withdrawal deadline, the Department extended the deadline for withdrawing review requests. Because all requesting parties withdrew their respective requests for review of the following entities, the Department is rescinding this review with respect to these entities, in accordance with 19 CFR 351.213(d)(1):

Alexandre International Corp., Southern Art Development Ltd., Alexandre Furniture (Shenzhen) Co. Ltd., Southern Art Furniture Factory
Art Heritage International Ltd., Super Art Furniture Co. Ltd., Artwork Metal & Plastic Co., Ltd., Jibson Industries Ltd., Always Loyal International
Billy Wood Industrial (Dong Guan), Great Union Industrial (Dongguan) Co., Ltd., Time Faith Ltd.
Changshu HTC Import & Export Co. Ltd.
Cheng Meng Furniture (PTE) Co., Ltd.,[2] Cheng Meng Decoration & Furniture (Suzhou) Co., Ltd.
Chuan Fa Furniture Factory
Clearwise Co., Ltd.
COE, Ltd.
Dalian Huafeng Furniture Co., Ltd.
Dongguan Cambridge Furniture Co., Ltd., Glory Oceanic Co., Ltd.
Dongguan Chunsan Wood Products Co., Ltd., Trendex Industries Limited
Dongguan Creation Furniture Co., Ltd., Creation Industries Co., Ltd.
Dongguan Grand Style Furniture Co., Ltd., Hong Kong DaZhi Furniture Company Ltd.
Dongguan Great Reputation Furniture Co., Ltd.
Dongguan Hero Way Woodwork Co., Ltd., Hero Way Enterprises, Ltd., Dongguan Da Zhong Woodwork Co., Ltd., Well Earth International Ltd.
Dongguan Hung Sheng Artware Products Co., Ltd., Coronal Enterprise Co., Ltd.
Dongguan Kin Feng Furniture Co., Ltd.
Dongguan Kingstone Furniture Co., Ltd., Kingstone Furniture Co., Ltd.
Dongguan Liaobushangdun Huada Furniture Factory, Great Rich (HK) Enterprises Co., Ltd.
Dongguan Lung Dong Furniture Co., Ltd., Dongguan Dong He Furniture Co., Ltd.
Dongguan Singways Furniture Co., Ltd.
Dongguan Sunrise Furniture Co., Taicang Sunrise Wood Industry Co., Ltd., Shanghai Sunrise Furniture Co., Ltd., Fairmont Designs
Dongying Huanghekou Furniture Industry Co., Ltd.
Dorbest Ltd., Rui Feng Woodwork Co., Ltd., Rui Feng Lumber Development Co., Ltd., aka, Dorbest Ltd., Rui Feng Woodwork (Dongguan) Co., Ltd., Rui Feng Lumber Development (Shenzhen) Co., Ltd.
Dream Rooms Furniture (Shanghai) Co., Ltd.
Eurosa (Kunshan) Co., Ltd., Eurosa Furniture Co., (PTE) Ltd.
Ever Spring Furniture Co., Ltd., S.Y.C. Family Enterprise Co., Ltd.
Fine Furniture (Shanghai) Ltd.
Foshan Guanqiu Furniture Co., Ltd.
Garri Furniture (Dong Guan) Co., Ltd., Molabile International, Inc., Weei Geo Enterprise Co., Ltd.
Green River Wood (Dongguan) Ltd.
Guangzhou Maria Yee Furnishings, Ltd., Pyla HK Ltd.
Hainan Jong Bao Lumber Co., Ltd., Jibbon Enterprise Co., Ltd.
Hamilton & Spill Ltd.
Hang Hai Woodcrafts Art Factory
Hualing Furniture (China) Co., Ltd., Tony House Manufacture (China) Co., Ltd., Buysell Investments Ltd., Tony House Industries Co., Ltd.
Jardine Enterprise, Ltd.
Jiangmen Kinwai Furniture Decoration Co., Ltd.
Jiangmen Kinwai International Furniture Co., Ltd.
Jiangsu Weifu Group Company Fullhouse Furniture Manufacturing Corp
Jiangsu Xiangsheng Bedtime Furniture Co., Ltd.
Jiangsu Yuexing Furniture Group Co., Ltd.
Jiedong Lehouse Furniture Co., Ltd.
King's Way Furniture Industries Co., Ltd., Kingsyear, Ltd.
Kuan Lin Furniture (Dong Guan) Co., Ltd., Kuan Lin Furniture Factory, Kuan Lin Furniture Co., Ltd.
Kunshan Lee Wood Product Co., Ltd.
Kunshan Summit Furniture Co. Ltd.
Langfang TianCheng Furniture Co., Ltd.
Leefu Wood (Dongguan) Co., Ltd., King Rich International, Ltd.
Link Silver Ltd. (V.I.B.), Forward Win Enterprises Co. Ltd., Dongguan Haoshun Furniture Ltd.
Locke Furniture Factory, Kai Chan Furniture Co. Ltd., Kai Chan (Hong Kong) Enterprise Ltd., Taiwan Kai Chan Co. Ltd.
Longrange Furniture Co. Ltd.
Maria Yee, Inc.
Nanhai Baiyi Woodwork Co. Ltd.
Nanhai Jiantai Woodwork Co. Ltd., Fortune Glory Industrial, Ltd. (HK Ltd.)
Nantong Dongfang Orient Furniture Co., Ltd.
Nantong Yushi Furniture Co., Ltd.
Nathan International Ltd., Nathan Rattan Factory
Ningbo Furniture Industries Limited, Techniwood Industries Ltd., Ningbo Hengrun Furniture Co., Ltd.
Orient International Holding Shanghai Foreign Trading Co., Ltd.
Passwell Corporation, Pleasant Wave Ltd.
Perfect Line Furniture Co., Ltd.
Primewood International Co., Ltd., Prime Best International Co., Ltd., Prime Best Factory, Liang Huang (Jiaxing) Enterprise Co., Ltd.
PuTian JingGong Furniture Co., Ltd.
Qingdao Liangmu Co., Ltd.
Restonic (Dongguan) Furniture Ltd., Restonic Far East (Samoa) Ltd.
RiZhao SanMu Woodworking Co., Ltd.
Season Furniture Manufacturing Co., Season Industrial Development Co.
Sen Yeong International Co. Ltd., Sheh Hau International Trading Ltd.
Shanghai Jian Pu Export & Import Co., Ltd.
Shanghai Maoji Imp. & Exp. Co. Ltd.
Sheng Jing Wood Products (Beijing) Co., Ltd., Telstar Enterprises Ltd.
Shenyang Shining Dongxing Furniture Co., Ltd.
Shenzhen Forest Furniture Co., Ltd.
Shenzhen Jiafa High Grade Furniture Co., Ltd., Golden Lion International Trading Ltd.
Shenzhen New Fudu Furniture Co., Ltd. Shenzhen Wonderful Furniture Co., Ltd.
Shenzhen Xiande Furniture Factory
Shing Mark Enterprise Co., Ltd., Carven Industries Ltd. (BVI), Carven

[2] The Department received a request from petitioners to review Chen Meng Furniture (PTE) Co. Ltd. However, we have determined that the correct name for this company is review Cheng Meng Furniture (PTE) Co. Ltd.

Industries Limited (HK), Dongguan Zhenxin Furniture Co., Ltd., Dongguan Yongpeng Furniture Co., Ltd.
Shun Feng Furniture Co., Ltd.
Songgang Jasonwood Furniture Factory, Jasonwood Industrial Co., Ltd. S.A.
Starwood Furniture Manufacturing Co., Ltd.
Starwood Industries Ltd.
Strongson Furniture (Shenzhen) Co., Ltd., Strongson Furniture Co., Ltd., Strongson (HK) Co.
Sunforce Furniture (Hui-Yang) Co., Ltd., SunFung Wooden Factory, Sun Fung Co., Shin Feng Furniture Co. Ltd., Stupendous International Co. Ltd.
Superwood Co. Ltd., Lianjiang Zongyu Art Products Co., Ltd.
Tarzan Furniture Industries, Ltd., Samso Industries Ltd.
Tianjin Fortune Furniture Co. Ltd.
Tianjin Master Home Furniture
Tianjin Phu Shing Woodwork Enterprise Co., Ltd.
Tube-Smith Enterprises (ZhangZhou) Co., Ltd., Tube-Smith Enterprise (Haimen) Co., Ltd., Billionworth Enterprise, Ltd.
U-Rich Furniture (ZhangZhou) Co., Ltd., U-Rich Furniture, Ltd.
Wanhengtong Nueevder (Furniture) Manufacture Co., Ltd., Dongguan Wanhengtong Industry Co., Ltd.
Woodworth Wooden Industries (Dong Guan) Co., Ltd.
Xiamen Yongquan Sci-Tech Development Co., Ltd.
Xingli Arts & Crafts Factory of Yangchun
Yida Co. Ltd., Yitai Worldwide Ltd., Yili Co., Ltd., Yetbuild Co., Ltd.
Yihua Timber Industry Co., Ltd., aka Guangdong Yihua Timber Industry Co., Ltd.
ZhangZhou Sanlong Wood Product Co., Ltd.
Zhangjiagang Daye Hotel Furniture Co., Ltd.
Zhangzhou Guohui Industrial & Trade Co. Ltd.
Zhanjiang Sunwin Arts & Crafts Co., Ltd.
Zhong Shan Fullwin Furniture Co., Ltd.
Zhongshan Fookyik Furniture Co., Ltd.
Zhongshan Golden King Furniture Industrial Co., Ltd.
Zhoushan For-Strong Wood Co., Ltd.

Assessment

The Department will instruct U.S. Customs and Border Protection (''CBP'') to assess antidumping duties on all appropriate entries for the above-named entities. For those companies for which this review has been rescinded, antidumping duties shall be assessed at rates equal to the cash deposit of estimated antidumping duties required at the time of entry, or withdrawal from warehouse, for consumption, in accordance with 19 CFR 351.212(c)(1)(i). The Department will issue appropriate assessment instructions directly to CBP 15 days after the publication of this notice in the **Federal Register**.

In addition, the Department is rescinding this review with respect to the following entities which did not receive a separate rate in any completed prior segment of this proceeding. For purposes of initiation of this administrative review, the Department accepted requests for review of these entities based upon the premise that such entities would seek to demonstrate in this review that they were, in law and in fact, separate from the PRC-wide entity, and therefore, entitled to a rate separate from the rate established for the PRC-wide entity. However, as the requests for review of these entities have been withdrawn, these entities may be subject to this review as part of the single PRC-wide entity.[3] Therefore, the Department will provide assessment instructions to CBP for the PRC-wide entity, which includes the following companies, after the final results of this administrative review.

Engmost Investments Limited
Golden Well International (HK), Ltd.
Hainan Rulai Furniture Co., Ltd.
Huizhou Jadom Furniture Co., Ltd., Jadom Furniture Co., Ltd.
Kong Fong Furniture, Kong Fong Mao Iek Hong
Kunshan Junsen Furniture Co., Ltd.
Nathan China Group
Putian Ou Dian Furniture Co., Ltd.
Time Crown (U.K.) International Ltd., China United International Co.
Tradewinds Furniture Ltd.
Tradewinds International Enterprise Ltd.
Trendex Industries Limited (BVI)

The review will continue with respect to all other entities identified in the *Initiation Notice.*

Notification to Importers

This notice serves as a final reminder to importers of their responsibility under 19 CFR 351.402(f) to file a certificate regarding the reimbursement of antidumping duties prior to liquidation of the relevant entries during this review period. Failure to comply with this requirement could result in the Secretary's assumption that reimbursement of antidumping duties occurred and subsequent assessment of double antidumping duties.

Notification Regarding Administrative Protective Orders (''APOs'')

This notice also serves as a reminder to parties subject to APOs of their responsibility concerning the return or destruction of proprietary information disclosed under an APO in accordance with 19 CFR 351.305, which continues to govern business proprietary information in this segment of the proceeding. Timely written notification of the return/destruction of APO materials or conversion to judicial protective order is hereby requested. Failure to comply with the regulations and terms of an APO is a violation which is subject to sanction.

This notice is in accordance with section 777(i)(1) of the Act, and 19 CFR 351.213(d)(4) of the Department's regulations.

Dated: July 25, 2007 .

Stephen J. Claeys,

Deputy Assistant Secretary for Import Administration.

[FR Doc. E7–14953 Filed 8–1–07; 8:45 am]

BILLING CODE 3510–DS–P

[3] If one of the companies remaining under review does not qualify for a separate rate, all other exporters of wooden bedroom furniture from the PRC that have not qualified for a separate rate are deemed to be covered by this review as part of the single PRC-wide entity of which the named exporter is a part.

DEPARTMENT OF COMMERCE

International Trade Administration

Methodist Hospitals of Dallas, et al. Notice of Consolidated Decision on Applications for Duty– Free Entry of Electron Microscopes

This is a decision consolidated pursuant to Section 6(c) of the Educational, Scientific, and Cultural Materials Importation Act of 1966 (Pub. L. 89–651,as amended by Pub. L. 106–36, 80 Stat. 897; 15 CFR part 301). Related records can be viewed between 8:30 a.m. and 5 p.m. in Room 2104, U.S. Department of Commerce, 14th and Constitution Avenue., NW., Washington, DC.

Docket Number: 07–036. Applicant: Methodist Hospitals of Dallas, Dallas, TX. Instrument: Electron Microscope, Model H–7650. Manufacturer: Hitachi High Technologies, Japan. Intended Use: See notice at 72 FR 36961, July 6, 2007.

Docket Number: 07–037. Applicant: Regents of the University of California, Los Angeles, CA. Instrument: Electron Microscope, Model Tecnai G2 F20. Manufacturer: FEI Company, The Netherlands. Intended Use: See notice at 72 FR 36961, July 6, 2007.

Docket Number: 07–038. Applicant: Regents of the University of California, Los Angeles, CA. Instrument: Electron

Microscope, Model FP 5600/XX Titan Krios cryo–EM. Manufacturer: FEI Company, The Netherlands. Intended Use: See notice at 72 FR 36961, July 6, 2007.
Docket Number: 07–039. Applicant: Regents of the University of California, Los Angeles, CA. Instrument: Electron Microscope, Model FP 5600/30 Titan 80–300 S/TEM. Manufacturer: FEI Company, The Netherlands. Intended Use: See notice at 72 FR 36961, July 6, 2007.
Docket Number: 07–043. Applicant: Scripps Research Institute, La Jolla, CA. Instrument: Electron Microscope, Model Technai G2 Spirit TWIN. Manufacturer: FEI Company, Czech Republic. Intended Use: See notice at 72 FR 36961, July 6, 2007.
Docket Number: 07–044. Applicant: Johns Hopkins University, Baltimore, MD. Instrument: Electron Microscope, Model Technai G2 Spirit TWIN. Manufacturer: FEI Company, The Netherlands. Intended Use: See notice at 72 FR 36961, July 6, 2007.
Comments: None received. Decision: Approved. No instrument of equivalent scientific value to the foreign instrument, for such purposes as these instruments are intended to be used, was being manufactured in the United States at the time the instruments were ordered. Reasons: Each foreign instrument is an electron microscope and is intended for research or scientific educational uses requiring an electron microscope. We know of no electron microscope, or any other instrument suited to these purposes, which was being manufactured in the United States at the time of order of each instrument.

Dated July 26, 2007.

Faye Robinson,

Director.

Statutory Import Programs Staff.

[FR Doc. E7–14926 Filed 8–1–07; 8:45 am]

BILLING CODE 3510–DS–S

DEPARTMENT OF COMMERCE

International Trade Administration

[C–570–911]

Circular Welded Carbon Quality Steel Pipe from the People's Republic of China: Notice of Postponement of Preliminary Determination in the Countervailing Duty Investigation

AGENCY: Import Administration, International Trade Administration, Department of Commerce.

EFFECTIVE DATE: August 2, 2007.

FOR FURTHER INFORMATION CONTACT: Damian Felton or Nancy Decker, AD/CVD Operations, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue, NW, Washington, DC 20230; telephone: (202) 482–0133 and (202) 482–0196, respectively.

SUPPLEMENTARY INFORMATION:

Background

On June 27, 2007, the Department of Commerce (''the Department'') initiated the countervailing duty investigation of circular welded carbon quality steel pipe from the People's Republic of China. *See Notice of Initiation of Countervailing Duty Investigation: Circular Welded Carbon Quality Steel Pipe from the People's Republic of China*, 72 FR 36668 (July 5, 2007). Currently, the preliminary determination is due no later than August 31, 2007.

Postponement of Due Date for Preliminary Determinations

Section 703(b)(1) of the Tariff Act of 1930, as amended (''the Act''), requires the Department to issue the preliminary determination in a countervailing duty investigation within 65 days after the date on which the Department initiated the investigation. However, if the Department concludes that the parties concerned in the investigation are cooperating and determines that the investigation is extraordinarily complicated, section 703(c)(1)(B)(i) of the Act allows the Department to postpone making the preliminary determination until no later than the 130 days after the date on which the administering authority initiated the investigation.

The Department concludes that, thus far, the parties concerned are cooperating. Furthermore, due to the complexity of the alleged countervailable subsidy practices being investigated, which include provision of goods or services for less than adequate remuneration and government restraints on exports, it is not practicable to complete the preliminary determination of this investigation within the original time limit (i.e., August 31, 2007). Therefore, in accordance with section 703(c)(1)(B)(i) of the Act, we are fully extending the due date for the preliminary determination to no later than 130 days after the day on which the investigation was initiated. As this deadline falls on a weekend, however, the fully extended deadline is the next business day, November 5, 2007.

This notice is issued and published pursuant to section 703(c)(2) of the Act.

Dated: July 26, 2007.

Stephen J. Claeys,

Deputy Assistant Secretary for Import Administration.

[FR Doc. E7–15032 Filed 8–1–07; 8:45 am]

BILLING CODE 3510–DS–S

DEPARTMENT OF COMMERCE

International Trade Administration

[C–533–821]

Hot–Rolled Carbon Steel Products from India: Extension of Time Limit for Preliminary Results of Countervailing Duty Administrative Review

AGENCY: Import Administration, International Trade Administration, Department of Commerce.

EFFECTIVE DATE: August 2, 2007.

FOR FURTHER INFORMATION CONTACT: Gayle Longest or Robert Copyak, AD/CVD Operations, Office 3, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue NW, Washington, DC 20230; telephone: (202) 482–3338 or (202) 482–2209, respectively.

SUPPLEMENTARY INFORMATION:

Background

On February 2, 2007, the U.S. Department of Commerce (''the Department'') published a notice of initiation of the administrative review of the countervailing duty order on certain hot–rolled carbon steel flat products from the India covering the period of review January 1, 2006, through December 31, 2006. *See Initiation of Antidumping and Countervailing Duty Administrative Reviews*, 72 FR 5005 (February 2, 2007). The preliminary results are currently due no later than September 4, 2007.

Extension of Time Limit for Preliminary Results

Section 751(a)(3)(A) of the Tariff Act of 1930, as amended (''the Act''), requires the Department to make a preliminary determination within 245 days after the last day of the anniversary month of an order or finding for which a review is requested. Section 751(a)(3)(A) of the Act further states that if it is not practicable to complete the review within the time period specified, the administering authority may extend the 245-day period to issue its preliminary results by up to 120 days.

Due to new subsidy allegations and the large number of companies and programs in this administrative review, we have determined that it is not

practicable to complete the preliminary results of this review within the 245-day period. Therefore, in accordance with section 751(a)(3)(A) of the Act, we are extending the time period for issuing the preliminary results of the review to 365 days. The preliminary results are now due no later than December 31, 2007. The final results continue to be due 120 days after publication of the preliminary results.

This notice is issued and published in accordance with section 751(a)(3)(A) of the Act.

Dated: July 27, 2007.

Stephen J. Claeys,

Deputy Assistant Secretary for Import Administration.

[FR Doc. E7–15017 Filed 8–1–07; 8:45 am]

BILLING CODE 3510–DS–S

DEPARTMENT OF COMMERCE

International Trade Administration

[Docket No.: 070725409–7410–01]

Solicitation of Applications for Allocation of Tariff Rate Quotas on the Imports of Certain Cotton Shirting Fabric to Persons Who Cut and Sew Men's and Boys' Cotton Shirts in the United States

AGENCY: Department of Commerce, International trade Administration.

ACTION: Notice.

SUMMARY: The Department hereby solicits applications from persons (including firms, corporations, or other legal entities) who cut and sew men's and boys' cotton shirts in the United States for an allocation of the 2007 tariff rate quotas on certain cotton woven fabric. Interested persons must submit ITA Form 4156P to the address listed below. After the Department has made its allocations of the 2007 tariff rate quotas, the Department will publish in the **Federal Register** a notice informing the public of this action.

DATES: To be considered, applications must be received or postmarked by 5 p.m. EDT on September 4, 2007.

ADDRESSES: Applications must be submitted to the Office of Textiles and Apparel, Room 3001, United States Department of Commerce, Washington, D.C. 20230 (telephone: (202) 482–4058). Application forms may be obtained from that office (via facsimile or mail) or from the following Internet address: http://web.ita.doc.gov/tacgi/cottontrq.nsf/TRQApp.

FOR FURTHER INFORMATION CONTACT: Sergio Botero, Office of Textiles and Apparel, U.S. Department of Commerce, (202) 482–4058.

SUPPLEMENTARY INFORMATION:

Background

On December 9, 2006, President Bush signed into law the Tax Relief and Health Care Act of 2006 (HR 6406/HR 6111) (''the Act''). Section 406(b)(1) of the Act requires the Secretary of Commerce to fairly allocate tariff rate quotas on the import of certain cotton woven fabrics through December 31, 2009. Section 406 (b)(1) authorizes the Secretary of Commerce to issue licenses to eligible manufacturers under headings 9902.52.08 through 9902.52.19 of the Harmonized Tariff Schedule of the United States, specifying the restrictions under each such license on the quantity of cotton woven fabrics that may be entered each year on behalf of the manufacturer. The Act created an annual tariff rate quota providing for temporary reductions through December 31, 2009 in the import duties of cotton woven fabrics suitable for making cotton shirts (new Harmonized Tariff Schedule of the United States (HTS) headings 9902.52.08, 9902.52.09, 9902.52.10, 9902.52.11, 9902.52.12, 9902.52.13, 9902.52.14, 9902.52.15, 9902.52.16, 9902.52.17, 9902.52.18, and 9902.52.19). The reduction in duty is limited to 85 percent of the total square meter equivalents of all imported woven fabrics of cotton containing 85 percent or more by weight cotton used by manufacturers in cutting and sewing men's and boy's cotton shirts in the United States and purchased by such manufacturer during calendar year 2000.

The Act requires that the tariff rate quotas be allocated to persons (including firms, corporations, or other legal entities) who, during calendar year 2000, were manufacturers cutting and sewing men's and boy's cotton shirts in the United States from imported woven fabrics of cotton containing 85 percent or more by weight cotton of the kind described in HTS 9902.52.08 through 9902.5219 purchased by such manufacturer during calendar year 2000. On July 24, 2007, the Department published regulations establishing procedures for allocating the TRQ. 72 FR 40235, 15 CFR 336. In order to receive an allocation, an applicant must submit ITA Form 4156P provided at http://web.ita.doc.gov/tacgi/cotton.nsf/TRQApp to the address listed above by 5 p.m. on September 4, 2007 in compliance with the requirements of 15 CFR 336. Any business confidential information that is marked business confidential will be kept confidential and protected from disclosure to the full extent permitted by law.

Dated: July 27, 2007.

R. Matthew Priest,

Deputy Assistant Secretary for Textiles and Apparel.

[FR Doc. E7–15035 Filed 8–1–07; 8:45 am]

BILLING CODE 3510–DS–S

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[Docket No. 030602141–6143–38]

RIN 0648–XB71

2007 Monkfish Research Set-aside Program

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice; reallocation of set-aside days-at-sea.

SUMMARY: NMFS notifies the public of the reallocation of monkfish research days-at-sea (DAS) as exempted DAS. These are DAS that were set aside under the 2007 Monkfish Research Set-Aside (RSA) Program, but were not distributed through the NOAA grant process. These exempted DAS may be used for the conduct of monkfish related research activities during fishing year (FY) 2007 (May 1, 2007, through April 30, 2008). Requests for a monkfish DAS exemption must be submitted with a complete application for an exempted fishing permit (EFP).

DATES: Projects involving the use of exempted DAS, under this program, must be completed prior to the end of FY 2007, on April 30, 2008.

ADDRESSES: Applications for an EFP must be sent to the Regional Administrator (RA), NMFS, Northeast Regional Office, One Blackburn Drive, Gloucester, MA 01930.

FOR FURTHER INFORMATION CONTACT: Allison McHale, Fishery Policy Analyst, by phone 978–281–9103, by fax 978–281–9135, or by e-mail at *Allison.McHale@noaa.gov*.

SUPPLEMENTARY INFORMATION:

Background

Amendment 2 to the Monkfish Fishery Management Plan (FMP) (70 FR 21927, April 28, 2005) established the Monkfish RSA Program, which annually sets aside 500 monkfish DAS from the total number of monkfish DAS allocated to limited access monkfish vessels to be used for cooperative monkfish research

programs. Amendment 2 also established a Monkfish Exemption Program, which requires the Regional Administrator (RA) to reallocate as exempted DAS any monkfish research DAS not allocated through the Monkfish RSA Program. These exempted DAS may be then used by vessels for the conduct of monkfish research activities during the current fishing year (e.g., FY 2007).

On June 12, 2006, NMFS published a notice in the **Federal Register** announcing the 2007 Monkfish RSA Program (71 FR 33898), and solicited proposals for monkfish research activities to be conducted under this RSA program. Four proposals were received as part of this solicitation, and three were granted awards totaling 367 monkfish research DAS. As a result, there are 133 DAS available to be reallocated as exempted DAS during FY 2007. Therefore, the RA, pursuant to the regulations governing the monkfish fishery at 50 CFR 648.92(c)(1)(v), reallocates these unused research DAS from the FY 2007 Monkfish RSA Program, as exempted DAS, that may be used for the conduct of monkfish research projects during FY 2007.

All requests for monkfish DAS exemptions under the Monkfish DAS Exemption Program must be submitted to the RA along with a complete application for an EFP. The requirements for submitting a complete EFP application are provided in the regulations implementing the Magnuson-Stevens Fishery Conservation and Management Act at § 600.745(b).

Classification

This action is required by 50 CFR part 648 and is exempt from review under Executive Order 12866.

This document contains collection-of-information requirements subject to the Paperwork Reduction Act (PRA). The information requested in an EFP application has been approved under Office of Management and Budget (OMB) Control Number 0648–0309. Notwithstanding any other provision of law, no person is required to respond to, nor shall any person be subject to a penalty for failure to comply with, a collection of information subject to the requirements of the PRA unless that collection of information displays a currently valid OMB control number.

Authority: 16 U.S.C. 1801 *et seq.*

Dated:July 26, 2007.

James P. Burgess,

Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. E7–14934 Filed 8–01–07; 8:45 am]

BILLING CODE 3510–22–S

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

RIN 0648–XB10

Endangered Species; File No. 1526–01

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice; issuance of permit modification.

SUMMARY: Notice is hereby given that Andre Landry, Sea Turtle and Fisheries Ecology Research Lab, Texas A&M University at Galveston, 5007 Avenue U, Galveston, TX 77553 has been issued a modification to scientific research Permit No. 1526.

ADDRESSES: The modification and related documents are available for review upon written request or by appointment in the following office(s):

Permits, Conservation and Education Division, Office of Protected Resources, NMFS, 1315 East-West Highway, Room 13705, Silver Spring, MD 20910; phone (301)713–2289; fax (301)427–2521; and

Southeast Region, NMFS, 263 13th Ave South, St. Petersburg, FL 33701; phone (727)824–5312; fax (727)824–5309.

FOR FURTHER INFORMATION CONTACT: Patrick Opay or Kate Swails, (301)713–2289.

SUPPLEMENTARY INFORMATION: On May 24, 2007, notice was published in the **Federal Register** (72 FR 29132) that a modification of Permit No. 1526, issued August 1, 2005 (70 FR 44091), had been requested by the above-named individual. The requested modification has been granted under the authority of the Endangered Species Act of 1973, as amended (ESA; 16 U.S.C. 1531 *et seq.*) and the regulations governing the taking, importing, and exporting of endangered and threatened species (50 CFR 222–226).

The modification allows Dr. Landry to expand his sample size. It extends the annual take of sea turtles through 2010; authorizes the attachment of additional satellite transmitters to animals; and allows the collection of biopsy samples of skin and carapace scute tissue from green sea turtles for stable isotope analysis to document life history changes, foraging and habitat selection, migration, and diet in green sea turtles.

Issuance of this modification, as required by the ESA was based on a finding that such permit (1) was applied for in good faith, (2) will not operate to the disadvantage of such endangered or threatened species, and (3) is consistent with the purposes and policies set forth in section 2 of the ESA.

Dated: July 26, 2007.

P. Michael Payne,

Chief, Permits, Conservation and Education Division, Office of Protected Resources, National Marine Fisheries Service.

[FR Doc. E7–15050 Filed 8–1–07; 8:45 am]

BILLING CODE 3510–22–S

CORPORATION FOR NATIONAL AND COMMUNITY SERVICE

Renewal of a Currently Approved Information Collection

AGENCY: Corporation for National and Community Service.

ACTION: Notice.

SUMMARY: The Corporation for National and Community Service (hereinafter the ''Corporation''), is conducting a pre-clearance consultation for renewal of the AmeriCorps Performance Measurement Survey information collection request (ICR) in accordance with the Paperwork Reduction Act of 1995 (Pub. L. 104–13), (44 U.S.C. Chapter 35). Copies of the individual ICR may be obtained by calling the Corporation for National and Community Service, Brooke Nicholas, (202) 606–6627. Individuals who use a telecommunications device for the deaf (TTY–TDD) may call (202) 606–3472 between 8:30 a.m. and 5 p.m. Eastern time, Monday through Friday.

ADDRESSES: Comments may be submitted, identified by the title of the information collection activity, to the Corporation for National and Community Service, Attn: Ms. Brooke Nicholas, by any of the following two methods within 60 days from the date of this publication in the **Federal Register**:

(1) *By fax to:* (202) 3606–3464, *Attention:* Ms. Brooke Nicholas; and

(2) *Electronically by e-mail to: bnicholas@cns.gov.*

SUPPLEMENTARY INFORMATION:

Description: The Corporation is strongly committed to making its performance measurement and management systems more results oriented in order to strengthen the accountability and performance of its

programs. As part of its effort to do so, there is a need to collect outcome information regarding the Corporation's AmeriCorps programs consisting of AmeriCorps*State and National, AmeriCorps*VISTA, and AmeriCorps*National Civilian Community Corps (NCCC). Information on program performance will be informed by a series of surveys of a sample of AmeriCorps members and sub-grantee organizations that deliver services.

The OMB is particularly interested in comments which:

- Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the Corporation, including whether the information will have practical utility;
- Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;
- Propose ways to enhance the quality, utility, and clarity of the information to be collected; and
- Propose ways to minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submissions of responses.

Type of Review: Renewal.

Agency: Corporation for National and Community Service.

Title: Performance Measurement in AmeriCorps: Surveys of Members, Organizations and End Beneficiaries.

OMB Number: 3045–0094.

Frequency: Annual.

Affected Public: Individuals and households, community and faith-based organizations, non-profits, state and local government and education institutions.

Number of Respondents: 10,000.

Estimated Time Per Respondent: Ten minutes

Total Burden Hours: 1,667 hours.

Total Burden Cost (capital/startup): None.

Total Annual Cost (operating/maintaining systems or purchasing services): None.

Dated: July 27, 2007.

Kevin Cramer,

Acting Director, Department of Research and Policy Development.

[FR Doc. E7–14944 Filed 8–1–07; 8:45 am]

BILLING CODE 6050–$$–P

DEPARTMENT OF DEFENSE

Office of the Secretary

National Security Education Board Group of Advisors Meeting

AGENCY: Under Secretary of Defense Personnel and Readiness.

ACTION: Notice of meeting.

SUMMARY: Pursuant to Public Law 92–463, notice is hereby given of a forthcoming meeting of the National Security Education Board Group of Advisors. The purpose of the meeting is to review and make recommendations to the Board concerning requirements established by the David L. Boren National Security Education Act, Title VIII of Public Law 102–183, as amended.

DATES: September 7, 2007.

TIME: 9–11 a.m.

ADDRESSES: Holiday Inn on the Hill, Congressional Room (Lobby Level), 415 New Jersey Ave., NW., Washington, DC 20001.

FOR FURTHER INFORMATION CONTACT: Dr. Kevin Gormley, Program Officer, National Security Education Program, 1101 Wilson Boulevard, Suite 1210, Rosslyn P.O. Box 20010, Arlington, Virginia 22209–2248; (703) 696–1991. Electronic mail address: *Gormleyk@ndu.edu.*

SUPPLEMENTARY INFORMATION: The National Security Education Board Group of Advisors meeting is open to the public. The public is afforded the opportunity to submit written statements associated with NSEP.

Dated: July 26, 2007.

C.R. Choate,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 07–3763 Filed 8–1–07; 8:45 am]

BILLING CODE 5001–06–M

DEPARTMENT OF EDUCATION

Submission for OMB Review; Comment Request

AGENCY: Department of Education.

SUMMARY: The Acting Leader, Regulatory Information Management Services, Office of Management invites comments on the submission for OMB review as required by the Paperwork Reduction Act of 1995.

DATES: Interested persons are invited to submit comments on or before September 4, 2007.

ADDRESSES: Written comments should be addressed to the Office of Information and Regulatory Affairs, Attention: Education Desk Officer, Office of Management and Budget, 725 17th Street NW., Room 10222, Washington, DC 20503. Commenters are encouraged to submit responses electronically by e-mail to *oira_submission@omb.eop.gov* or via fax to (202) 395–6974. Commenters should include the following subject line in their response ''Comment: [insert OMB number], [insert abbreviated collection name, e.g., ''Upward Bound Evaluation'']. Persons submitting comments electronically should not submit paper copies.

SUPPLEMENTARY INFORMATION: Section 3506 of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35) requires that the Office of Management and Budget (OMB) provide interested Federal agencies and the public an early opportunity to comment on information collection requests. OMB may amend or waive the requirement for public consultation to the extent that public participation in the approval process would defeat the purpose of the information collection, violate State or Federal law, or substantially interfere with any agency's ability to perform its statutory obligations. The Acting Leader, Regulatory Information Management Services, Office of Management, publishes that notice containing proposed information collection requests prior to submission of these requests to OMB. Each proposed information collection, grouped by office, contains the following: (1) Type of review requested, e.g. new, revision, extension, existing, or reinstatement; (2) Title; (3) Summary of the collection; (4) Description of the need for, and proposed use of, the information; (5) Respondents and frequency of collection; and (6) Reporting and/or Recordkeeping burden. OMB invites public comment.

Dated: July 30, 2007.

James Hyler,

Acting Leader, Information Management Case Services Team, Regulatory Information Management Services Office of Management.

Institute of Education Sciences

Type of Review: New.

Title: A Study of the Effectiveness of a School Improvement Intervention.

Frequency: Semi-annually, annually.

Affected Public: Not-for-profit institutions.

Reporting and Recordkeeping Hour Burden:

Responses: 3,979.

Burden Hours: 6,452.

Abstract: This randomized control trial study will examine the

effectiveness of Success in Sight (SiS) in 52 elementary schools with low to moderate student achievement. This study will specifically examine the impact of SiS on student achievement and on school practices associated with school improvement. The primary data collection will include a teacher survey assessing school improvement practices (data-based decision-making, practices associated with improved student achievement, shared leadership, and purposeful community) and student achievement data. Data collection will occur over a two-year period. Hierarchical Linear Modeling (HLM) will be used to determine the effects of SiS on school-level student achievement and school-level reform practices.

Requests for copies of the information collection submission for OMB review may be accessed from *http://edicsweb.ed.gov*, by selecting the ''Browse Pending Collections'' link and by clicking on link number 3361. When you access the information collection, click on ''Download Attachments '' to view. Written requests for information should be addressed to U.S. Department of Education, 400 Maryland Avenue SW., Potomac Center, 9th Floor, Washington, DC 20202–4700. Requests may also be electronically mailed to *ICDocketMgr@ed.gov* or faxed to 202–245–6623. Please specify the complete title of the information collection when making your request.

Comments regarding burden and/or the collection activity requirements should be electronically mailed to *ICDocketMgr@ed.gov*. Individuals who use a telecommunications device for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at 1–800–877–8339.

[FR Doc. E7–15016 Filed 8–1–07; 8:45 am]

BILLING CODE 4000–01–P

DEPARTMENT OF EDUCATION

Reading First Advisory Committee; Notice of Open Meeting

AGENCY: Department of Education, Office of Elementary and Secondary Education.

ACTION: Notice of open meeting.

SUMMARY: This notice sets forth the schedule and proposed agenda of the first open meeting of the Reading First Advisory Committee. The notice also describes the functions of the Committee. Notice of the meeting is required by section 10(a)(2) of the Federal Advisory Committee Act and is intended to notify the public of their opportunity to attend.

DATE AND TIME: August 20 from 10 a.m. to 3 p.m.; August 22 from 9 a.m. to 3 p.m.

ADDRESSES: The Beacon Hotel, 1615 Rhode Island Avenue, NW., Washington, DC 20036.

FOR FURTHER INFORMATION CONTACT: Deborah Spitz, Reading First Team Leader, Reading First Advisory Committee; 400 Maryland Avenue, SW., Washington, DC 20202; telephone: (202) 260–3793; fax: (202) 260–8969; e-mail: *Deborah.Spitz@ed.gov.*

Individuals who use a telecommunications device for the deaf (TDD) may call the Federal Information Relay Service (FRS) at 1–800–877–8339, Monday through Friday between the hours of 8 a.m. and 8 p.m., Eastern Standard Time.

SUPPLEMENTARY INFORMATION: The Reading First Advisory Committee is authorized by Sections 1203(c)(2)(a) and 1202(e)(2) of the Elementary and Secondary Education Act (ESEA) of 1965, as amended. The Committee is being established by the Department of Education to evaluate Reading First applications submitted by States, to review the progress reports that States submit after the third year of the grant period, to advise on the awarding of Targeted Assistance Grants, and to advise the Secretary on other issues that the Secretary deems appropriate.

At this meeting, members of the Committee will be sworn in and will discuss the purpose and responsibilities of the Committee. Committee members will select a Committee Chair, develop procedures for completing the tasks described in its charter, and plan future meetings. To the extent practicable, Committee members will begin the work described in the charter, including but not limited to reviewing applications for the Targeted Assistance Grants (TAG).

Individuals who will need accommodations for a disability in order to attend the meeting (e.g., interpreting services, assistance listening devices, or materials in alternative format) should notify Deborah Spitz at (202) 260–3793, no later than ten (10) days before the scheduled date of the meeting. We will attempt to meet requests for accommodations after this date but cannot guarantee their availability. The meeting site is accessible to individuals with disabilities.

Request for Written Comments: Written comments should be submitted via e-mail at least ten (10) days prior to the scheduled date of the meeting to Deborah Spitz at *Deborah.Spitz@ed.gov.* These comments will be shared with the members of the Committee.

Records are kept of all Committee proceedings and are available for public inspection at 400 Maryland Ave., SW., Washington, DC 20202, from the hours of 9 a.m. to 5 p.m., Eastern Standard Time, Monday through Friday.

Electronic Access to This Document: You may view this document, as well as all other documents of this Department published in the **Federal Register**, in text or Adobe Portable Document Format (PDF) on the Internet at the following site: *http://www.ed.gov/news/fedregister/index.html.*

To use PDF you must have Adobe Acrobat Reader, which is available free at this site. If you have questions about using PDF, call the U.S. Government Printing Office (GPO), toll free at 1–888–293–6498; or in the Washington, DC area at (202) 512–1530.

Note: The official version of this document is the document published in the **Federal Register**. Free Internet access to the official edition of the **Federal Register** and the Code of Federal Regulations is available on GPO Access at: *http://www.gpoaccess.gov/nara/index.html.*

Amanda Farris,

Deputy Assistant Secretary, The Office of Elementary and Secondary Education.

[FR Doc. 07–3758 Filed 08–1–07; 8:45 am]

BILLING CODE 4001–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. ER07–1106–000]

ArcLight Energy Marketing, LLC.; Notice of Issuance of Order

July 26, 2007.

ArcLight Energy Marketing, LLC. (AEM) filed an application for market-based rate authority, with an accompanying tariff. The proposed market-based rate tariff provides for the sale of energy, capacity and ancillary services at market-based rates. AEM also requested waivers of various Commission regulations. In particular, AEM requested that the Commission grant blanket approval under 18 CFR part 34 of all future issuances of securities and assumptions of liability by AEM.

On July 25, 2007, pursuant to delegated authority, the Director, Division of Tariffs and Market Development—West, granted the requests for blanket approval under part 34 (Director's Order). The Director's Order also stated that the Commission would publish a separate notice in the **Federal Register** establishing a period of

time for the filing of protests. Accordingly, any person desiring to be heard concerning the blanket approvals of issuances of securities or assumptions of liability by AEM should file a protest with the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426, in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure. 18 CFR 385.211, 385.214 (2004).

Notice is hereby given that the deadline for filing protests is August 24, 2007.

Absent a request to be heard in opposition to such blanket approvals by the deadline above, AEM is authorized to issue securities and assume obligations or liabilities as a guarantor, indorser, surety, or otherwise in respect of any security of another person; provided that such issuance or assumption is for some lawful object within the corporate purposes of AEM, compatible with the public interest, and is reasonably necessary or appropriate for such purposes.

The Commission reserves the right to require a further showing that neither public nor private interests will be adversely affected by continued approvals of AEM's issuance of securities or assumptions of liability.

Copies of the full text of the Director's Order are available from the Commission's Public Reference Room, 888 First Street, NE., Washington, DC 20426. The Order may also be viewed on the Commission's Web site at *http://www.ferc.gov,* using the eLibrary link. Enter the docket number excluding the last three digits in the docket number filed to access the document. Comments, protests, and interventions may be filed electronically via the internet in lieu of paper. See, 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's Web site under the ''e-Filing'' link. The Commission strongly encourages electronic filings.

Kimberly D. Bose,

Secretary.

[FR Doc. E7–14962 Filed 8–1–07; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. ER07–981–000]

Barclays Capital Energy, Inc.; Notice of Issuance of Order

July 26, 2007.

Barclays Capital Energy, Inc. (Barclays Capital) filed an application for market-based rate authority, with an accompanying rate schedule. The proposed market-based rate schedule provides for the sale of energy, capacity and ancillary services at market-based rates. Barclays Capital also requested waivers of various Commission regulations. In particular, Barclays Capital requested that the Commission grant blanket approval under 18 CFR part 34 of all future issuances of securities and assumptions of liability by Barclays Capital.

On July 25, 2007, pursuant to delegated authority, the Director, Division of Tariffs and Market Development—West, granted the requests for blanket approval under part 34 (Director's Order). The Director's Order also stated that the Commission would publish a separate notice in the **Federal Register** establishing a period of time for the filing of protests. Accordingly, any person desiring to be heard concerning the blanket approvals of issuances of securities or assumptions of liability by Barclays Capital should file a protest with the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426, in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure. 18 CFR 385.211, 385.214 (2004).

Notice is hereby given that the deadline for filing protests is August 24, 2007.

Absent a request to be heard in opposition to such blanket approvals by the deadline above, Barclays Capital is authorized to issue securities and assume obligations or liabilities as a guarantor, indorser, surety, or otherwise in respect of any security of another person; provided that such issuance or assumption is for some lawful object within the corporate purposes of Barclays Capital compatible with the public interest, and is reasonably necessary or appropriate for such purposes.

The Commission reserves the right to require a further showing that neither public nor private interests will be adversely affected by continued approvals of Barclays Capital's issuance of securities or assumptions of liability.

Copies of the full text of the Director's Order are available from the Commission's Public Reference Room, 888 First Street, NE., Washington, DC 20426. The Order may also be viewed on the Commission's Web site at *http://www.ferc.gov*, using the eLibrary link. Enter the docket number excluding the last three digits in the docket number filed to access the document. Comments, protests, and interventions may be filed electronically via the internet in lieu of paper. See, 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's Web site under the ''e-Filing'' link. The Commission strongly encourages electronic filings.

Kimberly D. Bose,

Secretary.

[FR Doc. E7–14964 Filed 8–1–07; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. ER07–1058–000]

Glacial Energy of Maryland, Inc.; Notice of Issuance of Order

July 26, 2007.

Glacial Energy of Maryland, Inc. (Glacial) filed an application for market-based rate authority, with an accompanying tariff. The proposed market-based rate tariff provides for the sale of energy and capacity at market-based rates. Glacial also requested waivers of various Commission regulations. In particular, Glacial requested that the Commission grant blanket approval under 18 CFR Part 34 of all future issuances of securities and assumptions of liability by Glacial.

On July 18, 2007, pursuant to delegated authority, the Director, Division of Tariffs and Market Development—West, granted the requests for blanket approval under Part 34 (Director's Order). The Director's Order also stated that the Commission would publish a separate notice in the **Federal Register** establishing a period of time for the filing of protests. Accordingly, any person desiring to be heard concerning the blanket approvals of issuances of securities or assumptions of liability by Glacial should file a protest with the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426, in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure. 18 CFR 385.211, 385.214 (2004).

Notice is hereby given that the deadline for filing protests is August 17, 2007.

Absent a request to be heard in opposition to such blanket approvals by the deadline above, Glacial is authorized to issue securities and assume obligations or liabilities as a guarantor, indorser, surety, or otherwise in respect of any security of another person; provided that such issuance or assumption is for some lawful object within the corporate purposes of Glacial, compatible with the public interest, and is reasonably necessary or appropriate for such purposes.

The Commission reserves the right to require a further showing that neither public nor private interests will be adversely affected by continued approvals of Glacial's issuance of securities or assumptions of liability.

Copies of the full text of the Director's Order are available from the Commission's Public Reference Room, 888 First Street, NE., Washington, DC 20426. The Order may also be viewed on the Commission's Web site at *http://www.ferc.gov,* using the eLibrary link. Enter the docket number excluding the last three digits in the docket number filed to access the document. Comments, protests, and interventions may be filed electronically via the internet in lieu of paper. See, 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's Web site under the ''e-Filing'' link. The Commission strongly encourages electronic filings.

Kimberly D. Bose,

Secretary.

[FR Doc. E7–14961 Filed 8–1–07; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket Nos. CP07–422–000]

Leaf River Energy Center, LLC.; Notice of Application

July 26, 2007.

Take notice that on July 24, 2007, Leaf River Energy Center, LLC. (Leaf River), 61 Wilton Road, Westport, CT, 06880, filed in Docket No. CP07–422–000, a petition for Exemption of Temporary Acts and Operations from Certificate Requirements, pursuant to Rule 207(a)(5) of the Commission's Rules of Practice and Procedure, and section 7(c)(1)(B) of the Natural Gas Act, seeking approval of an exemption from certificate requirements to perform temporary activities related to drilling three test wells and performing other activities to assess the feasibility of developing an underground natural gas storage facility in the New Home Salt Dome in Smith County, Mississippi, all as more fully set forth in the application which is on file with the Commission and open to public inspection. This filing may also be viewed on the Commission's Web site at *http://www.ferc.gov* using the ''eLibrary'' link. Enter the docket number, excluding the last three digits, in the docket number field to access the document. For assistance, call (202) 502–8659 or TTY, (202) 208–3676.

Any questions regarding this application should be directed to James F. Bowe, Jr., Dewey Ballantine, LLP., 975 F Street, NW., Washington, DC 20004, at (202) 862–1000, or by fax at (202) 862–1093, or e-mail *jbowe@deweyballantine.com.*

Pursuant to Section 157.9 of the Commission's rules, 18 CFR 157.9, within 90 days of this Notice the Commission staff will either: Complete its environmental assessment (EA) and place it into the Commission's public record (eLibrary) for this proceeding; or issue a Notice of Schedule for Environmental Review. If a Notice of Schedule for Environmental Review is issued, it will indicate, among other milestones, the anticipated date for the Commission staff's issuance of the final environmental impact statement (FEIS) or EA for this proposal. The filing of the EA in the Commission's public record for this proceeding or the issuance of a Notice of Schedule for Environmental Review will serve to notify federal and state agencies of the timing for the completion of all necessary reviews, and the subsequent need to complete all federal authorizations within 90 days of the date of issuance of the Commission staff's FEIS or EA.

There are two ways to become involved in the Commission's review of this project. First, any person wishing to obtain legal status by becoming a party to the proceedings for this project should, on or before the comment date stated below, file with the Federal Energy Regulatory Commission, 888 First Street, NW., Washington, DC 20426, a motion to intervene in accordance with the requirements of the Commission's Rules of Practice and Procedure (18 CFR 385.214 or 385.211) and the Regulations under the NGA (18 CFR 157.10). A person obtaining party status will be placed on the service list maintained by the Secretary of the Commission and will receive copies of all documents filed by the applicant and by all other parties. A party must submit 14 copies of filings made with the Commission and must mail a copy to the applicant and to every other party in the proceeding. Only parties to the proceeding can ask for court review of Commission orders in the proceeding.

However, a person does not have to intervene in order to have comments considered. The second way to participate is by filing with the Secretary of the Commission, as soon as possible, an original and two copies of comments in support of or in opposition to this project. The Commission will consider these comments in determining the appropriate action to be taken, but the filing of a comment alone will not serve to make the filer a party to the proceeding. The Commission's rules require that persons filing comments in opposition to the project provide copies of their protests only to the party or parties directly involved in the protest.

Persons who wish to comment only on the environmental review of this project should submit an original and two copies of their comments to the Secretary of the Commission. Environmental commentors will be placed on the Commission's environmental mailing list, will receive copies of the environmental documents, and will be notified of meetings associated with the Commission's environmental review process. Environmental commentors will not be required to serve copies of filed documents on all other parties. However, the non-party commentors will not receive copies of all documents filed by other parties or issued by the Commission (except for the mailing of environmental documents issued by the Commission) and will not have the right to seek court review of the Commission's final order.

The Commission strongly encourages electronic filings of comments, protests and interventions in lieu of paper using the ''eFiling'' link at *http://www.ferc.gov.* Persons unable to file electronically should submit an original and 14 copies of the protest or intervention to the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426.

This filing is accessible on-line at *http://www.ferc.gov,* using the ''eLibrary'' link and is available for review in the Commission's Public Reference Room in Washington, DC. There is an ''eSubscription'' link on the Web site that enables subscribers to receive e-mail notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please e-mail *FERCOnlineSupport@ferc.gov,* or call

(866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Comment Date: 5 pm Eastern Time on August 3, 2007.

Kimberly D. Bose,

Secretary.

[FR Doc. E7–14959 Filed 8–1–07; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. ER07–964–000]

UNS Electric, Inc.; Notice of Issuance of Order

July 26, 2007.

UNS Electric, Inc. (UNS Electric) filed an application for market-based rate authority, with an accompanying rate schedule. The proposed market-based rate schedule provides for the sale of energy, capacity and ancillary services at market-based rates. UNS Electric also requested waivers of various Commission regulations. In particular, UNS Electric requested that the Commission grant blanket approval under 18 CFR part 34 of all future issuances of securities and assumptions of liability by UNS Electric.

On July 25, 2007, pursuant to delegated authority, the Director, Division of Tariffs and Market Development—West, granted the requests for blanket approval under part 34 (Director's Order). The Director's Order also stated that the Commission would publish a separate notice in the **Federal Register** establishing a period of time for the filing of protests. Accordingly, any person desiring to be heard concerning the blanket approvals of issuances of securities or assumptions of liability by UNS Electric should file a protest with the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426, in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure. 18 CFR 385.211, 385.214 (2004).

Notice is hereby given that the deadline for filing protests is August 24, 2007.

Absent a request to be heard in opposition to such blanket approvals by the deadline above, UNS Electric is authorized to issue securities and assume obligations or liabilities as a guarantor, indorser, surety, or otherwise in respect of any security of another person; provided that such issuance or assumption is for some lawful object within the corporate purposes of UNS Electric, compatible with the public interest, and is reasonably necessary or appropriate for such purposes.

The Commission reserves the right to require a further showing that neither public nor private interests will be adversely affected by continued approvals of UNS Electric's issuance of securities or assumptions of liability.

Copies of the full text of the Director's Order are available from the Commission's Public Reference Room, 888 First Street, NE., Washington, DC 20426. The Order may also be viewed on the Commission's Web site at *http://www.ferc.gov*, using the eLibrary link. Enter the docket number excluding the last three digits in the docket number filed to access the document. Comments, protests, and interventions may be filed electronically via the internet in lieu of paper. See, 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's Web site under the ''e-Filing'' link. The Commission strongly encourages electronic filings.

Kimberly D. Bose,

Secretary.

[FR Doc. E7–14963 Filed 8–1–07; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. CP06–19–002]

Windy Hill Gas Storage, LLC; Notice of Compliance Filing

July 26, 2007.

Take notice that on June 29, 2007, Windy Hill Gas Storage, LLC (Windy Hill) tendered for filing a compliance filing pursuant to the Commission's order issued on June 21, 2007 in Docket No. CP06–19–001.

Windy Hill states that copies of the filing were served on parties on the official service list in the above-captioned proceeding.

Any person desiring to protest this filing must file in accordance with Rule 211 of the Commission's Rules of Practice and Procedure (18 CFR 385.211). Protests to this filing will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Such protests must be filed on or before the date as indicated below. Anyone filing a protest must serve a copy of that document on all the parties to the proceeding.

The Commission encourages electronic submission of protests in lieu of paper using the ''eFiling'' link at *http://www.ferc.gov.* Persons unable to file electronically should submit an original and 14 copies of the protest to the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426.

This filing is accessible on-line at *http://www.ferc.gov,* using the ''eLibrary'' link and is available for review in the Commission's Public Reference Room in Washington, DC. There is an ''eSubscription'' link on the web site that enables subscribers to receive email notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please e-mail *FERCOnlineSupport@ferc.gov,* or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Comment Date: 5 p.m. Eastern Time on August 3, 2007.

Kimberly D. Bose,

Secretary.

[FR Doc. E7–14965 Filed 8–1–07; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Combined Notice of Filings # 1

July 25, 2007.

Take notice that the Commission received the following electric corporate filings:

Docket Numbers: EC07–117–000.

Applicants: Sunbury Generation LP; Corona Power, LLC.

Description: Joint Application of Sunbury Generation LP and Corona Power LLC for authorization under section 203 of the Federal Power Act.

Filed Date: July 18, 2007.

Accession Number: 20070720–0050.

Comment Date: 5 p.m. Eastern Time on Wednesday, August 8, 2007.

Take notice that the Commission received the following exempt wholesale generator filings:

Docket Numbers: EG07–57–000.

Applicants: EL Segundo Power II LLC.

Description: Notice of Self-Certification of EL Segundo Power II LLC of exempt wholesale generator status.

Filed Date: July 6, 2007.

Accession Number: 20070606–5040.

Comment Date: 5 p.m. Eastern Time on Wednesday, August 1, 2007.

Docket Numbers: EG07–57–000.

Applicants: EL Segundo Power II LLC.

Description: Clarification of June 6, 2007 filing of EL Segundo Power II LLC.

Filed Date: June 26, 2007.
Accession Number: 20070626–5027.
Comment Date: 5 p.m. Eastern Time on Wednesday, August 1, 2007.

Docket Numbers: EG07–61–000.
Applicants: Warm Springs Biomass Project, LLC.
Description: Amendment to Notice of Self-Certification of Exempt Wholesale Generator Status.
Filed Date: July 12, 2007.
Accession Number: 20070711–5233.
Comment Date: 5 p.m. Eastern Time on Thursday, August 2, 2007.

Take notice that the Commission received the following electric rate filings:

Docket Numbers: ER01–666–009.
Applicants: EWO Marketing, LP.
Description: EWO Marketing LP submits the refund report related to refunds.
Filed Date: July 20, 2007.
Accession Number: 20070724–0180.
Comment Date: 5 p.m. Eastern Time on Friday, August 10, 2007.

Docket Numbers: ER04–831–003.
Applicants: Calpine Newark, LLC.
Description: Calpine Newark, LLC submits an updated market analysis in accordance with FERC's letter order dated July 21, 2004.
Filed Date: July 23, 2007.
Accession Number: 20070724–0200.
Comment Date: 5 p.m. Eastern Time on Monday, August 13, 2007.

Docket Numbers: ER04–925–017.
Applicants: Merrill Lynch Commodities, Inc.
Description: Triennial Updated Market Power Analysis for Merrill Lynch Commodities, Inc.
Filed Date: July 19, 2007.
Accession Number: 20070724–0175.
Comment Date: 5 p.m. Eastern Time on Thursday, August 9, 2007.

Docket Numbers: ER06–739–006; ER06–738–006; ER03–983–005; ER07–501–002; ER07–758–001; ER02–537–009.
Applicants: Cogen Technologies Linden Venture, L.P.
Description: Cogen Technologies Linden Venture, LP et al notifies FERC of a change in status resulting from the acquisition of a 100 percent indirect interest in Shady Hills by General Electric Capital Corp.
Filed Date: July 20, 2007.
Accession Number: 20070724–0178.
Comment Date: 5 p.m. Eastern Time on Friday, August 10, 2007.

Docket Numbers: ER07–570–003.
Applicants: New York Independent System Operator, Inc.
Description: New York Independent System Operator, Inc submits revised Market Administration and Control Area Services Tariff and Open Access Transmission Tariff Sheets in compliance w/FERC's July 21, 2007 order.
Filed Date: July 20, 2007.
Accession Number: 20070724–0179.
Comment Date: 5 p.m. Eastern Time on Friday, August 10, 2007.

Docket Numbers: ER07–946–002; ER07–947–002; ER07–948–002.
Applicants: Westar Energy, Inc.
Description: Westar Energy, Inc submits First Revised Sheet 8 to 1st Revised FERC Electric Rate Schedule 226.
Filed Date: July 19, 2007.
Accession Number: 20070724–0176.
Comment Date: 5 p.m. Eastern Time on Thursday, August 9, 2007.

Docket Numbers: ER07–954–001.
Applicants: American Transmission Company LLC.
Description: American Transmission Company LLC submits a response to an informal request for information by FERC Staff regarding the amended Distribution-Transmission Interconnection Agreement filed on May 25, 2007.
Filed Date: July 20, 2007.
Accession Number: 20070724–0177.
Comment Date: 5 p.m. Eastern Time on Friday, August 10, 2007.

Docket Numbers: ER07–1171–001.
Applicants: Arizona Public Service Company.
Description: Arizona Public Service Co submits an errata to the corrected version of the tariff sheets filed in section 205 Filing.
Filed Date: July 20, 2007.
Accession Number: 20070724–0135.
Comment Date: 5 p.m. Eastern Time on Friday, August 10, 2007.

Docket Numbers: ER07–1175–000.
Applicants: Illinois Power Company d/b/a AmerenIP.
Description: Illinois Power Co dba AmerenIP's et al requests approval of the Joint Ownership Agreement with Ameren Transco.
Filed Date: July 19, 2007.
Accession Number: 20070724–0130.
Comment Date: 5 p.m. Eastern Time on Thursday, August 9, 2007.

Docket Numbers: ER07–1176–000.
Applicants: Niagara Mohawk Power Corporation.
Description: Niagra Mohawk Power Co submits a notice of Cancellation of Rate Schedule 172 with Lockport Energy Associates, LP.
Filed Date: July 19, 2007.
Accession Number: 20070724–0131.
Comment Date: 5 p.m. Eastern Time on Thursday, August 9, 2007.

Docket Numbers: ER07–1177–000.
Applicants: Midwest Independent Transmission System Operator, Inc.
Description: Midwest Independent Transmission System Operator, Inc. submits an executed Small Generator Interconnection Agreement with Odin Wind Farm, LLC.
Filed Date: July 19, 2007.
Accession Number: 20070724–0132.
Comment Date: 5 p.m. Eastern Time on Thursday, August 9, 2007.

Docket Numbers: ER07–1178–000.
Applicants: Xcel Energy Operating Companies.
Description: Xcel Energy Services Inc submits the Revised and Restated Interconnection and Interchange Agreement dated July 23, 2007 b/w Northern States Power Company (Minnesota), Northern States Power Co (Wisconsin) etc.
Filed Date: July 19, 2007.
Accession Number: 20070724–0186.
Comment Date: 5 p.m. Eastern Time on Thursday, August 9, 2007.

Docket Numbers: ER07–1179–000.
Applicants: Pacific Gas and Electric Company.
Description: Pacific Gas and Electric Company submits its quarterly filing of Facilities Agreements pursuant to the Procedures for Implementation of section 3.3 of the 1987 Agreement.
Filed Date: July 20, 2007.
Accession Number: 20070724–0182.
Comment Date: 5 p.m. Eastern Time on Friday, August 10, 2007.

Docket Numbers: ER07–1180–000.
Applicants: California Independent System Operator Corporation
Description: Petition of the California Independent System Operator Corp to waive sanctions for violation of section 31.1.4.1 of its tariff through October 18, 2006.
Filed Date: July 20, 2007.
Accession Number: 20070724–0137.
Comment Date: 5 p.m. Eastern Time on Friday, August 10, 2007.

Docket Numbers: ER07–1181–000.
Applicants: New York Independent System Operator, Inc.
Description: New York Independent System Operator, Inc submits a single limited revision to its Open Access Transmission Tariff.
Filed Date: July 20, 2007.
Accession Number: 20070724–0136.
Comment Date: 5 p.m. Eastern Time on Friday, August 10, 2007.

Docket Numbers: ER07–1182–000.
Applicants: Midwest Independent Transmission System Operator, Inc.
Description: Midwest Independent Transmission System Operator, Inc submits its request for an extension of the Broad Constrained Area mitigation measures provided in their Open Access Transmission & energy Markets Tariff.

Filed Date: July 20, 2007.

Accession Number: 20070724–0134.

Comment Date: 5 p.m. Eastern Time on Friday, August 10, 2007.

Docket Numbers: ER07–1183–000.

Applicants: Susquehanna Energy Products, LLC.

Description: SIG Energy, LLLP submits a supplement to its June 8, 2007 Notice of Succession.

Filed Date: July 20, 2007.

Accession Number: 20070724–0133.

Comment Date: 5 p.m. Eastern Time on Friday, August 10, 2007.

Take notice that the Commission received the following electric securities filings:

Docket Numbers: ES07–41–000.

Applicants: Duquesne Light Company.

Description: Duquesne Light Co's Filing of Pro Forma Financial Statements.

Filed Date: July 19, 2007.

Accession Number: 20070719–5054.

Comment Date: 5 p.m. Eastern Time on Thursday, August 9, 2007.

Any person desiring to intervene or to protest in any of the above proceedings must file in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 385.214) on or before 5 p.m. Eastern time on the specified comment date. It is not necessary to separately intervene again in a subdocket related to a compliance filing if you have previously intervened in the same docket. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Anyone filing a motion to intervene or protest must serve a copy of that document on the Applicant. In reference to filings initiating a new proceeding, interventions or protests submitted on or before the comment deadline need not be served on persons other than the Applicant.

The Commission encourages electronic submission of protests and interventions in lieu of paper, using the FERC Online links at *http://www.ferc.gov.* To facilitate electronic service, persons with Internet access who will eFile a document and/or be listed as a contact for an intervenor must create and validate an eRegistration account using the eRegistration link. Select the eFiling link to log on and submit the intervention or protests.

Persons unable to file electronically should submit an original and 14 copies of the intervention or protest to the Federal Energy Regulatory Commission, 888 First St., NE., Washington, DC 20426.

The filings in the above proceedings are accessible in the Commission's eLibrary system by clicking on the appropriate link in the above list. They are also available for review in the Commission's Public Reference Room in Washington, DC. There is an eSubscription link on the Web site that enables subscribers to receive e-mail notification when a document is added to a subscribed dockets(s). For assistance with any FERC Online service, please e-mail *FERCOnlineSupport@ferc.gov.* or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Kimberly D. Bose

Secretary.

[FR Doc. E7–14957 Filed 8–1–07; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket Nos. EG07–45–000 through FC07–49–000]

Notice of Effectiveness of Exempt Wholesale Generator or Foreign Utility Company Status

July 26, 2007.

	Docket No.
Glacial Ridge Wind Power LLC	EG07–45–000
Entergy Nuclear Palisades, LLC	EG07–46–000
Covanta Waste to Energy Asia Ltd	EG07–47–000
Lock 7 Hydro Partners, LLC	EG07–48–000
Calpine Power L.P.	FC07–30–000
Calpine Island Cogeneration Limited Partnership, Marianas Energy Company LLC	FC07–31–000
EDP Gás—S.G.P.S., S.A.	FC07–32–000
EDP Imobiliária e Participações, S.A.	FC07–33–000
Nuevas Energías de Occidente	FC07–34–000
Balwerk—Consultadoria Económica e Participações, Sociedade Unipessoal, Lda.	FC07–35–000
EDP Comercial—Comercialização de Energia, S.A.	FC07–36–000
EDP Distribuição de Energia, S.A.	FC07–37–000
EDP Finance Company Ltd.	FC07–38–000
Enernova—Novas Energias S.A.	FC07–39–000
Electrica de la Ribera del Ebro, S.A.	FC07–40–000
Hidroeléctrica del Cantábrico, S.A.	FC07–41–000
DECA II—Distribuicion Elétrica Centroamericana Dos II, S.A.	FC07–42–000
EDP Energias do Brasil, S.A.	FC07–43–000
EDP Produção Bioelẽctrica, S.A.	FC07–44–000
EDP Gestąo da Produção de Energia, S.A.	FC07–45–000
Electra S.A.R.L.—Empresa de Electricidade e Água	FC07–46–000
REN—Energéticas Nacionais, SGPS, S.A.	FC07–47–000
EDP Investment, Lda.	FC07–48–000
CMS Generation LLC	FC07–49–000

Take notice that during the month of June 2007, the status of the above-captioned entities as Exempt Wholesale Generators or Foreign Utility Companies became effective by operation of the Commission's regulations. 18 CFR 366.7(a).

Kimberly D. Bose,

Secretary.

[FR Doc. E7–14960 Filed 8–1–07; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. RM98–1–000]

Records Governing Off-the Record Communications; Public Notice

July 26, 2007.

This constitutes notice, in accordance with 18 CFR 385.2201(b), of the receipt of prohibited and exempt off-the-record communications.

Order No. 607 (64 FR 51222, September 22, 1999) requires Commission decisional employees, who make or receive a prohibited or exempt off-the-record communication relevant to the merits of a contested proceeding, to deliver to the Secretary of the Commission, a copy of the communication, if written, or a summary of the substance of any oral communication.

Prohibited communications are included in a public, non-decisional file associated with, but not a part of, the decisional record of the proceeding. Unless the Commission determines that the prohibited communication and any responses thereto should become a part of the decisional record, the prohibited off-the-record communication will not be considered by the Commission in reaching its decision. Parties to a proceeding may seek the opportunity to respond to any facts or contentions made in a prohibited off-the-record communication, and may request that the Commission place the prohibited communication and responses thereto in the decisional record. The Commission will grant such a request only when it determines that fairness so requires. Any person identified below as having made a prohibited off-the-record communication shall serve the document on all parties listed on the official service list for the applicable proceeding in accordance with Rule 2010, 18 CFR 385.2010.

Exempt off-the-record communications are included in the decisional record of the proceeding, unless the communication was with a cooperating agency as described by 40 CFR 1501.6, made under 18 CFR 385.2201(e)(1)(v).

The following is a list of off-the-record communications recently received by the Secretary of the Commission. The communications listed are grouped by docket numbers in ascending order. These filings are available for review at the Commission in the Public Reference Room or may be viewed on the Commission's Web site at *http://www.ferc.gov* using the eLibrary link. Enter the docket number, excluding the last three digits, in the docket number field to access the document. For assistance, please contact FERC, Online Support at *FERCOnlineSupport@ferc.gov* or toll free at (866) 208–3676, or for TTY, contact (202) 502–8659.

EXEMPT

Docket No.	Date received	Presenter or requester
1. CP06–459–000	7–19–07	Hon. Michael LeVault.
2. Project No. 199–205	7–24–07	Allan Creamer/Dr. Stephanie Bolden [1].
3. Project No. 1971–000	7–25–07	Susan Pengilly Neitzel.
4. Project No. 1971–079	7–26–07	Craig Jones.

[1] Summary of Telephone Conference.

Kimberly D. Bose,

Secretary.

[FR Doc. E7–14958 Filed 8–1–07; 8:45 am]

BILLING CODE 6717–01–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OAR–2007–0563; FRL–8449–1]

Agency Information Collection Activities: Proposed Collection; Comment Request; National Volatile Organic Compound Emission Standards for Consumer Products; EPA ICR No. 1764.01; OMB Control No. 2060–0348

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (44 U.S.C. 3501, *et seq.*), this document announces that EPA is planning to submit a request to renew an existing approved Information Collection Request (ICR) to the Office of Management and Budget (OMB). This ICR is scheduled to expire on October 31, 2007. Before submitting the ICR to OMB for review and approval, EPA is soliciting comments on specific aspects of the proposed information collection as described below.

DATES: Comments must be submitted on or before October 1, 2007.

ADDRESSES: Submit your comments, identified by Docket ID No. EPA–HQ–OAR–2007–0563 by one of the following methods:

- *www.regulations.gov:* Follow the on-line instructions for submitting comments.
- *E-mail: a-and-r-Docket@epa.gov.*
- *Fax:* (202) 566–9744.
- *Mail:* National VOC Standards for Consumer Products—Information Collection Request Renewal, Environmental Protection Agency, Mailcode: 2822T, 1200 Pennsylvania Ave., NW., Washington, DC 20460.
- *Hand Delivery:* Air and Radiation Docket and Information Center, Public Reading Room, EPA West Building, Room 3334, 1301 Constitution Ave., NW., Washington, DC 20004. Such deliveries are only accepted during the Docket's normal hours of operation, and special arrangements should be made for deliveries of boxed information.

Instructions: Direct your comments to Docket ID No. EPA–HQ–OAR–2007–0563. EPA's policy is that all comments received will be included in the public docket without change and may be made available online at *www.regulations.gov,* including any personal information provided, unless the comment includes information claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Do not submit information that you consider to be CBI or otherwise protected through www.regulations.gov

or e-mail. The *www.regulations.gov* website is an ''anonymous access'' system, which means EPA will not know your identity or contact information unless you provide it in the body of your comment. If you send an e-mail comment directly to EPA without going through *www.regulations.gov,* your e-mail address will be automatically captured and included as part of the comment that is placed in the public docket and made available on the Internet. If you submit an electronic comment, EPA recommends that you include your name and other contact information in the body of your comment and with any disk or CD-ROM you submit. If EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment. Electronic files should avoid the use of special characters, any form of encryption, and be free of any defects or viruses. For additional information about EPA's public docket visit the EPA Docket Center homepage at *http://www.epa.gov/epahome/dockets.htm.*

FOR FURTHER INFORMATION CONTACT: Mr. Bruce Moore, U.S. Environmental Protection Agency, Office of Air Quality Planning and Standards, Sector Policies and Programs Division, Natural Resources and Commerce Group (E143–03), Research Triangle Park, NC 27711; telephone number: (919) 541–5460; fax number: (919) 541–3470; e-mail address: *moore.bruce@epa.gov.*

SUPPLEMENTARY INFORMATION:

How Can I Access the Docket and/or Submit Comments?

EPA has established a public docket for this ICR under Docket ID number EPA–HQ–OAR–2007–0563, which is available for online viewing at *www.regulations.gov,* or in person viewing at the Air and Radiation Docket and Information Center in the EPA Docket Center, EPA West Building, Room 3334, 1301 Constitution Ave., NW., Washington, DC. The EPA Docket Center Public Reading Room is open from 8:30 a.m. to 4:30 p.m., Monday through Friday, excluding legal holidays. The telephone number for the Reading Room is (202) 566–1744, and the telephone number for the Air and Radiation Docket and Information Center is (202) 566–1742.

Use *www.regulations.gov* to obtain a copy of the draft collection of information, submit or view public comments, access the index listing of the contents of the docket, and to access those documents in the public docket that are available electronically. Once in the system, select ''search,'' then key in the docket ID number identified in this document.

What Information is EPA Particularly Interested in?

Pursuant to section 3506(c)(2)(A) of the Paperwork Reduction Act, EPA specifically solicits comments and information to enable it to:

(i) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the Agency, including whether the information will have practical utility;

(ii) evaluate the accuracy of the Agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

(iii) enhance the quality, utility, and clarity of the information to be collected; and

(iv) minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses. In particular, EPA is requesting comments from very small businesses (those that employ less than 25) on examples of specific additional efforts that EPA could make to reduce the paperwork burden for very small businesses affected by this collection.

What Should I Consider when I Prepare My Comments for EPA?

You may find the following suggestions helpful for preparing your comments:

1. Explain your views as clearly as possible and provide specific examples.

2. Describe any assumptions that you used.

3. Provide copies of any technical information and/or data you used that support your views.

4. If you estimate potential burden or costs, explain how you arrived at the estimate that you provide.

5. Offer alternative ways to improve the collection activity.

6. Make sure to submit your comments by the deadline identified under **DATES**.

7. To ensure proper receipt by EPA, be sure to identify the docket ID number assigned to this action in the subject line on the first page of your response. You may also provide the name, date, and **Federal Register** citation.

What Information Collection Activity or ICR Does this Apply to?

Docket ID No. EPA–HQ–OAR–2007–0563.

Affected entities: Entities potentially affected by this action are those which manufacture, distribute, or import consumer products for sale or distribution in the United States, including the District of Columbia and all United States territories.

Title: National Volatile Organic Compound Emission Standards for Consumer Products.

ICR numbers: EPA ICR No. 1764.01, OMB Control No. 2060–0348.

ICR status: This ICR is currently scheduled to expire on October 31, 2007. An Agency may not conduct or sponsor, and a person is not required to respond to, a collection of information, unless it displays a currently valid OMB control number. The OMB control numbers for EPA's regulations in title 40 of the CFR, after appearing in the **Federal Register** when approved, are listed in 40 CFR part 9, are displayed either by publication in the **Federal Register** or by other appropriate means, such as on the related collection instrument or form, if applicable. The display of OMB control numbers in certain EPA regulations is consolidated in 40 CFR part 9.

Abstract: The information collection includes initial reports and periodic recordkeeping necessary for EPA to ensure compliance with Federal standards for volatile organic compounds in consumer products. Respondents are manufacturers, distributors, and importers of consumer products. Responses to the collection are mandatory under 40 CFR part 59, Subpart C—National Volatile Organic Compound Emission Standards for Consumer Products. All information submitted to the EPA for which a claim of confidentiality is made will be safeguarded according to the Agency policies set forth in 40 CFR part 2, Subpart B—Confidentiality of Business Information.

Burden Statement: The annual public reporting and recordkeeping burden for this collection of information is estimated to average 40 hours per respondent. Burden means the total time, effort, or financial resources expended by persons to generate, maintain, retain, or disclose or provide information to or for a Federal agency. This includes the time needed to review instructions; develop, acquire, install, and utilize technology and systems for the purposes of collecting, validating, and verifying information, processing and maintaining information, and disclosing and providing information; adjust the existing ways to comply with any previously applicable instructions and requirements which have subsequently changed; train personnel

to be able to respond to a collection of information; search data sources; complete and review the collection of information; and transmit or otherwise disclose the information.

The ICR provides a detailed explanation of the Agency's estimate, which is only briefly summarized here:

Estimated total number of potential respondents: 732.

Frequency of response: On occasion.

Estimated total average number of responses for each respondent: 1.

Estimated total annual burden hours: 29,613 hours.

Estimated total annual costs: $1,187,537. This includes an estimated burden cost of $1,187,537 and an estimated zero cost for capital investment or maintenance and operational costs.

Are There Changes in the Estimates from the Last Approval?

There is no change in hours in the total estimated respondent burden compared with that identified in the ICR currently approved by OMB. However, the estimated total annual costs are increased by $83,480 due to increased costs of employment compensation since the previous approval.

What is the Next Step in the Process for this ICR?

EPA will consider the comments received and amend the ICR as appropriate. The final ICR package will then be submitted to OMB for review and approval pursuant to 5 CFR 1320.12. At that time, EPA will issue another **Federal Register** notice pursuant to 5 CFR 1320.5(a)(1)(iv) to announce the submission of the ICR to OMB and the opportunity to submit additional comments to OMB. If you have any questions about this ICR or the approval process, please contact the technical person listed under **FOR FURTHER INFORMATION CONTACT**.

Dated: July 25, 2007.

Jan Cortelyou Lee,

Acting Director, Office of Air Quality Planning and Standards.

[FR Doc. E7–14984 Filed 8–1–07; 8:45 am]

BILLING CODE 6560–50–P

FEDERAL RESERVE SYSTEM

Change in Bank Control Notices; Acquisition of Shares of Bank or Bank Holding Companies

The notificants listed below have applied under the Change in Bank Control Act (12 U.S.C. 1817(j)) and § 225.41 of the Board's Regulation Y (12 CFR 225.41) to acquire a bank or bank holding company. The factors that are considered in acting on the notices are set forth in paragraph 7 of the Act (12 U.S.C. 1817(j)(7)).

The notices are available for immediate inspection at the Federal Reserve Bank indicated. The notices also will be available for inspection at the office of the Board of Governors. Interested persons may express their views in writing to the Reserve Bank indicated for that notice or to the offices of the Board of Governors. Comments must be received not later than August 15, 2007.

A. Federal Reserve Bank of St. Louis (Glenda Wilson, Community Affairs Officer) 411 Locust Street, St. Louis, Missouri 63166-2034:

1. Harry Roberts, individually, and as part of The Roberts Group, that consists of Willa Roberts, Harry L. Roberts and Sherry Roberts all of Owensboro, Kentucky; to acquire First Security, Inc., Owensboro, Kentucky and thereby indirectly acquire voting shares of First Security Bank of Owensboro, Inc., Owensboro, Kentucky.

Board of Governors of the Federal Reserve System, July 27, 2007.

Robert deV. Frierson,

Deputy Secretary of the Board.

[FR Doc. E7–14903 Filed 8–1–07; 8:45 am]

BILLING CODE 6210–01–S

FEDERAL RESERVE SYSTEM

Formations of, Acquisitions by, and Mergers of Bank Holding Companies

The companies listed in this notice have applied to the Board for approval, pursuant to the Bank Holding Company Act of 1956 (12 U.S.C. 1841 *et seq.*) (BHC Act), Regulation Y (12 CFR Part 225), and all other applicable statutes and regulations to become a bank holding company and/or to acquire the assets or the ownership of, control of, or the power to vote shares of a bank or bank holding company and all of the banks and nonbanking companies owned by the bank holding company, including the companies listed below.

The applications listed below, as well as other related filings required by the Board, are available for immediate inspection at the Federal Reserve Bank indicated. The application also will be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the standards enumerated in the BHC Act (12 U.S.C. 1842(c)). If the proposal also involves the acquisition of a nonbanking company, the review also includes whether the acquisition of the nonbanking company complies with the standards in section 4 of the BHC Act (12 U.S.C. 1843). Unless otherwise noted, nonbanking activities will be conducted throughout the United States. Additional information on all bank holding companies may be obtained from the National Information Center website at *www.ffiec.gov/nic/*.

Unless otherwise noted, comments regarding each of these applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than August 27, 2007.

A. Federal Reserve Bank of Kansas City (Donna J. Ward, Assistant Vice President) 925 Grand Avenue, Kansas City, Missouri 64198-0001:

1. Community State Bankshares, Inc.; to become a bank holding company by acquiring 100 percent of the voting shares of Community State Bank (in organization) both of Lamar, Colorado.

Board of Governors of the Federal Reserve System, July 27, 2007

Robert deV. Frierson,

Deputy Secretary of the Board.

[FR Doc. E7–14902 Filed 8–1–07; 8:45 am]

BILLING CODE 6210–01–S

FEDERAL RESERVE SYSTEM

Formations of, Acquisitions by, and Mergers of Bank Holding Companies

The companies listed in this notice have applied to the Board for approval, pursuant to the Bank Holding Company Act of 1956 (12 U.S.C. 1841 *et seq.*) (BHC Act), Regulation Y (12 CFR Part 225), and all other applicable statutes and regulations to become a bank holding company and/or to acquire the assets or the ownership of, control of, or the power to vote shares of a bank or bank holding company and all of the banks and nonbanking companies owned by the bank holding company, including the companies listed below.

The applications listed below, as well as other related filings required by the Board, are available for immediate inspection at the Federal Reserve Bank indicated. The application also will be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the standards enumerated in the BHC Act (12 U.S.C. 1842(c)). If the proposal also involves the acquisition of a nonbanking company, the review also includes whether the acquisition of the nonbanking company complies with the standards in section 4 of the BHC Act (12 U.S.C. 1843). Unless otherwise noted, nonbanking activities will be conducted throughout the United States. Additional information on all bank

holding companies may be obtained from the National Information Center website at *www.ffiec.gov/nic/*.

Unless otherwise noted, comments regarding each of these applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than August 27, 2007.

A. Federal Reserve Bank of New York (Anne MacEwen, Bank Applications Officer) 33 Liberty Street, New York, New York 10045-0001:

1. Allied Irish Banks, plc, Dublin, Ireland; to acquire additional shares of M&T Bank Corporation, Buffalo, New York, for a total of 29 percent, and thereby indirectly control M&T Bank, National Association, Oakfield, New York, and M&T Trust Company, Buffalo, New York.

B. Federal Reserve Bank of Richmond (A. Linwood Gill, III, Vice President) 701 East Byrd Street, Richmond, Virginia 23261-4528:

1. Blue Ridge Financial Corporation; to become a bank holding company by acquiring 100 percent of the voting shares of Blue Ridge Bank of Walhalla, both of Walhalla, South Carolina.

C. Federal Reserve Bank of Atlanta (David Tatum, Vice President) 1000 Peachtree Street, N.E., Atlanta, Georgia 30309:

1. FBC Bancorp, Inc., Orlando, Florida; to acquire 100 percent of the voting shares of Prime Bank, Melbourne, Florida.

D. Federal Reserve Bank of Chicago (Burl Thornton, Assistant Vice President) 230 South LaSalle Street, Chicago, Illinois 60690-1414:

1. Sidney Bancorp.; to become a bank holding company by acquiring 100 percent of the voting shares of Sidney State Bank, both of Sidney, Michigan.

E. Federal Reserve Bank of Dallas (W. Arthur Tribble, Vice President) 2200 North Pearl Street, Dallas, Texas 75201-2272:

1. Mineola Community Mutual Holding Company, and Mineola Community Financial Group, Inc., to become bank holding companies by acquiring 100 percent of the voting shares of Mineola Community Bank, S.S.B., all of Mineola, Texas.

Board of Governors of the Federal Reserve System, July 30, 2007.

Robert deV. Frierson,

Deputy Secretary of the Board.

[FR Doc. E7–14979 Filed 8–1–07; 8:45 am]

BILLING CODE 6210–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

[Document Identifier: OS–0990–0000; 30-day notice]

Agency Information Collection Activities: Proposed Collection; Comment Request

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Office of the Secretary (OS), Department of Health and Human Services, is publishing the following summary of a proposed collection for public comment. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

Type of Information Collection Request: New collection

Title of Information Collection: Homelessness Data for Health and Human Services Mainstream Programs

Form/OMB No.: 0990–0000

Use: The Office of the Assistant Secretary for Planning and Evaluation will study data collection practices by Temporary Assistant for Needy Families (TANF) and Medicaid state programs regarding homelessness and housing status. Telephone interviews will be conducted with state officials from all 50 states and the District of Columbia who administer the TANF and Medicaid programs to collect information about the type and quality of data related to homelessness and housing status that are collected from and recorded about TANF and Medicaid applicants. This information will be used to determine whether these two HHS mainstream programs are collecting information from program applicants and/or participants regarding their housing status.

Frequency: One time

Affected Public: State, Local and Tribal Government

Annual Number of Respondents: 102

Total Annual Responses: 102

Average Burden per Response: 60 minutes

Total Annual Hours: 102

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, e-mail your request, including your address, phone number, OMB number, and OS document identifier, to *Sherette.funncoleman@hhs.gov,* or call the Reports Clearance Office on (202) 690–6162. Written comments and recommendations for the proposed information collections must be received within 30 days of this notice directly to the Desk Officer at the address below: OMB Desk Officer: John Kraemer, OMB Human Resources and Housing Branch, Attention: (OMB #0990–0000), New Executive Office Building, Room 10235, Washington DC 20503.

Date: July 25, 2007.

Seleda Perryman,

Office of the Secretary, Paperwork Reduction Act Reports Clearance Officer.

[FR Doc. E7–14978 Filed 8–1–07; 8:45 am]

BILLING CODE 4150–05–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the National Coordinator for Health Information Technology; American Health Information Community; Announcement of Public Comment Period About the Design and Implementation of the American Health Information Community Successor

SUMMARY: This notice announces a public comment period, from August 6, 2007 to August 31, 2007, to collect input about ideas for the design and implementation of a successor entity for the American Health Information Community (AHIC) as described in the *American Health Information Community Successor White paper, July 2007* (available on the Web at *http://www.hhs.gov/healthit/community/background/AHICsuccessor. html* on or after July 31, 2007).

The ANIC is a federally-chartered advisory committee that provides input and recommendations to the Department of Health and Human Services (HHS) on how to make health records digital and interoperable, and how to assure that the privacy and security of those records are protected. The charter of the AHIC requires that its responsibilities be transferred to a successor entity. Therefore, HHS and the AHIC are embarking upon a project that will take the AHIC to the next level. The successor entity will be an independent, sustainable public-private partnership that brings together the best of the public and private sectors. This

new public-private partnership will develop a unified approach to realize an effective, interoperable nationwide health information system that supports the health and well-being of the people of this country. The input from this public comment period will be used to inform the plans for transitioning the locus of activity from a Federal advisory committee to a independent public-private partnership.

HHS and the AHIC are eager to hear the thoughts of your organization with respect to the AHIC successor entity. To facilitate your participation in this process, you are encouraged to provide your comments organized by the following concepts:

- Purpose and scope of the successor entity
- Membership, including classes and sectors
- Governing body and decision-making process
- Protections, incorporation, management, and staffing
- Value of participation in the successor entity for stakeholders

All comments in any format will be accepted.

DATES: Comments should be received by the Office of the National Coordinator for Health Information Technology, Department of Health and Human Services, on or before 5 p.m. EST on August 31, 2007.

ADDRESSES: electronic responses are preferred and may be recorded via the Web site at *http://www.hhs.gov/healthit/commhnity/background/AHICsuccessor.html* or may be sent via e-mail addressed to *AHICsuccessor@hhs.gov* in the Office of the National Coordinator for Health Information Technology, Department of Health and Human Services. Please include ''AHIC Successor White Paper Comments'' in the subject line.

Paper-based responses will also be accepted. Please send to: Office of the National Coordinator for Health Information Technology, Department of Health and Human Services, Attention: AHIC Successor White Paper Comments, Mary C. Switzer Building, 330 C Street, SW., Room 4080, Washington, DC 20201, or fax to (202) 690–6079, Attention: AHIC Successor White Paper Comments.

FOR FURTHER INFORMATION: Visit *http://www.hhs.gov/healthit/community/background/AHICsuccessor.html.*

Dated: July 27, 2007.

Michelle Murray,

Office of Programs and Coordination, Office of the National Coordinator for Health Information Technology.

[FR Doc. 07–3768 Filed 8–1–07; 8:45 am]

BILLING CODE 4150–24–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60–Day–07–07BN]

Proposed Data Collections Submitted for Public Comment and Recommendations

In compliance with the requirement of Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 for opportunity for public comment on proposed data collection projects, the Centers for Disease Control and Prevention (CDC) will publish periodic summaries of proposed projects. To request more information on the proposed projects or to obtain a copy of the data collection plans and instruments, call 404–639–5960 and send comments to Maryam I. Daneshvar, CDC Acting Reports Clearance Officer, 1600 Clifton Road, MS–D74, Atlanta, GA 30333 or send an e-mail to *omb@cdc.gov.*

Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Written comments should be received within 60 days of this notice.

Proposed Project

Pilot Project to Estimate the Incidence of Hepatitis C Virus (HCV) Infection Among Young Injection Drug Users (IDUs) Using Serial Cross-Sectional Seroprevalence Surveys—New—National Center for HIV, Hepatitis, STD, and TB Prevention (NCHHSTP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Hepatitis C is the most prevalent bloodborne infection in the United States; approximately 3.2 million persons are chronically infected with HCV. National recommendations for prevention and control of HCV infection emphasize primary prevention activities to reduce the risk of HCV transmission. Identifying and reaching persons at risk for HCV infection to provide risk-reduction counseling is thus critical to prevent infection. Currently the Centers for Disease Control and Prevention (CDC) monitors the national incidence of acute hepatitis C through passive surveillance of acute, symptomatic cases of laboratory confirmed hepatitis C. However, only a minority of people with acute infection have symptoms at all (<25%) and passive surveillance only captures a small fraction of acutely infected people, i.e., those who have symptoms and receive medical attention and appropriate laboratory testing during the acute phase of the disease. Injection drug users (IDUs), who are the primary risk group for acute hepatitis C (70% of identified acute cases), have additional barriers to health care access and/or utilization resulting in the potential for a further underestimation of overall incidence. Thus, it is necessary to consider strategies other than passive surveillance for incidence monitoring. One such strategy is to conduct Serial Cross-Sectional Seroprevalence Surveys (SCSS) among populations at increased risk of infection such as IDUs.

For the proposed pilot project, funding will be awarded to selected U.S. sites that will develop and test different methods to recruit a sample of young IDUs that is most representative of the population of young IDUs at risk for HCV infection. These sampling methods will be compared and contrasted to identify a methodology to be used in ongoing SCSSs among young IDUs. Better methods of identification of persons at risk will enhance current surveillance efforts to monitor the incidence of HCV infection which in turn are the best means to direct and assess primary prevention strategies, determine new transmission patterns, and identify and control outbreaks. Moreover, methods developed in this study can be used in other areas to gather representative data on incidence of acute disease and the burden of disease caused by HCV infection.

In addition, instruments for collecting behavioral/risk factor data from IDUs will be developed and pilot tested. It is estimated that data will be collected over 15 months from a total of 2000

respondents. The total annual burden for this project is expected to be 1600 hours. The information to be collected includes demographic data, risk factors for HCV infection, missed opportunities for prevention (including hepatitis A and B vaccination), access to medical care, and knowledge, attitudes, and beliefs about HCV infection. The utility of using HCV nucleic acid testing (NAT), antigen-antibody testing and other testing modalities to identify sero-incident (window period) infections will also be assessed. Knowledge of factors associated with acquiring hepatitis C virus infection is essential to guide the development of prevention and control strategies.

Participation in the data collection is voluntary and there is no cost to respondents to participate in the survey other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Respondents	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
Young injection drug users	1600	1	1	1600

Dated: July 27, 2007.

Maryam I. Daneshvar,

Acting Reports Clearance Officer, Centers for Disease Control and Prevention.

[FR Doc. E7–15020 Filed 8–1–07; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60 Day-07–0020]

Proposed Data Collections Submitted for Public Comment and Recommendations

In compliance with the requirement of Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 for opportunity for public comment on proposed data collection projects, the Centers for Disease Control and Prevention (CDC) will publish periodic summaries of proposed projects. To request more information on the proposed projects or to obtain a copy of the data collection plans and instruments, call 404–639–5960 and send comments to Maryam I. Daneshvar, CDC Acting Reports Clearance Officer, 1600 Clifton Road, MS–D74, Atlanta, GA 30333 or send an email to *omb@cdc.gov*.

Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Written comments should be received within 60 days of this notice.

Proposed Project

Coal Workers' X-ray Surveillance Program (CWXSP) OMB # 0920–0020—Extension—The National Institute for Occupational Safety and Health (NIOSH), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The CWXSP is a federally mandated program under the Federal Mine Safety and Health Act of 1977, Public Law 95–164. The Act provides the regulatory authority for the administration of the CWXSP, a surveillance program to protect the health and safety of underground coal miners. This Program requires the gathering of demographic and logistical information from coal mine operators, participating miners, participating x-ray facilities, and participating physicians. The Appalachian Laboratory for Occupational Safety and Health (ALOSH), located in Morgantown, WV, is charged with administration of this Program. Over the past two years, participation in the CWXSP has increased, which is reflected in this submission for renewal. Based on an average of 5,000 x-rays coming into the Program per year (each x-ray receives two readings), and using the average hourly wage rates taken from the Bureau of Labor Statistics, National Occupational Employment and Wage Estimates, the total annualized burden hours is 2,329. Physicians (B Readers) will fill out forms regarding their interpretations of the x-rays. Based on prior practice it takes the physician approximately 3 minutes per form. Physicians taking the B Reader Examination are asked to complete a registration form which takes approximately 10 minutes to complete. There are approximately 300 physicians each year taking the certification exam.

Miners participating in the CWXSP must fill out the Miner Identification Document which requires approximately 20 minutes. There are about 5,000 miners participating in the CWXSP Program. Mine operators are required to file a Mine x-ray Plan with NIOSH approximately every 3 years. It takes the mine operator approximately 30 minutes to complete this form. Approximately 200 mine operators have x-ray plans that are due for renewal each year. An x-ray facility that applies to be a NIOSH-approved facility for providing miners x-rays must complete an approval packet. The forms associated with this approval process require approximately 30 minutes for completion. There are approximately 25 x-ray facilities each year seeking approval into the CWXSP Program. Overall, there will be no costs to study participants.

ESTIMATES OF ANNUALIZED BURDEN HOURS

Respondents	Number of respondents	Number of responses/ respondent	Average burden/response (in hrs.)	Total burden (in hrs.)
Physicians/interpretations	10,000	1	3/60	500

ESTIMATES OF ANNUALIZED BURDEN HOURS—Continued

Respondents	Number of respondents	Number of responses/ respondent	Average burden/response (in hrs.)	Total burden (in hrs.)
Physicians/certification	300	1	10/60	50
Miners	5000	1	20/60	1,666
Mine operators	200	1	30/60	100
X-ray facilities	25	1	30/60	13
Total				2,329

Dated: July 27, 2007.

Maryam I. Daneshvar,

Acting Reports Clearance Officer, Centers for Disease Control and Prevention.

[FR Doc. E7–15027 Filed 8–1–07; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

Animal Drug User Fee Rates and Payment Procedures for Fiscal Year 2008

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing the rates and payment procedures for fiscal year (FY) 2008 animal drug user fees. The Federal Food, Drug, and Cosmetic Act (the act), as amended by the Animal Drug User Fee Act of 2003 (ADUFA), authorizes FDA to collect user fees for certain animal drug applications, on certain animal drug products, on certain establishments where such products are made, and on certain sponsors of such animal drug applications and/or investigational animal drug submissions. This notice establishes the fee rates for FY 2008.

For FY 2008, the animal drug user fee rates are: $172,500 for an animal drug application; $86,250 for a supplemental animal drug application for which safety or effectiveness data is required; $4,125 for an annual product fee; $52,700 for an annual establishment fee; and $43,900 for an annual sponsor fee. FDA will issue invoices for FY 2008 product, establishment and sponsor fees by December 30, 2007, and these invoices will be due and payable by January 31, 2008.

The application fee rates are effective for applications submitted on or after October 1, 2007, and will remain in effect through September 30, 2008. Applications will not be accepted to review until FDA has received full payment of application fees and any other animal drug user fees owed.

FOR FURTHER INFORMATION CONTACT: Visit the FDA Web site at *http://www.fda.gov/oc/adufa* or contact Roxanne Schweitzer, Center for Veterinary Medicine (HFV–10), Food and Drug Administration, 7529 Standish Pl., Rockville, MD 20855, 240–276–9705. For general questions, you may also e-mail the Center for Veterinary Medicine (CVM) at *cvmadufa@fda.gov*.

SUPPLEMENTARY INFORMATION:

I. Background

Section 740 of the act (21 U.S.C. 379j–12) establishes four different kinds of user fees: (1) Fees for certain types of animal drug applications and supplements, (2) annual fees for certain animal drug products, (3) annual fees for certain establishments where such products are made, and (4) annual fees for certain sponsors of animal drug applications and/or investigational animal drug submissions (21 U.S.C. 379j–12(a)). When certain conditions are met, FDA will waive or reduce fees (21 U.S.C. 379j–12(d)).

For FY 2004 through FY 2008, the act establishes aggregate yearly base revenue amounts for each of these fee categories. Base revenue amounts established for years after FY 2004 are subject to adjustment for inflation and workload. Fees for applications, establishments, products, and sponsors are to be established each year by FDA so that the revenue for each fee category will approximate the level established in the statute, after the level has been adjusted for inflation and workload.

II. Revenue Amount for FY 2008 and Adjustments for Inflation and Workload

A. Statutory Fee Revenue Amounts

ADUFA (Public Law 108–130) specifies that the aggregate revenue amount for FY 2008 for each of the four animal drug user fee categories is $2,500,000, before any adjustments for inflation or workload are made (21 U.S.C. 379j–12(b)(1)–(4)).

B. Inflation Adjustment to Fee Revenue Amount

ADUFA provides that fee revenue amounts for each FY after 2004 shall be adjusted for inflation (see 21 U.S.C. 379j–12(c)(1)). The adjustment must reflect the greater of the following: (1) The total percentage change that occurred in the Consumer Price Index (CPI) for all urban consumers (all items; U.S. city average) during the 12-month period ending June 30 preceding the FY for which fees are being set, or (2) the total percentage pay change for the previous FY for Federal employees stationed in Washington, DC. ADUFA provides for this annual adjustment to be cumulative and compounded annually after FY 2004 (21 U.S.C. 379j–12(c)(1)).

The inflation adjustment for FY 2005 was 4.42 percent. This was the greater of the CPI increase during the 12-month period ending June 30, 2004, (3.27 percent) or the increase in pay for FY 2004 for Federal employees stationed in Washington, DC (4.42 percent).

The inflation adjustment for FY 2006 was 3.71 percent. This was the greater of the CPI increase during the 12-month period ending June 30, 2005, (2.53 percent) or the increase in pay for FY 2005 for Federal employees stationed in Washington, DC (3.71 percent).

The inflation adjustment for FY 2007 was 4.32 percent. This was the greater of the CPI increase for the 12-month period ending June 30, 2006, (4.32 percent) or the increase in pay for FY 2006 for Federal employees stationed in Washington, DC (3.44 percent).

The inflation adjustment for FY 2008 is 2.69 percent. This is the greater of the CPI increase for the 12-month period ending June 30, 2007, (2.69 percent) or the increase in pay for FY 2007 for Federal employees stationed in Washington, DC (2.64 percent).

Compounding these amounts (1.0442 times 1.0371 times 1.0432 times 1.0269) yields a total compounded inflation adjustment of 16.01 percent for FY 2008.

The inflation-adjusted revenue amount for each category of fees for FY 2008 is the statutory fee amount ($2,500,000) increased by 16.01 percent, the inflation adjuster for FY 2008. The inflation-adjusted revenue amount is $2,900,000 for each category of fee, rounded to the nearest thousand dollars, for a total inflation-adjusted fee revenue amount of $11,600,000 for all four categories of fees in FY 2008.

C. Workload Adjustment to Inflation Adjusted Fee Revenue Amount

For each FY beginning in FY 2005, ADUFA provides that fee revenue amounts, after they have been adjusted for inflation, shall be further adjusted to reflect changes in review workload (21 U.S.C. 379j–12(c)(2)).

FDA calculated the average number of each of the five types of applications and submissions specified in the workload adjustment provision (animal drug applications, supplemental animal drug applications for which data with respect to safety or efficacy are required, manufacturing supplemental animal drug applications, investigational animal drug study submissions, and investigational animal drug protocol submissions) received over the 3-year period that ended on September 30, 2002 (the base years), and the average number of each of these types of applications and submissions over the most recent 3-year period that ended May 31, 2007.

The results of these calculations are presented in the first two columns of table 1 of this document. Column 3 reflects the percent change in workload over the two 3-year periods. Column 4 shows the weighting factor for each type of application, reflecting how much of the total FDA animal drug review workload was accounted for by each type of application or submission in the table during the most recent 3 years. Column 5 of table 1 is the weighted percent change in each category of workload, and was derived by multiplying the weighting factor in each line in column 4 by the percent change from the base years in column 3. At the bottom right of the table the sum of the values in column 5 is added, reflecting a total change in workload of negative 16.7 percent for FY 2008. This is the workload adjuster for FY 2008.

TABLE 1.—WORKLOAD ADJUSTER CALCULATION (NUMBERS MAY NOT ADD DUE TO ROUNDING)

Application Type	Column 1 3-Year Avg. (Base Years)	Column 2 Latest 3-Year Avg.	Column 3 Percent Change	Column 4 Weighting Factor	Column 5 Weighted Percent Change
New Animal Drug Applications (NADAs)	22	13	-39%	4%	-1.5%
Supplemental NADA's with Safety or Efficacy Data	31	12	-62%	2%	-1.4%
Manufacturing Supplements	368	409	+11%	16%	+1.8%
Investigational Study Submissions	272	217	-20%	60%	-12.1%
Investigational Protocol Submissions	283	229	-19%	18%	-3.4%
FY 2008 Workload Adjuster					-16.7%

ADUFA specifies that the workload adjuster may not result in fees that are less than the inflation-adjusted revenue amount (21 U.S.C. 379j–12(c)(2)(B)). For this reason, the workload adjustment will not be applied in FY 2008, and the inflation-adjusted revenue amount for each category of fees for FY 2008 ($2,900,000) becomes the revenue target for fees in FY 2008, for a total inflation-adjusted fee revenue target in FY 2008 of $11,600,000 for fees from all four categories.

III. Adjustment for Excess Collections in Previous Years

Under the provisions of ADUFA, if the agency collects more fees than were provided for in appropriations in any year, FDA is required to reduce its anticipated fee collections in a subsequent year by that amount (21 U.S.C. 379j–12(g)(4)).

In FY 2004, Congress appropriated a total of $5,000,000 to FDA in ADUFA fee revenue. As of July 1, 2007, collections for FY 2004 totaled $5,154,700—or $154,700 in excess of the appropriation limit. Also, in FY 2005 Congress appropriated a total of $8,354,000 to FDA in ADUFA fee revenue, and FDA collected a total of $8,519,101 as of July 1, 2007. This is $165,101 in excess of appropriations. The total in excess collections for the 2 years is $319,801. These are the only fiscal years since ADUFA began in which FDA has collected more in ADUFA fees than Congress appropriated.

The total of $319,801 will be offset against FY 2008 revenue collections, lowering the net amount that would otherwise be collected. One-fourth of this amount, or $80,000, rounded to the nearest thousand dollars, will be subtracted from the FY 2008 adjusted revenue amount for each fee category in the previous section. Thus, after adjustment for prior-year excess collections, the adjusted FY 2008 revenue target for each fee category is:

- Application Fee Revenue Amount: $2,820,000 ($2,900,000 minus $80,000)
- Establishment Fee Revenue Amount: $2,820,000 ($2,900,000 minus $80,000)
- Product Fee Revenue Amount: $2,820,000 ($2,900,000 minus $80,000)
- Sponsor Fee Revenue Amount: $2,820,000 ($2,900,000 minus $80,000)

Thus the adjusted revenue amount from all 4 categories after this adjustment totals $11,280,000.

IV. Final Year Adjustment

Under the provisions of ADUFA, the Secretary of Health and Human Services may, in addition to the inflation and workload adjustments, further increase the fees and fee revenues if such an adjustment is necessary to provide for not more than 3 months of operating reserves of carryover user fees for the process for the review of animal drug applications for the first 3 months of FY

2009. The rational for the amount of this increase shall be contained in the annual notice establishing fee revenues and fees for FY 2008 (21 U.S.C. 379j–12(c)(3)).

As of June 30, 2007, FDA has unallocated cash carryover balances of $4,453,000. In addition, the agency is estimating that application fees over the final 3 months of FY 2007 will add another $675,000 to this balance, for an estimated cash carryover of $5,128,000 on September 30, 2007.

In FY 2008, FDA expects to collect a total of $11,280,000 after adjustments, as noted at the end of section III of this document. To sustain current operations in FY 2008, FDA expects to obligate a total of $13,084,000 (compared with anticipated obligations in FY 2007 of about $12,355,000). The anticipated obligations of $13,084,000 will be about $1,768,000 more than anticipated collections. This will reduce the estimated carryover balance over the course of FY 2008 from $5,128,000 to an estimated $3,360,000 ($5,128,000 minus $1,768,000).

To sustain operations supported from user fees for the first 3 months of FY 2009, FDA estimates that it will need one-fourth of the $13,084,000 it expects to spend in FY 2008, or $3,271,000 (rounded to the nearest thousand). However this amount will need to be increased for inflation by an estimated 5.9 percent (the average amount by which FDA's costs per full-time employee have increased over the past 5 years). The amount needed to sustain operations for the first 3 months of FY 2009 is thus estimated at $3,464,000 (rounded to the nearest thousand), while the estimated carryover balance at the beginning of FY 2009 is estimated at only $3,360,000. Thus FDA will need an additional $104,000 as the final year adjustment to assure sufficient operating reserves for the first 3 months of FY 2009. One-fourth of this amount or $26,000 will be added to the FY 2008 adjusted revenue amount for each of the four fee categories in the previous section. Thus, after the final-year adjustment, the adjusted FY 2008 revenue target for each fee category is:

- Application Fee Revenue Amount: $2,846,000 ($2,820,000 plus $26,000)
- Establishment Fee Revenue Amount: $2,846,000 ($2,820,000 plus $26,000)
- Product Fee Revenue Amount: $2,846,000 ($2,820,000 plus $26,000)
- Sponsor Fee Revenue Amount: $2,846,000 ($2,820,000 plus $26,000)

Thus, after the final year adjustment, the adjusted FY 2008 revenue target from all fee types combined totals $11,384,000.

V. Application Fee Calculations for FY 2008

The terms ''animal drug applications'' and ''supplemental animal drug applications'' are defined in 21 U.S.C. 379j–11(1).

A. Application Fee Revenues and Numbers of Fee-Paying Applications

The application fee must be paid for any animal drug application or supplemental animal drug application that is subject to fees under ADUFA and that is submitted on or after September 1, 2003. The application fees are to be set so that they will generate $2,846,000 in fee revenue for FY 2008. This is the amount set out in the statute after it has been adjusted for inflation and workload, as set out in section II of this document, for excess collections in previous years as set out in section III of this document, and for the final year adjustment as set out in section IV of this document. The fee for a supplemental animal drug application for which safety or effectiveness data are required is to be set at 50 percent of the animal drug application fee (21 U.S.C. 379j–12(a)(1)(A)(ii)).

To set animal drug application fees and supplemental animal drug application fees to realize $2,846,000, FDA must first make some assumptions about the number of fee-paying applications and supplements it will receive in FY 2008.

The agency knows the number of applications that have been submitted in previous years. That number fluctuates significantly from year to year. In estimating the fee revenue to be generated by animal drug application fees in FY 2008, FDA is assuming that the number of applications that will pay fees in FY 2008 will equal the average number of submissions over the 4 most recent years (including an estimate for the current year). This may not fully account for possible year to year fluctuations in numbers of fee-paying applications, but FDA believes that this is a reasonable approach after nearly 4 years of experience with this program.

Over the past 4 years, the average number of animal drug applications that would have been subject to the full fee was 10.25, including the number for the most recent year, estimated at 15. Over this same period, the average number of supplemental applications that would have been subject to half of the full fee was 12.5, including the number for the most recent year, estimated at 13.

Thus, for FY 2008, FDA estimates receipt of 10.25 fee paying original applications and 12.5 fee-paying supplemental animal drug applications.

B. Fee Rates for FY 2008

FDA must set the fee rates for FY 2008 so that the estimated 10.25 applications that pay the full fee and the estimated 12.5 supplements that pay half of the full fee will generate a total of $2,846,000. To generate this amount, the fee for an animal drug application, rounded to the nearest hundred dollars, will have to be $172,500, and the fee for a supplemental animal drug application for which safety or effectiveness data are required will have to be $86,250.

VI. Product Fee Calculations for FY 2008

A. Product Fee Revenues and Numbers of Fee-Paying Products

The animal drug product fee (also referred to as the product fee) must be paid annually by the person named as the applicant in an animal drug application or supplemental animal drug application for an animal drug product submitted for listing under section 510 of the act (21 U.S.C. 360), and who had an animal drug application or supplemental animal drug application pending at FDA after September 1, 2003, (21 U.S.C. 379j–12(a)(2)). The term ''animal drug product'' is defined in 21 U.S.C. 379j–11(3). The product fees are to be set so that they will generate $2,846,000 in fee revenue for FY 2008. This is the amount set out in the statute after it has been adjusted for inflation and workload, as set out in section II of this document, for excess collections in previous years as set out in section III of this document, and for the final year adjustment as set out in section IV of this document.

To set animal drug product fees to realize $2,846,000, FDA must make some assumptions about the number of products for which these fees will be paid in FY 2008. FDA developed data on all animal drug products that have been submitted for listing under section 510 of the act, and matched this to the list of all persons who had an animal drug application or supplement pending after September 1, 2003. As of July 1, 2007, FDA found a total of 767 products submitted for listing by persons who had an animal drug application or supplemental animal drug application pending after September 1, 2003. Based on this, FDA believes that a total of 767 products will be subject to this fee in FY 2008.

In estimating the fee revenue to be generated by animal drug product fees in FY 2008, FDA is assuming that 10 percent of the products invoiced, or 77, will not pay fees in FY 2008 due to fee waivers and reductions. Based on experience with other user fee programs

and the first 4 years of ADUFA, FDA believes that this is a reasonable basis for estimating the number of fee-paying products in FY 2008.

Accordingly, the agency estimates that a total of 690 (767 minus 77) products will be subject to product fees in FY 2008.

B. Product Fee Rates for FY 2008

FDA must set the fee rates for FY 2008 so that the estimated 690 products that pay fees will generate a total of $2,846,000. To generate this amount will require the fee for an animal drug product, rounded to the nearest five dollars, to be $4,125.

VII. Establishment Fee Calculations for FY 2008

A. Establishment Fee Revenues and Numbers of Fee-Paying Establishments

The animal drug establishment fee (also referred to as the establishment fee) must be paid annually by the person who: (1) Owns or operates, directly or through an affiliate, an animal drug establishment; (2) is named as the applicant in an animal drug application or supplemental animal drug application for an animal drug product submitted for listing under section 510 of the act; (3) had an animal drug application or supplemental animal drug application pending at FDA after September 1, 2003; and (4) whose establishment engaged in the manufacture of the animal drug product during the FY (21 U.S.C. 379j–12(a)(3)). An establishment subject to animal drug establishment fees is assessed only one such fee per FY (21 U.S.C. 379j–12(a)(3)). The term ''animal drug establishment'' is defined in 21 U.S.C. 379j–11(4). The establishment fees are to be set so that they will generate $2,846,000 in fee revenue for FY 2008. This is the amount set out in the statute after it has been adjusted for inflation and workload, as set out in section II of this document, for excess collections in previous years as set out in section III of this document, and for the final year adjustment as set out in section IV of this document.

To set animal drug establishment fees to realize $2,846,000, FDA must make some assumptions about the number of establishments for which these fees will be paid in FY 2008. FDA developed data on all animal drug establishments and matched this to the list of all persons who had an animal drug application or supplement pending after September 1, 2003. As of July 1, 2007, FDA found a total of 60 establishments owned or operated by persons who had an animal drug application or supplemental animal drug application pending after September 1, 2003. Based on this, FDA believes that 60 establishments will be subject to this fee in FY 2008.

In estimating the fee revenue to be generated by animal drug establishment fees in FY 2008, FDA is assuming that 10 percent of the establishments invoiced, or six, will not pay fees in FY 2008 due to fee waivers and reductions. Based on experience with the first 4 years of ADUFA, FDA believes that this is a reasonable basis for estimating the number of fee-paying establishments in FY 2008.

Accordingly, the agency estimates that a total of 54 establishments (60 minus 6) will be subject to establishment fees in FY 2008.

B. Establishment Fee Rates for FY 2008

FDA must set the fee rates for FY 2008 so that the estimated 54 establishments that pay fees will generate a total of $2,846,000. To generate this amount will require the fee for an animal drug establishment, rounded to the nearest 50 dollars, to be $52,700.

VIII. Sponsor Fee Calculations for FY 2008

A. Sponsor Fee Revenues and Numbers of Fee-Paying Sponsors

The animal drug sponsor fee (also referred to as the sponsor fee) must be paid annually by each person who: (1) Is named as the applicant in an animal drug application, except for an approved application for which all subject products have been removed from listing under section 510 of the act or has submitted an investigational animal drug submission that has not been terminated or otherwise rendered inactive; and (2) had an animal drug application, supplemental animal drug application, or investigational animal drug submission pending at FDA after September 1, 2003, (21 U.S.C. 379j–11(6) and 379j–12(a)(4)). An animal drug sponsor is subject to only one such fee each FY (21 U.S.C. 379j–12(a)(4)). The sponsor fees are to be set so that they will generate $2,846,000 in fee revenue for FY 2008. This is the amount set out in the statute after it has been adjusted for inflation and workload, as set out in section II of this document, for excess collections in previous years as set out in section III of this document, and for the final year adjustment as set out in section IV of this document.

To set animal drug sponsor fees to realize $2,846,000, FDA must make some assumptions about the number of sponsors who will pay these fees in FY 2008. Based on the number of firms that would have met this definition in each of the past 4 years, FDA estimates that a total of 138 sponsors will meet this definition in FY 2008.

Careful review indicates that about one third or 33 percent of all of these sponsors will qualify for minor use/minor species exemption. Based on the agency's experience to date with sponsor fees, FDA's current best estimate is that an additional 20 percent will qualify for other waivers or reductions, for a total of 53 percent of the sponsors invoiced, or 73, who will not pay fees in FY 2008 due to fee waivers and reductions. FDA believes that this is a reasonable basis for estimating the number of fee-paying sponsors in FY 2008.

Accordingly, the agency estimates that a total of 65 sponsors (138 minus 73) will be subject to sponsor fees in FY 2008.

B. Sponsor Fee Rates for FY 2008

FDA must set the fee rates for FY 2008 so that the estimated 65 sponsors that pay fees will generate a total of $$2,846,000. To generate this amount will require the fee for an animal drug sponsor, rounded to the nearest 50 dollars, to be $43,900.

IX. Fee Schedule for FY 2008

The fee rates for FY 2008 are summarized in table 2 of this document.

TABLE 2.—FY 2008 FEE RATES

Animal Drug User Fee Category	Fee Rate for FY 2008
Animal Drug Application Fee	
Animal Drug Application	$172,500
Supplemental Animal Drug Application for which Safety or Effectiveness Data are Required	$86,250
Animal Drug Product Fee	$4,125

TABLE 2.—FY 2008 FEE RATES—Continued

Animal Drug User Fee Category	Fee Rate for FY 2008
Animal Drug Establishment Fee[1]	$52,700
Animal Drug Sponsor Fee[2]	$43,900

[1]An animal drug establishment is subject to only one such fee each FY.
[2]An animal drug sponsor is subject to only one such fee each FY.

X. Procedures for Paying the FY 2008 Fees

A. Application Fees and Payment Instructions

The appropriate application fee established in the new fee schedule must be paid for an animal drug application or supplement subject to fees under ADUFA that is submitted after September 30, 2007. Payment must be made in U.S. currency by check, bank draft, or U.S. postal money order payable to the order of the Food and Drug Administration. On your check, bank draft, or U.S. postal money order, please write your application's unique Payment Identification Number, beginning with the letters AD, from the upper right-hand corner of your completed Animal Drug User Fee Cover Sheet. Also write the FDA post office box number (PO Box 953877) on the enclosed check, bank draft, or money order. Your payment and a copy of the completed Animal Drug User Fee Cover Sheet can be mailed to: Food and Drug Administration, P.O. Box 953877, St. Louis, MO, 63195–3877.

If you prefer to send a check by a courier such as FEDEX or UPS, the courier may deliver the check and printed copy of the cover sheet to: US Bank, Attn: Government Lockbox 953877, 1005 Convention Plaza, St. Louis, MO 63101. (Note: This address is for courier delivery only. If you have any questions concerning courier delivery contact the US Bank at 314–418–4821. This phone number is only for questions about courier delivery.)

The tax identification number of the Food and Drug Administration is 530196965. (Note: In no case should the check for the fee be submitted to FDA with the application.)

It is helpful if the fee arrives at the bank at least a day or two before the application arrives at FDA's Center for Veterinary Medicine. FDA records the official application receipt date as the later of the following: The date the application was received by FDA's Center for Veterinary Medicine, or the date US Bank notifies FDA that your check in the full amount of the payment due has been received. US Bank is required to notify FDA within 1 working day, using the Payment Identification Number described previously.

B. Application Cover Sheet Procedures

Step One—Create a user account and password. Log onto the ADUFA Web site at *http://www.fda.gov/oc/adufa* and, under the ''Forms'' heading, click on the link ''User Fee Cover Sheet.'' For security reasons, each firm submitting an application will be assigned an organization identification number, and each user will also be required to set up a user account and password the first time you use this site. Online instructions will walk you through this process.

Step Two—Create an Animal Drug User Cover Sheet, transmit it to FDA, and print a copy. After logging into your account with your user name and password, complete the steps required to create an Animal Drug User Fee Cover Sheet. One cover sheet is needed for each animal drug application or supplement. Once you are satisfied that the data on the cover sheet is accurate and you have finalized the cover sheet, you will be able to transmit it electronically to FDA and you will be able to print a copy of your cover sheet showing your unique Payment Identification Number.

Step Three—Send the Payment for your application as described in section X.A of this document.

Step Four—Please submit your application and a copy of the completed Animal Drug User Fee Cover Sheet to the following address: Food and Drug Administration, Center for Veterinary Medicine, Document Control Unit (HFV–199), 7500 Standish Pl., Rockville, MD 20855.

C. Product, Establishment and Sponsor Fees

By December 30, 2007, FDA will issue invoices and payment instructions for product, establishment, and sponsor fees for FY 2008 using this Fee Schedule. Payment will be due and payable by January 31, 2008. FDA will issue invoices in October 2008 for any products, establishments, and sponsors subject to fees for FY 2008 that qualify for fees after the December 2007 billing.

Dated: July 27, 2007.

Randall W. Lutter,

Deputy Commissioner for Policy.

[FR Doc. 07–3782 Filed 7–30–07; 4:29 pm]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Agency Information Collection Activities: Submission For OMB Review; Comment Request

Periodically, the Health Resources and Services Administration (HRSA) publishes abstracts of information collection requests under review by the Office of Management and Budget (OMB), in compliance with the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35). To request a copy of the clearance requests submitted to OMB for review, call the HRSA Reports Clearance Office on (301) 443–1129.

The following request has been submitted to the Office of Management and Budget for review under the Paperwork Reduction Act of 1995:

Proposed Project: The Smallpox Vaccine Injury Compensation Program (OMB No. 0915–0282)—Extension

The Smallpox Emergency Personnel Protection Act (SEPPA) authorized the Secretary of Health and Human Services to establish The Smallpox Vaccine Injury Compensation Program, which provides benefits and/or compensation to certain persons harmed as a direct result of receiving smallpox covered countermeasures, including the smallpox vaccine, or as a direct result of contracting vaccinia through certain accidental exposures.

The benefits available under the Program include compensation for unreimbursed medical care expenses, lost employment income, and survivor death benefits. To be considered for Program benefits, requesters (i.e., smallpox vaccine recipients, vaccinia contacts, survivors, or the representatives of the estates of deceased smallpox vaccine recipients or vaccinia contacts), or persons filing on

their behalf as their representatives, must file a Request Form and the documentation required under SEPPA and its implementing regulations (42 CFR Part 102) to show that they are eligible.

Requesters must submit appropriate documentation to allow the Secretary to determine if the requesters are eligible for Program benefits. This documentation will vary somewhat depending on whether the requester is filing as a smallpox vaccine recipient, a vaccinia contact, a survivor, or a representative of an estate.

All requesters must submit medical records sufficient to demonstrate that a covered injury was sustained by a smallpox vaccine recipient or a vaccinia contact.

The Estimated Annual Burden is as follows:

Form	Number of respondents	Responses per respondent	Total responses	Hours per response	Total burden hours
Request Form	25	1	25	5	125
Certification	25	1	25	1	25
Total	25	.....	25	.....	150

Written comments and recommendations concerning the proposed information collection should be sent within 30 days of this notice to the desk officer for HRSA, either by e-mail to *OIRA_submission@omb.eop.gov* or by fax to 202–395–6974. Please direct all correspondence to the ''attention of the desk officer for HRSA.''

Dated: July 25, 2007.

Alexandra Huttinger,

Acting Director, Division of Policy Review and Coordination.

[FR Doc. E7–14928 Filed 8–1–07; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

National Advisory Committee on Rural Health and Human Services; Notice of Meeting

In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), notice is hereby given that the following committee will convene its fifty-seventh meeting.

Name: National Advisory Committee on Rural Health and Human Services.

Dates and Times: September 12, 2007, 8 a.m.–5:30 p.m.; September 13, 2007, 8 a.m.–5 p.m.; September 14, 2007, 8 a.m.–11 a.m.

Place: Best Western Inn on the Park, 22 South Carroll Street, Madison, WI 53703, Phone: 608–257–8811.

Status: The meeting will be open to the public.

Purpose: The National Advisory Committee on Rural Health and Human Services provides advice and recommendations to the Secretary with respect to the delivery, research, development and administration of health and human services in rural areas.

Agenda: Wednesday morning, at 8 a.m., the meeting will be called to order by the Chairperson of the Committee, the Honorable David Beasley. The first session will be a snapshot of Wisconsin, focusing on the challenges related to jobs, income, and educational level and a look at health and human services assets and liabilities. The next presentation will examine collaborative approaches to increase the supply of physicians for rural Wisconsin. Following this presentation will be discussions on State Medicaid waivers to improve access to healthcare and welfare reform. The next presentation will be a panel discussion by Toyota on health and human services integration in Tupelo, Mississippi, and the implications on the community of the new Toyota factory. The Committee will break into Subcommittee format for the remainder of the day's meeting. The Wednesday meeting will close at 5:30 p.m.

Thursday morning, September 13, at 8 a.m., the Committee will meet briefly to discuss the site visit. At 8:30 a.m., the Committee will depart for Sauk City, Wisconsin. The Committee will hear presentations on health and human services issues facing the community. Transportation to the site visit will not be provided. The Committee will return to the Best Western Inn on the Park to resume the meeting in Subcommittee format at 2 p.m. The Thursday meeting will close at 5 p.m.

The final session will be convened Friday morning, September 14, at 8 a.m. The Committee will have a discussion on the site visit. Following this discussion will be a report by the Subcommittees on the progress with the report chapters; discussion on the letter to the Secretary; and discussion on the upcoming February meeting. The meeting will be adjourned at 11 a.m.

FOR FURTHER INFORMATION CONTACT: Anyone requiring information regarding the Committee should contact Tom Morris, M.P.A., Executive Secretary, National Advisory Committee on Rural Health and Human Services, Health Resources and Services Administration, Parklawn Building, Room 9A–55, 5600 Fishers Lane, Rockville, MD 20857, telephone (301) 443–0835, Fax (301) 443–2803.

Persons interested in attending any portion of the meeting should contact Michele Pray-Gibson, Office of Rural Health Policy (ORHP), telephone (301) 443–0835. The Committee meeting agenda will be posted on ORHP's Web site *http://www.ruralhealth.hrsa.gov*.

Dated: July 24, 2007.

Alexandra Huttinger,

Acting Director, Division of Policy Review and Coordination.

[FR Doc. E7–14927 Filed 8–1–07; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental health Services Administration

Agency Information Collection Activities: Submission for OMB Review; Comment Request

Periodically, the Substance Abuse and Mental Health Services Administration (SAMHSA) will publish a summary of information collection requests under OMB review, in compliance with the Paperwork Reduction Act (44 U.S.C. Chapter 35). To request a copy of these documents, call the SAMHSA Reports Clearance Officer on (240) 276–1243.

Proposed Project: Confidentiality of Alcohol and Drug Abuse Patient Records—(OMB No. 0930–0092)—Revision

Statute (42 U.S.C. 290dd–2) and regulations (42 CFR Part 2) require federally conducted, regualted, or directly or indirectly assisted alcohol and drug abuse programs to keep alcohol and drug abuse patient records confidential. Information requirements are (1) written disclosure to patients about Federal laws and regulations that protect the confidentiality of each patient, and (2) documenting ''medical personnel'' status of recipients of a disclosure to meet a medical emergency. Annual burden estimates for these requirements are summarized in the table below:

ANNUALIZED BURDEN ESTIMATES

	Annual number of respondents [1]	Responses per respondent	Total responses	Hours per response	Total hour burden
Disclosure:					
42 CFR 2.22	10,629	174	[2] 1,849,548	.20	369,910
Recordkeeping:					
42 CFR 2.51	10,629	2	21,258	.167	3,550
Total	10,629		1,870,806		373,460

[1] The number of publicly funded alcohol and drug facilities from SAMHSA's 2005 National Survey of Substance Abuse Treatment Services (N–SSATS).
[2] The number of treatment admissions from SAMHSA's 2005 Treatment Episode Data Set (TEDS).

Written comments and recommendations concerning the proposed information collection should be sent by September 4, 2007 to: SAMHSA Desk Officer, Human Resources and Housing Branch, Office of Management and Budget, New Executive Office Building, Room 10235, Washington, DC 20503; due to potential delays in OMB's receipt and processing of mail sent through the U.S. Postal Service, respondents are encouraged to submit comments by fax to: 202–395–6974.

Dated: July 30, 2007.

Elaine Parry,

Acting Director, Office of Program Services.

[FR Doc. 07–3769 Filed 8–1–07; 8:45 am]

BILLING CODE 4162–20–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Agency Information Collection Activities: Submission for OMB Review; Comment Request

Periodically, the Substance Abuse and Mental Health Services Administration (SAMHSA) will publish a summary of information collection requests under OMB review, in compliance with the Paperwork Reduction Act (44 U.S.C. Chapter 35). To request a copy of these documents, call the SAMHSA Reports Clearance Officer on (240) 276–1243.

Proposed Project: Opioid Treatment Data Systems for Disaster Planning Project (Pilot)—NEW

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), has identified a critical need for Opioid Treatment Programs (OTPs, also commonly known as Methadone Clinics) to be able to access limited but specific patient dosage data for patients displaced due to service disruptions affecting the OTP from which they regularly receive treatment (the patient's 'Home OTP'). Service disruptions in home OTPs have ranged in cause from events such as the September 11th terrorist attacks or more recently, Hurricanes Katrina and Rita, to more common events such as snow storms or electrical black-outs.

The proposed system will ensure that, in such circumstances, patients displaced from their home OTPs will still be able to obtain safe and effective treatment at an alternative OTP (referred to in this project as a 'Guest OTP'). In reviewing past events involving OTP service disruptions and their impact on patients, SAMHSA, in tandem with numerous stakeholders, established four basic principles that would guide creation of a deliberately simple, centralized Web-based system to house patient data. Such a system would facilitate Guest OTPs in providing safe and effective continuity of treatment for patients temporarily unable to obtain treatment from their Home OTPs due to any form of service disruption. The proposed centralized data system is known as the Opioid Treatment Data Systems for Disaster. Subsequently, in a small sample study of five (5) OTPs, SAMHSA tested a protocol and data collection instrument for use in determining functional requirements for the proposed system. In the fall 2005, SAMHSA provided funding for the current project, to support creation of the necessary infrastructure for a pilot system, to be followed by testing on a regional basis. This pilot project will focus on creating the means by which vital dosage data for OTP patients can be made accessible to Guest OTPs called upon to treat patients of other programs in the event of service disruptions, most specifically, in disaster scenarios, so that patients are not forced during such circumstances to forgo or discontinue treatment. Ultimately, the pilot system will be reviewed to determine its effectiveness and ability to support a national implementation, should funding for such a system become available.

This notice is being provided for a survey to be distributed to OTPs in the region(s) selected by SAMHSA to gather information regarding their present data collection and reporting capabilities and practices. Technical information from the surveys will be used exclusively for development of the overall system and to help inform selection of sites best suited for participation as pilot sites for testing of the Opioid Treatment Data Systems for Disaster Planning. OTP respondents will have the option of completing an on-line or paper version of the survey. The survey consists of approximately 25 questions predominantly formatted as yes/no responses with one to two words fill in the blank responses. The estimated maximum annual response burden to collect this information is as follows:

Number of facilities (OTPs)	Responses per facility	Burden/response (hours)	Annual burden (hours)
200	1	1.0	200

Written comments and recommendations concerning the proposed information collection should be sent by September 4, 2007 to: SAMHSA Desk Officer, Human Resources and Housing Branch, Office of Management and Budget, New Executive Office Building, Room 10235, Washington, DC 20503; due to potential delays in OMB's receipt and processing of mail sent through the U.S. Postal Service, respondents are encouraged to submit comments by fax to: 202–395–6974.

Dated: July 30, 2007.

Elaine Parry,

Acting Director, Office of Program Services.

[FR Doc. E7–14985 Filed 8–1–07; 8:45 am]

BILLING CODE 4162–20–P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–5121–N–26]

Notice of Proposed Information Collection; Comment Request; Lender Qualifications for Multifamily Accelerated Processing (MAP)

AGENCY: Office of the Assistant Secretary for Housing-Federal Housing Commissioner, HUD.

ACTION: Notice.

SUMMARY: The proposed information collection requirement described below will be submitted to the Office of Management and Budget (OMB) for review, as required by the Paperwork Reduction Act. The Department is soliciting public comments on the subject proposal.

DATES: *Comments Due Date:* October 1, 2007.

ADDRESSES: Interested persons are invited to submit comments regarding this proposal. Comments should refer to the proposal by name and/or OMB Control Number and should be sent to: Lillian Deitzer, Reports Management Officer, Department of Housing and Urban Development, 451 7th Street, SW., L'Enfant Plaza Building, Room 8001, Washington, DC 20410 or *Wayne_Eddins@hud.gov*.

FOR FURTHER INFORMATION CONTACT: Joseph E. Malloy, Acting Director, Office of Multifamily Development, Department of Housing and Urban Development, 451 7th Street, SW., Washington, DC 20410, telephone (202) 708–1142 (this is not a toll free number) for copies of the proposed forms and other available information.

SUPPLEMENTARY INFORMATION: The Department is submitting the proposed information collection to OMB for review, as required by the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35, as amended).

This Notice is soliciting comments from members of the public and affected agencies concerning the proposed collection of information to: (1) Evaluate whether the proposed collection is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; (2) Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information; (3) Enhance the quality, utility, and clarity of the information to be collected; and (4) Minimize the burden of the collection of information on those who are to respond; including the use of appropriate automated collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.

This Notice also lists the following information:

Title of Proposal: Lender Qualifications for Multifamily Accelerated Processing (MAP).

OMB Control Number, if applicable: 2502–0541.

Description of the Need for the Information and Proposed Use: Multifamily Accelerated Processing (MAP) is a procedure that permits approved lenders to prepare, process, and submit loan applications for Federal Housing Administration (FHA) multifamily mortgage insurance. An FHA-approved multifamily Lender wishing to participate in MAP must submit a MAP application package so that HUD may determine whether or not it meets the additional qualifications required of a MAP Lender. A Quality Control Plan is a required exhibit in the Lender application package.

Agency Form Numbers, if Applicable: None.

Estimation of the Total numbers of Hours Needed To Prepare the Information Collection Including Number of Respondents, Frequency of Response, and Hours of Response: The annual number of respondents is 25 preparing 25 responses annually. The hours per response are 20 hours for the MAP Lender application, and the frequency of response is on occasion. The total estimated annual burden hours is 500.

Status of the Proposed Information Collection: Extension of a currently approved collection.

Authority: The Paperwork Reduction Act of 1995, 44 U.S.C., Chapter 35, as amended.

Dated: July 19, 2007.

Frank L. Davis,

General Deputy Assistant Secretary for Housing, Deputy Federal Housing Commissioner.

[FR Doc. E7–14940 Filed 8–1–07; 8:45 am]

BILLING CODE 4210–67–P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–5117–N–61]

Notice of Submission of Proposed Information Collection to OMB; Survey of Participating Jurisdictions in ADDI/HOME Programs

AGENCY: Office of the Chief Information Officer, HUD.

ACTION: Notice.

SUMMARY: The proposed information collection requirement described below has been submitted to the Office of Management and Budget (OMB) for review, as required by the Paperwork Reduction Act. The Department is soliciting public comments on the subject proposal.

The U.S. Senate Committee Report of the FY 2006 Transportation, Treasury and HUD Appropriations Act directed HUD to report on the default and delinquency rate of households who receive downpayment assistance through the American Dream Downpayment Initiative (ADDI) and HOME Investment Partnerships Program (HOME). A sample of Participating Jurisdiction (PJs) who met the eligibility requirements for the ADDI/HOME Program will provide the information for this study.

DATES: *Comments Due Date:* September 4, 2007.

ADDRESSES: Interested persons are invited to submit comments regarding this proposal. Comments should refer to the proposal by name and/or OMB approval Number (2528–Pending) and should be sent to: HUD Desk Officer,

Office of Management and Budget, New Executive Office Building, Washington, DC 20503; fax: 202–395–6974.

FOR FURTHER INFORMATION CONTACT: Lillian Deitzer, Departmental Reports Management Officer, QDAM, Department of Housing and Urban Development, 451 Seventh Street, SW., Washington, DC 20410; e-mail *Lillian_L._Deitzer@HUD.gov* or telephone (202) 708–2374. This is not a toll-free number. Copies of available documents submitted to OMB may be obtained from Ms. Deitzer or from HUD's Web site at *http://www5.hud.gov:63001/po/i/icbts/collectionsearch.cfm.*

SUPPLEMENTARY INFORMATION: This notice informs the public that the Department of Housing and Urban Development has submitted to OMB a request for approval of the information collection described below. This notice is soliciting comments from members of the public and affected agencies concerning the proposed collection of information to: (1) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; (2) Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information; (3) Enhance the quality, utility, and clarity of the information to be collected; and (4) Minimize the burden of the collection of information on those who are to respond; including through the use of appropriate automated collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.

This notice also lists the following information:

Title of Proposal: Survey of Participating Jurisdictions in ADDI/HOME programs.

OMB Approval Number: 2528–Pending.

Form Numbers: None

Description of the Need for the Information and Its Proposed Use: The U.S. Senate Committee Report of the FY 2006 Transportation, Treasury and HUD Appropriations Act directed HUD to report on the default and delinquency rate of households who receive downpayment assistance through the American Dream Downpayment Initiative (ADDI) and HOME Investment Partnerships Program (HOME). A sample of Participating Jurisdiction (PJs) who met the eligibility requirements for the ADD/HOME Program will provide the information for this study.

Frequency of Submission: Other—one time.

	Number of respondents	×	Annual responses	×	Hours per response	=	Burden hours
Reporting Burden	116		1		12		1,392

Total Estimated Burden Hours: 1,392.

Status: New collection.

Authority: Section 3507 of the Paperwork Reduction Act of 1995, 44 U.S.C. 35, as amended.

Dated: July 26, 2007.

Lillian L. Deitzer,

Departmental Paperwork Reduction Act Officer, Office of the Chief Information Officer.

[FR Doc. E7–14941 Filed 8–1–07; 8:45 am]

BILLING CODE 4210–67–P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–5130–N–09]

Privacy Act; Proposed New Systems of Records; Grants Interface Management System (GIMS/P017)

AGENCY: Office of the Chief Information Officer, HUD.

ACTION: Establish a new Privacy Act system of records.

SUMMARY: HUD proposes to establish a new record system to add to its inventory of systems of records subject to the Privacy Act of 1974 (5 U.S.C. 552a), as amended. The proposed new system of records is the Grants Interface Management System (GIMS/P017), HUD/ADM–08. HUD's Departmental Grants Management and Oversight Office will utilize the GIM system to manage the transmission of electronic grant applications received from the *http://www.Grants.gov* portal, which is the central storehouse for information on federal government grant programs. HUD will also utilize this new system as the repository for the electronic applications received.

DATES: *Effective Date:* This action shall be effective without further notice on September 4, 2007 unless comments are received during or before this period that would result in a contrary determination.

Comments Due Date: September 4, 2007.

ADDRESSES: Interested persons are invited to submit comments regarding this notice to the Rules Docket Clerk, Office of General Counsel, Department of Housing and Urban Development, 451 Seventh Street, SW., Room 10276, Washington, DC 20410–0500. Communications should refer to the above docket number and title. A copy of each communication submitted will be available for public inspection and copying between 8 a.m. and 5 p.m. weekdays at the above address.

FOR FURTHER INFORMATION CONTACT: The Departmental Privacy Act Officer, 451 Seventh Street, SW., Room 4178, Washington, DC 20410, telephone number (202) 708–2374 or the System Manager, Loyd Lamois, Supervisory Program Analyst, 451 Seventh Street, SW., Room 3156, Washington, DC 20410, telephone number (202) 708–0667. (These are not a toll-free numbers.) Telecommunication device for hearing and speech-impaired individuals (TTY) is available at (800) 877–8339 (Federal Information Relay Service).

SUPPLEMENTARY INFORMATION: Title 5 U.S.C. 552a(e)(4) and (11) provide that the public be afforded a 30-day period in which to comment on the new system of records, and require published notice of the existence and character of the system of records.

The new system report was submitted to the Office of Management and Budget (OMB), the Senate Committee on Homeland Security and Governmental Affairs, and the House Committee on Oversight and Government Reform pursuant to paragraph 4c of Appendix 1 to OMB Circular No. A–130, ''Federal Responsibilities for Maintaining Records About Individuals,'' July 25, 1994 (59 FR 37914).

Authority: 5 U.S.C. 552a.

Dated: July 27, 2007.

Lisa Schlosser,

Chief Information Officer.

HUD/ADM–08

SYSTEM NAME:

Grants Interface Management System (GIMS).

SYSTEM LOCATION:

HUD Headquarters, Charleston, West Virginia.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

Electronic applicants to HUD competitive (discretionary) grant programs.

CATEGORIES OF RECORDS IN THE SYSTEM:

Electronic grant applications which typically include statements of qualifications, which may include resumes, program budgets and work plans, evaluation plans, and supporting documents such as proof of local support. Resumes may include name, home address, home telephone number, personal email address.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

Records are authorized by regulations governing administration of grants and cooperative agreements (24 CFR, Part 84 or 85), and the HUD Reform Act of 1989 Public Law 101–235 (24 CFR Part 4) and scheduled per the NARA requirements for records disposition at 36 CFR Part 1228.

PURPOSES:

The purpose of this system is to receive grant applications from the Grants.gov portal. Records are maintained in compliance with the requirements of the HUD Reform Act of 1989, Public Law 101–235 (24 CFR Part 4) and scheduled per the NARA requirements for records disposition at 36 CFR Part 1228.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSES OF SUCH USES:

In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act, other routine uses are as follows: Routine uses include review of applications. Persons with access at various points in the process include reviewers and program managers.

POLICIES AND PRACTICES FOR STORING, RETRIEVING, ACCESSING, RETAINING, AND DISPOSING OF RECORDS IN THE SYSTEM:

Under this section the following subsections must be listed:

STORAGE:

Paper applications are maintained in locked file cabinets and access is granted to personnel who service the records. Electronic data is maintained in the GIMS database.

RETRIEVABILITY:

Applications are indexed by application tracking number, award tracking number, applicant organization name.

SAFEGUARDS:

Paper Records are typically stored in locked cabinets and limited to those personnel who service the records. System access is granted by program administrators and by user ID and password.

RETENTION AND DISPOSAL:

Records are retained per the requirements of the HUD Reform Act of 1989 Pub. Law 101–235 (24 CFR Part 4), and scheduled under the NARA requirements for records disposition at 36 CFR Part 1228.

SYSTEM MANAGER(S) AND ADDRESS:

Loyd Lamois, Supervisory Program Analyst, Office of Departmental Grants Managements and Oversight, Department of Housing and Urban Development, 451 Seventh Street SW., Room 3156, Washington, DC 20410.

NOTIFICATION PROCEDURES:

''For information, assistance, or inquiry about the existence of records, contact the Privacy Act Officer at the Department of Housing and Urban Development, 451 Seventh Street SW., Room 4178, Washington, DC 20410. Written requests must include the full name, document with photo (driver's license, etc.), date of birth, current address, and telephone number of the individual making the request.

CONTESTING RECORD PROCEDURES:

Procedures for the amendment or correction of records, and procedures for applicants who want to appeal initial agency determinations appear in 24 CFR part 16.

If additional information is needed, contact:

(i) In relation to contesting contents of records, the Privacy Act Officer at HUD, 451 Seventh Street, SW., Room 4178, Washington, DC 20410; and,

(ii) In relation to appeals of initial denials, HUD, Departmental Privacy Appeals Officer, Office of General Counsel, 451 Seventh Street, SW., Washington, DC 20410.

RECORD SOURCE CATEGORIES:

Information is submitted by Authorized Organizational Representatives registered at Grants.gov and authorized by applicant organizations.

EXEMPTIONS FROM CERTAIN PROVISIONS OF THE ACT:

''None.''

[FR Doc. E7–14942 Filed 8–1–07; 8:45 am]

BILLING CODE 4210–67–P

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

Endangered and Threatened Species Permit Applications

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Notice of availability of permit applications; request for comments.

SUMMARY: The following applicant has applied for a permit to conduct certain activities with endangered species.

DATES: We must receive any written comments on or before September 4, 2007.

ADDRESSES: Regional Director, Attn: Peter Fasbender, U.S. Fish and Wildlife Service, Ecological Services, 1 Federal Drive, Fort Snelling, MN 55111–4056; electronic mail, *permitsR3ES@fws.gov.*

FOR FURTHER INFORMATION CONTACT: Mr. Peter Fasbender, (612) 713–5343.

SUPPLEMENTARY INFORMATION:

Endangered Species

The Endangered Species Act of 1973, as amended (16 U.S.C. 1531 *et seq.*) (Act), with some exceptions, prohibits activities affecting endangered species unless authorized by a permit from the Service. Before issuing a permit, we invite public comment on it. Accordingly, we invite public comment on the following applicant's permit application for certain activities with endangered species authorized by section 10(a)(1)(A) of the Act and the regulations governing the taking of endangered species (50 CFR 17). Submit your written data, comments, or requests for copies of the complete applications to the address shown in **ADDRESSES**.

Permit Number TE023664–15

Applicant: Environmental Solutions and Innovations, Inc., Cincinnati, OH.

The applicant requests a permit amendment to take listed mussels throughout Indiana, Illinois, Kentucky, Michigan, New York, Ohio, Pennsylvania, and West Virginia. The scientific research is aimed at enhancement of survival of the species in the wild.

Permit Number TE126861–0

Applicant: Bat Conservation and Management, Inc., Carlisle, PA.

The applicant requests a permit amendment to take the Indiana bat (*Myotis sodalis*) throughout Michigan and Missouri. The scientific research is aimed at enhancement of survival of the species in the wild.

Permit Number TE128263–1

Applicant: Ecological Specialties, LLC., Symsonia, KY.

The applicant requests a permit amendment to take Indiana bat throughout Iowa, Okalahoma, Georgia, North Carolina, South Carolina, Wisconsin, Vermont, Florida, Michigan, Mississippi, Maryland, New Jersey, Connecticut, and Massachusetts. The scientific research is aimed at enhancement of survival of the species in the wild.

Permit Number TE160180

Applicant: Amy Halsall, Woodridge, IL.

The applicant requests a permit to take the Indiana bat (*Myotis sodalis*) throughout Illinois and Indiana. The scientific research is aimed at enhancement of survival of the species in the wild.

Permit Number TE160235

Applicant: The Ohio Department of Transportation, Columbus, OH.

The applicant requests a permit to take the Indiana bat (*Myotis sodalis*) throughout Ohio. The scientific research is aimed at enhancement of survival of the species in the wild.

Public Comments

We solicit public review and comment on this permit application. Please refer to the respective permit number when you submit comments. Comments and materials we receive are available for public inspection, by appointment, during normal business hours at the address shown in the **ADDRESSES** section. Before including your address, phone number, e-mail address, or other personal identifying information in your comment, you should be aware that your entire comment—including your personal identifying information—may be made publicly available at any time. While you can ask us in your comment to withhold your personal identifying information from public review, we cannot guarantee that we will be able to do so.

National Environmental Policy Act (NEPA)

In compliance with NEPA (42 U.S.C. 4321 *et seq.*), we have made an initial determination that the activities proposed by this permit are categorically excluded from the requirement to prepare an environmental assessment or environmental impact statement.

Dated: July 12, 2007.

TJ Miller,

Chief, Endangered Species, Ecological Services, Region 3, Fort Snelling, Minnesota.

[FR Doc. E7–15015 Filed 8–1–07; 8:45 am]

BILLING CODE 4310–55–P

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

Endangered and Threatened Wildlife and Plants; 5-Year Review of Nine Southeastern Species

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Notice.

SUMMARY: The Fish and Wildlife Service is initiating 5-year reviews of the Louisiana black bear (*Ursus americanus luteolus*), Alabama red-bellied turtle (*Pseudemys alabamensis*), goldline darter (*Percina aurolineata*), blue shiner (*Cyprinella caerulea*), fat pocketbook (*Potamilus capax*), slender campeloma (*Campeloma decampi*), armored snail (*Pyrgulopsis* (=Marstonia) *pachyta*), cave crayfish (*Cambarus zophonastes*), and lyrate bladderpod (*Lesquerella lyrata*), under section 4(c)(2) of the Endangered Species Act (Act) of 1973 (16 U.S.C. 1531 *et seq.*), as amended. The purpose of reviews conducted under this section of the Act is to ensure that the classification of species as threatened or endangered on the List of Endangered and Threatened Wildlife and Plants (50 CFR 17.11 and 17.12) is accurate. A 5-year review is an assessment of the best scientific and commercial data available at the time of the review.

DATES: To allow us adequate time to conduct this review, information submitted for our consideration must be received on or before October 1, 2007. However, we will continue to accept new information about any listed species at any time.

ADDRESSES: Information submitted on the Louisiana black bear should be sent to Field Supervisor, Lafayette Field Office, Fish and Wildlife Service, 646 Cajundome Blvd., Suite 400, Lafayette, Louisiana 70506, fax 337/291–3139. Information on the Alabama red-bellied turtle, goldline darter, blue shiner, fat pocketbook, and lyrate bladderpod should be sent to Field Supervisor, Jackson Field Office, Fish and Wildlife Service, 6578 Dogwood View Parkway, Jackson, Mississippi 39216, fax 601–965–4340. Information on the slender campeloma and armored snail should be sent to Field Supervisor, Daphne Field Office, Fish and Wildlife Service, 1208–B Main St., Daphne, Alabama 36526, fax 251/441–6222. Information submitted on the cave crayfish should be sent to Field Supervisor, Conway Field Office, Fish and Wildlife Service, 110 S. Amity Rd., Suite 300, Conway, Arkansas, fax 501/513–4480. Information received in response to this notice of review will be available for public inspection by appointment, during normal business hours, at the same addresses.

FOR FURTHER INFORMATION CONTACT: Debbie Fuller at the Lafayette, Louisiana office, address above, (telephone, 337/291–3124, e-mail *deborah_fuller@fws.gov*); Cary Norquist at the Jackson, Mississippi office, address above, (telephone, 601/321–1128, e-mail *cary_norquist@fws.gov*); Jeff Powell at the Daphne, Alabama office, address above, (telephone, 251/441–5181, *e-mail jeff_powell@fws.gov*); and David Kampwerth at the Conway, Arkansas office, address above, (telephone, 501/513–4477, e-mail *david_kampwerth@fws.gov*).

SUPPLEMENTARY INFORMATION: Under the Act, the Service maintains a list of endangered and threatened wildlife and plant species at 50 CFR 17.11 (for wildlife) and 17.12 (for plants) (collectively referred to as the List). Section 4(c)(2)(A) of the Act requires that we conduct a review of listed species at least once every 5 years. Then, on the basis of such reviews, under section 4(c)(2)(B), we determine whether or not any species should be removed from the List (delisted), or reclassified from endangered to threatened or from threatened to endangered. Delisting a species must be supported by the best scientific and commercial data available and only considered if such data substantiate that the species is neither endangered nor threatened for one or more of the following reasons: (1) The species is considered extinct; (2) the species is considered to be recovered; and/or (3) the original data available when the species was listed, or the interpretation of such data, were in error. Any change in Federal classification would require a separate rulemaking process. Amendments to the List through final rules are published in the **Federal Register**.

The regulations at 50 CFR 424.21 require that we publish a notice in the **Federal Register** announcing those species currently under active review. This notice announces our active review of the following species that are currently listed as endangered: Alabama red-bellied turtle, slender campeloma, armored snail, cave crayfish, and lyrate bladderpod. This notice also announces

our active review of the following species that are currently listed as threatened: Louisiana black bear, goldline darter, and blue shiner.

The List is also available on our internet site at *http://endangered.fws.gov/wildlife.html#Species.*

What Information Is Considered in the Review?

A 5-year review will consider the best scientific and commercial data that have become available since the current listing determination or most recent status review of each species, such as:

A. Species biology, including but not limited to population trends, distribution, abundance, demographics, and genetics;

B. Habitat conditions, including but not limited to amount, distribution, and suitability;

C. Conservation measures that have been implemented to benefit the species;

D. Threat status and trends (see five factors under heading ''How do we determine whether a species is endangered or threatened?''); and

E. Other new information, data, or corrections, including but not limited to taxonomic or nomenclatural changes, identification of erroneous information contained in the List, and improved analytical methods.

Definitions Related to This Notice?

The following definitions are provided to assist those persons who contemplate submitting information regarding the species being reviewed:

A. *Species* includes any species or subspecies of fish, wildlife, or plant, and any distinct population segment of any species of vertebrate which interbreeds when mature.

B. *Endangered* means any species that is in danger of extinction throughout all or a significant portion of its range.

C. *Threatened* means any species that is likely to become an endangered species within the foreseeable future throughout all or a significant portion of its range.

How Do We Determine Whether a Species Is Endangered or Threatened?

Section 4(a)(1) of the Act establishes that we determine whether a species is endangered or threatened based on one or more of the following five factors:

A. The present or threatened destruction, modification, or curtailment of its habitat or range;

B. Overutilization for commercial, recreational, scientific, or educational purposes;

C. Disease or predation;

D. The inadequacy of existing regulatory mechanisms; or

E. Other natural or manmade factors affecting its continued existence.

What Could Happen as a Result of This Review?

If we find that there is new information concerning any of these nine species indicating that a change in classification may be warranted, we may propose a new rule that could do one of the following: (a) Reclassify the species from endangered to threatened (downlist); (b) reclassify the species from threatened to endangered (uplist); or (c) delist the species. If we determine that a change in classification is not warranted, then the species will remain on the List under its current status.

Public Solicitation of New Information

We request any new information concerning the status of any of these nine species. See ''What information is considered in the review?'' heading for specific criteria. Information submitted should be supported by documentation such as maps, bibliographic references, methods used to gather and analyze the data, and/or copies of any pertinent publications, reports, or letters by knowledgeable sources. Our practice is to make comments, including names and home addresses of respondents, available for public review during regular business hours. Individual respondents may request that we withhold their names and home addresses, etc., but if you wish us to withhold this information, you must state this prominently at the beginning of your comments. In addition, you must present rationale for withholding this information. This rationale must demonstrate that disclosure would constitute a clearly unwarranted invasion of privacy. Unsupported assertions will not meet this burden. In absence of exceptional, undocumented circumstances, this information will be released. We will make all submissions from organizations or businesses, and from individuals identifying themselves as representatives or officials of organizations or businesses, available for public inspection in their entirety.

Authority

This document is published under the authority of the Endangered Species Act (16 U.S.C. 1531 *et seq.*).

Dated: June 23, 2007.

Cynthia K. Dohner,

Acting Regional Director, Southeast Region

[FR Doc. E7–15023 Filed 8–1–07; 8:45 am]

BILLING CODE 4310–55–P

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

Notice of Availability of the Recovery Plan for the Endangered Vermilion Darter

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Notice of document availability.

SUMMARY: We, the Fish and Wildlife Service, announce the availability of the final recovery plan for the endangered vermilion darter (*Etheostoma chermocki*). The vermilion darter is a medium-sized darter found only in the Turkey Creek drainage, Jefferson County, Alabama. The recovery plan includes specific recovery objectives and criteria to be met to delist the vermilion darter under the Endangered Species Act of 1973, 16 U.S.C. 1531 *et seq.*, as amended (Act).

ADDRESSES: You may obtain a copy of the recovery plan by visiting our recovery plan website on the Internet at *http://endangered.fws.gov/recovery/index.html#plans* or by contacting the Jackson Field Office, Fish and Wildlife Service, 6578 Dogwood View Parkway, Suite A, Jackson, Mississippi 39213 (Telephone 601/321–1127).

FOR FURTHER INFORMATION CONTACT: Daniel Drennen at the above address and telephone number.

SUPPLEMENTARY INFORMATION:

Background

The vermilion darter (*Etheostoma chermocki* (Teleostei: Percidae)) was officially described in 1992 from Turkey Creek, a tributary of the Locust Fork, which is within the Black Warrior River drainage of Jefferson County, Alabama. The vermilion darter belongs to the subgenus *Ulocentra* (snubnose darters) which includes fish that are slightly laterally compressed, have complete lateral lines, broadly connected gill membranes, a short head, and a small pronounced mouth. The vermilion darter is a medium-sized darter, reaching about 7.1 centimeters (2.8 inches) total length (length from tip of snout to longest portion of tail fin). The vermilion darter was listed as endangered under the Act on November 28, 2001 (66 FR 59367).

The current range of the vermilion darter is 14.1 kilometers (km) (8.7 miles (mi)) of the main stem of Turkey Creek, the lowermost reaches (0.8 km (0.5 mi)) of Dry and Beaver creeks and within a spring run of an unnamed spring that drains into Beaver Creek along Alabama Highway 79. Restricted and localized in range, the vermilion darter is vulnerable

to sedimentation (excess sediments suspended or deposited in a stream), nutrificiation (excessive nutrients present, such as nitrogen and phosphorus), and barriers or restrictions to stream flow.

Restoring an endangered or threatened animal or plant to the point where it is again a secure, self-sustaining member of its ecosystem is a primary goal of the Act and of our endangered species program. To help guide the recovery effort, we prepare recovery plans for most listed species. Recovery plans describe actions considered necessary for conservation of the species, establish criteria for downlisting or delisting them, and estimate time and cost for implementing recovery measures.

The Act requires the development of recovery plans for listed species unless such a plan would not promote the conservation of a particular species. Section 4(f) of the Act requires us to provide public notice and an opportunity for public review and comment during recovery plan development. A notice of availability of the technical agency draft for the vermilion darter was published in the **Federal Register** on July 21, 2005 (70 FR 42087). A 60-day comment period was opened with the notice, closing on September 19, 2005. We received comments from four parties, including comments from one peer reviewer of the recovery plan. Comments and information submitted were considered in the preparation of this final plan and, where appropriate, incorporated.

The objective of this recovery plan is to provide a framework for the recovery of the vermilion darter until that protection under the Act is no longer necessary. As recovery criteria are met, the status of the species will be reviewed, and it will be considered for removal from the Federal List of Endangered and Threatened Wildlife and Plants (50 CFR part 17). Actions needed to recover the vermilion darter include: (1) Protect vermilion darter populations and habitat; (2) ensure and support implementation of effective protective actions; (3) determine habitat requirements and population information of the vermilion darter; (4) determine the necessary husbandry techniques of the species, to produce them in captivity and establish an additional population in the known range; (5) identify, acquire, and restore properties in the Turkey Creek watershed; and (6) promote partnerships and voluntary stewardship within the watershed.

Authority

The authority for this action is section 4(f) of the Endangered Species Act, 16 U.S.C. 1533(f).

Dated: June 19, 2007.

Cynthia K. Dohner,

Acting Regional Director.

[FR Doc. E7–15024 Filed 8–1–07; 8:45 am]

BILLING CODE 4310–55–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[F–19155–3; AK–964–1410–KC–P]

Alaska Native Claims Selection

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of decision approving lands for conveyance.

SUMMARY: As required by 43 CFR 2650.7(d), notice is hereby given that an appealable decision approving the surface and subsurface estates in certain lands for conveyance pursuant to the Alaska Native Claims Settlement Act will be issued to Doyon, Limited. The lands are in the vicinity of Stevens Village, Alaska, and are located in:

Fairbanks Meridian, Alaska

T. 15 N., R. 5 W.,
Secs. 5 to 8, inclusive.
Containing 2,486.40 acres.
T. 15 N., R. 7 W.,
Secs. 13 to 36, inclusive.
Containing 13,748.13 acres.
Aggregating 16,234.53 acres.

Notice of the decision will also be published four times in the Anchorage Daily News.

DATES: The time limits for filing an appeal are:

1. Any party claiming a property interest which is adversely affected by the decision shall have until September 4, 2007 to file an appeal.

2. Parties receiving service of the decision by certified mail shall have 30 days from the date of receipt to file an appeal.

Parties who do not file an appeal in accordance with the requirements of 43 CFR part 4, Subpart E, shall be deemed to have waived their rights.

ADDRESSES: A copy of the decision may be obtained from: Bureau of Land Management, Alaska State Office, 222 West Seventh Avenue, #13, Anchorage, Alaska 99513–7504.

FOR FURTHER INFORMATION, CONTACT: The Bureau of Land Management by phone at 907–271–5960, or by e-mail at *ak.blm.conveyance@ak.blm.gov*. Persons who use a telecommunication device (TTD) may call the Federal Information Relay Service (FIRS) at 1–800–877–8330, 24 hours a day, seven days a week, to contact the Bureau of Land Management.

Michael Bilancione,

Land Law Examiner, Branch of Adjudication II.

[FR Doc. E7–15019 Filed 8–1–07; 8:45 am]

BILLING CODE 4310–$$–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[CA–310–0777–XG

Notice of Public Meeting: Northwest California Resource Advisory Council

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of public meeting.

SUMMARY: In accordance with the Federal Land Policy and Management Act of 1976 (FLPMA), and the Federal Advisory Committee Act of 1972 (FACA), the U.S. Department of the Interior, Bureau of Land Management (BLM) Northwest California Resource Advisory Council will meet as indicated below.

DATES: The meeting will be held Thursday and Friday, Sept. 20–21, 2007, in Redding, California. On Sept. 20, the council members convene at 10 a.m. at the BLM Redding Field Office, 355 Hemsted Dr., and depart immediately for a field tour of BLM-managed public lands near Redding. Members of the public are welcome on the tour, but they must provide their own transportation and lunch. On Sept. 21, the council convenes at 8 a.m. in the Conference Room of the Redding Field Office. Time for public comment has been set aside for 11 a.m.

FOR FURTHER INFORMATION CONTACT: Rich Burns, BLM Ukiah Field Office manager, (707) 468–4000; or BLM Public Affairs Officer Joseph J. Fontana, (530) 252–5332.

SUPPLEMENTARY INFORMATION: The 12-member council advises the Secretary of the Interior, through the BLM, on a variety of planning and management issues associated with public land management in Northwest California. At this meeting, agenda topics include an update on management proposals for the Sacramento River Bend, field office reports on minerals management, a report on the BLM Managing for Excellence initiative, and status reports on management plan development for Cow Mountain and Lacks Creek.

Members will also hear status reports on activities in the Arcata, Redding and Ukiah field offices and the California Coastal National Monument. All meetings are open to the public. Members of the public may present written comments to the council. Each formal council meeting will have time allocated for public comments. Depending on the number of persons wishing to speak, and the time available, the time for individual comments may be limited. Members of the public are welcome on field tours, but they must provide their own transportation and lunch. Individuals who plan to attend and need special assistance, such as sign language interpretation and other reasonable accommodations, should contact the BLM as provided above.

Dated: July 26, 2007.

Joseph J. Fontana,

Public Affairs Officer.

[FR Doc. 07–3766 Filed 8–1–07; 8:45 am]

BILLING CODE 4310–40–M

DEPARTMENT OF THE INTERIOR

Bureau of Reclamation

San Joaquin River Restoration Program

AGENCY: Bureau of Reclamation, Interior.

ACTION: Notice of Intent to prepare a Program Environmental Impact Statement/Environmental Impact Report (PEIS/EIR) and Notice of Scoping Meetings.

SUMMARY: Pursuant to the National Environmental Policy Act (NEPA) and the California Environmental Quality Act (CEQA), the Bureau of Reclamation (Reclamation) and the California Department of Water Resources (DWR) propose to prepare a PEIS/EIR for the San Joaquin River Restoration Program (Program). The proposed Program is expected to be implemented by Reclamation, Fish and Wildlife Service (USFWS), the National Marine Fisheries Service (NMFS), the California Department of Fish and Game (DFG), and the DWR.

DATES: Four scoping meetings will be held to solicit public input on alternatives, concerns, and issues to be addressed in the PEIS/EIR. The meeting dates are:

- Tuesday, August 28, 2007, 6 p.m. to 8:30 p.m., Tulare, CA
- Wednesday, August 29, 2007, 6 p.m. to 8:30 p.m., Fresno, CA
- Thursday, August 30, 2007, 6 p.m. to 8:30 p.m., Los Banos, CA
- Monday, September 10, 2007, 1:30 p.m. to 4 p.m., Sacramento, CA

Written comments on the scope of the PEIS/EIR should be sent by September 21, 2007 to Ms. Margaret Gidding, Bureau of Reclamation, 2800 Cottage Way MP–140, Sacramento, CA 95825 or via e-mail at *mgidding@mp.usbr.gov*.

ADDRESSES: The scoping meeting locations are:

- International Agri-Center, Banquet Hall, 4450 S. Laspina St., Tulare, CA 93274
- Piccadilly Inn, University, Ballroom, 4961 North Cedar Ave., Fresno, CA 93726
- Merced County Fairgrounds, Germino Room, 403 F St., Los Banos, CA 93635
- Library Galleria, 828 I St., Sacramento, CA 95814

FOR FURTHER INFORMATION CONTACT: Ms. Margaret Gidding at the above address, by telephone at 916–978–5104, TDD 916–978–5608 or via fax at 916–978–5114. Additional information is available online at *http://www.restoresjr.com*. If special assistance is required at one of the scoping meetings, please contact Ms. Margaret Gidding via the phone number or e-mail listed above no less than five working days prior to the meetings.

SUPPLEMENTARY INFORMATION: Development of the PEIS/EIR for the Program is being carried out under Congressional authorization granted to the Secretary of the Interior under section 3406(c)(1) of the Central Valley Project Improvement Act (CVPIA) and will serve as the initial planning and environmental review activities necessary to implement the Settlement described below.

In 1992, Congress passed the CVPIA (Pub. L. 102–575, Title XXXIV) in order to protect, restore, and enhance fish, wildlife, and associated habitats in California's Central Valley. Specifically, CVPIA Section 3406(c)(1) requires the Secretary of the Interior to ''[d]evelop a comprehensive plan, which is reasonable, prudent, and feasible, to address fish, wildlife, and habitat concerns on the San Joaquin River, including but not limited to the streamflow, channel, riparian habitat, and water quality improvements that would be needed to reestablish where necessary and to sustain naturally reproducing anadromous fisheries from Friant Dam to its confluence with the San Francisco Bay/Sacramento-San Joaquin Delta Estuary.''

In 1988, a coalition of environmental groups, led by the Natural Resources Defense Council (NRDC), filed a lawsuit challenging the renewal of the long-term water service contracts between the United States and the Central Valley Project, Friant Division contractors. After more than 18 years of litigation of this lawsuit, known as the *Natural Resources Defense Council et al.*, v. *Rodgers, et al.*, a Settlement was reached. On September 13, 2006, the Settling Parties reached agreement on the terms and conditions of the Settlement which was subsequently approved by the Court on October 23, 2006. The ''Settling Parties'' include the NRDC, Friant Water Users Authority, and the Departments of the Interior and Commerce.

The Settlement is based on two parallel goals:

- To restore and maintain fish populations in ''good condition'' in the main stem of the San Joaquin River below Friant Dam to the confluence of the Merced River, including naturally reproducing and self-sustaining populations of salmon and other fish (Restoration Goal); and
- To reduce or avoid adverse water supply impacts to all of the Friant Division long-term contractors that may result from the Interim Flows and Restoration Flows provided for in the Settlement (Water Management Goal).

The Settlement states that the Secretary of the Interior will implement the terms and conditions of the Settlement. Additionally, the Settling Parties agreed that implementation of the Settlement will also require participation of the State of California (State). Therefore, concurrent with the execution of the Settlement, the Settling Parties entered into a Memorandum of Understanding (MOU) with the State (by and through the California Resources Agency, DWR, DFG, and the California Environmental Protection Agency) regarding the State's role in the implementation of the Settlement. The ''implementing agencies'', which include Reclamation, USFWS, NMFS, DWR, and DFG, are responsible for the management of the Program to implement the Settlement.

Public Disclosure

Before including your name, address, phone number, e-mail address, or other personal identifying information in your comment, you should be aware that your entire comment—including your personal identifying information—may be made publicly available at any time. While you can ask us in your comment to withhold your personal identifying information from public review, we cannot guarantee that we will be able to do so.

Dated: July 27, 2007.

John F. Davis,

Deputy Regional Director, Mid-Pacific Region.

[FR Doc. E7–15029 Filed 8–1–07; 8:45 am]

BILLING CODE 4310–MN–P

DEPARTMENT OF JUSTICE

Federal Bureau of Investigation

[OMB Number 1110–0042]

Agency Information Collection Activities; Proposed New Collection; Comments Requested

ACTION: 60-Day Notice of Information Collection Under Review: CJIS Customer Satisfaction Surveys

The Department of Justice (DOJ), Federal Bureau of Investigation (FBI), Criminal Justice Information Services (CJIS) Division will be submitting the following information collection request to the Office of Management and Budget (OMB) for review and clearance in accordance with review procedures of the Paperwork Reduction Act of 1995. Comments are encouraged and will be accepted for ''sixty days'' until [––]. This process is conducted in accordance with 5 CFR 1320.10.

If you have comments, especially on the estimated public burden or associated response time, suggestions, or need a copy of the proposed information collection instrument with instructions or additional information, please contact Ashley K. Grove, IT Specialist, Federal Bureau of Investigation, CJIS Division, Module D3, 1000 Custer Hollow Road, Clarksburg, West Virginia 26306–0151, or facsimile at (304) 625–3457.

Written comments and suggestions from the public and affected agencies concerning the proposed collection of information are encouraged. Your comments should address one or more of the following four points:

—Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency/component, including whether the information will have practical utility;

—Evaluate the accuracy of the agencies/components estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

—Enhance the quality, utility, and clarity of the information to be collected; and

—Minimize the burden of the collection of information on those who are to respond, including the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.

Overview of this Information Collection:

(1) *Type of Information Collection:* Revision of a previously approved collection.

(2) *Title of the Form/Collection:* CJIS Customer Satisfaction Surveys.

(3) *Agency Form Number, if any, and the applicable component of the department sponsoring the collection*:

Form Number: 1–760, 1–761, 1–762, 1–763, 1–764, 1–765, 1–766, 1–770.

Criminal Justice Information Services Division, Federal Bureau of Investigation, Department of Justice.

(4) *Affected Public who will be asked or required to respond, as well as a brief abstract*:

Primary: State, local or tribal governments. Other: Federal Government and business or other for-profit.

Brief Abstract: The FBI established the CJIS Division to serve as the focal point and central repository for criminal justice information services within the FBI. The CJIS Division is responsible for the following programs administered by the FBI for the benefit of local, state, federal, and foreign criminal justice agencies: Integrated Automated Fingerprint Identification System; Law Enforcement Online; National Crime Information Center; National Instant Criminal Background Check System—Federal Firearm Licensees; National Instant Criminal Background Check System—Point of Contact and Partial Point of Contact States; Uniform Crime Reporting; Interstate Identification Index; and the CJIS Division Intelligence Group.

CJIS will be conducting a customer service survey for each of the eight aforementioned programs. These surveys will be used to establish approval rating baselines of CJIS Division services in addition to identifying areas where our services can be improved or new services established to assist the criminal justice community with the performance of their official duties.

(5) *An estimate of the total number of respondents and the amount of time estimated for an average respondent to respond*:

Integrated Automated Fingerprint Identification System – Respondents = 400, Average Completion Time = 4 minutes; Law Enforcement Online – Respondents = 400, Average Completion Time = 2 minutes; National Crime Information Center – Respondents = 400, Average Completion Time = 3 minutes; National Instant Criminal Background Check System – Federal Firearm Licensees – Respondents = 400, Average Completion Time = 2 minutes; National Instant Criminal Background Check System – Point of Contact and Partial Point of Contact – Respondents = 21, Average Completion Time = 11 minutes; Uniform Crime Reporting – Respondents = 400, Average Completion Time = 3 minutes; Interstate Identification Index – Respondents = 400, Average Completion Time = 3 minutes; and the CJIS Division Intelligence Group – Respondents = 400, Average Completion Time = 3 minutes.

(6) *An estimate of the total public burden (in hours) associated with the collection*:

There are an estimated 137 total public burden hours associated with this collection. If additional information is required contact: Ms. Lynn Bryant, Department Clearance Officer, Policy and Planning Staff, Justice Management Division, United States Department of Justice, Patrick Henry Building, Suite 1600, 601 D Street, NW., Washington, DC 20530.

Dated: July 27,2007.

Lynn Bryant,

Department Clearance Officer, PRA, United States Department of Justice.

[FR Doc. E7–14951 Filed 8–1–07; 8:45 am]

BILLING CODE 4410–02–P

DEPARTMENT OF JUSTICE

Office of Justice Programs

[OMB Number 1121–NEW]

Agency Information Collection Activities; Proposed Collection; Comments Requested

ACTION: 60–Day Notice of Information Collection Under Review: 2007 Census of Law Enforcement Aviation Units.

The Department of Justice (DOJ), Office of Justice Programs, Bureau of Justice Statistics (BJS), will be submitting the following information collection request to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act of 1995. The proposed information collection is published to obtain comments from the public and affected agencies. Comments are encouraged and will be accepted for ''sixty days'' until October 1, 2007. This

process is conducted in accordance with 5 CFR 1320.10.

If you have comments especially on the estimated public burden or associated response time, suggestions, or need a copy of the proposed information collection instrument with instructions or additional information, please contact Steven Smith, Bureau of Justice Statistics, 810 Seventh St., NW., Washington, DC 20531.

Written comments and suggestions from the public and affected agencies concerning the proposed collection of information are encouraged. Your comments should address one or more of the following four points:

—Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

—Evaluate the accuracy of the agencies' estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

—Enhance the quality, utility, and clarity of the information to be collected; and

—Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.

Overview of This Information Collection

(1) *Type of Information Collection:* Proposed Collection.

(2) *Title of the Form/Collection:* 2007 Census of Law Enforcement Aviation Units.

(3) *Agency form number, if any, and the applicable component of the Department of Justice sponsoring the collection:* Not applicable.

(4) *Affected public who will be asked or required to respond, as well as a brief abstract:* Primary: Federal, State, and Local Government. This information collection is a census of State and local law enforcement agency aviation units. The census will provide detailed statistics on the operations, personnel, expenditures, equipment, and other information about these important units.

(5) *An estimate of the total number of respondents and the amount of time estimated for an average respondent to respond:* It is estimated that 250 respondents will complete a one-hour questionnaire.

(6) *An estimate of the total public burden (in hours) associated with the collection:* There are an estimated 250 total annual burden hours associated with this collection.

If additional information is required contact: Lynn Bryant, Department Clearance Officer, United States Department of Justice, Justice Management Division, Policy and Planning Staff, Patrick Henry Building, Suite 1600, 601 D Street, NW., Washington, DC 20530.

Dated: July 27, 2007.

Lynn Bryant,

Department Clearance Officer, Department of Justice.

[FR Doc. E7–14949 Filed 8–1–07; 8:45 am]

BILLING CODE 4410–18–P

DEPARTMENT OF LABOR

Employment and Training Administration

Investigations Regarding Certifications of Eligibility To Apply for Worker Adjustment Assistance and Alternative Trade Adjustment Assistance

Petitions have been filed with the Secretary of Labor under section 221(a) of the Trade Act of 1974 (''the Act'') and are identified in the Appendix to this notice. Upon receipt of these petitions, the Director of the Division of Trade Adjustment Assistance, Employment and Training Administration, has instituted investigations pursuant to section 221(a) of the Act.

The purpose of each of the investigations is to determine whether the workers are eligible to apply for adjustment assistance under Title II, Chapter 2, of the Act. The investigations will further relate, as appropriate, to the determination of the date on which total or partial separations began or threatened to begin and the subdivision of the firm involved.

The petitioners or any other persons showing a substantial interest in the subject matter of the investigations may request a public hearing, provided such request is filed in writing with the Director, Division of Trade Adjustment Assistance, at the address shown below, not later than August 13, 2007.

Interested persons are invited to submit written comments regarding the subject matter of the investigations to the Director, Division of Trade Adjustment Assistance, at the address shown below, not later than August 13, 2007.

The petitions filed in this case are available for inspection at the Office of the Director, Division of Trade Adjustment Assistance, Employment and Training Administration, U.S. Department of Labor, Room C–5311, 200 Constitution Avenue, NW., Washington, DC 20210.

Signed at Washington, DC, this 24th day of July 2007.

Richard Church,

Certifying Officer, Division of Trade Adjustment Assistance.

APPENDIX—TAA

[petitions instituted between 7/16/07 and 7/20/07]

TA–W	Subject firm (petitioners)	Location	Date of institution	Date of petition
61828	Freightliner (Wkrs)	Cleveland, NC	07/16/07	07/13/07
61829	Crane Plumbling LL (State)	Dallas, TX	07/16/07	07/12/07
61830	Renfro-Charleston Hosiery (Wkrs)	Fort Payne, AL	07/16/07	07/16/07
61831	CVG-Global Truck Division, Seattle 031 (Comp)	Seattle, WA	07/16/07	07/13/07
61832	Magnecomp Corporation (Wkrs)	Temecula, CA	07/16/07	07/10/07
61833	Chapin Watermatics, Inc. (Wkrs)	Watertown, NY	07/17/07	07/16/07
61834	Slinger Manufacturing Company (AFLCIO)	Slinger, WI	07/17/07	07/16/07
61835	Caraustar Mill Group (Comp)	Sinking Spring, PA	07/18/07	07/18/07
61836	Hutchinson FTS Inc. (Comp)	Quincy, MI	07/18/07	07/17/07
61837	St. Paul Metalcraft (State)	Arden Hills, MN	07/18/07	07/17/07
61838	Tyler Pipe (USW)	Tyler, TX	07/18/07	07/16/07
61839	AstenJohnson, Inc. (Comp)	Walterboro, SC	07/19/07	07/18/07
61840	Converse Industries, Inc. (Wkrs)	Kenosha, WI	07/19/07	07/18/07

APPENDIX—TAA—Continued

[petitions instituted between 7/16/07 and 7/20/07]

TA–W	Subject firm (petitioners)	Location	Date of institution	Date of petition
61841	Kay Home Products (Wkrs)	Antioch, IL	07/19/07	07/18/07
61842	Seton Company (Comp)	Saxton, PA	07/20/07	07/19/07
61843	Kraft Foods Global, Inc (Comp)	Rochelle, IL	07/20/07	07/19/07
61844	Carter-Pertaine Inc. (State)	Houston, TX	07/20/07	07/13/07
61845	NYC American, Inc. (Wkrs)	Brooklyn, NY	07/20/07	07/19/07
61846	Tingstol (Wkrs)	Elk Grove Village, IL	07/20/07	07/03/07
61847	Cedar Ideas (Comp)	Oakfield, ME	07/20/07	07/19/07
61848	Kentucky Derby Hosiery/Gildan—Plant 4 and Fowler Rd. (Comp).	Mt Airy, NC	07/20/07	07/18/07
61849	Ada Gage (Comp)	Ada, MI	07/20/07	07/19/07
61850	Southern Loom Reed (Comp)	Gaffney, SC	07/20/07	07/13/07
61851	Bosch Security System (IBEW)	Lancaster, PA	07/20/07	07/19/07
61852	Schnadig Corporation (Comp)	Montoursville, PA	07/20/07	07/12/07

[FR Doc. E7–14996 Filed 8–1–07; 8:45 am]
BILLING CODE 4510–FN–P

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–58,984]

Independent Steel Castings Company, New Buffalo, MI; Notice of Revised Determination of Alternative Trade Adjustment Assistance on Remand

On July 10, 2007, the U.S. Court of International Trade (USCIT) remanded to the U.S. Department of Labor (Department) *Former Employees of Independent Steel Castings Company, Inc.* v. *United States Department of Labor,* Court No. 06–00338. In its order, the USCIT directed the Department to acquire additional information on criterion two of the Alternative Trade Adjustment Assistance (ATAA) program (whether the adversely affected workers in the petitioning workers' firm possess job skills that are not easily transferable to other employment).

The Department's determination regarding the subject workers' eligibility to apply for Trade Adjustment Assistance (TAA) and ineligibility to apply for Alternative Trade Adjustment Assistance (ATAA) was issued on June 16, 2006. The Department's Notice of determination was published in the **Federal Register** on July 14, 2006 (71 FR 40157). The determination stated that of the three criteria used to assess eligibility for ATAA —(1) Significant number of adversely affected workers age 50 or over; (2) whether workers possess skills that are easily transferable; and (3) whether competitive conditions within the workers' industry are adverse—workers at the subject firm had not satisfied the second criterion because they possessed skills that were easily transferable. The subject workers had been engaged in the production of investment castings (i.e. steel, aluminum and bronze castings). The subject firm closed May 2005.

The petitioner, the International Union, United Automobile, Aerospace and Agricultural Implement Workers of America (UAW), requested administrative reconsideration of the negative ATAA determination. The request alleged that the county in which the subject firm is located ''has not seen any significant employment growth in the last four years'' and has a high unemployment rate.

By a letter dated July 31, 2006, the Department denied the request for reconsideration, stating that the UAW had not presented evidence that the Department had erred in its interpretation of facts or of the law. The letter also outlined the Department's ATAA investigation methodology—Training and Employment Guidance Letter No. 2–03 (TEGL 2–03)—and stated that the UAW's allegations were insufficient to satisfy ATAA criterion two (whether workers possess skills that are easily transferable).

In the complaint, the Plaintiffs alleged that the separated workers did not possess skills that are easily transferable; that the Department ''relied on conclusory assertions'' provided by the subject firm ''while ignoring evidence presented by the Union;'' and that the Department ''relied on unverified information'' provided by the subject firm official.

While the USCIT upheld the Department's position that it was reasonable for the Department to rely on information provided by a knowledgeable subject firm official, the USCIT found that the Department's conclusion on ATAA criterion two was not supported by substantial evidence. Accordingly, the USCIT remanded the matter to the Department for further investigation and a redetermination of the subject workers' ATAA eligibility.

During the remand investigation, the Department contacted the Plaintiffs' counsel to obtain the position descriptions and lists of skill sets of each of the separated workers. The Department also attempted to contact the subject firm official who provided the Department information during the initial investigation to obtain more information regarding the workers' skills and the skills required to gain new employment in the New Buffalo, Michigan local commuting area. In addition, the Department surveyed companies in the New Buffalo, Michigan local commuting area to determine whether their jobs required the same skills as those which the subject workers possessed.

As a result of the remand investigation, the Department finds that workers at the subject firm do not possess skills that are easily transferable. Accordingly, the workers have satisfied criterion two. Further, the Department finds that at least five percent of the workforce at the subject firm is at least fifty years of age and that competitive conditions within the industry are adverse. Therefore, the Department has concluded that all three ATAA criteria have been met.

Conclusion

After careful review of the additional facts obtained on remand, I conclude that the requirements of section 246 of the Trade Act of 1974, as amended, have been met for workers at the subject firm. In accordance with the provisions of the Act, I make the following certification:

''All workers of Independent Steel Castings Company, New Buffalo, Michigan, who became totally or partially separated from employment on or after March 2, 2005

through June 16, 2008 are eligible to apply for adjustment assistance under section 223 of the Trade Act of 1974, and are also eligible to apply for alternative trade adjustment assistance under section 246 of the Trade Act of 1974.''

Signed in Washington, DC, this 19th day of July, 2007.

Elliott S. Kushner,

Certifying Officer, Division of Trade Adjustment Assistance.

[FR Doc. E7–14998 Filed 8–1–07; 8:45 am]

BILLING CODE 4510–FN–P

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–59,168]

Amended Certification Regarding Eligibility To Apply for Worker Adjustment Assistance and Alternative Trade Adjustment Assistance; Joan Fabrics Corporation Including Workers Who's Wages Were Paid By Accuforce Staffing Service; Siler City, North Carolina

In accordance with Section 223 of the Trade Act of 1974 (19 U.S.C. 2273), and Section 246 of the Trade Act of 1074 (26 U.S.C. 2813), as amended, the Department of Labor issued a Certification of Eligibility to Apply for Worker Adjustment Assistance and Alternative Trade Adjustment Assistance on April 25, 2006, applicable to workers of Joan Fabrics Corporation, Siler City, North Carolina. The notice was published in the **Federal Register** on May 11, 2006 (71 FR 27519).

At the request of a company official, the Department reviewed the certification for workers of the subject firm. The workers were engaged in the production of upholstery, wall panel and tie lining fabrics.

New information shows that following a change in ownership, some workers of the Siler City, North Carolina location of the subject firm will become employees of AccuForce Staffing Service.

Workers separated from employment at the Siler City, North Carolina location of the subject firm had their wages reported under a separate unemployment insurance (UI) tax account for AccuForce Staffing Service.

Accordingly, the Department is amending the certification to properly reflect this matter.

The intent of the Department's certification is to include all workers of Joan Fabrics Corporation, including workers who's wages were paid by AccuForce Staffing Service, Siler City, North Carolina who were adversely affected by a shift in production to Mexico.

The amended notice applicable to TA–W–59,168 is hereby issued as follows:

''All workers of Joan Fabrics Corporation, including workers who's wages were paid by AccuForce Staffing Service, Siler City, North Carolina, who became totally or partially separated from employment on or after April 5, 2005, through April 25, 2008, are eligible to apply for adjustment assistance under Section 223 of the Trade Act of 1974, and are also eligible to apply for alternative trade adjustment assistance under Section 246 of the Trade Act of 1974.''

Signed at Washington, DC, this 26th day of July 2007.

Elliott S. Kushner,

Certifying Officer, Division of Trade Adjustment Assistance.

[FR Doc. E7–14995 Filed 8–1–07; 8:45 am]

BILLING CODE 4510–FN–P

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–57,746B]

Amended Certification Regarding Eligibility To Apply for Worker Adjustment Assistance and Alternative Trade Adjustment Assistance; Joan Fabrics Corporation Mastercraft Fabrics, LLC.; Oakland Plant Including Workers Who's Wages Were Paid By Accuforce Staffing Service; Spindale, NC

In accordance with Section 223 of the Trade Act of 1974 (19 U.S.C. 2273), and Section 246 of the Trade Act of 1074 (26 U.S.C. 2813), as amended, the Department of Labor issued a Certification of Eligibility to Apply for Worker Adjustment Assistance and Alternative Trade Adjustment Assistance on September 27, 2005, applicable to workers of Joan Fabrics Corporation, Mastercraft Fabrics, LLC., Oakland Plant, Spindale, North Carolina. The notice was published in the **Federal Register** on October 31, 2005 (70 FR 72347). The certification was previously amended on November 23, 2005 to correct the impact date. The notice was published in the **Federal Register** on December 8, 2005 (70 FR 73033)

At the request of a company official, the Department reviewed the certification for workers of the subject firm. The workers were engaged in the production of jacquard furniture fabric.

New information shows that following a change in ownership, some workers of the Oakland Plant, Spindale, North Carolina location of the subject firm will become employees of AccuForce Staffing Service. Workers separated from employment at the Oakland Plant, Spindale, North Carolina location of the subject firm had their wages reported under a separate unemployment insurance (UI) tax account for AccuForce Staffing Service.

Accordingly, the Department is amending the certification to properly reflect this matter.

The intent of the Department's certification is to include all workers of Joan Fabrics Corporation, Mastercraft Fabrics, LLC., Oakland Plant, including workers who's wages were paid by AccuForce Staffing Service, Spindale, North Carolina who were adversely affected by a shift in production to Mexico.

The amended notice applicable to TA–W–57,746B is hereby issued as follows:

''All workers of Joan Fabrics Corporation, Mastercraft Fabrics, LLC., Oakland Plant, including workers who's wages were paid by AccuForce Staffing Service, Spindale, North Carolina, who became totally or partially separated from employment on or after November 11, 2005, through September 27, 2007, are eligible to apply for adjustment assistance under section 223 of the Trade Act of 1974, and are also eligible to apply for alternative trade adjustment assistance under Section 246 of the Trade Act of 1974.''

Signed at Washington, DC, this 25th day of July. 2007.

Richard Church,

Certifying Officer, Division of Trade Adjustment Assistance.

[FR Doc. E7–14997 Filed 8–1–07; 8:45 am]

BILLING CODE 4510–FN–P

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–61,313]

Circa 1801 Doblin, a Subsidiary of Joan Fabrics Corporation, EBM Textiles, LLC Division, Now Known as Valdese Weavers, Connelly Springs, NC; Amended Certification Regarding Eligibility To Apply for Worker Adjustment Assistance and Alternative Trade Adjustment Assistance

In accordance with section 223 of the Trade Act of 1974 (19 U.S.C. 2273), and section 246 of the Trade Act of 1974 (26 U.S.C. 2813), as amended, the Department of Labor issued a Certification Regarding Eligibility to Apply for Worker Adjustment Assistance and Alternative Trade

Adjustment Assistance on May 23, 2007, applicable to workers of Circa 1801 Doblin, a subsidiary of Joan Fabrics Corporation, EBM Textiles, LLC Division, Connelly Springs, North Carolina. The notice was published in the **Federal Register** on June 7, 2007 (72 FR 31615).

At the request of a company official, the Department reviewed the certification for workers of the subject firm. The workers are engaged in the production of woven fabric, used primarily for upholstery.

New information shows that following a change in ownership, Circa 1801 Doblin, a subsidiary of Joan Fabrics Corporation, EBM Textiles, LLC Division, is now known as Valdese Weavers.

Workers separated from employment at the subject firm had their wages reported under a separate unemployment insurance (UI) tax account for Valdese Weavers.

Accordingly, the Department is amending this certification to properly reflect this matter.

The intent of the Department's certification is to include all workers of Circa 1801 Doblin, a subsidiary of Joan Fabrics Corporation, EBM Textiles, LLC Division, now known as Valdese Weavers, who were adversely affected by increased customer imports.

The amended notice applicable to TA–W–61,313 is hereby issued as follows:

''All workers of Circa 1801 Doblin, a subsidiary of Joan Fabrics Corporation, EBM Textiles, LLC Division, now known as Valdese Weavers, Connelly Springs, North Carolina, who became totally or partially separated from employment on or after April 13, 2006, through May 23, 2009, are eligible to apply for adjustment assistance under section 223 of the Trade Act of 1974, and are also eligible to apply for alternative trade adjustment assistance under section 246 of the Trade Act of 1974.''

Signed at Washington, DC, this 26th day of July, 2007.

Elliott S. Kushner,

Certifying Officer, Division of Trade Adjustment Assistance.

[FR Doc. E7–15006 Filed 8–1–07; 8:45 am]

BILLING CODE 4510–FN–P

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–60,870]

Lear Corporation, Now Known as International Automotive Components Group, Interior Systems Division, Sidney, OH; Amended Certification Regarding Eligibility To Apply for Worker Adjustment Assistance and Alternative Trade Adjustment Assistance

In accordance with section 223 of the Trade Act of 1974 (19 U.S.C. 2273), and section 246 of the Trade Act of 1974 (26 U.S.C. 2813), as amended, the Department of Labor issued a Certification Regarding Eligibility to Apply for Worker Adjustment Assistance and Alternative Trade Adjustment Assistance on March 15, 2007, applicable to workers of Lear Corporation, Interior Systems Division, Sidney, Ohio. The notice was published in the **Federal Register** on March 30, 2007 (72 FR 15168).

At the request of a company official, the Department reviewed the certification for workers of the subject firm. The workers are engaged in the production of automotive carpeting (for full floor, deck lids, cargo panels and trunks).

New information shows that following a merger on April 1, 2007, Lear Corporation, is now known as International Automotive Components Group (IAC).

Workers separated from employment at the subject firm had their wages reported under a separate unemployment insurance (UI) tax account for International Automotive Components Group (IAC), Interior Systems Division.

Accordingly, the Department is amending this certification to properly reflect this matter.

The intent of the Department's certification is to include all workers of Lear Corporation, Interior Systems Division, now known as International Automotive Components Group (IAC), Interior Systems Division who were adversely affected by increased imports.

The amended notice applicable to TA–W–60,870 is hereby issued as follows:

''All workers of Lear Corporation, Interior Systems Division, now known as International Automotive Components Group (IAC), Interior Systems Division, Sidney, Ohio, who became totally or partially separated from employment on or after January 25, 2006, through March 15, 2009, are eligible to apply for adjustment assistance under section 223 of the Trade Act of 1974, and are also eligible to apply for alternative trade adjustment assistance under section 246 of the Trade Act of 1974.''

Signed at Washington, DC, this 24th day of July, 2007.

Elliott S. Kushner,

Certifying Officer, Division of Trade Adjustment Assistance.

[FR Doc. E7–15004 Filed 8–1–07; 8:45 am]

BILLING CODE 4510–FN–P

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–60,851]

Mastercraft Fabrics, LLC, Joan Fabrics Corporation, Eagle Mountain Finishing, Including Workers Who's Wages Were Paid by Accuforce Staffing Service Cramerton, NC; Amended Certification Regarding Eligibility To Apply for Worker Adjustment Assistance and Alternative Trade Adjustment Assistance

In accordance with section 223 of the Trade Act of 1974 (19 U.S.C. 2273), and section 246 of the Trade Act of 1074 (26 U.S.C. 2813), as amended, the Department of Labor issued a Certification of Eligibility to Apply for Worker Adjustment Assistance and Alternative Trade Adjustment Assistance on March 9, 2007, applicable to workers of Mastercraft Fabrics, LLC, Joan Fabrics Corporation, Eagle Mountain Finishing, Cramerton, North Carolina. The notice was published in the **Federal Register** on March 22, 2007 (72 FR 13528).

At the request of a company official, the Department reviewed the certification for workers of the subject firm. The workers were engaged in the production of finished fabrics.

New information shows that following a change in ownership, some workers of the Eagle Mountain Finishing facility of the subject firm will become employees of AccuForce Staffing Service.

Workers separated from employment at Eagle Mountain Finishing, Cramerton, North Carolina location of the subject firm had their wages reported under a separate unemployment insurance (UI) tax account for AccuForce Staffing Service.

Accordingly, the Department is amending the certification to properly reflect this matter.

The intent of the Department's certification is to include all workers of Mastercraft Fabrics, LLC, Joan Fabrics Corporation, Eagle Mountain Finishing,

including workers whose wages were paid by AccuForce Staffing Service who were adversely affected by customer imports.

The amended notice applicable to TA–W–60,851 is hereby issued as follows:

''All workers of Mastercraft Fabrics LLC, Joan Fabrics Corporation, Eagle Mountain Finishing, including workers who's wages were paid by AccuForce Staffing Service, Cramerton, North Carolina, who became totally or partially separated from employment on or after January 29, 2007, through March 9, 2009, are eligible to apply for adjustment assistance under section 223 of the Trade Act of 1974, and are also eligible to apply for alternative trade adjustment assistance under section 246 of the Trade Act of 1974.''

Signed at Washington, DC this 26th day of July, 2007.

Elliott S. Kushner,

Certifying Officer, Division of Trade Adjustment Assistance.

[FR Doc. E7–15003 Filed 8–1–07; 8:45 am]

BILLING CODE 4510–FN–P

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–60,515]

Maytag Corporation, A Wholly Owned Subsidiary of Whirlpool Corporation, Newton Division; Including On-Site Leased Workers of Henkel Corp., Randstad Corp., Ryerson Steel, Chem-Tool, Barnes Electric, Mid Iowa Tools, Kimco Janitorial, Johnson Controls, and Baker Electric Newton, IA; Amended Certification Regarding Eligibility To Apply for Worker Adjustment Assistance and Alternative Trade Adjustment Assistance

In accordance with section 223 of the Trade Act of 1974 (19 U.S.C. 2273), and section 246 of the Trade Act of 1974 (26 U.S.C. 2813), as amended, the Department of Labor issued a Certification of Eligibility to Apply for Worker Adjustment Assistance and Alternative Trade Adjustment Assistance on December 26, 2006, applicable to workers of Maytag Corporation, a wholly owned subsidiary of Whirlpool Corporation, Newton Division, Newton, Iowa. The notice was published in the **Federal Register** on January 16, 2007 (72 FR 1770).

At the request of a company official, the Department reviewed the certification for workers of the subject firm. The workers are engaged in the production of laundry products (clothes washers and dryers) and are not separately identifiable by specific product.

New information shows that leased workers of the above listed firms were contracted to work on-site at the Newton, Iowa location of Maytag Corporation, a wholly owned subsidiary of Whirlpool Corporation, Newton Division. These workers provided a variety of functions in support of the production of laundry equipment (clothes washers and dryers) manufactured at the subject firm. The Department has determined that the above listed on-site worker groups are sufficiently under the control of Maytag Corporation to be considered leased workers.

The intent of the Department's certification is to include all workers employed at Maytag Corporation, a wholly owned subsidiary of Whirlpool Corporation, Newton Division, Newton, Iowa who were adversely affected by increased company imports.

The amended notice applicable to TA–W–60,515 is hereby issued as follows:

''All workers of Maytag Corporation, a wholly owned subsidiary of Whirlpool Corporation, Newton Division, including on-site leased workers of Henkel Corp., Randstad Corp., Ryerson Steel, Chem-Tool, Barnes Electric, Mid Iowa Tools, Kimco Janitorial, Johnston Controls, and Baker Electric, Newton, Iowa, who became totally or partially separated from employment on or after December 24, 2006, through December 26, 2008, are eligible to apply for adjustment assistance under section 223 of the Trade Act of 1974, and are also eligible to apply for alternative trade adjustment assistance under section 246 of the Trade Act of 1974.''

Signed at Washington, DC, this 26th day of July, 2007.

Richard Church,

Certifying Officer, Division of Trade Adjustment Assistance.

[FR Doc. E7–15002 Filed 8–1–07; 8:45 am]

BILLING CODE 4510–FN–P

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–59,909]

McCormick and Co., Inc., CPD—Salinas Plant, Including On-Site Leased Workers of Spherion Staffing Group, Salinas, CA; Amended Certification Regarding Eligibility To Apply for Worker Adjustment Assistance and Alternative Trade Adjustment Assistance

In accordance with section 223 of the Trade Act of 1974 (19 U.S.C. 2273), and section 246 of the Trade Act of 1974 (26 U.S.C. 2813), as amended, the Department of Labor issued a Certification of Eligibility to Apply for Worker Adjustment Assistance and Alternative Trade Adjustment Assistance on August 31, 2006, applicable to workers of McCormick and Co., Inc., CPD—Salinas Plant, Salinas, California. The notice was published in the **Federal Register** on September 21, 2006 (71 FR 55216).

At the request of the State agency, the Department reviewed the certification for workers of the subject firm. The workers were engaged in the production of spices.

New information shows that leased workers of Spherion Staffing Group were employed on-site at the Salinas, California location of McCormick and Co., Inc., CPD—Salinas Plant. The Department has determined that the Spherion Staffing Group workers were sufficiently under the control of McCormick and Co., Inc. to be considered leased workers.

Based on these findings, the Department is amending this certification to include leased workers of Spherion Staffing Group working on-site at the Salinas, California location of the subject firm.

The intent of the Department's certification is to include all workers employed at McCormick and Co., Inc., CPD—Salinas Plant, including on-site leased workers of Spherion Staffing Group, Salinas, California who were adversely affected by a shift in production to Canada.

The amended notice applicable to TA–W–59,909 is hereby issued as follows:

''All workers of McCormick and Co., Inc., CPD—Salinas Plant, including on-site leased workers of Spherion Staffing Group, Salinas, California, who became totally or partially separated from employment on or after August 14, 2005 through August 31, 2008, are eligible to apply for adjustment assistance under section 223 of the Trade Act of 1974, and are also eligible to apply for alternative trade adjustment assistance under Section 246 of the Trade Act of 1974.''

Signed at Washington, DC, this 26th day of July, 2007.

Richard Church,

Certifying Officer, Division of Trade Adjustment Assistance.

[FR Doc. E7–15000 Filed 8–1–07; 8:45 am]

BILLING CODE 4510–FN–P

DEPARTMENT OF LABOR

Employment and Training Administration

Notice of Determinations Regarding Eligibility To Apply for Worker Adjustment Assistance and Alternative Trade Adjustment Assistance

In accordance with section 223 of the Trade Act of 1974, as amended (19 U.S.C. 2273) the Department of Labor herein presents summaries of determinations regarding eligibility to apply for trade adjustment assistance for workers (TA–W) number and alternative trade adjustment assistance (ATAA) by (TA–W) number issued during the period of July 16 through July 20, 2007.

In order for an affirmative determination to be made for workers of a primary firm and a certification issued regarding eligibility to apply for worker adjustment assistance, each of the group eligibility requirements of section 222(a) of the Act must be met.

I. Section (a)(2)(A) All of the Following Must Be Satisfied:

A. A significant number or proportion of the workers in such workers' firm, or an appropriate subdivision of the firm, have become totally or partially separated, or are threatened to become totally or partially separated;

B. The sales or production, or both, of such firm or subdivision have decreased absolutely; and

C. Increased imports of articles like or directly competitive with articles produced by such firm or subdivision have contributed importantly to such workers' separation or threat of separation and to the decline in sales or production of such firm or subdivision; or

II. Section (a)(2)(B) Both of the Following Must Be Satisfied:

A. A significant number or proportion of the workers in such workers' firm, or an appropriate subdivision of the firm, have become totally or partially separated, or are threatened to become totally or partially separated;

B. there has been a shift in production by such workers' firm or subdivision to a foreign country of articles like or directly competitive with articles which are produced by such firm or subdivision; and

C. One of the Following Must Be Satisfied:

1. The country to which the workers' firm has shifted production of the articles is a party to a free trade agreement with the United States;

2. The country to which the workers' firm has shifted production of the articles to a beneficiary country under the Andean Trade Preference Act, African Growth and Opportunity Act, or the Caribbean Basin Economic Recovery Act; or

3. There has been or is likely to be an increase in imports of articles that are like or directly competitive with articles which are or were produced by such firm or subdivision.

Also, in order for an affirmative determination to be made for secondarily affected workers of a firm and a certification issued regarding eligibility to apply for worker adjustment assistance, each of the group eligibility requirements of section 222(b) of the Act must be met.

(1) Significant number or proportion of the workers in the workers' firm or an appropriate subdivision of the firm have become totally or partially separated, or are threatened to become totally or partially separated;

(2) The workers' firm (or subdivision) is a supplier or downstream producer to a firm (or subdivision) that employed a group of workers who received a certification of eligibility to apply for trade adjustment assistance benefits and such supply or production is related to the article that was the basis for such certification; and

(3) Either—

(A) The workers' firm is a supplier and the component parts it supplied for the firm (or subdivision) described in paragraph (2) accounted for at least 20 percent of the production or sales of the workers' firm; or

(B) A loss or business by the workers' firm with the firm (or subdivision) described in paragraph (2) contributed importantly to the workers' separation or threat of separation.

In order for the Division of Trade Adjustment Assistance to issue a certification of eligibility to apply for Alternative Trade Adjustment Assistance (ATAA) for older workers, the group eligibility requirements of Section 246(a)(3)(A)(ii) of the Trade Act must be met.

1. Whether a significant number of workers in the workers' firm are 50 years of age or older.

2. Whether the workers in the workers' firm possess skills that are not easily transferable.

3. The competitive conditions within the workers' industry (i.e., conditions within the industry are adverse).

Affirmative Determinations for Worker Adjustment Assistance

The following certifications have been issued. The date following the company name and location of each determination references the impact date for all workers of such determination.

The following certifications have been issued. The requirements of section 222(a)(2)(A) (increased imports) of the Trade Act have been met.

TA–W–61,625; Performance Machine, La Palma, CA: June 6, 2006.

TA–W–61,803; Rima Manufacturing Company, Piston Division, Hudson, MI: June 14, 2006.

TA–W–61,608; Personnel Management, Inc., Diverisco, Working at Toyota Motor, Princeton, IN: May 29, 2006.

The following certifications have been issued. The requirements of section 222(a)(2)(B) (shift in production) of the Trade Act have been met.

NONE.

The following certifications have been issued. The requirements of section 222(b) (supplier to a firm whose workers are certified eligible to apply for TAA) of the Trade Act have been met.

NONE.

The following certifications have been issued. The requirements of section 222(b) (downstream producer for a firm whose workers are certified eligible to apply for TAA based on increased imports from or a shift in production to Mexico or Canada) of the Trade Act have been met.

NONE.

Affirmative Determinations for Worker Adjustment Assistance and Alternative Trade Adjustment Assistance

The following certifications have been issued. The date following the company name and location of each determination references the impact date for all workers of such determination.

The following certifications have been issued. The requirements of section 222(a)(2)(A) (increased imports) and section 246(a)(3)(A)(ii) of the Trade Act have been met.

TA–W–61,753; WestPoint Home Inc., Bath Products Divisions, Wagram, NC: August 11, 2007.

TA–W–61,806; Laufen International, Inc., Canton Distribution Center, Canton, OH: July 9, 2006.

TA–W–61,554; SemiTool Incorporated, LC Staffing, Express Personnel, Workplace, Inc., Kalispell, MT: May 18, 2006.

TA–W–61,554A; SemiTool Incorporated—Birch Grove Site, Birch Grove Site, LC Staff, Express Personnel, Kalispell, MT: May 18, 2006.

TA–W–61,554B; SemiTool Incorporated—Libby Plant, Libby Plant, Kalispell, MT: May 18, 2006.

TA–W–61,638; Belcher Corporation LLC, South Easton, MA: May 25, 2006.
TA–W–61,575; Herzman and Company, Inc., Lebanon, PA: May 17, 2006.

The following certifications have been issued. The requirements of section 222(a)(2)(B) (shift in production) and section 246(a)(3)(A)(ii) of the Trade Act have been met.

TA–W–61,779; Siemens Power Transmission and Distribution, Distribution Products Division, Wendell, NC: June 29, 2006.
TA–W–61,780; Harman Becker Automotive Systems, Inc., Martinsville, IN: June 28, 2006.
TA–W–61,791; Mahe Engine Components, Division of Mahle Industries, Inc., Franklin, KY: July 3, 2006.
TA–W–61,796; Greatbatch Hittman, Inc., Medical Solutions Div., Superior, Swift, Kelly, Anchor, Columbia, MD: June 29, 2006.
TA–W–61,576; Paper Magic Group, Inc., Scranton, PA: May 17, 2006.
TA–W–61,576A; Paper Magic Group, Inc., Scranton, PA: May 17, 2006.
TA–W–61,576B; Paper Magic Group, Inc., Troy, PA: May 17, 2006.
TA–W–61,775; Tandy Brands Accessories, Yoakum, TX: June 28, 2006.
TA–W–61,816; L. Hardy Company, Worcester, MA: July 5, 2006.

The following certifications have been issued. The requirements of section 222(b) (supplier to a firm whose workers are certified eligible to apply for TAA) and section 246(a)(3)(A)(ii) of the Trade Act have been met.

TA–W–61,746; Carolina Warp Print, Inc., Gastonia, NC: June 26, 2006.

The following certifications have been issued. The requirements of section 222(b) (downstream producer for a firm whose workers are certified eligible to apply for TAA based on increased imports from or a shift in production to Mexico or Canada) and section 246(a)(3)(A)(ii) of the Trade Act have been met.

NONE.

Negative Determinations for Alternative Trade Adjustment Assistance

In the following cases, it has been determined that the requirements of 246(a)(3)(A)(ii) have not been met for the reasons specified.

The Department has determined that criterion (1) of section 246 has not been met. The firm does not have a significant number of workers 50 years of age or older.

TA–W–61,625; Performance Machine, La Palma, CA.
TA–W–61,803; Rima Manufacturing Company, Piston Division, Hudson, MI.
TA–W–61,608; Personnel Management, Inc., Diverisco, Working at Toyota Motor, Princeton, IN.

The Department has determined that criterion (2) of section 246 has not been met. Workers at the firm possess skills that are easily transferable.

NONE.

The Department has determined that criterion (3) of section 246 has not been met. Competition conditions within the workers' industry are not adverse.

NONE.

Negative Determinations for Worker Adjustment Assistance and Alternative Trade Adjustment Assistance

In the following cases, the investigation revealed that the eligibility criteria for worker adjustment assistance have not been met for the reasons specified.

Because the workers of the firm are not eligible to apply for TAA, the workers cannot be certified eligible for ATAA.

The investigation revealed that criteria (a)(2)(A)(I.A.) and (a)(2)(B)(II.A.) (employment decline) have not been met.

TA–W–61,666; Furnlite Inc., Fallston, NC.
TA–W–61,703; Image Screens Inc., Paterson, NJ.
TA–W–61,754; IBM Corporation, Manpower, Inc. and CTG, Rochester, MN.

The investigation revealed that criteria (a)(2)(A)(I.B.) (Sales or production, or both, did not decline) and (a)(2)(B)(II.B.) (shift in production to a foreign country) have not been met.

TA–W–61,797; Arrow Interventional, Subsidiary of Arrow International, Everett, MA.

The investigation revealed that criteria (a)(2)(A)(I.C.) (increased imports) and (a)(2)(B)(II.B.) (shift in production to a foreign country) have not been met.

TA–W–61,635; Sunset Manufacturing Company, Tualatin, OR.
TA–W–61,677; Needle Nacks Ltd., Madison, NC.
TA–W–61,689; Johnson Controls, Inc., Oberlin, OH.
TA–W–61,647; Smurfit-Stone Container Corporation, Teterboro, NJ.
TA–W–61,696; Medtronic, Inc., Cardiovascular Division, Santa Rosa, CA.

The workers' firm does not produce an article as required for certification under section 222 of the Trade Act of 1974.

TA–W–61,787; National City Mortgage Corp., Final Documents Control Post Closing Dept., Miamisburg, OH.

The investigation revealed that criteria of section 222(b)(2) has not been met. The workers' firm (or subdivision) is not a supplier to or a downstream producer for a firm whose workers were certified eligible to apply for TAA.

NONE.

I hereby certify that the aforementioned determinations were issued during the period of July 16 through July 20, 2007. Copies of these determinations are available for inspection in Room C–5311, U.S. Department of Labor, 200 Constitution Avenue, NW., Washington, DC 20210 during normal business hours or will be mailed to persons who write to the above address.

Dated: July 20, 2007.

Richard Church,

Certify Officer, Division of Trade Adjustment Assistance.

[FR Doc. E7–15007 Filed 8–1–07; 8:45 am]

BILLING CODE 4510–FN–P

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–61,157; TA–W–61,157A]

Visteon Systems, LLC, Climate Control Division Evaporators, Connersville, IN; Visteon Systems, LLC, Climate Control Division, Radiator/Heat Exchange, Connersville, IN; Including On-Site Leased Workers From CDI–IT Services and Synova, Employed Through IBM Corporation, Securitas Security Services USA, Inc., Premier MFG. Services, Kleenaway Services, Waste Management Upstream, PMI, Inc., Coolant Controls, Pitney Bowes and CNC Logistics; Amended Certification Regarding Eligibility To Apply for Worker Adjustment Assistance and Alternative Trade Adjustment Assistance

In accordance with section 223 of the Trade Act of 1974 (19 U.S.C. 2273), and section 246 of the Trade Act of 1974 (26 U.S.C. 2813), as amended, the Department of Labor issued a Certification of Eligibility to Apply for Worker Adjustment Assistance and Alternative Trade Adjustment Assistance on April 23, 2007, applicable to workers of Visteon Systems, LLC, Climate Control Division, Evaporators, Connersville, Indiana and Visteon Systems, LLC Climate Control Division Radiator/Heat Exchange, Connersville,

Indiana. The notice was published in the **Federal Register** on May 9, 2007 (72 FR 26424).

At the request of the State agency, the Department reviewed the certification for workers of the subject firm. The workers are engaged in the production of evaporators and radiators/heat exchanges for the automotive industry.

The investigation revealed that the leased workers of the above listed firms were contracted to work on-site at the Connersville, Indiana location of Visteon Systems, LLC Climate Control Division. These workers provided a variety of functions supporting the production of evaporators and radiator/heat exchange units manufactured at the subject firm. The Department has determined that the above listed on-site worker groups are in support of the production of evaporators and radiator/heat exchange units at the subject firm and are sufficiently under the control of the subject firm.

Since the workers of Visteon Systems, LLC, Climate Control Division, Evaporators and Radiator/Heat Exchange, Connersville, Indiana are certified eligible to apply for ATAA, the Department is extending that eligibility to the employees of the above listed firms working on-site at the subject firm.

The intent of the Department's certification is to include all workers employed at Visteon Systems, LLC, Climate Control Division, Evaporators and Radiator/Heat Exchange, Connersville, Indiana who were adversely affected by a shift in production to Mexico.

The amended notice applicable to TA–W–61,157 is hereby issued as follows:

''Workers of Visteon Systems, LLC, Climate Control Division, Evaporators, Connersville, Indiana (TA–W–61,157) and Visteon Systems, LLC Climate Control Division, Radiator/Heat Exchange, Connersville, Indiana (TA–W–61,157A), including on-site leased workers from CDI–IT Services and Synova, employed through IBM Corporation, Securitas Security Services USA, Inc., Premier Mfg. Services, KleenAway Services, Waste Management Upstream, PMI, Inc., Pitney Bowes and CNC Logistics, who became totally or partially separated from employment on or after March 19, 2006 through April 23, 2009, are eligible to apply for adjustment assistance under section 223 of the Trade Act of 1974, and are also eligible to apply for alternative trade adjustment assistance under section 246 of the Trade Act of 1974.''

Signed at Washington, DC, this 26th day of July, 2007.

Elliott S. Kushner,

Certifying Officer, Division of Trade Adjustment Assistance.

[FR Doc. E7–15005 Filed 8–1–07; 8:45 am]

BILLING CODE 4510–FN–P

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–61,813]

Wyeth Pharmaceuticals; Rouses Point, NY; Notice of Termination of Investigation

Pursuant to Section 221 of the Trade Act of 1974, an investigation was initiated on July 11, 2007 in response to a worker petition filed by a company official on behalf of workers at Wyeth Pharmaceuticals, Rouses Point, New York.

The petitioner has requested that the petition be withdrawn. Consequently, the investigation has been terminated.

Signed at Washington, DC, this 26th day of July, 2007.

Richard Church,

Certifying Officer, Division of Trade Adjustment Assistance.

[FR Doc. E7–14999 Filed 8–1–07; 8:45 am]

BILLING CODE 4510–FN–P

DEPARTMENT OF LABOR

Employment and Training Administration

Labor Certification for the Permanent Employment of Aliens in the United States; Establishment of E-Mail Address for Receipt of Reports of Potential Non-Compliance

AGENCY: Employment and Training Administration, Labor.

ACTION: Notice.

SUMMARY: The Department of Labor (DOL or Department) is publishing an e-mail address for the receipt and processing of reports of potential violations of its recently published Final Rule seeking to protect the integrity of the permanent labor certification program and reduce incentives for fraud and abuse.

FOR FURTHER INFORMATION CONTACT: William L. Carlson, Administrator, Office of Foreign Labor Certification, 200 Constitution Avenue, NW., Washington, DC 20210; telephone (202) 693–3010 (this is not a toll-free number). Individuals with hearing or speech impairments may access the telephone number above via TTY by calling the toll-free Federal Information Relay Service at (800) 877–8339.

SUPPLEMENTARY INFORMATION: On May 17, 2007, the Department published a Final Rule to protect the integrity of the permanent labor certification program, to reduce the incentives and opportunities for fraud, and to further fulfill the Department's statutory obligation to protect the wages and working conditions of U.S. workers. 72 FR 27904 (May 17, 2007). As part of that Rule, the Department informed the public it was considering the establishment of a toll-free telephone number, or development of other means, to receive reports on potential non-compliance with the Final Rule's provisions.

The Department continues its consideration of a toll-free number, and has determined that as an initial matter, employers, foreign workers, U.S. workers, and others who wish to submit information on potential violations may do so through an e-mail box: *laborcert.fraud@dol.gov.*

This box will be monitored for reports of alleged non-compliance with the regulations governing the permanent labor certification program. The Employment and Training Administration will determine an appropriate course of action for each report, and may refer individual inquiries to DOL's Employment Standards Administration, the DOL Office of Inspector General, the Department of Homeland Security, and/or other authorities. If appropriate, DOL may determine that no response is required.

Signed at Washington, DC, this 30 day of July, 2007.

Emily Stover Derocco,

Assistant Secretary, Employment and Training Administration.

[FR Doc. E7–14989 Filed 8–1–07; 8:45 am]

BILLING CODE 4510–FP–P

NUCLEAR REGULATORY COMMISSION

[Docket No. 50–390]

Tennessee Valley Authority; Notice of Withdrawal of Application for Amendment to Facility Operating License

The U.S. Nuclear Regulatory Commission (the Commission) has granted the request of the Tennessee Valley Authority (the licensee) to withdraw its May 8, 2006, application for proposed amendment to Facility

Operating License No. NPF–90 for the Watts Bar Nuclear Plant, Unit No. 1, located in Rhea County, Tennessee.

The proposed amendment would have revised the Technical Specifications to increase the temperature limit of the ultimate heat sink.

The Commission had previously issued a Notice of Consideration of Issuance of Amendment published in the **Federal Register** on May 23, 2006 (71 FR 29681). However, by letter dated July 20, 2007, the licensee withdrew the proposed change.

For further details with respect to this action, see the application for amendment dated May 8, 2006, and the licensee's letter dated July 20, 2007, which withdrew the application for license amendment. Documents may be examined, and/or copied for a fee, at the NRC's Public Document Room (PDR), located at One White Flint North, Public File Area O1 F21, 11555 Rockville Pike (first floor), Rockville, Maryland. Publicly available records will be accessible electronically from the Agency-wide Documents Access and Management Systems (ADAMS) Public Electronic Reading Room on the internet at the NRC Web site, *http://www.nrc.gov/reading-rm.html*. Persons who do not have access to ADAMS or who encounter problems in accessing the documents located in ADAMS should contact the NRC PDR Reference staff by telephone at 1–800–397–4209, or 301–415–4737 or by e-mail to *pdr@nrc.gov*.

Dated at Rockville, Maryland, this 26th day of July 2007.

For the Nuclear Regulatory Commission.

Brendan T. Moroney,

Project Manager, Plant Licensing Branch II–2, Division of Operating Reactor Licensing, Office of Nuclear Reactor Regulation.

[FR Doc. E7–15047 Filed 8–1–07; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[EA–06–266, 06–278]

In the Matter of University of Pittsburgh; Confirmatory Order (Effective Immediately)

I

University of Pittsburgh (UPitt or licensee) is the holder of Byproduct Material License 37–00245–09 issued by the Nuclear Regulatory Commission (NRC or Commission) pursuant to 10 CFR Part 30. License No. 37–00245–09 was originally issued on February 5, 1987, and is due to expire on May 31, 2015.

II

On March 10, 2005, and March 23, 2006, the NRC Office of Investigations (OI) initiated investigations (OI Case Nos. 1–2005–008 and 1–2006–023) to determine whether UPitt willfully violated the physical presence requirements on March 4, 2005, and whether a neurosurgeon had willfully entered the authorized user's (AU) initials on written directives without the AU's knowledge or consent. The investigations were completed on June 15, 2006 and October 10, 2006. Based on a March 5, 2005, visit to the UPitt Medical Center Gamma Knife facility and the investigations, the NRC informed UPitt, in a letter dated February 27, 2007, that three apparent violations were being considered for escalated enforcement action in accordance with the NRC Enforcement Policy. To address the three apparent violations, the February 27, 2007, letter offered UPitt a choice to (1) Attend a Predecisional Enforcement Conference (PEC), or (2) request Alternative Dispute Resolution (ADR) with the NRC in an attempt to resolve any disagreement on whether a violation occurred, the appropriate enforcement action, and the appropriate corrective actions.

III

Subsequent to the NRC's identification of the apparent violations, UPitt took several actions to assure that these events would not recur. These actions included: (1) Ensuring that an Authorized Medical Physicist (AMP) and an AU are present during each GSR treatment; (2) issuance of a procedure for physical presence requirements and posting it at each GSR unit; and, (3) hiring another AMP.

Also, in response to the NRC's February 27, 2007 letter, UPitt requested the use of ADR to resolve the apparent violations and pending enforcement action. ADR is a process in which a neutral mediator, with no decision-making authority, assists the NRC and UPitt to resolve any disagreements on whether a violation occurred, the appropriate enforcement action, and the appropriate corrective actions. At UPitt's request, an ADR session was held in the Region I Office in King of Prussia, PA on May 17, 2007, between UPitt and the NRC. This ADR session was mediated by a professional mediator, arranged through Cornell University's Institute of Conflict Management. Based on the discussion during the ADR session, a settlement agreement was reached regarding this matter. The elements of the settlement agreement are as follows:

1. As noted in an NRC letter dated February 27, 2007, based on an NRC inspection and NRC investigations, the NRC identified three apparent violations of NRC requirements at the University of Pittsburgh Medical Center Gamma Knife facility. The first apparent violation, which involved a failure to meet physical presence requirements described in 10 CFR 35.615(f)(3), included three examples, two of which involved willfulness. The examples included: (1) A March 4, 2005, failure to meet physical presence requirements in that a GSR treatment was conducted without the continuous physical presence of an AMP; (2) multiple incidents between May 13, 2004 and March 10, 2005, when two neurosurgeons, in careless disregard of NRC regulations, initiated GSR treatments in separate suites with only one AMP available to meet physical presence requirements; and, (3) a February 22, 2005, incident when one neurosurgeon willfully initiated a treatment without a written directive signed by an AU and without the physical presence of an AU. The second apparent violation involved licensee management's failure to ensure that GSR activities met NRC requirements, as required by 10 CFR 35.24(b). The third apparent violation involved multiple occasions when a neurosurgeon recorded the Radiation Therapist's initials on the GSR written directive, causing the licensee to violate 10 CFR 35.32. In the NRC February 27, 2007 letter, the NRC noted that it had not determined that violations had occurred or that enforcement should be taken, and the NRC offered the licensee an opportunity to attend a PEC prior to making an enforcement decision. In the alternative, the NRC offered the licensee the opportunity to attend an ADR mediation session to resolve these matters.

2. As a result of an ADR mediation session conducted on May 17, 2007, the licensee and the NRC agreed to final disposition of this matter by way of a single violation of the regulatory requirements in 10 CFR 35.24(b). Specifically, the licensee through the Radiation Safety Officer: (a) Failed to ensure from May 13, 2004 through March 10, 2005, the physical presence requirements of 10 CFR 35.615(f)(3) were consistently met; and (b) failed to ensure between 1998 and 2000 that written directives were consistently signed by all three members of the Gamma Knife team prior to administration of GSR treatments in accordance with 10 CFR 35.32. The NRC

concluded that certain aspects of the 10 CFR 35.24(b) violation were willful. The licensee disputed this conclusion. The NRC and the licensee have agreed to disagree regarding any willful aspects of this violation.

3. Prior to the ADR mediation session, the licensee described the actions that it had taken to address the apparent violations identified by the NRC. Those actions included: (1) Ensuring that an AMP and an AU are present during each GSR treatment; (2) issuance of a procedure for physical presence requirements and posting it at each GSR unit; and, (3) hiring another AMP. Some of these actions were verified by the NRC during the following: (1) An on-site inspection on March 15–17, 2005; (2) the NRC's review of the UPitt response to a Confirmatory Action Letter (CAL), dated April 28, 2005; (3) an on-site inspection on May 12, 2005 to follow-up on the CAL; and, (4) a routine inspection performed September 25–29, 2006.

4. During the ADR mediation session, the licensee also described additional corrective actions that it had taken or planned, which includes: (1) Having the RSO initiate a requirement for a physical presence log to be maintained at each gamma knife treatment console, to include patient name, AU physically present, AMP physically present, date, and start/stop time of treatment; (2) having the RSO staff provide annual radiation safety training to the gamma knife staff, including a review of all applicable requirements in 10 CFR Parts 19, 20, and 35, with emphasis on the physical presence and written directive requirements; (3) having an outside independent consultant (medical RSO) conduct an audit of the Radiation Safety Program with special emphasis on the gamma knife program and management oversight; (4) increasing surveillance of GSR treatments by RSO staff; and, (5) developing a program to heighten awareness of the need to report concerns, and including this program in initial and refresher training for all radiation workers, to foster an environment for raising safety concerns.

5. To provide further opportunity for other licensees in the industry to learn from this incident, UPitt also agreed to: (1) Enhance its 40 hour GSR training course provided to users at other facilities throughout the United States, including expanding the lecture on NRC regulatory requirements to include the physical presence requirements, including a description of this experience as part of the training; and, (2) submit a lessons-learned article for the Operational Radiation Safety publication and the Elekta Newsletter, *eWavelength*, describing these occurrences. The licensee will provide a copy of the training syllabus before conducting the training, and a copy of the article to the NRC at least 30 days prior to the submittal of the article to the organization.

6. In light of the actions that the licensee has taken, or committed to take, as described in Items 3–5 above, as well as the fact that the violation did not result in any known safety consequences to patients, workers, or the public, the NRC agrees to issue a Notice of Violation without a civil penalty for the violation as characterized in Item 2 and to classify the violation at Severity Level III. This action will be publically available in ADAMS and on the NRC ''Significant Enforcement Actions'' Web site.

7. The licensee also agreed to issuance of a Confirmatory Order confirming this agreement.

IV

In light of the actions UPitt has taken and agreed to take to correct the violations and prevent recurrence, as set forth in Section III above, the NRC has concluded that its concerns can be resolved through implementation of UPitt's commitments as outlined in this Confirmatory Order. The NRC has also determined that these commitments shall be confirmed by this Confirmatory Order. Based on the above and UPitt's consent, this Confirmatory Order is immediately effective upon issuance.

V

Accordingly, pursuant to Sections 81, 161b, 161i, 161o, 182, and 186 of the Atomic Energy Act of 1954, as amended, and the Commission's regulations in 10 CFR Part 2.202 and 10 CFR Part 30 and 35, it is hereby ordered, that within one year of the date of this order:

1. UPitt will enhance its 40 hour GSR training course provided to users at other facilities throughout the United States, including expanding the lecture on NRC regulatory requirements to include the physical presence requirements, including a description of this experience as part of the training;

2. UPitt will provide the NRC a copy of the training syllabus before conducting the training;

3. UPitt will submit a lessons-learned article for the Operational Radiation Safety publication and the Elekta Newsletter, *eWavelength*, describing these occurrences;

4. UPitt will provide a copy of the article to the NRC at least 30 days prior to the submission of the article to the organization; and

5. UPitt will send a letter to the NRC informing the NRC that the actions in Sections V.1–4 are complete, and UPitt will send the letter within 30 days of completion of all of these actions.

The NRC Region I Regional Administrator may relax or rescind, in writing, any of the above conditions upon a showing by UPitt of good cause.

VI

Any person adversely affected by this Confirmatory Order, other than UPitt, may request a hearing within 20 days of its issuance. Where good cause is shown, consideration will be given to extending the time to request a hearing. A request for extension of time must be made in writing to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC 20555, and must include a statement of good cause for the extension. Any request for a hearing shall be submitted to the Secretary, U.S. Nuclear Regulatory Commission, ATTN: Chief, Rulemaking and Adjudications Staff, Washington, DC 20555. Copies of the hearing request shall also be sent to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington DC 20555, to the Assistant General Counsel for Materials Litigation and Enforcement, to the Director of the Division of Regulatory Improvement Programs at the same address, to the NRC Region I office at 475 Allendale Rd., King of Prussia, PA 19406, and to UPitt. Because of potential disruptions in delivery of mail to United States Government offices, it is requested that answers and requests for hearing be transmitted to the Secretary of the Commission either by means of facsimile transmission to 301–415–1101 or by e-mail to *hearingdocket@nrc.gov* and also to the Office of the General Counsel by means of facsimile transmission to 301–415–3725 or e-mail to *OGCMailCenter@nrc.gov*. If such a person requests a hearing, that person shall set forth with particularity the manner in which his interest is adversely affected by this Order, and shall address the criteria set forth in 10 CFR Part 2.309(d) and (f).

If a hearing is requested by a person whose interest is adversely affected, the Commission will issue an Order designating the time and place of any hearing. If a hearing is held, the issue to be considered at such hearing shall be whether this Confirmatory Order shall be sustained. An answer or a request for a hearing shall not stay the immediate effectiveness of this order.

Dated this 23th day of July 2007.

For the Nuclear Regulatory Commission.

Marc L. Dapas,

Deputy Regional Administrator.

[FR Doc. E7–15046 Filed 8–1–07; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[Docket No. 50–293]

Entergy Nuclear Operations, Inc.; Pilgrim Nuclear Power Station; Notice of Availability of the Final Supplement 29 to the Generic Environmental Impact Statement for License Renewal of Nuclear Plants, Regarding the License Renewal of Pilgrim Nuclear Power Station

Notice is hereby given that the U.S. Nuclear Regulatory Commission (NRC, Commission) has published a final plant-specific supplement to the ''Generic Environmental Impact Statement for License Renewal of Nuclear Plants (GEIS),'' NUREG–1437, regarding the renewal of operating license DPR–35 for an additional 20 years of operation for the Pilgrim Nuclear Power Station (Pilgrim). Pilgrim is located on the western shore of Cape Cod in the Town of Plymouth, Plymouth County, Massachusetts. It is 38 miles southeast of Boston, Massachusetts, and 44 miles east of Providence, Rhode Island. Possible alternatives to the proposed action (license renewal) include no action and reasonable alternative energy sources.

As discussed in Section 9.3 of the final Supplement 29, the recommendation of the staff is that the Commission determine that the adverse environmental impacts of license renewal for Pilgrim are not so great that preserving the option of license renewal for energy-planning decision makers would be unreasonable. The recommendation is based on: (1) The analysis and findings in the GEIS; (2) the Environmental Report submitted by Entergy; (3) consultation with Federal, State, and local agencies; (4) the staff's own independent review; and (5) the staff's consideration of public comments.

The final Supplement 29 to the GEIS is publicly available at the NRC Public Document Room (PDR), located at One White Flint North, 11555 Rockville Pike, Rockville, Maryland, 20852, or from the NRC's Agencywide Documents Access and Management System (ADAMS). The ADAMS Public Electronic Reading Room is accessible at *http://adamswebsearch.nrc.gov/dologin.htm*. The Accession Numbers for the final Supplement 29 to the GEIS are ML071990020 Volume 1 and ML071990027 Volume 2. Persons who do not have access to ADAMS, or who encounter problems in accessing the documents located in ADAMS, should contact the NRC's PDR reference staff by telephone at 1–800–397–4209, or 301–415–4737, or by e-mail at *pdr@nrc.gov*. In addition, the final supplement will be available at the following libraries for public inspection: the Plymouth Public Library, 132 South Street, the Duxbury Free Library, 77 Alden Street, and the Kingston Public Library, 6 Green Street.

FOR FURTHER INFORMATION, CONTACT: Ms. Alicia Williamson, Environmental Branch B, Division of License Renewal, Office of Nuclear Reactor Regulation, U.S. Nuclear Regulatory Commission, Mail Stop O–11F1, Washington, DC 20555–0001. Ms. Williamson may be contacted by telephone at 1–800–368–5642, extension 1878 or via e-mail at *arw1@nrc.gov*.

Dated at Rockville, Maryland, this 26th day of July, 2007.

For the Nuclear Regulatory Commission.

Rani L. Franovich,

Branch Chief, Environmental Branch B, Division of License Renewal, Office of Nuclear Reactor Regulation.

[FR Doc. E7–15051 Filed 8–1–07; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[Docket No. 030–07188]

Notice of Environmental Assessment Related to the Issuance of a License Amendment to By-product Material License No. 21–05199–02, for Unrestricted Release of Former Facilities for the State of Michigan, Department of Environmental Quality, Lansing, MI

AGENCY: Nuclear Regulatory Commission.

ACTION: Issuance of Environmental Assessment and Finding of No Significant Impact for License Amendment.

FOR FURTHER INFORMATION CONTACT: William Snell, Senior Health Physicist, Decommissioning Branch, Division of Nuclear Materials Safety, Region III, U.S. Nuclear Regulatory Commission, 2443 Warrenville Road, Lisle, Illinois 60532; telephone: (630) 829–9871; fax number: (630) 515–1259; or by email at *wgs@nrc.gov*.

SUPPLEMENTARY INFORMATION: The U.S. Nuclear Regulatory Commission (NRC) is considering the issuance of an amendment to NRC By-product Materials License No. 21–05199–02, which is held by the State of Michigan, Department of Environmental Quality (licensee). The amendment would authorize the decommissioning and unrestricted release of the licensee's former facilities located at 3423 and 3500 N. Martin Luther King Jr. Blvd., Lansing, Michigan (the facilities). The NRC has prepared an Environmental Assessment in support of this action in accordance with the requirements of 10 CFR Part 51. Based on the Environmental Assessment, the NRC has determined that a Finding of No Significant Impact is appropriate. The amendment to the State of Michigan's Department of Environmental Quality license will be issued following the publication of this Environmental Assessment and Finding of No Significant Impact.

I. Environmental Assessment

Identification of Proposed Action

The proposed action would approve the State of Michigan's Department of Environmental Quality request to amend its license and release the facilities for unrestricted use in accordance with 10 CFR Part 20, Subpart E. The proposed action does not pertain to the licensee's radiological laboratory at 815 Terminal Road, in Lansing, Michigan, where licensed activities will continue. The proposed action is in accordance with the licensee's request to the U.S. Nuclear Regulatory Commission (NRC) to amend its license by letter dated February 28, 2007 (ADAMS Accession No. ML070590426). The State of Michigan's Department of Environmental Quality was first licensed to use by-product materials at its facilities at 3500 N. Martin Luther King Jr. Blvd. (formerly 3500 N. Logan) on June 30, 1964, and at 3423 N. Martin Luther King Jr. Blvd. on February 21, 1997. The licensee is authorized to use by-product materials for activities involving instrument calibration and for analysis of environmental samples. The licensee was authorized to use sealed sources at the facilities containing cesium-137, cobalt-60, americium-241, nickel-63, and strontium-90. Isotopes that were authorized for use at the facilities in an unsealed form included any by-product material up to a maximum of 100 millicuries at any one time.

At the 3500 N. Martin Luther King Jr. Blvd. address, the licensee used by-product materials in two buildings. The licensee analyzed environmental and special samples in its Nuclear Counting Facility in Building 44, and stored radiological materials in its Radioactive

Material Storage Bunker in Building 20. The licensee ceased using the Nuclear Counting Laboratory and moved all calibration standards, environmental samples and special samples to its new radiological laboratory at 815 Terminal Road, Lansing, Michigan, prior to conducting final status surveys in November 2000 to verify that the 3500 N. Martin Luther King Jr. Blvd. facility could be released for unrestricted use.

In October 2000, the Michigan Department of Public Health requested the NRC terminate its SUB–1385 license, which also authorized the use of radioactive material in the Radioactive Material Storage Bunker in Building 20. The Michigan Department of Public Health provided a Final Status Survey Report that documented that the Radioactive Material Storage Bunker in Building 20 had been surveyed for residual contamination in 1998 and was acceptable for unrestricted use. In January 2001, the NRC terminated the SUB–1385 license and released the Radioactive Material Storage Bunker in Building 20 for unrestricted use. The licensee stated in a July 11, 2007, telephone conference, that it had not used the Radioactive Material Storage Bunker in Building 20 since it had been released for unrestricted use by the NRC in 2001.

At the 3423 N. Martin Luther King Jr. Blvd. address, the licensee maintained a facility for the calibration of portable radiation survey instruments and the storage of radioactive material. The licensee ceased using the calibration/storage facility and moved all radiation sources and environmental samples to its new calibration facility at 815 Terminal Road, Lansing, Michigan, prior to conducting final status surveys in November 2000 to verify that the 3423 N. Martin Luther King Jr. Blvd. facility could be released for unrestricted use.

The licensee conducted surveys of the facilities as part of its decommissioning activities and provided this information to the NRC to demonstrate that the radiological condition there is consistent with radiological criteria for unrestricted use in 10 CFR Part 20, Subpart E. The licensee was not required to submit a decommissioning plan to the NRC since any decommissioning activities and procedures implemented were consistent with those approved for routine operations. No radiological remediation activities are required to complete the proposed action.

Need for the Proposed Action

The licensee is requesting this license amendment because it has moved out of the facilities, and is conducting licensed activities at another location. The NRC is fulfilling its responsibilities under the Atomic Energy Act to make a decision on the proposed action for decommissioning that ensures that residual radioactivity is reduced to a level that is protective of the public health and safety and the environment, and allows the facilities to be released for unrestricted use.

Environmental Impacts of the Proposed Action

The NRC staff reviewed the information provided and surveys performed by the licensee to demonstrate that the release of the facilities is consistent with the radiological criteria for unrestricted use specified in 10 CFR 20.1402. Based on its review, the staff determined that there were no radiological impacts associated with the proposed action because no radiological remediation activities were required to complete the proposed action, and that the radiological criteria for unrestricted use in § 20.1402 have been met.

Based on its review, the staff determined that the radiological environmental impacts from the proposed action for the facilities are bounded by the ''Generic Environmental Impact Statement in Support of Rulemaking on Radiological Criteria for License Termination of NRC-Licensed Nuclear Facilities'' (NUREG–1496). Additionally, no non-radiological or cumulative impacts were identified. Therefore, the NRC has determined that the proposed action will not have a significant effect on the quality of the human environment.

Alternatives to the Proposed Action

The only alternative to the proposed action is to take no action. Under the no-action alternative, the facilities would remain under an NRC license and would not be released for unrestricted use. Denial of the license amendment request would result in no change to current conditions. The no-action alternative is not acceptable because it is inconsistent with 10 CFR 30.36, which requires that decommissioning of by-product material facilities be completed and approved by the NRC after licensed activities cease. This alternative would impose an unnecessary regulatory burden in controlling access to the former facility, and limit potential benefits from the future use of the facility.

Conclusion

The NRC staff concluded that the proposed action is consistent with the NRC's unrestricted release criteria specified in 10 CFR 20.1402. Because the proposed action will not significantly impact the quality of the human environment, the NRC staff concludes that the proposed action is the preferred alternative.

Agencies and Persons Consulted

The NRC staff has determined that the proposed action will not affect listed species or critical habitats. Therefore, no further consultation is required under Section 7 of the Endangered Species Act. Likewise, the NRC staff has determined that the proposed action is not a type of activity that has potential to cause effect on historic properties. Therefore, consultation under section 106 of the National Historic Preservation Act is not required.

The NRC consulted with the Michigan Department of Community Health (DCH). The Michigan DCH, Bureau of Health Systems, Division of Health Facilities and Services, was provided the draft EA for comment on July 13, 2007. Mr. Bruce Matkovich, Manager, Radiation Safety Section, with the Michigan DCH, responded to the NRC by e-mail on July 16, 2007, indicating that the State had no comments regarding the NRC Environmental Assessment for the release of the Michigan Department of Environmental Quality facilities.

II. Finding of No Significant Impact

On the basis of the EA in support of the proposed license amendment, the NRC has determined that the proposed action will not have a significant effect on the quality of the human environment. Thus, the NRC has not prepared an environmental impact statement for the proposed action.

III. Further Information

Documents related to this action, including the application for amendment and supporting documentation, are available electronically at the NRC's Electronic Reading Room at *http://www.nrc.gov/reading-rm/adams.html.* From this site, you can access the NRC's Agencywide Document Access and Management System (ADAMS), which provides text and image files of NRC's public documents. If you do not have access to ADAMS, or if there are problems in accessing the documents located in ADAMS, contact the NRC Public Document Room (PDR) Reference staff at 1–800–397–4209, 301–415–4737, or by e-mail to *pdr@nrc.gov.* The documents and ADAMS accession numbers related to this notice are:

1. Robert D. Skowronek, Michigan Department of Environmental Quality, letter to Patricia Pelke, U.S. Nuclear Regulatory Commission, February 22, 2007 (ADAMS Accession No. ML070590426).

2. Telephone Conversation Record, Initiated by William Snell, U.S. Nuclear Regulatory Commission, to Robert Skowronek, Michigan Department of Environmental Quality, on July 11, 2007 (ADAMS Accession No. ML071930403).

3. U.S. Nuclear Regulatory Commission, ''Environmental Review Guidance for Licensing Actions Associated with NMSS Programs,'' NUREG–1748, August 2003.

4. U.S. Nuclear Regulatory Commission, ''Generic Environmental Impact Statement in Support of Rulemaking on Radiological Criteria for License Termination of NRC-Licensed Nuclear Facilities,'' NUREG–1496, August 1994.

5. NRC, NUREG–1757, ''Consolidated NMSS Decommissioning Guidance,'' Volumes 1–3, September 2003.

Documents may also be viewed electronically on the public computers located at the NRC's PDR, O 1 F21, One White Flint North, 11555 Rockville Pike, Rockville, MD 20852. The PDR reproduction contractor will copy documents for a fee.

Dated at Lisle, Illinois, this 20th day of July 2007.

For the Nuclear Regulatory Commission.

Patrick L. Louden,

Chief, Decommissioning Branch, Division of Nuclear Materials Safety, Region III.

[FR Doc. E7–15040 Filed 8–1–07; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

Clarification to Regulatory Guide 1.200, Revision 1

AGENCY: Nuclear Regulatory Commission.

ACTION: Clarification to Regulatory Guide.

FOR FURTHER INFORMATION CONTACT: Mary Drouin, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001. Telephone: 301–415–6675; e-mail: *MXD@nrc.gov*.

Introduction

The U.S. Nuclear Regulatory Commission (NRC) is issuing a clarification to an existing guide in the agency's regulatory guide (RG) series. The NRC has developed this series to describe and make available to the public such information as methods that are acceptable to the NRC staff for implementing specific parts of the NRC's regulations, techniques that the staff uses in evaluating specific problems or postulated accidents, and data that the staff needs in its review of applications for permits and licenses.

At this time, the NRC is issuing a clarification to Revision 1 of RG 1.200, ''An Approach for Determining the Technical Adequacy of Probabilistic Risk Assessment Results for Risk-Informed Activities,'' issued January 2007. The purpose of this clarification is to provide additional explanation to the staff's regulatory position with regard to defining the technical acceptability of a probabilistic risk assessment (PRA), specifically with respect to the treatment of the sources of model uncertainty and the related assumptions in the base PRA.

The clarification to RG 1.200, Revision 1 can be found in Agencywide Documents Access and Management System (ADAMS) Accession Number ML071940235.

The clarification to Regulatory Guide 1.200, Revision 1, is intended for licensees of nuclear power plants. Revision 1 of this RG remains in effect for licensees of nuclear power plants.

The NRC staff encourages and welcomes comments and suggestions in connection with improvements to published RGs, as well as items for inclusion in RGs that are currently under development. You may submit comments by any of the following methods.

1. *Mail comments to:* Rulemaking, Directives and Editing Branch, Office of Administration, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001.

2. *Hand-deliver comments to:* Rulemaking, Directives and Editing Branch, Office of Administration, U.S. Nuclear Regulatory Commission, 11555 Rockville Pike, Rockville, Maryland 20852, between 7:30 a.m. and 4:15 p.m. on Federal workdays.

3. *Fax comments to:* Rulemaking, Directives and Editing Branch, Office of Administration, U.S. Nuclear Regulatory Commission at (301) 415–5144.

4. Direct requests for technical information about this clarification to Revision 1 of RG 1.200 to Ms. Mary Drouin at (301) 415–6675 or *MXD@nrc.gov*.

RGs are available for inspection or downloading through the NRC's public Web site at *http://www.nrc.gov/reading-rm/doc-collections/reg-guides/*. In addition, this clarification to Revision 1 of RG 1.200 is available for inspection or downloading through the Agencywide Documents Access and Management System (ADAMS) at *http://www.nrc.gov/reading-rm/adams.html* under ADAMS Accession No. ML071940235.

The clarification to Revision 1 of RG 1.200 and other related publicly available documents can also be viewed electronically on computers in the NRC's Public Document Room (PDR), which is located at 11555 Rockville Pike, Rockville, Maryland. The reproduction contractor at the PDR will make copies of documents for a fee. The mailing address for the PDR is USNRC, PDR, Washington, DC 20555–0001. The PDR can also be reached by telephone at (301) 415–4737 or (800) 397–4205, by fax at (301) 415–3548, and by e-mail to *PDR@nrc.gov*.

RGs are not copyrighted, and Commission approval is not required to reproduce them.

(5 U.S.C. 552(a))

Dated at Rockville, Maryland, this 27th day of July, 2007.

For the U.S. Nuclear Regulatory Commission.

Farouk Eltawila,

Director, Division of Risk Assessment and Special Projects, Office of Nuclear Regulatory Research.

[FR Doc. E7–15036 Filed 8–1–07; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

NUREG–1556, Volume 9, Revision 2, ''Consolidated Guidance About Materials Licenses Program-Specific Guidance About Medical Use Licenses; Draft Guidance Document for Comment

AGENCY: Nuclear Regulatory Commission.

ACTION: Notice of availability for public comment.

SUMMARY: The Nuclear Regulatory Commission (NRC) has amended its regulations to include jurisdiction over certain radium sources, accelerator-produced radioactive materials, and certain naturally occurring radioactive material, as required by the Energy Policy Act of 2005 (EPAct), which was signed into law on August 8, 2005. The EPAct expanded the Atomic Energy Act of 1954 definition of byproduct material to include these radioactive materials. Subsequently, these radioactive materials were placed under NRC's regulatory authority. NRC is revising its regulations to provide a regulatory framework that includes these newly added radioactive materials. See SECY–07–0062, ''Final Rule: Requirements for

Expanded Definition of Byproduct Material,'' dated April 3, 2007, for information on that rulemaking.

Two licensing guidance documents in the NUREG–1556 series are being revised along with these new regulations to provide guidance related to the new requirements: (1) NUREG–1556, Volume 13, Revision 1, ''Consolidated Guidance About Materials Licenses—Program-Specific Guidance About Commercial Radiopharmacy Licenses,'' and (2) NUREG–1556, Volume 9, Revision 2, ''Consolidated Guidance About Materials Licenses—Program Specific Guidance About Medical Use Licenses.'' A new volume in the NUREG–1556 series has also been developed to address the production of radioactive material using an accelerator. This NUREG is entitled NUREG–1556, Volume 21, ''Consolidated Guidance About Materials Licenses—Program-Specific Guidance About Possession Licenses for Production of Radioactive Material Using an Accelerator.''

This notice is announcing the availability of one of these three licensing guidance documents for public comment: NUREG–1556, Volume 9, Revision 2. The other two NUREGs were previously noticed for public comment: (1) NUREG–1556, Volume 13, Revision 1, on July 3, 2007 (72 FR 36526), and (2) NUREG–1556, Volume 21, on May 29, 2007 (72 FR 29555).

DATES: Please submit comments on NUREG–1556, Volume 9, Revision 2, by September 4, 2007. Comments received after this date will be considered if practical to do so, but the NRC staff is able to ensure consideration only for those comments received on or before this date.

ADDRESSES: NUREG–1556, Volume 9, Revision 2, ''Consolidated Guidance About Materials Licenses—Program-Specific Guidance About Medical Use Licenses,'' Draft Report for Comment, is available for inspection and copying for a fee at the NRC's Public Document Room (PDR), Public File Area O–1F21, One White Flint North, 11555 Rockville Pike, Rockville, Maryland. Publicly available documents created or received at the NRC after November 1, 1999, are available electronically at the NRC's Electronic Reading Room at *http://www.nrc.gov/NRC/ADAMS/index.html*. From this site, the public can gain entry into the NRC's Agencywide Document Access and Management System (ADAMS), which provides text and image files of the NRC's public documents. The ADAMS Accession Number for NUREG–1556, Volume 9, Revision 2, is ML071860070. If you do not have access to ADAMS or if there are problems in accessing the documents located in ADAMS, contact the NRC PDR Reference staff at 1–800–397–4209, 301–415–4737, or by e-mail to *pdr@nrc.gov*.

The document will also be posted on NRC's public Web site at: (1) *http://www.nrc.gov/reading-rm/doc-collections/nuregs/staff/sr1556/* on the ''Consolidated Guidance About Materials Licenses (NUREG–1556)'' Web site page, and (2) *http://www.nrc.gov/reading-rm/doc-collections/nuregs/docs4comment.html* on the ''Draft NUREG Series Publications for Comment.'' It will also be posted on the Office of Federal and State Materials and Environmental Management Programs' NARM (Naturally-Occurring and Accelerator-Produced Radioactive Material) Toolbox Web site page at: *http://nrc-stp.ornl.gov/narmtoolbox.html* under the heading of ''Licensing Guidance.''

A free single copy, to the extent of supply, may be requested by writing to the Office of the Chief Information Officer, Reproduction and Distribution Services, U.S. Nuclear Regulatory Commission, Printing and Graphics Branch, Washington, DC 20555–0001; facsimile: 301–415–2289; e-mail: *Distribution@nrc.gov*.

Please submit comments to Chief, Rulemaking, Directives and Editing Branch, Division of Administrative Services, Office of Administration, U.S. Nuclear Regulatory Commission, Washington, DC, 20555–0001. You may also deliver comments to 11545 Rockville Pike, Rockville, MD, between 7:30 a.m. and 4:30 p.m. Federal workdays, or by e-mail to: *nrcrep@nrc.gov*.

FOR FURTHER INFORMATION CONTACT: Torre Taylor, Division of Intergovernmental Liaison and Rulemaking, Office of Federal and State Materials and Environmental Management Programs, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001, telephone (301) 415–7900, e-mail: *tmt@nrc.gov*.

SUPPLEMENTARY INFORMATION:

Background

On August 8, 2005, the President signed into law the EPAct. Among other provisions, section 651(e) of the EPAct expanded the definition of byproduct material as defined in section 11e. of the Atomic Energy Act of 1954 (AEA), placing additional byproduct material under the NRC's jurisdiction, and required the Commission to provide a regulatory framework for licensing and regulating this additional byproduct material.

Specifically, section 651(e) of the EPAct expanded the definition of byproduct material by: (1) Adding any discrete source of radium-226 that is produced, extracted, or converted after extraction, before, on, or after the date of enactment of the EPAct for use for a commercial, medical, or research activity; or any material that has been made radioactive by use of a particle accelerator and is produced, extracted, or converted after extraction, before, on, or after the date of enactment of the EPAct for use for a commercial, medical, or research activity (Section 11e.(3) of the AEA); and (2) adding any discrete source of naturally occurring radioactive material, other than source material, that the Commission, in consultation with the Administrator of the Environmental Protection Agency, the Secretary of the Department of Energy, the Secretary of the Department of Homeland Security, and the head of any other appropriate Federal agency, determines would pose a threat similar to the threat posed by a discrete source of radium-226 to the public health and safety or the common defense and security; and is extracted or converted after extraction before, on, or after the date of enactment of the EPAct for use in a commercial, medical, or research activity (Section 11e.(4) of the AEA).

NRC is revising its regulations to provide a regulatory framework that includes these newly added radioactive materials. *See* SECY–07–0062, ''Final Rule: Requirements for Expanded Definition of Byproduct Material,'' dated April 3, 2007, for information on that rulemaking.

Discussion

As part of the rulemaking effort to address the mandate of the EPAct, the NRC also evaluated the need to revise certain licensing guidance documents to provide necessary guidance to applicants in preparing license applications to include the use of the newly added radioactive material as byproduct material. Two NUREG–1556 documents are being revised to provide additional guidance to licensees: (1) NUREG–1556, Volume 13, Revision 1, ''Consolidated Guidance About Materials Licenses—Program-Specific Guidance About Commercial Radiopharmacy Licenses,'' and (2) NUREG–1556, Volume 9, Revision 2, ''Consolidated Guidance About Materials Licenses—Program-Specific Guidance About Medical Use Licenses.'' Additionally, a new NUREG–1556 volume has been developed as Volume 21 to address production of radioactive

material using an accelerator. This NUREG–1556, Volume 21, is entitled: ''Consolidated Guidance About Materials Licenses—Program-Specific Guidance About Possession Licenses for Production of Radioactive Material Using an Accelerator.''

At this time, NRC is announcing the availability for public comment NUREG–1556, Volume 9, Revision 2, ''Consolidated Guidance About Materials Licenses—Program-Specific Guidance About Medical Use Licenses,'' Draft Report for Comment. The other two NUREGs were previously noticed for public comment: (1) NUREG–1556, Volume 13, Revision 1, on July 3, 2007 (72 FR 36526) and (2) NUREG–1556, Volume 21, on May 29, 2007 (72 FR 29555).

NUREG–1556, Volume 9, Revision 2, ''Consolidated Guidance About Materials Licenses—Program-Specific Guidance About Medical Use Licenses,'' provides guidance for applicants in preparing their license applications for the medical use of byproduct material. Volume 9 is being revised primarily to provide additional guidance related to the NARM rule, as discussed above.

In the draft final rule for the NARM rulemaking, the concept of consortiums and noncommercial distribution was addressed. In summary, because of the short-lived radionuclides associated with Positron Emission Tomography (PET), the source of these radioactive materials needs to be produced in the facility of use or within close proximity. The NRC developed a new regulatory process based on existing practices for consortiums and noncommercial distribution. For this purpose, educational institutions, medical use facilities or Federal facilities may form consortiums with adjacent or nearby hospitals to jointly own or share in the operation and maintenance costs of the PET radionuclide production facility. This is discussed in more detail in SECY–07–0062, ''Final Rule: Requirements for Expanded Definition of Byproduct Material,'' dated April 3, 2007, and within the draft **Federal Register** notice that is provided as an attachment to SECY–07–0062.

NUREG–1556, Volume 9, Revision 2, provides guidance for applicants in licensees about consortiums and noncommercial distribution in Sections 1 and 8, and in Appendix AA. NRC is requesting specific comments on this guidance to ensure that it is clear and easily understood by affected stakeholders.

It is also being revised to clarify training and experience requirements, replaces NRC Form 313A with six new NRC Form 313A forms specific to types of authorizations. References and information related to Subpart J of 10 CFR Part 35 have been removed since these regulatory requirements expired on October 25, 2005.

Additionally, other minor changes are being made that are administrative in nature, such as updating the Agreement State section and updating references. Also, information related to identifying and protecting sensitive information is being updated.

NRC is only requesting comments on the specific changes in this document related to those revisions discussed above. NRC will make corrections if any errors or editorial corrections are noted; however, any comments not related to these specific changes will be evaluated during the next routine review of NUREG–1556, Volume 9.

Dated at Rockville, Maryland, this 26th day of July, 2007.

For the Nuclear Regulatory Commission.

Dennis K. Rathbun,

Director, Division of Intergovernmental, Liaison and Rulemaking, Office of Federal and State Materials, and Environmental Management Programs.

[FR Doc. E7–15049 Filed 8–1–07; 8:45 am]

BILLING CODE 7590–01–P

OFFICE OF MANAGEMENT AND BUDGET

Amending Federal Financial Assistance-Related Forms to Include Universal Identifier

AGENCY: Office of Federal Financial Management and Office of Information and Regulatory Affairs, Office of Management and Budget.

ACTION: Notice; request for comments.

SUMMARY: The Office of Management and Budget (OMB) proposes to authorize each Federal agency that receives applications for Federal financial assistance to add a field for the applicant's Dun and Bradstreet Data Universal Numbering System (DUNS) number to application forms previously approved by OMB. This proposed update would broaden the directive's effect to all forms of Federal financial assistance covered by the Federal Funding Accountability and Transparency Act (the ''Act'') including grants, subgrants, loans, awards, cooperative agreements, and other forms of financial assistance.

DATES: Comments are due by September 4, 2007.

ADDRESSES: Comments should be addressed to Marguerite Pridgen, Office of Federal Financial Management, Office of Management and Budget, 725 17th Street, NW., Washington, DC 20503; telephone 202–395–7844; fax 202–395–3952; e-mail *mpridgen@omb.eop.gov.* Due to potential delays in OMB's receipt and processing of mail sent through the U.S. Postal Service, we encourage respondents to submit comments electronically to ensure timely receipt. We cannot guarantee that comments mailed will be received before the comment closing date. Please include ''Amending Forms for DUNS'' in the subject line of the email message; please also include the full body of your comments in the text of the message and as an attachment. Include your name, title, organization, postal address, telephone number, and e-mail address in your message.

FOR FURTHER INFORMATION CONTACT: Marguerite Pridgen at the addresses noted above.

Authority: Sec. 2, Pub. L. 109–282, 102 Stat. 1186.

SUPPLEMENTARY INFORMATION: The Office of Management and Budget (OMB) proposes to authorize each Federal agency that receives applications for Federal financial assistance to add a field for the applicant's Dun and Bradstreet Data Universal Numbering System (DUNS) number to application forms previously approved by OMB. The intent of authorizing agencies to add the field without additional OMB approval is to enable the agencies to require applicants other than individual persons to provide DUNS numbers for all applications submitted on or after October 1, 2007. This proposal thereby would update the policy in the OMB directive issued on June 27, 2003 [68 FR 38403], ''Use of a Universal Identifier by Grant Applicants.'' That directive authorized agencies to add the DUNS number as a required field for applications leading to the award of two specific forms of Federal financial assistance: Grants and cooperative agreements. This proposed update would broaden the directive's effect to all forms of Federal financial assistance covered by the Federal Funding Accountability and Transparency Act (the ''Act'') including grants, subgrants, loans, awards, cooperative agreements, and other forms of financial assistance. The reason for the proposed update is that the DUNS number will be used as the unique identifier for recipient entities that is required by the Federal Funding Accountability and Transparency Act of 2006 (Pub. L. 109–282). Under that Act, OMB must ensure the establishment and maintenance of a location on the World Wide Web

through which the public may access and search data on agencies' awards. The unique identifier of the recipient entity is one of the data elements that the Act requires for each award. Note that the Civilian Agency Acquisition Council and the Defense Acquisition Regulations Council (Councils) are addressing the Federal Funding Accountability and Transparency Act requirements for contracts, subcontracts, purchase orders, task orders and delivery orders under separate **Federal Register** notices.

Danny Werfel,

Deputy Controller.

[FR Doc. E7–15044 Filed 8–1–07; 8:45 am]

BILLING CODE 3110–01–P

OFFICE OF THE UNITED STATES TRADE REPRESENTATIVE

Notice of Effective Date for Goods of Mexico for Certain Modifications of the NAFTA Rules of Origin

AGENCY: Office of the United States Trade Representative.

ACTION: Notice of effective date.

SUMMARY: In Proclamation 8111 of February 28, 2007, the President modified the rules of origin for certain goods of Mexico under the North American Free Trade Agreement (the ''NAFTA'') incorporated in the Harmonized Tariff Schedule of the United States (the ''HTS''). The proclamation stated that the modifications would be effective on the date to be announced in the **Federal Register** by the United States Trade Representative (the ''USTR'') and would apply to goods of Mexico that are entered, or withdrawn from warehouse for consumption, on or after the date indicated in the proclamation. The purpose of this notice is to announce that the effective date for the modifications is July 30, 2007. The changes were printed in the **Federal Register** of March 6, 2007 (72 FR 10028).

FOR FURTHER INFORMATION CONTACT: For further information, please contact Caroyl Miller, Deputy Special Textile Negotiator, Office of the United States Trade Representative, 600 17th Street, NW., Washington, DC 20508, fax number, (202) 395–5639.

SUPPLEMENTARY INFORMATION: Presidential Proclamation 6641 of December 15, 1993 implemented the North American Free Trade Agreement (the ''NAFTA'') with respect to the United States and, pursuant to the North American Free Trade Agreement Implementation Act (Pub. L. 103–182) (the ''NAFTA Implementation Act''), incorporated in the Harmonized Tariff Schedule of the United States (the ''HTS'') the tariff modifications and rules of origin necessary or appropriate to carry out the NAFTA. Section 202 of the NAFTA Implementation Act (19 U.S.C. 3332) provides rules for determining whether goods imported into the United States originate in the territory of a NAFTA party and thus are eligible for the tariff and other treatment contemplated under the NAFTA. Section 202(q) of the NAFTA Implementation Act (19 U.S.C. 3332(q)) authorizes the President to proclaim, as a part of the HTS, the rules of origin set out in the NAFTA and to proclaim modifications to such previously proclaimed rules of origin, subject to the consultation and layover requirements of section 103(a) of the NAFTA Implementation Act (19 U.S.C. 3313(a)).

The President determined that the modifications to the HTS contained in Proclamation 8811 pursuant to sections 201 and 202 of the NAFTA Implementation Act were appropriate and proclaimed such changes with respect to goods of Mexico entered, or withdrawn from warehouse for consumption, on or after the date indicated in the Annex to that Proclamation. The President decided that the effective date of the modifications shall be announced by the United States Trade Representative (USTR).

On March 15, 2007, the government of Mexico obtained the necessary authorization to implement the rule of origin changes with respect to goods of the United States. Subsequently, officials from the government of Mexico and the government of the United States agreed to implement these changes with respect to each other's eligible goods, effective July 30, 2007.

Scott D. Quesenberry,

Special Textile Negotiator.

[FR Doc. E7–15034 Filed 8–1–07; 8:45 am]

BILLING CODE 3190–W7–P

POSTAL SERVICE BOARD OF GOVERNORS

Sunshine Act Meeting

DATE AND TIME: Tuesday, August 7, 2007, at 12:30 p.m.; and Wednesday, August 8, 2007, at 8:30 a.m. and 10:30 a.m.

PLACE: Washington, DC, at U.S. Postal Service Headquarters, 475 L'Enfant Plaza, SW., in the Benjamin Franklin Room.

STATUS: August 7–12:30 p.m.—Closed; August 8–8:30 a.m.—Open; August 8–10:30 a.m.—Closed.

MATTERS TO BE CONSIDERED

Tuesday, August 7 at 12:30 p.m. (Closed)

1. Strategic Issues.
2. Preliminary Report on Goals and Performance Assessment for Fiscal Year 2008.
3. Financial Update.
4. Preliminary Fiscal Year 2008 Integrated Financial Plan and Financial Outlook.
5. Rate Case Update.
6. Labor Negotiations Update.
7. Personnel Matters and Compensation Issues.
8. Governors' Executive Session—Discussion of prior agenda items and Board Governance.

Wednesday, August 8 at 8:30 a.m. (Open)

1. Minutes of Previous Meetings, May 1–2; June 19; and July 10, 2007.
2. Remarks of the Chairman and Vice Chairman of the Board.
3. Remarks of the Postmaster General and CEO Jack Potter.
4. Committee Reports.
5. Quarterly Report on Service Performance.
6. Quarterly Report on Financial Performance.
7. Tentative Agenda for the September 25–26, 2007, meeting in Washington, DC.

Wednesday, August 8 at 10:30 a.m. (Closed)—if needed

1. Continuation of Tuesday's closed session agenda.

CONTACT PERSON FOR MORE INFORMATION: Wendy A. Hocking, Secretary of the Board, U.S. Postal Service, 475 L'Enfant Plaza, SW., Washington, DC 20260–1000. Telephone (202) 268–4800.

Wendy A. Hocking

Secretary.

[FR Doc. 07–3785 Filed 7–30–07; 4:48 pm]

BILLING CODE 7710–12–M

SECURITIES AND EXCHANGE COMMISSION

[Release No. IC–27912]

Notice of Applications for Deregistration Under Section 8(f) of the Investment Company Act of 1940

July 27, 2007.

The following is a notice of applications for deregistration under section 8(f) of the Investment Company

Act of 1940 for the month of July, 2007. A copy of each application may be obtained for a fee at the SEC's Public Reference Branch (tel. 202–551–5850). An order granting each application will be issued unless the SEC orders a hearing. Interested persons may request a hearing on any application by writing to the SEC's Secretary at the address below and serving the relevant applicant with a copy of the request, personally or by mail. Hearing requests should be received by the SEC by 5:30 p.m. on August 22, 2007, and should be accompanied by proof of service on the applicant, in the form of an affidavit or, for lawyers, a certificate of service. Hearing requests should state the nature of the writer's interest, the reason for the request, and the issues contested. Persons who wish to be notified of a hearing may request notification by writing to the Secretary, U.S. Securities and Exchange Commission, 100 F. Street, NE., Washington, DC 20549–1090.

FOR FURTHER INFORMATION CONTACT: Diane L. Titus at (202) 551–6810, SEC, Division of Investment Management, Office of Investment Company Regulation, 100 F. Street, NE., Washington, DC 20549–4041.

Portico Funds, Inc.

[File No. 811–10511]

Summary: Applicant seeks an order declaring that it has ceased to be an investment company. Applicant has never made a public offering of its securities and does not propose to make a public offering or engage in business of any kind.

Filing Dates: The application was filed on October 25, 2002, and amended on July 18, 2007.

Applicant's Address: c/o U.S. Bancorp Asset Management, Inc., U.S. Bancorp Center, 800 Nicollet Mall, Minneapolis, MN 55402.

Conseco Fund Group

[File No. 811–7839]

Summary: Applicant seeks an order declaring that it has ceased to be an investment company. On April 1, 2004, applicant transferred its assets to The Managers Trust II, based on net asset value. Expenses of $920,370 incurred in connection with the reorganization were paid by 40/86 Advisors, Inc., applicant's investment adviser, and The Managers Funds LLC, the acquiring fund's investment adviser.

Filing Dates: The application was filed on June 25, 2007, and amended on July 20, 2007.

Applicant's Address: 11825 North Pennsylvania St., Carmel, IN 46032.

First Investors Fund For Income, Inc.

[File No. 811–2107]

Summary: Applicant seeks an order declaring that it has ceased to be an investment company. On January 27, 2006, applicant transferred its assets to First Investors Income Funds, based on net asset value. Expenses of $173,081 incurred in connection with the reorganization were paid by applicant.

Filing Date: The application was filed on July 2, 2007.

Applicant's Address: 95 Wall St., New York, NY 10005.

First Investors Special Bond Fund, Inc.

[File No. 811–2981]

Summary: Applicant seeks an order declaring that it has ceased to be an investment company. On April 28, 2006, applicant transferred its assets to First Investors Life Series Funds, based on net asset value. Expenses of $2,345 incurred in connection with the reorganization were paid by applicant.

Filing Date: The application was filed on July 2, 2007.

Applicant's Address: 95 Wall St., New York, NY 10005.

First Investors Global Fund, Inc.

[File No. 811–3169]

Summary: Applicant seeks an order declaring that it has ceased to be an investment company. On January 27, 2006, applicant transferred its assets to First Investors Equity Funds, based on net asset value. Expenses of $125,979 incurred in connection with the reorganization were paid by applicant.

Filing Date: The application was filed on July 2, 2007.

Applicant's Address: 95 Wall St., New York, NY 10005.

First Investors Insured Tax Exempt Fund, Inc.

[File No. 811–2923]

First Investors New York Insured Tax Free Fund, Inc.

[File No. 811–3843]

First Investors Multi-State Insured Tax Free Fund

[File No. 811–4623]

Executive Investors Trust

[File No. 811–4927]

Summary: Each applicant seeks an order declaring that it has ceased to be an investment company. On April 28, 2006, each applicant transferred its assets to First Investors Tax Exempt Funds, based on net asset value. Expenses of $131,377, $24,636, $68,163 and $16,938, respectively, incurred in connection with the reorganizations were paid by the applicants.

Filing Date: The applications were filed on July 2, 2007.

Applicants' Address: 95 Wall St., New York, NY 10005.

Badgley Funds, Inc.

[File No. 811–8769]

Summary: Applicant seeks an order declaring that it has ceased to be an investment company. On May 24, 2007, applicant made its final liquidating distribution to shareholders, based on net asset value. Expenses of $33,041 incurred in connection with the liquidation were paid by applicant and Badgley, Phelps & Bell, applicant's investment adviser.

Filing Dates: The application was filed on May 30, 2007, and amended on July 17, 2007.

Applicant's Address: Badgley Funds, Inc., 1420 Fifth Ave., Seattle, WA 98101.

American Century Avanti Funds, Inc.

[File No. 811–10217]

Summary: Applicant seeks an order declaring that it has ceased to be an investment company. Applicant has never made a public offering of its securities and does not propose to make a public offering or engage in business of any kind.

Filing Dates: The application was filed on June 1, 2007, and amended on July 16, 2007.

Applicant's Address: 4500 Main St., Kansas City, MO 64111.

Prudential Europe Growth Fund, Inc.

[File No. 811–7167]

Summary: Applicant seeks an order declaring that it has ceased to be an investment company. On November 20, 2003, applicant transferred its assets to Jennison Global Growth Fund, a series of Prudential World Fund, Inc., based on net asset value. Expenses of approximately $248,434 incurred in connection with the reorganization were paid by applicant.

Filing Date: The application was filed on July 3, 3007.

Applicant's Address: Gateway Center Three, 100 Mulberry St., Newark, NJ 07102–4077.

First Investors Series Fund

[File No. 811–5690]

Summary: Applicant seeks an order declaring that it has ceased to be an investment company. On January 27, 2006 and April 28, 2006, applicant transferred its assets to First Investors Equity Funds, First Investors Income Funds, and First Investors Tax Exempt Funds, based on net asset value. Expenses of $422,564 incurred in

connection with the reorganization were paid by applicant.

Filing Date: The application was filed on July 2, 2007.

Applicant's Address: 95 Wall St., New York, NY 10005.

Value Line Hedged Opportunity Fund, Inc.

[File No. 811–8607].

Value Line Smaller Companies Fund, Inc.

[File No. 811–21608].

Value Line Value Fund, Inc.

[File No. 811–21639].

Summary: Each applicant seeks an order declaring that it has ceased to be an investment company. Applicants have never made a public offering of their securities and do not propose to make a public offering or engage in business of any kind.

Filing Dates: The applications were filed on May 30, 2007, and amended on July 11, 2007.

Applicants' Address: 220 East 42nd St., New York, NY 10017.

Vestaur Securities Fund

[File No. 811–2320]

Summary: Applicant, a closed-end investment company, seeks an order declaring that it has ceased to be an investment company. On May 23, 2005, applicant transferred its assets to Evergreen Fixed Income Trust, based on net asset value. Expenses of $147,380 incurred in connection with the reorganization were paid by applicant and Evergreen Investment Management Company, LLC, investment adviser to both applicant and the acquiring fund.

Filing Dates: The application was filed on October 12, 2006, and amended on July 13, 2007.

Applicant's Address: 200 Berkeley St., Boston, MA 02116.

4086 Series Trust

[File No. 811–3641]

Summary: Applicant seeks an order declaring that it has ceased to be an investment company. On March 29, 2007, three series of 40|86 Series Trust, Fixed Income Portfolio, Government Securities Portfolio and Money Market Portfolio, were liquidated and cash was distributed to each series' respective shareholders pro rata based on share ownership. On May 2, 2007, the shares of the two remaining series of 40|86 Series Trust, Equity Portfolio and Balanced Portfolio, were redeemed in kind by the sole shareholder of each series, which is unaffiliated with the investment adviser of 40|86 Series Trust. Expenses of approximately $ 177,500 incurred in connection with the liquidation were paid by 40|86 Advisors, Inc., applicant's investment adviser.

Filing Dates: The application was filed on June 13, 2007, and amended on July 18, 2007 and July 20, 2007.

Applicant's Address: 11825 N. Pennsylvania Street, Carmel, IN 46032.

Huntington VA Funds

[File No. 811–9481]

Summary: Applicant seeks an order declaring that it has ceased to be an investment company. On June 23, 2006, Applicant made a distribution of its assets to its shareholders, based on net asset value, in connection with the merger of Applicant (a Massachusetts business trust) into the Huntington Funds (a Delaware statutory trust). Expenses of $138,306.12 were incurred in connection with the merger. These expenses were shared pro-rata among all portfolios of Applicant and the Huntington Funds.

Filing Dates: The application was filed on March 6, 2007, and amended on June 28, 2007.

Applicant's Address: Huntington VA Funds, 5800 Corporate Drive, Pittsburgh, Pennsylvania 15237–7010.

For the Commission, by the Division of Investment Management, pursuant to delegated authority.

Florence E. Harmon,

Deputy Secretary.

[FR Doc. E7–14913 Filed 8–1–07; 8:45 am]

BILLING CODE 8010–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. IC–27916; 812–13358]

HealthShares, Inc., et al.; Notice of Application

July 27, 2007.

AGENCY: Securities and Exchange Commission (''Commission'').

ACTION: Notice of application to amend a prior order under section 6(c) of the Investment Company Act of 1940 (''Act'') for an exemption from sections 2(a)(32), 5(a)(1), 22(d), and 24(d) of the Act and rule 22c–1 under the Act, and under sections 6(c) and 17(b) of the Act for an exemption from sections 17(a)(1) and (a)(2) of the Act.

Summary of Application: Applicants request an order to amend a prior order that permits: (a) Open-end management investment companies, whose series are based on certain equity securities indices created by an affiliate of the investment adviser, to issue shares redeemable only in large aggregations; (b) secondary market transactions in the shares of the series to occur at negotiated prices; (c) dealers to sell shares to purchasers in the secondary market unaccompanied by a prospectus when prospectus delivery is not required by the Securities Act of 1933 (''Securities Act''); and (d) certain affiliated persons of the series to deposit securities into, and receive securities from, the series in connection with the purchase and redemption of aggregations of the series' shares (''Prior Order'').[1] Applicants seek to amend the Prior Order in order to offer additional series that would hold equity and fixed income securities and to provide that certain representations and undertakings contained in the Prior Order shall not apply to a series where an entity that creates, compiles, sponsors, or maintains an underlying index is not an affiliated person, or an affiliated person of an affiliated person, of the series, its investment adviser, distributor, promoter, or any sub-adviser to the series. In addition, the order would delete a condition related to future relief in the Prior Order.

Applicants: HealthShares, Inc., XShares Advisors LLC (formerly, X–Shares Advisors, LLC) (the ''Advisor''), XShares Group LLC (formerly, Ferghana-Wellspring LLC) and TDAX Funds, Inc.

Filing Dates: The application was filed on January 19, 2007 and amended on June 4, 2007 and on July 20, 2007. Applicants have agreed to file an amendment during the notice period, the substance of which is reflected in this notice.

Hearing or Notification of Hearing: An order granting the requested relief will be issued unless the Commission orders a hearing. Interested persons may request a hearing by writing to the Commission's Secretary and serving applicants with a copy of the request, personally or by mail. Hearing requests should be received by the Commission by 5:30 p.m. on August 17, 2007, and should be accompanied by proof of service on applicants, in the form of an affidavit or, for lawyers, a certificate of service. Hearing requests should state the nature of the writer's interest, the reason for the request, and the issues contested. Persons who wish to be notified of a hearing may request notification by writing to the Commission's Secretary.

ADDRESSES: Secretary, U.S. Securities and Exchange Commission, 100 F

[1] HealthShares, Inc., et al., Investment Company Act Release Nos. 27553 (November 16, 2006) (notice) and 27594 (December 7, 2006) (order).

Street, NE., Washington, DC 20549–1090. Applicants: Attn. Anthony F. Dudzinski, Esq., 420 Lexington Avenue, Suite 2550, New York, NY 10170; and Michael R. Rosella, Esq., Paul, Hastings, Janofsky & Walker LLP, Park Avenue Tower, 75 East 55th Street, First Floor, New York, NY 10022.

FOR FURTHER INFORMATION CONTACT: Deepak T. Pai, Senior Counsel, at (202) 551–6876 or Mary Kay Frech, Branch Chief, at (202) 551–6821 (Division of Investment Management, Office of Investment Company Regulation).

SUPPLEMENTARY INFORMATION: The following is a summary of the application. The complete application may be obtained for a fee at the Commission's Public Reference Branch, 100 F. Street, NE., Washington, DC 20549–0102 (tel. 202–551–5850).

Applicants' Representations

1. HealthShares, Inc. is an open-end management investment company organized as a Maryland corporation and is comprised of multiple series (the ''Initial Funds''). TDAX Funds, Inc. (the ''Company'') is an open-end management investment company organized as a Maryland corporation that is comprised of five (5) series of underlying ''lifecycle'' portfolios (each a ''New Fund'' and together, the ''New Funds''). The Advisor, which is registered as an investment adviser under the Investment Advisers Act of 1940 (the ''Advisers Act''), serves as the investment adviser to the Initial Funds and will serve as investment adviser to the New Funds. The Advisor expects to enter into sub-advisory agreements with Amerivest Investment Management, LLC and BNY Investment Advisors (collectively, ''Sub-Advisors'') to serve as sub-advisers to the New Funds. Each Sub-Advisor is registered as an investment adviser under the Advisers Act. Neither Sub-Advisor is an affiliated person, or an affiliated person of an affiliated person, of the Advisor or Zacks Investment Research Inc. (''Zacks''), the creator of the Underlying Indexes (as defined below). ALPS Distributors, Inc. (the ''Distributor''), a broker-dealer registered under the Securities Exchange Act of 1934 (the ''Exchange Act''), will serve as the principal underwriter and distributor for the New Funds.

2. The applicants are currently permitted to offer the Initial Funds based on equity securities indices developed by an affiliated person of the Advisor in reliance on the Prior Order. Applicants seek to amend the Prior Order to permit the offering of the New Funds, as well as series that may be created in the future that are advised by the Advisor or an entity controlled by or under common control with the Advisor and that comply with the terms and conditions of the Prior Order, as modified by the requested relief (the ''Future Funds,'' together with the Initial Funds and the New Funds, the ''Funds''). The New Funds would operate in a manner identical to the Initial Funds that are subject to the Prior Order, except as described in the application.

3. The investment objective of each New Fund is to track the performance, before fees and expenses, of a particular underlying index (''Underlying Index'') by investing in a portfolio of securities generally consisting of the component securities (''Component Securities'') of the Underlying Index.[2] Each Underlying Index is a ''lifestyle'' index that rebalances allocations among asset classes over time in an attempt to maximize capital appreciation at a target date. No entity that creates, compiles, sponsors, or maintains an Underlying Index is or will be an affiliated person, as defined in section 2(a)(3) of the Act, or an affiliated person of an affiliated person, of the Company, the Advisor, the Distributor, promoter, or any sub-adviser to a New Fund.

4. The applicants represent that the Component Securities of each Underlying Index include equity securities of U.S. and international companies (including common stocks and real estate investment trusts), American Depository Receipts based on equity securities of international companies, and fixed-income securities (including bonds, treasury bills and notes, mortgage real estate investment trusts, U.S. government agency mortgage pass-through securities, cash equivalents or short-term money market instruments). The fixed income securities included in the Component Securities will be investment grade fixed income securities and will not include corporate mortgage-backed securities, asset-backed securities, high yield bonds, or Rule 144A securities.[3] Each New Fund will attempt to track its Underlying Index by investing at least 90%, and typically substantially all, of its assets in the securities that make up the Underlying Index, holding each security in approximately the same proportion as its weighting in the Underlying Index.[4] Each New Fund also may invest up to 10% of its assets in futures contracts, options on futures contracts, options, as well as swaps on securities of companies in the Underlying Index. Applicants expect that the returns of each New Fund should be highly correlated with the returns of its Underlying Index, expecting that the correlation coefficient between each New Fund and its Underlying Index will exceed 95% over extended periods.

5. The Prior Order relates to Funds that track indices created by an affiliated person of the Advisor. Because such Funds could introduce potential conflicts of interest, the Prior Order contains certain representations and undertakings relating to the transparency of the methodology for those underlying indices, and the establishment of certain policies and procedures to limit communication between index personnel and employees of the Advisor and any sub-adviser. Applicants assert that these conflicts of interest do not exist where the index creator is not an affiliated person, or an affiliated person of an affiliated person, of an exchange-traded fund or its investment adviser or any sub-adviser, such as in the case of the New Funds. Applicants therefore seek to amend the Prior Order to provide that the relevant representations and undertakings shall not apply to a Fund where an entity that creates, compiles, sponsors, or maintains the underlying index is not an affiliated person, as defined in section 2(a)(3) of the Act, or an affiliated person of an affiliated person, of the Fund, the Advisor, the Distributor, promoter or any sub-adviser to a Fund.

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[2] The Underlying Indices for the New Funds are the Zacks 2010 Lifecycle Index, Zacks 2020 Lifecycle Index, Zacks 2030 Lifecycle Index, Zacks 2040 Lifecycle Index, and Zacks In-Target Lifecycle Index.

[3] If an underlying index of a Future Fund includes restricted securities eligible for resale pursuant to rule 144A under the Securities Act (''Rule 144A securities''), applicants acknowledge that in accepting deposit securities (''Deposit Securities'') and satisfying redemptions with securities that are Rule 144A securities, the Future Funds will comply with the conditions of rule 144A. The prospectus for a Future Fund would also state that an authorized participant that is not a ''Qualified Institutional Buyer,'' as defined in rule 144A under the Securities Act, will not be able to receive, as part of a redemption, restricted securities eligible for resale under rule 144A.

[4] The New Funds may seek to track the performance of any U.S. government agency mortgage pass-through securities included in an Underlying Index by investing in ''to-be announced'' (''TBA'') transactions on such securities. A TBA transaction is a method of trading mortgage-backed securities where the buyer and seller agree upon general trade parameters such as agency, settlement date, par amount and price. The actual pools delivered are determined two days prior to settlement date. A New Fund may designate the mortgage pass-through TBAs to be included in the Deposit Securities and will accept ''cash in lieu'' of delivery of the designated mortgage pass-through TBAs. The amount of substituted cash in the case of TBA transactions will be equivalent to the value of the TBA transaction listed as a Deposit Security.

6. Applicants state that the New Funds will operate in a manner identical to the operation of the Initial Funds in the Prior Order, except as specifically noted by applicants (and summarized in this notice), and will comply with all of the terms, provisions and conditions of the Prior Order, as amended by the present application. Applicants believe that the requested relief continues to meet the necessary exemptive standards.

7. Applicants also seek to amend the Prior Order to modify the terms under which the applicants, in the future, may offer Future Funds based on other equity or fixed income indices. The Prior Order is currently subject to a condition that does not permit applicants to register the shares of any Future Fund by means of filing a post-effective amendment to a Fund's registration statement or by any other means, unless applicants have requested and received with respect to such Future Fund, either exemptive relief from the Commission or a no-action letter from the Division of Investment Management of the Commission, or if the Future Fund could be listed on a national securities exchange (''Exchange'') without the need for a filing pursuant to rule 19b–4 under the Exchange Act.

8. The order would amend the Prior Order to delete this condition. Any Future Funds will (a) be advised by the Advisor or an entity controlled by or under common control with the Advisor; and (b) comply with the terms and conditions of the Prior Order, as amended by any order issued in connection with the present application.

9. Applicants believe that the modification of the future relief available under the Prior Order would be consistent with sections 6(c) and 17(b) of the Act and that granting the requested relief will facilitate the timely creation of Future Funds and the commencement of secondary market trading of such Future Funds by removing the need to seek additional exemptive relief. Applicants submit that the terms and conditions of the Prior Order, as amended by the requested order, are appropriate for the Funds and would remain appropriate for Future Funds. Applicants also submit that tying exemptive relief under the Act to the ability of a Future Fund to be listed on an Exchange without the need for a rule 19b–4 filing under the Exchange Act is not necessary to meet the standards under sections 6(c) and 17(b) of the Act.

Applicants' Condition

Applicants agree that any amended order granting the requested relief will be subject to the same conditions as those imposed by the Prior Order, except for condition 1 to the Prior Order, which will be deleted.

For the Commission, by the Division of Investment Management, pursuant to delegated authority.

Jill M. Peterson,

Assistant Secretary.

[FR Doc. E7–15021 Filed 8–1–07; 8:45 am]

BILLING CODE 8010–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. IC–27915; 812–13394]

The BISYS Group, Inc., et al.; Temporary Order

July 27, 2007.

AGENCY: Securities and Exchange Commission (''Commission'').

ACTION: Temporary order under section 9(c) of the Investment Company Act of 1940 (''Act'').

SUMMARY: Applicants have received a temporary order exempting them from section 9(a) of the Act, with respect to an injunction entered against The BISYS Group, Inc. (''BISYS'') on or about July 27, 2007 by the United States District Court for the Southern District of New York (the ''Injunction''), until the Commission takes final action on an application for a permanent order or, if earlier, September 24, 2007.

Applicants: BISYS, BISYS Fund Services Limited Partnership, BNY Hamilton Distributors, Inc., Funds Distributor, Inc., Heartland Investor Services, LLC, Mercantile Investment Services, Inc., Performance Funds Distributor, Inc., ProFunds Distributors, Inc. and Victory Capital Advisers, Inc. (collectively, other than BISYS, the ''Underwriter Applicants'', and, together with BISYS, the ''Applicants'').[1]

Filing Date: The application was filed on June 6, 2007.

ADDRESSES: Secretary, U.S. Securities and Exchange Commission, 100 F Street, NE., Washington, DC 20549–1090. Applicants, BISYS, 105 Eisenhower Parkway, Roseland, New Jersey 07068, the Underwriter Applicants, 100 Summer Street, 15th Floor, Boston, Massachusetts 02110.

[1] Applicants request that any relief granted pursuant to the application also apply to any other company of which BISYS is an affiliated person or may become an affiliated person in the future (together with the Applicants, the ''Covered Persons'').

FOR FURTHER INFORMATION CONTACT: Shannon Conaty, Senior Counsel, at (202) 551–6827, or Janet M. Grossnickle, Branch Chief, at (202) 551–6821, (Division of Investment Management, Office of Investment Company Regulation).

SUPPLEMENTARY INFORMATION: The application may be obtained for a fee at the Commission's Public Reference Desk, 100 F Street, NE., Washington, DC 20549–0102 (tel. 202–551–8090).

Applicants' Representations

1. BISYS, a Delaware corporation, directly and through wholly-owned subsidiaries, provides products and support services to financial institutions, including insurance companies, banks and mutual funds. Each of the Underwriter Applicants is an indirect, wholly-owned subsidiary of BISYS and serves as principal underwriter for one or more registered management investment companies (''Funds''). Each Underwriter Applicant is registered with the Commission as a broker-dealer under section 15 of the Securities Exchange Act of 1934 (''Exchange Act'').

2. On or about July 27, 2007, the United States District Court for the Southern District of New York entered the Injunction against BISYS in a matter brought by the Commission.[2] The Commission alleged in the complaint (''Complaint'') that BISYS violated sections 13(a) and 13(b)(2)(A) and (B) of the Exchange Act and rules 12b–20, 13a–1, 13a–11 and 13a–13 thereunder when it engaged in improper accounting practices that resulted in an overstatement of BISYS's financial results for fiscal years 2001 through 2003 by about $180 million. Without admitting or denying the allegations in the Complaint, except as to jurisdiction, BISYS consented to the entry of the Injunction and the payment of disgorgement and prejudgment interest.

Applicants' Legal Analysis

1. Section 9(a)(2) of the Act, in relevant part, prohibits a person who has been enjoined from engaging in or continuing any conduct or practice in connection with the purchase or sale of a security from acting, among other things, as an investment adviser or depositor of any registered investment company or a principal underwriter for any registered open-end investment company, registered unit investment trust or registered face-amount certificate company. Section 9(a)(3) of

[2] *United States Securities and Exchange Commission* v. *The BISYS Group, Inc.*, 07–CIV–4010 (KMK) (S.D.N.Y. May 23, 2007).

the Act extends the prohibitions of section 9(a)(2) to a company any affiliated person of which has been disqualified under the provisions of section 9(a)(2). Section 2(a)(3) of the Act defines ''affiliated person'' to include any person directly or indirectly controlling, controlled by, or under common control with, the other person. Applicants state that BISYS is an affiliated person of each of the other Applicants. Applicants state that the entry of the Injunction would result in Applicants being subject to the disqualification provisions of section 9(a) of the Act.

2. Section 9(c) of the Act provides that the Commission shall grant an application for exemption from the disqualification provisions of section 9(a) if it is established that these provisions, as applied to the Applicants, are unduly or disproportionately severe or that the Applicants' conduct has been such as not to make it against the public interest or the protection of investors to grant the exemption. Applicants have filed an application pursuant to section 9(c) seeking a temporary and permanent order exempting the Applicants and the other Covered Persons from the disqualification provisions of section 9(a) of the Act.

3. Applicants state that no current officer or employee of any of the Underwriter Applicants who is or was involved in providing underwriting services to the Funds participated in the conduct which resulted in the filing of the Complaint. Applicants also state that none of the Applicants has ever previously applied for an exemption pursuant to section 9(c) of the Act.

4. Applicants assert that, if the Underwriter Applicants were barred from serving as principal underwriter to the Funds, the effect on their businesses and employees would be severe. Applicants further represent that the inability of the Underwriter Applicants to continue to serve as principal underwriter to the Funds would result in potentially severe hardships for the Funds and their shareholders.

5. For these and other reasons discussed in the application, Applicants believe they meet the standard for exemption specified in section 9(c).

Applicants' Condition

Applicants agree that any order granting the requested relief will be subject to the following condition:

Any temporary exemption granted pursuant to the application shall be without prejudice to, and shall not limit the Commission's rights in any manner with respect to, any Commission investigation of, or administrative proceedings involving or against, Applicants, including without limitation, the consideration by the Commission of a permanent exemption from section 9(a) of the Act requested pursuant to the application, or the revocation or removal of any temporary exemptions granted under the Act in connection with the application.

Temporary Order

Rule 30–5(a)(7) of the Commission's Rules of Practice and Investigations provides that the Division of Investment Management may exempt persons, for a temporary period not exceeding 60 days, from section 9(a) of the Act, if, on the basis of the facts then set forth in the application, it appears that: (i)(A) the prohibitions of section 9(a), as applied to the applicant, may be unduly or disproportionately severe, or (B) the applicant's conduct has been such as not to make it against the public interest or the protection of investors to grant the temporary exemption; and (ii) granting the temporary exemption would protect the interests of the investment companies being served by the applicant by allowing time for the orderly consideration of the application for permanent relief or the orderly transition of the applicant's responsibilities to a successor, or both.

The Division has considered the matter and, without necessarily agreeing with all of the facts represented or all of the arguments asserted by the Applicants, finds, in accordance with 17 CFR 200.30–5(a)(7), that it appears that (i) The prohibitions of section 9(a), as applied to the Applicants, may be unduly or disproportionately severe, (ii) the Applicants' conduct has been such as not to make it against the public interest or the protection of investors to grant the temporary exemption, and (iii) granting the temporary exemption would protect the interests of the investment companies served by the Applicants by allowing time for the orderly consideration of the application for permanent relief.

Accordingly, in the matter of The BISYS Group, Inc., *et al.* (File No. 812–13394),

It is hereby ordered, pursuant to section 9(c) of the Act, that the Applicants are granted a temporary exemption from the provisions of section 9(a), effective forthwith, solely with respect to the Injunction, subject to the condition in the application, until the date the Commission takes final action on their application for a permanent order or, if earlier, September 24, 2007.

For the Commission, by the Division of Investment Management, pursuant to delegated authority.

Jill M. Peterson,

Assistant Secretary.

[FR Doc. E7–15022 Filed 8–1–07; 8:45 am]

BILLING CODE 8010–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–56149; File No. SR–BSE–2007–38]

Self-Regulatory Organizations; Boston Stock Exchange, Inc.; Notice of Filing and Immediate Effectiveness of Proposed Rule Change To Extend the Penny Pilot Program

July 26, 2007.

Pursuant to section 19(b)(1) of the Securities Exchange Act of 1934 (''Act''),[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on July 24, 2007, the Boston Stock Exchange, Inc. (''BSE'' or ''Exchange'') filed with the Securities and Exchange Commission (''Commission'') the proposed rule change as described in Items I and II below, which Items have been substantially prepared by the BSE. The Exchange filed the proposal as a ''non-controversial'' proposed rule change pursuant to section 19(b)(3)(A) of the Act[3] and Rule 19b–4(f)(6) thereunder,[4] which rendered the proposal effective upon filing with the Commission. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to extend the Boston Options Exchange (''BOX'') pilot program that permits BOX to quote certain classes in penny increments (''Penny Pilot Program'') through September 27, 2007. The text of the proposed rule change is available at BSE, the Commission's Public Reference Room, and *http://www.bostonstock.com.*

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the Exchange included statements concerning the purpose of, and basis for, the proposed rule change and discussed any comments it received on the

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] 15 U.S.C. 78s(b)(3)(A).

[4] 17 CFR 240.19b–4(f)(6).

proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in Sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

The purpose of the proposed rule change is to extend the Penny Pilot Program under the Rules of the BOX for approximately an additional two months, extending the program through September 27, 2007. The Penny Pilot Program permits BOX to quote certain designated classes in penny increments.[5] The proposed extension will amend Section 33, (''Penny Pilot Program'') of Chapter V (''Doing business on BOX'') of the BOX Rules.

Currently, all six options exchanges, including BOX, participate in the Penny Pilot Program which includes the following thirteen options: Ishares Russell 2000 (IWM); NASDAQ–100 Index Tracking Stock (QQQQ); SemiConductor Holders Trust (SMH); General Electric Company (GE); Advanced Micro Devices, Inc. (AMD), Microsoft Corporation (MSFT); Intel Corporation (INTC); Caterpillar, Inc. (CAT); Whole Foods Market, Inc. (WFMI); Texas Instruments, Inc. (TXN); Flextronics International Ltd. (FLEX); Sun Microsystems, Inc. (SUNW); and Agilent Technologies, Inc. (A).

The minimum price variation for all classes included in the Penny Pilot Program, except for the QQQQs, will continue to be $0.01 for all quotations in option series that are quoted at less than $3 per contract and $0.05 for all quotations in option series that are quoted at $3 per contract or greater. The QQQQs will continue to be quoted in $0.01 increments for all options series.

BOX will deliver a report to the Commission during the first month after the expiration of the pilot, which will be composed of data from approximately the last five months of trading, from May 1, 2007 through September 27, 2007. The report will analyze the impact of penny pricing on market quality and options system capacity.

2. Statutory Basis

The Exchange believes that its proposed rule change is consistent with section 6(b) of the Act[6] in general, and furthers the objectives of section 6(b)(5) of the Act,[7] in particular, in that it is designed to foster cooperation and coordination with persons engaged in regulating, clearing, settling, processing information with respect to, and facilitating transactions in securities, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general, to protect investors and the public interest.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were either solicited or received by the Exchange.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The proposed rule change has become effective pursuant to section 19(b)(3)(A) of the Act[8] and Rule 19b–4(f)(6) thereunder,[9] because the foregoing proposed rule does not: (i) Significantly affect the protection of investors or the public interest; (ii) impose any significant burden on competition; and (iii) become operative for 30 days from the date on which it was filed, or such shorter time as the Commission may designate if consistent with the protection of investors and the public interest.

A proposed rule change filed under Rule 19b–4(f)(6) normally may not become operative prior to 30-days after the date of filing.[10] However, Rule 19b–4(f)(6)(iii) permits the Commission to designate a shorter time if such action is consistent with the protection of investors and the public interest.[11] The Exchange has requested that the Commission waive the 5-day pre-filing requirement and the 30-day operative delay. The Commission believes that waiving the 5-day pre-filing requirement and the 30-day operative delay is consistent with the protection of investors and the public interest because such waiver will ensure continuity of the Exchange's rules and will allow the Penny Pilot Program to remain in effect without interruption. For these reasons, the Commission designates the proposal to be operative upon filing with the Commission.[12]

At any time within 60 days of the filing of the proposed rule change, the Commission may summarily abrogate such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.[13]

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an e-mail to *rule-comments@sec.gov.* Please include File Number SR–BSE–2007–38 on the subject line.

Paper Comments

- Send paper comments in triplicate to Nancy M. Morris, Secretary, Securities and Exchange Commission, 100 F. Street, NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–BSE–2007–38. This file number should be included on the subject line if e-mail is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written

[5] Under BOX's Rules, the Penny Pilot Program is currently set to expire on July 26, 2007. *See* Securities Exchange Act Release No. 55155 (January 23, 2007), 72 FR 4741 (February 1, 2007) (SR–BSE–2006–49); *see also* Securities Exchange Act Release No. 54789 (November 20, 2006), 71 FR 68654 (November 27, 2006) (SR–BSE–2006–49) (respectively, the ''Original Penny Pilot Program Approval Order'' and ''Notice'').

[6] 15 U.S.C. 78f(b).

[7] 15 U.S.C. 78f(b)(5).

[8] 15 U.S.C. 78s(b)(3)(A).

[9] 17 CFR 240.19b–4(f)(6).

[10] 17 CFR 240.19b–4(f)(6)(iii). In addition, Rule 19b–4(f)(6)(iii) requires the self-regulatory organization to give the Commission notice of its intent to file the proposed rule change, along with a brief description and text of the proposed rule change, at least five business days prior to the date of filing of the proposed rule change, or such shorter time as designated by the Commission.

[11] 17 CFR 240.19b–4(f)(6)(iii).

[12] For purposes only of waiving the 30-day operative delay, the Commission has considered the proposed rule's impact on efficiency, competition, and capital formation. 15 U.S.C. 78c(f).

[13] *See* 15 U.S.C. 78s(b)(3)(C).

communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Room, 100 F. Street, NE., Washington, DC 20549, on official business days between the hours of 10 a.m. and 3 p.m. Copies of the filing also will be available for inspection and copying at the principal office of the BSE. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–BSE–2007–38 and should be submitted on or before August 23, 2007.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[14]

Florence E. Harmon,

Deputy Secretary.

[FR Doc. E7–14915 Filed 8–1–07; 8:45 am]

BILLING CODE 8010–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–56151; File No. SR–ISE–2007–68]

Self-Regulatory Organizations; International Securities Exchange, LLC; Notice of Filing and Immediate Effectiveness of Proposed Rule Change Relating to an Extension of the Penny Pilot Program

July 26, 2007.

Pursuant to section 19(b)(1) of the Securities Exchange Act of 1934 (''Act''),[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on July 26, 2007, the International Securities Exchange, LLC (''ISE'' or ''Exchange'') filed with the Securities and Exchange Commission (''Commission'') the proposed rule change as described in Items I and II below, which Items have been substantially prepared by the ISE. The Exchange filed the proposal as a ''non-controversial'' proposed rule change pursuant to section 19(b)(3)(A) of the Act[3] and Rule 19b–4(f)(6) thereunder,[4] which rendered the proposal effective upon filing with the Commission. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to extend the Penny Pilot Program. The text of the proposed rule change is available at ISE, the Commission's Public Reference Room, and *http://www.iseoptions.com.*

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, ISE included statements concerning the purpose of, and basis for, the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

On January 24, 2007, the Commission approved ISE's rule filing (SR–ISE–2006–62),[5] which permits thirteen option classes to quote in penny increments in connection with the implementation of an industry wide, six month penny pilot program (''Penny Pilot Program''). Under the Penny Pilot Program, the minimum price variation for all thirteen option classes, except for the Nasdaq-100 Index Tracking Stock (''QQQQs''), will continue to be $0.01 for all quotations in option series that are quoted at less than $3 per contract and $0.05 for all quotations in options series that are quoted at $3 per contract or greater. The QQQQs will continue to be quoted in $0.01 increments for all options series. The Penny Pilot Program is scheduled to expire on July 26, 2007. ISE proposes to extend the Penny Pilot Program in the thirteen options classes for an additional two months, until September 27, 2007, while the Commission analyzes whether it would be appropriate for the options exchanges to continue the pilot, extend it, or expand it.

As proposed in the Initial Filing, ISE represents that options trading in penny increments will not be eligible for split pricing, as permitted under ISE Rule 716. In the Initial Filing, the Exchange made references to the quote mitigation strategies that are currently in place and proposed to apply them to all option classes during to the Penny Pilot Program.[6] The Exchange proposes to continue applying those quote mitigation strategies during the extension of the Penny Pilot Program. Specifically, as proposed in ISE Rule 804, ISE will continue to utilize a holdback timer that delays quotation updates for up to, but not longer than, one second. The Exchange's monitoring and delisting policies, as proposed in the Initial Filing, shall continue to apply.

Finally, ISE will deliver a report to the Commission during the first month after the expiration of the pilot, which will be composed of data from approximately the last five months of trading, from May 1, 2007 through September 27, 2007. The report will analyze the impact of penny pricing on market quality and options system capacity.

2. Statutory Basis

The Exchange believes that its proposal is consistent with section 6(b) of the Act[7] in general, and furthers the objectives of section 6(b)(5) of the Act[8] in particular, in that it is designed to promote just and equitable principles of trade, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general, to protect investors and the public interest.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were either solicited or received by the Exchange.

[14] 17 CFR 200.30–3(a)(12).

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] 15 U.S.C. 78s(b)(3)(A).

[4] 17 CFR 240.19b–4(f)(6).

[5] *See* Securities Exchange Act Release No. 55161 (January 24, 2007), 72 FR 4754 (February 1, 2007) (SR–ISE–2006–62) (the ''Initial Filing'').

[6] The Exchange confirmed that the quote mitigation strategies in place during the Penny Pilot Program applied to all options classes. Telephone conversation between Samir Patel, Assistant General Counsel, ISE and Jennifer Colihan, Special Counsel, Division of Market Regulation, Commission, on July 26, 2006.

[7] 15 U.S.C. 78f(b).

[8] 15 U.S.C. 78f(b)(5).

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The proposed rule change has become effective pursuant to section 19(b)(3)(A) of the Act [9] and Rule 19b–4(f)(6) thereunder,[10] because the foregoing proposed rule does not: (i) Significantly affect the protection of investors or the public interest; (ii) impose any significant burden on competition; and (iii) become operative for 30 days from the date on which it was filed, or such shorter time as the Commission may designate if consistent with the protection of investors and the public interest.

A proposed rule change filed under Rule 19b–4(f)(6) normally may not become operative prior to 30-days after the date of filing.[11] However, Rule 19b–4(f)(6)(iii) permits the Commission to designate a shorter time if such action is consistent with the protection of investors and the public interest.[12] The Exchange has requested that the Commission waive the 5-day pre-filing requirement and the 30-day operative delay. The Commission believes that waiving the 5-day pre-filing requirement and the 30-day operative delay is consistent with the protection of investors and the public interest because such waiver will ensure continuity of the Exchange's rules and will allow the Penny Pilot Program to remain in effect without interruption. For these reasons, the Commission designates the proposal to be operative upon filing with the Commission.[13]

At any time within 60 days of the filing of the proposed rule change, the Commission may summarily abrogate such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.[14]

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an e-mail to *rule-comments@sec.gov.* Please include File Number SR–ISE–2007–68 on the subject line.

Paper Comments

- Send paper comments in triplicate to Nancy M. Morris, Secretary, Securities and Exchange Commission, 100 F. Street, NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–ISE–2007–68. This file number should be included on the subject line if e-mail is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Room, 100 F. Street, NE., Washington, DC 20549, on official business days between the hours of 10 a.m. and 3 p.m. Copies of the filing also will be available for inspection and copying at the principal office of the ISE. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–ISE–2007–68 and should be submitted on or before August 23, 2007.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[15]

Florence E. Harmon,

Deputy Secretary.

[FR Doc. E7–14916 Filed 8–1–07; 8:45 am]

BILLING CODE 8010–01–P

[9] 15 U.S.C. 78s(b)(3)(A).

[10] 17 CFR 240.19b–4(f)(6).

[11] 17 CFR 240.19b–4(f)(6)(iii). In addition, Rule 19b–4(f)(6)(iii) requires the self-regulatory organization to give the Commission notice of its intent to file the proposed rule change, along with a brief description and text of the proposed rule change, at least five business days prior to the date of filing of the proposed rule change, or such shorter time as designated by the Commission.

[12] 17 CFR 240.19b–4(f)(6)(iii).

[13] For purposes only of waiving the 30-day operative delay, the Commission has considered the proposed rule's impact on efficiency, competition, and capital formation. 15 U.S.C. 78c(f).

[14] *See* 15 U.S.C. 78s(b)(3)(C).

[15] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–56143; File No. SR–NYSE–2007–59]

Self-Regulatory Organizations; New York Stock Exchange LLC; Notice of Filing and Immediate Effectiveness of Proposed Rule Change To Amend NYSE Rules 342(c) (''Offices—Approval, Supervision and Control'') and 343 (''Offices—Sole Tenancy, Hours, Display of Membership Certificates'')

July 26, 2007.

Pursuant to section 19(b)(1) of the Securities Exchange Act of 1934 (''Act'') [1] and Rule 19b–4 thereunder,[2] notice is hereby given that on June 29, 2007, the New York Stock Exchange LLC (''NYSE'' or ''Exchange'') filed with the Securities and Exchange Commission (''Commission'') the proposed rule change as described in Items I and II below, which Items have been substantially prepared by NYSE. On July 26, 2007, the Exchange submitted Amendment No. 1 to the proposed rule change. The Exchange filed the proposal as a ''non-controversial'' rule change pursuant to section 19(b)(3)(A)(iii) of the Act [3] and Rule 19b–4(f)(6) thereunder,[4] which renders the proposal effective upon receipt of this filing by the Commission. The Commission is publishing this notice to solicit comments on the proposed rule change, as amended, from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The NYSE is filing with the Commission (''SEC'' or ''Commission'') proposed amendments to NYSE Rules 342(c) (''Offices—Approval, Supervision and Control'') to replace the prior consent requirement for branch office approval with a notice requirement and 343 (''Offices—Sole Tenancy, Hours, Display of Membership Certificates'') to eliminate the requirement under Rule 343 that member organizations display an Exchange-provided ''certificate of membership'' at all branch office locations. The text of the proposal is available on the Exchange's Web site (*http://www.nyse.com*), at the principal office of the NYSE, and at the Commission's Public Reference Room.

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] 15 U.S.C. 78s(b)(3)(A)(iii).

[4] 17 CFR 240.19b–4(f)(6).

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, NYSE included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. NYSE has prepared summaries, set forth in Sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange is proposing to amend NYSE Rule 342(c) and delete paragraph (d) of Rule 343 as part of its continuing Self Regulatory Organization (''SRO'') Rule Harmonization initiative.[5] The proposed amendment to Rule 342(c) will replace the prior consent requirement for branch office approval with a notice requirement and make the provision consistent with the definition of ''branch office'' set forth in Rule 342.10. The proposed amendment to Rule 343 will delete the Rule 343(d) requirement that member organizations display an Exchange-provided ''certificate of membership'' at all branch offices.

a. Rule 342(c) (''Offices—Approval, Supervision and Control'') Background

NYSE Rule 342.10 defines ''branch office'' as ''any location where one or more associated persons of a member or member organization regularly conduct the business of effecting any transactions in, or inducing or attempting to induce the purchase or sale of any security, or is held out as such * * *'' Rule 342(c) requires that member organizations obtain the Exchange's prior consent or approval (hereinafter referred to as the ''prior consent'' requirement) for each office to be established, other than a main office.

Currently, member organizations are required to submit requests for approval of branch office locations via Form BR (Uniform Branch Office Registration Form),[6] filed with the Central Registration Depository (''CRD''). All filings made with CRD, whether Exchange member organizations or not, are subjected to numerous system completeness checks.[7]

Once filed with CRD, a branch office application is routed to the NYSE via four daily feeds from the NASD, for review through the NYSE's Branch Office System (''BOS'') application. BOS conducts a series of data validation reviews in addition to the CRD completeness checks on the filings received to determine whether to ''auto-approve'' the application when a filing does not have any validation issues, or route the filing to designated NYSE personnel for further review of the application.

Current Rule 342(c) Standard

Under the current prior consent requirement set forth by NYSE Rule 342(c), a vast majority of member organization branch offices are approved. In the limited situations where such consent is not initially given by the Exchange, a member organization may be required to amend its request for branch office approval. Even in these situations, however, such consent is nearly always granted by the Exchange, rendering the prior consent requirement unnecessary.[8]

Current NASD Standard

The NASD requires that any office other than the main office be properly designated and registered, if required, with the NASD[9] (hereinafter referred to as the ''notice'' requirement). The NASD rule and a vast majority of the states'' laws and regulations do not require prior consent to open a branch office. Since there is no corresponding requirement for NASD members, the NYSE's prior consent requirement results in disparate regulatory standards for dual NYSE/NASD member organizations, and the utility of the NASD registration requirement is limited, as dual members have to comply with the more stringent NYSE requirement.

Proposed Rule Change

The Exchange proposes to replace the Rule 342(c) prior consent requirement for branch office approval with a notice requirement consistent with the NASD notice requirement. Specifically, the Exchange proposes to amend Rule 342(c) to state that a ''member organization shall provide, in a manner prescribed by the Exchange, notice to the Exchange of each branch office established by such member organization.'' Under the proposed notice requirement, the Exchange will continue to receive the same information it currently receives under the prior consent requirement, which will still allow the Exchange to monitor branch office applications. Thus the front-end completeness checks in CRD, coupled with the continued receipt of branch office profile information contained on Form BR, will afford the Exchange the opportunity to thoroughly monitor branch office filings submitted and take action where appropriate without unduly delaying the initiation of business activities at such offices.

The Exchange also proposes to conform Rule 342(c) with the definition of ''branch office'' set forth in Rule 342.10. As noted above, Rule 342(c) currently applies to ''each office * * * other than a main office.'' The Exchange proposes to delete the phrase ''other than a main office'' from Rule 342(c) because, based on the definition of branch office in Rule 342.10, a branch office may include a main office location, depending on the functions performed at that location.

In addition, the Exchange proposes to delete the term ''member'' from Rule 342(c) as part of an ongoing process to eliminate, where appropriate, this designation from its rules. The proposed deletion of the term reflects the fact that the Rule has been redefined in the context of the NYSE/ARCA business model [10] and no longer has regulatory relevance in the context of Rule 342(c).

Also, the Exchange proposes deleting the requirement under Rule 343(d) that member organizations display an Exchange-provided ''certificate of membership'' at all branch office locations. The Exchange believes this practice has become outdated.

The Exchange requests that the rule change be effective immediately.

[5] *See* SR–NYSE–2007–22 for additional information.

[6] *See* NYSE Information Memo 05–75 (Approval of Form BR (Uniform Branch Office Registration Form)).

[7] Completeness checks conducted on Form BR filings include, for example, a review for proper registration, pursuant to National Association of Securities Dealers, Inc. (''NASD'') Rules, of supervisory individuals. A Form BR would not be processed by CRD if any completeness checks were not satisfied.

[8] From November 1, 2005 through December 31, 2006, NYSE received 3,831 branch office applications, of which, slightly under half, that is 1,913, were ''auto'' or ''managed'' approved applications, requiring intervention only on a technical support level in some instances. Of the remaining applications received, 1,918, the vast majority were manually reviewed and approved by NYSE personnel. The 3,831 office applications received and reviewed resulted in only 76 rejections, or roughly 2% of the total received. These office applications were rejected for reasons such as individuals designated as supervisors not being properly qualified under NYSE requirements or incorrect designation of office type (*e.g.*, ''Small'' instead of ''Regular'' branch office).

[9] *See* NASD Rule 3010(g)(2)(A) and NASD IM–1000–4.

[10] *See* Securities Exchange Act Release No. 53382 (February 27, 2006), 71 FR 11251 (March 6, 2006) (order approving SR–NYSE–2005–77) and SR–NYSE–2007–22.

2. Statutory Basis

The statutory basis for the proposed rule change is section 6(b)(5) of the Act[11] which requires, among other things, that the rules of the Exchange be designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to foster cooperation and coordination with persons engaged in regulating, clearing, settling, processing information with respect to, and facilitating transactions in securities, to remove impediments to and perfect the mechanism of a free and open market and national market system, and in general, to protect investors and the public interest.

The Exchange believes the proposed amendment to Rule 342(c) will provide greater harmonization between the Exchange and NASD rules by eliminating the prior consent requirement for branch office approval and replacing it with a notice requirement so that dual NYSE/NASD member organizations must only comply with one standard.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

The Exchange has neither solicited nor received written comments on the proposed rule change.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Because the foregoing proposed rule change does not: (A) Significantly affect the protection of investors or the public interest; (B) impose any significant burden on competition; and (C) by its terms, become operative for 30 days from the date on which it was filed, or such shorter time as the Commission may designate, if consistent with the protection of investors and the public interest, it has become effective pursuant to Section 19(b)(3)(A) of the Act[12] and Rule 19b–4(f)(6) thereunder.[13]

A proposed rule change filed under 19b–4(f)(6) normally may not become operative prior to 30 days after the date of filing. However, Rule 19b–4(f)(6)(iii) permits the Commission to designate a shorter time if such action is consistent with the protection of investors and the public interest.

The Exchange believes that good cause exists to justify immediate effectiveness because under the proposed amendments to Rule 342(c), the Exchange will continue to receive the same information it currently receives under the prior consent requirement and thus, will be able to monitor branch office applications. Also, the front-end completeness checks in CRD, coupled with the continued receipt of branch office profile information contained on Form BR, will afford the Exchange the opportunity to thoroughly monitor branch office filings submitted and take action where appropriate without unduly delaying the initiation of business activities at such offices.

The Commission believes that for these reasons, and because the proposed rule change more closely conforms NYSE and NASD regulatory standards, waiving the 30-day operative delay is consistent with the protection of investors and the public interest. Therefore, the Commission designates the proposed rule change to be operative upon filing with the Commission.[14]

At any time within 60 days of the filing of such proposed rule change, the Commission may summarily abrogate such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.[15]

IV. Solicitation of Comments

Interested persons are invited to submit written data, views and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an e-mail to *rule-comments@sec.gov.* Please include File Number SR–NYSE–2007–59 on the subject line.

Paper Comments

- Send paper comments in triplicate to Nancy M. Morris, Secretary, Securities and Exchange Commission, 100 F. Street, NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–NYSE–2007–59. This file number should be included on the subject line if e-mail is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Room, 100 F. Street, NE., Washington, DC 20549, on official business days between the hours of 10 a.m. and 3 p.m. Copies of such filing also will be available for inspection and copying at the principal office of NYSE. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–NYSE–2007–59 and should be submitted on or before August 23, 2007.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[16]

Florence E. Harmon,

Deputy Secretary.

[FR Doc. E7–14914 Filed 8–1–07; 8:45 am]

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[11] 15 U.S.C. 78f(b)(5).

[12] 15 U.S.C. 78s(b)(3)(A).

[13] 17 CFR 240.19b–4(f)(6). In addition, Rule 19b–4(f)(6)(iii) requires that a self-regulatory organization submit to the Commission written notice of its intent to file the proposed rule change, along with a brief description and text of the proposed rule change, at least five business days prior to the date of filing of the proposed rule change, or such shorter time as designated by the Commission. The Commission notes that NYSE has satisfied the five-day pre-filing notice requirement.

[14] For purposes only of waiving the 30-day operative delay, the Commission has considered the proposed rule's impact on efficiency, competition, and capital formation. *See* 15 U.S.C. 78c(f).

[15] For purposes of calculating the 60-day period within which the Commission may summarily abrogate the proposed rule change under Section 19(b)(3)(C) of the Act, the Commission considers the period to commence on July 26, 2007, the date on which NYSE submitted Amendment No. 1. *See* 15 U.S.C. 78s(b)(3)(C).

[16] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–56162; File No. SR–NYSE–2007–013]

Self-Regulatory Organizations; New York Stock Exchange LLC, Notice of Filing of Proposed Rule and Amendment No. 1 Relating to a Proposed New Rule on Notification of Fees

July 27, 2007.

Pursuant to section 19(b)(1) of the Securities Exchange Act of 1934 (the ''Act''),[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on February 6, 2007, the New York Stock Exchange (''NYSE'') filed with the Securities and Exchange Commission (''Commission'') the proposed new rule as described in Items I, II and III below, which Items have been substantially prepared by NYSE. On July 27, 2007, NYSE filed Amendment No. 1 to the proposed rule. The Commission is publishing this notice to solicit comments on the proposed rule from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule

NYSE is filing with the Commission proposed new Rule 405B (''Notification of Fees'').

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule

In its filing with the Commission, the Exchange included statements concerning the purpose of, and basis for, the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule

1. Purpose

The NYSE is proposing new Rule 405B (''Notification of Fees'') which would require member organizations to provide their customers with written notification of all fees related to their customers' accounts as well as require that fees be reasonable and not unfairly discriminatory between customers.

a. Background

A significant number of operational complaints that were reported to the Exchange pursuant to NYSE Rule 351(d)[3] concerned member organizations' insufficient notification of fees to their customers.[4] Specifically, many of these complaints involved increases in account fees and service charges or other charges which customers felt were imposed on them without notification. In June of 2005, the Exchange published Information Memo 05–41 (''Customer Notification of Service Fees and Service Fee Changes''), which provided guidance to firms regarding notification of fees. New Rule 405B is proposed to codify such guidance so as to emphasize the importance of notification of fees to customers.[5]

b. Proposed Rule

As proposed, Rule 405B would require member organizations to provide their customers with written notification of relevant fees regarding their accounts. Specifically, Rule 405B(1)(a) would require member organizations to provide each of its customers with written notification of all fees that are in effect at the time the account is opened, or that will take effect within 30 days of the account being opened. Additionally, Rule 405B(1)(b) would require member organizations to mail written notification of increased fees, or imposition of any new fees, at least 30 days prior to the increase or imposition related to an account to the last known address of every customer whose account is subject to such fees. Further, member organizations would be required to post a notification of the types of fee changes, and the projected date of such changes, on their internet website (if they maintain a website). This proposed Rule would better allow customers to stay apprised of their account fees as well as any changes to such fees.

Proposed Rule 405B(2) provides for methods of notification. Specifically, the proposed new rule would allow member organizations to either send a separate written notification to inform customers of fees or include the fee notices with account statements or newsletters.

Furthermore, Rule 405B(3) describes the types of fees which are included under the notification requirements of Rule 405B. Specifically, proposed Rule 405B(3) states, in part, that fees ''shall be construed broadly to include, but not be limited to, charges such as commissions, charges for any managed or non-managed accounts, or charges for other account-related services, such as reinvestment of dividends or interest, transfer or custody of securities, appraisals, safe-keeping, or margin.''

Also, proposed Rule 405B(4) would require that fees imposed on customers by member organizations be reasonable and not unfairly discriminatory.[6] The Exchange recognizes that fees charged to certain customers by member organizations may differ in some circumstances depending on various factors including, for example, the type of account, the amount invested, and the length and type of relationship. Thus, the proposed rule would not prohibit or restrict firms' ability to structure their pricing schedules based upon the uniqueness of their various customer relationships.

In addition, proposed Rule 405B(5) would provide customers with an option to receive notification of fees electronically in lieu of by mail, provided the customer affirmatively opts out of receiving such notification in writing.[7] This proposed rule is an effort to provide greater convenience to the investing public by providing customers with an option as to how they would like to receive fee notifications.

2. Statutory Basis

The statutory basis for this proposed rule change is section 6(b)(5) of the Exchange Act.[8] Under that section, rules of the Exchange must be designed to prevent fraudulent and manipulative acts and practices and promote just and equitable principles of trade. Proposed new Rule 405B would require member

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] NYSE Rule 351 (''Reporting Requirements'') specifies certain occurrences, incidents, and periodic information that member organizations must report to the Exchange.

[4] *See* NYSE Information Memo 05–41 (June 13, 2005) (Customer Notification of Service Fees and Service Fee Changes) stating that over 25% of customer operational complaints made to the Exchange in 2004 concerned ''fee/commissions'' problems.

[5] There has continued to be abuses in this area of excessive fees charged to customers and fee notification to customers. *See* NASD action involving McLaughlin, Piven and Vogel Securities (October 26, 2006).

[6] This is substantially similar to NASD Rule 2430 (''Charges for Services Performed''), but proposed NYSE Rule 405B contains notification requirements, whereas NASD Rule 2430 does not.

[7] This approach is similar to a recently approved amendment to NYSE Rule 409 (''Statements of Accounts to Customers'') permitting institutional customers doing business solely on a deliver versus payment/receive versus payment basis (''RVP/DVP'') to opt out of receiving statements as otherwise required by the rule. *See* Release No. 34–54810 (November 22, 2006), 71 FR 69165 (November 29, 2006) (SR–NYSE–2005–90). The SEC also approved similar revisions to NASD Rule 2340 in Release No. 34–54811 (November 22, 2006), 71 FR 69161 (November 29, 2006) (SR–NASD–2006–066). *See also* NYSE Information Memo 06–80 (November 30, 2006).

[8] 15 U.S.C. 78a *et. seq.*

organizations to provide their customers with written notification of fees. This proposed new rule is, therefore, consistent with section 6(b)(5) of the Exchange Act because it would provide for greater transparency to customers with respect to fees charged and will provide guidance to firms with respect to the fees they impose upon their customers.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange believes that the proposed rule change does not impose any burden on competition not necessary or appropriate in furtherance of the purposes of the Exchange Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Received from Members, Participants or Others

Written comments were neither solicited nor received.

III. Date of Effectiveness of the Proposed Rule and Timing for Commission Action

Within 35 days of the date of publication of this notice in the **Federal Register** or within such longer period (i) as the Commission may designate up to 90 days of such date if it finds such longer period to be appropriate and publishes its reasons for so finding or (ii) as to which the self-regulatory organization consents, the Commission will:

A. By order approve such proposed rule, or

B. institute proceedings to determine whether the proposed rule should be disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule is consistent with the Act. We invite interested persons to discuss whether a de minimis exception to paragraph (1) would help member organizations comply with the proposed rule and/or increase the effectiveness of the disclosures. If a de minimis exception is warranted, we also invite interested persons to discuss under what circumstances a fee or fee increase should be considered ''de minimis.'' Comments may be submitted by any of the following methods:

Electronic Comments

• Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or

• Send an e-mail to *rule-comments@sec.gov.* Please include File Number SR–NYSE–2007–013 on the subject line.

Paper Comments

• Send paper comments in triplicate to Nancy M. Morris, Secretary, Securities and Exchange Commission, 100 F. Street, NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–NYSE–2007–013. This file number should be included on the subject line if e-mail is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule that are filed with the Commission, and all written communications relating to the proposed rule between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Room, 100 F. Street, NE., Washington, DC 20549, on official business days between the hours of 10 a.m. and 3 p.m. Copies of such filing also will be available for inspection and copying at the principal office of NYSE. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–NYSE–2007–013 and should be submitted on or before August 23, 2007.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[9]

Nancy M. Morris,

Secretary.

[FR Doc. E7–14990 Filed 8–1–07; 8:45 am]

BILLING CODE 8010–01–P

[9] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–56158; File No. SR–NYSE–2005–48]

Self-Regulatory Organizations; New York Stock Exchange LLC; Order Approving Proposed Rule Change as Modified by Amendment Nos. 1, 2, 3, and 4 Thereto and Notice of Filing and Order Granting Accelerated Approval to Amendment No. 5 to Revise Rule 619 Pertaining to Subpoenas for the Production of Documents and Appearances of Witnesses

July 27, 2007.

I. Introduction

On July 13, 2005, the New York Stock Exchange LLC (''NYSE'' or ''Exchange'') filed with the Securities and Exchange Commission (''Commission''), pursuant to section 19(b)(1) of the Securities Exchange Act of 1934 (''Act'')[1] and Rule 19b–4 thereunder,[2] a proposed rule change amending NYSE Rule 619, which pertains to subpoenas for the production of documents and the appearance of witnesses. On September 26, 2005, the Commission published for comment the proposed rule change in the **Federal Register**.[3] The Commission received no comments on the proposal. On April 18, 2006, November 2, 2006, December 22, 2006, and February 8, 2007, the NYSE submitted Amendment Nos. 1, 2, 3, and 4, respectively, to the proposed rule change.[4] On April 13, 2007, the Commission published for comment the proposed rule change, as amended, in the **Federal Register**.[5] The Commission received two comments on the proposal.[6] On July 13, 2007, NYSE

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] *See* Securities Exchange Act Release No. 52468 (Sept. 19, 2005), 70 FR 56201 (Sept. 26, 2005).

[4] Amendment No. 1 clarified that only the arbitrator(s) may issue subpoenas and delineated the manner in which a party may request the issuance of a subpoena. Amendment No. 2 established a time frame for the parties to make and respond to objections to the requested subpoena and clarified that the arbitrator(s) may not rule on such a request until this time period has elapsed. Amendment No. 3 made technical changes to the rule and clarified that the arbitrator(s) must receive copies of any objections to the issuance of a subpoena. Amendment No. 4 clarified that a party requesting a subpoena may not serve the request or the draft subpoena on a non-party.

[5] *See* Securities Exchange Act Release No. 55594 (April 6, 2007), 72 FR 18710 (April 13, 2007).

[6] *See* letters from Steven B. Caruso, President, Public Investors Arbitration Bar Association (''PIABA''), dated April 17, 2007; and Martin L. Feinberg, dated May 4, 2007 (''Feinberg''). The NYSE responded to these comments in telephone conversations with Commission staff. Telephone conversations among Karen Kupersmith, Director of Arbitration, NYSE; Lourdes Gonzalez, Assistant

Continued

submitted Amendment No. 5 to the proposed rule change.

This notice and order solicits comment from interested persons on Amendment No. 5 and approves the proposal, as amended, on an accelerated basis. The text of the proposed rule change is available at *http://www.nyse.com,* the principal offices of the NYSE, and the Commission's Public Reference Room.

II. Description of the Proposed Rule Change

In its amended filing, the NYSE proposed to revise Rule 619 to provide that only the arbitrator(s) may issue subpoenas for the production of documents and the appearance of witnesses. The rule also provides that the arbitrator(s), and not the courts, will rule on discovery disputes concerning the issuance of subpoenas. Under the rules, the party who requests a subpoena must make a written request asking the arbitrator(s) to issue the subpoena and send a copy of the request and the requested draft subpoena to the Director of Arbitration, each arbitrator, and all parties to the arbitration in a manner reasonably expected to result in delivery to everyone on the same day. The requesting party may not serve the request or the requested draft subpoena on any non-party.

If a party has an objection to the propriety or scope of the subpoena, that party must file objections in writing with the Director of Arbitration and send copies to all other parties, including each arbitrator, within 10 days of service of the request and draft subpoena. The party requesting the subpoena could file a reply to the objection within five days of receipt of the objection. The arbitrator(s) then determine the propriety and scope of the requested subpoena after the time period for filing objections or replies had elapsed. If a subpoena is issued by the arbitrator(s), the party that requested the subpoena must serve the subpoena at the same time and in the same manner on all parties, and, if applicable, on any non-party receiving the subpoena.

In addition, the proposed rule change provides that any party that receives documents in response to a subpoena served upon a non-party must provide notice to all other parties within five days of receipt of the documents. Thereafter, any party may request copies of those documents and, if such a request is made, the documents must be provided within 10 days following receipt of the request. The party requesting the documents is responsible for the reasonable costs associated with the production of the copies, unless the panel determines otherwise.

Amendment No. 5 clarified that calendar days, and not business days, apply to (1) The 10-day period to object to the scope or propriety of subpoenas, (2) the five-day period to respond to an objection, (3) the five-day period to notify all other parties of receipt of documents from a third party, and (4) the 10-day period to request copies of these documents.

III. Summary of Comments Received and NYSE Response

One commenter [7] noted that the proposed rule does not expressly state whether calendar or business days apply to various filing deadlines, and urged the NYSE to clarify in the rule specify that calendar days govern the applicable time periods. In response to this comment, the NYSE filed Amendment No. 5, which clarified that calendar days apply to all deadlines under the proposed rule. Both commenters criticized the proposed rule's requirement that the party receiving documents in response to a subpoena will be responsible for the reasonable costs associated with the production, unless the panel determines otherwise. PIABA stated that this ''cost-shifting'' will increase arbitration expenses associated with the initiation and prosecution of every arbitration proceeding, while Feinberg maintained that the rule should not require payment for subpoenaed documents.

The NYSE responded that although the proposed rule is ambiguous, this provision only applies to the receipt of documents from a third-party, and does not apply more broadly to all subpoenas, as the commenters suggest. The arbitration panel still may allocate fees among the parties pursuant to NYSE Rule 629(c)(2), which permits arbitrators to determine in the award the amount of costs incurred pursuant to Rule 619 (among other rules) and, unless applicable law directs otherwise, other costs and expenses of the parties.[8]

One commenter [9] contended that under the proposed rule, read in light of the subpoena service requirements of the Federal Arbitration Act, would require personal service of subpoenas and copies of subpoenas. In the commenter's view, this would be expensive, burdensome and unnecessary. The NYSE responded that neither the proposed rule nor its other rules require personal service.[10] In particular, NYSE stated that Rule 612 provides that ''[s]ervice and filing are accomplished on the date of mailing either by first-class postage prepaid or by means of overnight mail service or, in the case of other means of service, on the date of delivery.'' [11]

IV. Solicitation of Comments

Interested persons are invited to submit written data, views and arguments concerning Amendment No. 5, including whether Amendment No. 5 is consistent with the Exchange Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml)*; or
- Send an e-mail to *rule-comments@sec.gov*. Please include File Number SR–NYSE–2005–48 on the subject line.

Paper Comments

- Send paper comments in triplicate to Nancy M. Morris, Secretary, Securities and Exchange Commission, 100 F Street NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–NYSE–2005–48. This file number should be included on the subject line if e-mail is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml).* Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Room, 100 F Street, NE., Washington, DC 20549, on official business days between the hours of 10 a.m. and 3 p.m. Copies of such filing also will be available for inspection and copying at the principal office of NYSE. All comments received will be posted

Chief Counsel—Sales Practices, Commission; and Michael Hershaft, Special Counsel, Commission (July 11, 2007 and July 27, 2007) (''NYSE Response'').

[7] PIABA.

[8] NYSE Response.

[9] Feinberg.

[10] NYSE Response.

[11] *Id.*

without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–NYSE–2005–48 and should be submitted on or before August 23, 2007.

V. Discussion and Commission Findings

After careful review, the Commission finds that the proposed rule change is consistent with the Act and the rules and regulations thereunder applicable to the NYSE, and, in particular, with section 6(b)(5) of the Act.[12] Section 6(b)(5) requires, among other things, that the NYSE's rules be designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, and, in general, to protect investors and the public interest.[13] The Commission believes that the proposed rule change is designed to accomplish these ends by permitting only arbitrators to issue subpoenas and by making the arbitration subpoena process more orderly and efficient.

Accelerated Approval of Amendment No. 5

The Commission finds good cause for approving Amendment No. 5 to the proposed rule change prior to the thirtieth day after the amendment is published for comment in the **Federal Register** pursuant to section 19(b)(2) of the Act. Amendment No. 5 clarifies that calendar days, and not business days, apply to various filing deadlines under the proposed rule. The Commission anticipates that these changes will provide for greater clarity with respect to the subpoena process. Accordingly, the Commission finds that accelerated approval of Amendment No. 5 is appropriate.

VI. Conclusion

It is therefore ordered, pursuant to section 19(b)(2) of the Act[14] that the proposed rule change, as modified by Amendment Nos. 1, 2, 3, 4, and 5, (SR–NYSE–2005–48), be, and hereby is, approved on an accelerated basis.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[15]

Nancy M. Morris,

Secretary.

[FR Doc. E7–14993 Filed 8–1–07; 8:45 am]

BILLING CODE 8010–01–P

[12] 15 U.S.C. 78f(b)(5).

[13] *Id.*

[14] 15 U.S.C. 78s(b)(2).

[15] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–56157; File No. SR–NYSEArca–2007–71]

Self-Regulatory Organizations; NYSE Arca, Inc.; Notice of Filing and Immediate Effectiveness of Proposed Rule Change Relating to Rule 6.86

July 27, 2007.

Pursuant to section 19(b)(1) of the Securities Exchange Act of 1934 (''Act''),[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on July 26, 2007, NYSE Arca, Inc., (''NYSE Arca'' or ''Exchange'') filed with the Securities and Exchange Commission (''Commission'') the proposed rule change as described in Items I and II below, which Items have been substantially prepared by the NYSE Arca. The Exchange filed the proposal as a ''non-controversial'' proposed rule change pursuant to section 19(b)(3)(A) of the Act[3] and Rule 19b–4(f)(6) thereunder,[4] which rendered the proposal effective upon filing with the Commission. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

NYSE Arca proposes to implement the Exchange's quote mitigation strategy, reflected in NYSE Arca Rule 6.86, on a permanent basis. The text of the proposed rule change is available at NYSE Arca, the Commission's Public Reference Room, and *http://nysearca.com.*

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, NYSE Arca included statements concerning the purpose of, and basis for, the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] 15 U.S.C. 78s(b)(3)(A).

[4] 17 CFR 240.19b–4(f)(6).

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange proposes to implement the Exchange's quote mitigation strategy, reflected in NYSE Arca Rule 6.86, on a permanent basis. The Exchange's quote mitigation strategy, which is designed to reduce the number of quotations generated by NYSE Arca for all option issues traded on NYSE Arca, not just issues in the Penny Pilot, was previously approved by the Commission in conjunction with approval of the Penny Pilot.[5] According to that approval order, the Commission approved both the Penny Pilot and the changes to NYSE Arca Rule 6.86 for a six month period, ending July 25, 2007. The quote mitigation strategy reflected in NYSE Arca Rule 6.86 was not intended to be approved on a pilot or short term basis.[6]

2. Statutory Basis

The Exchange believes that its proposal is consistent with section 6(b) of the Act[7] in general, and furthers the objectives of section 6(b)(5) of the Act[8] in particular, in that it is designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to foster cooperation and coordination with persons engaged in facilitating transactions in securities, and to remove impediments to and perfect the mechanism of a free and open market and a national market system.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were either solicited or received by the Exchange.

[5] *See* Securities Exchange Act Release No. 34–55156 (January 23, 2007), 72 FR 4759 (February 1, 2007) (SR–NYSEArca–2006–73).

[6] The Exchange reported that its quote mitigation strategy has resulted in a daily mitigation savings of, on average, 13% of NYSE Arca's daily quote traffic sent to the Options Price Reporting Authority. *See* Exhibit 3 to SR–NYSEArca–2007–56, ''*Understanding Economic and Capacity Impacts of the Penny Pilot*'' (analyzing data collected during the first three months of the Penny Pilot).

[7] 15 U.S.C. 78f(b).

[8] 15 U.S.C. 78f(b)(5).

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The proposed rule change has become effective pursuant to section 19(b)(3)(A) of the Act [9] and Rule 19b–4(f)(6) thereunder,[10] because the foregoing proposed rule does not: (i) Significantly affect the protection of investors or the public interest; (ii) impose any significant burden on competition; and (iii) become operative for 30 days from the date on which it was filed, or such shorter time as the Commission may designate if consistent with the protection of investors and the public interest.

A proposed rule change filed under Rule 19b–4(f)(6) normally may not become operative prior to 30-days after the date of filing.[11] However, Rule 19b–4(f)(6)(iii) permits the Commission to designate a shorter time if such action is consistent with the protection of investors and the public interest.[12] The Exchange has requested that the Commission waive the 30-day operative delay. The Commission believes that waiving the 30-day operative delay is consistent with the protection of investors and the public interest because such waiver will ensure continuity of the Exchange's rules and will allow the Exchange's quote mitigation strategy to remain in effect without interruption. For these reasons, the Commission designates the proposal to be operative upon filing with the Commission.[13]

At any time within 60 days of the filing of the proposed rule change, the Commission may summarily abrogate such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.[14]

[9] 15 U.S.C. 78s(b)(3)(A).

[10] 17 CFR 240.19b–4(f)(6).

[11] 17 CFR 240.19b–4(f)(6)(iii). In addition, Rule 19b–4(f)(6)(iii) requires the self-regulatory organization to give the Commission notice of its intent to file the proposed rule change, along with a brief description and text of the proposed rule change, at least five business days prior to the date of filing of the proposed rule change, or such shorter time as designated by the Commission. The Exchange provided written notice of its intent to file the proposed rule change on July 24, 2007. The Commission deems this to satisfy the pre-filing requirement.

[12] 17 CFR 240.19b–4(f)(6)(iii).

[13] For purposes only of waiving the 30-day operative delay, the Commission has considered the proposed rule's impact on efficiency, competition, and capital formation. 15 U.S.C. 78c(f).

[14] *See* 15 U.S.C. 78s(b)(3)(C).

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an e-mail to *rule-comments@sec.gov.* Please include File Number SR–NYSE Arca–2007–71 on the subject line.

Paper Comments

- Send paper comments in triplicate to Nancy M. Morris, Secretary, Securities and Exchange Commission, 100 F. Street, NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–NYSEArca–2007–71. This file number should be included on the subject line if e-mail is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Room, 100 F. Street, NE., Washington, DC 20549, on official business days between the hours of 10 a.m. and 3 p.m. Copies of the filing also will be available for inspection and copying at the principal office of the NYSE Arca. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–NYSEArca–2007–71 and should be submitted on or before August 23, 2007.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[15]

Nancy M. Morris,

Secretary.

[FR Doc. E7–14992 Filed 8–1–07; 8:45 am]

BILLING CODE 8010–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–56150; File No. SR–NYSEArca–2007–56]

Self-Regulatory Organizations; NYSE Arca, Inc.; Notice of Filing and Immediate Effectiveness of Proposed Rule Change as Modified by Amendment Nos. 1 and 2 thereto Relating to NYSE Arca Rule 6.72 and the Penny Pilot for Options Trading

July 26, 2007.

Pursuant to section 19(b)(1) of the Securities Exchange Act of 1934 (''Act''),[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on June 18, 2007, NYSE Arca, Inc. (''NYSE Arca'' or ''Exchange'') filed with the Securities and Exchange Commission (''Commission'') the proposed rule change as described in Items I and II below, which Items have been substantially prepared by NYSE Arca. On July 23, 2007, the Exchange filed Amendment No. 1 to the proposed rule change.[3] The Exchange filed Amendment No. 2 to the proposal on July 25, 2007. The Exchange filed the proposal as a ''non-controversial'' proposed rule change pursuant to section 19(b)(3)(A) of the Act [4] and Rule 19b–4(f)(6) thereunder,[5] which rendered the proposal effective upon filing with the Commission.[6] The Commission is publishing this notice to solicit comments on the proposed rule change, as amended, from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

NYSE Arca proposes to amend its option trading rules in order to extend the Penny Pilot in options classes in certain issues (''Pilot Program'') previously approved by the Commission through September 27, 2007. The text of the proposed rule change is available on NYSE Arca's Web site at *http://www.nysearca.com,* at the Exchange's

[15] 17 CFR 200.30–3(a)(12).

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] Amendment No. 1 superseded and replaced the original filing in its entirety.

[4] 15 U.S.C. 78s(b)(3)(A).

[5] 17 CFR 240.19b–4(f)(6).

[6] *See* Amendment No. 1.

Office of the Secretary, and at the Commission's Public Reference Room.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the Exchange included statements concerning the purpose of, and basis for, the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange proposes to extend the time period of the Pilot Program [7] through September 27, 2007. The Exchange believes the benefits to public customers and other market participants who will be able to express their true prices to buy and sell options have been demonstrated to outweigh the increase in quote traffic. The Exchange previously filed with the Commission its economic and capacity analysis of the Pilot Program.[8] The Exchange attached its report as Exhibit 3 to the proposed rule change. The report assessed, among other things, the impact of the Pilot Program upon quote rates, effective spreads, quoted spreads, available liquidity, data mitigation, and volume changes.

According to the Exchange, the results detailed in the report indicate that the pre-pilot capacity fears were unfounded and unrealized and the pre-pilot predictions of spread compression were justified—much to the benefit of investors. The Exchange believes that these results strongly support the extension of the Pilot Program.

The Exchange, pursuant to discussions with Commission staff, intends to file a separate request to further extend and expand the Pilot Program, prior to September 27, 2007.

The Exchange agrees to submit a report to the Commission that includes data and written analysis of information collected from May 1, 2007 through September 27, 2007. This report will include, but is not limited to: (1) Data and written analysis on the number of quotations generated for options selected for the Pilot Program; (2) an assessment of the quotation spreads for the options selected for the Pilot Program; (3) an assessment of the impact of the Pilot Program on the capacity of the NYSE Arca's automated systems; (4) any capacity problems or other problems that arose related to the operation of the Pilot Program and how the Exchange addressed them; and (5) an assessment of trade through complaints that were sent by the Exchange during the operation of the Pilot Program and how they were addressed.

2. Statutory Basis

The Exchange believes that its proposed rule change is consistent with Section 6(b) of the Act [9] in general, and furthers the objectives of section 6(b)(5) of the Act,[10] in particular, in that it is designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to foster cooperation and coordination with persons engaged in facilitating transactions in securities, and to remove impediments to and perfect the mechanism of a free and open market and a national market system.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received from Members, Participants, or Others

On July 20, 2007, Citadel submitted a comment letter to the Commission in response to the Exchange's original filing regarding the Penny Pilot (SR–NYSEArca–2007–56).[11] No other written comments were solicited or received by the Exchange.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The proposed rule change has become effective pursuant to section 19(b)(3)(A) of the Act [12] and Rule 19b–4(f)(6) thereunder,[13] because the foregoing proposed rule does not: (i) Significantly affect the protection of investors or the public interest; (ii) impose any significant burden on competition; and (iii) become operative for 30 days from the date on which it was filed, or such shorter time as the Commission may designate if consistent with the protection of investors and the public interest.[14]

A proposed rule change filed under Rule 19b–4(f)(6) normally may not become operative prior to 30-days after the date of filing.[15] However, Rule 19b–4(f)(6)(iii) permits the Commission to designate a shorter time if such action is consistent with the protection of investors and the public interest.[16] The Exchange has requested that the Commission waive the 5-day pre-filing requirement and the 30-day operative delay. The Commission believes that waiving the 5-day pre-filing requirement and the 30-day operative delay is consistent with the protection of investors and the public interest because such waiver will ensure continuity of the Exchange's rules and will allow the Penny Pilot Program to remain in effect without interruption. For these reasons, the Commission designates the proposal to be operative upon filing with the Commission.[17]

At any time within 60 days of the filing of the proposed rule change, the Commission may summarily abrogate such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.[18]

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[7] *See* Securities Exchange Act Release No. 34–55156 (January 23, 2007), 72 FR 4759 (February 1, 2007) (SR–NYSEArca–2006–73).

[8] *See* Exhibit 3 to proposed rule change, *''Understanding Economic and Capacity Impacts of the Penny Pilot''* previously submitted to the Commission by NYSE Arca on May 31, 2007.

[9] 15 U.S.C. 78f(b).

[10] 15 U.S.C. 78f(b)(5).

[11] The Exchange subsequently filed Amendment No. 1, which superseded and replaced the original filing in its entirety. Amendment No. 1 changed the original scope of the proposed extension and expansion considerably. As a result, the Exchange believes that Citadel's comments are no longer applicable.

[12] 15 U.S.C. 78s(b)(3)(A).

[13] 17 CFR 240.19b–4(f)(6).

[14] The Commission notes that the effective date of the proposed rule change is July 23, 2007, the date on which Amendment No. 1 was filed.

[15] 17 CFR 240.19b–4(f)(6)(iii). In addition, Rule 19b–4(f)(6)(iii) requires the self-regulatory organization to give the Commission notice of its intent to file the proposed rule change, along with a brief description and text of the proposed rule change, at least five business days prior to the date of filing of the proposed rule change, or such shorter time as designated by the Commission.

[16] 17 CFR 240.19b–4(f)(6)(iii).

[17] For purposes only of waiving the 30-day operative delay, the Commission has considered the proposed rule's impact on efficiency, competition, and capital formation. 15 U.S.C. 78c(f).

[18] For purposes of calculating the 60-day period within which the Commission may summarily abrogate the proposed rule change under Section

Continued

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change, as amended, is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

• Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or

• Send an e-mail to *rule-comments@sec.gov*. Please include File Number SR–NYSEArca–2007–56 on the subject line.

Paper Comments

• Send paper comments in triplicate to Nancy M. Morris, Secretary, Securities and Exchange Commission, 100 F Street, NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–NYSEArca–2007–56. This file number should be included on the subject line if e-mail is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Room, 100 F Street, NE., Washington, DC 20549, on official business days between the hours of 10 a.m. and 3 p.m. Copies of the filing also will be available for inspection and copying at the principal office of the NYSE Arca. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–NYSEArca–2007–56 and should be submitted on or before August 23, 2007.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[19]

Nancy M. Morris,

Secretary.

[FR Doc. E7–14991 Filed 8–1–07; 8:45 am]

BILLING CODE 8010–01–P

SMALL BUSINESS ADMINISTRATION

Disaster Declaration #10923 and #10924; Kansas Disaster Number KS–00022

AGENCY: U.S. Small Business Administration.

ACTION: Amendment 3.

SUMMARY: This is an amendment of the Presidential declaration of a major disaster for the State of Kansas (FEMA–1711–DR), dated 07/05/2007.

Incident: Severe Storms and Flooding.

Incident Period: 06/26/2007 and continuing.

Effective Date: 07/24/2007.

Physical Loan Application Deadline Date: 09/04/2007.

EIDL Loan Application Deadline Date: 04/07/2008.

ADDRESSES: Submit Completed Loan Applications To: U.S. Small Business Administration, Processing and Disbursement Center, 14925 Kingsport Road, Fort Worth, TX 76155.

FOR FURTHER INFORMATION CONTACT: A. Escobar, Office of Disaster Assistance, U.S. Small Business Administration, 409 3rd Street, SW., Suite 6050, Washington, DC 20416.

SUPPLEMENTARY INFORMATION: The notice of the Presidential disaster declaration for the State of Kansas, dated 07/05/2007 is hereby amended to include the following areas as adversely affected by the disaster:

Primary Counties:

Edwards, Harper, Pawnee.

Contiguous Counties:

Kansas: Barber, Barton, Ford, Hodgeman, Kingman, Kiowa, Ness, Pratt, Rush, Stafford.

Oklahoma: Alfalfa, Grant.

All other information in the original declaration remains unchanged.

(Catalog of Federal Domestic Assistance Numbers 59002 and 59008)

Herbert L. Mitchell ,

Associate Administrator for Disaster Assistance.

[FR Doc. E7–14976 Filed 8–1–07; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

Disaster Declaration #10895 and #10896; Missouri Disaster Number MO–00011

AGENCY: U.S. Small Business Administration.

ACTION: Amendment 1.

SUMMARY: This is an amendment of the Presidential declaration of a major disaster for the State of Missouri (FEMA–1708–DR), dated 06/11/2007.

Incident: Severe Storms and Flooding.

Incident Period: 05/05/2007 through 05/18/2007.

Effective Date: 7/25/2007.

Physical Loan Application Deadline Date: 08/10/2007.

EIDL Loan Application Deadline Date: 03/11/2008.

ADDRESSES: Submit Completed Loan Applications To: U.S. Small Business Administration, Processing and Disbursement Center, 14925 Kingsport Road, Fort Worth, TX 76155.

FOR FURTHER INFORMATION CONTACT: A. Escobar, Office of Disaster Assistance, U.S. Small Business Administration, 409 3rd Street, SW., Suite 6050, Washington, DC 20416.

SUPPLEMENTARY INFORMATION: The notice of the Presidential disaster declaration for the State of Missouri, dated 06/11/2007 is hereby amended to include the following areas as adversely affected by the disaster:

Primary Counties:

Clinton.

All other counties contiguous to the above named primary county have previously been declared.

All other information in the original declaration remains unchanged.

(Catalog of Federal Domestic Assistance Numbers 59002 and 59008)

Herbert L. Mitchell,

Associate Administrator for Disaster Assistance.

[FR Doc. E7–14970 Filed 8–1–07; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

Disaster Declaration # 10956; Nebraska Disaster # NE–00014

AGENCY: U.S. Small Business Administration.

ACTION: Notice.

SUMMARY: This is a Notice of the Presidential declaration of a major disaster for Public Assistance Only for the State of Nebraska (FEMA–1714–DR), dated 07/24/2007.

19(b)(3)(C) of the Act, the Commission considers the period to commence on July 25, 2007, the date on which NYSE Arca submitted Amendment No. 2. *See* 15 U.S.C. 78s(b)(3)(C).

[19] 17 CFR 200.30–3(a)(12).

Incident: Severe storms and flooding.
Incident Period: 05/28/2007 through 06/02/2007.
Effective Date: 07/24/2007.
Physical Loan Application Deadline Date: 09/24/2007.

ADDRESSES: Submit Completed Loan Applications to: U.S. Small Business Administration, Processing and Disbursement Center, 14925 Kingsport Road, Fort Worth, TX 76155.

FOR FURTHER INFORMATION CONTACT: A. Escobar, Office of Disaster Assistance, U.S. Small Business Administration, 409 3rd Street, SW., Suite 6050, Washington, DC 20416.

SUPPLEMENTARY INFORMATION: Notice is hereby given that as a result of the President's major disaster declaration on 07/24/2007, Private Non-Profit organizations that provide essential services of a governmental nature may file disaster loan applications at the address listed above or other locally announced locations.

The following areas have been determined to be adversely affected by the disaster:

Primary Counties:
Buffalo, Custer, Dawson, Frontier Greeley, Hayes, Hitchcock, Howard Kearney, Lincoln, Logan, Loup, Madison, Valley, Wheeler.

The Interest Rates are:

	Percent
Other (Including Non-Profit Organizations) With Credit Available Elsewhere	5.250
Businesses And Non-Profit Organizations Without Credit Available Elsewhere	4.000

The number assigned to this disaster for physical damage is 10956.

(Catalog of Federal Domestic Assistance Number 59008)

James E. Rivera,

Acting Associate Administrator for Disaster Assistance.

[FR Doc. E7–15042 Filed 8–1–07; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

Disaster Declaration # 10949 and # 10950; New York Disaster # NY–00051

AGENCY: U.S. Small Business Administration.

ACTION: Notice.

SUMMARY: This is a notice of an Administrative declaration of a disaster for the State of NEW YORK dated 07/27/2007.
Incident: Steam Pipe Explosion.
Incident Period: 07/18/2007.
Effective Date: 07/27/2007.
Physical Loan Application Deadline Date: 09/25/2007.
Economic Injury (EIDL) Loan Application Deadline Date: 04/28/2008.

ADDRESSES: Submit Completed Loan Applications to: U.S. Small Business Administration, Processing and Disbursement Center, 14925 Kingsport Road, Fort Worth, TX 76155.

FOR FURTHER INFORMATION CONTACT: A. Escobar, Office of Disaster Assistance, U.S. Small Business Administration, 409 3rd Street, SW., Suite 6050, Washington, DC 20416.

SUPPLEMENTARY INFORMATION: Notice is hereby given that as a result of the Administrator's disaster declaration, applications for disaster loans may be filed at the address listed above or other locally announced locations.

The Following Areas Have Been Determined To Be Adversely Affected By the Disaster:

Primary Counties: New York.
Contiguous Counties:
New York; Bronx, Kings, Queens. New Jersey; Bergen, Hudson.

The Interest Rates Are:

	Percent
Homeowners With Credit Available Elsewhere	5.750
Homeowners Without Credit Available Elsewhere	2.875
Businesses With Credit Available Elsewhere	8.000
Businesses & Small Agricultural Cooperatives Without Credit Available Elsewhere	4.000
Other (Including Non-Profit Organizations) With Credit Available Elsewhere	5.250
Businesses And Non-Profit Organizations Without Credit Available Elsewhere	4.000

The number assigned to this disaster for physical damage is 10949 4 and for economic injury is 10950 0.

The States which received an EIDL Declaration # are New York, New Jersey.

(Catalog of Federal Domestic Assistance Numbers 59002 and 59008)

Dated: July 27, 2007.

Steven C. Preston,

Administrator.

[FR Doc. E7–15038 Filed 8–1–07; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

Disaster Declaration #10948; North Dakota Disaster #ND–00008

AGENCY: U.S. Small Business Administration.

ACTION: Notice.

SUMMARY: This is a Notice of the Presidential declaration of a major disaster for Public Assistance Only for the State of North Dakota (FEMA–1713–DR), dated 07/17/2007.
Incident: Severe Storms and Flooding.
Incident Period: 06/02/2007 through 06/18/2007.
Effective Date: 07/17/2007.
Physical Loan Application Deadline Date: 09/17/2007.

ADDRESSES: *Submit Completed Loan Applications To:* U.S. Small Business Administration, Processing and Disbursement Center, 14925 Kingsport Road, Fort Worth, TX 76155.

FOR FURTHER INFORMATION CONTACT: A. Escobar, Office of Disaster Assistance, U.S. Small Business Administration, 409 3rd Street, SW., Suite 6050, Washington, DC 20416.

SUPPLEMENTARY INFORMATION: Notice is hereby given that as a result of the President's major disaster declaration on 07/17/2007, Private Non-Profit organizations that provide essential services of a governmental nature may file disaster loan applications at the address listed above or other locally announced locations.

The Following Areas Have Been Determined To Be Adversely Affected By the Disaster:

Primary Counties:
Barnes, Bowman, Dickey, Grant Lamoure, Logan, McHenry, Ransom Richland, Sargent, and Stutsman.

The Interest Rates are:

	Percent
Other (Including Non-Profit Organizations) With Credit Available Elsewhere	5.250
Businesses And Non-Profit Organizations Without Credit Available Elsewhere	4.000

The number assigned to this disaster for physical damage is 10948.

(Catalog of Federal Domestic Assistance Number 59008)

Herbert L. Mitchell,

Associate Administrator for Disaster Assistance.

[FR Doc. E7–14968 Filed 8–1–07; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

Disaster Declaration # 10894; Oklahoma Disaster Number OK–00011

AGENCY: U.S. Small Business Administration.

ACTION: Amendment 1.

SUMMARY: This is an amendment of the Presidential declaration of a major disaster for Public Assistance Only for the State of Oklahoma (FEMA–1707–DR), dated 06/07/2007.

Incident: Severe Storms, Tornadoes, and Flooding.

Incident Period: 05/04/2007 through 05/11/2007.

Effective Date: 07/23/2007.

Physical Loan Application Deadline Date: 08/06/2007.

ADDRESSES: Submit Completed Loan Applications To: U.S. Small Business Administration, Processing and Disbursement Center, 14925 Kingsport Road, Fort Worth, TX 76155.

FOR FURTHER INFORMATION CONTACT: A. Escobar, Office of Disaster Assistance, U.S. Small Business Administration, 409 3rd Street, SW., Suite 6050, Washington, DC 20416.

SUPPLEMENTARY INFORMATION: The notice of the President's major disaster declaration for Private Non-Profit organizations in the State of Oklahoma, dated 06/07/2007, is hereby amended to include the following areas as adversely affected by the disaster.

Primary Counties:

Canadian: Cotton, Grady, Grant, Hughes, Logan, McClain, McIntosh, Pawnee, Tillman.

All other information in the original declaration remains unchanged.

(Catalog of Federal Domestic Assistance Number 59008)

Herbert L. Mitchell,

Associate Administrator for Disaster Assistance.

[FR Doc. E7–14969 Filed 8–1–07; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

Disaster Declaration #10919 and #10920; Texas Disaster Number TX–00254

AGENCY: Small Business Administration.

ACTION: Amendment 3.

SUMMARY: This is an amendment of the Presidential declaration of a major disaster for the State of Texas (FEMA—1709—DR) , dated 06/29/2007.

Incident: Severe Storms, Tornadoes, and Flooding.

Incident Period: 06/16/2007 and continuing.

Effective Date: 07/25/2007.

Physical Loan Application Deadline Date: 08/28/2007.

EIDL Loan Application Deadline Date: 03/31/2008.

ADDRESSES: Submit Completed Loan Applications To: U.S. Small Business Administration, Processing and Disbursement Center, 14925 Kingsport Road, Fort Worth, TX 76155.

FOR FURTHER INFORMATION CONTACT: A. Escobar, Office of Disaster Assistance, U.S. Small Business Administration, 409 3rd Street, SW., Suite 6050, Washington, DC 20416.

SUPPLEMENTARY INFORMATION: The notice of the Presidential disaster declaration for the State of Texas, dated 06/29/2007 is hereby amended to include the following areas as adversely affected by the disaster:

Primary Counties:

Brown, Cherokee, Comanche, Hamilton, Llano, Runnels, Smith, and Travis.

Contiguous Counties:

Texas, Anderson, Angelina, Caldwell, Coke, Coleman, Concho, Gillespie, Gregg, Hays, Henderson, Houston, Mason, Mcculloch, Nacogdoches, Nolan, Rusk , Taylor, Tom Green, Upshur, Van Zandt, and Wood.

All other information in the original declaration remains unchanged.

(Catalog of Federal Domestic Assistance Numbers 59002 and 59008)

Herbert L. Mitchell,

Associate Administrator for Disaster Assistance.

[FR Doc. E7–14967 Filed 8–1–07; 8:45 am]

BILLING CODE 8025–01–P

DEPARTMENT OF STATE

[Public Notice 5872]

Culturally Significant Objects Imported for Exhibition Determinations: ''Taddeo and Federico Zuccaro''

SUMMARY: Notice is hereby given of the following determinations: Pursuant to the authority vested in me by the Act of October 19, 1965 (79 Stat. 985; 22 U.S.C. 2459), Executive Order 12047 of March 27, 1978, the Foreign Affairs Reform and Restructuring Act of 1998 (112 Stat. 2681, *et seq.*; 22 U.S.C. 6501 note, *et seq.*), Delegation of Authority No. 234 of October 1, 1999, Delegation of Authority No. 236 of October 19, 1999, as amended, and Delegation of Authority No. 257 of April 15, 2003 [68 FR 19875], I hereby determine that the objects to be included in the exhibition ''Taddeo and Federico Zuccaro,'' imported from abroad for temporary exhibition within the United States, are of cultural significance. The objects are imported pursuant to loan agreements with the foreign owners or custodians. I also determine that the exhibition or display of the exhibit objects at the J. Paul Getty Museum, from on or about October 2, 2007, until on or about January 6, 2008, and at possible additional venues yet to be determined, is in the national interest. Public Notice of these Determinations is ordered to be published in the **Federal Register**.

FOR FURTHER INFORMATION CONTACT: For further information, including a list of the exhibit objects, contact Richard Lahne, Attorney-Adviser, Office of the Legal Adviser, U.S. Department of State (telephone: 202/453–8058). The address is U.S. Department of State, SA–44, 301 4th Street, SW., Room 700, Washington, DC 20547–0001.

Dated: July 25, 2007.

C. Miller Crouch,

Principal Deputy Assistant Secretary for Educational and Cultural Affairs, Department of State.

[FR Doc. E7–15041 Filed 8–1–07; 8:45 am]

BILLING CODE 4710–05–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

Notice of Intent To Release Certain Properties From All Terms, Conditions, Reservations and Restrictions of a Quitclaim Deed Agreement Between the City of Orlando and the Federal Aviation Administration for the Orlando Executive Airport, Orlando, FL

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Request for public comment.

SUMMARY: The FAA hereby provides notice of intent to release certain airport properties, 5.958 acres at the Orlando Executive Airport, Orlando, FL from the conditions, reservations, and restrictions as contained in a Quitclaim Deed agreement between the FAA and the City of Orlando, dated August 9, 1961. The release of property will allow the City of Orlando to dispose of the property for other than aeronautical purposes. The property is located in a portion of the Southwest ¼ of Section 28, Township 22 South, Range 30 East, Orange County, Florida. The parcel is currently designated as non-aeronautical use. The property will be disposed of for the purpose of constructing the Orlando-Orange County Expressway Authority Operations Center. The fair market value of the property has been determined by appraisal to be $1,557,200. The airport will receive fair market value for the property, which will be subsequently reinvested in another eligible airport improvement project.

Documents reflecting the Sponsor's request are available, by appointment only, for inspection at the Greater Orlando Aviation Authority and the FAA Airports District Office.

SUPPLEMENTARY INFORMATION: Section 125 of The Wendell H. Ford Aviation Investment and Reform Act for the 21st Century (AIR–21) requires the FAA to provide an opportunity for public notice and comment prior to the ''waiver'' or ''modification'' of a sponsor's Federal obligation to use certain airport land for non-aeronautical purposes.

DATES: September 4, 2007.

ADDRESSES: Documents are available for review at the Greater Orlando Aviation Authority, One Airport Boulevard, Orlando, FL 32827 and the FAA Airports District Office, 5950 Hazeltine National Drive, Suite 400, Orlando, FL 32822. Written comments on the Sponsor's request must be delivered or mailed to: Juan C. Brown, Program Manager, Orlando Airports District Office, 5950 Hazeltine National Drive, Suite 400, Orlando, FL 32822–5024.

FOR FURTHER INFORMATION CONTACT: Juan C. Brown, Program Manager, Orlando Airport District Office, 5950 Hazeltine National Drive, Suite 400, Orlando, FL 32822–5024.

W. Dean Stringer,

Manager, Orlando Airports District Office, Southern Region.

[FR Doc. 07–3756 Filed 8–1–08; 8:45 am]

BILLING CODE 4910–13–M

DEPARTMENT OF TRANSPORTATION

Surface Transportation Board

[STB Finance Docket No. 35063]

Michigan Central Railway, LLC—Acquisition and Operation Exemption—Lines of Norfolk Southern Railway Company

AGENCY: Surface Transportation Board.

ACTION: Notice of commencement of proceeding, revocation of exemption, and issuance of procedural schedule.

SUMMARY: By this decision and notice, the Board is commencing a proceeding under 49 U.S.C. 10502(b) and 49 CFR 1121.1 to consider the petition of Michigan Central Railway, LLC (MCR) to exempt its acquisition and operation of certain railroad lines of the Norfolk Southern Railway Company (NSR) in Michigan and Indiana. To allow this proceeding to go forward, we are granting MCR's petition to revoke the application of the class exemption, which would otherwise apply to this transaction. Our revocation of the class exemption as to this transaction will allow us to consider the transaction in greater detail than it could be considered under our regulations for processing notices invoking the class exemption, and it will facilitate the participation of interested persons pursuant to the procedural schedule we are adopting.

DATES: Comments on MCR's petition for exemption may be filed by any interested person by September 4, 2007. Replies by MCR and NSR are due by September 17, 2007. The Board will issue its final decision on October 11, 2007.

ADDRESSES: Any filing submitted in this proceeding must refer to STB Finance Docket No. 35063 and may be submitted either via the Board's e-filing format or in the traditional paper format. Any person using e-filing must attach a document and otherwise comply with the instructions found on the Board's ''*http://www.stb.dot.gov.*'' Web site, at the ''E-FILING'' link. Any person submitting a filing in the traditional paper format must submit an original and 10 paper copies of the filing (and also an electronic version) to: Surface Transportation Board, 395 E. Street, SW., Washington, DC 20423–0001. In addition, one copy of each filing in this proceeding must be sent (and may be sent by e-mail only if service by e-mail is acceptable to the recipient) to: Karl Morell, Of Counsel, Ball Janik, LLP, Suite 225, 1455 F. Street, NW., Washington, DC 20005; and G. Paul Moates, Sidley & Austin LLP 1501 K. Street, NW., Washington, DC 20005.

FOR FURTHER INFORMATION CONTACT: Joseph H. Dettmar, (202) 245–0395. [Federal Information Relay Service (FIRS) for the hearing impaired: 1–800–877–8339.]

SUPPLEMENTARY INFORMATION: By petition filed on July 13, 2007, in STB Finance Docket No. 35063, MCR requests, pursuant to 49 U.S.C. 10502, an exemption under the Board's formal (case-by-case) exemption procedures at 49 CFR 1121.1 to authorize it to acquire some 299 miles of rail line from NSR,[1] to acquire through assignment from NSR some 85.5 miles of existing trackage rights [2] and lease rights,[3] and to acquire yards and stations that are related to this track.[4] A map of the area to be served by MCR appears in Exhibit 1 attached to its petition for exemption.

If MCR becomes a carrier pursuant to the exemption sought here, it will grant limited local trackage rights to NSR, approval for which is being sought in a notice of exemption filed in a related proceeding.[5] If the proposed transaction is consummated, MCR would become a Class II rail carrier and would hire approximately 118 employees to operate these rail lines. Under that trackage rights agreement, NSR will retain the right to serve, under certain specified conditions, the General Motors facilities at Grand Rapids and Lansing, MI, and the RSOC of Michigan LLC automotive steel processing facility at Holt, MI, as well as any subsequent occupant(s) of any of these facilities.

In another related proceeding, Watco Companies, Inc. and its wholly owned subsidiary, Watco Transportation Services, Inc. (collectively, Watco), have filed a notice of exemption to continue in control of MCR upon MCR's becoming a rail carrier through its proposed acquisition and operation of these rail lines.[6] NSR will contribute these rail lines, trackage rights, and related assets to MCR, subject to certain traffic restrictions, in exchange for a noncontrolling 33% membership interest in MCR. Watco will contribute

[1] The NSR rail lines run generally between Elkhart, IN and Grand Rapids, MI; between Kalamazoo, MI, and a point near Ypsilanti, MI; and between Jackson, MI, and Lansing, MI. More specifically, the rail lines to be acquired run between the following mileposts: Milepost KH 1.4 at Elkhart, IN, and milepost KH 27.4 at Three Rivers, MI; milepost FB 27.3 at Three Rivers and milepost FB 102.3 at Grand Rapids, MI; milepost MH 143.03 at CP BO in Kalamazoo, MI, and milepost MH 28 at CP Ypsi; and milepost LZ 0.0 at Jackson, MI, and milepost LZ 36.9 at Lansing, MI.

[2] MCR will acquire through assignment by NSR 80 miles of trackage rights over the line of the National Railroad Passenger Corporation (Amtrak) between milepost MH 143.3 near Kalamazoo, MI, and milepost MH 222.8 at the Michigan/Indiana border (east of Michigan City, IN). Additionally, MCR will exercise NSR's trackage rights over lines of CSX Transportation, Inc. (CSXT) between: mileposts 0.0–1.0 M9 in Grand Rapids, MI; and mileposts LZ 36.8–37.9 and 0.0–2.2 HZ in Lansing, MI. MCR will also exercise NSR's trackage rights over a Canadian National Railway Company (CN) line between mileposts 176.7–175.5 in Battle Creek, MI. MCR will host trackage rights to CSXT for a short stretch of track between mileposts LZ 36.8–37.9 in Lansing, MI. Finally MCR will host trackage rights for CN between mileposts UP 2.2–UP 0.0, KY 0.0–KY 0.4, and FB 54.0–FB 56.3 in Kalamazoo, MI.

[3] Specifically, MCR will become lessor of the rail line leased to CN between Kalamazoo (MP 9.51) and Pavilion (MP 0.4).

[4] MCR plans to acquire and to operate NSR yards at: Kalamazoo, MI (Botsford); Grand Rapids, MI (Hughart); Jackson, MI; Lansing, MI (Saginaw); and Battle Creek (Hinman), MI.

[5] *See* NSR's notice invoking the class exemption at 49 CFR 1180.2(d)(7), currently filed on July 13, 2007, in *Norfolk Southern Railway Company—Trackage Rights Exemption—Michigan Central Railway, LLC,* STB Finance Docket No. 35065 (STB served July 27, 2007).

[6] *See* Watco's notice invoking the class exemption at 49 CFR 1180.2(d), concurrently filed on July 13, 2007, in *Watco Companies, Inc., and Watco Transportation Services, Inc.—Continuance in Control Exemption—Michigan Central Railway, LLC,* STB Finance Docket No. 35064 (STB served July 27, 2007).

$18 million in cash and locomotives over time to MCR in exchange for a controlling 67% membership interest. According to MCR, it will invest more than $20 million in these lines over the first 3 years, provide responsive service to local shippers, and develop a new traffic base. MCR states that there will be no adverse effect on overhead traffic and that no shipper will suffer a reduction in competition as a result of the proposed transaction.

MCR simultaneously filed a petition asking the Board to revoke the class exemption at 49 CFR 1150.31 that otherwise would apply to allow the agency to consider the transaction in greater detail than it could be considered under the regulations for processing notices invoking the class exemption. Under 49 U.S.C. 10502(d), the Board may revoke an exemption when it finds that application of regulation is necessary to carry out the Rail Transportation Policy of 49 U.S.C. 10101. We make such a finding here based on the particular circumstances of this transaction. Thus, the class exemption at 49 CFR 1150.31 will be revoked as to this transaction to permit MCR to proceed with seeking Board approval for the transaction through its petition for exemption.

As part of its revocation petition, MCR also has proposed a procedural schedule providing for comments from interested persons 50 days from the date MCR filed its petition, replies by MCR and NSR 65 days from the date the petition was filed, and a final Board decision by 90 days from the date the petition was filed. The proposed schedule will facilitate the participation of interested persons in this proceeding and will provide a timely process for our issuing a final decision. Accordingly, we will adopt the proposed procedural schedule.

MCR's petition for exemption raises issues that require consideration by the Board. Pursuant to 49 U.S.C. 10502(b), the Board must determine whether to begin a proceeding within 90 days of the filing of a petition for exemption. A decision must then be issued within 9 months of the date when the proceeding is formally instituted. The 90th day in this proceeding is October 11, 2007. In compliance with the statute, this order will be issued, and a proceeding will be formally instituted. The deadlines for the submission of comments are set forth above.

Board decisions, notices, and filings are available on its Web site at *http://www.stb.dot.gov.*

This action will not significantly affect either the quality of the human environment or the conservation of energy resources.

It is Ordered

1. MCR's petition to revoke the class exemption is granted.

2. Under 49 U.S.C. 10502(b) a proceeding is commenced to hear MCR's petition for exemption under the formal (case-by-case) exemption procedures at 49 CFR 1121.1, and comments in this proceeding will be due by the dates set forth above.

3. This decision will be published in the **Federal Register** on August 2, 2007.

4. This decision is effective on August 2, 2007.

Decided: July 30, 2007.

By the Board, Chairman Nottingham, Vice Chairman Buttrey, and Commissioner Mulvey.

Vernon Williams,

Secretary.

[FR Doc. E7–14975 Filed 8–1–07; 8:45 am]

BILLING CODE 4915–01–P

Corrections

Federal Register

Vol. 72, No. 148

Thursday, August 2, 2007

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

DEPARTMENT OF AGRICULTURE

Rural Utilities Service

Norborne Baseload Plant: Notice of Availability of Final Environmental Impact Statement

Correction

In notice document E7–13299 beginning on page 38559 in the issue of Friday, July 13, 2007, make the following correction:

On page 38559, In the second column, under the heading **DATE**, in the second line ''August 9, 2007'' should read '' August 13, 2007''.

[FR Doc. Z7–13299 Filed 8–1–07; 8:45 am]

BILLING CODE 1505–01–D

Federal Register

Thursday,
August 2, 2007

Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 410 and 416

Medicare Program; Revised Payment System Policies for Services Furnished in Ambulatory Surgical Centers (ASCs) Beginning in CY 2008; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 410 and 416

[CMS–1517–F]

RIN 0938–AO73

Medicare Program; Revised Payment System Policies for Services Furnished in Ambulatory Surgical Centers (ASCs) Beginning in CY 2008

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule revises the Medicare ambulatory surgical center (ASC) payment system to implement certain related provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). This final rule establishes the ASC list of covered surgical procedures, identifies covered ancillary services under the revised ASC payment system, and sets forth the amounts and factors that will be used to determine the ASC payment rates for calendar year (CY) 2008. The changes to the ASC payment system and ratesetting methodology in this final rule are applicable to services furnished on or after January 1, 2008.

DATES: *Effective Date:* This final rule is effective on January 1, 2008.

FOR FURTHER INFORMATION, CONTACT: Alberta Dwivedi, (410) 786–0378. Dana Burley, (410) 786–0378.

SUPPLEMENTARY INFORMATION:

Electronic Access

This **Federal Register** document is also available from the **Federal Register** online database through *GPO Access*, a service of the U.S. Government Printing Office. Free public access is available on a Wide Area Information Server (WAIS) through the Internet and via asynchronous dial-in. Internet users can access the database by using the World Wide Web; the Superintendent of Documents' home page address is *http://www.gpoaccess.gov/index.html*, by using local WAIS client software, or by telnet to swais.access.gpo.gov, then login as guest (no password required). Dial-in users should use communications software and modem to call (202) 512–1661; type swais, then login as guest (no password required).

Alphabetical List of Acronyms Appearing in This Final Rule

AHA American Hospital Association
AMA American Medical Association
APC Ambulatory payment classification
ASC Ambulatory surgical center
BESS [Medicare] Part B Extract Summary System
CAH Critical access hospital
CBSA Core-Based Statistical Area
CMS Centers for Medicare & Medicaid Services
CPI–U Consumer Price Index for All Urban Consumers
CPT [Physicians'] Current Procedural Terminology, Fourth Edition, 2007, copyrighted by the American Medical Association. CPT® is a trademark of the American Medical Association.
CY Calendar year
DRA Deficit Reduction Act of 2005, Public Law 109–171
FY Federal fiscal year
GAO Government Accountability Office
HCPCS Healthcare Common Procedure Coding System
HOPD Hospital outpatient department
HQA Hospital Quality Alliance
IOL Intraocular lens
IPPS [Hospital] Inpatient prospective payment system
MAC Medicare administrative contractor
MedPAC Medicare Payment Advisory Commission
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108–173
MPFS Medicare Physician Fee Schedule
MSA Metropolitan Statistical Area
NTIOL New technology intraocular lens
OCE Outpatient Code Editor
OMB Office of Management and Budget
OPPS [Hospital] Outpatient prospective payment system
PM Program memorandum
PPAC Practicing Physicians Advisory Council
PPS Prospective payment system
PRA Paperwork Reduction Act of 1995
RFA Regulatory Flexibility Act
RVU Relative value unit

To assist readers in referencing sections contained in this document, we are providing the following table of contents:

Table of Contents

I. Background

A. Legislative and Regulatory History

Section 1832(a)(2)(F)(i) of the Social Security Act (the Act) provides that benefits under the Medicare Supplementary Medical Insurance program (Part B) include payment for facility services furnished in connection with surgical procedures specified by the Secretary that are performed in an ambulatory surgical center (ASC). To participate in the Medicare program as an ASC, a facility must meet the standards specified in section 1832(a)(2)(F)(i) of the Act, which are implemented in 42 CFR Part 416, Subpart B and Subpart C of our regulations. The regulations at 42 CFR 416, Subpart B set forth general conditions and requirements for ASCs, and the regulations at Subpart C provide specific conditions for coverage for ASCs.

The ASC services benefit was enacted by Congress through the Omnibus Reconciliation Act of 1980 (Pub. L. 96–499). For a detailed discussion of the legislative history related to ASCs, we refer readers to the June 12, 1998 proposed rule (63 FR 32291).

Section 1833(i)(1)(A) of the Act requires the Secretary to specify surgical procedures that, although appropriately performed in an inpatient hospital setting, also can be performed safely on an ambulatory basis in an ASC, critical access hospital (CAH), or a hospital outpatient department (HOPD). The report accompanying the legislation explained that Congress intended procedures currently performed on an ambulatory basis in a physician's office that do not generally require the more elaborate facilities of an ASC not be included in the list of ASC covered procedures (H.R. Rep. No. 96–1167, at 390–91, reprinted in 1980 U.S.C.C.A.N. 5526, 5753–54). In a final rule published on August 5, 1982, in the **Federal Register** (47 FR 34082), we established regulations that included criteria for specifying which surgical procedures were to be included for purposes of implementing the ASC facility benefit. Medicare only allows payment to ASCs for procedures that are specified on the ASC list.

Section 626(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108–173, repealed the requirement formerly found in section 1833(i)(2)(A) of the Act that the Secretary conduct a survey of ASC costs for purposes of updating ASC payment rates and, instead, requires the Secretary to implement a revised ASC payment system, to be effective not later than January 1, 2008. Section 5103 of the Deficit Reduction Act of 2005 (DRA), Public Law 109–171, amended section 1833(i)(2) of the Act by adding a new subparagraph (E) to place a limitation on payments for surgical procedures in ASCs. Section 1833(i)(2) of the Act provides that if the standard overhead amount under section 1833(i)(2)(A) of the Act for a facility service for such procedure, without application of any geographic adjustment, exceeds the Medicare payment amount under the hospital outpatient prospective payment system (OPPS) for the service for that year, without application of any geographic adjustment, the Secretary shall substitute the OPPS payment amount for the ASC standard overhead amount. This provision applies to surgical procedures furnished in ASCs on or after January 1, 2007, and before the effective date of the revised ASC payment system implemented in this final rule.

In the November 24, 2006 final rule with comment period for the CY 2007 OPPS and ASC payment systems (71 FR 67960), we addressed the changes in payment to ASCs mandated by section 5103 of Public Law 109–171 and finalized § 416.1(a)(5) of the regulations to implement this provision. (Hereinafter, the November 24, 2006 final rule with comment period is referred to as the CY 2007 OPPS/ASC final rule with comment period.) We also addressed additions to and deletions from the ASC list of covered surgical procedures that were implemented on January 1, 2007. In addition, we made changes in the process to review payment adjustments for insertion of new technology intraocular lenses (NTIOLs) under section 1833(i)(2)(A)(iii) of the Act.

Section 416.65(a) of the regulations specifies general standards for procedures on the ASC list. ASC procedures are those surgical and other medical procedures that are—

- Commonly performed on an inpatient basis but may be safely performed in an ASC;
- Not of a type that are commonly performed or that may be safely performed in physicians' offices;
- Limited to procedures requiring a dedicated operating room or suite and generally requiring a postoperative recovery room or short-term (not overnight) convalescent room; and
- Not otherwise excluded from Medicare coverage.

Specific standards in § 416.65(b) limit covered ASC procedures to those that do not generally exceed 90 minutes operating time and a total of 4 hours recovery or convalescent time. If

anesthesia is required, the anesthesia must be local or regional anesthesia, or general anesthesia of not more than 90 minutes duration.

Section 416.65(b)(3) of the regulations excludes from the ASC list procedures that generally result in extensive blood loss, that require major or prolonged invasion of body cavities, that directly involve major blood vessels, or that are generally emergency or life-threatening in nature.

A detailed history of published changes to the ASC list and ASC payment rates can be found in the June 12, 1998 proposed rule (63 FR 32291). Subsequently, in accordance with § 416.65(c), we published updates of the ASC list in the **Federal Register** on March 28, 2003 (68 FR 15268), May 4, 2005 (70 FR 23690), and in the CY 2007 OPPS/ASC final rule with comment period (71 FR 67960).

During years when we have not updated the ASC list in the **Federal Register**, we have revised the list to be consistent with annual calendar year changes to the Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes. These annual coding updates have been implemented through program instructions to the carriers that process ASC claims. (We note that Medicare Part B carriers are transitioning to Medicare Administrative Contractors (MACs) through 2011, as described in a final rule with comment period published in the **Federal Register** on November 24, 2006 (71 FR 68229).) We last issued program instructions to update the list only to conform to CPT and HCPCS coding changes on December 20, 2006, via Transmittal 1134, Change Request 5211. This transmittal can be found on the CMS Web site at: *http://www.cms.hhs.gov/Transmittals/*).

B. ASC Payment Method

On August 23, 2006, we proposed in the **Federal Register** (71 FR 49635) a revised payment system for ASCs to be implemented effective January 1, 2008, in accordance with section 626(b) of Public Law 108–173, including revisions to the ratesetting methodology and the applicable ASC regulations to incorporate the requirements and payments for ASC services under the revised ASC payment system. We also proposed a new ''exclusionary'' approach for revising the ASC list of covered surgical procedures beginning CY 2008. We proposed to evaluate surgical procedures to identify those that could pose a significant safety risk or that would be expected to require an overnight stay when performed in ASCs, and that would, therefore, be excluded from Medicare payment under the revised ASC payment system. Using that exclusionary method, we developed a list of surgical procedures that we believed were safe for Medicare beneficiaries in ASCs and that were appropriate for Medicare payment. We proposed to adopt an exclusionary approach for identifying surgical procedures that were appropriate for payment under the revised ASC payment system, and the result of that process was a proposed list of surgical procedures for which separate payment would be made. We refer to that list of payable procedures hereinafter as the ASC ''list of covered surgical procedures.''

There are two primary elements in the total cost of performing a surgical procedure: (a) The cost of the physician's professional services to perform the procedure; and (b) the cost of items and services furnished by the facility where the procedure is performed (for example, surgical supplies, equipment, and nursing services). Payment for the first element is made under the Medicare Physician Fee Schedule (MPFS). The August 2006 OPPS/ASC proposed rule addressed the second element, payment for the cost of items and services furnished by the facility.

Under the current ASC payment system, the ASC payment rate is a standard overhead amount established on the basis of our estimate of a fee that takes into account the costs incurred by ASCs generally in providing facility services in connection with performing a specific procedure. The report of the Conference Committee accompanying section 934 of the Omnibus Reconciliation Act of 1980 states that this overhead amount is expected to be calculated on a prospective basis using sample survey data and similar techniques to establish reasonable estimated overhead allowances, which take into account volume (within reasonable limits), for each of the listed procedures (H.R. Rept. No. 96–1479, at 134–35 (1980)).

As stated earlier, to establish those reasonable estimated allowances for services furnished prior to implementation of the revised ASC payment system, section 626(b)(1) of Public Law 108–73 amended section 1833(i)(2)(A)(i) of the Act that required us to take into account the audited costs incurred by ASCs to perform a procedure in accordance with a survey. Further, beginning January 1, 2007, and prior to implementation of a revised ASC payment system, in accordance with section 5103 of Pub. L. 109–171, no ASC standard overhead amount may be greater than the OPPS payment rate for a given service for that year. Except for screening colonoscopies and flexible sigmoidoscopies, payment for ASC services is subject to the usual Medicare Part B deductible and coinsurance requirements, and the amounts paid by Medicare must be 80 percent of the standard overhead amount. As required by section 1834(d) of the Act and implemented in regulations at 42 CFR 410.152(i), the amount paid by Medicare must be 75 percent of the fee schedule payment amount for screening colonoscopies and flexible sigmoidoscopies.

Section 1833(i)(1) of the Act requires us to specify, in consultation with appropriate medical organizations, surgical procedures that are appropriately performed on an inpatient basis in a hospital but that can be safely performed in an ASC, a CAH, or an HOPD and to review and update the list of ASC procedures at least every 2 years.

Section 141(b) of the Social Security Act Amendments of 1994, Public Law 103–432, requires us to establish a process for reviewing the appropriateness of the payment amount provided under section 1833(i)(2)(A)(iii) of the Act for intraocular lenses (IOLs) that belong to a class of NTIOLs. That process was the subject of a separate final rule entitled ''Adjustment in Payment Amounts for New Technology Intraocular Lenses Furnished by Ambulatory Surgical Centers,'' published on June 16, 1999, in the **Federal Register** (64 FR 32198). We proposed changes to the NTIOL request for review process in the CY 2007 OPPS/ASC proposed rule published in the **Federal Register** on August 23, 2006 (71 FR 49631 through 49635) and finalized changes to that process in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68175 through 68181).

C. Provisions of Public Law 108–173 (MMA)

Section 626(a) of Public Law 108–173 (MMA) amended section 1833(i)(2)(C) of the Act, which requires the Secretary to update ASC payment rates using the Consumer Price Index for All Urban Consumers (CPI–U) (U.S. city average) if the Secretary has not otherwise updated the amounts under the revised ASC payment system. As amended by Pub. L. 108–173, section 1833(i)(2)(C) of the Act requires that, if the Secretary is required to apply the CPI–U increase, the CPI–U percentage increase is to be applied on a fiscal year (FY) basis beginning with FY 1986 through FY 2005 and on a

calendar year (CY) basis beginning with CY 2006.

Section 626(a) of Public Law 108–173 further amended section 1833(i)(2)(C) of the Act to require us in FY 2004, beginning April 1, 2004, to increase the ASC payment rates using the CPI–U as estimated for the 12-month period ending March 31, 2003, minus 3.0 percentage points. Section 626(a) of Public Law 108–173 also requires that the CPI–U adjustment factor equal zero percent in FY 2005, the last quarter of CY 2005, and each calendar year from CY 2006 through CY 2009.

Section 626(b) of Public Law 108–173 repealed the requirement that CMS conduct a survey of ASC costs upon which to base a standard overhead payment amount for surgical services performed in ASCs, and added section 1833(i)(2)(D) of the Act. Section 1833(i)(2)(D)(iii) of the Act requires us to implement by no earlier than January 1, 2006, and not later than January 1, 2008, a revised ASC payment system. The revised payment system under section 1833(i)(2)(D)(i) of the Act is to take into account the recommendations contained in a Report to Congress that the Government Accountability Office (GAO) was required to submit by January 1, 2005. Section 1833(i)(2)(D)(ii) of the Act requires that the revised ASC payment system be designed to result in the same aggregate amount of expenditures for surgical services furnished in ASCs the year the system is implemented as would be made if the new system did not apply as estimated by the Secretary. This requirement is to take into account the limitation in ASC expenditures resulting from implementation of section 5103 of Public Law 109–171 beginning January 1, 2007, as we described in sections XVII.A.1. and XVII.E. of the preamble to the CY 2007 OPPS/ASC final rule with comment period (71 FR 68165 and 68174, respectively).

Section 1833(i)(2)(D)(iv) of the Act exempts the classification system, relative weights, payment amounts, and geographic adjustment factor (if any) under the revised ASC payment system from administrative and judicial review.

Section 626(c) of Public Law 108–173 added a conforming amendment to section 1833(a)(1) of the Act, which provides that the amounts paid under the revised ASC payment system shall equal 80 percent of the lesser of the actual charge for the services or the payment amount that we determine under the revised ASC payment system.

D. Issuance of Proposed Rule

As stated earlier, in the August 23, 2006 **Federal Register** (71 FR 49635), we proposed to implement revisions to the ASC payment system so that the revised system is first effective on January 1, 2008.

In addition, we set forth an analysis of the impact that the proposed revised ASC payment system would have on affected entities and Medicare beneficiaries.

We received over 8,900 pieces of correspondence in response to our August 23, 2006 proposal for the revised ASC payment system, which included some comments recommending various changes to how CMS pays for ASC services and processes ASC claims that we did not propose in the August 23, 2006 **Federal Register**. While we read those comments with interest, we generally do not address them, nor have we made any changes in this final rule based on them. We summarize the numerous comments and recommendations that are pertinent to what we proposed, and we respond to them in the appropriate sections of this final rule.

E. Changes to the ASC List for CY 2007

As part of the CY 2007 OPPS/ASC final rule with comment period, we finalized additions to and deletions from the ASC list of covered surgical procedures, effective January 1, 2007 (71 FR 68166). We did not change the criteria for adding or deleting items from the ASC list effective January 1, 2007. However, in the August 2006 proposed rule (71 FR 49628), we discussed changes to the criteria in the context of developing the proposed revised ASC payment system to be effective January 1, 2008. The changes to the criteria that we proposed resulted in the proposed addition for CY 2008 of many procedures that do not meet the current criteria for addition to the list.

II. Revisions to the ASC Payment System Effective January 1, 2008

A. General

As we discussed earlier, generally, there are two primary elements in the total cost of performing a surgical procedure: (a) The cost of the physician's professional services for performing the procedure; and (b) the cost of services furnished by the facility where the procedure is performed (for example, surgical supplies, equipment, nursing services, and overhead). The former is covered by the MPFS. The latter is covered by a Medicare benefit enacted in 1980 that authorized payment of a fee to ASCs for services furnished in connection with performing certain surgical procedures.

Section 1833(i)(1) of the Act requires us to specify surgical procedures that are appropriately and safely performed on an ambulatory basis in an ASC. Moreover, we are required to review and update the list of these procedures not less often than every 2 years, in consultation with appropriate trade and professional associations. The ASC list of covered surgical procedures was limited in 1982 to approximately 100 procedures. Currently, the list consists of more than 2,500 CPT codes encompassing a cross-section of surgical services, although 150 of these codes account for more than 90 percent of the approximately 4.5 million procedures paid for each year under the ASC Part B benefit. Eye, pain management, and gastrointestinal endoscopic procedures are the highest volume ASC surgeries performed under the present ASC payment system.

In CY 2007, Medicare only allows payment to ASCs for procedures on the ASC list of covered surgical procedures. Except for screening colonoscopy services, payment for ASC facility services is subject to the usual Medicare Part B deductible and coinsurance requirements, and the amounts paid by Medicare must be 80 percent of the standard overhead amount. As discussed earlier, under section 626(b) of Public Law 108–173, Congress mandated implementation of a revised payment system for ASC surgical services by no later than January 1, 2008. Public Law 108–173 set forth several requirements for the revised payment system, but did not amend those provisions of the statute pertaining to the ASC list.

As we proposed in the August 2006 proposed rule (71 FR 49635), in this final rule, we address two components of the ASC payment system that will go into effect January 1, 2008. First, we are establishing the ASC list of covered surgical procedures for which an ASC may receive Medicare payment for facility services under the revised ASC payment system, as well as those covered ancillary services that may be separately paid if they are provided integral to a covered surgical procedure. Second, we are specifying the method we will use to set payment rates for ASC services furnished in association with covered surgical procedures. In this final rule, we also specify the regulatory changes that we are making to 42 CFR Parts 410 and 416 to incorporate the rules governing ASC payments that will be applicable beginning in CY 2008.

B. Factors Considered in the Development of the Revised ASC Payment System

On August 2, 2005, we convened a listening session teleconference on revising the Medicare ASC payment system. Over 450 callers participated, including ASC staff, physicians, and representatives of industry trade associations. The listening session provided an opportunity for participants to identify the issues and concerns that they wanted us to address as we developed the revised ASC payment system.

Callers encouraged us to foster beneficiary access to ASCs by creating incentives for physicians to use ASCs. The issues raised by participants included suggestions to expand or eliminate altogether the ASC list, recommendations to model payment on the OPPS, and concerns about how we would propose to treat the geographic wage index adjustment and the annual ASC payment rate update. Several callers also raised concerns about ensuring adequate payment for supplies, ancillary services, and implantable devices under the revised payment system, as well as developing a process to allow special payment for new technology.

We also met with representatives of the ASC industry over the past several years to discuss options for ratesetting other than conducting a survey, to discuss timely updates to the ASC list, and to listen to industry concerns related to the implementation of a revised payment system. We appreciate the thoughtful suggestions that were presented. We considered the concerns and issues brought to our attention, the proposals for revising the ASC list of covered surgical procedures, and the suggested methods by which we could set ASC payment rates in developing the policies in this final rule.

In the August 23, 2006 **Federal Register** (71 FR 49506), we proposed the policies for the revised ASC payment system to be effective beginning in CY 2008. In response to those proposed policies, we received over 8,900 pieces of correspondence from the public that we are addressing in this final rule.

Subsequent to publication of the August 2006 proposed rule for the revised ASC payment system, the GAO published the statutorily mandated report entitled, ''Medicare: Payment for Ambulatory Surgical Centers Should Be Based on the Hospital Outpatient Payment System'' (GAO–07–86) on November 30, 2006. We considered the report's methodology, findings, and recommendations in the development of this CY 2008 final rule for the revised ASC payment system. The GAO methodology, results, and recommendations are summarized below.

The GAO was directed to conduct a study comparing the relative costs of procedures furnished in ASCs to those furnished in HOPDs paid under the OPPS, including examining the accuracy of the ambulatory payment classifications (APC) with respect to surgical procedures furnished in ASCs. Section 626(d) of Pub. L. 108–173 indicated that the report should include recommendations on the following matters:

1. Appropriateness of using groups of covered services and relative weights established for the OPPS as the basis of payment for ASCs.

2. If the OPPS relative weights are appropriate for this purpose, whether the ASC payments should be based on a uniform percentage of the payment rates or weights under the OPPS, or should vary, or the weights should be revised based on specific procedures or types of services.

3. Whether a geographic adjustment should be used for ASC payment and, if so, the labor and nonlabor shares of such payment.

To compare the relative costs of procedures performed in ASCs and HOPDs, the GAO first compiled information on ASCs' costs and the surgical procedures performed. It conducted a survey of 600 randomly selected ASCs from the universe of all ASCs to obtain their CY 2004 cost and procedure data. The GAO received 397 responses from facilities and, through data reliability testing, determined that data from 290 responding facilities were sufficiently reliable and geographically representative of ASCs. Furthermore, to compare the delivery of surgical procedures and their relative costs between ASC and HOPD settings, the GAO analyzed OPPS claims data from CY 2003. It also interviewed officials at CMS, representatives from ASC industry organizations and physician specialty societies, and representatives from nine ASCs.

In order to allocate ASCs' total costs among the individual procedures they performed, the GAO developed a specific methodology to allocate the portion of an ASC's costs accounted for by each procedure. It constructed a relative weight scale for Medicare's covered ASC procedures that captured the general variation in resources associated with performing different procedures. Primarily, it used data that CMS collects for the purpose of setting the practice expense component of physician payment rates, supplemented by information from specialty societies and physicians who work for CMS for those procedures for which CMS had no data on the resources used.

To calculate per-procedure costs based upon data gathered through its survey of ASCs, the GAO deducted costs that Medicare considers unallowable, that is, advertising and entertainment costs. In addition, it also removed costs for services that Medicare pays for separately, such as physician and nonphysician practitioner services. The remaining facility costs were then divided into direct and indirect costs. The GAO defined direct costs as those associated with the clinical staff, equipment, and supplies utilized during the procedure. Indirect costs included all remaining costs. Next, to allocate each facility's direct costs across the procedures it performed, the GAO applied its relative weight scale. It allocated indirect costs equally across all procedures performed by the facility. For each procedure performed by a responding ASC facility, it summed the allocated direct and indirect costs to determine a total cost for the procedure. To obtain a per-procedure cost across all ASCs, the GAO arrayed the calculated costs for all ASCs performing that procedure and identified the median cost.

To compare per-procedure costs for ASCs and HOPDs, the GAO obtained the list of OPPS APCs and their assigned procedures, along with the OPPS median cost of each procedure and its related APC group. It then calculated a ratio between each procedure's ASC median cost as determined by the survey and the median cost of the procedure's corresponding APC group under the OPPS, referred to as the ASC-to-APC cost ratio. It calculated a corresponding ratio between each ASC procedure's median cost under the OPPS and the median cost of the procedure's APC group using CMS data, referred to as the OPPS-to-APC cost ratio. In order to evaluate the difference in procedure costs between the two settings, the GAO compared the ASC-to-APC cost ratio to the OPPS-to-APC cost ratio. Next, to assess how well the relative costs of procedures in the OPPS, defined by their assignment to APC groups, reflect the relative costs of procedures in the ASC setting, it evaluated the distribution of both the ASC-to-APC cost ratios and the OPPS-to-APC cost ratios.

The GAO also analyzed Medicare claims data for the top 20 procedures with the highest Medicare ASC claims volume in CY 2004 to examine the delivery of additional services with

surgical procedures in ASCs and HOPDs. Last, to calculate the percentage of labor-related costs among the responding ASCs, for each ASC, the GAO divided total labor costs by total costs and then determined the range of the percentage of labor-related costs among all of the ASCs between the 25th and the 75th percentile, as well as the mean and median percentage of labor-related costs.

Based on its extensive analyses, the GAO determined that the APC groups in the OPPS accurately reflect the relative costs of the procedures performed in ASCs. GAO's analysis of the cost ratios showed that the ASC-to-APC cost ratios were more tightly distributed around their median cost ratio than were the OPPS-to-APC cost ratios. These patterns demonstrated that the APC groups reflect the relative costs of procedures performed by ASCs and, therefore, that the APC groups could be used as the basis for an ASC payment system. The GAO determined, in fact, that there was less variation in the ASC setting between individual procedures' costs and the costs of their assigned APC groups than there is in the HOPD setting. It concluded that, as a group, the costs of procedures performed in ASCs have a relatively consistent relationship with the costs of the APC groups to which they would be assigned under the OPPS. The GAO's analysis also found that procedures in the ASC setting had substantially lower costs than those same procedures in the HOPD. While ASC costs for individual procedures varied, in general, the median costs for procedures were lower in ASCs, relative to the median costs of their APC groups, than the median costs for the same procedures in the HOPD setting. The median cost ratio among all ASC procedures was 0.39 (0.84 when weighted by Medicare volume based on CY 2004 claims), whereas the median cost ratio among all OPPS procedures was 1.04.

The GAO found many similarities in the additional items and services provided by ASCs and HOPDs for the top 20 ASC procedures. However, of these additional items and services, few resulted in additional payment in one setting but not the other. HOPDs were paid for some of the related services separately, while in the ASC setting, other Part B suppliers billed Medicare and received payment for many of the related services.

Finally, in its analysis of labor-related costs, the GAO determined that the mean labor-related proportion of costs was 50 percent. The range of the labor-related costs for the middle 50 percent of responding ASCs was 43 percent to 57 percent of total costs.

Based on its findings from the study, the GAO recommended that CMS implement a payment system for procedures performed in ASCs based on the OPPS, taking into account the lower relative costs of procedures performed in ASCs compared to HOPDs in determining ASC payment rates.

Comment: A number of commenters noted that, by the close of the public comment period for the August 2006 proposed rule for the revised ASC payment system, the GAO had not yet provided recommendations regarding ASC payment in a report to Congress that it was required to submit by January 1, 2005. Some commenters recommended that, although CMS was directed to take into account these recommendations in implementing the revised ASC payment system, should the GAO's recommendations be provided before publication of the final rule establishing the policies of the revised ASC payment system, CMS should not take them into consideration, given the public's inability to provide input to CMS during the comment period regarding the GAO's methodology, findings, and recommendations. Other commenters recommended that, if the GAO Report was forthcoming shortly, CMS should provide another opportunity for public comment prior to finalizing the policies of the revised ASC payment system in order to allow the public to provide CMS with their perspectives on those recommendations.

Response: As described earlier, the GAO published its report (GAO–07–86) on November 30, 2006. In accordance with section 1833(i)(2)(D)(i) of the Act, we did take into account the recommendations made in the GAO Report in developing the final policies for the revised ASC payment system. The GAO's findings and recommendations are summarized above, and its specific recommendations are further discussed in the particular sections of this final rule that address the related topics. We appreciate the public's interest in providing us with detailed input regarding the revised ASC payment system from a variety of perspectives. In regard to the commenters' recommendation for a second opportunity for public comment prior to finalizing the policies of the revised ASC payment system after the GAO Report was published, we note that the GAO's recommendations are in complete accord with our August 2006 proposal for the revised ASC payment system. Therefore, we are not providing another opportunity for public comment prior to finalizing the policies of the revised ASC payment system, because the proposed revised system is fully consistent with the recommendations of the GAO Report and we already provided a 90-day comment period regarding our proposal for CY 2008. We believe that the comment period for the August 2006 proposed rule provided the public with ample opportunity to comment on the policies that were recommended by the GAO. The considerable operational changes required to implement the revised ASC payment system necessitate significant lead time that would not be possible if we were to provide another comment period prior to finalizing the policies. We also believe that our consideration of the recent GAO study, as well as other available information regarding HOPD and ASC costs and payments, in addition to our prior discussions with stakeholders and the many public comments on the proposed rule, provide us with the necessary breadth and depth of information and viewpoints to finalize our payment policies for the revised ASC payment system in this final rule.

At its December 2006 meeting, the Practicing Physicians Advisory Council (PPAC) made two recommendations to CMS regarding the final rule for the revised ASC payment system. First, the PPAC recommended that CMS establish a process to consult with national medical specialty societies and the ASC community to develop and adopt a systematic and adaptable means of fairly reimbursing ASCs for all safe and appropriate services, allowing for changes in technology and current day practice. Second, the PPAC recommended that CMS apply any payment policies uniformly to both ASCs and HOPDs, as appropriate.

We have considered the GAO Report, in addition to the recommendations of the PPAC, all public comments received on the proposed rule, and other concerns and issues brought to our attention by interested parties over the past several years, in developing this final rule for the CY 2008 revised ASC payment system. Specific policies are discussed, comments summarized and responses provided, and policies finalized in subsequent sections of this final rule.

C. Rulemaking for the Revised ASC Payment System in CY 2008

In response to comments submitted timely regarding the proposals set forth in the proposed rule for the revised ASC payment system published on August 23, 2006, this final rule establishes the final policies and regulations of the

revised ASC payment system for initial implementation in CY 2008. All tables included in this final rule listing HCPCS codes subject to pertinent final policies of the revised ASC payment system, as well as estimated payment rates, are illustrative only, based on CY 2007 HCPCS codes and final CY 2007 OPPS and MPFS information, with application of the most current update estimates for CY 2008. The information in the Addenda to this final rule is also only illustrative, to provide examples of the results of applying the final policies of the revised ASC payment system, based on the most recent information available for CY 2007. As further discussed in sections V.E. and VI. of this final rule, we will propose the CY 2008 relative payment weights, payment amounts, specific HCPCS codes to which the final policies of the revised ASC payment system would apply, and other pertinent ratesetting information for the CY 2008 revised ASC payment system in the proposed OPPS/ASC rule to update the payment systems for CY 2008 to be issued in mid-summer of CY 2007. We will then publish final relative payment weights, payment amounts, specific CY 2008 HCPCS codes to which the final policies will apply, and other pertinent ratesetting information for the CY 2008 revised ASC payment system in the final OPPS/ASC rule to update the payment systems for CY 2008. The ASC payment system treatment of new CY 2008 HCPCS codes published in the CY 2008 OPPS/ASC final rule will provide interim determinations, open to public comment on that final rule, and we will respond to comments about those determinations in the OPPS/ASC final rule for CY 2009.

III. Covered Surgical Procedures Paid in ASCs On or After January 1, 2008

A. Payable Procedures

In its March 2004 Report to the Congress, the Medicare Payment Advisory Commission (MedPAC) recommended replacing the current ''inclusive'' list of procedures, which are the only surgical procedures for which Medicare allows payment to an ASC, with an ''exclusionary'' list. That is, rather than limiting payment to ASCs to a list of procedures that CMS specifies, Medicare would allow payment to ASCs for any surgical procedure except those that CMS explicitly excludes from payment. MedPAC further recommended that clinical safety standards and the need for an overnight stay be the only criteria for excluding a procedure from eligibility for Medicare ASC payment. MedPAC suggested that some of the criteria, such as site-of-service volume and time limits, which we have used in the past to identify procedures for the ASC list of covered surgical procedures, are probably no longer clinically relevant.

In the August 2006 proposed rule for the revised ASC payment system, we noted that we had given careful consideration to MedPAC's recommendations and participated in considerable discussion and consultation with members of ASC trade associations and physicians, who represent a variety of surgical specialties, regarding the criteria that we would use to identify procedures for payment under the revised ASC payment system. We agreed that adoption of a policy similar to that recommended by MedPAC would serve both to protect beneficiary safety and increase beneficiary access to procedures in appropriate clinical settings, recognizing the ASC industry's interest in obtaining Medicare payment for a much wider spectrum of services than is now allowed. Therefore, in the August 2006 proposed rule (71 FR 49636), we proposed that, under the revised ASC payment system for services furnished on or after January 1, 2008, Medicare would allow payment to ASCs for any surgical procedure performed in an ASC, except those surgical procedures that we determine are not payable under the ASC benefit.

Further, we proposed to establish beneficiary safety and the expected need for an overnight stay as the principal clinical considerations and decisive factors in determining whether ASC payment would be allowed for a particular surgical procedure. As discussed in section XVIII.B.2. of the preamble of the proposed rule, we also proposed to exclude from separate payment under the revised ASC payment system those surgical procedures that are on the OPPS inpatient list, that are not eligible for separate payment under the OPPS, and that are CPT surgical unlisted procedure codes.

We discuss below the criteria that we proposed as the basis for identifying procedures that would pose a significant safety risk to a Medicare beneficiary when performed in an ASC, or procedures following which we would expect a Medicare beneficiary to require overnight care.

1. Definition of Surgical Procedure

In order to delineate the scope of procedures that constitute ''outpatient surgical procedures'' in the August 2006 proposed rule, we first proposed to clarify what we considered to be a ''surgical'' procedure. Under the existing ASC payment system, we define a surgical procedure as any procedure described within the range of Category I CPT codes that the CPT Editorial Panel of the American Medical Association (AMA) defines as ''surgery'' (CPT codes 10000 through 69999). Under the revised payment system, we proposed to continue to define surgery using that standard. The CPT Editorial Panel is responsible for maintaining the CPT nomenclature, with authority to revise, update, or modify the CPT codes. A larger body of CPT advisors, the CPT Advisory Committee, supports the work of the CPT Editorial Panel. Members of the CPT Editorial Panel include individuals nominated by physician and hospital associations and insurers, providing for diverse specialty input.

In addition, in the August 2006 proposed rule for the revised ASC payment system, we proposed to include within the scope of surgical procedures payable in an ASC those procedures that are described by Level II HCPCS codes or by Category III CPT codes that directly crosswalk to or are clinically similar to procedures in the CPT surgical range. We proposed to include all three types of codes in our definition of surgical procedures because they all may be eligible for separate payment under the OPPS and, to the extent it is reasonable to do so, we proposed that the revised ASC payment system parallel the OPPS in its policies.

In the August 2006 proposed rule, we provided an example of a Level II HCPCS code that we believe represents a procedure that could be safely and appropriately performed in an ASC, specifically HCPCS code G0297 (Insertion of single chamber pacing cardioverter-defibrillator pulse generator). We developed this Level II HCPCS code for use in the OPPS because CPT code 33240 (Insertion of single or dual chamber pacing cardioverter-defibrillator pulse generator), which describes the surgical insertion of a cardioverter-defibrillator pulse generator, does not distinguish insertion of a single chamber cardioverter-defibrillator generator from insertion of a dual chamber cardioverter-defibrillator generator. Under the OPPS, we were concerned that different facility resources could be required for the insertion of these two types of cardioverter-defibrillator pulse generators, so we developed Level II HCPCS codes to permit HOPDs to more accurately report the resources required when these surgical procedures are performed. In instances such as this, when a Level II HCPCS code is

established as a substitute for a CPT surgical procedure code which does not adequately describe, from a facility perspective, the nature of a surgical service, we proposed to allow payment for the Level II HCPCS code under the proposed revised ASC payment system. We proposed not to allow ASC payment for Level II HCPCS codes or Category III CPT codes that describe services that fall outside the scope of, that is, that do not correspond to, surgical procedures described by CPT codes 10000 through 69999.

We recognized in the proposed rule that continuing to use this definition of surgery would exclude from ASC payment certain invasive, ''surgery-like'' procedures, such as cardiac catheterization or certain radiation treatment services which are assigned codes outside the CPT surgical range. However, we believed that continuing to rely on the CPT definition of surgery would be administratively straightforward, logically related to the categorization of services by physician experts who both establish the codes and perform the procedures, and consistent with our proposal to allow ASC payment for all outpatient surgical procedures. Given the number of other changes that we expected to implement as part of the revised payment system, along with the significant expansion of ASC covered surgical procedures that we proposed, we explained that we believed it would be prudent at the outset to continue to define surgery as it is defined by the CPT code set, which is used to report services for payment under both the MPFS and the OPPS. During the development of the August 2006 proposed rule, we reviewed thousands of CPT codes in the surgical range (CPT codes 10000 through 69999), and we proposed to not exclude from payment over 750 surgical procedures previously excluded, in addition to providing ASC payment for the more than 2,500 CPT codes on the CY 2007 ASC list of covered surgical procedures.

However, we are cognizant of the dynamic nature of ambulatory surgery, which has resulted in a dramatic shift of services from the inpatient setting to the outpatient setting over the past two decades. Therefore, in the proposed rule, we solicited comments regarding other services that are invasive and ''surgery-like,'' which could safely and appropriately be performed in an ASC, and which require the resources typical of an ASC, even though the procedures are described by codes that fall outside the range of CPT surgical codes. In particular, we were interested in considering commenters' views regarding what constitutes a ''surgical'' procedure.

We received many public comments about our August 2006 proposal to define the surgical procedures for which we would make payment to ASCs as those falling within the surgical code range specified by the CPT Editorial Panel.

Comment: While, in general, hospital associations and device manufacturers supported the proposal to maintain the definition of a surgical procedure used under the existing ASC payment system, many ASC industry representatives provided a broad range of suggestions about how the definition should be expanded. Some of the commenters requested that CMS place no limit on the procedures that would be payable in ASCs because there is no such limit on Medicare payments to HOPDs. Other commenters suggested a more limited expansion of procedures eligible for payment under the revised ASC payment system. These commenters specifically recommended that CMS expand its definition of a surgical procedure to include:

(a) Medical procedures that are invasive and require general anesthesia or that are specifically designated as intraoperative procedures;

(b) X-ray, fluoroscopy, and ultrasound procedures that require insertion of a needle, catheter, tube, or probe via a natural orifice or through the skin;

(c) Radiology procedures integral to performance of nonradiologic procedures, performed either during or immediately following the surgical procedure; and

(d) Level II HCPCS and Category III CPT codes that describe procedures that crosswalk directly or are clinically similar to those listed in suggestions (a) through (c) above.

Response: We have given consideration to the many recommendations of the commenters. In general, we continue to believe it is appropriate to provide payments to ASCs for the resources associated with performing those services that are surgical procedures as defined by the CPT Editorial Panel. From the Panel's broad experience in regularly addressing the complex issues associated with new and emerging health care technologies, as well as the difficulties encountered with obsolete procedures, we believe its members are well-positioned to maintain and refine the existing coding taxonomy, which defines certain procedures as surgery, to appropriately reflect medical practice in an evolving health care delivery system. In addition, we believe that our proposal to pay for surgical procedures in ASCs that are reported by Level II HCPCS and Category III CPT codes that directly crosswalk or are clinically similar to procedures in the surgical range of CPT codes that are payable in ASCs is consistent with our definition of surgery according to the CPT surgical code range, while providing ASC payment for some procedures that have not yet been categorized by the CPT Editorial Panel or for which Medicare recognizes alternative HCPCS codes for payment.

Although we are not changing our definition of surgery as suggested by commenters, we did review procedures that are coded by specific Level II HCPCS or Category III CPT codes that were identified by commenters as surgical procedures that should be payable in ASCs. We assessed those procedures using the same final criteria discussed in section III.A.2. of this final rule that we used to evaluate all surgical procedures for their safety or the expected need for an overnight stay in making decisions about their exclusion from ASC payment. As we proposed, we also evaluated the codes in the context of whether they directly crosswalk or are clinically similar to procedures in the CPT surgical range that we have determined do not pose a significant safety risk or for which an overnight stay is not expected when performed in ASCs. As a result of that review, 14 additional Level II HCPCS codes and 15 Category III CPT codes beyond those we proposed for CY 2008 payment will be payable as covered surgical procedures when performed in ASCs beginning in CY 2008.

Furthermore, as discussed in section IV. of this final rule, although we are not expanding our definition of surgical procedures, we will provide separate ASC payment for a number of covered ancillary services when they are furnished on the same day as a covered surgical procedure and are integral to the performance of that procedure in the ASC setting. Those services include certain radiology procedures, such as some fluoroscopy and ultrasound services, that some commenters recommended we define as surgical procedures for addition to the ASC list of covered surgical procedures.

Comment: Several commenters expressed concern regarding CMS' proposed exclusion from ASC payment of all procedures described within the range of Category I CPT codes defined as ''radiology'' in accordance with the CPT Editorial Panel designation. The commenters asserted that regulations regarding the Federal physician self-referral prohibition (section 1877 of the Act) exclude interventional and

intraoperative radiology services from the definition of ''radiology'' services subject to the law's self-referral prohibition, and that CMS should, therefore, treat those services as surgical services that are eligible for payment as covered surgical procedures under the revised ASC payment system. They believed that interventional radiology and intraoperative radiology services that require insertion of a needle, catheter, tube, probe, or similar device are appropriately considered surgical in nature for purposes of ASC payment.

Response: The commenters' statements with respect to the treatment of interventional radiology procedures under the physician self-referral regulations seem overly broad. The physician self-referral regulations provide that the following services (which may include some, but not all, interventional radiology procedures) are not ''radiology and certain other imaging services'' for purposes of section 1877 of the Act: (i) X-ray, fluoroscopy, or ultrasound procedures that require the insertion of a needle, catheter, tube, or probe through the skin or into a body orifice; and (ii) radiology procedures that are integral to the performance of a nonradiological medical procedure and performed either during the nonradiological medical procedure or immediately following the nonradiological medical procedure when necessary to confirm placement of an item inserted during the nonradiological medical procedure. We do not believe that Medicare's exclusion of specific services from the definition of ''radiology and certain other imaging services'' for purposes of the physician self-referral prohibition should result in such services being considered ''surgical services'' for purposes of the revised ASC payment system.

Further, as we explain above, we believe that the characterization of procedures as surgery for purposes of their performance in ASCs is best left to the expertise of the CPT Editorial Panel. We do not believe that services designated as radiology services by the CPT Editorial Panel are appropriately classified as covered surgical procedures in ASCs, facilities that specialize in the delivery of ambulatory surgical services. However, as discussed further in section IV.C.2. of this final rule, we do believe that it is appropriate to provide separate ASC payment for certain ancillary services that are integral to the covered surgical procedures. Thus, we will provide separate payment to ASCs under the revised payment system for radiology services that are integral to the performance of an ASC covered surgical procedure when that radiology procedure is one of those for which separate payment is made under the OPPS. That is, separate payment will be made for covered ancillary radiology services integral to covered surgical procedures that are provided in the ASC immediately before, during, or immediately following the surgical procedure.

After consideration of the public comments we received, we are finalizing our proposal to define surgery as those procedures described by CPT codes within the surgical range of 10000 through 69999, without modification. In addition, we are including within our definition of a covered surgical procedure payable in the ASC setting those Level II HCPCS codes or Category III CPT codes that directly crosswalk or are clinically similar to procedures in the CPT surgical range that we have determined do not pose a significant safety risk, that we would not expect to require an overnight stay when performed in ASCs, and that are separately paid under the OPPS. An illustrative list of covered surgical procedures under the revised ASC payment system, including Category I and Category III CPT codes and Level II HCPCS codes, can be found in Addendum AA to this final rule. An illustrative list of radiology services and other covered ancillary services that are eligible for separate ASC payment when provided integral to an ASC covered surgical procedure on the same day is located in Addendum BB to this final rule.

2. Procedures Excluded From Payment Under the Revised ASC Payment System

As stated above, in the August 2006 proposed rule for the revised ASC payment system, we proposed to allow payment to ASCs for all procedures described by CPT codes within the surgical range of 10000 through 69999, or by Level II HCPCS codes or Category III CPT codes that directly crosswalk or are clinically similar to procedures in the CPT surgical range, that do not pose a significant safety risk to Medicare beneficiaries and that are not expected to require an overnight stay. Having established what we consider to be a ''surgical procedure,'' we next considered criteria that would enable us to identify procedures that could pose a significant safety risk when performed in an ASC or that we expect would require an overnight stay within the bounds of prevailing medical practice. We discuss in the next section how we proposed to identify procedures that could pose a significant safety risk.

a. Significant Safety Risk

First, we proposed to exclude from ASC payment any procedure that is included on the current OPPS inpatient list, that is, those procedures designated as requiring inpatient care under § 419.22(n). (See Addendum E to the CY 2007 OPPS/ASC final rule with comment period (71 FR 68385 through 68398).) The procedures included on that list are typically performed in the hospital inpatient setting due to the nature of the procedure, the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged, or the underlying physical condition of the patient. We believed that any procedure for which we did not allow payment in the hospital outpatient setting due to safety concerns would not be safe to perform in an ASC.

Second, we proposed to exclude from ASC payment procedures that the CY 2005 Part B Extract Summary System (BESS) data indicated were performed 80 percent or more of the time in the hospital inpatient setting, even if those procedures were not included on the OPPS inpatient list. We selected an 80-percent threshold because we believed that an 80-percent level of inpatient performance was a fair indicator that a procedure is most appropriately performed on an inpatient basis and, as such, would pose a significant safety risk for Medicare beneficiaries if performed in an ASC. We believed that procedures with inpatient utilization frequencies above the proposed threshold were complex and were likely to require a longer and more intensive level of care postoperatively than what is provided in a typical ASC. We also believed that performing these procedures in an ASC, where immediate access to the full resources of an acute care hospital is not the norm, would pose a significant safety risk for beneficiaries.

Third, we proposed to retain some of the specific criteria for evaluating safety risks that are listed in § 416.65(b)(3) of our existing regulations. Procedures that involve major blood vessels, major or prolonged invasion of body cavities, extensive blood loss, or are emergent or life-threatening in nature could, by definition, pose a significant safety risk. Therefore, we proposed to exclude from ASC payment surgical procedures that may be expected to involve any of these characteristics, based on evaluation by our medical advisors. We noted that most of the procedures that our medical advisors identified as involving any of the characteristics listed in § 416.65(b)(3) also require overnight or

inpatient stays, reinforcing our belief that they should be excluded from ASC payment.

Finally, we proposed not to continue applying under the proposed revised system the current time-based, prescriptive criteria at §§ 416.65(b)(1) and (b)(2), which exclude from the ASC list procedures that exceed 90 minutes of operating time or 4 hours of recovery time or 90 minutes of anesthesia. We believed these criteria were no longer clinically appropriate for purposes of defining a significant safety risk for surgical procedures.

We indicated that, in light of the proposed changes for evaluating procedures to identify those that pose a significant safety risk for beneficiaries when performed in ASCs, we believed that it would not be appropriate to apply the existing standard at § 416.65(a)(1), which states that covered surgical procedures are those that are commonly performed on an inpatient basis but may be safely performed in an ASC, because this standard is no longer relevant to prevailing medical practice in the realm of ambulatory or outpatient surgery. Similarly, we believed that it would not be appropriate to continue applying the existing standard at § 416.65(a)(2), which states that procedures performed in an ASC are not of a type that are commonly performed, or that may be performed, in a physician's office. This standard did not seem relevant within the context of the proposal only to exclude from ASC payment under the revised payment system those surgical procedures that pose a safety risk or are expected to require an overnight stay. We would expect the types of surgical procedures that are commonly performed or that may be performed in a physician's office to pose no significant safety risk and to require no overnight stay.

We proposed to add new Subpart F to 42 CFR Part 416 to reflect coverage, scope, and payment for ASC services under the revised payment system. Included in the changes would be new § 416.166 to reflect the changes that we proposed to our current policy for evaluating and identifying those procedures that would pose a significant safety risk for beneficiaries and would be excluded from our list of ASC covered surgical procedures beginning January 1, 2008. To set the provisions that are applicable to our existing ASC payment system apart from those that would apply to the revised ASC payment system, as we proposed, in the CY 2007 OPPS/ASC final rule with comment period, we revised the section headings of Subparts D and E of Part 416 to clearly denote the provisions that govern covered surgical procedures furnished before January 1, 2008. We also added §§ 416.76 and 416.121 to clearly denote the effective dates of Subparts D and E (71 FR 68226).

Comment: Commenters provided many recommendations regarding the proposed criteria for evaluating which procedures should be excluded from the ASC list of covered surgical procedures that varied greatly. At one end of the spectrum, some commenters recommended that CMS only exclude from ASC payment those procedures that are included on the ''inpatient list'' used under the OPPS. They believed that all procedures not on the OPPS inpatient list are safe for performance in ASCs and that, by the specification of their payable status under the OPPS, they do not require an overnight stay.

Some commenters suggested that CMS create the ASC exclusionary list by individually reviewing surgical procedures based upon data that demonstrate the risks, complications, and overall safety of a given procedure, rather than attempting to specifically apply the standards of the proposed criteria. They believed that health outcomes databases, including the National Surgical Quality Improvement Project and patient and device registries, could provide further information to refine an initial safety assessment based on the proposed criteria when certain procedures were identified as needing further consideration and evaluation. The commenters recommended this flexible and specific approach to allow for full consideration of the surgical aspects of each procedure, in order to make an appropriate determination regarding its safety for ASC performance. The commenters believed CMS could work with surgical professional associations and external surgical experts to facilitate a smooth and efficient clinical review process.

In contrast, other commenters recommended that CMS implement more stringent review criteria than our criteria under the existing payment system for evaluating which procedures are unsafe for performance in ASCs. They believed that beneficiary safety could be better protected if CMS would adopt review criteria that would exclude more procedures from ASC performance than those criteria currently in place, while maintaining the existing limitations on operating and recovery room times.

Response: We believe that both ends of the spectrum of public comments are inconsistent with our goal of only excluding those procedures from ASC payment that are unsafe for performance in ASCs or are expected to require an overnight stay. We agree with the perspective of most commenters that procedures on the OPPS inpatient list should also be excluded from ASC payment. However, while we strongly disagree with the contention by some commenters that all procedures performed in HOPDs are appropriate for performance in ASCs, we also believe that instituting criteria that are more restrictive than those currently in place would be inappropriate, because we do not have safety concerns regarding procedures that are already included on the ASC list of covered surgical procedures.

Typically, HOPDs are able to provide much higher acuity care than ASCs. ASCs have neither patient safety standards consistent with those in place for hospitals, nor are they required to have the trained staff and equipment needed to provide the breadth and intensity of care that hospitals are required to maintain. According to current CMS standards, hospitals must meet numerous documentation, infection prevention, and patient assessment requirements that are not applied to ASCs. Therefore, there are some procedures that we believe may be appropriately provided in the HOPD setting that are unsafe for performance in ASCs. Thus, we are not adopting a final policy to exclude only those surgical procedures on the OPPS inpatient list from ASC payment under the revised payment system.

Nonetheless, as stated in our August 2006 proposal and consistent with MedPAC recommendations, we are committed to revising the ASC list of covered surgical procedures so that it excludes only those surgical procedures that pose significant safety risks to beneficiaries or that are expected to require an overnight stay. We believe that adoption of a policy similar to that recommended by MedPAC would serve both to protect beneficiary safety and increase beneficiary access to surgical procedures in appropriate clinical settings. We also believe that this approach is most consistent with the PPAC's recommendation that we provide payment under the revised ASC payment system for all safe and appropriate services. Thus, we do not believe that it would be appropriate to implement more restrictive criteria for evaluating procedures for exclusion from ASC payment or even to maintain all of the current criteria that we use under the existing payment system to evaluate the appropriateness of including procedures on the ASC list. We continue to believe the current limitations on operating room and recovery room times for ASC procedures

are no longer clinically relevant to assessing the safety risk of surgical procedures. Our comprehensive review of all surgical procedures has convinced us that there are procedures in addition to those included on the CY 2007 ASC list of covered surgical procedures that may be safely performed in ASCs, and that increasing the number and types of procedures for which Medicare provides ASC payment is appropriate.

Regarding our proposed overall approach to evaluating procedures for exclusion from the ASC list of covered surgical procedures, we believe that our evaluation process is generally consistent with the approach advised by some commenters that we apply the proposed criteria as part of an initial safety assessment, and then conduct procedure-specific analyses of possible risks and complications of individual procedures based on available data. In preparing the proposal for the revised ASC payment system, we reviewed each surgical procedure that is separately payable under the OPPS and not already on the CY 2007 ASC list and with inpatient utilization of less than 80 percent against the proposed safety and overnight stay criteria and identified a subset of procedures for further assessment if we had concerns about their potential safety risk. We then used all of the information available to us to arrive at a preliminary determination regarding each procedure's suitability for payment in the ASC setting. These preliminary determinations constituted our proposed treatment of the procedures under the revised ASC payment system, and the status of the codes was open to public comment in the August 2006 proposed rule. We received detailed information and recommendations from many commenters, including hospitals, ASCs, device manufacturers, and physician specialty organizations, as well as physician experts, regarding the proposed treatment of many surgical procedure codes. Summaries of these comments and our responses follow later in this section of this final rule.

Comment: A number of commenters expressed concerns about the safety implications of a greatly expanded list of surgical procedures to be performed in ASCs. They advocated implementation of specific additional measures for tightening and strengthening the criteria we proposed to use to evaluate the potential for beneficiary risk associated with surgical procedures. Included in the commenters' numerous recommendations were the following comments:

(1) Make no changes to the current criteria until the ASC Conditions for Coverage are revised to ensure that patient protections comparable to those in place in hospitals are in place in ASCs.

(2) Apply the existing and proposed criterion to exclude procedures from the ASC list that involve major blood vessels, by adopting a specific list of blood vessels that CMS defines as major blood vessels, in order to provide more certainty about which procedures would be excluded. Some commenters recommended that CMS adopt the definition of a major blood vessel advanced in a medical textbook, *Essentials of Anatomy & Physiology,* 6th Edition, by Seeley, Stephens and Tate. For procedures that involve blood vessels defined by Seeley, et al., as major, but that are already being performed safely in ASCs (for example, CPT code 36870, Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)), the commenters suggested that CMS retain them as ASC covered surgical procedures, thereby allowing their continued payment when performed in ASCs.

(3) Apply the existing and proposed criterion to exclude from ASC payment those procedures requiring major or prolonged invasion of body cavities, by defining ''prolonged'' invasion as referring to any procedure in which the patient is under anesthesia for 90 minutes or longer, and expand the definition of body cavity to include major blood vessels.

(4) Exclude from ASC payment procedures that commonly require systemic thrombolytic therapy. Some commenters recommended that CMS exclude procedures that involve blood vessels that, if occluded, would require inpatient lytic therapy, while other commenters recommended more generally that CMS exclude procedures that may result in a patient's need for lytic therapy. Lytic or inpatient thrombolytic therapy as used in this context both refer to systemic thrombolytic therapy.

(5) Disallow procedures that require puncturing of the femoral vessels for access. Some commenters recommended that this exclusion be for procedures accessing either the femoral artery or the femoral vein, while other commenters would have limited the exclusion to only those procedures requiring femoral arterial access.

(6) Implement a quantitative measure (greater than or equal to 15 percent of total blood volume) to define the existing and proposed criterion to exclude from the list procedures that generally result in extensive blood loss.

(7) Use a 50-percent inpatient threshold for excluding procedures from the ASC list instead of the proposed 80-percent threshold. While some commenters recommended lowering the proposed threshold for exclusion of procedures from the ASC list from 80 percent to 50 percent, several other commenters suggested that CMS should not apply a specific numerical threshold of inpatient utilization at all to its evaluation of procedure safety. They noted that this could have the unintended effect of automatically excluding some procedures from ASC payment simply because of limited data indicating their performance slightly more than 80 percent of the time in the inpatient setting, while data for clinically similar codes reflected inpatient performance slightly less than the 80-percent threshold. Instead, these commenters recommended that we evaluate each surgical procedure with respect to the other proposed criteria, based on the clinical characteristics of the procedure itself. The group of commenters recommending establishment of a lower threshold of 50 percent believed that this modified standard would better enable us to identify procedures that are typically clinically complex and have a higher risk of complications and extensive postoperative care. They suggested that setting the threshold at 50 percent would ensure that procedures performed the majority of time in the inpatient setting would be excluded from ASC payment.

(8) Require that patients be assessed for comorbidities and anesthesia risk using the American Society of Anesthesiologists' tool, and those patients who are high risk, such as patients over age 85 or with morbid obesity, should be required to go to hospital settings for surgical procedures.

(9) Identify and implement outcome and process measures to assess aspects of quality across care settings, including ASCs. To develop those measures, some commenters suggested that CMS work closely with the Hospital Quality Alliance (HQA) and the Ambulatory Quality Alliance (AQA) (formerly both organizations were known as the AQA). The HQA has already begun to include the measures of care used in the Surgical Care Improvement Project, and some commenters believed that the goal of preventing complications in the care of surgical patients provides an appropriate starting point for determining the correct measures for assessing important aspects of the safety

and quality of all types of ambulatory surgery.

Response: We appreciate the commenters' concerns regarding beneficiary safety and gave consideration to each of the individual recommendations listed above. We respond to each of these individually as follows:

(1) *Maintain the current procedure review criteria until after the ASC Conditions for Coverage are revised.*

We do not believe that postponing revisions to our review criteria until after the ASC Conditions for Coverage are revised is warranted. We cannot predict when those revisions will be issued, and we are confident that the criteria we will use to evaluate procedures for exclusion from the list of covered surgical procedures under the revised ASC payment system are appropriate and serve to protect beneficiary safety in the current environment.

(2) *Specifically adopt a defined list of ''major blood vessels.''*

As we stated earlier, we believe it is important to maintain flexibility in our review of procedures for safe performance in the ASC setting, consistent with our past practice regarding this criterion. As noted by commenters requesting a specific definition of this criterion, there are some procedures already on the ASC list that are being safely performed in ASCs and that involve vessels that would be defined as major according to the recommendations of some commenters. We do not agree with these commenters that it would be logical or clinically consistent for us to adopt a specific definition of major blood vessels to evaluate procedures for exclusion from ASC payment, yet still continue to provide ASC payment for procedures that would otherwise be excluded, except for their history of safe performance in ASCs. We believe the involvement of major blood vessels is best considered in the context of the clinical characteristics of individual procedures, as recommended by other commenters, and see no need to adopt a defined list of major blood vessels.

(3) *Define prolonged invasion of a body cavity as any procedure in which the patient is under anesthesia for 90 minutes or longer, and expand the definition of body cavity to include major blood vessels.*

We do not believe that considering major blood vessels to be included in the definition of a body cavity is clinically sensible, based on the general medical understanding of the terms. In addition, we already have a separate safety review criterion regarding major blood vessels, and we believe that evaluation of the safety of procedures involving major blood vessels will continue to be appropriately assessed using that criterion. We also do not believe that prolonged invasion should be defined as anesthesia for 90 minutes or longer. There are surgical procedures that require more than 90 minutes that do not invade a major body cavity at all, and maintaining that time-based restriction would be contrary to the recommendations of MedPAC and current clinical practice. We believe the criterion regarding major or prolonged invasion of body cavities is most appropriately evaluated through a flexible review approach, consistent with our past practice, in which we consider the criterion and its relationship to each specific surgical procedure. Therefore, we are not expanding the current criterion regarding invasion of a body cavity to include the length of time the beneficiary will be under anesthesia or to incorporate major blood vessels.

(4) *Exclude from ASC payment procedures that commonly require systemic thrombolytic therapy.*

We agree with the commenters that systemic thrombolytic therapy is unsafe for performance in ASCs. Systemic thrombolytic therapy involves significant clinical risks and is not an appropriate procedure for initiation in ASCs if its use is anticipated. We have historically considered in our clinical evaluation of the safety of procedures for performance in ASCs the likely need for systemic thrombolytic therapy in association with a surgical procedure, but we have never previously made that an explicit safety review criterion. We agree with the commenters that it should be a specific criterion for evaluation of procedure safety. Therefore, we are making it explicit that the final criteria used to evaluate the safety of procedures for performance in ASCs at § 416.166(c)(5) include the criterion that covered surgical procedures may not be of a type where systemic thrombolytic therapy would commonly be required.

(5) *Exclude procedures that require use of the femoral vessels for access.*

We do not agree with some commenters' position that excluding all procedures that involve the femoral vessels is reasonable or necessary to ensure the patient safety of surgical procedures performed in ASCs. Other commenters stated that there are instances in which the performance of procedures may require use of femoral vessels due to the beneficiary's particular physical condition. For example, a beneficiary who has experienced prolonged exposure to vascular sclerosing agents (such as chemotherapy) or has been on hemodialysis for many years may not have upper body peripheral blood vessels that are adequate even to support the basic intravenous access required during any surgical procedure performed under general anesthesia. In such a case, the surgeon may need to use the femoral vein just to provide routine intravenous access during surgery. In other cases, the use of the femoral vessels may be required for certain surgical procedures. For instance, the femoral blood vessels may be accessed to create an arteriovenous fistula for hemodialysis using a graft, as described by CPT code 36825 (Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft) or CPT code 36830 (Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft (e.g., biological collagen, thermoplastic graft)). Both of these procedures that may directly involve the femoral vessels have been on the list of covered ASC procedures since before July 2000, and we have no concerns about their safe performance in ASCs. We do not believe that it makes clinical sense to prohibit use of the femoral vessels in ASC procedures, knowing that they may be needed in any number of situations and that femoral access has been safely achieved in ASCs for years. We believe that our process for clinical review of individual procedures, during which our medical advisors consider the specific performance characteristics of a particular surgical procedure, is the most appropriate method for ensuring that procedures that pose a significant safety risk are excluded from ASC payment. As evidenced by the history of safe performance in ASCs of some procedures that utilize femoral access, we agree with the commenters who believe that it is the specific surgical procedure, rather than the method of vascular access, that must be fully evaluated to assess a procedure's safety in ASCs.

(6) *Adopt a quantitative definition of ''extensive blood loss.''*

We do not believe that the recommendation by some commenters that we revise the criteria used to evaluate procedures for exclusion from the ASC list by quantifying extensive blood loss is necessary or advisable. The existing and proposed criterion related to blood loss requires exclusion of procedures that ''generally result in extensive blood loss'' (42 CFR 416.65(b)(3)(i) and 42 CFR 416.166(c)(1),

respectively), and we have historically evaluated this criterion in considering surgical procedures for ASC payment. We do not believe that identifying a specific amount of blood loss that is considered by some to be ''extensive'' would improve our clinical review regarding procedural safety. For most surgical procedures, specific estimates of expected blood loss are not available, and we do not believe that a discussion of whether or not a procedure generally results in a loss of 14 percent versus 16 percent of a beneficiary's blood volume would be clinically meaningful and contribute to our ability to evaluate a surgical procedure's potential for safe performance in ASCs.

(7) *Adopt a 50-percent inpatient utilization threshold for exclusion of procedures from the ASC list.*

We reexamined our proposal to exclude all procedures from ASC payment that are performed in the inpatient setting 80 percent or more of the time. Although the recommendations of some commenters advocated using a lower threshold to exclude more procedures from ASC payment, we confirmed that using any relatively arbitrary threshold resulted in unintended inconsistencies in the treatment of clinically similar procedures. There were several instances in which one procedure in a clinical family would be excluded from ASC payment based on its inpatient utilization of just slightly over 80 percent, whereas our clinical review of other members of the family indicated that those procedures were safe for performance in ASCs, with inpatient utilization of slightly less than 80 percent. For example, we proposed to exclude CPT codes 33207 (Insertion or replacement of permanent pacemaker with transvenous electrode(s); ventricular) and 33208 (Insertion or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular) from ASC payment under the revised payment system because the inpatient utilization for those procedures was higher than 80 percent and, therefore, we did not specifically review the procedures to assess their clinical safety or need for an overnight stay before proposing to exclude them. We did not propose to exclude CPT code 33206 (Insertion or replacement of permanent pacemaker with transvenous electrode(s); atrial), the other procedure in the same family of codes as CPT codes 33207 and 33208, because the inpatient utilization for that procedure was somewhat lower than 80 percent, and our clinical review, based on the other safety and overnight stay criteria proposed for the revised ASC payment system, led to our belief that it was appropriate for performance in ASCs. When we performed a clinical review of CPT codes 33207 and 33208 in order to respond to public comments, we determined that CPT codes 33207 and 33208 do not pose a significant risk to beneficiary safety and are not expected to require an overnight stay, so they are appropriate for performance in ASCs, along with CPT code 33206. Therefore, we have removed both CPT codes 33207 and 33208 from the list of excluded procedures for the revised ASC payment system. We are also, as proposed, not excluding CPT code 33206 from eligibility for ASC payment. This more flexible approach, without application of a specific inpatient utilization threshold, allows us to treat the individual members of the same family of procedures consistently as a clinically coherent group, while considering them in the context of our final safety and overnight stay criteria for the revised ASC payment system.

We also identified a number of surgical procedures with high Medicare inpatient utilization because, most of the time, the procedures are performed with other surgical procedures for beneficiaries who are hospital inpatients. Thus, although the data reflect high inpatient utilization, the procedures themselves are not unsafe for ASC performance, nor do they typically require an overnight stay. Specifically, commenters argued that the high inpatient utilization of CPT code 64447 (Injection, anesthetic agent; femoral nerve, single) was due to its frequent use during inpatient surgical procedures, whereas the injection may also be performed safely in ASCs on its own as an ambulatory pain management intervention. They believed that using the inpatient utilization as the basis for the exclusion of this procedure from ASC payment was unfair because we should evaluate the procedure itself specifically based upon its clinical characteristics, rather than based upon utilization data which could be misleading with respect to the procedure's potential for safe performance in the ASC setting. Our clinical review of CPT code 64447, in response to comments, convinced us that it would clearly not pose a significant safety risk or be expected to require an overnight stay when performed in ASCs and should not be excluded from the list of covered surgical procedures under the revised ASC payment system.

Therefore, we concluded that, in the cases of CPT codes 33207, 33208, and 64447, the utilization data alone could not be relied upon to support a decision to exclude these procedures from ASC payment and, as evidenced by our proposed list of excluded procedures, there were many procedures paid under the OPPS that were not performed more than 80 percent of the time on an inpatient basis but that were proposed for exclusion from ASC payment because of their safety risk or expected need for an overnight stay. Therefore, for this final rule, we evaluated each of the procedures that we had proposed for exclusion from ASC payment based on inpatient utilization of 80 percent or more and made separate determinations about the safety and need for an overnight stay for each of those procedures using all available information, as we did for all other procedures in the surgical range of the CPT code set.

Thus, while we proposed an 80-percent inpatient utilization threshold as one criterion for excluding surgical procedures from ASC payment, we now believe that we will reach more appropriate, clinically consistent decisions regarding procedures for exclusion from ASC payment by not adopting any specific numerical threshold for inpatient utilization that would automatically exclude surgical procedures from ASC payment. Rather than institute a definite threshold for inpatient utilization, we will examine all the clinical information regarding a surgical procedure, including its inpatient utilization, to determine whether or not a procedure would pose a significant risk to beneficiary safety or would be expected to require an overnight stay if performed in an ASC. We will not make final our proposal to exclude procedures from the ASC list of covered surgical procedures based solely on their inpatient utilization of 80 percent or more.

(8) *Require beneficiary assessment of individual surgical risk and do not permit high risk patients to receive ASC services.*

We do not believe that it would be appropriate to accept the commenters' recommendation that patients with certain specified demographic characteristics or comorbidities be automatically excluded from being considered for surgery within an ASC. The recommendation would require ASCs to deny services to individual beneficiaries who are found, based on an appraisal through a specific assessment tool, to have a high level of risk. Section 416.2 defines an ASC as providing surgical services to patients not requiring hospitalization. Thus, ASCs must ensure that each patient is assessed for relevant risk factors by the physician prior to performing the

surgical procedure, in order to screen out patients who are likely to require hospitalization in connection with the planned procedure. We require physicians to make these assessments as a part of their decisions regarding where to perform a surgical procedure for specific Medicare beneficiaries, prior to referring them to facilities for those surgical procedures. The ASC Conditions for Coverage specifically state in § 416.42(a) that ''a physician must examine the patient immediately before surgery to evaluate the risk of anesthesia and of the procedure to be performed.'' In addition, we protect Medicare beneficiary safety through our process of excluding procedures from ASC payment that pose a significant safety risk for the typical Medicare patient. In summary, we do not believe that it is necessary or appropriate for CMS to mandate that ASCs use a specific assessment tool in conducting these required beneficiary assessments.

(9) *Identify and implement outcome and process measures in ASCs to assess quality of care.*

We will take into consideration for future action the recommendation by some commenters that we identify and implement outcome and process measures to assess aspects of quality of care across settings, including ASCs, taking into consideration our final policy for the CY 2009 OPPS that will require hospitals to meet quality reporting standards to receive the full OPPS update (71 FR 68189). We agree that this could be an appropriate next step and is consistent with CMS'' policies being implemented in other beneficiary care settings. In fact, section 109(b) of the Medicare Improvements and Extension Act under Division B of the Tax Relief and Health Care Act of 2006, Public Law 109–432, enacted on December 20, 2006, specifies that the Secretary may require that in order to receive the full annual payment update, ASCs must report data on selected measures of quality. The provisions for ASC services are to apply in a manner similar to which they apply to hospital outpatient services, effective January 1, 2009.

After considering the public comments received, we are finalizing our proposal, with modification, to exclude from ASC payment all surgical procedures that could pose a significant safety risk to Medicare beneficiaries or are expected to require an overnight stay. The criteria to be used to identify procedures that could pose a significant safety risk when performed in an ASC include those surgical procedures that: generally result in extensive blood loss; require major or prolonged invasion of body cavities; directly involve major blood vessels; are emergent or life-threatening in nature; commonly require systemic thrombolytic therapy; are designated as requiring inpatient care under § 419.22(n); can only be reported using a CPT unlisted surgical procedure code (see section III.B. of this final rule for further discussion); or are otherwise excluded under § 411.15. We are not adopting the specific 80-percent inpatient utilization threshold that we proposed for exclusion of surgical procedures from ASC payment. The final revised policy regarding covered surgical procedures is set forth in § 416.166 of this final rule, effective January 1, 2008.

b. Overnight Stay

A longstanding criterion for determining which procedures are appropriate for inclusion on the ASC list of covered surgical procedures has been that the procedures on the list do not require an extended recovery time. Section 416.65(a)(3) of the regulations provides that ASC procedures ''[a]re limited to those requiring a dedicated operating room (or suite), and generally requiring a postoperative recovery room or short-term (not overnight) convalescent room.'' Under § 416.65(b)(1)(ii), we have historically considered procedures that require more than 4 hours of recovery or convalescent time to be inappropriately performed in the ASC.

We have heard many differing opinions of what constitutes an ''overnight'' stay, ranging from ''more than 24 hours'' to time spent in recovery after sunset. After deliberation and consideration of several options, in the August 2006 proposed rule for the revised ASC payment system, we proposed to exclude from ASC payment any procedure for which prevailing medical practice dictates that the beneficiary would typically be expected to require active medical monitoring and care at midnight following the procedure (hereinafter ''overnight stay''). During the development of the August 2006 proposed rule, our clinical staff evaluated each surgical procedure using available claims and physician pricing data, as well as their clinical judgment, to determine which procedures would be expected to require monitoring at midnight of the day on which the surgical procedure was performed.

We proposed to use midnight as the defining measure of an overnight stay for several reasons. First, a patient's location at midnight is a generally accepted standard for determining his or her status as a hospital inpatient or skilled nursing facility patient and as such, it seems reasonable to apply the same standard in the ASC setting. Second, overnight care is not within the scope of ASC services for which Medicare makes payment. The expectation is that surgical procedures performed in an ASC are ambulatory in nature; that is, patients undergoing a procedure in an ASC will recover from anesthesia and return home on the same day that they report to the ASC for a scheduled procedure. Finally, the expected need for monitoring at midnight is a straightforward and easily understood defining measure of ''overnight stay.'' We proposed to add the requirement that procedures will typically not be expected to require active medical monitoring and care at midnight following the procedure to proposed new § 416.166(c)(5).

Comment: Some commenters recommended that CMS use ''less than 24 hours'' as the definition of an overnight stay. Several of the commenters stated that the same 24-hour postoperative recovery standard that applies in HOPDs should apply in ASCs. One commenter stated that CMS' definition of overnight stay related to survey and certification for ASCs is a planned stay of over 24 hours and, that conversely, when the ''length of stay is less than 24 hours, it is not considered an overnight stay.'' Further, several commenters noted that a number of States allow ASCs to perform procedures that require stays of up to 23 or 24 hours.

One commenter group argued that the terms ''ambulatory'' and ''outpatient'' surgery describe the same kind of care, and that the same 24-hour postoperative recovery standard should apply in both ASC and HOPD settings. Some commenters suggested that, if CMS allowed all procedures that are performed in HOPDs to be performed in ASCs, no specific definition of overnight stay would be required because any procedure paid under the OPPS would be presumed to require no overnight stay and that the same assumption should be applied to ASCs.

A number of other commenters agreed with our proposal that procedures requiring an overnight stay should not be performed in an ASC and specifically endorsed our definition of overnight stay. They also believed that the proposed definition is consistent with other accepted definitions and standards of the term.

Several commenters believed that our proposal, if adopted, would require ASCs performing and billing covered surgical procedures to transfer patients to other facilities if the recovery of

individual patients extended beyond midnight on the day of the procedure, in order to receive payment under the revised ASC payment system. Other commenters expressed concern that procedures performed later in the day in ASCs would be treated differently for purposes of ASC payment than those procedures that were performed in the morning, in terms of allowing for adequate recovery time.

Response: We want to clarify our proposal to use the expected need for medical monitoring at midnight following the performance of a procedure as a consideration in determining whether a surgical procedure should be excluded from ASC payment. Our proposal does not affect the distinct care ASCs may provide in individual cases at various times of the day, nor does it alter the ASC payment for covered surgical procedures and covered ancillary services. As we explained in the August 2006 proposed rule, we proposed to exclude surgical procedures from ASC payment only based on their expected need for an overnight stay or the risk they pose to beneficiary safety. We identified the need for medical monitoring at midnight as a clinical measure that was meaningful to our clinical staff and advisors in their assessment, on a procedure-by-procedure basis, of the expected postoperative needs of the typical Medicare beneficiary, in order to determine whether a procedure was likely to require an overnight stay.

We agree with some commenters that the criteria currently in place under the existing ASC payment system that limit covered surgical services to those that do not generally exceed a total of 90 minutes operating time and a total of 4 hours of recovery or convalescent time are both outdated and inconsistent with the proposed policy to base exclusion on the need for an overnight stay. We also agree with the commenters who recognized that the proposed revised measure to facilitate identification of those procedures requiring an overnight stay is considerably less restrictive than the current criteria and, at the same time, the use of midnight as a reference point is clinically meaningful and adequate to ensure beneficiary safety.

As stated above, a beneficiary's location at midnight is a generally accepted standard for determining his or her status as a hospital inpatient or skilled nursing facility patient and, as such, it seems reasonable to apply the same standard in the ASC setting. Second, as defined at § 416.2, ASC means ''any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization.'' Thus, ASCs are not certified by Medicare to provide overnight care, and there is longstanding policy to exclude from coverage in ASCs those surgical procedures that require overnight stays, as evidenced by our existing criterion at § 416.65(b)(1)(ii) that requires CMS to limit covered surgical procedures to those that do not generally exceed a total of 4 hours of recovery time following surgery. The expectation is that a beneficiary undergoing a procedure in an ASC will recover from anesthesia and return home on the same day that he or she reported to the ASC for a scheduled procedure. This expectation is inconsistent with a 24-hour postoperative recovery period as recommended by some commenters.

The commenters' comparisons of ASCs to HOPDs are not persuasive for many reasons. Most importantly among these is the fact that HOPDs, unlike ASCs, have medical and nursing staff on duty 24 hours a day and all of the resources of the hospital to support the care requirements of beneficiaries in that setting.

After consideration of the public comments we received, we continue to believe that it is appropriate to exclude from ASC payment any procedure for which standard medical practice dictates that the beneficiary would typically be expected to require active medical monitoring and care at midnight following the procedure. Therefore, we are finalizing, with editorial modification to include this requirement in the general standards for covered surgical procedures at § 416.166(b), our proposal to exclude these surgical procedures from ASC payment.

B. Treatment of Unlisted Procedure Codes and Procedures That Are Not Paid Separately Under the OPPS

Unlisted procedure CPT codes are used to report services and procedures that are not accurately described by any other, more specific CPT codes. An example of an unlisted CPT code is 33999 (Unlisted procedure, cardiac surgery). Within the surgical range of CPT codes, there are 91 such codes. None of the unlisted CPT codes in the surgical range is on the current ASC list of covered surgical procedures. Under the OPPS, we assign unlisted CPT codes to the lowest weighted APC in the relevant clinical group, regardless of the median cost for the unlisted procedure code, and we do not include the highly variable claims-based cost information for unlisted services in calculating APC median costs for purposes of establishing APC relative payment weights. Payment for procedures reported by unlisted CPT codes is made only at the discretion of the contractor under the MPFS.

Because of concerns about the potential for safety risks when procedures that may only be reported with unlisted procedure CPT codes are performed, in the August 2006 proposed rule for the revised ASC payment system, we proposed to continue excluding CPT unlisted surgical procedure codes from ASC payment. For example, when CPT code 33999 is reported on a claim, we know only that some kind of cardiac surgery was performed. We have no other information about the procedure, and we have no way of knowing whether the procedure involved major blood vessels, major or prolonged invasion of body cavities, or extensive blood loss, or was emergent or life-threatening in nature.

Prior to our evaluation of surgical procedure codes for their safety risk, we decided to propose that we would not make separate payment under the revised ASC payment system for CPT codes in the surgical range whose payments are packaged under the OPPS. Packaged CPT codes under the OPPS are identified by status indicator ''N'' in Addendum B of the CY 2007 OPPS/ASC final rule with comment period (71 FR 68283 through 68384), and their OPPS payment is provided through payment for other separately payable services. We made this proposal for two reasons. First, we would not be able to establish an ASC payment rate for packaged surgical procedures using the same method we proposed for all other ASC procedures because packaged surgical codes have no relative payment weights under the OPPS upon which to base an ASC payment rate. Second, ASCs, just like hospitals, would receive payment for these packaged surgical procedures because their costs would already be included in the APC relative payment weights upon which the ASC payment rates would be based.

Comment: A few commenters recommended that CMS not exclude all unlisted CPT codes from ASC payment as proposed. Some commenters believed that, because Medicare makes facility payments for unlisted CPT codes under the OPPS, CMS should provide the same treatment in ASCs. Other commenters suggested that, for groups of related CPT codes in which all codes but the related unlisted code are provided payment in ASCs, CMS should also include the unlisted code on the ASC list of covered surgical procedures. For example, all of the specific CPT codes in the surgical hysteroscopy

subsection of CPT (CPT codes 58558 through 58578) are currently on the ASC list. One commenter contended that because CMS had already determined that all of those specific hysteroscopy procedures are safe for performance in ASCs, the related unlisted hysteroscopy procedure (CPT code 58579, Unlisted hysteroscopy procedure, uterus) should also be deemed to pose no significant safety risk or require an overnight stay.

Response: We appreciate the commenters' examples of unlisted codes in families where all of the other procedures in the CPT subsection are not excluded from ASC payment, in support of their recommendation that the related unlisted procedure code should be treated comparably. However, the fact remains that we do not know what specific procedure would be represented by an unlisted code. Our charge requires us to evaluate each surgical procedure for potential safety risk and the expected need for overnight monitoring and to exclude such procedures from ASC payment. It is not possible to evaluate procedures that would be reported by unlisted CPT codes according to these criteria.

We continue to believe that because our final policy under the revised ASC payment system excludes from ASC payment those procedures that pose a significant safety risk in ASCs or would be expected to require an overnight stay, it would not be appropriate to provide ASC payment for unlisted CPT codes in the surgical range, even if payment may be provided under the OPPS. As discussed earlier, ASCs do not possess the breadth and intensity of services that hospitals must maintain to care for patients of higher acuity, and we would have no way of knowing what specific procedures reported by unlisted CPT codes were provided to patients, in order to ensure that they are safe for ASC performance. Therefore, we are finalizing in § 416.166(c)(7) our proposal, without modification, to exclude from ASC payment under the revised ASC payment system all procedures reported by unlisted surgical procedure codes.

Comment: A few commenters expressed concern that payments for certain surgical services that are packaged under the OPPS are frequently paid through the OPPS payments for more comprehensive services that we had proposed to define as nonsurgical because they are not classified by CPT within the surgical range of codes. Therefore, these packaged surgical services would not be paid under the revised ASC payment system. They pointed out that when ASCs perform these packaged surgical services as part of providing a more comprehensive nonsurgical service, the ASC would receive no payment for the surgical service. To illustrate the problem, commenters provided examples of the surgical codes that typically receive packaged payment under the OPPS through payment for radiology services. The minor packaged surgical procedures included numerous injection and catheter placement procedures in the surgical range of CPT codes that generally accompany radiology services for purposes of injecting contrast or facilitating another nonsurgical intervention. These commenters recommended that CMS expand the definition of surgical procedures to include invasive radiology services that have a surgical component, including those radiology procedures that are performed in association with a surgical procedure proposed for packaged payment under the revised ASC payment system, to enable ASCs to receive payment for the comprehensive service, including both the radiology service and the minor surgical procedure. Alternatively, several other commenters supported our proposal to package payment under the revised ASC payment system for the minor surgical procedures for which payment is also packaged under the OPPS, rather than paying for them separately.

Response: We continue to believe that packaging payment for those surgical services that are packaged under the OPPS is appropriate under the revised ASC payment system. This policy is aligned with the recommendation of the PPAC to apply payment policies uniformly in the ASC and HOPD settings. It also maintains comparable payment bundles under the OPPS and the revised ASC payment system for these services, consistent with the recommendation of MedPAC to maintain consistent payment bundles under both payment systems.

Packaged surgical services are minor procedures and are usually reported with a more comprehensive procedure that may itself be nonsurgical and, therefore, excluded from payment under the revised ASC payment system. See section III.A.1. of this final rule for a further discussion of the definition of surgical procedure under the revised ASC payment system. We believe that payment for these minor surgical procedures would be appropriately packaged into payment for comprehensive surgical procedures that are separately paid in the ASC setting, when those minor surgical procedures are provided in support of the comprehensive surgical procedures. In the circumstances referred to by the commenters, the minor surgical procedures are performed in support of comprehensive nonsurgical services and payment for the minor surgical procedures is packaged into payment for the nonsurgical services under the OPPS. Although the packaged procedures are surgical according to our definition for the revised ASC payment system, we do not believe it is reasonable or appropriate to assign a different packaging status for these procedures under the revised ASC payment system than is assigned under the OPPS. The minor surgical procedures are not separately paid in the OPPS and, thus, are not eligible for separate payment under the revised ASC payment system. In addition, if the procedures are only performed in conjunction with major services not payable in ASCs, Medicare also will make no packaged payment for these minor surgical procedures. As we discuss further in section III.A. of this final rule, Medicare pays ASCs for the performance of ambulatory surgical procedures, not for providing nonsurgical services. We do not agree that we should define surgical procedures under the revised ASC payment system to include other types of services, such as radiology services, just because they are provided in association with a minor surgical procedure in the CPT surgical range of codes. Instead, we continue to believe that the other types of services, including radiology services, are not appropriate for performance in ASCs unless they are integral to covered surgical procedures. We see no rationale for considering comprehensive radiology services to be integral to the minor surgical procedures.

After considering all public comments received, we are finalizing, without modification, our proposal to provide packaged payment under the revised ASC payment system for all surgical procedures packaged under the OPPS for the same calendar year. Therefore, we will exclude these surgical procedures from separate payment in the ASC setting under the revised payment system, and they will not be included on the ASC list of covered surgical procedures. We believe that this approach will provide appropriate packaged payment for minor surgical procedures provided in association with significant ASC covered surgical procedures. When these minor surgical procedures are performed in support of comprehensive nonsurgical procedures, they are not appropriate for ASC payment because the more comprehensive service is not a surgical

procedure paid under the revised ASC payment system. HCPCS codes for surgical procedures for which payment will be packaged under the revised ASC payment system are identified in Addendum AA to this final rule with payment indicator ''N1'' (Packaged service/item; no separate payment made).

C. Treatment of Office-Based Procedures

According to the general standard in § 416.65(a)(2) of the existing regulations, procedures that ''are commonly performed, or that may be safely performed, in physicians' offices'' are excluded from the ASC list of covered surgical procedures. We did not propose to continue to apply this provision under the revised ASC payment system. Rather, in the August 2006 proposed rule for the revised ASC payment system, we proposed to allow ASC payment for surgical procedures that are commonly and safely performed in the office setting. We reasoned that the types of procedures performed in physicians' offices would neither pose a significant safety risk nor require an overnight stay when performed in an ASC. However, we expressed concerns that allowing payment for office-based procedures under the ASC benefit could create an incentive for physicians inappropriately to convert their offices into ASCs or to move all their office surgery to an ASC.

To address this concern, we proposed to limit payment for office-based procedures to neutralize any such incentive (see section IV.E. of this final rule). We also proposed in new § 416.171(d) to set forth rules governing the payment of office-based procedures in ASCs. We specifically invited comment regarding the effect on the Medicare program, and on practice patterns for ambulatory surgery generally, of our proposal to allow ASC payment for office-based procedures that historically have been excluded from the ASC list of covered surgical procedures.

As we discussed in the August 2006 proposed rule, we proposed to limit payment for office-based procedures in ASCs in an attempt to mitigate potentially inappropriate migration of services from the physician office setting to the ASC. Alternatively, we acknowledged that we could entirely exclude office-based procedures or procedures that require relatively inexpensive resources to perform from the ASC list of covered surgical procedures.

Comment: Many commenters supported our proposal to not exclude from ASC payment those procedures that are performed most of the time in the physician's office setting. Numerous commenters requested that the payment rate for those procedures be set at a percentage of the OPPS amount, applying the same payment methodology under the revised ASC payment system as for all other surgical procedures not excluded from ASC payment. The commenters believed that the proposed treatment of office-based procedures is unfair because, when any of those procedures would be performed in the ASC setting, that facility site would be necessary due to an individual beneficiary's need for the higher acuity care setting. Therefore, the commenters concluded that the same level of payment, in relationship to OPPS payment for those procedures, should be made for office-based procedures as for other covered ASC procedures that are not office-based. Furthermore, commenters contended that there would be very little change in surgical practice patterns under the revised ASC payment system, and that procedures currently performed predominantly in physicians' offices would not move to ASC settings as a result of our proposal to provide payment for those procedures in ASCs.

Response: We appreciate the commenters' support for our proposal to not exclude office-based surgical procedures from ASC payment under the revised ASC payment system. Based on both our final definition of surgical procedures and our final safety and overnight stay criteria to be used in evaluating procedures for exclusion from ASC payment, we see no reason to exclude surgical procedures that are currently commonly performed in physicians' offices from payment under the revised ASC payment system. We believe there are a variety of reasons that may contribute to the choice of a particular care setting for the treatment of an individual beneficiary, including the patient's surgical risk, the geographic location of the beneficiary and physician, individual physician practice patterns and preferences, the availability of specialty ASCs, and others. We do not believe that individuals receiving surgical procedures in ASCs routinely require care that is of such greater acuity than care provided in the office-based setting that the facility resources are significantly and systematically increased when those procedures that are primarily office-based are performed occasionally in ASCs. While it may be true that some more acute cases are treated in ASCs rather than in physicians' offices, we continue to believe that the structure of payments should not provide a financial incentive for treatment in the ASC facility setting. Furthermore, this policy is consistent with the averaging principle that is common to all prospective payment systems; payment is based on the resources that are required to treat the typical case, and payment for the treatment of a specific Medicare beneficiary may, therefore, be higher than the costs of treating less severe cases but lower than the costs of treating more acute cases.

We believe that including these office-based procedures on the ASC list of covered surgical procedures will ensure Medicare beneficiary access to these services in the most appropriate ambulatory or outpatient setting. Our final payment policy for these procedures, along with public comments and our responses, is discussed in section IV.E. of this final rule, and the related payment rules are set forth in § 416.171(d).

After considering the public comments received, we are finalizing our proposal, without modification, to provide payment under the revised ASC payment system for surgical procedures that are currently performed predominantly in physicians' offices and that may be safety performed in ASCs, without requiring an overnight stay.

D. Specific Surgical Procedures Excluded From Payment under the Revised ASC Payment System

In Tables 44 and 45 of the August 2006 proposed rule (71 FR 49640 through 49646), we listed the HCPCS codes and short descriptors for surgical procedures that, in addition to those that comprised the OPPS inpatient list in Addendum E to the August 2006 proposed rule, we proposed to exclude from ASC payment on or after January 1, 2008, because they pose a significant safety risk or are expected to require an overnight stay. Table 44 included those surgical procedures proposed for exclusion from payment because at least 80 percent of Medicare cases are performed on an inpatient basis, while Table 45 listed those surgical procedures proposed for exclusion from payment because they require an overnight stay. In section III.A.2. of this final rule, we discuss our final rationale for excluding surgical procedures from ASC payment. We note that because our final policy, as discussed above, for the revised ASC payment system does not automatically exclude from payment those procedures for which at least 80 percent of Medicare cases are performed on an inpatient basis, all procedures listed in Table 44 of the August 2006

proposed rule were reviewed again for this final rule as described below, in the context of our final exclusionary patient safety and overnight stay criteria.

For many of the procedures listed in Table 45 of the August 2006 proposed rule, several disqualifying criteria could be applicable, such as ''requires inpatient stay'' or ''could potentially cause extensive blood loss'' or ''is emergent in nature.'' Rather than list multiple disqualifying criteria for individual codes in Table 45 of the August 2006 proposed rule, we defaulted to the one characteristic that is common to all of the codes listed. That is, we believed that, at a minimum, prevailing medical practice would dictate the provision of overnight care following each of the procedures listed in Table 45 of the August 2006 proposed rule. We acknowledged that we had to exercise a degree of clinical judgment in identifying those procedures that we proposed to exclude from ASC payment. Therefore, we solicited comments on the appropriateness of excluding the procedures in Table 45 from payment under the revised payment system. We requested that commenters who disagreed with a specific procedure's proposed exclusion from payment submit clinical evidence that demonstrates that the criteria we proposed in proposed new § 416.166 of the regulations are not factors when the procedure is performed in the majority of cases. We asked that commenters also provide data to support any assertion that the preponderance of Medicare beneficiaries upon whom the procedure is performed would not be expected to require overnight care or monitoring following the surgery. We noted in the proposed rule that simply asserting that the procedure could be safely performed in an ASC, without providing corroborative evidence and data, would not furnish us with sufficient information upon which to make an informed decision.

Comment: Several commenters requested that, if CMS decided not to adopt less than 24 hours as its definition of an overnight stay, CMS should revise the list of proposed excluded procedures that were included in Table 45 of the August 2006 proposed rule on the basis of their overnight stay requirement. The commenters disagreed with CMS' determinations that all of those procedures required at least active medical monitoring at midnight following the procedure. Many commenters provided specific recommendations regarding surgical services that they believed should not be excluded from payment under the revised ASC payment system. In addition, several commenters identified a number of procedures not on the OPPS inpatient list that CMS proposed to exclude from ASC payment but that were not displayed in Table 44 or Table 45 of the proposed rule and for which CMS provided no rationale for their exclusion.

Response: In response to these procedure-specific comments and to those comments that reflected the belief that all procedures not on the OPPS inpatient list should be payable under the revised ASC payment system, we reviewed a subset of all of the surgical procedures that we proposed to exclude from payment under the revised ASC payment system, identified as described below. This included reassessing the treatment of those codes that were proposed to be excluded but were inadvertently left out of Table 44 or Table 45 in the August 2006 proposed rule. To conduct this comprehensive review, we identified all codes within the surgical range of CPT codes that met all of the following criteria: (1) Not proposed for the CY 2008 list of ASC covered surgical procedures (Addendum BB to the August 2006 proposed rule); (2) not included on the CY 2007 OPPS inpatient list; (3) not packaged under the OPPS; (4) not CPT unlisted surgical procedure codes; and (5) recognized for separate payment under the OPPS. Elimination of all CPT codes not meeting these criteria yielded about 750 procedures designated for a second review by our medical advisors, in order to finalize their treatment under the CY 2008 revised ASC payment system.

Our clinical staff evaluated each of those procedures using all available claims and physician pricing data, as well as their clinical judgment and the public comments, to determine which procedures would be expected to require monitoring at midnight of the day on which the surgical procedure was performed or that otherwise would pose a significant safety risk to the typical Medicare beneficiary. Table 2 below, which provides an illustrative list of all surgical procedures excluded from ASC payment under the revised ASC payment system, reflects the final outcome of that comprehensive review process. In all, we are not excluding 17 of the procedures that we had initially proposed for exclusion from payment under the revised ASC payment system. The procedures for which we made a different final determination than our proposal regarding the appropriateness of their performance in ASCs include procedures from virtually all specialty areas within the surgical range, from dermatology to gastroenterology to ophthalmology. In addition, we reviewed all Category III CPT codes and Level II HCPCS codes in the context of the public comments and our final policy for the revised ASC payment system and concluded that 29 of these codes, in addition to those HCPCS codes on the CY 2007 ASC list of covered procedures, are appropriate for performance in ASCs under the revised payment system.

Comment: A number of commenters requested that CMS exclude additional procedures from the ASC list of covered surgical procedures. Specifically, several commenters requested that CMS exclude the procedures listed in Table 1 below, because they believed that they pose significant safety risks to beneficiaries when performed in ASCs. They stated that all of the procedures listed in Table 1 would violate at least one of the proposed procedure review criteria by involving major blood vessels or prolonged invasion of body cavities. Further, one commenter suggested that some of the procedures (as listed, CPT codes 35473 through 37650) should be excluded, because they involve femoral access and could require thrombolytic therapy.

TABLE 1.—SPECIFIC PROCEDURES THAT COMMENTERS REQUESTED BE EXCLUDED FROM ASC PAYMENT

HCPCS code	Short descriptor
21215 ...	Lower jaw bone graft.
32002 ...	Treatment of collapsed lung.
33206 ...	Insertion of heart pacemaker.
33214 ...	Upgrade of pacemaker system.
33215 ...	Reposition pacing-defib lead.
33216 ...	Insert lead pace-defib, one.
33217 ...	Insert lead pace-defib, dual.
33218 ...	Repair lead pace-defib, once.
33220 ...	Repair lead pace-defib, dual.
33222 ...	Revise pocket, pacemaker.
33223 ...	Revise pocket, pacing-defib.
33224 ...	Insert pacing lead & connect.
33225 ...	L ventric pacing lead add-on.
33226 ...	Reposition L ventric lead.
33234 ...	Removal of pacemaker system.
35473 ...	Repair arterial blockage.
35474 ...	Repair arterial blockage.
35475 ...	Repair arterial blockage (non-dialysis).
35476 ...	Repair venous blockage (non-dialysis).
35492 ...	Artherectomy, perc.
35761 ...	Exploration of artery/vein.
37205 ...	Transcath IV stent, perc.
37206 ...	Transcath IV stent/perc addl.
37250 ...	IV U.S. first vessel add-on.
37251 ...	IV U.S. each add vessel add-on.
37650 ...	Revision of major vein.
40700 ...	Repair cleft lip/nasal.
40701 ...	Repair cleft lip/nasal.
42200 ...	Reconstruct cleft palate.
42205 ...	Reconstruct cleft palate.
42210 ...	Reconstruct cleft palate.

TABLE 1.—SPECIFIC PROCEDURES THAT COMMENTERS REQUESTED BE EXCLUDED FROM ASC PAYMENT—Continued

HCPCS code	Short descriptor
42215 ...	Reconstruct cleft palate.
42220 ...	Reconstruct cleft palate.
G0297 ..	Insrt 1 chamb dfib pulse generator.

Response: We appreciate the commenters' concerns and conducted a comprehensive review of each of the procedures presented. We agree with the commenters that the procedures reported by CPT codes 35475 (Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or braches, each vessel); 37205 (Transcatheter placement of an intravascular stent(s), (except coronary, carotid, and vertebral vessel), percutaneous; initial vessel); and 37206 (Transcatheter placement of an intravascular stent(s), (except coronary, carotid, and vertebral vessel), each additional vessel) should be excluded from the ASC list of covered surgical procedures because they could pose a significant safety risk to beneficiaries in ASCs. We did not include CPT code 35475 in our proposed list of covered surgical procedures under the revised ASC payment system because we, like the commenters, believe that it poses a safety risk for beneficiaries if performed in ASCs. Although we did propose to add CPT codes 37205 and 37206 to the ASC list for CY 2007, we did not finalize that proposal for CY 2007 in response to comments and continue to agree with commenters that those procedures would likely require an overnight stay.

With regard to the remaining procedures, three of them, specifically CPT codes 33222 (Revision or relocation of skin pocket for pacemaker); 33223 (Revision of skin pocket for single or dual chamber pacing cardioverter-defibrillator); and 37650 (Ligation of femoral vein), are on the current ASC list of covered surgical procedures and have been safely performed in ASCs for some time. We do not believe that they represent a significant safety risk or are likely to require an overnight stay.

We did not propose to exclude any of the remaining procedures in Table 1 from the list of procedures for which ASCs may receive payment under the revised payment system because, based on our clinical review, we did not find that the procedures would be expected to require an overnight stay or pose a significant risk to beneficiary safety when performed in ASCs. Our review for this final rule, in consideration of the comments, did not alter our final opinion on the appropriate treatment of these other codes.

Therefore, we are finalizing our proposal, with modification, regarding specific surgical procedures that are excluded from ASC payment under the revised ASC payment system. Table 2 provides an illustrative list of CPT codes that are payable under the OPPS but that are excluded from the ASC list of covered surgical procedures. This illustrative list does not include those procedures that are on the OPPS inpatient list, packaged under the OPPS, or only reportable by CPT unlisted surgical procedure codes. All of the procedures listed in Table 2 are excluded from the list of covered surgical procedures for which Medicare will provide ASC payment under the revised ASC payment system because we believe, based on our review of each procedure's clinical characteristics, utilization data reflected in physician claims, and prevailing medical practice as reflected in the valuation of the services by the AMA/Specialty Society Relative Value Scale Update Committee (RUC), and consideration of the judgment of our medical advisors and all public comments to the proposed rule, that these surgical procedures pose a significant risk to beneficiary safety or are expected to require an overnight stay.

In this final rule, we are finalizing the addition of 793 new surgical procedures to the ASC list of covered surgical procedures for CY 2008, while we are excluding those procedures listed in Table 2 from ASC payment for CY 2008. This list will be updated for the CY 2008 revised ASC payment system through the CY 2008 OPPS/ASC annual rulemaking cycle.

TABLE 2.—ILLUSTRATIVE LIST OF SURGICAL PROCEDURES PAYABLE UNDER THE OPPS (NOT ON THE OPPS INPATIENT LIST, NOT PACKAGED UNDER THE OPPS AND NOT DESIGNATED AS CPT UNLISTED CODES) THAT ARE EXCLUDED FROM ASC PAYMENT BECAUSE THEY POSE A SIGNIFICANT SAFETY RISK OR ARE EXPECTED TO REQUIRE AN OVERNIGHT STAY

HCPCS code	Short descriptor
15170 ..	Acell graft trunk/arms/legs.
15171 ..	Acell graft t/arm/leg add-on.
15175 ..	Acellular graft, f/n/hf/g.
15176 ..	Acell graft, f/n/hf/g add-on.
19260 ..	Removal of chest wall lesion.
19307 ..	Mast, mod rad.

TABLE 2.—ILLUSTRATIVE LIST OF SURGICAL PROCEDURES PAYABLE UNDER THE OPPS (NOT ON THE OPPS INPATIENT LIST, NOT PACKAGED UNDER THE OPPS AND NOT DESIGNATED AS CPT UNLISTED CODES) THAT ARE EXCLUDED FROM ASC PAYMENT BECAUSE THEY POSE A SIGNIFICANT SAFETY RISK OR ARE EXPECTED TO REQUIRE AN OVERNIGHT STAY—Continued

HCPCS code	Short descriptor
20100 ..	Explore wound, neck.
20101 ..	Explore wound, chest.
20102 ..	Explore wound, abdomen.
21049 ..	Excis uppr jaw cyst w/repair.
21175 ..	Reconstruct orbit/forehead.
21195 ..	Reconst lwr jaw w/o fixation.
21261 ..	Revise eye sockets.
21263 ..	Revise eye sockets.
21408 ..	Treat eye socket fracture.
21470 ..	Treat lower jaw fracture.
21742 ..	Repair stern/nuss w/o scope.
21743 ..	Repair sternum/nuss w/scope.
22100.	Remove part of neck vertebra.
22101 ..	Remove part, thorax vertebra.
22222 ..	Revision of thorax spine.
22526 ..	Idet, single level.
22527 ..	Idet, 1 or more levels.
22612 ..	Lumbar spine fusion.
22614 ..	Spine fusion, extra segment.
22851 ..	Apply spine prosth device.
23470 ..	Reconstruct shoulder joint.
24150 ..	Extensive humerus surgery.
24151 ..	Extensive humerus surgery.
24935 ..	Revision of amputation.
25170 ..	Extensive forearm surgery.
26037 ..	Decompress fingers/hand.
27216 ..	Treat pelvic ring fracture.
27235 ..	Treat thigh fracture.
27412 ..	Autochondrocyte implant knee.
27415 ..	Osteochondral knee allograft.
27446 ..	Revision of knee joint.
27475 ..	Surgery to stop leg growth.
27524 ..	Treat kneecap fracture.
28360 ..	Reconstruct cleft foot.
29866 ..	Autgrft implnt, knee w/scope.
29867 ..	Allgrft implnt, knee w/scope.
29868 ..	Meniscal trnspl, knee w/scpe.
31292 ..	Nasal/sinus endoscopy, surg.
31293 ..	Nasal/sinus endoscopy, surg.
31294 ..	Nasal/sinus endoscopy, surg.
31600 ..	Incision of windpipe.
31601 ..	Incision of windpipe.
31610 ..	Incision of windpipe.
31785 ..	Remove windpipe lesion.
32005 ..	Treat lung lining chemically.
32020 ..	Insertion of chest tube.
32201 ..	Drain, percut, lung lesion.
32601 ..	Thoracoscopy, diagnostic.
32602 ..	Thoracoscopy, diagnostic.
32603 ..	Thoracoscopy, diagnostic.
32604 ..	Thoracoscopy, diagnostic.
32605 ..	Thoracoscopy, diagnostic.
32606 ..	Thoracoscopy, diagnostic.
32998 ..	Perq rf ablate tx, pul tumor.
33244 ..	Remove eltrd, transven.
34101 ..	Removal of artery clot.
34111 ..	Removal of arm artery clot.
34201 ..	Removal of artery clot.
34203 ..	Removal of leg artery clot.

TABLE 2.—ILLUSTRATIVE LIST OF SURGICAL PROCEDURES PAYABLE UNDER THE OPPS (NOT ON THE OPPS INPATIENT LIST, NOT PACKAGED UNDER THE OPPS AND NOT DESIGNATED AS CPT UNLISTED CODES) THAT ARE EXCLUDED FROM ASC PAYMENT BECAUSE THEY POSE A SIGNIFICANT SAFETY RISK OR ARE EXPECTED TO REQUIRE AN OVERNIGHT STAY—Continued

HCPCS code	Short descriptor
34421 ..	Removal of vein clot.
34471 ..	Removal of vein clot.
34490 ..	Removal of vein clot.
34501 ..	Repair valve, femoral vein.
34510 ..	Transposition of vein valve.
34520 ..	Cross-over vein graft.
34530 ..	Leg vein fusion.
35011 ..	Repair defect of artery.
35180 ..	Repair blood vessel lesion.
35184 ..	Repair blood vessel lesion.
35190 ..	Repair blood vessel lesion.
35201 ..	Repair blood vessel lesion.
35206 ..	Repair blood vessel lesion.
35226 ..	Repair blood vessel lesion.
35231 ..	Repair blood vessel lesion.
35236 ..	Repair blood vessel lesion.
35256 ..	Repair blood vessel lesion.
35261 ..	Repair blood vessel lesion.
35266 ..	Repair blood vessel lesion.
35286 ..	Repair blood vessel lesion.
35321 ..	Rechanneling of artery.
35458 ..	Repair arterial blockage.
35459 ..	Repair arterial blockage.
35460 ..	Repair venous blockage.
35470 ..	Repair arterial blockage.
35471 ..	Repair arterial blockage.
35472 ..	Repair arterial blockage.
35475 ..	Repair arterial blockage.
35484 ..	Atherectomy, open.
35485 ..	Atherectomy, open.
35490 ..	Atherectomy, percutaneous.
35491 ..	Atherectomy, percutaneous.
35493 ..	Atherectomy, percutaneous.
35494 ..	Atherectomy, percutaneous.
35495 ..	Atherectomy, percutaneous.
35500 ..	Harvest vein for bypass.
35685 ..	Bypass graft patency/patch.
35686 ..	Bypass graft/av fist patency.
35860 ..	Explore limb vessels.
35879 ..	Revise graft w/vein.
35881 ..	Revise graft w/vein.
35883 ..	Revise graft w/nonauto graft.
35884 ..	Revise graft w/vein.
35903 ..	Excision, graft, extremity.
36838 ..	Dist revas ligation, hemo.
37183 ..	Remove hepatic shunt (tips).
37195 ..	Thrombolytic therapy, stroke.
37201 ..	Transcatheter therapy infuse.
37202 ..	Transcatheter therapy infuse.
37204 ..	Transcatheter occlusion.
37205 ..	Transcath iv stent, precut.
37206 ..	Transcath iv stent/perc addl.
37207 ..	Transcath iv stent, open.
37208 ..	Transcath iv stent/open addl.
37209 ..	Change iv cath at thromb tx.
37210 ..	Embolization uterine fibroid.
37565 ..	Ligation of neck vein.
37600 ..	Ligation of neck artery.
37605 ..	Ligation of neck artery.
37606 ..	Ligation of neck artery.
37615 ..	Ligation of neck artery.
37620 ..	Revision of major vein.
38120 ..	Laparoscopy, splenectomy.
38240 ..	Bone marrow/stem transplant.
38720 ..	Removal of lymph nodes, neck.
39400 ..	Visualization of chest.
42225 ..	Reconstruct cleft palate.
42227 ..	Lengthening of palate.
42842 ..	Extensive surgery of throat.
42844 ..	Extensive surgery of throat.
43020 ..	Incision of esophagus.
43130 ..	Removal of esophagus pouch.
43280 ..	Laparoscopy, fundoplasty.
43510 ..	Surgical opening of stomach.
43647 ..	Lap impl electrode, antrum.
43648 ..	Lap revise/remv eltrd antrum.
43651 ..	Laparoscopy, vagus nerve
43652 ..	Laparoscopy, vagus nerve.
43752 ..	Nasal/orogastric w/stent.
43830 ..	Place gastrostomy tube.
43831 ..	Place gastrostomy tube.
44180 ..	Lap, enterolysis.
44186 ..	Lap, jejunostomy.
44206 ..	Lap part colectomy w/stoma.
44207 ..	Lcolectomy/coloproctostomy.
44208 ..	Lcolectomy/coloproctostomy.
44213 ..	Lap, mobil splenic fl add-on.
44500 ..	Intro, gastrointestinal tube.
44901 ..	Drain app abscess, precut.
44970 ..	Laparoscopy, appendectomy.
45541 ..	Correct rectal prolapse.
47011 ..	Percut drain, liver lesion.
47370 ..	Laparo ablate liver tumor rf.
47371 ..	Laparo ablate liver cryosurg.
47490 ..	Incision of gallbladder.
48511 ..	Drain pancreatic pseudocyst.
49021 ..	Drain abdominal abscess.
49041 ..	Drain, percut, abdom abscess.
49061 ..	Drain, percut, retroper absc.
49200 ..	Removal of abdominal lesion.
49323 ..	Laparo drain lymphocele.
49324 ..	Lap insertion perm ip cath.
49325 ..	Lap revision perm ip cath.
49326 ..	Lap w/omentopexy add-on.
49435 ..	Insert subq exten to ip cath.
49436 ..	Embedded ip cath exit-site.
49491 ..	Rpr hern preemie reduce.
49492 ..	Rpr ing hern premie, blocked.
50020 ..	Renal abscess, open drain.
50021 ..	Renal abscess, percut drain.
50080 ..	Removal of kidney stone.
50081 ..	Removal of kidney stone.
50541 ..	Laparo ablate renal cyst.
50542 ..	Laparo ablate renal mass.
50543 ..	Laparo partial nephrectomy.
50544 ..	Laparoscopy, pyeloplasty.
50945 ..	Laparoscopy, ureterolithotomy.
51990 ..	Laparo urethral suspension.
53500 ..	Urethrlys, transvag w/ scope.
57106 ..	Remove vagina wall, partial.
57107 ..	Remove vagina tissue, part.
57109 ..	Vaginectomy partial w/nodes.
57120 ..	Closure of vagina.
57282 ..	Colpopexy, extraperitoneal.
57283 ..	Colpopexy, intraperitoneal.
57284 ..	Repair paravaginal defect.
57292 ..	Construct vagina with graft.
57295 ..	Change vaginal graft.
57310 ..	Repair urethrovaginal lesion.
57330 ..	Repair bladder-vagina lesion.
57335 ..	Repair vagina.
57425 ..	Laparoscopy, surg, colpopexy.
57555 ..	Remove cervix/repair vagina.
58260 ..	Vaginal hysterectomy.
58262 ..	Vag hyst including t/o.
58263 ..	Vag hyst w/t/o & vag repair.
58270 ..	Vag hyst w/enterocele repair.
58290 ..	Vag hyst complex.
58291 ..	Vag hyst incl t/o, complex.
58292 ..	Vag hyst t/o & repair, compl.
58294 ..	Vag hyst w/enterocele, compl.
58541 ..	Lsh, uterus 250 g or less.
58542 ..	Lsh w/t/o ut 250 g or less.
58543 ..	Lsh uterus above 250 g.
58544 ..	Lsh w/t/o uterus above 250 g.
58553 ..	Laparo-vag hyst, complex.
58554 ..	Laparo-vag hyst w/t/o, compl.
58770 ..	Create new tubal opening.
58823 ..	Drain pelvic abscess, precut.
58920 ..	Partial removal of ovary(s).
58925 ..	Removal of ovarian cyst(s).
59030 ..	Fetal scalp blood sample.
59074 ..	Fetal fluid drainage w/us.
59409 ..	Obstetrical care.
59612 ..	Vbac delivery only.
60210 ..	Partial thyroid excision.
60212 ..	Partial thyroid excision.
60220 ..	Partial removal of thyroid.
60225 ..	Partial removal of thyroid.
60240 ..	Removal of thyroid.
60252 ..	Removal of thyroid.
60260 ..	Repeat thyroid surgery.
60500 ..	Explore parathyroid glands.
60502 ..	Re-explore parathyroids.
60512 ..	Autotransplant parathyroid.
60520 ..	Removal of thymus gland.
61623 ..	Endovasc tempory vessel occl.
61626 ..	Transcath occlusion, non-cns.
61720 ..	Incise skull/brain surgery.
62000 ..	Treat skull fracture.
62160 ..	Neuroendoscopy add-on.
62351 ..	Implant spinal canal cath.
63001 ..	Removal of spinal lamina.
63003 ..	Removal of spinal lamina.
63005 ..	Removal of spinal lamina.
63011 ..	Removal of spinal lamina.
63012 ..	Removal of spinal lamina.

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HCPCS code	Short descriptor
63015 ..	Removal of spinal lamina.
63016 ..	Removal of spinal lamina.
63017 ..	Removal of spinal lamina.
63020 ..	Neck spine disk surgery.
63030 ..	Low back disk surgery.
63035 ..	Spinal disk surgery add-on.
63040 ..	Laminotomy, single cervical.
63042 ..	Laminotomy, single lumbar.
63045 ..	Removal of spinal lamina.
63046 ..	Removal of spinal lamina.
63047 ..	Removal of spinal lamina.
63048 ..	Remove spinal lamina add-on.
63055 ..	Decompress spinal cord.
63056 ..	Decompress spinal cord.
63057 ..	Decompress spine cord add-on.
63064 ..	Decompress spinal cord.
63066 ..	Decompress spine cord add-on.
63075 ..	Neck spine disk surgery.
63741 ..	Install spinal shunt.
64448 ..	Nblock inj fem, cont inf.
64449 ..	Nblock inj, lumbar plexus.
64804 ..	Remove sympathetic nerves.
64910 ..	Nerve repair w/allograft.
64911 ..	Neurorraphy w/vein autograft.
69725 ..	Release facial nerve.
69955 ..	Release facial nerve.
69960 ..	Release inner ear canal.

IV. Ratesetting Methodology for the Revised ASC Payment System

A. Overview of Current ASC Payment System

Section 1833(i)(1) of the Act requires us to specify, in consultation with appropriate medical organizations, surgical procedures that are appropriately performed on an inpatient basis in a hospital but that also can be safely performed in an ASC and to review and update the list of procedures paid under the ASC payment system at least every 2 years.

Under the existing ASC payment system, the ASC payment rate is a standard overhead amount established on the basis of our estimate of a fee that takes into account the costs incurred by ASCs generally in providing facility services in connection with performing a specific procedure. We refer readers to section I.B. of this final rule for further history regarding the establishment of standard overhead amounts for ASC payment. The standard overhead amounts under the existing ASC payment system for procedures on the ASC list of covered surgical procedures were last rebased in 1990 using data collected in a 1986 survey of ASC costs. The process and methodology that we used to establish the payment system are explained in the February 8, 1990 **Federal Register** (55 FR 4526).

The existing ASC payment system consists of 9 standard overhead amounts ranging from $333 to $1,339, based on the data collected in the 1986 survey of ASC costs. An ASC payment group currently consists of all the procedures assigned to a particular standard overhead amount. ASC payment groups are heterogeneous in terms of clinical characteristics, cutting across all body systems and types of surgery. Medicare pays a $150 allowance for IOLs that are inserted during or subsequent to cataract surgery and an additional $50 for IOLs that are included in active NTIOL classes. Medicare also makes separate payment for implantable prosthetic devices and implantable durable medical equipment (DME) that are surgically inserted at an ASC under the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule. Payment for all other facility services that are directly related to performing a surgical procedure is packaged into the prospectively determined ASC payment for the covered surgical procedure.

Section 5103 of Public Law 109–171 requires us to substitute the OPPS payment amount for the ASC standard overhead amount for surgical procedures performed in an ASC on or after January 1, 2007, but prior to the revised ASC payment system, when the ASC standard overhead amount exceeds the OPPS payment amount for the procedure in that year. In Addendum AA to the CY 2007 OPPS/ASC final rule with comment period (71 FR 68243 through 68283), we identify the HCPCS codes on the CY 2007 ASC list for which the CY 2007 ASC payments are capped at the OPPS payment amounts in accordance with the provisions of section 5103 of Public Law 109–171, based on a comparison of the final CY 2007 OPPS payment rates and the ASC standard overhead amounts that are effective in CY 2007.

Except for screening flexible sigmoidoscopy and screening colonoscopy services, payment for ASC services is subject to the usual Medicare Part B deductible and coinsurance requirements and the amounts paid by Medicare must be 80 percent of the standard fee. As required by section 1834(d) of the Act, the coinsurance for screening flexible sigmoidoscopies and colonoscopies is 25 percent and the amounts paid by Medicare must be 75 percent of the standard fee.

Medicare currently accounts for geographic wage variations when calculating individual ASC payments by applying the relevant inpatient prospective payment system (IPPS) wage index values and localities that were established under the IPPS prior to implementation of the new Core Based Statistical Areas (CBSAs) issued by the Office of Management and Budget (OMB) in June 2003 to 34.45 percent of the national ASC standard overhead amount. The 1986 ASC survey data are the basis for attributing 34.45 percent of ASC facility costs to labor costs.

Section 1833(i)(2)(C) of the Act requires the Secretary to update ASC payment rates using the CPI–U (U.S. city average) (CPI–U) if the Secretary has not otherwise updated the amounts under the revised ASC payment system. As amended by Public Law 108–173, section 1833(i)(2)(C) of the Act provides that if the Secretary is required to apply the CPI–U increase, the CPI–U percentage increase is to be applied on a fiscal year basis beginning with FY 1986 through FY 2005 and on a calendar year basis beginning with 2006. Public Law 108–173 further amended section 1833(i)(2)(C) of the Act to require us in FY 2004, beginning April 1, 2004, to increase ASC payment rates using the CPI–U as estimated for the 12-month period ending March 31, 2003, minus 3.0 percentage points. Public Law 108–173 also requires that the CPI–U adjustment factor equal zero percent in FY 2005, the last quarter of CY 2005, and each of CYs 2006 through 2009.

Section 141(b) of the Social Security Act Amendments of 1994, Public Law 103–432, requires us to establish a process for considering requests for review of the appropriateness of the payment amount provided under section 1833(i)(2)(A)(iii) of the Act for IOLs to ensure that the ASC payment for the insertion procedure is reasonable and related to the cost of acquiring a lens that belongs to a class of NTIOLs. In the CY 2007 OPPS/ASC proposed rule that was published August 23, 2006 (71 FR 49631 through 49635), we proposed changes to the process for recognizing IOLs as belonging to a new NTIOL class. In the subsequent CY 2007 OPPS/ASC final rule with comment period (71 FR 68175 through 68181), we finalized the proposed changes to that process, beginning with requests for review for establishing new NTIOL classes for CY 2008 payment.

The revised ASC payment system that we are finalizing in this rule will implement requirements set forth in section 626 of Public Law 108–173. The

revised payment system mandated by section 626(d) of Public Law 108–173 requires us to take into account recommendations in a report to Congress prepared by the GAO. As mentioned earlier, that report (GAO–07–86) was published on November 30, 2006. Its methodology, findings, and recommendations are summarized in section II.B. of this final rule. Specific ASC payment system issues considered in the GAO Report are discussed in the individual sections below under the related topic areas.

B. ASC Relative Payment Weights Based on APC Groups and Relative Payment Weights Established Under the OPPS

As we stated in the August 2006 proposed rule for the revised ASC payment system (71 FR 49647), we considered several strategies and methodologies for setting ASC payment rates under a revised payment system. These options included requiring ASCs to submit modified cost reports as a basis for establishing ASC costs, expanding the number and payment range of the current ASC payment groups, basing payments to ASCs on the relative weights for surgical services established under the MPFS, basing payments to ASCs on the relative weights for surgical services established under the Medicare OPPS, as suggested in Public Law 108–173, or basing payments to ASCs on a flat percentage of the payment for the same services established under the OPPS, as advocated by representatives of several ASC associations.

After reviewing the advantages and disadvantages of each of these approaches, in the August 2006 proposed rule we proposed, within the parameters of section 626 of Public Law 108–173, to use the APC groups and the relative payment weights for surgical procedures established under the OPPS as the basis of the payment groups and the relative payment weights for surgical procedures performed in ASCs. These payment weights would be multiplied by an ASC conversion factor in order to calculate the ASC payment rates. Several factors persuaded us to advance this proposal over the other approaches that we considered.

First, in section 626(d) of Public Law 108–173, the Congress explicitly targets the OPPS for consideration by the GAO in its study of ASC payments. We believe it is reasonable to assume that Congress, by so doing, was highlighting the relative payment weights under the OPPS as a theoretical model for ASC relative payment weights under the revised payment system.

Second, the ASC benefit provides payment for services associated with performing surgical procedures. The OPPS has equipped us with nearly a decade of experience in developing and refining a relative payment system for all services furnished in connection with outpatient surgical procedures.

Third, Public Law 108–173 applies, for the first time, a budget neutrality requirement to the ASC benefit. That is, in the year the revised system is implemented, the system is to be designed to result in the same aggregate amount of expenditures that would be made if the revised payment system were not implemented. Because the OPPS is also a prospective payment system for facility services that is subject to budget neutrality requirements, it provides useful parallels for a ratesetting methodology based on relative facility payment weights for surgical services under the revised ASC payment system.

Fourth, in our analysis of the APC groups to which surgical procedures are assigned for payment under the OPPS, we found that, of the 150 highest volume surgical procedures furnished in HOPDs, more than half (80) are also among the 150 highest volume procedures performed in ASCs.

Finally, the ASC industry in numerous meetings with us over the past several years has frequently voiced its preference for a payment system that parallels the OPPS for the sake of promoting transparency across sites of service in the arena of outpatient surgery and to streamline and modernize how CMS sets payments and determines what is payable under the ASC benefit.

We explained in the August 2006 proposed rule that the OPPS payment rates are based on relative payment weights, which are updated annually based on the most recent year of hospital outpatient claims data and hospitals' latest Medicare cost reports. APCs to which surgical procedures are assigned are generally homogeneous both in terms of clinical characteristics and resource requirements. The APCs have been continually refined over the past 6 years through the work of the Advisory Panel on Ambulatory Payment Classification Groups (APC Panel) and as a result of comments received during the OPPS annual rulemaking cycles.

Moreover, we believed that the APC groups had matured with respect to their clinical and resource homogeneity, and the relativity in resource utilization among APCs containing surgical procedures had stabilized. Thus, we concluded in the proposed rule that the APC groups and their relative weights were reasonable and appropriate models for grouping outpatient surgical procedures and determining the relativity of the ASC payment weights under the revised payment system. For example, whether performed in an HOPD or in an ASC, we believed the time and facility resources required to perform a routine laparoscopic hernia repair described by CPT code 49650 (Laparoscopy, surgical; repair initial inguinal hernia), with a CY 2007 OPPS relative payment weight of 43.5488, were approximately 5 times higher than those required to perform a diagnostic colonoscopy described by CPT code 45378 (Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)), with a CY 2007 OPPS relative payment weight of 8.7686. Thus, we believed that the relative payment weights established under the OPPS for procedures performed in the hospital outpatient setting reasonably reflected the relative facility resources required for such procedures and did so with sufficient coherence to be applicable to other ambulatory sites of service. Taking all these factors into account, we proposed to use the APCs as a ''grouper'' and the APC relative payment weights as the basis for ASC relative payment weights and for calculating ASC payment rates under the revised payment system. Accordingly, we proposed to establish provisions in proposed new Subpart F, §§ 416.167 and 416.171, to reflect these proposed changes for calculating the ASC payment rates beginning January 1, 2008.

As further discussed in section II.B. of this final rule, on November 30, 2006, the GAO published the report mandated by section 626(d) of Public Law 108–173 (GAO–07–86), where it determined that the APC groups of the OPPS accurately reflect the relative costs of procedures performed in ASCs. It concluded that the APC groups in the OPPS reflect the relative costs of surgical procedures performed in ASCs in the same way that they reflect the relative costs of the same procedures when they are performed in HOPDs. Therefore, the GAO recommended that the APC groups could be applied to procedures performed in ASCs, and the OPPS could be used as the basis for an ASC payment system, thereby eliminating the need for ASC surveys and providing for an annual revision of the ASC payment groups. At its December 2006 meeting, the PPAC recommended that CMS apply any payment policies uniformly to both

ASCs and HOPDs as appropriate, confirming its belief that the OPPS and the revised ASC payment system could be closely linked.

We received a number of comments on our proposal to use the OPPS relative payment weights as the basis for establishing relative payment weights under the revised ASC payment system. A summary of the comments and our responses follow.

Comment: Many commenters agreed that using the OPPS APCs as a ''grouper'' and the APC relative payment weights to establish ASC payment rates for surgical procedures paid under the revised ASC payment system is appropriate because a significant number of surgical procedures furnished in the hospital outpatient setting are also performed in ASCs. Some commenters argued that because ASCs provide many similar procedures that are also performed in HOPDs and often utilize the same equipment, supplies, and clinical labor in performing these procedures, the relative costs of performing the procedures should be similar, if not identical, in both settings. Moreover, the commenters generally agreed that creating an ASC payment system that parallels the OPPS would promote transparency across sites of service in the area of outpatient surgery and would also promote greater alignment and coordination between the OPPS and the revised ASC payment system, including providing for the annual updating of payment weights in the ASC payment system.

Some commenters requested that CMS apply different conversion factors to the OPPS relative payment weights for specific types of procedures to calculate their ASC payment rates, because they suggested that the OPPS relativity was not correct for some services provided in single specialty ASCs (for example, gastroenterology and pain management procedures). They believed that the OPPS APC weights, based on all hospital services rather than just surgical services, may be flawed and that additional analyses of relative hospital and ASC costs are needed. They recommended that CMS develop firm data on the differences between hospital outpatient and ASC costs and the magnitude of those differences for numerous services before finalizing significant changes in ASC payments for procedures. One commenter specifically discussed a study commissioned by MedPAC in which RAND found that no single outpatient surgical setting, ASCs or HOPDs, had consistently higher rates of patient characteristics that would be expected to increase facility costs. Analyses by another commenter found that among a subset of gastrointestinal (GI) procedures, the majority of surgical CPT codes describing those procedures received OPPS payments that were less than hospitals' median costs for the individual procedures.

Response: We appreciate the commenters' general support for basing the revised ASC payment system relative weights on the OPPS APC groups and their relative weights. As discussed in detail in section II.B. of this final rule, in its November 2006 report on ASC payment, the GAO found that the APC groups in the OPPS accurately reflect the relative costs of procedures performed in ASCs. The GAO analyses also demonstrated that there is less variation in the ASC setting between individual procedures' costs and the costs of their assigned APC groups than there is in the HOPD setting, and that when compared to the median cost of the same APC group, procedures performed in ASCs had substantially lower costs than those same procedures performed in HOPDs.

The GAO findings were based upon data for all procedures performed in ASCs in CY 2004, as reported by those ASCs responding to the GAO survey. In view of the GAO's confirmation that the APC groups accurately reflect the relative costs of these procedures performed in ASCs in the same way that they reflect the relative costs of the same procedures when they are performed in HOPDs, substantiating a key assumption underlying our proposal for the revised ASC payment system, we do not believe there is a compelling rationale for using different ASC conversion factors to develop payment rates for various procedures under the revised ASC payment system. Applying more than one ASC conversion factor to different procedures would imply that we believe the OPPS APC payment weight relativity is not applicable to the ASC setting, contrary to our proposal and the GAO study results. APCs currently serve as a ''grouper'' for the OPPS and, as such, the payment for any given procedure under the OPPS does not specifically reflect the cost of that procedure in any one facility. Instead, the APC relative payment weights under the OPPS are developed based on the median cost of all single claims for all procedures assigned to each APC. Prospectively established APC payment rates provide an averaging effect on OPPS payments for individual services. With the significant expansion of covered surgical procedures eligible for ASC payment that we are finalizing in this final rule for the revised ASC payment system as discussed in section III. of this final rule, in many cases where one service in an APC is an ASC procedure, most of the other procedures assigned to the same APC will also be paid in the ASC setting. Thus, under the revised payment system, ASCs generally will have the potential to provide a mix of individual services assigned to those APCs that is similar to the mix of OPPS procedures attributable to certain APCs and, in many cases, all of the procedures assigned to certain APCs under the OPPS will also be ASC covered surgical procedures. We believe this uniform approach under the revised ASC payment system is fully consistent with the recommendation of the PPAC that we apply payment policies consistently to both ASCs and HOPDs, as appropriate. It also generally treats procedures performed in ASCs consistently for purposes of developing ASC payment rates under the revised ASC payment system, in accordance with the PPAC recommendation that we adopt a systematic and adaptable means of fairly reimbursing ASCs for their services.

While information provided by the commenters clearly demonstrated that some specific groups of procedures would experience a significant decrease in payment under the revised ASC payment system as compared with the existing payment structure, we are not convinced that the information we received contradicts the premise of our proposal and the GAO findings that the relativity of costs observed in HOPDs could appropriately be used as the basis for the relative payment weights in the revised ASC payment system. We also continue to see no clinical basis that would support the differential relativity of costs for various procedures performed in the ASC or HOPD settings.

While applying a single conversion factor to the OPPS relative weights may result in decreases to ASC payments for some services commonly provided in single specialty ASCs, we also believe that this approach should result in facilities receiving more appropriate payments for ASC services in general, where those payments more accurately reflect the facility resources required for their performance. As discussed further in section IV.J. of this final rule, our final policy of a 4-year transition to phase in the revised ASC payment system should mitigate the potential disruption in care that could be associated with significant increases or decreases in payments for specific surgical procedures under the revised payment system. Individual ASCs will have a longer period of time to evaluate and potentially modify the breadth of

surgical procedures they provide based on the expanded list of covered surgical procedures and the final policies of the revised ASC payment system. Further, our final ASC policies for payment of device=intensive procedures and covered ancillary services that more closely align the ASC and OPPS systems may moderate the magnitude of differences between current ASC payments and those under the revised payment system for individual surgical procedures. We do not believe that it would be appropriate to modulate changes in payment under the revised system by differentially adjusting the payment weights or the conversion factor for various types of services because, consistent with the GAO recommendation, we believe the OPPS relative payment weights upon which the revised ASC payment system is based appropriately reflect the relativity in ASC resource costs associated with different surgical procedures. We believe that the final payment policies for the revised payment system result in appropriate and equitable payments, and thus, we see no rationale for applying adjustments that are counter to the principles of a prospective payment system.

After considering the public comments received, we are finalizing our proposal, without modification, to establish the relative payment weights under the revised ASC payment system for most covered surgical procedures based on their OPPS APC relative payment weights for the same calendar year, with application of a single ASC conversion factor to determine the national unadjusted ASC payment rates, as set forth in §§ 416.167 and 416.171. Several exceptions to this general policy are discussed elsewhere in this final rule, specifically in sections IV.C. and IV.E. of this preamble.

C. Packaging Policy

1. General Policy

Payment for a surgical procedure under both the current OPPS and ASC payment systems represents payment for a package of various items and services, all of which are directly related and required in order to perform the procedure. In both systems, we package into a single facility payment the payment for a bundle of direct and indirect costs incurred by the facility to perform the surgical procedure. These costs include, but are not limited to, use of the facility, including an operating suite or procedure room and recovery room; nursing, technician, and related services; administrative, recordkeeping, and housekeeping items and services; medical and surgical supplies and equipment; surgical dressings; and materials for anesthesia.

CMS currently applies different rules under the ASC payment system and the OPPS for determining whether payment for other items and services directly related to a surgical procedure is packaged into the facility payment for the associated surgical procedure or paid for separately. These other items and services include drugs, biologicals, contrast agents, implantable devices, and diagnostic services such as imaging. Currently, CMS packages payment for the costs for all drugs, biologicals, and diagnostic services, including imaging, into the ASC standard overhead amount for the surgical procedure with which these items and services are associated. Under the OPPS, CMS pays separately for some of these items and services, in addition to paying for the surgical procedure.

ASCs currently receive separate payment for prosthetic implants and implantable DME, as well as additional payment for NTIOLs. Laboratory services, physicians' services, and x-ray or diagnostic procedures may also be paid separately under other Medicare Part B fee schedules. Conversely, under the OPPS, payment for prosthetic implants and implantable DME is packaged into the OPPS payment for the surgical procedure performed to insert the implants. Payments for IOLs, anesthesia materials, and implantable surgical supplies, such as stents, mesh, guidewires, pins, and catheters, are packaged into the associated surgical procedure payment under both the OPPS and the ASC payment system.

In developing the August 2006 proposed rule for the revised ASC payment system, we considered several packaging options. First, we considered making no change to the current policy regarding items and services for which payment is packaged into the ASC payment. That is, we would continue under the revised ASC payment system to package into the ASC payment all services listed at existing § 416.61(a). In addition, we would continue to pay separately, sometimes under other fee schedules, for items and services such as: NTIOLs; prosthetic implants and implantable DME surgically inserted at an ASC (DMEPOS fee schedule); laboratory services (Clinical Diagnostic Laboratory Fee Schedule); physician services (MPFS); and x-ray or diagnostic procedures other than those directly related to performance of the surgical procedure (MPFS).

We also considered proposing to apply the OPPS packaging rules to the ASC payment system and to pay under the revised ASC payment system the same way we pay under the OPPS for items and services directly related to a surgical procedure. If we adopted this option, payment for certain imaging procedures, drugs, biologicals, and contrast agents directly related to performing a covered surgical procedure would not be packaged into the ASC payment for the procedure but would, instead, be paid separately. Conversely, payment for most surgically implanted devices and implantable DME would be packaged.

Each of the preceding two options has characteristics that are inconsistent with a fundamental principle of a prospective payment system, which is to base payment on large bundles of items and services so as to promote the efficient provision of services. To preserve as much as possible the elements of a prospective payment system within the revised ASC payment system, in the August 2006 proposed rule for the revised ASC payment system, we proposed a third option (71 FR 49648). That is, we proposed to continue the current policy of packaging payment for all direct and indirect costs incurred by the facility to perform a covered surgical procedure into the ASC payment for the procedure. This would include payment for all drugs, biologicals, contrast agents, anesthesia materials, and imaging services, as well as the other items and services that were proposed for packaging into the ASC surgical procedure payment as listed in proposed § 416.164(a). Proposed § 416.164(a) addressed the services for which payment was proposed to be included in the ASC payment for the covered surgical procedures, and proposed § 416.164(b) addressed those services that were proposed *not* to be included in the ASC payment for the covered surgical procedures.

In addition, we proposed to cease making separate payment for implantable prosthetic devices and implantable DME inserted surgically in an ASC. Instead, under the revised payment system, we proposed to package payment for implantable prosthetic devices and implantable DME when they are surgically inserted into the ASC payment for the associated covered surgical procedure, as we do under the OPPS.

However, we proposed to continue excluding from ASC payment for covered surgical procedures the other services addressed in § 416.164(b). That is, payment for items and services for which payment is currently made under other Part B fee schedules, with the exception of implantable prosthetic devices and implantable DME, would

not be included in the ASC payment for the surgical procedure. Payment for items and services, such as physicians' professional services; laboratory, x-ray or diagnostic procedures (other than those directly related to performance of the surgical procedure); nonimplantable prosthetic devices; ambulance services; leg, arm, back and neck braces; artificial limbs; and DME for use in the patient's home would not be included in the ASC payment for the covered surgical procedure.

We proposed this third option for a number of reasons. First, in the August 2006 proposed rule, we explained that this approach to packaging is most consistent with the principles of a prospective payment system. Second, we noted that we believe that ASCs generally treat a less complex and severely ill patient case-mix and, as a result, we believe that ASCs are less likely to provide, on a regular basis, many of the separately paid items and services that patients might receive more consistently in a hospital outpatient setting. Thus, in the August 2006 proposed rule, we concluded that we did not believe there is a need to pay for these services separately in ASCs, because that would unbundle some items and services that are currently packaged into the ASC facility services payment under the existing payment system, reduce incentives for cost-efficient delivery of services in ASCs, and increase the complexity of the revised ASC payment system.

Moreover, after analysis of OPPS claims for surgical procedures, we were unable to identify ancillary items and services that are repeatedly and consistently reported separately in association with specific ambulatory surgical procedures. Rather, the OPPS claims for surgical procedures were of two types: one group showed a broad range of items and services that were provided on the same day that a surgical procedure was performed in the HOPD, only some of which were likely to be directly related to the surgical procedure; the second group of claims revealed that many surgical procedures are only infrequently associated with ancillary items and services paid separately under the OPPS.

We sought comments in the August 2006 proposed rule (71 FR 49648) from ASC clinical and administrative staff, and from physicians who perform surgeries in ASCs, regarding nonsurgical ancillary services or items that are directly related to a surgical procedure that would be paid separately under the OPPS but that would be packaged under our proposal for the revised ASC payment system. We specifically requested that commenters provide data to indicate the frequency with which specific items and services are typically furnished in association with given procedures, the reasons why one patient might require the additional items and services whereas another patient would not, and the costs of those items and services relative to the other costs incurred to perform the associated surgery.

At its December 2006 meeting, the PPAC recommended that CMS apply any payment policies uniformly to ASCs under the revised ASC payment system and HOPDs under the OPPS. In the GAO Report (GAO–07–86) published on November 30, 2006, based upon its study of the 20 most frequently performed ASC procedures in CY 2004, the GAO found that many additional services were billed with surgical procedures in both the ASC and HOPD settings, but few resulted in an additional payment in one setting but not the other. In general, HOPDs were paid separately for some of the related additional services they billed with the procedures and, in the ASC setting, other Part B suppliers usually billed Medicare for those services and received payment for them. Multiple surgical procedures performed in one session were typically paid separately in both settings, occurring in similar proportions of cases and subject to the same 50-percent reduction policy for the procedure with the lower payment rate. Laboratory services were paid under the OPPS according to the Clinical Diagnostic Laboratory Fee Schedule (CLFS) rates and were billed by another Medicare Part B supplier when provided in the context of a surgical procedure performed in an ASC. Similarly, some radiology services were paid separately under the OPPS, but when those radiology services were performed with procedures provided in the ASC setting, those services generally were furnished and billed by another Part B supplier. Anesthesia services in both settings were usually billed by another Part B supplier. While individual drugs were billed under the OPPS for most procedures, the GAO found that none of those individual drugs were separately payable in the HOPD setting, just as their payment was packaged in ASCs. Thus, the GAO concluded that there were many similarities in the additional services billed in the ASC or HOPD settings with the top 20 ASC procedures. Furthermore, the GAO found that, in the context of the existing ASC payment system, CMS generally made separate payment for similar additional services in both settings, although sometimes to other Part B suppliers than to the ASCs themselves.

We also note that we proposed, consistent with section 141(b) of the Social Security Act Amendments of 1994, Public Law 103–432, to continue to provide adjustment to payment amounts for NTIOLs under the revised ASC payment system as set forth in Subpart G that we finalized in the CY 2007 OPPS/ASC final rule with comment period.

We received numerous comments on our proposed packaging policies for the revised ASC payment system. The commenters submitted many suggestions regarding the various approaches that they believed CMS should follow when finalizing the packaging policies for certain items and services under the revised ASC payment system. A summary of the comments and our responses follow.

Comment: In general, many of the commenters agreed with CMS' proposal to continue to package under the revised ASC payment system payment for various items and services that are currently packaged under the OPPS and the existing ASC payment system. They recommended that CMS adopt its proposal to provide packaged payment for the costs of many items and services that are directly related to the provision of surgical procedures, such as facility overhead, operating and recovery room use, nursing and technician services, administrative and housekeeping items and services, appliances and equipment, materials for anesthesia, IOLs, surgical dressings, supplies, splints, and casts. They acknowledged that the statute requires that payment to ASCs for IOLs (other than NTIOLs which receive a supplemental payment) must be packaged into the ASC payment for IOL insertion procedures. In addition, the commenters agreed that CMS should continue to exclude from payment as part of the ASC payment for covered surgical procedures some items and services that are paid under other Part B fee schedules, specifically the professional services of physicians and nonphysician practitioners paid under the MFPS and laboratory services paid under the CLFS. Further, the commenters agreed that CMS should continue to provide additional payment for NTIOLs.

The commenters who supported continued packaging of the items and services described above generally provided those recommendations in the context of their broader recommendation to apply the same packaging policies under the revised ASC payment system as under the

OPPS, because the proposed payment rates under the revised ASC payment system were based upon the OPPS payment groups. They argued that parallel packaging policies were most consistent with promoting transparency between the two systems and minimizing any payment incentives to shift sites of service for various procedures. They also believed that this approach is the most appropriate, given the proposal to base the rates in the revised ASC payment system on the OPPS relative payment weights, with application of a single conversion factor. The commenters asserted that consistent packaging policies would ensure that some payment was made for the costs of all items and services used by facilities in performing surgical procedures, and that there was no duplicate payment for these items under either the OPPS or the revised ASC payment system.

MedPAC supported the proposal to expand the ASC payment bundles in the revised payment system by packaging payment for implantable prosthetics and DME, but recommended that CMS make the payment bundles under the revised ASC payment system and the OPPS even more compatible by expanding the payment bundles in the OPPS. MedPAC noted that different bundling policies under the two payment systems may lead to different relative payment amounts in each setting, even if the base payment rates share the same relative values in both settings.

Response: We appreciate the commenters' support for continuing to package payment under the revised ASC payment system for those items and services that also receive packaged payment under the OPPS. The commenters' recommendations are consistent with the PPAC recommendation that we apply payment policies uniformly across the two systems. We note that any changes to the OPPS payment bundles are outside the scope of this final rule for the revised ASC payment system. Such changes would have to be proposed and finalized through the OPPS annual rulemaking cycle, and we will keep MedPAC's recommendations in mind for future OPPS updates.

As set forth in final § 416.163, payment is made under the revised ASC payment system for ASC services furnished in connection with covered surgical procedures. As set forth in revised § 416.2, ASC services include both facility services, which are defined as items and services that are furnished in connection with a covered surgical procedure performed in an ASC and for which payment is packaged into the ASC payment for the covered surgical procedure, and covered ancillary services, which are defined as those items and services that are integral to a covered surgical procedure and for which separate payment may be made under the revised ASC payment system.

After considering all public comments received, we are finalizing, with modification, our proposal to provide packaged payment for ASC facility services into the ASC payment for covered surgical procedures under the revised ASC payment system. That is, we will continue to identify as within the scope of ASC facility services for which payment is packaged into the payment for covered surgical procedures as set forth in final § 416.164(a) the following: nursing, technician, and related services; use of the facility where the surgical procedures are performed; laboratory testing performed under a Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate of waiver; drugs and biologicals for which separate payment is not allowed under the OPPS; medical and surgical supplies not on pass-through status under the OPPS; equipment; surgical dressings; implanted prosthetic devices and related accessories and supplies not on pass-through status under the OPPS, including IOLs; implanted DME and related accessories and supplies not on pass-through status under the OPPS; splints and casts and related devices; radiology services for which separate payment is not allowed under the OPPS and other diagnostic tests or interpretive services that are integral to a surgical procedure; administrative, recordkeeping, and housekeeping items and services; materials, including supplies and equipment for the administration and monitoring of anesthesia; and supervision of the services of an anesthetist by the operating surgeon. Under the revised ASC payment system, the above items and services fall within the scope of ASC facility services, and we will package payment for them into the ASC payment for the covered surgical procedure in order to promote efficient use of resources. We will continue to provide a payment adjustment for insertion of an IOL approved as belonging to a class of NTIOLs, for the 5-year period of time established for that class, as set forth in Subpart G and new § 416.172(g) for the revised ASC payment system.

As a modification to our proposal, under the final policy of the revised ASC payment system, covered ancillary services that are integral to a covered ASC surgical procedure will be allowed separate payment. These covered ancillary services, which are outside of the scope of ASC facility services defined at § 416.2 and described at new § 416.164(a) for which payment is packaged into the ASC payment for covered surgical procedures, are defined at § 416.2 and described at new § 416.164(b) as follows: brachytherapy sources; certain implantable items that have pass-through status under the OPPS; certain items and services that we designate as contractor-priced (payment rate is determined by the Medicare contractor) including, but not limited to, the procurement of corneal tissue; certain drugs and biologicals for which separate payment is allowed under the OPPS; and certain radiology services for which separate payment is allowed under the OPPS. Public comments on the proposed rule and our responses regarding these specific items and services are discussed later in this section.

We will consider to be outside the scope of ASC services, as set forth in § 416.164(c), the following items and services, including, but not limited to: physicians' services (including surgical procedures and all preoperative and postoperative services that are performed by a physician); anesthetists' services; radiology services (other than those integral to performance of a covered surgical procedure); diagnostic procedures (other than those directly related to performance of a covered surgical procedure); ambulance services; leg, arm, back, and neck braces other than those that serve the function of a cast or splint; artificial limbs; and nonimplantable prosthetic devices and DME.

2. Policies for Specific Items and Services

Although in the August 2006 proposed rule we proposed to package payment for a broad array of items and services under the revised ASC payment system into the ASC payment for a covered surgical procedure as described earlier in this section, we solicited and received many public comments regarding our proposed treatment of those items or services that are directly related to a surgical procedure and that would be paid separately under the OPPS but that were proposed for packaging under the revised ASC payment system. We address those specific comments and provide our responses below.

Comment: A number of commenters indicated that, if the goal of the revised ASC payment system is to create a payment system that is based on OPPS relative weights and payment rates, then the packaging policy for ASCs should be

based on the same inclusions as those found under the OPPS. They suggested that following the OPPS payment policies under the revised ASC payment system would promote parity in payments between HOPDs and ASCs and, thereby, eliminate inappropriate incentives to base care decisions on payment considerations. Specifically, a number of commenters were concerned about payment differences that could arise between HOPDs and ASCs when services outside the CPT surgical range were provided in an ASC in conjunction with a covered surgical procedure on the ASC list. They noted that when HOPDs provide some of these services and items, they generally receive separate payment for them.

Response: Because we received numerous comments on various issues related to the proposed packaging of payment for specific items and services under the revised ASC payment system where the proposed packaging policy differs from the OPPS payment policy, we address them separately in the following sections:

a. Radiology Services

Under the existing ASC payment system, we define a surgical procedure as any procedure described within the range of Category I CPT codes that the AMA defines as ''surgery'' (CPT codes 10000–69999). In the August 2006 proposed rule, we indicated that we would continue this standard (71 FR 49636). Because the HCPCS codes that describe radiology services are outside of the CPT surgical range, payment for radiology services that are directly related to surgical procedures has been packaged into the ASC payment for the covered surgical procedure under the existing ASC payment system. The current regulatory definition of an ASC does not allow the ASC and another entity to mix functions and operations in a common space during concurrent or overlapping hours of operation. That is, the two facilities must be separated by time (different hours of operation) or the other entity may operate in the ASC's space when the ASC is not operating in that space. Historically, we have made an exception to this rule when there is a need for imaging services during the course of a covered surgical procedure in progress in an ASC under the existing ASC payment system. In that case, an Independent Diagnostic Testing Facility (IDTF) sharing the space with the ASC (normally at a different time) may conduct the required radiology service outside of its normal business hours, as needed, and receive Medicare payment for those services. Specifically, under the existing ASC payment system if an ASC enrolls in the Medicare program as an IDTF and bills as that supplier when furnishing a radiology service that is reasonable and necessary and directly related to and furnished in conjunction with a covered surgical procedure, the IDTF may bill and receive payment under the MPFS for imaging and guidance services, even though they are being provided during the ASC's designated hours.

The GAO Report on ASC payment released on November 30, 2006 confirmed that separate payment is commonly made to another Part B supplier for these radiology services provided in association with surgical procedures in ASCs. Currently, radiology services provided in association with surgical procedures paid under the OPPS are either packaged or paid separately through an OPPS facility payment. We received a number of comments regarding our proposal to package payment for radiology services into payment for their associated surgical procedures under the revised ASC payment system. A summary of the comments and our responses follow.

Comment: Numerous commenters opposed CMS' proposed policy of packaging payment for radiology services directly related to a surgical procedure into the ASC payment for the associated covered surgical procedure. Some commenters requested that CMS continue to follow the existing practice regarding separate payment for radiology services provided in association with surgical procedures under the current ASC payment system. That is, they recommended that CMS permit continued separate payments for such radiology services to IDTFs if the ASCs are enrolled as IDTFs and bill for the services as that type of supplier. On the other hand, other commenters believed that ASC enrollment as an IDTF supplier was unnecessarily administratively burdensome for those ASCs that only are providing radiology services necessary for the safe provision of surgical procedures. These commenters requested that CMS adopt the OPPS payment policy for radiology services under the revised ASC payment system, which either provides separate payment or packages their payment into the OPPS payment for the surgical procedure associated with the radiology services. They indicated that following the OPPS payment policy under the revised ASC payment system would promote parity in payments between HOPDs and ASCs, especially because the relative payment weights used in both payment systems were linked. In contrast, MedPAC recommended that CMS address the potentially inconsistent payment policies by creating larger payment bundles under the OPPS, consistent with CMS' proposal to package payment for radiology services directly related to a surgical procedure under the revised ASC payment system.

Response: We believe that appropriate radiology services may be necessary for the safe performance of covered surgical procedures that are provided to Medicare beneficiaries in ASCs, and we realize that under the current system, payments for many of these services are made to other Part B suppliers even though the radiology services are integral to the surgical procedures provided by ASCs. We have come to believe that the most prudent method for providing accurate payment for the ancillary radiology services that are integral to, and required for the successful performance of, covered surgical procedures is to provide separate payment for certain radiology services under our final policy for the revised ASC payment system. Payment for the costs of radiology services that are separately paid under the OPPS is not included in the OPPS payment weights upon which the revised ASC payment system is based so, under our proposal, ASCs may not have received the most appropriate payment for the costs of these associated radiology services. We will, therefore, provide separate payment to ASCs for certain ancillary radiology services when they are integral to the performance of a covered surgical procedure billed by the ASC on the same day, provided that separate payment for the radiology service would be made under the OPPS.

We specify that a radiology service is integral to the performance of a covered surgical procedure if it is required for the successful performance of the surgery and is performed in the ASC immediately preceding, during, or immediately following the covered surgical procedure. Based on our analysis of the OPPS data, we believe that, in most cases, a radiology service that is separately payable under the OPPS that is performed in the ASC on the same day as a covered surgical procedure will be provided integral to a covered surgical procedure, and the ASC will be able to receive separate payment for the service as a covered ancillary service. The separate ASC payments for these radiology services will be made at the lower of: (1) The amount calculated according to the standard methodology of the revised ASC payment system; or (2) the MPFS nonfacility practice expense amount for the service (specifically, for the

technical component (TC) if the service's HCPCS code is assigned a TC under the MPFS). This is similar to our final payment policy for covered office-based surgical procedures added to the ASC list in CY 2008 or later years. Payment for the costs of the facility resources associated with the radiology service would have been made to IDTFs under the existing ASC payment system at the MPFS nonfacility practice expense amount. Therefore, we believe the revised payment system beginning January 1, 2008, will both ensure appropriate and equitable payment for covered ancillary radiology services integral to covered surgical procedures and not provide a payment incentive for migration of services from physicians' offices or IDTFs to ASCs.

This final policy will not encourage the proliferation of ASCs enrolling as IDTF suppliers, a practice which could lead to even greater future increases in the volume of diagnostic imaging services than those recently observed for such services to Medicare beneficiaries. CMS defines an IDTF in § 410.33 as an entity independent of a hospital or physician's office in which diagnostic tests are performed by licensed or certified nonphysician personnel under appropriate physician supervision. ASCs are distinct entities that operate exclusively for the purpose of providing surgical services to patients not requiring hospitalization (§ 416.2). As discussed earlier, an ASC that is also enrolled as an IDTF must maintain separate, exclusive hours of operation from those of the IDTF, and there may be no overlap in the hours of operation of the two entities.

In order to bill for diagnostic tests, the IDTF must be enrolled as such with Medicare and meet specific requirements regarding its structure, ownership and, operation as set forth in § 410.33. As stated in § 416.49, an ASC is responsible for obtaining radiologic services from a Medicare approved facility to meet the needs of its patients and, as confirmed by the GAO in its report released on November 30, 2006, many ASCs currently provide those radiology services in association with covered surgical procedures through other Part B suppliers, specifically IDTFs.

Under the revised payment system, there is no incentive for ASCs that provide only those radiology services that are integral to the performance of covered surgical procedures to also enroll as IDTFs. In contrast to current policy, under the revised system, payment will be made to the ASC for radiology services that are furnished integral to a covered surgical procedure. Payment will no longer be permitted to IDTFs for covered ancillary radiology services furnished integral to covered surgical procedures in ASCs. Because ASCs are distinct entities that operate exclusively to provide ambulatory surgical services, we would not expect that IDTFs sharing space with ASCs would be billing for any services for a patient receiving those services in an ASC on the date of a covered surgical procedure because all such services would be integral to the surgical procedure.

Under the final policy, only the ASC can receive payment for the facility resources required to provide the ancillary radiology services. IDTFs would not be able to bill for radiology services integral to the performance of a covered surgical procedure, an existing practice which commenters claimed is unnecessarily administratively burdensome because it requires ASCs that are only providing radiology services related to the safe performance of surgical procedures also to enroll as IDTF suppliers under Medicare. As of January 1, 2008, we are no longer permitting the exception that has allowed billing by IDTFs for required radiology services provided in ASCs during the course of covered ASC surgical procedures. We are also not allowing any other suppliers to bill for the technical component of radiology services provided in ASCs that are integral to the performance of an ASC covered surgical procedure. Only ASCs will receive separate payment for the technical component of those radiology services that are separately payable under the OPPS to ensure that no duplicate payment is made. This policy will ensure that packaged or separate payment is made to ASCs for all radiology services integral to the performance of covered surgical procedures, thereby providing appropriate payment to ASCs for those radiology services that are essential to the delivery of safe, high quality surgical care.

In summary, under the revised ASC payment system, we are adopting the OPPS payment status for radiology services and will pay separately, at the lower of the amount developed according to the standard methodology of the revised ASC payment system or the MPFS nonfacility practice expense amount, for ancillary radiology services designated as separately payable under the OPPS when those radiology services are integral to the performance of a covered surgical procedure provided on the same day and billed by the ASC. Similarly, we will package payment for those services that are designated as packaged under the OPPS into the payment for the covered surgical procedure. The separate national, unadjusted ASC payment for a covered ancillary radiology service would be based either upon the OPPS payment weight for the APC group of the radiology service, with application of the uniform ASC conversion factor, or upon the MPFS nonfacility practice expense relative value units (RVUs) for the service. Payment under the revised ASC payment system for these covered ancillary radiology services would be subject to geographic adjustment, like payment for covered surgical procedures. IDTFs would no longer be able to receive payment for ancillary radiology services that are integral to the performance of a covered surgical procedure for which the ASC is billing Medicare. This policy is consistent with the PPAC's request for uniform payment policies across the OPPS and the revised ASC payment system and is responsive to MedPAC's concern about creating different payment bundles for ASCs and HOPDs. Because the packaging status of radiology services under the revised ASC payment system will parallel their treatment under the OPPS, any changes to the packaging of radiology services under the OPPS that would alter the OPPS payment bundles would also occur under the revised ASC payment system. Therefore, we believe that this approach is fully consistent with the recommendations of MedPAC and the PPAC in applying payment policies consistently to both ASCs and HOPDs.

Radiology services include all Category I CPT codes in the radiology range established by CPT, from 70000 to 79999, and Category III CPT codes and Level II HCPCS codes that describe radiology services that crosswalk or are clinically similar to procedures in the radiology range established by CPT. This revised ASC payment system policy for each calendar year will apply to all radiology services that are separately payable under the OPPS in that same calendar year. An illustrative listing that includes all radiology services that are separately payable under the CY 2007 OPPS, which will be proposed for updating and then finalized in the CY 2008 OPPS/ASC proposed and final rules, respectively, can be found in Addendum BB to this final rule. Covered ancillary radiology services are assigned to payment indicator ''Z2'' (Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS relative payment weight) or ''Z3'' (Radiology service paid separately when provided integral to a

surgical procedure on ASC list; payment based on MPFS nonfacility PE RVUs). ASC payment rates for these radiology services will be determined according to the standard methodology of the revised ASC payment system as discussed further in section V. of this final rule, or according to the MPFS nonfacility practice expense amount, whichever payment amount is lower. This final policy is set forth in §§ 416.171(d) and 416.167(b)(3).

After consideration of all public comments received, we are finalizing a policy to provide separate payment under the revised ASC payment system for those ancillary radiology services separately paid under the OPPS that are integral to the performance of covered surgical procedures for which the ASC bills Medicare. This final policy contrasts with our proposal which would have provided packaged payment for all ancillary radiology services. Instead, under the revised ASC payment system, we will provide separate payment for those ancillary radiology services that are separately paid under the OPPS when they are provided on the same day as, and integral to, the performance of a covered surgical procedure in an ASC. Payment for ancillary radiology services that are packaged under the OPPS will be packaged under the revised ASC payment system, and these services are identified in Addendum BB to this final rule with payment indicator ''N1'' (Packaged service/item; no separate payment made).

Separately paid radiology services are considered to be covered ancillary services. ASC payment for these radiology services will not be subject to the 4-year transition (see section IV.J. of this final rule) because the services have never received separate payment under the existing ASC payment system. The 4-year transition applies only to those services that receive separate payment under the existing CY 2007 ASC payment system. We also are revising proposed § 416.164(a) and (b) to reflect this final policy.

b. Brachytherapy Sources

As we stated in the August 2006 proposed rule, under the existing ASC payment system, a single payment is made to an ASC for all facility services furnished by the ASC in connection with a covered surgical procedure. However, a number of services and related items covered under Medicare may be furnished in an ASC, where these items and services are not considered to be facility services and, therefore, are not paid through the ASC payment for the covered surgical procedure. These items and related services may be covered and paid to other Part B suppliers, such as physicians. Such is sometimes the case with payment for brachytherapy sources implanted in ASCs, where the needles and catheters to implant the sources are implanted during surgical procedures that are on the ASC list. Under the existing ASC payment system, while payment is not made for brachytherapy sources to ASCs, these sources may be separately paid at contractor-priced rates by Medicare contractors under the MPFS to physicians who may also be billing the CPT codes for application of the brachytherapy sources in ASCs. Contractor-priced rates are those payment rates for certain items or services that are individually established by each Medicare contractor for payment of claims submitted to them. Brachytherapy source application codes, which are included in the radiology section of the CPT code book, are not on the existing ASC list because they do not fall within the CPT surgical range and, therefore, are not defined as surgery for purposes of ASC payment. While we did not explicitly discuss payment for brachytherapy sources in the August 2006 proposed rule, we received a number of comments regarding payment for brachytherapy sources under the revised ASC payment system. A summary of the comments and our responses follow.

Comment: Several commenters suggested that CMS pay separately for brachytherapy sources under the revised ASC payment system when they are implanted in ASCs. Other commenters recommended that CMS continue to pay separately under the MPFS for brachytherapy sources provided in ASCs. The commenters requested that CMS allow separate payment for brachytherapy sources to facilitate the treatment of cancer patients who have brachytherapy sources implanted in ASCs. As an example, they described a closely related sequence of procedures performed in the ASC setting for the brachytherapy treatment of patients with prostate cancer, including the placement of needles and catheters, reported with a CPT code on the ASC list; the application of brachytherapy sources, reported with a CPT code not on the ASC list; and the provision of numerous brachytherapy sources, reported with specific Level II HCPCS codes in the OPPS setting. The commenters noted that it would be appropriate to implant brachytherapy sources in ASCs for the treatment of prostate cancer, because the surgical procedure to insert the required needles and catheters is currently on the ASC list and, in the case of prostate cancer in particular, patients must have the sources implanted in the same session where the needles or catheters are placed. The commenters pointed out that each of these related items and services is separately paid under the OPPS, so the base OPPS payment weights for the surgical needle and catheter placement procedures do not provide payment for the brachytherapy source application or the sources themselves. They noted that all of these individual procedures and items are required to provide the full brachytherapy treatment.

Response: Based on the comments received and our review of the issue, we have concluded that the most appropriate policy under the revised ASC payment system is to provide separate payment to ASCs for the brachytherapy sources as covered ancillary services implanted in conjunction with covered surgical procedures billed by ASCs. Further, as evidenced by our decisions regarding payment for other covered ancillary services under the CY 2008 revised ASC payment system, our intention is to maintain consistent payment and packaging policies across HOPD and ASC settings for covered ancillary services that are integral to covered surgical procedures performed in ASCs. Therefore, consistent with our policy to pay separately for some drugs, biologicals, and radiology services as covered ancillary services, we also believe that adopting a payment policy consistent with the OPPS for payment of brachytherapy sources is reasonable and appropriate to ensure that the comprehensive brachytherapy service can be provided by ASCs. The application of the brachytherapy sources is integrally related to the surgical procedures for insertion of brachytherapy needles and catheters, which are appropriate for performance in ASCs. There is a statutory requirement that the OPPS establish separate payment groups for brachytherapy sources related to their number, radioisotope, and radioactive intensity, as well as for stranded and non-stranded sources as of July 1, 2007, OPPS procedure payments do not include payment for brachytherapy sources. We agree with both MedPAC and the PPAC that consistent payment bundles between the two payment systems are desirable. Therefore, under the revised ASC payment system, we will pay ASCs separately for brachytherapy sources when they are provided in association with a surgical

procedure not excluded from ASC payment and billed by the ASC on the same day. The ASC brachytherapy source payment rate for a given calendar year will be the same as the OPPS payment rate for that year or, if specific OPPS prospective payment rates are unavailable, ASC payments for brachytherapy sources will be contractor-priced. The ASC brachytherapy source payment rate will be established at its OPPS payment rate, without application of the ASC budget neutrality adjustment factor to the OPPS conversion factor. In addition, consistent with the payment of brachytherapy sources under the OPPS, the ASC payment rates for brachytherapy sources will not be adjusted for geographic wage differences. Because brachytherapy sources are implantable devices with relatively fixed costs for which we would not expect efficiencies that would permit ASCs to acquire them at lower costs than HOPDs, we believe it is most appropriate to pay for the brachytherapy sources at the same rates as the OPPS if possible. A list of brachytherapy sources recognized under the CY 2007 OPPS, for which payment according to the statute is made at charges reduced to cost under the CY 2007 OPPS, is included in Table 3 below, as well as in Addendum BB to this final rule, specifically those codes assigned to payment indicator ''H7'' (Brachytherapy source paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced).

An updated list will be proposed and finalized for CY 2008 in the CY 2008 OPPS/ASC proposed and final rules, respectively, as will the CY 2008 OPPS payment rates for brachytherapy sources. We also may establish new brachytherapy source HCPCS codes, revise the existing HCPCS codes, or both, for separate payment on a quarterly basis under the revised ASC payment system, as we currently do under the OPPS, in order to keep the two payment systems aligned. In addition, we note that the CPT codes for the application of brachytherapy sources are radiology services in the radiology range of Category I CPT codes, so they would also be separately paid in ASCs under the revised ASC payment system if provided in association with a covered surgical procedure, as described in section IV.C.2.a. of this final rule.

TABLE 3.—BRACHYTHERAPY SOURCES PAID SEPARATELY UNDER THE CY 2007 OPPS AS OF APRIL 1, 2007

HCPCS code	Long descriptor
A9527	Iodine I–125, sodium iodide solution, therapeutic, per millicurie.
C1716	Brachytherapy source, Gold-198, per source.
C1717	Brachytherapy source, High Dose Rate Iridium-192, per source.
C1718	Brachytherapy source, Iodine-125, per source.
C1719	Brachytherapy source, Non-High Dose Rate Iridium-192, per source.
C1720	Brachytherapy source, Palladium-103, per source.
C2616	Brachytherapy source, Yttrium-90, per source.
C2633	Brachytherapy source, Cesium-131, per source.
C2634	Brachytherapy source, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source.
C2635	Brachytherapy source, High Activity, Palladium-103, greater than 2.2 mCi (NIST), per source.
C2636	Brachytherapy linear source, Palladium-103, per 1MM.
C2637	Brachytherapy source, Ytterbium-169, per source.

After consideration of all public comments received, we are finalizing a policy to provide separate payment under the revised ASC payment system for ancillary brachytherapy sources implanted in association with the performance of a covered surgical procedure that is billed by the ASC to Medicare. Under our proposal, no payment would have been made to ASCs for the implantation of brachytherapy sources in conjunction with covered surgical procedures, although payment could have been made to other Part B suppliers. Under this final policy, ASC payment for brachytherapy sources as covered ancillary services in a calendar year will be made at the OPPS rates for that same year, or if OPPS rates are unavailable, ASC payment will be made at contractor-priced rates. Payment rates for brachytherapy sources will not be developed through application of the uniform ASC conversion factor, and they will not be subject to the geographic adjustment. Accordingly, we are revising proposed § 416.164(a) and (b) to reflect this final policy.

We would also caution that we expect ASCs to follow all Federal, State, and local safety requirements regarding the proper handling and disposal of these radioactive substances. ASCs that cannot comply with those guidelines should not provide brachytherapy services. ASC policies for the proper handling and disposal of brachytherapy sources also should include accommodations for the appropriate disposal of sources that were not implanted.

c. Drugs and Biologicals

In the August 2006 proposed rule, we indicated that under the existing ASC payment system, payment for all drugs and biologicals (whether packaged or separately payable under the OPPS) is packaged into the ASC payment for the covered surgical procedure. We proposed to continue that policy under the revised ASC payment system. Under the OPPS, CMS pays separately for all pass-through drugs and biologicals, while nonpass-through drugs and biologicals are either packaged or paid separately under the OPPS, depending on whether or not their cost is equal to or less than $55 per day or exceeds $55 per day, respectively, for CY 2007. We received a number of comments on our proposal to package payment for all drugs and biologicals into the payment for their associated surgical procedures under the revised ASC payment system. A summary of the comments and our responses follow.

Comment: While the commenters generally agreed with CMS' proposal to package payment for inexpensive drugs into the ASC payment for the covered surgical procedure under the revised ASC payment system consistent with current practice, many commenters objected to CMS' proposed packaging of payment for expensive drugs and biologicals and urged CMS to pay separately for them. Moreover, several commenters requested that CMS adopt the OPPS payment policies for both pass-through and nonpass-through drugs and biologicals under the revised ASC payment system. They indicated that following the OPPS payment policies under the revised ASC payment system would promote parity in

payments between HOPDs and ASCs and, thereby, eliminate inappropriate incentives to base care decisions on payment considerations. Specifically, a number of commenters were concerned about payment differences that could arise between HOPDs and ASCs when items were provided in an ASC in conjunction with a covered surgical procedure on the ASC list. They noted that when HOPDs provide pass-through and many nonpass-through drugs and biologicals, they generally receive separate payment for these items; therefore, the base OPPS payment rates contain no payment for these drugs and biologicals.

Several commenters expressed particular concern regarding CMS' proposal to package payment for expensive biologicals into the associated surgical procedure's ASC payment. These commenters cited surgical procedures for the application of skin substitutes, newly proposed as additions for ASC payment in CY 2008, as examples of relatively inexpensive surgical procedures that require the use of costly biologicals, for which separate payment is made under the OPPS. They argued that the additions of the procedures to the ASC list would not provide meaningful access to those services in ASCs, given that the relatively low procedure payments proposed for the revised ASC payment system included no payment for those necessary biologicals. The commenters further added that not paying separately for expensive drugs and biologicals in ASCs could result in a shift of services from ASCs to HOPDs or physicians' offices, where they are separately paid, even though ASCs could be the most appropriate clinical setting for care. Some commenters suggested that CMS select specific drugs and biologicals for separate payment under the revised ASC payment system based on specific criteria such as their cost, required use, or association with specific surgical procedures not excluded from ASC payment.

Response: After considering all the comments related to payment for drugs and biologicals, we agree with the commenters that the revised ASC payment system should provide separate payment for relatively costly drugs and biologicals that are integral to covered surgical procedures that are billed by ASCs and whose payments are not packaged into the base OPPS payment rates. Therefore, effective January 1, 2008, we will pay separately for all OPPS pass-through and nonpass-through drugs and biologicals that are separately paid under the OPPS, when they are provided in association with a covered surgical procedure that is billed by the ASC to Medicare.

Based on the November 30, 2006 GAO Report on ASC payment, we recognize that historically common ASC procedures generally used drugs that are packaged under the OPPS, but we believe that the significant expansion of the procedures eligible for payment under the revised ASC payment system, in addition to evolving surgical practice, may necessitate the use of different drugs and biologicals in ASCs in the future. To ensure appropriate access to all surgical procedures that are safe for performance in ASCs, we believe it is prudent under the revised ASC payment system to provide separate payment in the ASC setting for drugs and biologicals that are integral to covered surgical procedures for which the ASC is billing, when the costs of those drugs and biologicals were not included in developing the base procedure payment weights under the OPPS. We do not believe it would be appropriate to select only a subset of these drugs and biologicals that are separately payable under the OPPS because we do not see a clear rationale for doing so.

We specify that a drug or biological is integral to the performance of a covered surgical procedure if it is required for the successful performance of the surgery and is provided in the ASC immediately preceding, during, or immediately following the covered surgical procedure. Based on our analysis of OPPS data, we believe that, in most cases, a drug or biological that is separately payable under the OPPS that is provided in an ASC on the same day as a covered surgical procedure will be provided as integral to the covered surgical procedure, and the ASC will be able to receive separate payment for the drug or biological as a covered ancillary service.

The payments for separately payable drugs and biologicals under the revised ASC payment system for a calendar year will be equal to the payment rates developed according to the payment methodology used in the OPPS for that same year, without the application of the ASC budget neutrality adjustment to the OPPS conversion factor. Because OPPS payment for separately paid drugs and biologicals is provided at the average hospital acquisition cost and is not based upon the application of the OPPS conversion factor to relative payment weights, we believe the OPPS rates should also reflect the typical acquisition cost of these products in the ASC facility setting as well. The OPPS currently relies on the average sales price (ASP) methodology to establish payment rates for many separately paid drugs and biologicals, and ASP data are based upon manufacturers' reports of all drug sales, including those to different types of facilities and physicians' offices. The ASP methodology is also utilized to establish the physician's office payment for drugs and biologicals. Therefore, we believe that aligning the ASC payment methodology with the OPPS payment for these covered ancillary services is a consistent and logical approach to setting their ASC payment rates, and we will not apply the ASC budget neutrality adjustment to establish the ASC payment rates. Comparable to their treatment under the OPPS, the ASC payment for separately paid drugs and biologicals will also not be subject to the geographic wage adjustment. In addition, ASC payment for drugs and biologicals that are not separately payable under the OPPS will be packaged into the payments for the covered surgical procedures with which they are administered, consistent with the current OPPS payment methodology.

As noted above, under the CY 2007 OPPS, payment for separately payable nonpass-through drugs and biologicals is made according to the ASP methodology, and is generally equal to the ASP plus 6 percent in CY 2007, the same as the physician's office payment. Payment for pass-through drugs and biologicals is set at the rate under the Competitive Acquisition Program (CAP) for Part B drugs or, if the drug is not included in the CAP, at the rate established by the ASP methodology and generally equal to the ASP plus 6 percent. A list of the drugs and biologicals that are separately paid under the CY 2007 OPPS, along with their payment rates as of April 1, 2007, is included in Addendum BB to this final rule, specifically those codes assigned to payment indicator ''K2'' (Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate). Drugs and biologicals for which payment is packaged under the CY 2007 OPPS are also listed in Addendum BB, where they are assigned to payment indicator ''N1'' (Packaged service/item; no separate payment made).

The CY 2008 payment status and payment rates for drugs and biologicals will be proposed and finalized in the CY 2008 OPPS/ASC proposed and final rules, respectively. We also may establish new HCPCS codes for separately payable drugs and plan to update payment rates for drugs and biologicals based on new ASP information on a quarterly basis under

the revised ASC payment system, as we currently do under the OPPS, in order to keep the two payment systems aligned. This final policy is consistent with the recommendation of the PPAC and the comments of MedPAC to align the payment bundles under the OPPS and ASC payment systems.

In summary, after consideration of all public comments received, we are finalizing a policy to provide separate payment under the revised ASC payment system for drugs and biologicals that are separately paid under the OPPS, when those items are integral to the performance of a covered surgical procedure for which the ASC is billing. We proposed to provide packaged payment for all drugs and biologicals under the revised ASC payment system through the ASC payment for the covered surgical procedure. In contrast, this final policy will provide separate payment for those drugs and biologicals that are separately paid under the OPPS, when those items are provided on the same day as and integral to the performance of a covered surgical procedure in an ASC. Separate ASC payment for these drugs and biologicals will be made at the OPPS payment rate for the same calendar quarter. ASC payment for those drugs and biologicals that are integral to the performance of a covered surgical procedure and whose payment is packaged under the OPPS will receive packaged payment under the revised ASC payment system. Payment rates for drugs and biologicals will not be developed through application of the uniform ASC conversion factor, and they will not be subject to the geographic adjustment. We also are revising proposed § 416.164(a) and (b) to reflect this final policy.

d. Implantable Devices With Pass-Through Status Under the OPPS

In the August 2006 proposal for the revised ASC payment system, we proposed to pay for all implantable devices as part of the ASC payment for the covered surgical procedure, thereby packaging payment for all devices except for the additional ASC adjustment for NTIOLs. Under this proposal, payment for devices included in those device categories with pass-through status under the OPPS would also be packaged. In contrast, pass-through status under the OPPS provides payment for a device included in the pass-through device category on a claim-specific basis at the hospital's charges reduced to cost. That is, fiscal intermediaries apply the hospital's overall cost-to-charge ratio from the hospital's last submitted cost report to the submitted charges on the claim and pay the resulting amount on a claim-specific basis. A device offset amount is applied, if appropriate, to take into consideration the predecessor device payment already packaged into the OPPS payment for the associated implantation procedure, in order to ensure no duplicate payment. The predecessor device is the device that would have been used in the procedure if the pass-through device had not been implanted and for which the historical cost is packaged into the payment for the implantation procedure.

Under the existing ASC payment system, payment for OPPS designated pass-through devices is either packaged into the ASC payment for the covered surgical procedure or, if the device is implantable DME or an implantable prosthetic, separately paid under the DMEPOS fee schedule, independent from the ASC payment for the associated surgical procedure. We received many comments regarding our proposal to package payment for devices with OPPS pass-through status into payment for their associated surgical procedures under the revised ASC payment system. A summary of the comments and our responses follow.

Comment: Many commenters encouraged us to expand the OPPS pass-through program to the revised ASC payment system, to provide separate payment for those devices whose payments, in whole or in part, were not packaged into the base OPPS payment weights upon which the revised ASC payment system would be based. These commenters questioned how ASCs would be paid appropriately for devices that are paid separately under the OPPS as pass-through devices at the hospital's charges reduced to cost by the hospital's overall cost-to-charge ratio. The commenters did not believe it would be appropriate to provide payment for devices with pass-through status under the OPPS packaged into the ASC payment for the associated surgical procedure, when there are either no costs associated with those devices packaged into the base OPPS procedure payment weights or inadequate costs associated only with predecessor devices packaged into the base OPPS weights.

The commenters added that many of the OPPS designated pass-through devices that are implanted in ASCs are expensive, and their cost would not be adequately reflected in the ASC payment for the covered surgical procedure. They believed that the proposed policy would result in little access to these new technologies in the ASC setting, despite the fact that the associated surgical procedures for their implantation are appropriate for ASC payment. They pointed out that only devices that demonstrate significant clinical improvement are provided pass-through status under the OPPS; hence, Medicare beneficiaries would be unable to receive the most clinically beneficial procedures in ASCs.

Several commenters requested that CMS not provide ASC payments for many surgical procedures that use implantable devices, generally for patient safety reasons, whether pass-through devices are used or not.

Response: While the OPPS pass-through program is a statutory requirement of the OPPS under section 1833(t)(6) of the Act and, therefore, not specifically applicable to the revised ASC payment system, we agree with commenters that similar device payment policies for these devices under the OPPS and the revised ASC payment system are most appropriate to ensure access to procedures implanting these clinically beneficial devices in ASCs. Specifically in the case of OPPS pass-through devices, the costs of the devices are not fully packaged into the OPPS payment weights upon which the revised ASC payment system is based because the devices are separately paid under the OPPS. We agree with commenters that if payments to ASCs for the associated surgical implantation procedures are inadequate to cover the costs of these beneficial devices, then ASCs will not offer the procedures implanting these devices and beneficiary access to these effective devices will thereby be limited to other sites for the services.

When we examined the three device categories that currently have pass-through status under the CY 2007 OPPS, specifically C1820 (Generator, neurostimulator (implantable), with rechargeable battery and charging system), C1821 (Interspinous process distraction device (implantable)), and L8690 (Auditory osseointegrated device, includes all internal and external components), we noted that the surgical procedures associated with both C1820 and L8690 are currently payable in the ASC setting. We continue to believe that the procedures associated with these pass-through device categories are safe for ASC performance and, as such, the procedures will be paid under the revised ASC payment system. We remind the public that the list of device categories with pass-through status under the OPPS is updated quarterly, with the addition of new pass-through device categories, if applicable, and that the dates for the expiration of pass-through payment for device categories

are proposed and finalized during the OPPS annual rulemaking cycle. Only device categories C1821 and L8690 will continue with pass-through status under the CY 2008 OPPS, but there may be additional device categories established in the future that will have pass-through status during all or a portion of that calendar year. Under the OPPS, claim-specific device pass-through payment is calculated based on the device charge reduced to cost by application of the overall hospital cost-to-charge ratio and, if applicable, the resulting device cost is further subject to a payment reduction (device offset) that is equivalent to the device cost for predecessor devices already included in the APC median cost for the associated surgical procedure. This ensures that the OPPS does not provide duplicate payment for any portion of an implanted device with pass-through status. Of the three device categories currently with pass-through status under the OPPS, only one device category (C1820) has an associated device offset due to the costs of the predecessor nonrechargeable implantable neurostimulators already packaged into the base APC payment weights for neurostimulator implantation procedures.

Commenters have persuaded us that, under the revised ASC payment system, it is appropriate to provide separate payment for devices that are included in device categories with pass-through status under the OPPS. A list of the OPPS pass-through device categories as of April 1, 2007 is provided in Table 4 below, and their HCPCS codes are also included in Addendum BB to this final rule, where they are assigned to payment indicator ''J7'' (OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced). Implantable devices that received packaged payment because they do not have OPPS pass-through status are also listed in Addendum BB to this final rule, where they are assigned to payment indicator ''N1'' (Packaged service/item; no separate payment made).

TABLE 4.—ACTIVE OPPS PASS-THROUGH DEVICE CATEGORIES UNDER THE CY 2007 OPPS AS OF APRIL 1, 2007

HCPCS code	Long descriptor
C1820	Generator, neurostimulator (implantable), with rechargeable battery and charging system.
C1821	Interspinous process distraction device (implantable).
L8690	Auditory osseointegrated device, includes all internal and external components.

It is not possible to pay for these devices using the specific OPPS payment methodology, because cost-to-charge ratios are not available for ASCs to convert ASC charges to cost in order to establish a claim-specific device payment. Because these devices are new technology and the number of device categories with pass-through status under the OPPS has been limited over the past several years, we believe that contractor-priced rates are the most appropriate payment methodology for these devices under the revised ASC payment system since there would be little or no OPPS claims data available to establish prospective payment rates for these devices. Therefore, we will pay ASCs separately for devices with pass-through status under the OPPS in that same quarter of the calendar year at contractor-priced rates when they are implanted in ASCs during a covered surgical procedure that is billed by the ASC. As under the OPPS, ASC payment for these devices would not be subject to the geographic wage adjustment, nor would the uniform ASC conversion factor be applied because there is no OPPS payment weight available for these devices and there is little clinical labor associated with the device acquisition by the ASC. The associated nondevice facility resources for the device implantation procedures would be paid through an ASC surgical procedure service payment based upon the payment weight for the nondevice portion of the related OPPS APC payment weight, as described further below with respect to ASC payment for implantable devices without pass-through status under the OPPS. This policy, similar to the device offset policy under the OPPS, would ensure no duplicate device payment by removing, if applicable, the costs of related predecessor devices packaged into the base procedure's OPPS payment weight. Under this policy, we will pay separately in ASCs for new devices that result in significant clinical improvement, consistent with the pass-through policy under the OPPS. This similar treatment of devices included in device categories with OPPS pass-through status under both the OPPS and revised ASC payment systems will help to ensure that beneficiaries have access to the devices in both settings. We believe this approach is fully consistent with the recommendation of the PPAC to apply payment policies uniformly to both ASCs and HOPDs, and with the comments of MedPAC in support of comparable payment bundles in the two systems.

As we have stated earlier in this final rule, we are firmly committed to ensuring that outpatient procedures are not limited to certain sites of service and that all surgical procedures that can safely be performed in ASCs and that are not expected to require an overnight stay are on the ASC list of covered surgical procedures so that Medicare beneficiaries have full access to surgical services in all appropriate settings. We believe that paying separately for those devices that are included in device categories with pass-through status under the OPPS and that are implanted during ASC covered surgical procedures under the revised ASC payment system will promote efficient resource use and ensure appropriate access to care.

After considering all public comments received, we are finalizing a policy to provide separate payment under the revised ASC payment system for ancillary devices included in device categories with pass-through status under the OPPS in the same quarter of the same calendar year that the devices are implanted during a covered surgical procedure that is billed by the ASC. In contrast with our proposal which would have provided packaged payment for these devices, but consistent with their separate payment under the OPPS, this specific subset of implantable devices will receive separate payment under the revised ASC payment system as covered ancillary services. ASC payment will be made for the devices at contractor-priced rates and will not be subject to geographic wage adjustment, and payment for the associated surgical procedures will be made according to our standard methodology for the revised ASC payment system, based on only the service (nondevice) portion of the procedure's OPPS relative payment weight. Accordingly, we are revising proposed § 416.164(a) and (b) to reflect this final policy.

e. Implantable Devices Without Pass-Through Status Under the OPPS

Historically, separate payment for implantable DME and prosthetics provided in association with procedures on the ASC list of covered surgical procedures has been made to ASCs on the basis of the DMEPOS fee schedule. Payment for other devices that are not implantable DME or prosthetics, including some nonpass-through devices under the OPPS, has historically been made as part of the ASC payment for the covered surgical procedure because such items have been considered to be supplies.

In the August 2006 proposed rule for the revised ASC payment system, we proposed to pay for nonpass-through devices as part of the ASC payment that would be based on the OPPS relative payment weight of the associated surgical procedure, thereby packaging payment for all nonpass-through devices, consistent with their treatment under the OPPS. We also proposed to apply an ASC budget neutrality adjustment of 62 percent to the OPPS conversion factor to calculate the ASC payment rates for all covered surgical services, regardless of the specific nature of the surgical procedures. Therefore, payment for surgical procedures with high device costs, referred to as device-intensive procedures, would be calculated like payment for all other surgical procedures not excluded from ASC payment under the revised payment system. We received many comments on our proposed payment policy for devices without pass-through status under the OPPS. A summary of the comments and our responses follow.

Comment: Many commenters objected to the packaging of payment for all devices as proposed, principally on the basis that, where the device cost exceeds 62 percent of the APC payment rate, the ASC would not be paid enough to cover the cost of the device, let alone the other service costs of the implantation procedure. Some commenters suggested that CMS continue to pay separately for devices for which it currently pays separately under the DMEPOS fee schedule and provide payment through the ASC payment for only the nondevice portion of the implantation procedure. They recommended that CMS apply the ASC conversion factor only to the nondevice portion of the APC payment weight to calculate the ASC service payment for the implantation procedure. Other commenters believed that CMS should not apply the ASC conversion factor to the device portion of the APC payment, but instead should pass the OPPS payment amount for the device through to the ASC payment system directly because ASCs would be unable to obtain the devices at lower cost than HOPDs. They argued that ASCs would see no efficiencies regarding the fixed device costs, so it would be inappropriate to apply the ASC conversion factor to develop this portion of the ASC procedure payment. These commenters suggested that CMS could then apply the ASC conversion factor to the nondevice portion of the APC payment to develop a service payment, and sum the two partial payments (for the device and the service) to calculate the full ASC payment for these device-intensive procedures under the revised ASC payment system. They concluded that, in this manner, the OPPS and the revised ASC payment system would be aligned, because both systems would provide packaged payment for devices without OPPS pass-through status.

Several commenters requested that CMS not provide ASC payments for many procedures that use devices and that are currently paid under the OPPS, generally for patient safety reasons.

Response: For purposes of the revised ASC payment system, we are defining device-intensive procedures as all those ASC covered surgical procedures in CY 2008 that are assigned to device-dependent APCs under the OPPS, where the APC device cost is greater than 50 percent of the median APC cost. There are 40 such procedures that fall into this group based on their CY 2007 APC assignments, 25 of which are on the CY 2007 ASC list and 15 of which will be newly recognized for ASC payment beginning in CY 2008. They are listed in Tables 5 and 6, respectively, below. These procedures are also identified in Addendum AA to this final rule.

Specific payment policies have been applied to device-dependent APCs under the OPPS over the past several years (71 FR 68063 through 68070). There are about 194 OPPS device-dependent procedures, specifically those procedures that are assigned to the 42 OPPS device-dependent APCs under the CY 2007 OPPS, and 89 of these device-dependent procedures are also paid in ASCs in CY 2007. However, only 25 of those 89 procedures are assigned to APCs that have device costs that exceed 50 percent of the APC median costs and would be subject to the payment policy applied to device-intensive procedures under the revised ASC payment system. Thus, as noted above, based on current data, there are 40 device-intensive surgical procedures for which ASC payment will be made in CY 2008. ASC payments for these 40 device-intensive procedures will be made according to the policy described for device-intensive ASC procedures based on their assignments to 19 of the 42 device-dependent APCs under the OPPS for CY 2007.

We do not agree with the commenters who believe that many device-intensive procedures are unsafe for performance in ASCs because most of these device-intensive procedures have been on the ASC list of covered surgical procedures for several years and no safety concerns have arisen. In the context of developing this final rule, we have once again reviewed the clinical characteristics of all of these device-intensive procedures based on the public comments and our final policies regarding surgical procedures for exclusion from ASC payment, as discussed in section III.A.2. of this final rule. We continue to believe that many device-intensive procedures are appropriate for performance in ASCs under the final policies of the revised ASC payment system.

We also are persuaded that it would be inappropriate to continue to provide separate payment for some implantable prosthetics and DME under the DMEPOS fee schedule by maintaining the practice of the existing ASC payment system. Payment for these devices is already packaged into the base OPPS payment weights, and separate payment for devices under the ASC payment system could essentially pay twice for the device. Separate payment for devices under the revised ASC payment system would also be contrary to MedPAC's support for our proposal to increase the size of the ASC payment bundles and to create comparable payable bundles under the OPPS and the revised ASC payment system. Most importantly, separate payment for certain devices would not provide the incentives for efficiency that would occur through packaging device payment into payment for the associated surgical implantation procedure, because increased packaging through larger payment bundles would encourage ASCs to provide surgical services as cost-effectively as possible. In addition, there are some expensive implantable devices, such as ICDs, which are not currently paid under the DMEPOS fee schedule, but for which we will provide payment for their associated surgical implantation procedures in ASCs beginning in CY 2008. If the separate DMEPOS payment methodology were to be continued, ASCs would be significantly underpaid for such procedures because the device would not be separately paid if it were neither implantable DME nor an implantable prosthetic device. The

commenters who recommended continued separate payment for some devices under the DMEPOS fee schedule provided no suggestions for developing the appropriate ASC payment for expensive implantable devices that are neither implantable DME nor implantable prosthetics.

We agree with the commenters who are concerned that our standard methodology for the revised ASC payment system that applies a uniform ASC conversion factor to the OPPS relative payment weights could provide inadequate payment for device-intensive procedures under the revised ASC payment system. The estimated budget neutrality adjustment for the revised ASC payment system was 62 percent of the OPPS conversion factor in the proposed rule, and it is currently 67 percent as discussed in section V. of this final rule (the final CY 2008 ASC budget neutrality adjustment will be proposed and finalized through the CY 2008 OPPS/ASC rulemaking cycle). Because of the expected magnitude of the difference between the estimated ASC procedure payments, calculated by application of the ASC conversion factor to the OPPS payment weights under the revised ASC payment system, and the OPPS payment rates for those same procedures, we are particularly concerned that under the revised ASC payment system device-intensive procedures would be underpaid if we paid for them as proposed.

We would not expect that ASCs' device costs for expensive devices would differ significantly from the device costs of HOPDs because we do not believe that ASCs would realize more substantial efficiencies in their acquisition of devices in comparison with HOPDs. On the other hand, we believe that ASCs would experience significant efficiencies in comparison with HOPDs when performing the implantation procedures themselves, consistent with the findings of the GAO Report regarding the lower cost of procedures in ASCs in comparison with HOPDs. These lower ASC costs may be attributable to a variety of factors, including lower facility overhead costs due to ASCs' limited operating hours, lack of emergency departments, specialization of ASCs contributing to efficient delivery of services, and the characteristics of different patient populations treated in ASCs versus HOPDs. Therefore, we believe it would be most appropriate under the revised ASC payment system to apply a modified payment methodology to this group of device-intensive services. Accordingly, in developing the ASC payment rates under the revised payment system for device-intensive procedures, we will calculate the device portion of the ASC procedure payment separately from the service portion, in order to provide special consideration for the packaged device costs that are unlikely to vary significantly across different facility settings.

Our final payment methodology for device-intensive procedures under the revised ASC payment system is as follows. We will apply the OPPS device offset percentage to the OPPS national unadjusted payment to acquire the device cost included in the OPPS payment rate for a device-intensive ASC covered surgical procedure, which we will then set as equal to the device portion of the national unadjusted ASC payment rate for the procedure. The device offset percentage, which is used under the OPPS to remove the predecessor device cost from the device pass-through payment when a pass-through device is paid at charges reduced to cost, so that the pass-through payment for the device only represents the incremental payment for the new device over the payment for predecessor devices already packaged into the APC payment is our best estimate of the amount of device cost included in an APC payment under the OPPS. We believe that use of the OPPS device offset percentage is appropriate to establish the device amount of payment when device-intensive procedures are furnished in an ASC under the revised ASC payment system. The OPPS device offset percentage is calculated for each OPPS device-dependent APC based upon the most recent year of hospital outpatient claims data available and represents the relative amount of device payment that we believe exists in the total APC payment. The device offset percentage is also applied to reduce the APC payment when a typically expensive device is provided to the hospital without cost or with full credit for the device being replaced and, therefore, the hospital incurs no device cost for implanting the replacement device. For more background on the calculation and use of the device offset percentage, we refer readers to the CY 2007 OPPS/ASC final rule with comment period (71 FR 68077 through 68079).

We will then calculate the service portion of the ASC payment for device-intensive procedures by applying the uniform ASC conversion factor as specified in new § 416.171 to the service (nondevice) portion of the OPPS relative payment weight for the device-intensive procedure. Finally, we will sum the ASC device portion and ASC service portion to establish the full payment for the device-intensive procedure under the revised ASC payment system.

Tables 5 and 6 include the most current device-intensive procedures that would be subject to this modified payment methodology under the revised ASC payment system. The device-intensive procedure lists for the CY 2008 revised ASC payment system will be proposed and finalized in conjunction with the OPPS treatment of these procedures in the CY 2008 OPPS/ASC proposed and final rules, respectively. The device-intensive procedures in Tables 5 and 6 are listed in Addendum AA to this final rule, where they are assigned to payment indicators ''H8'' (Device-intensive procedure on ASC list in CY 2007; paid at adjusted rate) and ''J8'' (Device-intensive procedure added to ASC list in CY 2008 or later; paid at adjusted rate), respectively.

TABLE 5.—ILLUSTRATIVE LIST OF DEVICE-INTENSIVE PROCEDURES ON THE CY 2007 ASC LIST SUBJECT TO THE MODIFIED PAYMENT METHODOLOGY UNDER THE REVISED ASC PAYMENT SYSTEM BEGINNING IN CY 2008

HCPCS code	Short descriptor	CY 2007 OPPS APC	CY 2007 device-dependent APC offset percent
33212	Insertion of pulse generator	0090	74.74
33213	Insertion of pulse generator	0654	77.35
36566	Insert tunneled cv cath	0625	57.56
53445	Insert uro/ves nck sphincter	0386	61.16
53447	Remove/replace ur sphincter	0386	61.16
54401	Insert self-contd prosthesis	0386	61.16
54405	Insert multi-comp penis pros	0386	61.16
54410	Remove/replace penis prosth	0386	61.16

TABLE 5.—ILLUSTRATIVE LIST OF DEVICE-INTENSIVE PROCEDURES ON THE CY 2007 ASC LIST SUBJECT TO THE MODIFIED PAYMENT METHODOLOGY UNDER THE REVISED ASC PAYMENT SYSTEM BEGINNING IN CY 2008—Continued

HCPCS code	Short descriptor	CY 2007 OPPS APC	CY 2007 device-dependent APC offset percent
54416	Remv/repl penis contain pros	0386	61.16
55873	Cryoablate prostate	0674	53.78
61885	Insrt/redo neurostim 1 array	0039	78.85
61886	Implant neurostim arrays	0315	83.19
62361	Implant spine infusion pump	0227	80.27
62362	Implant spine infusion pump	0227	80.27
63650	Implant neuroelectrodes	0040	54.06
63685	Insrt/redo spine n generator	0222	77.65
64553	Implant neuroelectrodes	0225	79.04
64561	Implant neuroelectrodes	0040	54.06
64573	Implant neuroelectrodes	0225	79.04
64575	Implant neuroelectrodes	0061	60.06
64577	Implant neuroelectrodes	0061	60.06
64580	Implant neuroelectrodes	0061	60.06
64581	Implant neuroelectrodes	0061	60.06
64590	Insrt/redo pn/gastr stimul	0222	77.65
69930	Implant cochlear device	0259	84.61

TABLE 6.—ILLUSTRATIVE LIST OF DEVICE-INTENSIVE PROCEDURES NEW TO THE CY 2008 ASC LIST SUBJECT TO THE MODIFIED PAYMENT METHODOLOGY UNDER THE REVISED ASC PAYMENT SYSTEM BEGINNING IN CY 2008

HCPCS code	Short descriptor	CY 2007 OPPS APC	CY 2007 device-dependent APC offset percent
33206	Insertion of heart pacemaker	0089	77.11
33207	Insertion of heart pacemaker	0089	77.11
33208	Insertion of heart pacemaker	0655	76.59
33214	Upgrade of pacemaker system	0655	76.59
33224	Insert pacing lead & connect	0418	87.32
33225	Lventric pacing lead add-on	0418	87.32
33282	Implant pat-active ht record	0680	76.40
63655	Implant neuroelectrodes	0061	60.06
64555	Implant neuroelectrodes	0040	54.06
64560	Implant neuroelectrodes	0040	54.06
64565	Implant neuroelectrodes	0040	54.06
G0297	Insert single chamber/cd	0107	90.44
G0298	Insert dual chamber/cd	0107	90.44
G0299	Inser/repos single icd+leads	0108	89.40
G0300	Insert reposit lead dual+gen	0108	89.40

Table 7 provides an example of how we will calculate the ASC payment for a device-intensive procedure. We use the example of insertion of a cochlear implant, CPT code 69930 (Cochlear device implantation, with or without mastoidectomy), that is included in Table 5 above. For purposes of this illustration, we are using the CY 2007 OPPS/ASC final rule with comment period device offset percentage and payment rate for APC 0259 (Level VI ENT Procedures), the APC to which CPT code 69930 is assigned under the CY 2007 OPPS. We also assume that the ASC budget neutrality adjustment remains at 0.67 under both the first transition year and full implementation scenarios, yielding an ASC conversion factor of $42.543 based on our current estimate of the CY 2008 OPPS conversion factor. The example includes the estimated ASC payment in the first year of the 4-year transition and the estimated payment under full implementation of the revised ASC payment system.

TABLE 7.—EXAMPLE OF CALCULATION OF ASC PAYMENT FOR A DEVICE-INTENSIVE COVERED SURGICAL PROCEDURE ACCORDING TO THE MODIFIED PAYMENT METHODOLOGY OF THE REVISED ASC PAYMENT SYSTEM

	First year of 4-year transition	Full implementation of revised system
OPPS CY 2007 national unadjusted payment rate	$25,499.72	$25,499.72
OPPS CY 2007 device offset percent	84.61%	84.61%
OPPS/ASC device portion	$21,575.31 ($25,499.72 × 0.8461)	$21,575.31 ($25,499.72 × 0.8461)
OPPS service portion	$3,924.41	$3,924.41

TABLE 7.—EXAMPLE OF CALCULATION OF ASC PAYMENT FOR A DEVICE-INTENSIVE COVERED SURGICAL PROCEDURE ACCORDING TO THE MODIFIED PAYMENT METHODOLOGY OF THE REVISED ASC PAYMENT SYSTEM—Continued

	First year of 4-year transition	Full implementation of revised system
OPPS relative payment weight attributable to service (OPPS service portion divided by estimated CY 2008 OPPS conversion factor)	61.8047 ($3,924.41/63.497)	61.8047 ($3,924.41/63.497)
ASC service portion (OPPS relative payment weight for service portion multiplied by estimated CY 2008 ASC conversion factor)	$2,629.36 (61.8047 × $42.543)	$2,629.36 (61.8047 × $42.543)
CY 2007 ASC payment (without device payment)	$995	N/A
ASC service payment (see following paragraph)	$1,403.59 (0.25 × $2,629.36) + (0.75 × $995)	$2,629.36
Estimated CY 2008 ASC total payment (sum of service payment and device payment)	$22,978.90 ($1,403.59 + $21,575.31)	$24,204.67 ($2,629.36 + $21,575.31)

As discussed further in section IV.J. of this final rule and as shown in the example above, we will apply the transitional blend only to the service portion of the ASC procedure payment. Consistent with their treatment under the OPPS, we will apply the ASC geographic wage adjustment to payment for device-intensive procedures under the revised ASC payment system.

Comment: Several commenters encouraged CMS to pay the same amount and apply the same payment policies regarding implantable devices in both ASCs and HOPDs. In particular, they recommended that ASCs be paid 100 percent of the portion of the OPPS procedure payment that is device-related, when ASCs perform device-intensive procedures.

Response: We agree with commenters that providing the same device payment amount for expensive devices under the revised ASC payment system as under the OPPS is appropriate, and our final payment methodology accomplishes that. As we discuss above, we will specifically calculate the amount of OPPS device payment in APCs that contain devices for which the device cost exceeds 50 percent of the APC median cost. We will then add the OPPS device payment amount to the ASC service payment for each device-intensive procedure that is a covered ASC surgical procedure, in order to determine the total payment for the device-intensive procedure when it is performed in an ASC.

We also agree that the same payment policies that exist with regard to payment for costly devices under the OPPS should also apply to payment for devices implanted in ASCs. In particular, under the OPPS, beginning on January 1, 2007, when a device is replaced without cost to the hospital or with full credit for the cost of the device being replaced, CMS reduces the APC payment to the hospital by the amount that we estimate represents the cost of the device. The application of this same policy to ASC payment for certain device-intensive procedures is fully consistent with the comments that CMS should pay ASCs for expensive devices in the same manner that they are paid under the OPPS, and with the recommendation of the PPAC that CMS should apply payment policies uniformly under the OPPS and revised ASC payment systems. Therefore, in accordance with the OPPS policy implemented in CY 2007, beginning in CY 2008, we will reduce the amount of payment made to ASCs for device-intensive procedures assigned to certain OPPS APCs in those cases in which the necessary device is furnished without cost to the ASC or the beneficiary, or with a full credit for the cost of the device being replaced. We will provide the same amount of payment reduction that would apply under the OPPS for performance of those procedures under the same circumstances. Specifically, when an ASC performs a procedure that is listed in Table 8 below and the case involves implantation of a no cost or full credit device listed in Table 9, the ASC must report the HCPCS ''FB'' modifier on the line with the covered surgical procedure code to indicate that a major implantable device in Table 9 was furnished without cost. We expect that this scenario will occur most often in cases in which there is a recall, field action, or other activity that results in the ASC receiving a device from a device manufacturer, for which the facility has no obligation to pay. In these cases, this policy is necessary to be consistent with section 1862(a)(2) of the Act, which excludes from Medicare coverage items and services for which neither the beneficiary nor anyone on the beneficiary's behalf has an obligation to pay. This reduction policy is consistent with the modified payment methodology for device-intensive procedures under the revised ASC payment system that would generally provide the same device-related payment amount in HOPD and ASC settings, both in those cases where the facility bears the cost of the device and those situations where it does not. Tables 8 and 9 list those specific procedures and implantable devices to which the reduction policy applies under the CY 2007 OPPS. The list of device-dependent APCs and their associated procedures and implantable devices to which this policy will apply in CY 2008 will be proposed and finalized in the CY 2008 OPPS/ASC proposed and final rules, respectively. See the CY 2007 OPPS/ASC final rule with comment period (71 FR 68071 through 68077) for further discussion of this policy.

When the ''FB'' modifier is reported with a procedure code that is listed in Table 8, the contractor will reduce the ASC payment for the procedure by the amount of payment that CMS attributed to the device when the ASC payment rate was calculated. The reduction of ASC payment in this circumstance is necessary to pay appropriately for the covered surgical procedure being furnished by the ASC.

TABLE 8.—ILLUSTRATIVE LIST OF ADJUSTMENTS TO PAYMENTS FOR ASC COVERED SURGICAL PROCEDURES IN CY 2008 IN CASES OF DEVICES REPORTED WITHOUT COST OR FOR WHICH FULL CREDIT IS RECEIVED

HCPCS code	Short descriptor	CY 2007 OPPS APC	APC group title	CY 2007 OPPS offset percent
61885	Insrt/redo neurostim 1 array	0039	Level I Implantation of Neurostimulator	78.85
63650	Implant neuroelectrodes	0040	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	54.06
64555	Implant neuroelectrodes.			
64560	Implant neuroelectrodes.			
64561	Implant neuroelectrodes.			
64565	Implant neuroelectrodes.			
63655	Implant neuroelectrodes	0061	Laminectomy or Incision for Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	60.06
64575	Implant neuroelectrodes.			
64577	Implant neuroelectrodes.			
64580	Implant neuroelectrodes.			
64581	Implant neuroelectrodes.			
33206	Insertion of heart pacemaker	089	Insertion/Replacement of Permanent Pacemaker and Electrodes.	77.11
33207	Insertion of heart pacemaker.			
33212	Insertion of pulse generator	0090	Insertion/Replacement of Pacemaker Pulse Generator.	74.74
33210	Insertion of heart electrode	0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes.	41.88
33211	Insertion of heart electrode.			
33216	Insert lead pace-defib, one.			
33217	Insert lead pace-defib, dual.			
G0297	Insert single chamber/cd	0107	Insertion of Cardioverter-Defibrillator	90.44
G0298	Insert dual chamber/cd.			
G0299	Inser/repos single icd+leads	0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads.	89.40
G0300	Insert reposit lead dual+gen.			
63685	Insrt/redo spine n generator	0222	Implantation of Neurological Device	77.65
64590	Insrt/redo perph n generator.			
64553	Implant neuroelectrodes	0225	Implantation of Neurostimulator Electrodes, Cranial Nerve.	79.04
64573	Implant neuroelectrodes.			
62361	Implant spine infusion pump	0227	Implantation of Drug Infusion Device	80.27
62362	Implant spine infusion pump.			
69930	Implant cochlear device	0259	Level VI ENT Procedures	84.61
61886	Implant neurostim arrays	0315	Level II Implantation of Neurostimulator	83.19
53440	Male sling procedure	0385	Level I Prosthetic Urological Procedures	46.86
53444	Insert tandem cuff.			
54400	Insert semi-rigid prosthesis.			
53445	Insert uro/ves nck sphincter	0386	Level II Prosthetic Urological Procedures	61.16
53447	Remove/replace ur sphincter.			
54401	Insert self-contd prosthesis.			
54405	Insert multi-comp penis pros.			
54410	Remove/replace penis prosth.			
54416	Remv/repl penis contain pros.			
33224	Insert pacing lead & connect	0418	Insertion of Left Ventricular Pacing Elect	87.32
33225	L ventric pacing lead add-on.			
33213	Insertion of pulse generator	0654	Insertion/Replacement of a permanent dual chamber pacemaker.	77.35
33214	Upgrade of pacemaker system	0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker.	76.59
33208	Insertion of heart pacemaker.			
33282	Implant pat-active ht record	0680	Insertion of Patient Activated Event Recorders.	76.40

TABLE 9.—ILLUSTRATIVE LIST OF DEVICES FOR WHICH THE ''FB'' MODIFIER MUST BE REPORTED WITH THE PROCEDURE CODE WHEN FURNISHED WITHOUT COST OR FOR WHICH FULL CREDIT IS RECEIVED

Device	Short descriptor
C1721	AICD, dual chamber.
C1722	AICD, single chamber.
C1764	Event recorder, cardiac.
C1767	Generator, neurostim, imp.
C1771	Rep dev, urinary, w/sling.
C1772	Infusion pump, programmable.
C1776	Joint device (implantable.
C1777	Lead, AICD, endo single coil.

TABLE 9.—ILLUSTRATIVE LIST OF DEVICES FOR WHICH THE ''FB'' MODIFIER MUST BE REPORTED WITH THE PROCEDURE CODE WHEN FURNISHED WITHOUT COST OR FOR WHICH FULL CREDIT IS RECEIVED—Continued

Device	Short descriptor
C1778	Lead, neurostimulator.
C1779	Lead, pmkr, transvenous VDD.
C1785	Pmkr, dual, rate-resp.
C1786	Pmkr, single, rate-resp.
C1813	Prosthesis, penile, inflatab.
C1815	Pros, urinary sph, imp.
C1820	Generator, neuro rechg bat sys.

TABLE 9.—ILLUSTRATIVE LIST OF DEVICES FOR WHICH THE ''FB'' MODIFIER MUST BE REPORTED WITH THE PROCEDURE CODE WHEN FURNISHED WITHOUT COST OR FOR WHICH FULL CREDIT IS RECEIVED—Continued

Device	Short descriptor
C1882	AICD, other than sing/dual.
C1891	Infusion pump, non-prog, perm.
C1895	Lead, AICD, endo dual coil.
C1896	Lead, AICD, non sing/dual.
C1897	Lead, neurostim, test kit.
C1898	Lead, pmkr, other than trans.
C1899	Lead, pmkr/AICD combination.

TABLE 9.—ILLUSTRATIVE LIST OF DEVICES FOR WHICH THE ''FB'' MODIFIER MUST BE REPORTED WITH THE PROCEDURE CODE WHEN FURNISHED WITHOUT COST OR FOR WHICH FULL CREDIT IS RECEIVED—Continued

Device	Short descriptor
C1900 ..	Lead coronary venous.
C2619 ..	Pmkr, dual, non rate-resp.
C2620 ..	Pmkr, single, non rate-resp.
C2621 ..	Pmkr, other than sing/dual.
C2622 ..	Prosthesis, penile, non-inf.
C2626 ..	Infusion pump, non-prog, temp.
C2631 ..	Rep dev, urinary, w/o sling.
L8614 ...	Cochlear device/system.

After considering all public comments received, while we are finalizing our proposed policy to package payment under the revised ASC payment system for all implantable devices without pass-through status under the OPPS into the ASC payment for the associated surgical implantation procedure, we are adopting a modified methodology to calculate the payment rates for device-intensive procedures under the revised ASC payment system. We proposed to pay for these devices and their associated implantation procedures according to the standard revised ASC payment system methodology, with application of the uniform ASC conversion factor to the applicable OPPS payment weight for the procedure. However, our final payment policy will apply a modified payment methodology to develop the ASC payment rates for device-intensive covered surgical procedures, in order to provide the same payment amount to ASCs for the implantable devices as is made under the OPPS. This methodology will apply to ASC covered surgical procedures that are assigned to device-dependent APCs under the OPPS for the same calendar year, where those APCs have a device cost of greater than 50 percent of the APC cost (device offset percentage greater than 50). While lists of device-intensive procedures under the revised ASC payment system to which this policy would apply based on their CY 2007 OPPS status are included in Tables 5 and 6 of this final rule, the list of ASC procedures subject to this modified payment methodology will be proposed and finalized in the CY 2008 OPPS/ASC proposed and final rules, respectively.

We will also reduce the ASC procedure payment for certain device-intensive procedures when the necessary device is furnished to the ASC or the beneficiary at no cost or when a full credit for the device being replaced is provided to the ASC, by the same amount as the OPPS payment reduction for the same calendar year because neither the HOPD nor the ASC incur a device cost for the replaced device in such situations. Accordingly, we are adding new § 416.179 to reflect this payment reduction policy.

D. Payment for Corneal Tissue Under the Revised ASC Payment System

In a memorandum dated May 21, 1992, CMS (known at the time as the Health Care Financing Administration or ''HCFA'') notified Regional Administrators that carriers could pay corneal tissue acquisition costs when HCPCS code V2785 (Processing, preserving and transporting corneal tissue) is reported with corneal transplant procedures performed in an ASC. The memorandum indicated that payment for corneal tissue acquisition costs is subject to the usual coinsurance and deductible requirements, and could be paid as an add-on to either the ASC payment or the physician's fee for corneal transplant surgery performed at an ASC. In the June 12, 1998 proposed rule to revise the ASC ratesetting methodology and payment rates, we proposed to package the costs incurred by an ASC to procure corneal tissue into the payment for the associated corneal transplant procedure, rather than continue making separate payment for those costs (63 FR 32312 and 32313). We also proposed to package corneal tissue acquisition costs into the APC payment for corneal transplant procedures in the September 8, 1998 proposed rule to implement the OPPS (63 FR 47760).

We received numerous comments from physicians, eye banks, and health care associations opposing both proposals. In the April 7, 2000 final rule with comment period, which implemented the OPPS, we summarized the comments that we received in response to the September 8, 1998 proposal, and we determined that we would not implement our proposal to package payment under the OPPS for corneal tissue acquisition costs but would, instead, make separate payment based on hospitals' reasonable costs to procure corneal tissue (65 FR 18448 and 18449). Because we never made final the changes in the ASC payment rates and ratesetting methodology that we proposed in the June 12, 1998 **Federal Register**, the policy issued in the June 1992 memorandum remains in effect, which allows carriers (now MACs) to make separate payment for the costs incurred to procure corneal tissue for transplant at an ASC.

In the August 2006 proposed rule to revise the ASC ratesetting methodology and payment rates beginning in CY 2008, we proposed to continue to pay ASCs separately, based on their invoiced costs, for the procurement of corneal tissue (71 FR 49648). We had no evidence to suggest that costs incurred to procure corneal tissue are any less variable now than they were in 1992, in 1998, or in 2000. We noted that, if we were to package payment for the procurement of corneal tissue into the APC payment for corneal transplant procedures, we believed the resulting payment rate would overpay those facilities that are able to acquire corneal tissue at little or no cost through philanthropic organizations and underpay those facilities that must pay for corneal tissue processing, testing, preservation, and transportation costs. We further proposed in the August 2006 proposed rule to exclude, through proposed new § 416.164(b), the costs of procurement of corneal tissue furnished in an ASC on or after January 1, 2008 from the scope of ASC facility services.

We invited comments and submission of data that supported or challenged this proposal to continue paying ASCs separately for corneal tissue on an acquisition cost basis.

Comment: Several commenters agreed with our proposal to continue to pay separately for the acquisition costs of corneal tissue under the revised ASC payment system, rather than package payment for corneal tissue costs into the payment for the associated corneal transplant procedure. The commenters indicated that this proposed methodology is consistent with the way physicians and HOPDs are currently paid for corneal tissue procurement. They believed that this policy of paying separately for the procurement of corneal tissue has been, and continues to be, the most appropriate payment policy for these services provided in ASC settings, because of the continuing significant variability in the costs of corneal tissue procurement. The commenters further reiterated that packaging these costs should not be considered, because such an option would result in overpayments to certain facilities that have been able to acquire corneal tissue at little or no cost through philanthropic organizations and would undoubtedly result in underpayments to other facilities that paid for the corneal tissue processing, testing, preservation, and transportation costs.

Response: After consideration of the public comments we received, we are finalizing our proposed CY 2008 ASC corneal tissue procurement payment policy, with modification to clarify that

corneal tissue is a covered ancillary service within the scope of ASC services, but not within the scope of ASC facility services. Corneal tissue procurement will be included in the scope of ASC services as a covered ancillary service when it is integral to the performance of an ASC covered surgical procedure, but its payment will not be packaged into the ASC payment for the associated covered surgical procedure. Specifically, under the revised ASC payment system, we will continue to pay ASCs separately, based on their invoiced costs, for the acquisition costs of corneal tissue for transplant in an ASC. The HCPCS code for corneal tissue processing, V2785, is listed in Addendum BB to this final rule, where it is assigned to payment indicator ''F4'' (Corneal tissue processing; paid at reasonable cost). Accordingly, we are reflecting this final policy in revised proposed §§ 416.164(b)(3) and 416.171(b).

E. Payment for Office-Based Procedures

Since the inception of the ASC benefit, procedures that are commonly performed or that can be safely performed in a physician's office have generally been excluded from the ASC list of covered surgical procedures. We refer to these procedures as ''office-based'' in this preamble discussion. Over the past 15 years, physicians and ASC associations have urged CMS to add office-based procedures to the ASC list of covered surgical procedures or to retain on the ASC list procedures that were originally performed most commonly in an institutional setting, but that have subsequently moved to an office setting as surgical techniques and technology have advanced. Representatives of the ASC industry have argued that although, for most patients, the office is an appropriate setting for most high volume office procedures, there are some patients for whom an ASC or another more resource-intensive setting is required. The physician may decide that a facility setting is necessary for individual patients for various clinical reasons, such as the need for more nursing staff, a sterile operating room, or a piece of equipment not typically available in the office setting. CPT code 52000 (Cystourethroscopy (separate procedure)) is a prime example of a high volume procedure that is performed more than 80 percent of the time in an office setting, but for which a small number of patients require resources usually available only in an ASC or a hospital. Representatives of the ASC industry have contended that unless we made an exception to the criteria that historically governed which procedures comprised the ASC list and allowed an office-based procedure to remain on the ASC list, as we have done with CPT code 52000, the hospital would be the only facility setting available as an alternative to the office setting. ASC industry commenters asserted in the past that this limitation was burdensome both to physicians and to beneficiaries and could, in some cases, limit beneficiary access to needed surgery.

We generally interpret ''office-based'' or ''commonly performed in a physician's office'' to mean a surgical procedure that the most recent BESS data available indicate is performed more than 50 percent of the time in the physician's office setting. In the August 2006 proposed rule for the revised ASC payment system and as discussed in section III.A.2. of this final rule, we proposed to expand the ASC list of covered surgical procedures to allow payment for all surgical procedures, except those procedures that pose a significant safety risk or would be expected to require an overnight stay. Because office-based surgical procedures typically do not pose a significant safety risk and do not require an overnight stay, we proposed not to exclude them from ASC payment under the revised ASC payment system. However, we were concerned that allowing payment to ASCs for office-based procedures based on OPPS relative payment weights could have a significant impact on Medicare program costs. Approximately two-thirds of the additional procedures which we proposed not to exclude from ASC payment beginning in CY 2008 are office-based, that is, they are performed in the physician's office more than 50 percent of the time. The practice expense payment for many of these procedures under the MPFS, when they are performed in the physician's office, would be lower than the payment for the same procedures under the OPPS or under the standard methodology of the revised ASC payment system as proposed. Therefore, we indicated that the proposed ASC payment rates based on the OPPS relative payment weights could result in a significant program cost if these high volume procedures were to shift from the office-based setting to the ASC setting.

One reason why we were concerned about the possibility of a sizable shift of office-based procedures to ASCs is the impact that such a shift might have on ASC payments in light of the statutory requirements that the revised ASC payment system be designed to result in the same aggregate amount of expenditures that would be made if the revised payment system were not implemented. In the August 2006 proposed rule, we explained that, depending on the methodology for determining the requisite budget neutrality adjustment (71 FR 49657), an influx of high-volume, relatively low cost office-based surgical procedures into the ASC setting under the revised payment system could lower the payment amounts for other procedures made to ASCs due to the constraints of budget neutrality. In other words, we might have had to scale the ASC conversion factor downward in order for estimated aggregate expenditures under the revised system to not exceed what they would have been if the revised payment system were not implemented. Payment for procedures with relatively high payments would have to be reduced in order to offset increased aggregate costs resulting from an influx of relatively low cost, high volume office-based procedures shifting to ASCs. (See section V. of this final rule for a detailed discussion of our proposed and final policies regarding calculation of an ASC conversion factor.)

In the August 2006 proposed rule, we explained that we are committed to refining Medicare payment systems wherever possible to prevent payment incentives from inappropriately driving decisions about where to perform a surgical procedure, when those decisions should properly be based on clinical considerations. Towards that end, we proposed to cap payment for office-based surgical procedures for which ASC payment would be newly allowed under the revised payment system as of January 1, 2008, at the lesser of the MPFS nonfacility practice expense amount or the ASC rate developed according to the standard methodology of the revised ASC payment system. We also proposed to exempt procedures that are on the ASC list as of January 1, 2007, and that meet our criterion for designation as office-based, from the payment limitation proposed for office-based procedures for which ASC payment would be allowed for the first time beginning January 1, 2008. Accordingly, we proposed to incorporate in proposed new § 416.171(e) the payment basis for these office-based procedures beginning January 1, 2008.

When we started to identify the codes that we would propose to classify as office-based surgical procedures beginning in CY 2008, we encountered some anomalous cases that required further refinement of our office-based criterion beyond strict application of a

50-percent utilization threshold. For example, we identified some CPT codes that met the 50-percent office utilization threshold but for which a nonfacility practice expense amount had not been developed under the MPFS. We proposed to classify as office-based any surgical codes that our physicians' claims data indicated are performed more than 50 percent of the time in an office setting, even if the codes currently lack a nonfacility practice expense value under the MPFS. We further proposed to cap payment for these procedures, as appropriate, once a nonfacility practice expense amount is established. Until that time, we proposed to calculate payment for these office-based surgical CPT codes using the methodology we proposed for other surgical procedures under the revised ASC payment system. Similarly, until a national nonfacility practice expense amount is established for office-based surgical CPT codes that are contractor-priced (that is, carriers typically determine the payment for a procedure for which there is no calculated national payment) under the MPFS, we proposed to calculate the ASC payment using the same methodology that we proposed for surgical procedures that are not office-based. Application of the cap to codes designated as office-based would be updated through rulemaking as part of the annual OPPS/ASC payment update.

In applying the 50-percent threshold, we discovered some apparent contradictions in the BESS data that required us to further refine our definition of office-based procedures. For example, we noted instances in which seemingly similar procedures had inconsistent site-of-service utilization data. The BESS data showed high levels of office utilization for some complex procedures that we expected to be performed relatively infrequently in an office setting, whereas simpler but related procedures showed lower levels of office utilization.

Therefore, we undertook another, more detailed level of review and identified groups of surgical CPT codes related to procedures that are performed 50 percent or more of the time in the office setting to determine if there was a logical correlation between procedure complexity within a group of related procedures and the frequency with which those procedures were performed in the office setting. For example, according to CPT coding, the following three codes are related:

- 13120, Repair, complex, scalp arms and/or legs; 1.1 cm to 2.5 cm.
- 13121, Repair, complex, scalp arms and/or legs; 2.6 cm to 7.5 cm.
- 13122, Repair, complex, scalp arms and/or legs; each additional 5 cm or less.

As is often the case for groups of related codes in the CPT coding system, the first of these codes is the least complex clinically and, in this example, the complexity of the procedure increases in proportion to the increase in the size of the area to be repaired. If utilization data indicated that CPT code 13122 was performed in the office 67 percent of the time in CY 2005, we would expect to find that both CPT codes 13120 and 13121 were also performed in the physician's office more than 50 percent of the time during that year. Because the most complex procedure was provided in the office most of the time, logically, it would seem that the less complex procedures would also have been performed frequently in that site of service. However, the BESS data showed that this was not always the case.

Although our expectation was that the less complex procedures within a group of related procedure codes would typically be performed most often in the office and the more complex procedures less often in the office, there were instances in which the less complex procedures within the code group were billed more commonly in an ASC or HOPD, while the more complex procedures within the code group were billed more frequently in the office setting. Therefore, we believed it was prudent to consider the clinical characteristics and utilization data of related CPT codes in determining the codes to be proposed as office-based, to supplement our consideration of data specific to the codes under review.

In our analysis of the BESS site-of-service data, we also took into consideration the volume of cases represented in the data. There were a few instances in which we initially identified a procedure as office-based because the data indicated that 100 percent of the cases were performed in the physician's office. However, closer inspection revealed that there was only one case reported for the procedure with a physician's office as the site of service. We were concerned about using such a low volume of procedure claims as the basis for identifying a procedure as office-based. Therefore, we also believed it was wise to consider the volume of claims for procedures in the context of our assessment of their utilization data, to determine those codes to propose as office-based for the revised ASC payment system.

Because of the occasional unevenness and inconsistency of the data associated with some of the codes we initially classified as office-based, we conducted a code-by-code analysis to buttress inconclusive data with the clinical judgment of our medical advisors. As a result, in our proposed rule, there were some procedures that met the 50-percent office performance threshold when evaluated in isolation from other closely related codes, but that we did not propose to designate as office-based after more specific review.

In the August 2006 proposed rule for the revised ASC payment system, we proposed to assess each year, based on the most recent available BESS and other data available to us and detailed clinical review, whether there are additional procedures that we would propose to newly classify as office-based, beginning in the update year. We would solicit comments on the proposed classification of additional codes as office-based as part of the annual OPPS/ASC rulemaking cycle. In addition, we proposed that once we identify a procedure as office-based, that classification could not change in future updates of the ASC payment system. We reasoned that once a procedure becomes safe enough to be performed in more than 50 percent of cases in the office setting, it would be improbable for it to revert to an institutional setting.

To summarize, the list of codes that we proposed as office-based took into account the most recent available volume and utilization data for each individual procedure code and/or, if appropriate, the clinical characteristics, utilization, and volume of related codes. We proposed to apply the office-based designation only to procedures that would no longer be excluded from ASC payment beginning in CY 2008 or later years. Moreover, we proposed to exempt all procedures on the CY 2007 ASC list from application of the office-based classification. We believed that the resulting list accurately reflected Medicare practice patterns and was clinically coherent. The procedures that we proposed to designate as subject to the office-based payment limit were identified in Addendum BB to the proposed rule (71 FR 49845 through 49948). Those procedures for which the CY 2008 payment would be based on the MPFS nonfacility practice expense RVUs according to our analysis for the August 2006 proposed rule were flagged in Addendum BB to that rule. The ASC relative payment weights shown for procedures in Addendum BB to the proposed rule that would be capped by the MPFS nonfacility practice expense RVUs were adjusted to reflect the capped payment amounts. We reminded readers in the August 2006 proposed rule that the ASC payment rates in

Addendum BB to that rule were based on the proposed CY 2007 OPPS relative payment weights and the proposed CY 2007 MPFS nonfacility practice expense RVUs. Similarly, the information in Addenda AA and BB to this final rule is also only illustrative, meaning that the Addenda provide examples of the results of applying the final policies of the revised ASC payment system, based on the final information available for CY 2007 and projected CY 2008 updates. As further discussed in sections V.E. and VI. of this final rule, we will propose the CY 2008 relative payment weights, payment amounts, specific HCPCS codes to which the final policies of the revised ASC payment system would apply, and other pertinent ratesetting information for the CY 2008 revised ASC payment system in the proposed OPPS/ASC rule to update the payment systems for CY 2008 to be issued in mid-summer of CY 2007. We will then publish final relative payment weights, payment amounts, specific CY 2008 HCPCS codes to which the final policies will apply, and other pertinent ratesetting information for the CY 2008 revised ASC payment system in the final OPPS/ASC rule to update the payment systems for CY 2008.

Comment: Several commenters suggested that instituting a cap on payment for office-based surgical procedures would result in payment levels that would make it economically infeasible for many ASCs to perform certain surgical procedures, forcing patients who could be treated safely and more cost effectively in an ASC to go to an HOPD for surgery. Other commenters suggested that there is no empirical evidence that payment of office-based procedures in ASCs would lead to overutilization of ASCs or result in physicians converting their offices into ASCs. The commenters pointed out that, in historical cases where CMS has made exceptions to allow ASC payment for procedures primarily performed in the office, there have not been significant shifts in the sites of service for these procedures. Several commenters suggested that imposing a cap on payment for these procedures would be tantamount to a penalty and an affirmative policy intended to discourage these procedures from performance in the ASC setting. The commenters strongly recommended that the best policy would be to allow physicians to select the site of service they believe is the most clinically appropriate for their patients, especially because sicker patients may require the additional infrastructure and safeguards of an ASC or a HOPD. Other commenters pointed out that CMS' proposal for the revised ASC payment system depends on the use of the relative payment weights for the OPPS that CMS argued in the proposed rule would be expected to reasonably reflect the relativity of ASC resources for surgical procedures. They stated that CMS has no evidence to suggest that the OPPS relativity of payment weights for office-based procedures does not reflect the relative resource use for the performance of these procedures in ASCs and, therefore, application of a payment limitation for these procedures is unwarranted.

The commenters also expressed concern that the establishment of a payment cap for office-based procedures would be problematic and detrimental to CMS' desire to create a setting-neutral payment system. The commenters recommended that CMS exclude this provision from the final rule and pay all procedures using a single ASC conversion factor applied to the applicable OPPS relative payment weight. Several commenters suggested that CMS could follow trends in the sites of service for office-based procedures, and should CMS find significant and unwarranted migration of certain procedures to ASCs, implement the proposed policy at a later date.

Response: We acknowledge the commenters' concerns regarding our proposal to cap payments for office-based surgical procedures performed in ASCs. Nevertheless, we continue to believe that capping the payment for office-based surgical procedures performed in ASCs would be the best approach to eliminating differential payment as a factor in site-of-service decisions regarding minor surgical procedures. The combined ASC and physician payment exceeds the single payment the physician would receive for services performed in the office, even with the application of the proposed payment limitation for office-based procedures. Therefore, we are concerned that allowing payment for office-based procedures under the ASC benefit may create an incentive for physicians inappropriately to convert their offices into ASCs or to move all their office surgery to an ASC. As discussed further in section V. of this final rule, the final policy for the budget neutrality adjustment for the revised ASC payment system which would cap payment for office-based surgical procedures as we proposed takes into account the expected migration of 15 percent of the current office utilization of office-based procedures that will be newly paid in CY 2008 under the revised ASC payment system over the first 4 years of the revised payment system. As commenters observed, a setting-neutral payment system is most consistent with the principle that physicians should be free to make site-of-service decisions on the basis of clinical and quality of care considerations alone. We strongly agree that the health of the patient should be the primary consideration. The proposed cap significantly reduces the payment differential that would otherwise exist when office-based surgical procedures are performed in ASCs and is, thus, more consistent with the principle of site-neutral payment.

After consideration of the public comments we received, we are finalizing our proposal under § 416.167(b)(3) and § 416.171(d), without modification, to cap payment for office-based surgical procedures for which ASC payment would first be allowed under the revised payment system beginning in January 1, 2008, or later years at the lesser of the MPFS nonfacility practice expense amount or the ASC rate developed according to the standard methodology of the revised ASC payment system. For those office-based procedures for which there is no available MPFS nonfacility practice expense amount, we will implement the cap, as appropriate, once a MPFS nonfacility practice expense amount is available. Until that time, those procedures that are office-based but for which there is no available MPFS nonfacility practice expense amount available for the comparison will be paid using the standard methodology for calculating ASC payment under the revised ASC payment system.

The procedures that we are finalizing as office-based for CY 2008 are identified in Addendum AA to this final rule, assigned to payment indicators of ''P2'' (Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight); ''P3'' (Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs); and ''R2'' (Office-based surgical procedure added to ASC list in CY 2008 or later without MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight). These payment indicators identify the office-based procedures' estimated payment status under the CY 2008 revised ASC payment system, based on the final CY 2007 information for the OPPS and the MPFS as discussed above, and their illustrative CY 2008 relative payment weights and payment rates reflect

application of the capped payment amounts for those procedures with a payment status indicator of ''P3.'' We note that the actual proposed and final ASC relative payment weights and payment amounts for CY 2008 will be proposed and finalized through the CY 2008 OPPS/ASC proposed and final rules, respectively. We will continue to monitor the appropriateness of the payment cap for office-based surgical procedures performed in ASCs and explore other opportunities to promote site-neutral payments as we gain experience under the revised ASC payment system.

Comment: Several commenters expressed concern about the ''50-percent rule'' we proposed to use to designate which procedures would be considered office-based. One commenter indicated that if a procedure is performed in an office 50 percent of the time, that means half the time the physician has determined that the office is not the appropriate setting for specific patients. Commenters further indicated that clinical circumstances dictate the site of service and not the physician's personal preference, as suggested by the policy proposed for the revised payment system. One commenter stated that surgeons often perform a procedure in the office when anesthesia is not required and perform the same procedure in an ASC when anesthesia is required due to the complexity of individual patient factors.

The commenters offered several suggestions for modifying the specific proposal for designating procedures as office-based. In particular, one commenter requested that there be a reasonable, fair, and efficient mechanism for removing a procedure from the office-based list if the typical site of service for a procedure does change for a legitimate clinical reason. Other commenters recommended that CMS consider raising the threshold above 50 percent to a number that shows the clear majority of cases are performed in the physician's office or allow an exemption to the cap for procedures that are performed in ASCs because of the need for anesthesia. Another commenter suggested that CMS could implement this policy through the use of a modifier that indicates the surgeon selected the ASC over the physician's office as the site of service because of the necessity of anesthesia or patient factors, whereupon the payment limitation would not be applied.

Response: As indicated in our proposed rule, office-based procedures are surgical procedures that the most recent BESS data available indicate are performed more than 50 percent of the time in the physician's office setting. We believe our ''50-percent rule'' proposed policy is the best option at this point in time. It is our current practice to consider procedures that are performed more than 50 percent of the time in the physician's office setting as office-based procedures, and we will continue to monitor whether the 50-percent threshold is appropriate for this categorization. These office-based procedures, as categorized through application of the ''50-percent rule,'' are typically procedures that have transitioned from low volume in the office setting and high volume in the facility setting to higher volume in the office setting and lower volume in the facility setting. The 50-percent threshold marks the point in that transition at which a procedure comes to be performed more often in the office. Typically, procedures that come to be performed more frequently in offices than in the facility setting remain primarily office-based once that transition has taken place. Therefore, we continue to believe that the 50-percent threshold is an appropriate, objective measure for determining which procedures ought to be considered office-based. Moreover, a rigorous review of procedures that met the aforementioned threshold took into account the most recent available volume and utilization data for each individual procedure code and, if appropriate, the utilization and volume of related codes. In addition, we conducted a code-by-code analysis to bolster inconclusive data with the clinical judgment of our medical advisors.

We will continue to assess each year, based on the most recent available BESS and other data available to us, whether there are additional procedures that we would propose to classify as office-based. However, we note that we proposed that once we identify a procedure as office-based, that classification would not change in future updates of the ASC payment system, except in cases of new codes, where those initial determinations are temporary, as explained further in section V.E. of this final rule. As we have explained above, once a procedure becomes safe enough to be performed in more than 50 percent of cases in the office setting, it is unlikely to revert to a facility setting.

The vast majority of procedures designated as office-based under the revised ASC payment system would require only either local anesthesia or at most moderate or ''conscious'' sedation, that is, sedation to achieve a medically controlled state of depressed consciousness while maintaining the patient's airway, protective reflexes, and ability to respond to stimulation or verbal commands. The use of general anesthesia for the performance of these office-based procedures would be expected to be highly unusual. In those cases where local anesthesia or ''conscious'' sedation are the typical types of anesthesia used in the performance of certain procedures, the procedure's MPFS nonfacility practice expense amount would have already been valued to include payment for the anesthesia typically used, so appropriate payment would be provided in the ASC setting if the procedure were subject to the office-based payment limitation. However, even when general anesthesia may be required because of uncommon patient-specific considerations, basing a surgical procedure's prospective payment rate on the typical case when anesthesia is not required and the procedure can be performed safely in the office is consistent with the averaging principle that is the basis for all our prospective payment systems, including the revised ASC payment system.

Therefore, after considering all comments received, we are finalizing our proposal, without modification, to identify office-based surgical procedures for the revised ASC payment system as those surgical procedures no longer excluded from ASC payment beginning in CY 2008 or later years that are performed more than 50 percent of the time in physicians' offices, taking into account the most recent available volume and utilization data for each individual procedure code and/or, if appropriate, the clinical characteristics, utilization, and volume of related codes. We will annually assess whether there are additional procedures that we would propose to classify as office-based as part of the annual OPPS/ASC rulemaking cycle. With the exception of new codes for which our determinations would remain preliminary until there are adequate physicians' claims data available to assess their predominant sites of service as discussed further in section V.E. of this final rule, the classification of a procedure as office-based would not change in future updates of the ASC payment system. Those procedures whose office-based designation for CY 2008 is temporary because they are new codes for which there is not yet adequate physicians' claims data are flagged with an asterisk (*) in Addendum AA to this final rule.

Comment: One commenter indicated that code CPT 64555 (Percutaneous implantation of neurostimulator electrodes; peripheral nerve (excludes

sacral nerve)), should not be designated as an office-based procedure under the revised ASC payment system because not all of the procedures described by the code can be done in the physician's office. The commenter further stated that payment accuracy should be included as a goal of any new payment system, to avoid site-of-service decisions that are based on financial factors rather than clinical appropriateness. The commenter reasoned that the proposed payment method for procedures similarly identified as office-based would inappropriately impact site-of-service decisions, because it would not be possible to provide the procedures in the ASC setting.

Another commenter suggested that CPT code 15340 (Tissue cultured allogeneic skin substitute, first 25 sq cm or less) be removed from the proposed list of office-based procedures so as to ensure appropriate payment for the procedure in the ASC setting and thereby provide Medicare beneficiaries with increased access to the procedure. The commenter noted that this CPT code was new for CY 2006 and, therefore, there were no CY 2005 utilization data available for our review. They also explained that the predecessor CPT code was not performed in the physician's office more than 50 percent of the time, and they did not believe this new code would be determined to be office-based based on the 50-percent threshold when CY 2006 data were available.

Response: We have identified CPT code 64555, newly proposed for ASC payment beginning in CY 2008, as a device-intensive procedure that is clinically similar to other CPT codes for implantation of neuroelectrodes that are not office-based procedures, although some of the other procedures are ASC covered surgical procedures prior to January 2008. The code is assigned to APC 0040 (Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve) under the CY 2007 OPPS, where other neurostimatulor electrode implantation procedures reside. Therefore, we believe it is most appropriate to remove CPT code 64555 from the list of office-based procedures under the revised ASC payment system, so that it will be paid in the ASC setting according to the modified payment methodology we are adopting for device-intensive procedures. We refer readers to section IV.C.2.e. of this final rule for a detailed discussion of our proposed and final policies regarding ASC payment for procedures with significant device costs. In addition, we note that, while we had also proposed an office-based designation for CPT code 64565 (Percutaneous implantation of neurostimulator electrodes; neuromuscular) beginning with its initial ASC payment in CY 2008, under the OPPS this code is assigned to the same clinical APC as CPT code 64555, which it resembles from both clinical and facility resource perspectives. Therefore, we will also remove CPT code 64565 from the list of office-based procedures for the CY 2008 revised ASC payment system. Following the removal of these two codes from the list of office-based procedures, there are no ASC covered surgical procedures that are both device-intensive and office-based for the CY 2008 revised ASC payment system.

With respect to CPT code 15340, as the commenter pointed out, we have no utilization data from CY 2005 available for this procedure to review in developing this final rule. We note that we did not propose to designate the CPT add-on code for an additional area of application, 15341 (Tissue cultured allogeneic skin substitute, each additional 25 sq cm) as office-based under the revised ASC payment system. The proposed ASC treatment of CPT code 15340 was a temporary designation for the new code, subject to change in response to public comments and our examination of utilization data when available. At this time, we have decided to remove this CPT code from the office-based list because, after further review, we believe it is not likely to be performed more than 50 percent of the time in the physician's office setting. However, we will continue to evaluate the appropriateness of this action as new data become available and will annually reassess whether this code, or other procedures newly paid in ASCs in CY 2008 or later years that are not already designated as office-based or for which that classification is temporary, should be proposed as office-based for ASC payment, in the context of each year's OPPS/ASC annual update. We note, specifically, that our treatment of CPT code 15340 in this CY 2008 ASC final rule is not a final determination for CY 2008, because we expect to have CY 2006 utilization data available for the CY 2008 OPPS/ASC proposed rule, where we may propose that additional codes be classified as office-based for the CY 2008 revised ASC payment system.

After considering all public comments received, we are finalizing our proposal, with modification, of the office-based list of covered surgical procedures under the CY 2008 revised ASC payment system. At this point, we are removing CPT codes 64555, 64565, and 15340 from the office-based list for the CY 2008 revised ASC payment system. As new data become available, we may propose that additional HCPCS codes newly paid in ASCs in CY 2008 be classified as office-based in the CY 2008 OPPS/ASC proposed rule, and the final CY 2008 ASC list of covered office-based surgical procedures will be published in the CY 2008 OPPS/ASC final rule.

F. Payment Policies for Multiple and Interrupted Procedures

1. Multiple Procedure Discounting Policy

In the August 2006 proposed rule for the revised ASC payment system, we proposed to mirror the OPPS policy for discounting when a beneficiary has more than one surgical procedure performed on the same day at an ASC facility (71 FR 49651). The current policy for multiple procedure discounting in the ASC, as specified in § 416.120(c)(2)(ii) of our regulations, is based on a simple count of procedures performed on the same day. The most costly procedure is paid the full amount and all other procedures are discounted by half.

Under the OPPS, certain surgical procedures are not subject to the discounting policy. Generally, the procedures that are exempted are those performed to implant costly devices. They are not discounted even when performed in association with other surgical procedures because the cost of the implantable device does not change; therefore, resource savings due to efficiencies would be minimal.

Until now, there has been no reason to exempt any procedure from the multiple procedure discounting policy in ASCs because separate payments have been made for implantable devices. Although the ASC payment for the procedure may have been discounted, the cost of the device was paid outside of that rate and was unaffected by the multiple procedure discount methodology.

Under the revised ASC payment system in the August 2006 proposed rule, we proposed to package payment for implantable devices into the procedure payment made to the ASC, as under the OPPS. Because we are trying wherever possible to implement parallel payment policies across both systems, we proposed to adopt the OPPS discounting policy that is applied to surgical procedures so that the costs of performing multiple procedures for the implantation of costly devices are taken into account. Thus, payment for the

same set of multiple procedures under the OPPS and the ASC payment system would be made using similar packaging and payment rules.

For the revised ASC payment system, we proposed in Table 46 of the August 2006 proposed rule (71 FR 49652) a listing of the covered surgical procedures that would be exempt from multiple procedure discounting based on CY 2007 OPPS proposed procedure-specific discounting designations (71 FR 49652 through 49654). These exempt procedures were those surgical procedures proposed for ASC payment in CY 2008 that were also proposed for assignment to a status indicator other than ''T'' under the CY 2007 OPPS, indicating that a multiple surgical procedure reduction would not apply. We proposed to update this list annually in the OPPS/ASC proposed and final rules, and solicited comments on the list.

We also proposed to incorporate our proposed policy on multiple procedure discounting in proposed new § 416.172(e).

Comment: Several commenters supported our proposal to apply the multiple procedure discounting policy of the OPPS to procedures provided under the revised ASC payment system. The commenters noted that this policy would ensure that payments for ASC covered surgical procedures with high fixed costs are not discounted, and that the full costs of procedures to implant expensive devices are taken into account when these device-intensive procedures are performed in conjunction with other surgical procedures. The commenters also suggested that adopting the OPPS multiple procedure discounting policy would provide parity in payments to both HOPDs and ASCs, as well as minimize any payment incentive to shift services between the two settings because of different policies. They believed that this consistency would result in appropriate and parallel policies for payment of multiple surgical procedures performed in a single operative session in both of these delivery settings where outpatient surgery is commonly performed.

Response: We appreciate the commenters' support for the proposed ASC multiple procedure discounting policy. Specifically, when more than one covered surgical procedure is provided by an ASC in a single operative session to a Medicare beneficiary, the procedure with the highest ASC payment rate would be paid 100 percent of the ASC payment amount, and ASC payments for any other surgical procedures not expressly exempt from the discounting policy would be reduced by half. Certain ASC covered surgical procedures with relatively high fixed costs would be specifically exempt from the ASC multiple procedure discounting policy, consistent with the current OPPS multiple procedure discounting policy for those surgical procedures assigned to a status indicator other than ''T'' under the OPPS. We agree with the commenters' general reasoning and further believe that adopting an ASC policy that parallels the OPPS discounting policy would assist in timely and coordinated updates to the multiple procedure discounting status of services payable under both payment systems.

Comment: Several commenters indicated that CMS inappropriately included only one of three similar CPT codes for the placement of breast brachytherapy catheters (specifically CPT code 19298 (Placement of radiotherapy after loading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance)) on the list of procedures proposed for exemption from multiple procedure discounting, which was provided as Table 46 in the CY 2008 ASC proposed rule (and which has been updated as Table 10 below based on the CY 2007 OPPS final procedure-specific discounting designations). These commenters explained that the general surgical approach and devices required to perform CPT code 19298 are similar to those used to provide CPT code 19296 (Placement of radiotherapy after loading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy) and CPT code 19297 (Placement of radiotherapy after loading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; concurrent with partial mastectomy). Moreover, the commenters believed that, because all three CPT codes are assigned to status indicator ''S'' under the OPPS, indicating that multiple procedure discounting does not apply to payment for their performance in the hospital outpatient setting, all of these codes should also be exempt from multiple procedure discounting under the revised ASC payment system.

Response: While CPT code 19298 is assigned to status indicator ''S'' under the CY 2007 OPPS, CPT codes 19296 and 19297 are assigned to status indicator ''T'' under the OPPS effective January 1, 2007. As discussed in the CY 2007 OPPS final rule with comment period (71 FR 68028), CPT codes 19296 and 19297 were reassigned from New Technology APCs to a clinical APC effective January 1, 2007. Along with their APC reassignments, CPT codes 19296 and 19297 were also reassigned from status indicator ''S'' to ''T'' effective January 1, 2007. During the CY 2007 OPPS rulemaking cycle, in considering the public comments and finalizing the new assignments of CPT codes 19296 and 19297 to a clinical APC with status indicator ''T,'' the implications of the multiple procedure reduction to payment for CPT codes 19296 and 19297 in various clinical scenarios were taken into consideration. Therefore, consistent with our proposed multiple procedure discounting policy for the revised ASC payment system, these two procedures were not included on the proposed list of procedures for exemption from multiple procedure discounting under the revised ASC payment system. Their OPPS payment status of ''T'' implies that the multiple procedure payment reduction would be appropriate, and the possibility of a 50-percent payment reduction has already specifically been evaluated with respect to the hospital outpatient resources required to perform the procedures. However, because CPT code 19298 is assigned to status indicator ''S'' under the CY 2007 OPPS, where it remains in its original New Technology APC while additional hospital cost data are being collected, we believe that CPT code 19298 would be appropriately exempted from multiple procedure discounting in both the ASC and HOPD settings, consistent with our overall proposal for discounting under the revised ASC payment system.

After considering the public comments we received, we are finalizing our proposed payment policy for multiple surgical procedure discounting under the revised ASC payment system under § 416.172(e) with only editorial modification. We will mirror the OPPS payment policy for discounting when a beneficiary has more than one covered surgical procedure performed in a single operative session in an ASC in CY 2008, by exempting those surgical procedures on the ASC list of covered surgical procedures that are assigned to a status indicator other than ''T'' under the CY 2008 OPPS from multiple procedure discounting under the revised ASC payment system. The discounting policy of the revised ASC payment system, like

the policy of the existing ASC payment system, will apply the multiple procedure reduction if the same procedure is performed bilaterally, consistent with the general discounting policy of the OPPS for payment of surgical procedures that are performed bilaterally. A procedure performed bilaterally in one operative session would be paid at 150 percent of the single procedure payment under the revised ASC payment system. The multiple procedure discounting policy will only apply to ASC payment for covered surgical procedures. ASC payment for covered ancillary services, as discussed further in section IV.C.2. of this final rule, will not be subject to the multiple procedure discount.

The specific multiple procedure discounting policy that applies to each ASC covered surgical procedure is identified in Addendum AA to this final rule. Table 10 provides an illustrative summary list of the CY 2007 HCPCS codes on the ASC list of covered surgical procedures for CY 2008, and their respective APCs as of January 1, 2007 under the OPPS, which will be exempt from multiple procedure discounting in ASCs effective January 1, 2008, if no changes are made to their OPPS discounting designation for CY 2008. We will update this list annually in the OPPS/ASC proposed and final rulemaking process, which includes the solicitation of public comments. The CY 2008 list of exemptions will be proposed and finalized for the CY 2008 revised ASC payment system through the OPPS/ASC rulemaking cycle for CY 2008.

TABLE 10.—ILLUSTRATIVE LIST OF PROCEDURES EXEMPT FROM MULTIPLE PROCEDURE DISCOUNTING UNDER THE REVISED ASC PAYMENT SYSTEM IN CY 2008

HCPCS code	Short descriptor	APC
11980	Implant hormone pellet(s).	0340
11981	Insert drug implant device.	0340
11982	Remove drug implant device.	0340
11983	Remove/insert drug implant.	0340
15852	Dressing change not for burn.	0340
15860	Test for blood flow in graft.	0340
19295	Place breast clip, percut	0657
19298	Place breast rad tube/caths.	1524
20665	Removal of fixation device.	0340

TABLE 10.—ILLUSTRATIVE LIST OF PROCEDURES EXEMPT FROM MULTIPLE PROCEDURE DISCOUNTING UNDER THE REVISED ASC PAYMENT SYSTEM IN CY 2008—Continued

HCPCS code	Short descriptor	APC
20975	Electrical bone stimulation.	0340
20979	Us bone stimulation	0340
29010	Application of body cast	0426
29015	Application of body cast	0426
29020	Application of body cast	0058
29025	Application of body cast	0058
29035	Application of body cast	0426
29040	Application of body cast	0058
29044	Application of body cast	0426
29049	Application of figure eight.	0058
29055	Application of shoulder cast.	0426
29058	Application of shoulder cast.	0058
29065	Application of long arm cast.	0426
29075	Application of forearm cast.	0426
29085	Apply hand/wrist cast	0058
29086	Apply finger cast	0058
29105	Apply long arm splint	0058
29125	Apply forearm splint	0058
29126	Apply forearm splint	0058
29130	Application of finger splint.	0058
29131	Application of finger splint.	0058
29200	Strapping of chest	0058
29220	Strapping of low back	0058
29240	Strapping of shoulder	0058
29260	Strapping of elbow or wrist.	0058
29280	Strapping of hand or finger.	0058
29305	Application of hip cast	0426
29325	Application of hip casts	0426
29345	Application of long leg cast.	0426
29355	Application of long leg cast.	0426
29358	Apply long leg cast brace.	0426
29365	Application of long leg cast.	0426
29405	Apply short leg cast	0426
29425	Apply short leg cast	0426
29435	Apply short leg cast	0426
29440	Addition of walker to cast.	0058
29445	Apply rigid leg cast	0426
29450	Application of leg cast	0058
29505	Application, long leg splint.	0058
29515	Application lower leg splint.	0058
29520	Strapping of hip	0058
29530	Strapping of knee	0058
29540	Strapping of ankle and/or ft.	0058
29550	Strapping of toes	0058
29580	Application of paste boot.	0058
29590	Application of foot splint	0058

TABLE 10.—ILLUSTRATIVE LIST OF PROCEDURES EXEMPT FROM MULTIPLE PROCEDURE DISCOUNTING UNDER THE REVISED ASC PAYMENT SYSTEM IN CY 2008—Continued

HCPCS code	Short descriptor	APC
29700	Removal/revision of cast.	0058
29705	Removal/revision of cast.	0058
29710	Removal/revision of cast.	0426
29715	Removal/revision of cast.	0058
29720	Repair of body cast	0058
29730	Windowing of cast	0058
29740	Wedging of cast	0058
29750	Wedging of clubfoot cast.	0058
30300	Remove nasal foreign body.	0340
31500	Insert emergency airway.	0094
31620	Endobronchial us add-on.	0670
33282	Implant pat-active ht record.	0680
36002	Pseudoaneurysm injection trt.	0267
36430	Blood transfusion service.	0110
36440	Bl push transfuse, 2 yr or <.	0110
36450	Bl exchange/transfuse, nb.	0110
36511	Apheresis wbc	0111
36512	Apheresis rbc	0111
36513	Apheresis platelets	0111
36514	Apheresis plasma	0111
36515	Apheresis, adsorp/reinfuse.	0112
36516	Apheresis, selective	0112
36522	Photopheresis	0112
36598	Inj w/fluor, eval cv device.	0340
37250	Iv us first vessel add-on	0416
37251	Iv us each add vessel add-on.	0416
38205	Harvest allogenic stem cells.	0111
38206	Harvest auto stem cells	0111
38230	Bone marrow collection	0123
38241	Bone marrow/stem transplant.	0123
38242	Lymphocyte infuse transplant.	0111
40804	Removal, foreign body, mouth.	0340
42809	Remove pharynx foreign body.	0340
46600	Diagnostic anoscopy	0340
51701	Insert bladder catheter	0340
51702	Insert temp bladder cath.	0340
51798	Us urine capacity measure.	0340
53440	Male sling procedure	0385
53444	Insert tandem cuff	0385
53445	Insert uro/ves nck sphincter.	0386
53447	Remove/replace ur sphincter.	0386

TABLE 10.—ILLUSTRATIVE LIST OF PROCEDURES EXEMPT FROM MULTIPLE PROCEDURE DISCOUNTING UNDER THE REVISED ASC PAYMENT SYSTEM IN CY 2008—Continued

HCPCS code	Short descriptor	APC
54400	Insert semi-rigid prosthesis.	0385
54401	Insert self-contd prosthesis.	0386
54405	Insert multi-comp penis pros.	0386
54410	Remove/replace penis prosth.	0386
54416	Remv/repl penis contain pros.	0386
61795	Brain surgery using computer.	0302
61885	Insrt/redo neurostim 1 array.	0039
62252	Csf shunt reprogram	0691
62367	Analyze spine infusion pump.	0691
62368	Analyze spine infusion pump.	0691
63650	Implant neuroelectrodes	0040
63655	Implant neuroelectrodes	0061
64553	Implant neuroelectrodes	0225
64555	Implant neuroelectrodes	0040
64560	Implant neuroelectrodes	0040
64561	Implant neuroelectrodes	0040
64565	Implant neuroelectrodes	0040
64573	Implant neuroelectrodes	0225
64575	Implant neuroelectrodes	0061
64577	Implant neuroelectrodes	0061
64580	Implant neuroelectrodes	0061
64581	Implant neuroelectrodes	0061
65205	Remove foreign body from eye.	0698
65210	Remove foreign body from eye.	0698
65220	Remove foreign body from eye.	0698
65222	Remove foreign body from eye.	0698
65430	Corneal smear	0698
65450	Treatment of corneal lesion.	0231
67500	Inject/treat eye socket	0231
67820	Revise eyelashes	0698
67938	Remove eyelid foreign body.	0698
68040	Treatment of eyelid lesions.	0698
68200	Treat eyelid by injection	0230
68760	Close tear duct opening	0231
68761	Close tear duct opening	0231
68801	Dilate tear duct opening	0698
68810	Probe nasolacrimal duct	0231
68840	Explore/irrigate tear ducts.	0698
69200	Clear outer ear canal	0340
69210	Remove impacted ear wax.	0340
C9725	Place endorectal app	1507
C9726	Rxt breast appl place/remov.	1508
C9727	Insert palate implants	1510
G0104	CA screen; flexi sigmoidscope.	0159

2. Interrupted Procedure Policies

When a procedure requiring anesthesia is discontinued after the beneficiary is prepared for the procedure and taken to the room where it is to be performed, but before the administration of anesthesia, ASCs currently report modifier 73 (Discontinued outpatient procedure prior to anesthesia administration) appended to the discontinued procedure and receive 50 percent of the ASC payment for the planned surgical procedure. We believe that ASCs, like hospital outpatient facilities, realize significant savings when procedures for which anesthesia is to be used are discontinued prior to their initiation but after the beneficiary is taken to the procedure room. We believe that savings are recognized for the costs associated with a variety of facility resources, including treatment/operating room time, single use devices, drugs, equipment, supplies, and recovery room time. When a procedure is interrupted after its initiation or the administration of anesthesia, ASCs currently report these cases using modifier 74 (Discontinued outpatient procedure after anesthesia administration) appended to the interrupted procedure, and the full ASC payment for the covered surgical procedure is made. Similar to hospital outpatient procedures that are discontinued after the administration of anesthesia or the initiation of the procedure, in cases where modifier 74 is reported by ASCs, we believe that the facility costs incurred for these discontinued procedures that were initiated to some degree are generally as significant to the ASC as those for a completed procedure, including resources for patient preparation, operating room use, and recovery room care. In the August 2006 proposed rule, we proposed no change to the existing ASC payment policy for procedures reported with modifier 73 or 74 under the revised ASC payment system, and note that the policy under the existing ASC payment system is the same as the OPPS policy in these circumstances.

Under the existing ASC payment system, ASCs do not report modifier 52 (Reduced services) for interrupted procedures, because most interrupted covered surgical procedures paid in ASCs would be appropriately reported with modifier 73 or 74 because they generally require anesthesia. Modifier 52 is appended to a service under the OPPS to signify that a service that did not require anesthesia was partially reduced or discontinued at the physician's discretion. Modifier 52 is reported under the OPPS for a variety of types of interrupted services, such as radiology services, and we believe that there are considerable resource savings to the facility under the circumstances where it is reported. Therefore, under the OPPS, we apply a 50 percent reduction to the facility payment for interrupted procedures and services reported with modifier 52.

The PPAC recommended that we apply payment policies consistently under the revised ASC payment system and the OPPS. We received a number of public comments recommending consistency of payment policies between the two payment systems. Although not discussed in our proposed rule for the revised ASC payment system, we received comments on the application of the current interrupted procedure policies to the revised ASC payment system and respond to these comments below.

Comment: Many commenters recommended that we establish consistent payment policies under the OPPS and the revised ASC payment system, because the hospital and ASC facilities provide many of the same services to similar patients. In particular, several commenters compared current payment policies that were similar between the existing ASC payment system and the OPPS, including the payment policy that reduces the payment for interrupted procedures reported with modifier 73 by 50 percent in both payment systems.

Response: We agree with commenters that consistent policies between the revised ASC payment system and the OPPS are desirable whenever possible, because the revised ASC payment system will be based upon the OPPS relative payment weights. We also note that, with the significant expansion of procedures eligible for ASC payment under the revised ASC payment system, it is possible that some of the additional procedures payable in the ASC setting beginning in CY 2008 may not always require anesthesia. In addition, as further discussed in section IV.C.2. of this final rule, we will be providing separate payment for some ancillary radiology services that are integral to the performance of covered surgical procedures under the revised ASC payment system. Therefore, we believe that the revised ASC payment system should also allow ASCs to report interrupted services not requiring anesthesia with modifier 52, consistent with the OPPS reporting of these services. Because we expect ASCs to utilize fewer facility resources in such situations, similar to ASC procedures where modifier 73 is reported and to

HOPDs where modifier 73 or 52 is reported, we believe that it is appropriate to provide the same payment reduction of 50 percent under the revised ASC payment system as under the OPPS when modifier 52 is reported.

After considering the public comments received, we are clarifying here the payment policies for interrupted procedures in ASCs. First, procedures requiring anesthesia that are terminated after the patient has been prepared for surgery and taken to the operating room but before the administration of anesthesia will be reported with modifier 73, and the ASC payment for the covered surgical procedure will be reduced by 50 percent. Second, procedures and services not requiring anesthesia that are partially reduced or discontinued at the physician's discretion will be reported with modifier 52, and the ASC payment for the covered surgical procedure or covered ancillary service will be reduced by 50 percent. Third, procedures requiring anesthesia that are terminated after the administration of anesthesia or the initiation of the procedure will be reported with modifier 74, and the full ASC payment for the covered surgical procedure will be provided. We are adding new § 416.172(f) to reflect this final policy.

G. Geographic Adjustment

Currently, Medicare adjusts 34.45 percent of the national ASC payment rates using wage index values and localities that were established under the hospital IPPS prior to implementation of the new CBSAs issued by OMB in June 2003. Medicare currently adjusts 60 percent of national OPPS payment rates by the IPPS wage index value assigned to hospitals using the June 2003 OMB definitions for geographical statistical areas and wage adjustments required under Public Law 108–173.

Since 1990, ASC payments have been adjusted for regional wage variations using the IPPS wage index values. As we discussed in the August 2006 proposed rule, we believe that standardization continues to be appropriate in recognition of widely varying labor market costs tied to geographic localities. We also explained in the proposed rule that we believe it is advisable to maintain consistency in locality designations between ASCs and hospitals and acknowledge parity of labor costs between ASCs and HOPDs that are competing for staff in the same locality. Therefore, we proposed to apply to ASCs the IPPS pre-reclassification wage index values associated with the June 2003 OMB geographic localities, as recognized under the IPPS and OPPS, to adjust national ASC payment rates for geographic wage differences under the revised payment system.

Although we had not collected new data to identify whether the current labor-related share is correct, the results of a 1994 survey of ASC costs generally supported the current 34.45-percent labor adjustment factor, and we had received no complaints from the ASC community, prior to our proposal, about our continued use of the 34.45/65.55 ratio of labor to nonlabor costs for purposes of adjusting payments for regional wage differences. Moreover, in the proposed rule, we stated our belief that it is reasonable to expect ASCs to have a lower labor adjustment factor than that of hospitals. For example, most OPPS HOPDs are staffed 24 hours per day to provide emergency department services and observation care, and these patterns of operation could lead to relatively higher labor costs for hospital services overall. Therefore, we proposed to continue using 34.45 percent as the labor adjustment factor for regional wage differences under the revised ASC payment system, beginning in CY 2008. We proposed to establish rules governing this proposal in new § 416.172(c).

Subsequent to the publication of the August 2006 proposed rule for the revised ASC payment system, the GAO issued the report, ''Medicare: Payment for Ambulatory Surgical Centers Should Be Based on the Hospital Outpatient Payment System,'' (GAO–07–86), which is discussed in further detail in section II.B. of this final rule. In this report, the GAO determined that based upon the 2004 ASC cost data from a geographically representative group of ASCs received in response to its ASC survey, the mean labor-related proportion of ASC costs was 50 percent.

Comment: Several commenters agreed with CMS' proposal to use the IPPS pre-reclassification wage index values associated with the June 2003 OMB geographic localities. However, many commenters indicated that the current 34.45-percent labor factor is based on old data and is too low, leading to their recommendation that the 60-percent OPPS labor factor would be more appropriate. Some commenters explained that it was difficult to assess the appropriateness of CMS' proposal in the absence of the GAO Report on the ASC payment system that was directed to address whether a geographic adjustment should be provided for payment of procedures furnished in ASCs and, if so, the labor and nonlabor shares of ASC payment. Other commenters recommended that CMS collect more recent data on the costs of delivering services in the ASC setting or suggested that ASCs be asked to submit cost reports to inform the development of an appropriate, contemporary labor factor reflecting current ASC costs.

Response: For the reasons stated in the proposed rule and reiterated above, we agree with the commenters that we should use the IPPS pre-reclassification wage index values associated with the June 2003 OMB geographic localities. While we share the concerns of commenters about the age of the survey data used for the current 34.45-percent labor factor, we disagree that it would be appropriate to use the same 60-percent labor factor used under the OPPS. The commenters who indicated a preference for the OPPS labor factor did not address the fact that most OPPS HOPDs are staffed 24 hours per day to provide emergency department services and observation care. Other than their request for parity with the OPPS labor adjustment, they provided no specific data to support the appropriateness of a 60-percent labor factor based on current ASC costs for performing procedures.

However, we agree with commenters that the 34.45 labor-related share that we proposed for the revised payment system is likely too low to accurately reflect the current proportion of ASCs' labor costs. The data used to develop the 34.45 labor-related share are 20 years old, and 1994 ASC survey cost data, which have never been used for ASC payment, showed a slightly higher labor-related share of 37.66 percent that we believe was likely reflective of a generally increasing proportion of ASC labor costs. ASCs and HOPDs operate in some of the same communities, using similar clinical staff to perform certain procedures, and ASC staff wages may be comparable to those of hospital staff. However, we have no data to indicate that ASCs and HOPDs have equivalent ratios of labor to nonlabor costs, on average, for all the services each type of facility provides. As discussed above, because ASCs only provide a subset of surgical procedures compared with the wide variety of OPPS services that we expect could be, overall, relatively more labor-intensive than ambulatory surgical procedures specifically, we believe that the most appropriate ASC labor-related share would be lower than the 60 percent used to adjust HOPD payment. The GAO Report determined, on the basis of the 2004 ASC cost data received from a geographically representative group of ASCs in response to its ASC survey, that the mean labor-related

proportion of costs was 50 percent. In addition, the GAO found that the range of the labor-related costs for the middle 50 percent of ASCs responding to the survey was relatively narrow, at 43 percent to 57 percent of total costs.

Therefore, in response to comments about the age of the historical data used for the existing and proposed revised ASC payment system labor factor, in addition to consideration of the GAO's determination based on the most recent ASC survey findings, we reviewed the labor-related share indicated by the 1994 ASC survey cost data and assessed the clinical labor required to provide both ASC and OPPS services, in the context of the full facility resource costs associated with those services. Based on all of those considerations, we believe that it is not necessary to collect additional ASC cost data in order to determine the appropriate labor-related factor for use under the revised ASC payment system and that a 50-percent labor factor for the revised ASC payment system is most appropriate. Fifty percent is significantly higher than the current labor-related share (34.45 percent) that we proposed to maintain but is also lower than the OPPS labor-related share of 60 percent, a differential we believe is appropriate given the broader range of labor-intensive services provided in the HOPD setting. A 50-percent labor-related share is fully consistent with the GAO findings that we believe provide a more accurate representation of the present-day labor-related proportion of ASC costs than the data upon which we currently rely. In the future, if we believe that the collection of additional ASC cost data is important to providing appropriate payment to ASCs and such an activity is administratively feasible, we may consider gathering such information from ASCs.

After considering the public comments received, we are finalizing our proposal to apply to ASC payments under the revised ASC payment system the IPPS pre-reclassification wage index values associated with the June 2003 OMB geographic localities, as recognized under the IPPS and OPPS, in order to adjust national ASC payment rates for geographic wage differences under the revised payment system. However, rather than adopting 34.45 percent as the labor adjustment factor as we proposed, we are adopting 50 percent as the labor-related proportion under the revised ASC payment system. The geographic adjustment policy of the revised ASC payment system is set forth in § 416.172(c).

H. Adjustment for Inflation

As noted above, section 1833(i)(2)(C)(iv) of the Act, as amended by section 626(a) of Public Law 108–173, requires the adjustment of ASC payment amounts for inflation for FY 2005, the last quarter of CY 2005, and each of CYs 2006 through 2009 to equal zero percent. Otherwise, section 1833(i)(2)(C)(i) of the Act provides that ASC payment amounts are to be adjusted by the percentage increase in the CPI–U during years when the ASC payment amounts are not updated.

Although we are only required to increase the ASC payment rates by the percentage increase in the CPI–U during years in which we have not updated the ASC payment amounts, we proposed to update the ASC conversion factor annually using the CPI–U. For CY 2008 and CY 2009, the statute requires a zero percent CPI–U increase for ASC services. Beginning in CY 2010, in the August 2006 proposed rule for the revised ASC payment system, we proposed to update the ASC conversion factor by the percentage increase in the CPI–U (U.S. city average) as estimated for the 12-month period ending with the midpoint of the year involved. Accordingly, we proposed to establish rules in proposed new §§ 416.171 and 416.172 to reflect our proposed policy for applying an inflation adjustment under the proposed revised payment system beginning January 1, 2008. (These sections of the proposed regulations also included our proposed policies for calculating a conversion factor and standardizing labor-related costs, respectively, under the proposed revised payment system.)

Comment: A number of commenters recommended that CMS use the hospital market basket as an update for inflation in the revised ASC payment system. The commenters generally indicated that the hospital market basket more appropriately reflects inflation in the costs of providing surgical services. These commenters pointed out that the CPI–U is a measure of consumer inflation rather than health care provider inflation, and that the hospital market basket was specifically designed to measure the cost of hospital inflation. They concluded that the hospital market basket is, thus, a better proxy for the inflationary pressures faced by ASCs. One commenter presented data indicating that the cost of operating an ASC rose by an average of 13.4 percent between 2003 and 2005 and that, during that same period, the CPI–U fell 36 percent short of meeting these increased costs.

Some commenters expressed concern that the use of two different factors to update payments for ASCs and HOPDs would further increase the discrepancies between payments in the two settings. They further suggested that alignment with hospital updates and policies in general would achieve parity and transparency in the market and ensure that facility decisions are made based upon what is best for the patient. Other commenters suggested that CMS develop another method that would more closely approximate the rising cost of operating an ASC if the proposal to base the annual update of the ASC conversion factor on the CPI–U is finalized.

Response: As we explained in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68003), the OPPS conversion factor is updated annually using the hospital inpatient market basket percentage increase. The statute specifically required us to take into account the recommendations of a GAO Report studying the appropriateness of aligning a revised ASC payment system with the payment rates and relative weights established under the OPPS. However, the statute gives the Secretary broad authority in designing the specific features of the revised system. In particular, the statute gives the Secretary considerable discretion in determining an appropriate update mechanism for the revised ASC payment system. Section 1833(i)(2)(C)(i) of the Act requires that the Secretary update the payment amounts established under the revised system ''by the percentage increase in the Consumer Price Index for all urban consumers,'' but only if the Secretary has not otherwise ''updated amounts established'' under the revised system for that year. The statute, therefore, does not mandate the adoption of any particular update mechanism, but it does establish the CPI–U as the default update mechanism in the absence of any other update. In addition, section 1833(i)(2)(C)(iv) of the Act mandates a zero CPI–U adjustment in CY 2008 and CY 2009 for ASCs, the first 2 years under the revised payment system, suggesting that maintaining continuity in the update mechanism under the revised system may be appropriate. Therefore, we proposed, under the revised system beginning in CY 2010, to apply the CPI–U adjustment to update the ASC conversion factor for inflation on an annual basis. While we understand the arguments of commenters in favor of adopting the hospital market basket as the update mechanism under the revised ASC

payment system, we continue to believe that it is appropriate to adopt the default update mechanism designated by Congress for the revised system.

Therefore, we are finalizing our proposal, beginning in CY 2010, to update the conversion factor by the percentage increase in the CPI–U (U.S. city average) as estimated for the 12-month period ending with the midpoint of the year involved. At the same time, we recognize that we continue to have flexibility under the statute to employ a different update mechanism under the revised ASC payment system. As one example, we do not intend for the revised ASC payment system to result in additional Medicare expenditures over time. We will be monitoring this issue closely in the coming years. Consequently, we will reconsider the ASC update if expenditures increase inappropriately in future years.

Therefore, after consideration of all public comments received, we are finalizing our proposal under § 416.171(a)(2), without modification, to apply the CPI–U to update the ASC conversion factor for inflation on an annual basis under the revised ASC payment system.

I. Beneficiary Coinsurance

Payment for ASC services is subject to the Medicare Part B deductible and coinsurance requirements. Currently, Medicare pays participating ASCs 80 percent of a prospectively determined standard overhead amount, adjusted for regional wage variations for ASC covered surgical procedures, except for screening colonoscopies. The beneficiary deductible and coinsurance make up the other 20 percent of payment for ASC services, except for screening colonoscopies for which there is no deductible and for which the coinsurance is equal to 25 percent. Section 1834(d) of the Act requires this higher coinsurance for screening colonoscopies and screening flexible sigmoidoscopies. However, only screening colonoscopies are on the CY 2007 ASC list of covered surgical procedures. In addition, effective January 1, 2007, a deductible is no longer applied for colorectal cancer screening tests, including screening flexible sigmoidoscopy and screening colonoscopy procedures performed in ASCs or other settings, as specified in section 1833(b)(8) of the Act (as added by section 5113 of Public Law 109–171).

Section 626(c) of Public Law 108–173 amended section 1833(a)(1) of the Act to provide that, beginning with the implementation date of the revised payment system, the Medicare program payment to ASCs shall equal 80 percent of the lesser of the actual charge for the services or the payment amount that we determine under the revised payment system for the services. This amendment, however, did not affect section 1834(d) of the Act. Therefore, we proposed to make this change and to continue to maintain the beneficiary deductible and coinsurance at 20 percent under the revised ASC payment system, except for screening colonoscopies and screening flexible sigmoidoscopies (which are both ASC covered surgical procedures in CY 2008) for which the statute requires 25 percent beneficiary coinsurance. In the August 2006 proposed rule for the revised ASC payment system, we proposed to reflect the 20 percent beneficiary coinsurance in proposed new §§ 416.172(b) and (d); however, the proposed regulation text did not address the statutory requirement of 25 percent coinsurance for screening flexible sigmoidoscopies and screening colonoscopies. Consistent with the provisions of section 1834(d) of the Act, we implemented the 25 percent coinsurance requirement for screening colonoscopies (screening flexible sigmoidoscopies are not on the CY 2007 ASC list of covered surgical procedures) in ASCs, effective January 1, 2007, as finalized in § 410.152(i) and discussed in the preamble to the CY 2007 OPPS/ASC final rule with comment period (71 FR 68174).

Comment: Many commenters supported our proposal to continue to apply the 20 percent coinsurance provision to payment for covered surgical procedures performed in ASCs and paid under the revised ASC payment system.

Response: We appreciate the comments. The statute requires Medicare to pay 80 percent of the lesser of the actual charge for the service or the amount we determine under the revised payment system, other than for screening colonoscopy and screening flexible sigmoidoscopy procedures. Beneficiary coinsurance will remain at 20 percent for ASC services under the revised ASC payment system, except for screening flexible sigmoidoscopy and screening colonoscopy procedures. The coinsurance for screening colonoscopies and screening flexible sigmoidoscopies will be 25 percent, as required by section 1834(d) of the Act, with no deductible for those services under the revised ASC payment system. This requirement is reflected in our regulations at §§ 416.172(b) and (d).

J. Phase-In of Full Implementation of Payment Rates Calculated Under the Revised ASC Payment System Methodology

We discussed in section XXVII.D. of the preamble to the August 2006 proposed rule for the revised ASC payment system (71 FR 49690 through 49695), our analysis of the impact that the revised ASC payment system and estimated payment rates for implementation in CY 2008 could have on certain ASCs that specialize in or perform high volumes of procedures for which payment under the new system would decrease. We wanted to ensure that the revised payment system does not cause a sudden, unwarranted migration of services from ASCs to other ambulatory settings, or the reverse; that ASCs would have an opportunity to balance their Medicare case-mix between procedures whose rates decrease and procedures whose rates increase; and that beneficiaries and their physicians would continue to have a robust choice of sites where important preventive and other surgical services are paid under Medicare.

In the August 2006 proposed rule, we proposed to implement the revised ASC payment system in CY 2008 using transitional payment rates that would be based upon a 50/50 blend of the CY 2007 ASC payment rate for a procedure on the CY 2007 ASC list of covered surgical procedures and the final payment rate for that same procedure calculated under the revised payment system methodology described in the proposed rule and reflected in proposed new § 416.171(c). We further proposed that, in CY 2009, we would fully implement the ASC payment rates calculated under the proposed payment methodology, discontinuing the blended transitional payment rates for services furnished beginning January 1, 2009. This was proposed in new § 416.171(d).

Comment: Several commenters expressed concern that the proposed 2-year transition period would threaten the viability of many ASCs. The commenters indicated that given the size of the payment cuts contemplated under the proposed rule for certain procedures and specialties, especially gastrointestinal, pain management, and ophthalmology services, 1 year would not provide adequate time for ASCs to adjust to the changes and that a 4-year phase-in would allow a more gradual and less disruptive transition to the new payment system. Many commenters urged CMS to implement policies to further address the decrease in payments for procedures whose rates would fall significantly during a

transition to the new payment system. One commenter suggested that CMS hold harmless procedures that were on the ASC list of covered surgical procedures prior to CY 2008 to prevent significant changes in payments during the transition. Some commenters expressed concern that if CMS revises both the payment system and the geographic localities used for wage adjustment at the same time, providers in certain areas could experience dramatic shifts in payment as a result of the cumulative effect of the wage index and other policy changes that were described in the proposed rule. These commenters encouraged CMS to consider the cumulative effects of the wage index and other policy changes on payments to ASCs under the revised ASC payment system and develop a transitional approach that protects providers from significant reductions in payment.

A number of commenters supported the proposed 2-year phase-in of the ASC payment rates based on the final methodology of the revised ASC payment system. The commenters generally believed that the transition period as proposed would provide sufficient notice and time for ASCs to adapt to the revised payment system.

Some commenters stated that the proposed transition does not appropriately address payment for device-intensive procedures that implant devices that are paid separately according to the DMEPOS fee schedule under the existing payment system during the transitional year of CY 2008. Some of these commenters urged CMS to devise a strategy that would accelerate full implementation of payment for device-intensive procedures according to the proposed methodology for the revised ASC payment system. Alternatively, other commenters suggested that CMS develop a final transitional policy that does not exclude the payments for implanted devices now paid separately under the DMEPOS fee schedule in calculating the CY 2007 ASC payment contributions to the blended payment rates for device-intensive procedures for CY 2008.

Response: After consideration of all of these public comments, we agree with the majority of the commenters who indicated that a 2-year transition may provide some ASCs with insufficient time to adapt to the revised payment system. During the transition to the revised system, we believe it is important to maintain appropriate Medicare beneficiary access to ASC services. In addition, we do not believe that the transition should be asymmetrical, meaning that procedures with decreasing payments under the revised payment system should be transitioned differently from those with increasing payments. We also do not believe that the transition should lead to increases or decreases in overall Medicare ASC expenditures.

Therefore, in order to provide additional time for ASCs to adapt to the revised payment system and to facilitate Medicare beneficiary access to ambulatory surgical procedures at those ASCs that may not adjust as quickly as others to the revised payment system, we are extending the transition from our proposed 2 years to 4 years for all services on the CY 2007 ASC list of covered surgical procedures, as reflected in § 416.171(c). We believe a transition period of 4 years, comparable to transition periods provided under other payment systems (for example, the recent practice expense changes to the MPFS) and as suggested in comments concerning this issue, will provide a reasonable and balanced approach to implementation that addresses two important objectives, in particular offering sufficient notice and time for ASCs to adapt to the revised payment system and providing more accurate and appropriate ASC payments for covered surgical procedures. The contribution of CY 2007 ASC payment rates to the blended transitional rates will decrease by 25 percentage point increments each year of transitional payment, until CY 2011, when we will fully implement the ASC payment rates calculated under the final methodology of the revised payment system. Procedures new to ASC payment for CY 2008 or later calendar years will receive payments determined according to the final methodology of the revised ASC payment system, as reflected in § 416.171(a), without the need for a transition. ASC covered surgical procedures listed in Addendum AA to this final rule that are subject to the transition are assigned to payment indicators ''A2'' (Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight) and ''H8'' (Device-intensive procedure on ASC list in CY 2007; paid at adjusted rate). ASC covered surgical procedures listed in Addendum AA to this final rule that are not subject to the transition are assigned to payment indicators ''G2'' (Non office-based surgical procedure added to ASC list in CY 2008 or later; payment based on OPPS relative payment weight); ''J8'' (Device-intensive procedure added to ASC list in CY 2008 or later; paid at adjusted rate); ''P2'' (Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight); ''P3'' (Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs); and ''R2'' (Office-based surgical procedure added to ASC list in CY 2008 or later without MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight).

In addition, we agree with commenters who indicated that an adjustment should be made during the transition period for certain procedures that implant devices that are separately payable under the existing ASC payment system. For device-intensive procedures utilizing separately payable devices of significant cost, ideally, we would adjust the CY 2007 base rates for the procedures to appropriately reflect the fact that associated devices may have been separately paid to ASCs in CY 2007 under the DMEPOS fee schedule, but beginning in CY 2008 implantable device payment will be packaged into the ASC payment for the covered surgical procedure under the revised ASC payment system. This would require associating the current separately provided implantable device payments with specific covered surgical procedures, in order to determine an appropriate CY 2007 base payment rate for the transition for each procedure. However, due to the challenges in making these associations, including the common historical practice of payment at contractor-priced rates for some implantable devices that have been reported only under Level II HCPCS unlisted codes under the existing payment system, we cannot accurately allocate those device payments to covered surgical procedures using the ASC data.

Under the final methodology of the revised ASC payment system for calculating payment for procedures with significant device costs as discussed in section IV.C.2.e. of this final rule, for device-intensive procedures on the CY 2007 ASC list of covered surgical procedures, we will separately determine both the device payment and service payment portions of the total ASC payment under the revised payment system. We will apply the ASC conversion factor only to the specially calculated OPPS relative payment weight for the service portion, while providing the same packaged payment for the device portion as would be made under the OPPS. That is, we will determine the payment amount attributable to the device, as currently determined under the OPPS, and

combine that payment amount with the adjusted ASC service payment, resulting in a total ''bundled'' ASC payment for the device-intensive procedure under the revised ASC payment system.

Consistent with that approach, we also will apply our transition policy differentially to those portions of the total ASC payment. While we will not subject the device payment portion of the total ASC payment for the procedure under the revised ASC payment system to the transition policy, we will transition the service payment portion of the total ASC payment for the procedure over the 4-year phase-in period. Device-intensive procedures that are new to the ASC list of covered surgical procedures for CY 2008 or later years will be exempted from any transition period and will be paid at the fully implemented revised ASC payment system rates beginning in CY 2008 or the applicable update year, just like all other new ASC surgical procedures. During each of the transition years, when the CY 2007 ASC payment rate for a device-intensive procedure that did not previously include packaged ASC payment for the implantable device itself is blended with the payment developed under the methodology of the revised ASC payment system that would otherwise package the device payment, the full device payment amount will be paid to ASCs in the transition year, with blended payment determined only for the service portion of the ASC payment, for which a corresponding CY 2007 ASC payment rate exists. This methodology achieves an appropriate payment for costly, implantable devices, because it recognizes that, in general, the device costs are similar for ASCs and HOPDs. This specific transition approach for device-intensive procedures ensures that ASCs receive appropriate packaged payment for implantable devices during the transition years, even though payment for such devices is generally not included in their base CY 2007 ASC payment rates under the existing ASC payment system.

A full discussion of the calculation of the payment rates for these device-intensive procedures can be found in section IV.C.2.e. of this final rule, in the context of establishing payment weights for device-intensive procedures under the revised ASC payment system. Tables 5 and 6 above are illustrative of the device-intensive procedures likely to be subject to this special transitional policy for device-intensive procedures under the revised ASC payment system, pending updating of their OPPS status in CY 2008 and future years.

After considering the public comments received, we are finalizing a policy to phase in implementation of the payment rates calculated under the revised ASC payment system over 4 years. For CYs 2008, 2009, and 2010, payment will be made for each procedure on the CY 2007 ASC list of covered surgical procedures based on a 25/75, 50/50, and 75/25 blend, respectively, of the CY 2007 payment rate for the procedure and the payment rate for that procedure calculated under the standard revised payment system methodology set forth in § 416.171(a). Procedures that are newly approved for ASC payment in CY 2008 or later years are not subject to the transition policy. In CY 2011, we will fully implement the ASC payment rates calculated under the standard payment methodology of the revised ASC payment system. This final transition policy is set forth in § 416.171(c).

The service payment portion of the total ASC payment for device-intensive procedures that are on the ASC list of covered surgical procedures in CY 2007 will be subject to the transition. The service payment portion calculated under the fully implemented revised ASC payment system methodology will be blended with the ASC payment for the procedure under the existing payment system. In contrast, the device payment portion of the total ASC payment for these procedures, where the device would generally have been paid separately according to the DMEPOS fee schedule under the existing ASC payment system, will not be subject to the transition. Rather, the contribution of the device payment portion to the total ASC payment during the transitional years will be calculated according to the methodology of the fully implemented revised ASC payment system. During the years of phase-in of the revised ASC payment system, the device payment portion will be summed with the blended service payment portion (that is, the 25/75, 50/50, or 75/25 blend, as appropriate) to establish the total ASC payment for these device-intensive procedures for each year of the transition. Device-intensive procedures new to the ASC list of covered surgical procedures for CY 2008 or later years will be paid the fully implemented revised payment system rates.

V. Calculation of ASC Conversion Factor and ASC Payment Rates for CY 2008

A. Overview

As discussed in section IV.B. of this final rule, in the August 2006 proposed rule, we proposed to base ASC relative payment weights and payment rates under the revised ASC payment system on APC groups and relative payment weights established under the OPPS. We also proposed to set the ASC relative payment weight for certain office-based surgical procedures so that the national ASC payment rate does not exceed the MPFS unadjusted nonfacility practice expense amount. We explained that the proposed ASC payment weights would be multiplied by an ASC conversion factor to calculate the ASC payment rates. In the August 2006 proposed rule, our estimate for the CY 2008 budget neutral ASC conversion factor was $39.688. In this final rule, we estimate that the ASC conversion factor for CY 2008 will be approximately $42.543. This new estimate of the ASC conversion factor differs from the estimate in the August 2006 proposed rule for a number of reasons, including: (1) Use of the final OPPS relative payment weights for CY 2007; (2) use of the final MPFS nonfacility practice expense payment amounts for CY 2007; (3) use of updated utilization data for the full year of CY 2005; (4) a 4-year instead of 2-year transition to the revised payment system rates, with a modified transition for device-intensive procedures; (5) more recent estimates of the hospital market basket update and the MPFS conversion factor update for CY 2008; and (6) adoption of the with-migration approach to calculation of the budget neutrality adjustment using different time periods for the assumed migration of procedures from physicians' offices and HOPDs to ASCs under the revised ASC payment system. Specific details regarding our final methodology for estimating the revised ASC payment system conversion factor are discussed later in this section.

We are not able to provide the final CY 2008 ASC conversion factor in this final rule for the revised ASC payment system because the final conversion factor will be based on the final OPPS relative payment weights for CY 2008, the final MPFS nonfacility practice expense payment amounts for CY 2008, and updated and complete CY 2006 utilization data, all of which are unavailable at this time but will be available for the CY 2008 OPPS/ASC final rule. Therefore, in this final rule, we are finalizing the methodology for calculating the ASC conversion factor for the revised ASC payment system. When the necessary data are available, they will be used in the methodology described in this final rule, and we will provide the final CY 2008 ASC conversion factor and ASC relative

payment weights and rates in the CY 2008 OPPS/ASC final rule.

B. Budget Neutrality Requirement

Section 626(b) of Public Law 108–173 amended section 1833(i)(2) of the Act by adding subparagraph (D) to require that in the year the revised ASC system is implemented:

''* * * [S]uch system shall be designed to result in the same aggregate amount of expenditures for such services as would be made if this subparagraph did not apply, as estimated by the Secretary. * * *''

As discussed in the August 2006 proposed rule for the revised ASC payment system, the ASC conversion factor is calculated so that estimated total Medicare payments under the revised ASC payment system would be budget neutral to estimated total Medicare payments under the current ASC payment system as required by the statute. That is, application of the ASC conversion factor would be designed to result in aggregate expenditures under the revised ASC payment system in CY 2008 equal to aggregate expenditures that would have occurred in CY 2008 in the absence of the revised system, taking into consideration the cap on payments in CY 2007 as required under section 5103 of Public Law 109–171, which we discuss further in section IV.A. of this final rule.

We note that, in the August 2006 proposed rule (71 FR 49656), we considered the term ''expenditures'' in the context of section 626(b) of the Public Law 108–173 budget neutrality requirement to mean expenditures from the Medicare Part B Trust Fund. We did not consider expenditures to include beneficiary coinsurance and copayments.

C. Calculation of the ASC Payment Rates for CY 2008

1. Proposed Method for Calculation of the ASC Payment Rates for CY 2008 in the August 2006 Proposed Rule

In the August 2006 proposed rule, we proposed to calculate the ASC payment rates for CY 2008 as follows:

a. Estimated Medicare Program Payments (Excluding Beneficiary Coinsurance) Under the Current ASC Payment System in the August 2006 Proposed Rule

Step 1: To estimate the aggregate amount of expenditures that would be made in CY 2008 under the current ASC payment system, we first multiplied the estimated CY 2008 ASC volume for each HCPCS code on the CY 2007 ASC list of covered surgical procedures by the estimated CY 2008 ASC payment rate for the HCPCS code under the existing ASC system, and then subtracted beneficiary coinsurance. In the August 2006 proposed rule, the estimated CY 2008 ASC payment rates were based on the proposed CY 2007 ASC payment rates, which were listed in Addendum AA to the rule, taking into account the OPPS cap on ASC services at the OPPS rate as required by section 5103 of Public Law 109–171 and reflecting the zero percent CY 2008 update for ASC services mandated by section 1833(i)(2)(C)(iv) of the Act. Although we did not specify in the August 2006 proposed rule that we did so, we also estimated the amount the Medicare program would pay in CY 2008 for implantable prosthetic devices and implantable DME for which ASCs currently receive separate payment under the DMEPOS fee schedule. We then summed the estimated DMEPOS fee schedule total amount and all of the estimated procedure payment amounts for services on the CY 2007 ASC list of covered surgical procedures to estimate the aggregate amount of expenditures that would be made in CY 2008 under the policies of the current ASC payment system.

b. Estimated Medicare Program Payments (Excluding Beneficiary Coinsurance) Under the Proposed Revised ASC Payment System in the August 2006 Proposed Rule

Step 2: To estimate the aggregate amount of expenditures that would be made in CY 2008, we used estimated CY 2008 OPPS payment amounts instead of estimated CY 2008 ASC payment amounts under the current system, and we multiplied the estimated CY 2008 ASC volume for each HCPCS code on the CY 2007 ASC list of covered surgical procedures by the estimated CY 2008 OPPS payment rate for the HCPCS code, and then subtracted beneficiary coinsurance. We summed the results for all services on that ASC list of covered surgical procedures.

c. Calculation of the Proposed CY 2008 Budget Neutrality Adjustment in the August 2006 Proposed Rule

Step 3: To calculate the proposed CY 2008 ASC budget neutrality adjustment, we divided the total expenditures calculated in Step 1 by the total expenditures calculated in Step 2. We calibrated this estimate of the budget neutrality adjustment to take into account that, in CY 2008, the payment rate for procedures on the CY 2007 ASC list of covered surgical procedures was proposed to be 50 percent of the CY 2007 ASC payment amount and 50 percent of the CY 2008 ASC payment rate calculated according to the proposed revised payment system methodology without the transition. The result of these calculations was a budget neutrality adjustment of 0.62.

d. Application of the Budget Neutrality Adjustment To Determine the Proposed CY 2008 ASC Conversion Factor in the August 2006 Proposed Rule

Step 4: To determine the proposed CY 2008 ASC conversion factor, we multiplied the estimated CY 2008 OPPS conversion factor by the result of Step 3. The proposed estimated CY 2008 OPPS conversion factor was $64.013. Multiplying the estimated CY 2008 OPPS conversion factor by the 0.62 budget neutrality adjustment yielded our proposed CY 2008 ASC conversion factor of $39.688.

e. Calculation of the Proposed CY 2008 ASC Payment Rates Under the Revised ASC Payment System in the August 2006 Proposed Rule

Step 5: To determine the proposed national ASC payment rates for covered surgical procedures under the revised payment system (including beneficiary coinsurance), we multiplied the ASC conversion factor from Step 4 by the ASC relative payment weight.

The proposed ASC relative payment weights for covered surgical procedures were based on the relative payment weights for the APC groups established under the OPPS as described in section IV.B. of this final rule. However, as further discussed in section IV.E. of this final rule, the ASC relative payment weights for certain office-based surgical procedures were set so that the national ASC payment rate did not exceed the MPFS unadjusted nonfacility practice expense amount.

f. Calculation of the Proposed CY 2008 ASC Payment Rates Under the Transition in the August 2006 Proposed Rule

Step 6: We proposed to fully implement the revised ASC payment rates through a 2-year transition to 100 percent implementation of the revised ASC payment rates for procedures included on the CY 2007 ASC list of covered surgical procedures. In the first year of the transition, the payment rate would be based on 50 percent of the final CY 2007 ASC payment rate under the existing ASC payment system and 50 percent of the final CY 2008 ASC payment rate calculated under the proposed revised payment methodology. The CY 2008 payment for procedures not on the CY 2007 ASC list of covered surgical procedures, but for which we proposed to make payment

under the revised payment system beginning in CY 2008, would be made at the fully implemented revised ASC payment rates.

2. Alternative Option for Calculating the Proposed Budget Neutrality Adjustment in the August 2006 Proposed Rule

In the August 2006 proposed rule, we presented an alternative approach to calculating the budget neutrality adjustment under the revised ASC payment system, which would take into account the effects of migration of procedures across ASCs, physicians' offices, and HOPDs that might be attributable to the revised ASC payment system (71 FR 49657 through 49658). In the following discussion, the phrase ''new ASC procedure'' refers to a surgical procedure not on the CY 2007 ASC list of covered surgical procedures but for which we proposed to make payment under the revised ASC payment system beginning in CY 2008.

Under this alternative, we assumed that 25 percent of the HOPD utilization for new ASC procedures would migrate to ASCs, and we also assumed that 15 percent of the physician's office utilization for new ASC procedures would migrate to ASCs in the first year of the revised ASC payment system. In the August 2006 proposed rule, we also noted our belief that our assumptions of 25 percent and 15 percent migration from HOPDs and physicians' offices to ASCs, respectively, were reasonable, given the general utilization relationships between those settings for services on the CY 2007 ASC list of covered surgical procedures. Services on the ASC list of covered surgical procedures that are predominantly performed in ASC and HOPD settings are, on average, performed 30 percent of the time in the ASC setting. Furthermore, services on the existing ASC list of covered surgical procedures that are mainly performed in ASC and physician's office settings are, on average, performed 17 percent of the time in the ASC setting. We assumed that new ASC procedures would migrate at slightly lower rates in the first year of the revised ASC payment system, yielding our migration assumptions to ASCs of 25 percent for the HOPD services and 15 percent for the physician's office services.

We also assumed that the net impact of migration of services on the existing CY 2007 ASC list of covered surgical procedures would be negligible. We noted that payment rates for the current highest volume ASC procedures would generally decrease under the proposed revised ASC payment system, and the lower volume ASC procedures would experience significant payment increases. We believed it was reasonable to assume that some of the higher volume services would migrate from ASCs to other settings, and some of the current lower volume procedures would migrate to the ASC setting as a result of the payment changes.

In order to calculate the budget neutrality adjustment under this alternative option in the August 2006 proposed rule, first we estimated expenditures that would occur if we did not revise the ASC payment system. We estimated CY 2008 expenditures if the ASC payment rates were not revised and the ASC list of covered surgical procedures was not expanded, as described below.

a. Estimated Medicare Program Payments (Excluding Beneficiary Coinsurance) Under the Existing ASC Payment System in the August 2006 Proposed Rule

Step 1: Migration from HOPDs to ASCs was valued using estimated CY 2008 OPPS payment rates.

(a) We multiplied the estimated CY 2008 HOPD utilization for each new ASC procedure by 0.25, consistent with our assumption that 25 percent of the HOPD utilization for new ASC procedures would migrate to the ASC.

(b) For each new ASC procedure, we multiplied the results of Step 1(a) by the estimated CY 2008 OPPS payment rate for the procedure, and then subtracted beneficiary coinsurance for the procedure.

(c) We summed the results of Step 1(b) across all new ASC procedures.

Step 2: Migration of procedures from physicians' offices to ASCs was valued using estimated CY 2008 MPFS physician in-office payment rates. ''Physician in-office payment rate'' was equal to the MPFS nonfacility practice expense RVUs multiplied by the estimated CY 2008 MPFS conversion factor.

(a) To estimate the payment associated with our assumption that 15 percent of the physicians' office utilization for new ASC procedures would migrate to the ASC, we multiplied the projected CY 2008 physicians' office utilization for each new ASC procedure by 0.15.

(b) For each new ASC procedure, we multiplied the results of Step 2(a) by the estimated CY 2008 physician in-office payment rate for the procedure, and then subtracted beneficiary coinsurance for the procedure.

(c) We summed the results of Step 2(b) across all new ASC procedures.

Step 3: CY 2007 ASC services valued using the estimated CY 2008 ASC payment rates under the current ASC system.

This is described under Step 1 in the Estimated Payments under the Current ASC Payment System section, specifically section V.C.1.a. above.

Step 4: The results of Steps 1–3 were summed.

b. Estimated Medicare Program Payments (Excluding Beneficiary Coinsurance) Under the Proposed Revised ASC Payment System in the August 2006 Proposed Rule

Step 5: HOPD migration was valued using estimated CY 2008 OPPS payment rates.

This step is the same as Step 1 in section V.C.2.a. above.

Step 6: We identified new ASC procedures that were office-based (as discussed in section III.C. of this final rule).

Step 7: Migration of new ASC office-based procedures from physicians' offices to ASCs was valued based on estimated CY 2008 OPPS payment rates capped at the estimated CY 2008 physician in-office payment rates, if appropriate.

(a) For each new ASC procedure determined to be office-based, we multiplied the results of Step 2(a) from section V.C.2.a. above by the lesser of—

(1) The estimated CY 2008 OPPS payment rate for the procedure; or

(2) The estimated CY 2008 physician in-office payment rate for the procedure, and then subtracted beneficiary coinsurance for the procedure. (As noted in subsequent discussion in section V.C.3. of this final rule, we applied this adjustment for the capped office-based procedures after publication of the proposed rule and posted the results on our Web site.)

(b) The results of Step 7(a) were summed across all new ASC procedures considered to be office-based.

Step 8: Migration of new ASC procedures that were not determined to be office-based from physicians' offices to ASCs was valued using the estimated CY 2008 OPPS rates.

(a) For each new ASC procedure not considered to be office-based, we multiplied the results of Step 2(a) from section V.C.2.a. above by the estimated CY 2008 OPPS rate for the procedure, and then subtracted beneficiary coinsurance for the procedure.

(b) The results of Step 8(a) were summed across all new ASC procedures not considered to be office-based.

Step 9: Migration of new ASC procedures from physicians' offices to ASCs was valued using the estimated CY 2008 MPFS physician out-of-office payment rates. ''Physician out-of-office

payment rate'' was equal to the facility practice expense RVUs multiplied by the estimated CY 2008 MPFS conversion factor.

(a) For each new ASC procedure, we multiplied the results of Step 2(a) from section V.C.2.a. above by the estimated CY 2008 physician out-of-office payment rate for the procedure, and then subtracted beneficiary coinsurance for the procedure.

(b) The results of Step 9(a) were summed across all new ASC procedures.

Step 10: Current ASC services were valued using the estimated CY 2008 OPPS payment rates.

This is described under Step 2 in section V.C.1.b. above.

Step 11: The results of Steps 5 and 7–10 were summed.

c. Calculation of the Proposed CY 2008 Budget Neutrality Adjustment in the August 2006 Proposed Rule

Step 12: The result of Step 4 was divided by the result of Step 11.

Step 13: The calculation of the budget neutrality adjustment in Step 12 was calibrated in a number of ways. The application of the cap at the estimated CY 2008 MPFS nonfacility practice expense amount that occurred in Step 7 was dependent on the ASC conversion factor. The ASC budget neutrality adjustment resulting from Step 12 was calibrated to take into account the effects of the physician's office payment cap on the ASC conversion factor. The ASC budget neutrality calculation was also calibrated to take into account the fact that the additional physician out-of-office payments under the revised ASC payment system calculated in Step 9 must be fully offset by the budget neutrality adjustment to ASC services under the revised payment system. Furthermore, the budget neutrality calculation was calibrated to take into account the CY 2008 transitional payment rates for procedures on the CY 2007 ASC list of covered surgical procedures.

As reported in the August 2006 proposed rule (71 FR 49658), the budget neutrality adjustment calculated using this alternative option that incorporated CMS' migration assumptions was 0.62, indicating that under the migration assumptions described above there was no difference, rounded to the nearest hundredth, between our proposed budget neutrality adjustment without migration (0.62) and the alternative budget neutrality adjustment with migration (0.62).

d. Discussion of the Alternative Calculation of the Budget Neutrality Adjustment

We chose to propose calculation of the budget neutrality adjustment based on the CY 2007 final ASC list of covered surgical procedures and the most recent available ASC utilization data because we believed this was the most appropriate approach to estimating expenditures to result in a budget neutral payment system in CY 2008. We believed that the data available to us did not enable us to precisely estimate the net potential migration of services between the ASC, outpatient hospital, and physician's office settings that might result from implementation of the revised ASC payment system. Moreover, basing our estimate of expenditures on current ASC utilization without including migration from other sites of service was consistent with how we estimate expenditures for purposes of establishing budget neutrality in other Medicare payment systems. However, we recognized, that significant service migration would not generally be expected to occur under these other payment systems and acknowledged that the potential for migration could be significantly greater under the revised ASC payment system, with a possible effect on Medicare expenditures. Our recognition of the uniqueness of the revised ASC payment system was the reason we presented the alternative with-migration budget neutrality adjustment calculation in the August 2006 proposed rule, so commenters would have the opportunity to fully examine this model, in addition to the traditional without-migration methodology that we proposed to use.

Given that the revised ASC payment system includes a significant expansion of procedures for which ASC payment would be allowed, in addition to the expected service mix changes that result from the changes in payment incentives that accompany the introduction of any revised payment system, we expected that some commenters might believe that it would be more appropriate to estimate the ASC budget neutrality adjustment taking into account the potential migration of services between the ASC, hospital outpatient, and physician's office settings, consistent with the alternative with-migration model discussed in the August 2006 proposed rule. In that proposed rule, we explained that we would welcome data supporting the use of specific migration assumptions in the calculation of the ASC budget neutrality adjustment. We described the budget neutrality calculation under the alternative approach based on our best estimate of the potential migration of services between the different settings, hoping to facilitate and stimulate comment on migration that could occur and specifically to encourage the submission of pertinent quantitative evidence of service migration resulting from changes in payment rates. We welcomed data on all of the migration assumptions presented in the proposed rule discussion of the alternative approach. We noted that there was no difference between our proposed budget neutrality calculation without migration (0.62) and the alternative budget neutrality adjustment with migration (0.62), when rounded to the nearest hundredth.

Comment: Many commenters recommended different interpretations of section 626(b) of Public Law 108–173. The commenters believed that CMS' interpretation of the law's requirement that CMS ensure the budget neutrality of the revised system was overly restrictive and that consequently, the proposed budget neutrality factor was not adequate to make fair ASC payments. According to the commenters' interpretations of the law, they believed that CMS has the clear legal authority to make assumptions regarding the migration of procedures between different sites of service, and that expenditures for all services covered by the ASC payment system, including beneficiary coinsurance, should be considered in the calculation of budget neutrality. Most of the commenters recommended that CMS include projected case migration across ASC, HOPD, and physician's office settings in its budget neutrality model and use total expenditures across all Medicare Part B sites of service, rather than limit the base solely to estimated CY 2008 aggregate expenditures under the ASC payment system. Several commenters supported the use of the alternative option for calculating budget neutrality that incorporated the case migration assumptions as they were presented in the August 2006 proposed rule, with the stipulation that several technical corrections to fully account for the Medicare expenditures for all procedures that were assumed to migrate to the ASC would be made and that the resulting conversion factor would be 64.6 percent. Most other commenters believed that case migration would certainly be one result of implementation of the revised ASC payment system, and that CMS' budget neutrality adjustment model should include recognition of those changes in sites of service and the related Medicare expenditures. They recommended that

CMS use a model like the alternative option for calculating budget neutrality presented in the August 2006 proposed rule and discussed above in this final rule, but that the specific assumptions CMS used should be revised as indicated in their comments.

Response: As discussed in the August 2006 proposed rule, we were interested in comments from the public about our interpretation of budget neutrality and our proposed methodology for developing the budget neutrality adjustment factor for the revised ASC payment system. We will fully address each of the specific technical corrections (for example, that we account for differences in beneficiary coinsurance amounts in HOPD and ASC settings) and migration assumption modifications that were recommended by commenters in section V.C.3. of this final rule. At the more general level, we noted the strong preference among commenters for CMS to use the alternative, with-migration methodology that would take into account the effects of assumed migration of cases across ambulatory sites of service that could result from the payment changes associated with the revised ASC payment system. The August 2006 proposal reflected our belief that adoption of the without-migration model was more appropriate than the alternative with-migration model that was also discussed. In the proposal, we explained that basing our estimate of expenditures on current utilization without including migration from other sites of services was consistent with how we estimate expenditures for purposes of maintaining budget neutrality in other Medicare payment systems. We realized that the influx of newly covered procedures was unique to our proposal for the revised ASC payment system, but because the budget neutrality adjustment that resulted from both models in the August 2006 proposed rule was the same and data to determine estimates of potential case migration were limited, we adopted the without-migration model in our proposal, consistent with our previous modeling to ensure that our payment systems are budget neutral.

We agree with commenters that the flexibility to include migration assumptions in our calculation of budget neutrality for the revised ASC payment system is provided by the statute. Furthermore, our review of the extensive comments on the August 2006 proposed rule led to our conclusion in this final rule that the significant expansion of ASC covered surgical procedures proposed as part of the revised system is not only a unique aspect of the revised ASC payment system, but that its effects on ASC expenditures may be substantial. An influx of new covered services has not been a factor in developing the budget neutrality adjustment factors for our other prospective payment systems. The scope of services in other payment systems does not change significantly from one year to the next, as does the ASC scope of services between CYs 2007 and 2008 in the context of our final policies for the revised ASC payment system, as discussed in sections III. and IV. of this final rule.

In view of our belief that the revised ASC payment system is unique because of the significant expansion of covered surgical procedures and covered ancillary services to be paid under the revised ASC payment system, we conclude that including estimates of case migration of the new procedures, as well as the existing ASC covered surgical procedures, is the most accurate method for developing the budget neutrality adjustment in this case. After reviewing all of the public comments and reexamining the available data, we believe that there is sufficient evidence to indicate that adoption of a with-migration methodology for calculating the budget neutrality adjustment for the revised ASC payment system is appropriate. Thus, we have determined that it would be prudent, and more accurate, to adopt a with-migration budget neutrality estimation methodology, in order to take into account the effects of the migration of procedures between ASCs, physicians' offices, and HOPDs that might be attributable to the revised ASC payment system. While the budget neutrality estimation methodology that takes into account migration increases the complexity associated with establishing the budget neutrality adjustment, we believe that its application provides us with the most reasonable approach to establishing payment rates under the revised ASC payment system in order to assist in ensuring continued access to current ASC procedures and expanded access to new surgical procedures for Medicare beneficiaries in ASCs.

Although we are convinced that the with-migration model is more appropriate for calculating the final budget neutrality adjustment factor for the revised ASC payment system, we calculated the budget neutrality adjustment for this final rule using both with-migration and without-migration models, as we had for the August 2006 proposed rule. However, in contrast to the results of our work for that proposed rule, where application of either model resulted in the same adjustment factor, the budget neutrality factors that resulted from application of the two methods for this final rule were different. The adjustment factor that resulted from application of our proposed model that did not consider migration was 0.64, while the with-migration model resulted in a 0.67 budget neutrality adjustment factor. For a full discussion of the calculation of the final budget neutrality adjustment factor, we refer readers to section V.C.3. of this final rule.

Comment: Several commenters agreed with the use of a blended rate for CY 2008 to calculate budget neutrality for the revised ASC payment system, based on the proposal for a 2-year transition to the fully implemented revised payment system. They believed this use of discretion was an appropriate interpretation of the legislation and produced the most reasonable result. They believed that, because the proposed CY 2008 rates were a 50/50 blend of the CY 2007 ASC rate and the estimated CY 2008 ASC rate calculated according to the methodology of the proposed revised ASC payment system, the ASC payment system would have increased expenditures in CY 2009 unless migration patterns differed from the assumptions discussed in the proposed rule regarding the alternative calculation of the budget neutrality adjustment. These commenters concluded that the increased expenditures that would result from our adoption of their recommendation to utilize a modification of the alternative calculation of the proposed budget neutrality adjustment were expected, appropriate, and consistent with the budget neutrality provision of section 626(b) of Public Law 108–173 for the revised ASC payment system.

Response: We agree with commenters that the migration assumptions influence the relationship between estimated expenditures under the current ASC system and the revised ASC payment system over time. As noted elsewhere in sections IV.J. and V.C.4 of this final rule, we have extended the transition period for payment of services on the CY 2007 ASC list of covered surgical procedures and have also modified our migration assumptions to reflect migration over a more extended time period than was reflected in our discussion of the alternative option for calculating the budget neutrality adjustment in the August 2006 proposed rule. As described in section X. of this final rule, we estimate that, over time, the expenditures under the revised ASC system using our final migration assumptions would be slightly less than

the expenditures that would occur if we did not revise the system.

3. Calculation of the Estimated CY 2008 Budget Neutrality Adjustment According to the Final Policy

In the August 2006 proposed rule, and as discussed earlier in this section of the final rule, we described two methodologies for determining the budget neutrality adjustment under the revised ASC payment system that could then be used to establish the ASC conversion factor for CY 2008 (71 FR 49656 through 49658). We proposed that, under the standard methodology of the revised ASC payment system, the ASC conversion factor would be multiplied by the ASC payment weight for each covered surgical procedure to determine the procedure's CY 2008 ASC payment rate. As discussed in detail in section IV.C. of this final rule, our final policy will also provide separate payment for covered ancillary services under the revised ASC payment system. While the payment rates for separately payable drugs and biologicals, brachytherapy sources, corneal tissue acquisition, and implantable devices with OPPS pass-through status that are covered ancillary services, along with the device portion of ASC payment for device-intensive covered surgical procedures, will be determined without application of the ASC conversion factor, the final standard methodology of the revised ASC payment system will apply the ASC conversion factor to ASC payment weights to calculate the fully implemented payment rates for covered surgical procedures and covered ancillary radiology services. We received a number of general and specific comments on our proposal for calculating the CY 2008 ASC payment rates under the revised ASC payment system.

Comment: There was general agreement among the commenters that, in the absence of cost data for surgical procedures performed in ASCs, CMS' proposal to base the revised ASC payment system on the OPPS APC groups and their relative payment weights was sound policy that could reasonably be expected to result in accurate ASC payments for most procedures. Further, the commenters generally agreed that ASC facility costs are lower than the HOPD costs for providing the same surgical services. The commenters gave specific examples of the reasons why higher costs are incurred by hospitals, including the requirement that HOPDs satisfy quality and safety standards that are not applied to ASCs; the fact that hospitals' resources are available 24 hours a day, 7 days a week; Emergency Medical Treatment and Labor Act of 1986-related (EMTALA-related) requirements; treatment of a more acutely ill population with greater comorbidities; and higher uncompensated care rates. Moreover, those commenters cited MedPAC's findings reported in 2003 and 2004 that hospitals probably incur higher costs than ASCs for providing similar procedures, because HOPDs are subject to additional regulatory requirements which are likely to increase their overhead costs, and HOPDs also treat patients who are more medically complex.

Beyond these points, the commenters diverged on their opinions about the accuracy and appropriateness of the proposed conversion factor, as discussed in detail below.

Response: We appreciate the commenters' general support of our proposal to base payment under the revised ASC payment system on the OPPS relative payment weights and the APC groups. These comments were consistent with the recommendation of the GAO (GAO–07–86) that CMS should implement a payment system for procedures performed in ASCs based on the OPPS, taking into account the lower relative costs of procedures performed in ASCs compared to HOPDs. For further discussion of this subject, as well as a summary of additional public comments and our responses, we refer readers to section IV.B. of this final rule.

Comment: Several commenters specifically recommended that CMS adopt 75 percent as the multiplier to the OPPS conversion factor, so that payment rates under the revised ASC payment system would be 75 percent of the OPPS rates. They cited legislation that was introduced in the U.S. Senate in 2003 in which payments to ASCs were to have been provided at 75 percent of the OPPS rates. The proponents of that proposed legislation believed that, by using a 75 percent factor to reduce OPPS rates in order to provide payment for ASCs to perform procedures, Medicare would save 25 cents for every dollar spent for procedures performed in the ASC setting instead of the HOPD.

Several commenters also believed that, because ASC rates have been frozen since 2003 while OPPS rates have been increased annually for inflation, an unfair differential in payments between the two payment systems has grown over the past several years. These commenters argued that by calculating budget neutrality for the revised ASC payment system using the static ASC rates in comparison with annually updated OPPS rates, CMS proposed an inappropriately low budget neutrality adjustment factor. They were convinced that, if CMS had implemented the revised ASC payment system immediately after Congress passed Public Law 108–173 in 2003, before the differential between the payment rates for the two systems increased due to the continued freeze on ASC rates, the budget neutrality adjustment for the revised payment system would have been close to 85 percent, rather than 62 percent as CMS proposed for the revised payment system to be implemented in CY 2008. Other commenters, noting that Congress gave CMS the authority to implement the revised payment system between CY 2006 and CY 2008, expressed their belief that, had CMS implemented the revised ASC payment system in an earlier year, the budget neutrality adjustment would have been at least 8 percent higher than the 62 percent that was proposed.

Response: We see no rationale for estimating the budget neutrality adjustment by comparing existing ASC payment system rates with OPPS rates from an earlier calendar year, prior to implementation of the revised ASC payment system. Congress provided CMS with the latitude to implement the revised ASC payment system beginning on or after January 1, 2006, and not later than January 1, 2008. We believe that the statute provides direction that the revised ASC payment system is to be budget neutral in its design in order to result in the same aggregate expenditures for services as would be made if the provisions of the revised ASC payment system did not apply, that the ASC conversion factor is not to be updated before CY 2010, and that implementation of the revised system by January 1, 2008 is timely. There is no evidence that Congress intended for CMS to attempt to maintain the relationship between OPPS payment rates and ASC payments that existed at the time of enactment of Public Law 108–173 (CY 2003) in the development of the revised ASC payment system. We also see no rationale for adopting an arbitrary multiplier, such as 75 percent of OPPS payment rates, that is not founded on explicit consideration of budget neutrality as required by the statute.

We received many public comments in response to our proposed budget neutrality adjustment factor. A number of commenters included seven specific recommendations, three of which were related to the migration assumptions discussed as an alternative option for calculating the budget neutrality adjustment in the proposed rule. The

other four were technical in nature and related to our proposed budget neutrality model. A summary of the comments and our responses follow, beginning with the four recommended technical modifications to our proposed methodology, followed by the three migration assumption recommendations.

Comment: One of the recommended technical modifications was that, instead of basing ASC payments on CY 2007 rates for all procedures on the CY 2007 ASC list of covered surgical procedures, CMS should use the payment amounts that would be made in CY 2008 in the absence of the revised payment system for those ASC procedures whose payments are capped in CY 2007 due to section 5103 of Public Law 109–171. The commenters believed that using the lower CY 2007 rates for ASC procedures capped by section 5103 of Public Law 109–171 was an unfair representation of estimated ASC payments under the existing payment system in CY 2008. Their rationale was that, if the revised ASC system were not implemented in CY 2008, the payments for those services under the policy of the existing ASC payment system would increase in CY 2008, consistent with the overall projected increase in OPPS rates of 4 percent. The commenters expected that incorporation of this adjustment would result in a 0.11 percentage point increase to the budget neutrality adjustment.

Response: We do not agree that the ASC rates for these specific services would necessarily increase consistent with an overall increase in OPPS rates for CY 2008. Through the annual update of the OPPS, while the aggregate spending is generally projected to increase in the update, the specific payments for individual services may rise or fall from year to year based on a variety of factors, including APC recalibration. Because the ASC procedures that are capped at the OPPS rates in CY 2007 are a small subset of all OPPS services, we are unable to project that their rates would be subject to a 4 percent increase, or indeed any increase, as suggested by the commenters. In addition, we believe that Congress intended for the revised ASC payment system rates and budget neutrality to be related to the estimated aggregate expenditures for ASC services based on ASC payment rates from the year prior to implementation of the revised system. Congress mandated that the revised ASC system be budget neutral and be implemented by CY 2008. It also set ASC updates to zero percent for the calendar years through 2009. We believe all of those actions, in combination, provide clear indication that Congress did not intend for estimates of aggregate expenditures under the existing ASC payment system to take into account updated ASC payment rates for CY 2008. The limitations on ASC payments prior to implementation of the revised ASC payment system, specifically both section 626 of Public Law 108–173 that specifies that ASC rates would not be updated before CY 2010 and, further, the limit on ASC payment at the lesser of the OPPS or ASC rate, as required in section 5103 of Public Law 109–171 that extends until implementation of the revised ASC payment system, provide clear evidence that the CY 2007 ASC rates for covered procedures are to be used in developing the budget neutrality adjustment for the revised payment system. We continue to believe, for the purposes of this final rule, that the most appropriate course for calculation of the budget neutrality adjustment, consistent with our proposal, is to estimate that the CY 2008 rates for the ASC procedures subject to the cap set forth in section 5103 of Public Law 109–171 in CY 2007 will be the same as their CY 2007 rates.

Comment: Some commenters stated that, in CMS' calculation of estimated ASC payments under the existing ASC payment system for comparison to payments under the proposed methodology for the revised ASC payment system, CMS did not include payments for the costs of implantable prosthetic devices that are currently separately paid to ASCs under the DMEPOS fee schedule. The commenters recommended that CMS include the amount paid to ASCs to cover the costs of separately payable implantable prosthetics and DME under the DMEPOS fee schedule to avoid understating Medicare's current full cost related to the surgical implantation procedures. The commenters believed that inclusion of those payments would increase the budget neutrality adjustment by 0.41 percentage points.

Response: We agree with the commenters that the payments to ASCs for the implantable prosthetic devices and DME should be included in estimating total ASC payments for CY 2008 under the policies of the existing ASC payment system. In fact, we did include those payments in our proposed budget neutrality adjustment calculation, but we failed to explicitly state that in our explanation in the August 2006 proposed rule. Therefore, the effect of including those payments was reflected in the budget neutrality adjustment that we proposed. We have also included these payments in our calculation of the budget neutrality adjustment for this final rule.

Comment: Several commenters believed that, although CMS accounted for the 20 percent beneficiary coinsurance in ASCs by discounting by 20 percent all of the payment rates used to estimate the CY 2008 payments under the existing ASC system and under the proposed methodology of the revised ASC payment system, CMS did not appropriately account for beneficiary coinsurance associated with the new ASC office-based procedures for which payment was proposed to be limited to the MPFS unadjusted nonfacility practice expense amount. They believed that CMS should apply the 20 percent discount to those procedures because that approach would more accurately and consistently reflect the Medicare program costs, and they concluded that this change would increase the budget neutrality adjustment by 0.43 percentage points.

Response: While we did not apply this discount to payment rates for the capped office-based procedures newly proposed for ASC payment in CY 2008 in our calculation of the proposed budget neutrality adjustment, we agree with this recommendation. Recognizing those lower costs to the Medicare program, consistent with our calculation of program costs under the existing ASC payment system and the standard methodology of the revised ASC payment system, would be more accurate. Soon after publication of the August 2006 proposed rule, we discovered this oversight, made the appropriate adjustments to the data, and posted the revised data on our Web site (*http://www.cms.hhs.gov/ASCPayment*).

Comment: Commenters noted that CMS did not account for the variable copayment amounts associated with procedures under the OPPS for purposes of establishing the budget neutrality adjustment under the revised ASC payment system. The beneficiary copayment under the OPPS varies from 20 to 40 percent of the payment rate, depending on the procedure, whereas the coinsurance under the ASC payment system is 20 percent for all procedures. The commenters believed that as a result of not considering the sometimes much higher copayments under the OPPS, CMS artificially inflated Medicare's estimated payments under the proposed methodology of the revised ASC payment system. They believed that accurately accounting for the OPPS copayments would increase the budget neutrality adjustment by 1.04 percentage points.

Response: We agree with the commenters regarding this

recommendation. We did not apply the variable OPPS copayment amounts in the model that was proposed. However, soon after publication of the August 2006 proposed rule, we discovered this oversight, made the appropriate adjustments to the data, and posted the revised data on our Web site (*http://www.cms.hhs.gov/ASCPayment*).

After considering the first four technical recommendations of many commenters and making the two technical adjustments as described above, the resulting increase in the proposed budget neutrality adjustment was approximately 2.6 percentage points. We have applied these same two technical adjustments in our calculation of the budget neutrality adjustment for this final rule. In addition, we made another technical change in this final rule by taking the multiple procedure discount into account in our estimates of ASC, OPPS, and MPFS expenditures both before and after implementation of the revised ASC payment system. We factored the multiple procedure discount into our estimates of ASC, OPPS, and MPFS spending under the existing and revised ASC payment systems. We assumed that the pattern of multiple surgical procedures furnished in ASCs and physicians' offices would be similar to the pattern in HOPDs. Based on claims data indicating the prevalence of multiple procedures in HOPDs, we estimated the percentage of discounted units to total units for each procedure and then reduced the volume for those procedures prior to estimating expenditures in each year. We incorporated this reduction into our estimates of Medicare expenditures under the ASC, OPPS, and MPFS payment systems both before and after implementation of the revised ASC payment system. We had not factored the multiple procedure discount into the August 2006 proposed rule estimates.

The final three recommendations by commenters that were related to the migration assumptions used in the alternative option for calculating the budget neutrality adjustment presented in the August 2006 proposed rule are discussed below.

Comment: Many commenters believed that the alternative method for calculating the budget neutrality adjustment that CMS discussed in the August 2006 proposed rule described a preferable and superior method for developing the budget neutrality adjustment for the revised ASC payment system. They believed that developing and applying some assumptions to account for the migration of services and their payment across Medicare Part B sites of care would be the most appropriate method for ensuring budget neutrality. However, they recommended that CMS revise some of the assumptions regarding migration that were described in that proposed rule.

The first of their recommendations in this regard was that CMS use a much lower migration assumption of 2 percent for new ASC procedures migrating from physicians' offices to ASCs. They were convinced that CMS' assumption in the proposed rule that 15 percent of the current office utilization of new ASC procedures would migrate to ASCs was far greater than would be possible. They stated that ASCs do not have the capacity to absorb that level of services. Furthermore, they explained that ASCs have found that, once physicians acquire the equipment and resources to provide a procedure in their offices, they prefer to perform it there. The commenters believed that physicians only typically perform procedures in an ASC or HOPD setting when there is a particular patient need that requires the facility setting. They argued that by allowing the new ASC procedures to receive payment in ASCs, CMS would realize savings because cases could be moved from the office to an ASC instead of to the more costly HOPD setting when the physician determines that relocation of the service is preferable for a particular beneficiary.

Furthermore, the commenters stated that ASCs would not only be overwhelmed by the volume of cases CMS assumed would migrate to that setting, but that ASCs would not welcome the influx of low paying, minor procedures that could generally be performed in physicians' offices over the more complex, higher paying procedures that ASCs are accustomed to providing in the more efficient and intensive facility setting. The commenters believed that adjusting the assumption for migration of new ASC procedures from physicians' offices to ASCs to 2 percent of the cases would be more appropriate and would result in a 3.11 percentage point increase in the budget neutrality adjustment.

In addition, the commenters believed that CMS did not accurately adjust for the likely negative migration of cases involving procedures paid under the existing ASC payment system out of ASCs and into more costly HOPDs under the proposal for the revised payment system. They developed a model that they believed would more correctly predict the migration of procedures out of ASCs and into HOPDs based on the magnitude of the procedure's proposed payment rate decrease. In that model, the commenters assumed that for every 10 percent decrease in a procedure's ASC payment rate from the existing to the revised payment system, 1.5 percent of the ASC volume would migrate to HOPDs. They believed that CMS' application of this adjustment would result in a 0.51 percentage point decrease to the budget neutrality adjustment.

They also recommended that CMS account for the positive migration of existing ASC covered procedures from HOPDs to ASCs by assuming that for every 10 percent increase in a procedure's ASC payment rate under the proposal for the revised ASC payment system, 1.5 percent of the HOPD volume would migrate to ASCs, up to a maximum of 25 percent of the procedure's current HOPD volume. Furthermore, commenters suggested that ASC capacity would limit movement of these procedures to no more than 25 percent of each procedure's existing ASC volume. The commenters believed that, although ASCs have significant excess capacity, as confirmed by a CY 2006 industry study that showed that only about one quarter of ASCs were operating above 60 percent operating room capacity, they could not absorb more than 25 percent of the HOPD volume for all ASC procedures for which payment was expected to increase under the proposed revised payment system. They explained that application of their assumption would result in a 5.57 percentage point increase in the budget neutrality adjustment.

Response: We appreciate the extensive comments we received regarding the appropriate migration assumptions to be applied in determining the budget neutrality adjustment for the revised ASC payment system. While commenters provided a number of suggestions regarding migration assumptions for both the procedures on the CY 2007 ASC list of covered surgical procedures and new ASC procedures, they did not provide data supporting all of the specific assumptions regarding the relationship between expected service migration and changes in payment rates that they recommended we adopt along with their other migration assumptions. However, as stated above, we are adopting a with-migration model for calculation of the final budget neutrality adjustment factor because we believe that it is more accurate than the without-migration model that we proposed that does not consider the migration of new procedures across sites of service, but we did not adopt the assumptions recommended by some commenters.

The CMS Office of the Actuary (OACT) developed the assumptions utilized in the final budget neutrality model. With respect to current ASC covered surgical procedures paid under the existing ASC payment system, we did not accept the recommendation by commenters that we should assume that negative migration, that is, movement of existing ASC covered procedures out of ASCs and into the higher cost HOPD setting, would have an effect on our budget neutrality adjustment that is not equal to the effect of positive migration of cases from other settings into ASCs. Rather, in this final rule, after reviewing information provided by commenters and reevaluating current site-of-service utilization patterns for exiting and new ASC procedures, we are assuming that the effect on budget neutrality due to movement of cases involving existing ASC procedures out of ASCs will be balanced by movement of additional cases involving existing ASC procedures into ASCs. We believe that it is reasonable to assume that the payment increases for many currently low volume ASC procedures will result in higher ASC volumes for those procedures under the revised ASC payment system. Moreover, we believe that this anticipated positive migration of those procedures will balance the estimated negative migration of the high volume ASC procedures for which payment will decrease. Our actuaries project that the net budgetary effect of migration into and out of ASCs for procedures currently on the ASC list of covered surgical procedures will be negligible.

Consistent with our assumption for the alternative budget neutrality adjustment model discussed in the August 2006 proposed rule, under the final methodology for the revised ASC payment system, we assume that 25 percent of the current HOPD volume of new ASC procedures would ultimately migrate from HOPDs to ASCs. However, taking into consideration the final, longer 4-year transition period to the fully implemented payment weights of the revised ASC payment system and the final modifications to several aspects of the proposed payment policy as discussed in this preamble, for this final rule, we assume that the 25 percent case migration would occur more gradually, over the first 2 years of the transition, instead of all in the first year. We believe the migration would occur over the first 2 years of the 4-year transition, as the ASC industry adapts to the revised ASC payment system and the significant expansion of covered surgical procedures described in this final rule. We agree with commenters that the level of migration in a single year, as discussed in our presentation of the with-migration budget neutrality adjustment model in the August 2006 proposed rule, would be difficult for ASCs to accommodate in a single year, but we believe, based on current ASC and HOPD utilization and ASC industry information, that the 25 percent case migration over 2 years is most likely.

We believe that our assumption of 25 percent migration of current HOPD volume for new ASC procedures is reasonable, given the general utilization relationships between ASCs and HOPDs for services as discussed in section V.C.2. above. We also note that commenters generally did not disagree with our proposed HOPD migration assumption for the new ASC procedures. As discussed in the August 2006 proposed rule (71 FR 49657), services on the ASC list of covered surgical procedures that are predominantly performed in ASC and HOPD settings are, on average, performed 30 percent of the time in the ASC setting. Thus, for calculation of the budget neutrality adjustment according to the final policy of this final rule, we assume that new ASC procedures would migrate at the slightly slower rate of 25 percent over the first 2 years of the 4-year transition, reflecting their movement toward the general 30-percent site-of-service utilization pattern currently observed for ASC covered surgical procedures as ASCs transition to the revised ASC payment system.

Our assumed 25 percent migration of new ASC procedures from HOPDs to ASCs differs considerably from the commenters' recommended positive migration assumptions, because the commenters' model included all current ASC procedures and applied a formula linking the magnitude of ASC payment changes under the revised ASC payment system to the expected volume of migration. Given that the commenters based their estimate for this assumption on existing ASC procedures, they used 25 percent of current HOPD volume as the upper limit for migration from HOPDs to ASCs, the same assumption we used for the migration of new ASC procedures in CY 2008. However, because they believed that ASC capacity would ultimately limit procedure movement, they also limited the movement to 25 percent of the existing ASC volume for those procedures. Our actuaries determined migration assumptions separately for existing ASC covered procedures and new ASC procedures. As mentioned earlier, the net effect of migration of existing procedures into and out of ASCs is assumed to be negligible. For the new ASC procedures, it is assumed that 25 percent of the current HOPD volume will migrate to ASCs during the first 2 years of the revised ASC payment system.

The commenters assumed some negative migration of existing ASC covered procedures from ASCs to HOPDs in response to price changes under the revised ASC payment system, based on a relationship between a procedure's decrease in ASC payment and its volume of migration. However, as discussed above, we also believe that we have adequately accounted for the expected migration of procedures currently covered in ASCs from the ASC to the HOPD setting under the revised ASC payment system.

Finally, the commenters' recommendation that we assume much less migration from physicians' offices to ASCs for new ASC procedures due to ASC capacity limitations led us to reconsider our earlier assumption articulated in the August 2006 proposed rule for the alternative model to calculate the budget neutrality adjustment. Thus, for this final rule, although the actuaries' assumption is that 15 percent of the physicians' office volume of new ASC procedures may eventually be expected to move into ASCs, they did take into consideration the commenters' argument that such a level of migration could not be fully accommodated by ASCs in CY 2008. Therefore, in our final policy we assume that the migration of these currently office-based cases would occur more gradually, with an additional one quarter of the total migration occurring in each year of the full 4-year transition period. Thus, we expect that only 3.75 percent of the office utilization of new ASC procedures would migrate to ASCs in CY 2008, followed by an additional quarter of new cases in each subsequent year, reaching the full 15 percent by the end of the transition period to the fully implemented revised ASC payment rates. Given the current 17 percent ASC utilization of procedures that are predominantly performed in physicians' offices and ASCs that are on the existing ASC list of covered surgical procedures, we see no reason to assume that only 2 percent of the current office volume for new ASC procedures would migrate to ASCs, as suggested by some commenters. Instead, we believe the eventual utilization data for those procedures would most likely resemble the site-of-service utilization for procedures predominantly performed in ASC and physician's office settings that are currently paid in ASCs. Our

assumption of 15 percent is slightly lower than the current pattern of 17 percent ASC utilization, consistent with our expectation that migration of the broad array of new ASC procedures would result in slightly lower ASC utilization in 4 years than the currently observed pattern for procedures on the CY 2007 ASC list of covered surgical procedures that are predominantly performed in physicians' offices and ASCs.

In addition, in the context of developing the budget neutrality adjustment for the revised ASC payment system under the with-migration model, the actuaries took into consideration the final payment policies of the revised ASC payment system. These include the final changes to the payment rate calculations for device-intensive procedures, as well as the separate payment for covered ancillary services. While specific current and projected ASC utilization of covered ancillary services is difficult to estimate, in establishing the final budget neutrality adjustment, the actuaries took into account the findings of the GAO that payment for many of these ancillary services is currently provided to other Medicare Part B suppliers under the existing ASC payment system, and that most drugs and biologicals utilized with current ASC procedures do not receive separate payment under the OPPS.

In summary, since our discussion of the alternative model for calculating the budget neutrality adjustment presented in the August 2006 proposed rule for the revised ASC payment system, the actuaries have continued to refine the assumptions and estimates related to the with-migration budget neutrality model to take into account policy decisions made in this final rule, additional research, information from industry experts, and public comments. Application of our final revised migration assumptions, along with changes to the OPPS rates, MPFS rates, and updated utilization data, as well as the final payment policies for the revised ASC payment system, taken together result in an estimated budget neutrality adjustment of 0.67. The estimated budget neutrality adjustment of 0.67 in this July 2007 final rule for the revised ASC payment system is based on the CY 2007 OPPS relative payment weights, with an estimated update factor for CY 2008, the CY 2007 MPFS PE RVUs trended forward to CY 2008, and CY 2005 utilization data projected forward to CY 2008. It is important to note that the budget neutrality estimate in this final rule is illustrative only. The CY 2008 ASC budget neutrality adjustment will be proposed in the CY 2008 OPPS/ASC proposed rule based on the methodology for calculating budget neutrality established in this final rule and incorporating the proposed CY 2008 OPPS relative payment weights, the proposed CY 2008 MPFS PE RVUs, and CY 2006 utilization information projected forward to CY 2008. The final CY 2008 ASC budget neutrality adjustment will be established in the CY 2008 OPPS/ASC final rule with comment period. The final CY 2008 ASC budget neutrality factor will be calculated in that rule in accord with the methodology for calculating budget neutrality established in this July 2007 final rule and based on the final CY 2008 OPPS relative payment weights, the final CY 2008 MPFS PE RVUs, and updated CY 2006 utilization data projected forward to CY 2008.

4. Final Calculation of the Estimated ASC Payment Rates for CY 2008

The following is a step-by-step illustration of the final budget neutrality adjustment calculation.

a. Estimated CY 2008 Medicare Program Payments (Excluding Beneficiary Coinsurance) Under the Existing ASC Payment System

Step 1: Migration from HOPDs to ASCs is valued using estimated CY 2008 OPPS payment rates.

(a) We multiply the estimated CY 2008 HOPD utilization for each new ASC procedure by 0.125, consistent with our assumption that 25 percent of the HOPD utilization for new ASC procedures will migrate to the ASC over the first 2 years of the revised ASC payment system, only half of which would be in CY 2008. In estimating HOPD utilization for CY 2008, we take into account the impact of the multiple procedure discount (as discussed in more detail in section V.C.3. of this final rule).

(b) For each new ASC procedure, we multiply the results of Step 1(a) by the estimated CY 2008 OPPS payment rate for the procedure, and then subtract beneficiary coinsurance for the procedure.

(c) We sum the results of Step 1(b) across all new ASC procedures.

Step 2: Migration of procedures from physicians' offices to ASCs is valued using estimated CY 2008 physician in-office payment rates. ''Physician in-office payment rate'' is equal to the MPFS nonfacility practice expense RVUs multiplied by the estimated CY 2008 MPFS conversion factor.

(a) We multiply the estimated physician office utilization for CY 2008 for each new ASC procedure by 0.0375, consistent with our assumption that 15 percent of the physician's office utilization for new ASC procedures will migrate to the ASC over the full 4-year transition period.

(b) For each new ASC procedure, we multiply the results of Step 2(a) by the estimated CY 2008 physician in-office payment rate for the procedure, and then subtract beneficiary coinsurance for the procedure.

(c) We sum the results of Step 2(b) across all new ASC procedures.

Step 3: CY 2007 ASC services are valued using the estimated CY 2008 ASC payment rates under the current ASC system.

To estimate the aggregate expenditures that would be made in CY 2008 under the existing ASC payment system:

(a) We multiply the estimated CY 2008 ASC utilization for each HCPCS code on the CY 2007 ASC list by the estimated CY 2008 ASC payment rate for the HCPCS code under the existing ASC payment system, and then subtract beneficiary coinsurance for the procedure. The estimated CY 2008 ASC payment rates are based on the CY 2007 ASC payment rates, which were listed in Addendum AA to the CY 2007 OPPS/ASC final rule with comment period and take into account the OPPS cap on payment for ASC services as required by section 5103 of Public Law 109–171 and reflect the zero percent CY 2008 update for ASC services mandated by section 1833(i)(2)(C) of the Act. In estimating ASC utilization for CY 2008, we take into account the impact of the multiple procedure discount (as discussed in section V.C.3. of this final rule).

(b) We estimate the amount the Medicare program would pay in CY 2008 for implantable prosthetic devices and implantable DME for which ASCs currently receive separate payment under the DMEPOS fee schedule.

(c) We sum the results of Steps 3(a) and 3(b) to estimate the aggregate amount of expenditures that would be made in CY 2008 for current covered surgical procedures under the existing ASC payment system.

Step 4: Sum the results of Steps 1–3.

b. Estimated Medicare Program Payments (Excluding Beneficiary Coinsurance) Under the Revised ASC Payment System

Step 5: HOPD migration is valued using estimated CY 2008 OPPS payment rates.

This step is the same as Step 1, above.

Step 6: We identify new ASC procedures that are office-based (as discussed in section III.C. of this final rule).

Step 7: Migration of new ASC office-based procedures from physicians' offices to ASCs is valued based on estimated CY 2008 OPPS payment rates capped at the estimated CY 2008 physician in-office payment rates, if appropriate.

(a) For each new ASC procedure determined to be office-based, we multiply the results of Step 2(a) above by the lesser of—

(1) The estimated CY 2008 OPPS rate for the procedure; or

(2) The estimated CY 2008 physician in-office payment rate for the procedure, and then subtract beneficiary coinsurance for the procedure.

(b) The results of Step 7(a) are summed across all new ASC procedures considered to be office-based.

Step 8: Migration of new ASC procedures not determined to be office-based from physicians' offices to ASCs is valued using the estimated CY 2008 OPPS rates.

(a) For each new ASC procedure not considered to be office-based, we multiply the results of Step 2(a) above by the estimated CY 2008 OPPS rate for the procedure, and then subtract beneficiary coinsurance for the procedure.

(b) The results of Step 8(a) are summed across all new ASC procedures not considered to be office-based.

Step 9: Migration of new ASC procedures from physicians' offices to ASCs is valued using the estimated CY 2008 MPFS physician out-of-office payment rate. ''Physician out-of-office payment rate'' is equal to the facility practice expense RVUs multiplied by the estimated CY 2008 MFPS conversion factor.

(a) For each new ASC procedure, we multiply the results of Step 2(a) from above by the estimated CY 2008 physician out-of-office payment rate for the procedure, and then subtract beneficiary coinsurance for the procedure.

(b) The results of Step 9(a) are summed across all new ASC procedures.

Step 10: Current ASC services are valued using the estimated CY 2008 OPPS payment rates.

To estimate the aggregate amount of expenditures that would be made in CY 2008, we use estimated CY 2008 OPPS payment amounts instead of estimated CY 2008 ASC payment amounts under the current system, and we multiply the estimated CY 2008 ASC volume for each HCPCS code on the CY 2007 ASC list by the estimated CY 2008 OPPS payment rate for the HCPCS code, and then subtract beneficiary coinsurance for the procedure. We sum the results over all services on that ASC list.

Step 11: The results of Steps 5 and 7–10 are summed.

c. Calculation of the Final Estimated CY 2008 Budget Neutrality Adjustment

Step 12: The result of Step 4 is divided by the result of Step 11.

Step 13: The application of the cap at the estimated CY 2008 physician in-office payment rates that occurs in Step 7 is dependent on the ASC conversion factor. The ASC budget neutrality adjustment resulting from Step 12 is calibrated to take into account the interactive nature of the ASC conversion factor and the physician's office payment cap. The ASC budget neutrality calculation is also calibrated to take into account the fact that the additional physician out-of-office payment rates under the revised ASC payment system calculated in Step 9 must be fully offset by the budget neutrality adjustment to ASC services under the revised payment system. Furthermore, the budget neutrality calculation is calibrated to take into account the CY 2008 transitional payment rates for procedures on the CY 2007 ASC list of covered surgical procedures.

d. Calculation of the Final Estimated CY 2008 ASC Payment Rates

As described earlier, the application of the methodology to the data available for this final rule results in an estimated budget neutrality adjustment of 0.67. The CY 2008 budget neutrality adjustment for the revised ASC payment system, based on the methodology outlined above, will be proposed in the CY 2008 OPPS/ASC proposed rule and finalized in the CY 2008 OPPS/ASC final rule with comment period, based on the methodology for calculating budget neutrality established in this July 2007 final rule.

After developing the estimated CY 2008 budget neutrality adjustment of 0.67 according to the policies established in this final rule, in order to determine the estimated CY 2008 ASC conversion factor we multiply the estimated CY 2008 OPPS conversion factor by the budget neutrality adjustment. At this time, our estimate of the CY 2008 OPPS conversion factor is $63.497. Multiplying the estimated CY 2008 OPPS conversion factor by the 0.67 budget neutrality adjustment yields our estimated CY 2008 ASC conversion factor of $42.543 for this final rule. To determine the fully implemented ASC payment rates for this final rule, including beneficiary coinsurance, according to the final payment methodology that applies to covered surgical procedures and covered ancillary radiology services under the revised ASC payment system, we multiply the ASC conversion factor by the ASC relative payment weight for each procedure or service. As further discussed in sections IV.C. and IV.E. of this final rule, the ASC relative payment weights for certain office-based surgical procedures and covered ancillary radiology services are set so that the national unadjusted ASC payment rate does not exceed the MPFS unadjusted nonfacility practice expense amount. In addition, as discussed in section IV.C of this final rule, the ASC relative payment weights for device-intensive covered surgical procedures are set according to a modified payment methodology to ensure the same device payment under the revised ASC payment system as under the OPPS. We then calculate the estimated CY 2008 payment rate for procedures on the CY 2007 ASC list of covered surgical procedures using a blend of 75 percent of the final CY 2007 ASC payment rate and 25 percent of the estimated revised ASC payment rate developed according to methodology of the revised ASC payment system, applying the special transition treatment to device-intensive procedures as discussed in section IV.J. of this final rule. See Addenda AA and BB to this final rule for the illustrative estimated CY 2008 ASC payment weights and payment rates for covered surgical procedures and covered ancillary services that are expected to be paid separately under the CY 2008 revised ASC payment system.

D. Calculation of the ASC Payment Rates for CY 2009 and Future Years

1. Updating the ASC Relative Payment Weights

In the August 2006 proposed rule, we proposed to update the ASC relative payment weights each year using the national OPPS relative payment weights for that calendar year, as well as the practice expense payment amounts under the MPFS schedule for that calendar year because some covered office-based surgical procedures and covered ancillary services will be paid according to MPFS amounts if those are less than the rates calculated under the standard methodology of the revised ASC payment system. We further proposed to uniformly scale the ASC relative payment weights for each update year so that estimated aggregate expenditures using updated ASC relative payment weights would be the same as estimated aggregate expenditures using the current year ASC

relative payment weights. That is, we proposed to make the relative payment weights budget neutral to ensure that changes in the relative payment weights from year to year would not cause the estimated amount of expenditures to ASCs to increase or decrease as a function of those changes. For example, we proposed to uniformly scale the ASC relative payment weights for CY 2009 so that estimated expenditures for CY 2009 using the updated CY 2009 ASC relative payment weights would be the same as they would be using the CY 2008 ASC relative payment weights. Similarly, we proposed to uniformly scale the ASC relative payment weights for CY 2010 so that estimated expenditures for CY 2010 using the updated CY 2010 ASC relative payment weights would be the same as they would be using the CY 2009 ASC relative payment weights.

We proposed to scale the relative payment weights annually because we believed that the purpose of using relative payment weights as part of the ratesetting methodology under the proposed revised ASC payment system was only to establish appropriate relativity among surgical procedures paid in ASCs. Changes in weights should not, in and of themselves, change aggregate payment levels under a prospective payment system. Scaling the relative payment weights each year would also serve as a buffer to protect ASCs from sudden changes that could occur under the OPPS. For example, by making the relative payment weights budget neutral under the revised ASC payment system, the ASC relative weights would not drop were there to be a sudden upsurge in costs associated with outpatient hospital emergency or clinic visits relative to outpatient hospital surgical costs. Moreover, making the ASC relative weights budget neutral would shield the ASC payment system from the inadvertent impact of unrelated aggregate changes in OPPS expenditures. We proposed to continue this methodology to update the revised ASC payment system in future years.

Comment: Several commenters supported the proposal to annually update ASC relative payment weights using the national OPPS payment weights for the corresponding year; conversely, some commenters also expressed concern regarding our proposed policy of rescaling ASC relative weights. They were concerned that annual rescaling would cause divergence of the relative weights between the OPPS and the revised ASC payment system for individual procedures.

Response: We appreciate commenters' support for annually updating ASC relative payment weights in coordination with the OPPS update, consistent with the proposed relationship between the two payment systems. We believe this process would provide more appropriate payments for surgical services under the revised ASC payment system that would reflect ongoing changes in the facility costs associated with different surgical procedures. We also acknowledge commenters' concerns about our proposed policy of rescaling ASC relative weights. However, we note that rescaling the relative payment weights in the ASC payment system would not cause divergence in the relativity of the weights of various services under the two payment systems. Rescaling of the weights would equally increase or decrease the relative payment weights of services under the revised ASC payment system in comparison to the relative weights of the same services under the OPPS, but only to the extent necessary to ensure that changes in the relative weights do not, in and of themselves, change aggregate payments to ASCs.

Rescaling of relative weights or the application of a budget neutrality adjustment is a common feature of Medicare payment systems, designed to ensure that the estimated aggregate payments under a payment system for an upcoming year would be neither greater than nor less than the aggregate payments that would be made in the prior year, taking into consideration any changes or recalibrations for the upcoming year. For example, in CY 2006, as required by section 1833(t)(9)(B) of the Act, we scaled relative weights under the OPPS by applying a budget neutrality adjustment to ensure that changes due to APC reclassification and recalibration changes, wage index changes, and other adjustments were made in a manner that ensured that estimated aggregate OPPS payments for CY 2006 would not exceed aggregate payments for CY 2005 (70 FR 68542). We continue to believe that this principle should apply as well in the revised ASC payment system. We note that while we do not currently have a provider-level dataset of ASC utilization that accurately identifies unique ASCs and their geographic information that would allow us to compare changes in geographic adjustment over time for budget neutrality purposes, we intend to take these changes into account in maintaining budget neutrality for the revised ASC payment system as soon as our provider-level ASC data permit.

In addition to considerations that are common to many payment systems, there is another reason for adopting annual rescaling of the relative weights in the revised ASC payment system. Because we are finalizing our proposal to generally employ the relative payment weights developed under the OPPS in the revised ASC payment system as discussed earlier in section IV.B. of this final rule, aggregate payments to ASCs could, in the absence of rescaling, be affected by changes in the cost structure of HOPDs that ought to be relevant only under the OPPS. We provided an example of such a scenario in the August 2006 proposed rule. A sudden increase in the costs of hospital outpatient emergency or clinic visits due, for instance, to an increase in the volume of cases, would have the effect of increasing the weights for these services relative to the weights for surgical procedures in the hospital outpatient setting. In the absence of rescaling, this change in the relative weights under the OPPS would result in a decrease in the relative weights for surgical procedures under the ASC payment system and, therefore, a decrease in aggregate ASC payments for these same procedures. Because ASCs principally receive payment for surgical procedures, aggregate payments to ASCs could decline; ASCs would receive lower payments for surgical procedures without realizing the benefits of the higher payments provided to HOPDs for emergency or clinic visits. As we explained in the August 2006 proposed rule (71 FR 49657), we believe that changes in relative weights each year under the OPPS should not, in and of themselves, cause aggregate payments under the revised ASC payment system to increase or decrease. In fact, scaling the relative weights each year under the revised ASC payment system would serve as a buffer to protect ASCs from sudden changes that could occur under the OPPS.

Rescaling of relative payment weights in a budget neutral manner under the revised ASC payment system would thus shield the ASC payment system from the inadvertent impact of unrelated aggregate changes in OPPS expenditures. It is important to note that the specific adjustment factor applied in the scaling process could be positive or negative in any particular year. Annual scaling would prevent both sudden decreases in aggregate payments to ASCs and sudden windfall payments due solely to changes in HOPD costs for nonsurgical services. In the example given above, the scaling adjustment would be positive, that is, scaling would increase the relative weights of all surgical procedures under the ASC payment system in order to maintain aggregate ASC payments for the

procedures at the same level, in the absence of other factors affecting the relative payment weights of hospital outpatient emergency or clinic visits and surgical procedures under the OPPS.

After considering the public comments we received, we are finalizing our proposal, without modification, to update the ASC relative payment weights in the revised ASC payment system each year using the national OPPS relative payment weights for that same calendar year and to uniformly scale the ASC relative payment weights for each update year to make them budget neutral. For example, holding ASC utilization and the mix of services constant, for CY 2009, we will compare the total weight using the CY 2008 ASC relative payment weights under the 75/25 blend (of the CY 2007 payment rate and the revised payment rate) with the total weight using CY 2009 relative payment weights under the 50/50 blend (of the CY 2007 payment rate and the revised payment rate), taking into account the changes in the OPPS relative payment weights between CY 2008 and CY 2009. We will use the ratio of CY 2008 to CY 2009 total weight to scale the ASC relative payment weights for CY 2009. Scaling of ASC relative payment weights would apply to covered surgical procedures and covered ancillary radiology services whose payment rates are related to OPPS relative payment weights. Scaling would not apply in the case of ASC payment for other separately payable covered ancillary services that have a predetermined national payment amount (that is, their national payment amounts are not based on OPPS relative payment weights) such as drugs and biologicals that are separately paid under the OPPS. Any service with a predetermined national payment amount would be included in the budget neutrality comparison, but scaling of the relative payment weights would not apply to those services that have a predetermined payment amount. The ASC payment weights for those services without predetermined national payment amounts (that is, their national payment amounts would be based on OPPS relative payment weights if a payment limitation did not apply) would be scaled to eliminate any difference in the total payment weight between the current year and the update year.

2. Updating the ASC Conversion Factor

Section 1833(i)(2)(C) of the Act requires that, if the Secretary has not updated the ASC payment amounts in a calendar year after CY 2009, the payment amounts shall be increased by the percentage increase in the CPI–U as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved. Therefore, in the August 2006 proposed rule for the revised ASC payment system we proposed to update the ASC conversion factor using the CPI–U in order to adjust ASC payment rates for inflation.

We received a number of comments regarding our proposal to use the CPI–U to adjust payments to ASCs for inflation, and these comments and our responses are discussed in section IV.H. of this final rule, which addresses the adjustment for inflation under the revised ASC payment system. We did not receive any public comments regarding our proposal to adjust ASC payments for inflation by applying the inflation adjustment to the conversion factor under the revised ASC payment system.

As explained in section IV.H. of this final rule, after consideration of the public comments we received, we are finalizing our proposal under §§ 416.171(a) and (b), without modification, to apply the CPI–U to adjust payments to ASCs for inflation. We will implement the annual update through an adjustment to the conversion factor under the revised ASC payment system, beginning in CY 2010 when the statutory requirement for a zero update no longer applies.

E. Annual Updates

Currently, under the existing ASC payment system, we update the ASC list of covered surgical procedures every 2 years through the notice and comment regulation process. We make additions to and deletions from the ASC list of covered surgical procedures based on clinical judgment and data that are available regarding utilization of care settings. We last published an updated list of the ASC covered surgical procedures in the CY 2007 OPPS/ASC final rule with comment period (71 FR 67960).

Under the revised ASC payment system, which will be implemented effective January 1, 2008, we proposed in the August 2006 proposed rule to update on an annual calendar year basis the ASC conversion factor, the relative payment weights and APC assignments, the ASC payment rates, and the list of procedures for which Medicare would not make payment of an ASC payment rate. To the extent possible under the rules and policies of the revised ASC payment system, we proposed to maintain consistency between the OPPS and the ASC payment system in the way we treat new and revised HCPCS and CPT codes for payment under the ASC payment system. We also proposed to invite comment as part of the annual update cycle to determine if there are procedures that we exclude from payment in the ASC setting that merit reconsideration as a result of changes in clinical practice or innovations in technology.

We proposed to update the ASC list of covered surgical procedures and payment system as part of the annual proposed and final rulemaking cycle updating the hospital OPPS. We believed that including the ASC update as part of the OPPS rulemaking cycle would ensure that updates of the ASC payment rates and the list of covered surgical procedures for which Medicare makes payment to ASCs would be issued in a regular, predictable, and timely manner. Moreover, the ASC payment system would be updated concurrent with changes in the APC groups and the OPPS inpatient list, making it easier to predict changes in payment for particular services from year to year.

In the August 2006 proposed rule for the revised ASC payment system, we proposed to issue a final rule in the first part of CY 2007 in which we would respond to comments submitted timely regarding the proposals set forth in that proposed rule and make final the policy and regulations for the revised ASC payment system for implementation effective January 1, 2008. We also proposed to include the CY 2008 ASC payment rates for surgical procedures payable in an ASC as part of the proposed and final rules for the CY 2008 OPPS update.

In addition, in the August 2006 proposed rule we proposed to evaluate each year all new HCPCS codes that describe surgical procedures to make preliminary determinations regarding whether or not they should be payable in the ASC setting and, if so, whether they are office-based procedures. In the absence of claims data that would indicate where procedures described by new codes are being performed and identify the facility resources required to perform them, we proposed to use other available information, including our clinical advisors' judgment, predecessor CPT and Level II HCPCS codes, information submitted by representatives of specialty societies and professional associations, and information submitted by commenters during the public comment period following publication of the final rule with comment period in the **Federal Register**. We would publish in the annual OPPS/ASC payment update final rule those interim determinations for

the new codes to be active January 1 of the update year. The ASC payment system treatment of those procedures would be open to comment on that final rule, and we would respond to comments about our interim determinations in the final rule for the following year, just as we currently respond to comments about our APC assignments for new codes in the OPPS final rule for the following year. After our review of public comments and in the absence of physicians' claims data, if our determination regarding a new code was that it should reside on the ASC list of covered surgical procedures as an office-based procedure subject to the payment limitation, this determination would remain preliminary until we were able to consider more recent volume and utilization data for each individual procedure code and/or, if appropriate, the clinical characteristics, utilization, and volume of related codes. Using that information, if we confirmed our determination that the new code was appropriately assigned to an office-based payment indicator, it would then be permanently assigned to the list of office-based procedures subject to the payment limitation.

Accordingly, we proposed to reflect this annual rulemaking and publication of revised payment methodologies and payment rates in new § 416.173 in proposed new Subpart F.

Comment: Several commenters recommended that CMS continue to consider the input of interested parties submitting comments regarding the assignment of HCPCS codes to appropriate APCs, additions to and deletions from the ASC list of covered surgical procedures, and creation of payment mechanisms to account for new technology.

Response: As stated in our August 2006 proposal for the annual update process, we intend to invite comments from interested parties as part of the consolidated annual update cycle for updating the hospital OPPS and revised ASC payment system. As always, the OPPS treatment, including APC assignments, of all HCPCS codes would be open to comment, and we proposed also to invite comment regarding whether there are procedures that we exclude from payment in the ASC setting that merit reconsideration as a result of changes in clinical practice or innovations in technology. This approach is consistent with the recommendation of the PPAC that we utilize a process for the revised ASC payment system to obtain input from national medical specialty societies and the ASC community in order to provide payment to ASCs for all safe and appropriate procedures and to allow for changes in technology and evolution in medical practice. Annual updating will provide for the adaptable methodology that the PPAC recommends for the revised ASC payment system.

Comment: Some commenters supported our proposal for the annual updates, indicating that the proposed alignment of annual updates to the revised ASC payment system with the OPPS updates is appropriate and allows the industry to review and contemplate the changes in both payment systems simultaneously.

Response: We appreciate the commenters' support and continue to believe that including the ASC update as part of the OPPS rulemaking cycle would ensure that updates of the ASC payment rates and the list of surgical procedures for which Medicare pays ASCs would be issued in a regular, predictable, and timely manner. Moreover, the ASC payment system would be updated concurrent with changes in the APC groups and the OPPS inpatient list, making it easier to predict changes in payment for particular services from year to year. We believe this approach is especially appropriate, given the final policy of the revised ASC payment system as discussed further in section IV.B. of this final rule, to use the APC groups and relative payment weights for surgical procedures established under the OPPS as the basis of the payment groups and the relative payment weights for surgical procedures paid in ASCs beginning in CY 2008. The annually updated OPPS device offset percents will be used to establish ASC payment rates for device-intensive procedures. In addition, according to the final policies established in this final rule, the OPPS relative payment weights and rates will be used as the basis for the payment of most covered ancillary services under the revised ASC payment system, so coordinated annual updating of the OPPS and the revised ASC payment system is particularly important.

Comment: A number of commenters indicated that many ASCs were interested in submitting bills to Medicare using the same claim form that is used by HOPDs, the CMS UB–92 (soon to be the UB–04), so that CMS would have additional information available for the annual ASC update under the revised ASC payment system. The commenters stated that the CMS–1500 billing form currently used by most Medicare Part B providers and suppliers, including ASCs, limits the amount of information that ASCs can report on claims. The commenters expressed concern that, as a result of having to use the CMS–1500, the true costs incurred by ASCs to provide services are not available to CMS and that, consequently, CMS cannot include actual ASC costs in its analyses to develop and update the revised payment system. They recommended that ASCs be allowed to report to CMS the same level of detail about the services they provide as do HOPDs. Further, the commenters stated that it would be less burdensome than the current Medicare billing policy because ASCs already use the UB–92 to submit bills to commercial payors. Thus, they concluded that allowing ASCs to use the UB–92 for Medicare Part B billing would be advantageous for both CMS and ASCs, because ASCs could provide more detailed cost information to CMS and this change would reduce the administrative burden on ASCs that currently are maintaining billing capabilities for both the CMS–1500 and UB–92 formats.

Response: For future ASC update years, we will explore the feasibility of adopting the ASC billing change recommended by commenters, but this is not a change that we can make by January 2008. We understand the commenters' concerns in this regard and investigated the possibility of implementing this recommendation as part of the revised payment system, effective January 2008. A policy change that requires ASCs to use a different billing format would have to incorporate adequate time for CMS and ASCs to make the necessary systems changes and for CMS to provide training for contractors and ASCs prior to implementing the new format. Although we will continue to explore this recommendation, not only is there insufficient time to make systems changes and provide training before implementation of the revised ASC payment system, but CMS is in the midst of a comprehensive reorganization of its contracting functions, making adoption of any significant billing change at this time even more challenging. During the next few years, Medicare Part A and B claims will be processed by reconfigured contracting entities, and we believe that allowing ASCs to bill using the same format as HOPDs should be explored as part of that larger contractor reform. We plan to pursue the feasibility of this option and to coordinate any possible change to ASC billing requirements with CMS' overall contracting transition. We welcome additional information from the public regarding recommendations for ASC billing

modifications or improvements that we should consider once the revised payment system is implemented. We note that, under our final annual update methodology for the revised ASC payment system, we would not require ASC information beyond that currently available to us through the CMS–1500 in order to annually update the ASC payment system.

After consideration of the public comments we received, we are finalizing our proposal as reflected in § 416.173, without modification, to annually update the ASC conversion factor, the relative payment weights and OPPS APC assignments of covered surgical procedures paid in ASCs, the ASC payment rates, and the list of surgical procedures for which Medicare would not make payment to ASCs as part of the annual proposed and final rulemaking cycle updating the hospital OPPS. In addition, we will annually update the list of covered ancillary services and their ASC payment rates. We also are finalizing our proposal, without modification, to evaluate each year all new HCPCS codes that describe surgical procedures to make preliminary determinations regarding whether they should be payable in the ASC setting and, if so, whether they are office-based procedures. The ASC treatment of these procedures would be open to comment in the final rule, and we would provide responses in the final rule for the following calendar year. Designations of new surgical procedure codes as office-based would remain preliminary until there are adequate physicians' claims data to assess their predominant sites of services, whereupon if we confirm their office-based nature, the codes would be permanently assigned to the list of office-based procedures subject to the ASC payment limitation.

VI. Information in Addenda Related to the Revised CY 2008 ASC Payment System

We include addenda to the preamble of proposed and final rules updating the ASC payment system to present national ASC unadjusted payment rates, by HCPCS code, and other factors that affect ratesetting. For example, in Addendum BB to the August 2006 proposed rule for the revised ASC payment system, we listed the HCPCS codes of surgical procedures for which we proposed to allow payment to ASCs in CY 2008, the short descriptors for those codes, and whether or not the code was proposed to be newly added to the list of covered surgical procedures. We also indicated for each HCPCS code: (1) Whether or not we proposed to designate it as office-based; (2) whether or not we proposed to cap it at the MPFS nonfacility practice expense rate; (3) the estimated proposed CY 2008 ASC relative payment weight; (4) the estimated proposed CY 2008 full payment and coinsurance amounts; and (5) the estimated proposed CY 2008 transitional payment and coinsurance amounts using a 50/50 blend of the current and proposed new rates. Addendum CC to the August 2006 proposed rule listed the specific subset of HCPCS codes and their short descriptors for procedures proposed for payment limitation at the MPFS nonfacility practice expense amount under the revised ASC payment system.

We will continue to use addenda to summarize, as part of the annual proposed and final OPPS/ASC rules updating both payment systems, the annual update of the relative payment weights of ASC covered surgical procedures, the national unadjusted ASC payment amounts for those procedures, the procedures designated as office-based that are subject to payment limitation at the MPFS nonfacility practice expense amount, and other pertinent information that bears on the determination of the payment status and payment rates for services under the revised ASC payment system for the update year. We will also summarize in the addenda the covered ancillary services that will be separately paid under the revised ASC payment system if they are integral to the performance of a covered surgical procedure, including their updated relative payment weights as appropriate, the national unadjusted ASC payment amounts for those services, and other pertinent information.

Although we are including addenda to this final rule, we emphasize that the information presented in these addenda is intended solely to demonstrate the payment rates that result from application of the revised ASC payment system methodology that we are finalizing in this final rule based on the most current data available. We caution readers that the illustrative relative payment weights, national payment amounts, and other information shown in the addenda to this final rule are neither the proposed nor final ASC rates for the CY 2008 revised ASC payment system. The information in the addenda to this final rule exemplifies the results of applying the revised ASC payment system methodology implemented in this final rule to the final or most recently updated CY 2007 OPPS information, with application of the estimated CY 2008 OPPS update, including the CY 2007 APC groupings and relative payment weights, the CY 2007 second quarter OPPS payment rates for drugs and biologicals, the CY 2007 OPPS payment methodology for brachytherapy sources, the specification of surgical procedures as subject to OPPS multiple procedure discounting, the designation of surgical procedures as inpatient only under the OPPS, the identification of surgical procedures for which payment is packaged under the OPPS rather than separately paid, and the CY 2007 OPPS device-dependent APCs and their respective device offset percents. The information is also based on the most recently available Part B utilization data derived from the full year of CY 2005 ASC and physicians' claims, and the CY 2008 estimated transitional nonfacility practice expense payment amounts for the CY 2008 MPFS, with application of the projected CY 2008 MPFS update.

We reiterate that the information in the addenda to this final rule does not represent the rates that we will be proposing for implementation in CY 2008 under the revised ASC payment system, but merely serves to illustrate application of the final ratesetting methodology under the revised ASC payment system. All information included in Addendum AA and Addendum BB to this final rule is subject to change in the annual cycle of notice and comment rulemaking to update the OPPS/ASC payment rates for CY 2008, with the exception of the office-based designation of procedures whose designation is not marked as temporary. We note that we have also included in Addenda AA and BB to this final rule HCPCS codes for those surgical procedures, radiology services, implantable devices, and drugs and biologicals whose payment is packaged under the OPPS and which, therefore, would not be eligible for separate ASC payment as covered surgical procedures or covered ancillary services, in order to facilitate review of the ASC payment policies for these groups of services. Payment to ASCs under the revised ASC payment system for these services would also be packaged. We will propose the relative payment weights, payments rates, and other pertinent ratesetting information for the CY 2008 revised ASC payment system in the OPPS/ASC proposed rule to update both payment systems for CY 2008. This proposed rule will be issued in mid-summer of CY 2007. The relative payment weights and payment rates and other pertinent ratesetting information proposed for the revised ASC payment system in CY 2008 will be based on proposed CY 2008 OPPS payment weights and APC groups, proposed CY

2008 MPFS nonfacility practice expense payment amounts, CY 2007 second quarter OPPS payment rates for drugs and biologicals as established based on the ASP information for that quarter, and the most recent Part B utilization data available to us from CY 2006 claims.

CMS will publish final relative payment weights and final payment rates and other pertinent ratesetting information for the CY 2008 revised ASC payment system in the final OPPS/ASC rule that updates both payment systems for CY 2008.

Changes in CY 2008 payments for physicians' services under the MPFS, in first quarter CY 2008 prices for drugs and biologicals based on the most recent available ASP data, and in CY 2008 HCPCS codes and pricing of OPPS services that may occur and that would affect the CY 2008 revised ASC payment system between publication of the CY 2008 OPPS/ASC final rule and release of the January 2008 OPPS PRICER and the ASC payment files will be reflected in updated addenda that we will post on the CMS Web site.

We have created Addendum DD1 to this final rule to define ASC payment indicators that we will use in Addenda AA and BB to provide payment information regarding covered surgical procedures and covered ancillary services, respectively, under the revised ASC payment system. Analogous to the OPPS payment status indicators that we publish in Addendum D1 as part of the annual OPPS rulemaking cycle, the ASC payment indicators in Addendum DD1 are intended to capture policy-relevant characteristics of HCPCS codes that may receive packaged or separate payment in ASCs, including their ASC payment status prior to CY 2008; their designation as device-intensive; their designation as office-based and the corresponding ASC payment methodology; and their classification as a separately payable radiology service, brachytherapy source, OPPS pass-through device, corneal tissue acquisition service, drug or biological, or NTIOL.

VII. ASC Regulatory Changes

In the August 23, 2006 proposed rule, we proposed to modify applicable ASC regulations under 42 CFR Parts 410, 414, and 416 to incorporate the requirements and conditions for payments for ASC facility services under the revised payment system that was proposed for implementation beginning January 1, 2008.

A. Regulatory Changes That Were Finalized in the CY 2007 OPPS/ASC Final Rule With Comment Period

In the August 23, 2006 proposed rule (71 FR 49631), we proposed the following regulatory changes which we finalized in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68174).

- We proposed to revise the current regulations at Part 416, Subparts D and E, to ensure that the rules governing the current ASC payment system are clearly distinguishable from those that would apply to the revised system beginning January 1, 2008.
- We proposed to revise Subparts D and E to Part 416 to reflect the rules governing the ASC payment system prior to January 1, 2008.
- We proposed to redesignate existing Subpart F as Subpart G under Part 416 to codify the rules governing the ASC payment adjustment for NTIOLs (71 FR 49631).
- We proposed several technical changes to Part 416 (71 FR 49659).
- We proposed to revise existing § 416.1 (Basis and scope) to remove the obsolete reference to ''a hospital outpatient department,'' and to add provisions of section 5103 of Public Law 109–171 and applicable provisions of Public Law 108–173.
- We proposed to revise existing § 416.65 (Covered surgical procedures) to modify the introductory text to clearly denote the section's application to covered surgical procedures furnished before January 1, 2008. In addition, we proposed to remove the obsolete cross-reference in paragraph (a)(4) to § 405.310 and replace it with the correct cross-reference to § 411.15.
- We proposed to revise § 416.125 (ASC facility services payment rate) to incorporate the limitation on payment imposed by section 5103 of Public Law 109–171.
- We proposed to revise § 488.1 (Definitions) to add ambulatory surgical centers to the definition of a supplier in conformance with section 1861(d) of the Act.
- We proposed to add new § 416.76 and new § 416.121 to Subparts D and E, respectively, to clearly state that the provisions of Subparts D and E apply to services furnished before January 1, 2008.

The bases for these proposed regulatory changes were discussed in detail throughout the preamble of the August 23, 2006 proposed rule. We did not receive any public comments on these proposed revisions. In the CY 2007 OPPS/ASC final rule with comment period, we made these provisions final as proposed, without modification (71 FR 68174).

B. Regulatory Changes Included in This Final Rule

In the August 23, 2006 proposed rule (71 FR 49699), we proposed to add a new Subpart F to Part 416 entitled ''Subpart—Coverage, Scope of ASC Facility Services, and Prospective Payment System for Facility Services Furnished On or After January 1, 2008,'' which would include the following new sections:

§ 416.160 Basis and scope.
§ 416.161 Applicability.
§ 416.163 General rules.
§ 416.164 Scope of ASC facility services.
§ 416.166 Covered surgical procedures.
§ 416.167 Basis of payment.
§ 416.171 Calculation of prospective payment rates for ASC services.
§ 416.172 Adjustments to national payment rates.
§ 416.173 Publication of revised payment methodologies and payment rates.
§ 416.178 Limitations on administrative and judicial review.

We also proposed a technical change to 42 CFR Part 414 to conform with changes we were proposing under Part 416, new Subpart F (71 FR 49659), and we likewise proposed to revise § 410.152(i) to make it consistent with provisions of the revised ASC payment system. The numerous public comments that we received regarding the revised ASC payment system we proposed to implement January 1, 2008, are addressed in detail throughout the preamble of this final rule.

As a result of our review of the public comments, in this final rule, we have made a number of modifications to our proposals for the revised ASC payment system. These modifications, which are also discussed in detail in other sections of this final rule, have necessitated corresponding changes in the regulations that we proposed for the revised ASC payment system. The following is a summary of changes to 42 CFR 410 and 416 that reflect those modifications, which we are finalizing in this final rule.

- We added a new paragraph (i)(2) under § 410.152 to specify the amount of payment the Medicare program makes for ASC services beginning January 1, 2008.
- We decided not to finalize the proposed revision of § 414.22(b)(5)(i)(B) in this final rule.
- In § 416.2, we revised the definitions of ''ASC services,'' ''Covered surgical procedures,'' and ''Facility

services,'' and we added a definition of ''Covered ancillary services.''

• We added new Subpart F, as proposed, but modified the title to read ''Coverage, Scope of ASC Services, and Prospective Payment System for ASC Services Furnished on or after January 1, 2008.'' We also modified certain proposed sections under Subpart F and added other provisions as outlined below.

• We revised the section headings of §§ 416.161 and 416.164 to read ''Applicability of this subpart'' and ''Scope of ASC services,'' respectively.

We also revised the section heading of § 416.171 to read ''Determination of payment rates for ASC services.'' In addition, we added new § 416.179 with a new section heading.

• We added § 416.160(a)(4), which addresses payment rules for screening flexible sigmoidoscopy and screening colonoscopy services. Also, we reordered the paragraphs of § 416.160.

• We revised § 416.160(b) to conform the text with the changes to the definitions in § 416.2.

• We made a technical change to §§ 416.163(b) and (c) to specify that payment for anesthetists' services is made in accordance with 42 CFR part 414, in addition to editorial changes to § 416.163(a) to reference ASC services rather than ASC facility services.

• We revised § 416.164(a), ''Included facility services,'' and we renamed and revised § 416.164(b) as ''Covered ancillary services,'' to reflect the policy regarding the packaging of services which is made final in section IV.C. of this final rule. Proposed § 416.164(b) becomes final § 416.164(c), ''Excluded services,'' where we revised anesthetists' services, which are paid under 42 CFR part 414 and where we changed x-ray procedures to radiology services and separated diagnostic procedures and radiology services into separate items. Also, ''Excluded services'' no longer includes costs incurred to procure corneal tissue.

• In § 416.166(c), ''General exclusions,'' we deleted the phrase ''other medical procedures'' from the introductory sentence to conform with the definition of the type of procedures covered under the ASC benefit as discussed in section III. of this final rule. We moved the criterion proposed as paragraph (c)(5) (regarding the expected requirement for active medical monitoring and care at midnight following the procedure) to § 416.166(b) as an element of the ''General standards.'' We also added the following as new criteria for exclusion of a procedure from coverage when performed in an ASC: (1) Commonly require systemic thrombolytic therapy; (2) are designated as requiring inpatient care under § 419.22(n); and (3) can only be reported using a CPT unlisted surgical procedure code.

• We made technical and editorial changes to § 416.167(a) and (b) to reference payment for ASC services and covered ancillary services.

• We revised § 416.171 to reflect the modifications that we are making final in this final rule regarding separate payment for certain covered ancillary services and the extension of transitional payment rates from 1 to 3 years, as discussed in section IV. J. of this final rule.

• We revised § 416.172 as follows: (1) Made minor changes to paragraphs (a), (b), (d), and (e) to reference ASC services and to clarify that the comparison for purposes of assessing the lesser of the actual charge or the prospective rate is to the geographically adjusted payment rate; and (2) revised paragraph (c) to exclude application of a geographic adjustment to payment rates for certain drugs, devices, and brachytherapy sources, as discussed in section IV. C. of this final rule. In addition, we added new paragraph (f) to reflect the payment adjustment when ASC services are interrupted due to circumstances that threaten the well-being of the beneficiary. We also added new paragraph (g) to reflect the payment adjustment for the insertion of NTIOLs.

• We made editorial changes to § 416.173 and § 416.178.

• We added new § 416.179, ''Payment and coinsurance reduction for devices replaced without cost or when full credit is received,'' as discussed in section IV.C. of this final rule.

VIII. Files Available to the Public Via the Internet

Addenda AA, BB, and DD1 to this final rule provide various data pertaining to the CY 2008 ASC list of covered procedures and the covered ancillary services that will be separately paid to ASCs beginning in CY 2008 when provided by an ASC as integral to a covered surgical procedure on the same day as the procedure. All relative payment weights and payment rates are illustrative only, demonstrating the payment rates that result from application of the revised ASC payment system methodology that we are finalizing in this final rule based on the most current data available. They exemplify the results of applying the revised ASC payment system methodology implemented in this final rule to the final or most recently updated CY 2007 OPPS information as updated by the currently estimated CY 2008 OPPS update factor and to the CY 2008 estimated transitional nonfacility practice expense amounts for the CY 2008 MPFS, with application of the projected CY 2008 MPFS update.

As further discussed in section VI. of this final rule, Addendum DD1 defines the payment indicators that are used in Addenda AA and BB of this final rule, while Addenda AA and BB provide payment information regarding covered surgical procedures and covered ancillary services under the revised ASC payment system.

These addenda, as well as the final rule preamble tables and other supporting data files, are included on the CMS Web site at: *http://www.cms.hhs.gov/ASCPayment/* in a format that can easily be downloaded and manipulated. Proposed and final ASC relative weights and payment rates for CY 2008 will be published in the proposed and final CY 2008 OPPS/ASC rules, respectively, and related data files will be included on the CMS Web site as noted above. The OPPS data files are available to the public on the CMS Web site at: *http://www.cms.hhs.gov/HospitalOutpatientPPS,* and the MPFS data files are located at: *http://www.cms.hhs.gov/PhysicianFeeSched.*

We are not including as addenda to this final rule reprints of the final FY 2007 IPPS wage indexes that were included in a notice published in the **Federal Register** on October 11, 2006 (71 FR 59886). Rather, we are providing a link on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN* to all of the final FY 2007 IPPS wage index related tables. The final CY 2008 ASC payment system will utilize the FY 2008 IPPS wage index related tables that will be proposed and finalized in the FY 2008 IPPS rulemaking cycle, and we will provide a link on the CMS Web site to those proposed and final wage index related tables in the CY 2008 OPPS/ASC proposed and final rules, respectively. For additional assistance, contact Gift Tee, (410) 786–0378.

IX. Collection of Information Requirements

This document does not impose any 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 1995 (44 U.S.C. 35).

X. Regulatory Impact Analysis

A. Overall Impact

We have examined the impacts of this final rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

1. Executive Order 12866

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

We estimate that the revised ASC payment system and the expanded ASC list of covered surgical procedures that we are implementing in CY 2008 will have no net effect on Medicare expenditures compared to the level of Medicare expenditures that would have occurred in CY 2008 in the absence of the revised payment system. A more detailed discussion of the effects of the changes to the ASC list of covered surgical procedures and the effects of the revisions to the ASC payment system in CY 2008 is provided in section X.B. below.

While we estimate that there will be no net change in Medicare expenditures in CY 2008 as a result of the revised ASC payment system, we estimate that the revised system will result in savings of $240 million over 5 years due to migration of new ASC covered surgical procedures from HOPDs and physicians' offices to ASCs over time. In addition, we note there will be a total increase in Medicare payments to ASCs for CY 2008 of approximately $270 million compared to Medicare expenditures that would have occurred in CY 2008 in the absence of the revised payment system. These additional payments to ASCs of approximately $270 million in CY 2008 will be fully offset by savings from reduced Medicare spending in HOPDs and physicians' offices on services that migrate from these settings to ASCs in CY 2008 (as discussed in detail in section V.C. of this final rule). Therefore, this final rule is an economically significant rule under Executive Order 12866 and a major rule under 5 U.S.C. 804(2).

2. Regulatory Flexibility Act

The RFA requires agencies to determine whether a rule would have a significant economic impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $9 million to $31.5 million in any 1 year (65 FR 69432).

For purposes of the RFA, we have determined that approximately 73 percent of ASCs would be considered small businesses according to the Small Business Administration (SBA) size standards. Individuals and States are not included in the definition of a small entity. We anticipate that this final rule will have a significant impact on a substantial number of small entities.

3. Small Rural Hospitals

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA). The Secretary certifies that this final rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

4. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $120 million. This final rule will not mandate any requirements for State, local, or tribal government, nor will it affect private sector costs.

5. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it publishes any rule (proposed or final) that imposes substantial direct costs on State and local governments, preempts State law, or otherwise has Federalism implications.

We have examined this final rule in accordance with Executive Order 13132, Federalism, and have determined that it would not have an impact on the rights, roles, and responsibilities of State, local or tribal governments. The changes related to payments to ASCs in CY 2008 will not affect payments to government hospitals.

B. Effects of Revisions to the ASC Payment System for CY 2008

In CY 2008, we are implementing a revised Medicare ASC payment system that could have a far-reaching effect on the provision of outpatient surgical services for a number of years to come. First, we are greatly expanding the list of procedures that will be eligible for payment under the revised ASC payment system. Second, we are moving from a limited fee schedule based on nine disparate payment groups to a payment system incorporating relative payment weights for groups of procedures with similar clinical and resource characteristics, based on the APCs that are key elements of the OPPS.

Implementation by January 1, 2008 of a revised ASC payment system designed to result in budget neutrality is mandated by section 626 of Public Law 108–173. To set ASC payment rates for CY 2008 under the revised payment system, we are multiplying ASC relative payment weights for surgical procedures by an ASC conversion factor that we calculate to result in the same amount of aggregate Medicare expenditures for those services in CY 2008 as we estimate would have been made if the revised payment system were not implemented.

The effects of the expanded numbers and types of procedures for which an ASC payment may be made and other policy changes that affect the revised payment system, combined with significant changes in payment rates for covered surgical procedures, will vary across ASCs, depending on whether or not the ASC limits its services to those in a particular surgical specialty area, the volume of specific services provided by the ASC, the extent to which ASCs will offer different services, and the percentage of its patients that are Medicare beneficiaries.

In this July 2007 final rule for the revised ASC payment system, we have estimated the CY 2008 ASC payment rates, budget neutrality factor, and impacts using the CY 2007 OPPS relative payment weights with an estimated update factor for CY 2008, the CY 2007 MPFS PE RVUs trended forward to CY 2008, and CY 2005

utilization data projected forward to CY 2008. We emphasize that the impact estimates in this final rule are illustrative only. The CY 2008 ASC payment rates and budget neutrality factor will be proposed in the CY 2008 OPPS/ASC proposed rule based on the methodology for calculating budget neutrality established in this final rule and incorporating the proposed CY 2008 OPPS relative payment weights, the proposed CY 2008 MPFS PE RVUs, and CY 2006 utilization information projected forward to CY 2008. The final CY 2008 ASC payment rates and budget neutrality factor will be established in the CY 2008 OPPS/ASC final rule with comment period, in accordance with the methodology for calculating budget neutrality established in this final rule and based on the final CY 2008 OPPS payment weights, the final CY 2008 MPFS RVUs, and updated CY 2006 utilization data projected forward to CY 2008.

As discussed fully in section V.C. of this final rule, our final methodology for calculating the budget neutrality factor considers not only the effects of the new payment rates to be implemented under the revised payment system, but also the estimated net effect of migration of new ASC procedures across ambulatory care settings. The methodology for calculating the budget neutrality adjustment factor finalized in this rule assumes that over the first 2 years of the revised payment system, approximately 25 percent of the HOPD volume of new ASC procedures would migrate from the HOPD service setting to ASCs, and that over the 4-year transition period, approximately 15 percent of the physicians' office volume of new ASC procedures would migrate to ASCs.

We estimate that the revised ASC payment system established in this final rule will result in neither savings nor costs to the Medicare program in CY 2008. That is, because it is designed to be budget neutral, in CY 2008, the revised ASC payment system will neither increase nor decrease expenditures under Part B of Medicare. We further estimate that beneficiaries will save approximately $20 million under the revised ASC payment system in CY 2008, because ASC payment rates will, in most cases, be lower than OPPS payment rates for the same services and, because, except for screening flexible sigmoidoscopy and screening colonoscopy procedures, beneficiary coinsurance for ASC services is 20 percent rather than 20 to 40 percent as is the case under the OPPS. (The only possible instance in which an ASC coinsurance amount could exceed the OPPS copayment amount would be when the coinsurance amount for a procedure under the revised ASC payment system exceeds the hospital inpatient deductible. Section 1833(t)(8)(C)(i) of the Act provides that the copayment amount for a procedure paid under the OPPS cannot exceed the inpatient deductible established for the year in which the procedure is performed, but there is no such requirement related to the ASC coinsurance amount.) Beneficiary coinsurance for services migrating from physicians' offices to ASCs may decrease or increase under the revised ASC payment system, depending on the particular service and whether the Medicare payment to the physician for providing that service in his or her office is higher or lower than the sum of the Medicare payment to the ASC for providing the facility portion of that service and the Medicare payment to the physician for providing that service in a facility (nonoffice) setting. As noted previously, the net effect of the revised ASC payment system on beneficiary coinsurance, taking into account the migration of services from HOPDs and physicians' offices, is estimated to be $20 million in beneficiary savings in CY 2008.

1. Alternatives Considered

We are issuing this final rule to meet a statutory requirement to implement, no later than January 1, 2008, a revised payment system for ASCs. We are implementing the revised ASC payment system through rulemaking in the **Federal Register**. Through the August 2006 proposed rule, we have afforded interested parties an opportunity to comment on revisions we proposed to make to the policies and rules for identifying surgical procedures that would be excluded from payment in ASCs, to the ASC ratesetting methodology and payment policies, and to the regulations for the revised ASC payment system.

Throughout the preamble of this final rule, we discuss the various options we considered as we developed policies to redesign the ASC payment system in broad terms, and specific policies, such as those affecting payment for covered ancillary services integral to covered surgical procedures, the definition of a covered surgical procedure, criteria for identifying procedures that are not safely or appropriately performed in an ASC, and the payment methodology for device-intensive procedures, among others.

Although we proposed to phase in the new ASC payment rates under the revised payment system over a 2-year period, we are finalizing a policy to phase in the ASC payment rates under the revised payment system over a 4-year period. As we discuss in section X.B.3. of this final rule, we believe that allowing a longer transition period is appropriate in light of the adverse financial impact that some ASCs could potentially experience if they perform a high volume of procedures whose rates would decrease significantly under the revised payment system. We believe the 4-year transition will give ASCs time to reconfigure their mix of services and make other needed adjustments so they can focus on achieving more efficient delivery of a broader range of surgical procedures.

2. Limitations of Our Analysis

Presented here are the projected effects of the policy and statutory changes that will be effective for CY 2008 on aggregate ASC utilization and Medicare payments. One limitation of this analysis is that we could only infer the effects of the revised payment system on different types of ASCs, for example, single or multispecialty, high or low volume, and urban or nonurban ASCs, based on an overall comparison of procedure volumes and facility payments between the current and the revised payment system. At this time, we do not have a provider-level dataset of CY 2005 ASC utilization that accurately identifies unique ASCs and their geographic information that would allow us to compare estimated payments and geographic adjustment among classes of ASCs based on a provider-level analysis.

A second limitation is our lack of information on ASC resource use. ASCs are not required to file Medicare cost reports and, therefore, we do not have cost information to evaluate whether or not the payments for ASC services coincide with the resources required by ASCs to provide those services.

A third limitation is our inability to predict changes in service mix between CY 2005 and CY 2008. The aggregated impact tables below are based upon a methodology that assumes no changes in service-mix with respect to the CY 2005 ASC data used for this final rule. We believe that the net effect on Medicare expenditures of changes in service-mix for current ASC covered surgical procedures will be negligible, in the aggregate. Such changes may have differential effects across surgical specialty procedure groups as ASCs adjust to the revised payment system. However, we are unable to accurately project such changes at a disaggregated level. Clearly, individual ASCs will experience changes in payment that

differ from the aggregated estimated changes presented in the tables below.

Because we do not have experience with ASC payment under the revised payment system, we have relied on comments and information from stakeholders in response to our August 2006 proposed rule for the revised ASC payment system to mitigate the limitations in the data available to us for analysis of the impact of the changes on specific procedures, on classes of specialty ASCs, and on beneficiaries.

3. Estimated Effect of This Final Rule on ASCs

Some ASCs are multispecialty facilities that perform the gamut of surgical procedures, from excision of lesions to hernia repair to cataract extraction; others focus on a single specialty and perform only a limited range of surgical procedures, such as eye procedures, gastrointestinal procedures, or orthopedic surgery. The combined effect on an individual ASC of the CY 2008 revised payment system and the expanded ASC list of covered surgical procedures will depend on a number of factors, including, but not limited to, the mix of services the ASC provides, the volume of specific services provided by the ASC, the percentage of its patients who are Medicare beneficiaries, and the extent to which an ASC will choose to provide different services under the revised payment system. The following discussion presents two tables that provide estimates of the impact of the revised ASC payment system on Medicare payments to ASCs for current ASC services, assuming the same mix of services as offered by ASCs in our CY 2005 claims data. The first table depicts aggregate percent change in payment by surgical specialty group and the other compares payment for procedures estimated to receive the most payment in CY 2008 under the current payment system.

In section IV.J. of this final rule, we finalize our policy of a transition of 4 years for the revised payment rates, rather than the proposed 2-year transition, where payments will generally be made using a blend of the rates based on the CY 2007 ASC payment rate and the revised ASC payment rate. In comparing estimated payment rates for CY 2008 under the existing system with the estimated payment rates for CY 2008 under the revised system, we noted the negative effect the estimated proposed payment rates would have on Medicare payments to ASCs for certain surgical procedures that currently are performed frequently in ASCs. We were concerned about the impact of the revised payment rates on ASCs that specialize in a limited number of surgical procedures for which payment would decrease under the revised system and wanted to encourage ASCs to continue to provide access to the high volume procedures that are currently performed there because, in all likelihood, the ASC has become an extremely efficient setting for those procedures, such as cataract extractions and colonoscopies. Moreover, we believe that a positive outcome of the revised ASC payment system could be to expand beneficiary and physician choice in selection of an appropriate site for ambulatory surgical services, as a consequence of the expansion of surgical procedures for which Medicare will make an ASC payment and the revised rates that will pay more appropriately for those services. We believe a 4-year transition will give ASCs additional time to reconfigure their mix of surgical services and make other needed adjustments so that they can focus on achieving more efficient delivery of a broader range of surgical procedures.

In CY 2008, we will pay ASCs using a 75/25 blend, in which payment will be calculated by adding 75 percent of the CY 2007 ASC rate for a surgical procedure on the CY 2007 ASC list of covered surgical procedures and 25 percent of the revised CY 2008 ASC rate for the same procedure. For CYs 2009 and 2010, the blend will be transitioned first to 50/50 and then to a 25/75 blend of the CY 2007 ASC rate and the revised ASC payment rate. Beginning in CY 2011, payments will be made to ASCs for covered surgical procedures on the CY 2007 ASC list at the fully implemented revised ASC payment rates. Procedures that were not included on the ASC list of covered surgical procedures in CY 2007 will not be paid at the transitional rates for CYs 2008 through 2010 because they have no CY 2007 ASC payment rate. Those procedures will be paid at the fully implemented ASC rate, beginning in CY 2008.

Table 11 shows the impact of the revised payment system at the surgical specialty group level. We have aggregated the surgical HCPCS codes by specialty group and estimated the effect on aggregated payment for surgical specialty groups, considering separately the CY 2008 transitional rate and the fully implemented revised payment rate. The groups are sorted for display in descending order by estimated Medicare program payment to ASCs for CY 2008 in the absence of the revised ASC payment system. The following is an explanation of the information presented in Table 11:

- Column 1—*Surgical Specialty Group* indicates the surgical specialties into which ASC procedures are grouped. We used the CPT code range definitions and added the related Level II HCPCS codes and Category III CPT codes, as appropriate, to account for all surgical procedures to which the Medicare program payments are attributed.
- Column 2—*Estimated CY 2008 ASC Payments* in the absence of the revised ASC payment system were calculated by multiplying the CY 2007 ASC payment rate by CY 2008 ASC utilization (which is based on CY 2005 ASC utilization multiplied by a factor of 1.305 to take into account expected volume growth with volume adjustment, as appropriate, for the multiple procedure discount). The resulting amount was then multiplied by 0.8 to estimate the Medicare program's share of the total payments to the ASC. The payment amounts are expressed in millions of dollars.
- Column 3—*Estimated CY 2008 Percent Change with Transition (75/25 Blend)* is the aggregate percentage increase or decrease in Medicare program payment to ASCs for each surgical specialty group that is attributable to changes in the ASC payment rates for CY 2008 under the 75/25 blend of the CY 2007 ASC payment rate and the revised ASC payment rate.
- Column 4—*Estimated CY 2008 Percent Change without Transition (Fully Implemented)* is the aggregate percentage increase or decrease in Medicare program payment to ASCs for each surgical specialty group that is attributable to changes in the ASC payment rates for CY 2008 if there were no transition period to the revised payment rates. The percentages appearing in column 4 are presented as a comparison for the transition policy in column 3 and do not depict the impact of the fully implemented proposal in CY 2011.

Table 11 reflects the changes for ASCs at the surgical specialty level and shows that for all but gastrointestinal procedures, if an ASC offers the same mix of services in CY 2008 that is reflected in our national CY 2005 claims data, Medicare payments to the ASC for services in that surgical specialty area would be estimated to increase under the revised payment system. If the revised payment system were fully implemented in CY 2008, we would expect all but gastrointestinal procedures and nervous system procedures to receive greater Medicare payment. In addition to the impacts on

Medicare payments for current ASC procedures shown in Table 11, it is important to note that overall CY 2008 payments to ASCs are estimated to increase by about $270 million as a result of the revised payment system. This increased spending in ASCs is projected to be fully offset by savings from reduced spending in HOPDs and physicians' offices due to service migration.

TABLE 11.—ESTIMATED CY 2008 IMPACT OF THE REVISED ASC PAYMENT SYSTEM ON ESTIMATED AGGREGATE CY 2008 MEDICARE PROGRAM PAYMENTS UNDER THE 75/25 TRANSITION BLEND AND WITHOUT A TRANSITION, BY SURGICAL SPECIALTY GROUP

Surgical specialty group	Estimated CY 2008 ASC payments (in millions)	Estimated CY 2008 percent change with transition (75/25 blend)	Estimated CY 2008 percent change without transition (fully implemented)
(1)	(2)	(3)	(4)
Eye and ocular adnexa	$1,365	1	5
Digestive system	721	−4	−15
Nervous system	274	2	−5
Musculoskeletal system	167	24	97
Integumentary system	85	4	15
Genitourinary system	76	10	38
Respiratory system	23	16	65
Cardiovascular system	8	25	95
Auditory system	4	30	85
Hemic and lymphatic systems	2	28	110
Other systems	0.1	19	75

Table 12 below shows the estimated impact of the revised payment system on aggregate ASC payments for selected procedures during the first year of implementation (CY 2008) with and without the transitional blended rate. The table displays 30 of the procedures receiving the highest estimated CY 2008 ASC payments under the existing Medicare payment system. The HCPCS codes are sorted in descending order by estimated CY 2008 ASC program payments in the absence of the revised ASC payment system.

- Column 1—*HCPCS code.*
- Column 2—*Short Descriptor* of the HCPCS code.
- Column 3—*Estimated CY 2008 ASC Payments* in the absence of the revised payment system were calculated by multiplying the CY 2007 ASC payment rate by CY 2008 ASC utilization (which is based on CY 2005 ASC utilization multiplied by a factor of 1.305 to take into account expected volume growth with volume adjustment, as appropriate, for the multiple procedure discount). The resulting amount was then multiplied by 0.8 to estimate the Medicare program's share of the total payments to the ASC. The payment amounts are expressed in millions of dollars.
- Column 4—*CY 2008 Percent Change with Transition (75/25 Blend)* reflects the percent differences between the estimated ASC payment rates for CY 2008 under the current system and the estimated payment rates for CY 2008 under the revised system, incorporating a 75/25 blend of the estimated ASC payment using the CY 2007 ASC payment rate and the revised ASC payment rate.
- Column 5—*CY 2008 Percent Change without Transition (Fully Implemented)* reflects the percent differences between the estimated ASC payment rates for CY 2008 under the current system and the estimated payment rates for CY 2008 under the revised payment system if there were no transition period to the revised payment rates. The percentages appearing in column 5 are presented as a comparison for the transition policy in column 4 and do not depict the impact of the fully implemented proposal in CY 2011.

TABLE 12.—ESTIMATED CY 2008 IMPACT OF REVISED ASC PAYMENT SYSTEM ON AGGREGATE PAYMENTS FOR PROCEDURES WITH THE HIGHEST ESTIMATED CY 2008 PAYMENTS UNDER THE CURRENT SYSTEM

HCPCS code	Short descriptor	Estimated CY 2008 ASC payments (in millions)	Estimated CY 2008 percent change (75/25 blend)	Estimated CY 2008 percent changes without transition (fully implemented)
(1)	(2)	(3)	(4)	(5)
66984	Cataract surg w/iol, 1 stage	$1,112	1	3
45378	Diagnostic colonoscopy	153	−4	−16
43239	Upper GI endoscopy, biopsy	148	−5	−21
45380	Colonoscopy and biopsy	114	−4	−16
66821	After cataract laser surgery	102	−8	−31
45385	Lesion removal colonoscopy	96	−4	−16
62311	Inject spine l/s (cd)	81	−5	−19
45384	Lesion remove colonoscopy	44	−4	−16

TABLE 12.—ESTIMATED CY 2008 IMPACT OF REVISED ASC PAYMENT SYSTEM ON AGGREGATE PAYMENTS FOR PROCEDURES WITH THE HIGHEST ESTIMATED CY 2008 PAYMENTS UNDER THE CURRENT SYSTEM—Continued

HCPCS code	Short descriptor	Estimated CY 2008 ASC payments (in millions)	Estimated CY 2008 percent change (75/25 blend)	Estimated CY 2008 percent changes without transition (fully implemented)
(1)	(2)	(3)	(4)	(5)
64483	Inj foramen epidural l/s	44	−5	−19
G0121	Colon ca scrn not hi rsk ind	37	−6	−25
15823	Revision of upper eyelid	35	−4	−17
66982	Cataract surgery, complex	33	1	3
64476	Inj paravertebral l/s add-on	29	−7	−27
G0105	Colorectal scrn; hi risk ind	27	−6	−25
43235	Uppr gi endoscopy, diagnosis	25	2	6
52000	Cystoscopy	24	−4	−17
64475	Inj paravertebral l/s	24	−5	−19
67904	Repair eyelid defect	22	4	16
64721	Carpal tunnel surgery	17	18	70
29881	Knee arthroscopy/surgery	16	23	93
43248	Uppr gi endoscopy/guide wire	15	−5	−21
62310	Inject spine c/t	14	−5	−19
29880	Knee arthroscopy/surgery	11	23	93
64484	Inj foramen epidural add-on	11	−5	−19
28285	Repair of hammertoe	10	18	70
67038	Strip retinal membrane	10	31	122
29848	Wrist endoscopy/surgery	9	−2	−9
64623	Destr paravertebral n add-on	9	−5	−19
45383	Lesion removal colonoscopy	9	−4	−16
26055	Incise finger tendon sheath	9	14	54

Over time, we believe that the current ASC payment system has served as an incentive to ASCs to focus on providing procedures for which they determine Medicare payments are adequate to support the ASC's continued operation. We would expect that, under the existing payment system, the ASC payment rates for many of the most frequently performed procedures in ASCs are similar to the OPPS payment rates for the same procedures. Conversely, we would expect that procedures with existing ASC payment rates that are substantially lower than the OPPS rates would be performed less often in ASCs. We believe the revised ASC payment system represents a major stride towards encouraging greater efficiency in ASCs and promoting a significant increase in the breadth of surgical procedures performed in ASCs, because it more appropriately distributes payments across the entire spectrum of covered surgical procedures, based on a coherent system of relative payment weights that are related to the clinical and facility resource characteristics of those procedures.

Table 12 identifies a number of ASC procedures receiving the highest estimated CY 2008 payments under the current system and shows that most of them will experience payment decreases in CY 2008 under the revised ASC payment system. This contrasts with the estimated aggregate payment increases at the surgical specialty group level displayed in Table 11. In fact, Table 11 shows only one surgical specialty group of procedures for which the payments are expected to see a small decrease in the first year under the revised ASC payment system, and only two groups for which a decrease would be expected if there were no transition period to the revised payment rates. The increased payments at the full group level are due to the moderating effect of the payment increases for the less frequently performed procedures within the surgical specialty group. The exception to this is the surgical specialty group of eye and ocular adnexa where the aggregate increase in CY 2008 is driven by a small increase in payment for the highest volume procedure (CPT code 66984, Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedures), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification)).

As a result of the redistribution of payments across the expanded breadth of surgical procedures for which Medicare will provide an ASC payment, we believe that ASCs may change the mix of services they provide over the next several years. The revised ASC payment system should encourage ASCs to expand their service mix beyond the handful of the highest paying procedures which comprise the majority of ASC utilization under the existing ASC payment system. For example, although cystoscopy (CPT code 52000), the highest volume ASC genitourinary procedure, is expected to experience a 4 percent payment rate decrease in CY 2008, overall payment to ASCs for the group of genitourinary procedures currently performed in ASCs is expected to increase by 10 percent. Although a urology specialty ASC may currently perform far more cystoscopy procedures than any other genitourinary procedure, we believe that under the revised ASC payment system, the ASC has the opportunity to adapt to the payment decrease for its most frequently performed procedures by offering an increased breadth of procedures, still within the clinical specialty area, and receive payments that are adequate to support continued operations. Similarly, payments for all of the highest volume pain management injection procedures are expected to decrease in CY 2008, although payments for nervous system procedures overall

are expected to increase. However, if there were no transition for CY 2008, payments would also decrease slightly for the nervous system surgical specialty group.

For those procedures that will be paid a significantly lower amount under the revised payment system than they are currently paid, we believe that their current payment rates, which are closer to the OPPS payment rates than other ASC procedures, are likely to be generous relative to ASC costs, so ASCs would in all likelihood continue performing those procedures under the revised payment system. We also note that the majority of the most frequently performed ASC procedures specifically studied by the GAO, as described in the section II.B. of this final rule for the revised ASC payment system, appear in Table 12 with estimated payment decreases under the revised ASC payment system. The GAO concluded that, for these procedures, the OPPS APC groups accurately reflect the relative costs of procedures performed at ASCs and that ASCs have substantially lower costs.

Generally, the payment changes for individual surgical procedures are relatively small in the first year under the transition to the revised payment system. As displayed in Table 12, a 1 percent increase in payment for the most common cataract surgery, CPT code 66984, is expected and mirrors the effect of the revised payment system on payment for the eye and ocular adnexa surgical specialty group (Table 11), even though payment for another relatively high volume eye procedure, CPT code 66821 (Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (e.g., YAG laser) (one or more stages)), is expected to decrease by 8 percent.

For some procedures the estimated payment amounts in CY 2008 under the revised ASC payment system are much higher than the CY 2007 rates currently paid to ASCs. For example, payment for CPT code 67038 (Vitrectomy, mechanical, pars plana approach; with epiretinal membrane stripping) increases by 31 percent compared to estimated CY 2008 payments under the current system. Similarly, the estimated CY 2008 ASC payment for CPT code 29880 (Arthroscopy, knee, surgical; with meniscetomy (medial and lateral, including any meniscal shaving)) increases by 23 percent. For these two procedures and the other procedures with estimated payment increases greater than 10 percent, the increases are due to the comparatively higher OPPS rates which, when adjusted by the ASC budget neutrality factor and blended with the CY 2007 ASC payment amounts, generate CY 2008 ASC payment rates that are substantially above the current CY 2007 ASC payment rates.

We estimate that payments for most of the highest volume colonoscopy and upper gastrointestinal endoscopy procedures will decrease under the revised payment system. In fact, payment decreases also are expected for the gastrointestinal surgical specialty group overall. We believe that decreased payments for so many of the gastrointestinal procedures are because current ASC payment rates are close to the OPPS rates. Procedures with current payment rates that are nearly as high as their OPPS rates are affected more negatively under the revised payment system than procedures for which ASC rates have historically been much lower than the comparable OPPS rates. The payment decreases expected in the first year under the revised ASC payment system for some of the high volume gastrointestinal procedures are not large (all less than 7 percent). We believe that ASCs can generally continue to cover their costs for these procedures, and that ASCs specializing in providing those services will be able to adapt their business practices and case-mix to manage declines for individual procedures.

In CY 2008, we also are adding hundreds of surgical procedures to the already extensive list of procedures for which Medicare allows payment to ASCs, creating new opportunities for ASCs to expand their range of covered surgical procedures. For the first time, ASCs will be paid separately for covered ancillary services that are integral to covered surgical procedures, including certain radiology procedures, costly drugs and biologicals, devices with pass-through status under the OPPS, and brachytherapy sources. While separately paid radiology services will be paid based on their ASC relative payment weight calculated according to the standard ratesetting methodology of the revised ASC payment system or to the MPFS nonfacility practice expense amount, whichever is lower, the other items newly eligible for separate payment in ASCs will be paid comparably to their OPPS rates because we would not expect ASCs to experience efficiencies in providing them. Lastly, this final rule establishes a specific payment methodology for device-intensive procedures that provides the same packaged payment for the device as under the OPPS, while providing a reduced service payment that is subject to the 4-year transition if the device-intensive procedure is on the CY 2007 ASC list of covered surgical procedures. This final methodology should allow ASCs to continue to expand their provision of device-intensive services and to begin performing new device-intensive ASC procedures.

4. Estimated Effects of This Final Rule on Beneficiaries

We estimate that the changes for CY 2008 will be positive for beneficiaries in at least two respects. Except for screening colonoscopy and flexible sigmoidoscopy procedures, the ASC coinsurance rate for all procedures is 20 percent. This contrasts with procedures performed in HOPDs where the beneficiary is responsible for copayments that range from 20 percent to 40 percent. In addition, ASC payment rates under the revised payment system are lower than payment rates for the same procedures under the OPPS, so the beneficiary coinsurance amount under the ASC payment system almost always will be less than the OPPS copayment amount for the same services. (The only exceptions will be when the ASC coinsurance amount exceeds the inpatient deductible. The statute requires that copayment amounts under the OPPS not exceed the inpatient deductible.) Beneficiary coinsurance for services migrating from physicians' offices to ASCs may decrease or increase under the revised ASC payment system, depending on the particular service and the relative payment amounts for that service in the physician's office compared with the ASC. As noted previously, the net effect of the revised ASC payment system on beneficiary coinsurance, taking into account the migration of services from HOPDs and physicians' offices, is estimated to be $20 million in beneficiary savings in CY 2008.

In addition to the lower out-of-pocket expenses, we believe that beneficiaries also will have access to more services in ASCs as a result of the addition of 793 surgical procedures to the ASC list of covered surgical services eligible for Medicare payment. We expect that ASCs will provide a broader range of surgical services under the revised payment system and that beneficiaries will benefit from having access to a greater variety of surgical procedures in ASCs.

5. Conclusion

The changes to the ASC payment system for CY 2008 will affect each of the more than 4,600 ASCs currently approved for participation in the Medicare program. The effect on an

individual ASC will depend on the ASC's mix of patients, the proportion of the ASC's patients that are Medicare beneficiaries, the degree to which the payments for the procedures offered by the ASC are changed under the revised payment system, and the degree to which the ASC chooses to provide a different set of procedures. The revised ASC payment system is designed to result in the same aggregate amount of Medicare expenditures in CY 2008 that would be made in the absence of the revised ASC payment system. As mentioned previously, we estimate that the revised ASC payment system and the expanded ASC list of covered surgical procedures that we are implementing in CY 2008 will have no net effect on Medicare expenditures compared to the level of Medicare expenditures that would have occurred in CY 2008 in the absence of the revised payment system. However, there will be a total increase in Medicare payments to ASCs for CY 2008 of approximately $270 million as a result of the revised ASC payment system, which will be fully offset by savings from reduced Medicare spending in HOPDs and physicians' offices on services that migrate from these settings to ASCs (as discussed in detail in section V.C. of this final rule). Furthermore, we estimate that the revised ASC payment system will result in Medicare savings of $240 million over 5 years due to migration of new ASC services from HOPDs and physicians' offices to ASCs over time. We anticipate that this final rule will have a significant economic impact on a substantial number of small entities.

6. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehousegov/omb/circulars/a004/a-4.pdf*), in Table 13 below, we have prepared an accounting statement showing the classification of the expenditures associated with the implementation of the CY 2008 revised ASC payment system, based on the provisions of this final rule. As explained above, we estimate that Medicare payments to ASCs in CY 2008 will be about $270 million higher than they would otherwise be in the absence of the revised ASC payment system. This $270 million in additional payments to ASCs in CY 2008 will be fully offset by savings from reduced spending in HOPDs and physicians' offices on services that migrate from these settings to ASCs. This table provides our best estimate of Medicare payments to providers and suppliers as a result of the CY 2008 revised ASC payment system, as presented in this final rule. All expenditures are classified as transfers.

TABLE 13.—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES FROM CY 2007 TO CY 2008 AS A RESULT OF THE CY 2008 REVISED ASC PAYMENT SYSTEM

Category	Transfers
Annualized Monetized Transfers.	$0 Million.
From Whom to Whom	Federal Government to Medicare Providers and Suppliers.
Annualized Monetized Transfer.	$0 Million.
From Whom to Whom	Premium Payments from Beneficiaries to Federal Government.
Total	$0 Million.

C. Executive Order 12866

In accordance with the provisions of Executive Order 12866, this final rule was reviewed by the OMB.

List of Subjects

42 CFR Part 410

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

42 CFR Part 416

Health facilities, Kidney diseases, Medicare, Reporting and recordkeeping requirements.

■ For reasons stated in the preamble of this final rule, the Centers for Medicare & Medicaid Services is amending 42 CFR Chapter IV as set forth below:

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

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

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

■ 2. Section 410.152 is amended by adding a new paragraph (i)(2) to read as follows:

§ 410.152 Amounts of payment.

* * * * *

(i) * * *

(2) For ASC services furnished on or after January 1, 2008, in connection with the covered surgical procedures specified in § 416.166 of this subchapter, except as provided in paragraphs (i)(2)(i) and (i)(2)(ii) of this section, Medicare Part B pays the lesser of 80 percent of the actual charge or 80 percent of the prospective payment amount, geographically adjusted, if applicable, as determined under Subpart F of Part 416 of this subchapter. Part B coinsurance is 20 percent of the actual charge or 20 percent of the prospective payment amount, geographically adjusted, if applicable.

(i) If the limitation described in § 416.167(b)(3) of this subchapter applies, Medicare pays 80 percent of the amount determined under Subpart B of Part 414 of this subchapter and Part B coinsurance is 20 percent of the applicable payment amount.

(ii) Medicare Part B pays 75 percent of the applicable payment amount for screening flexible sigmoidoscopies and screening colonoscopies, and Part B coinsurance is 25 percent of the applicable payment amount.

* * * * *

PART 416—AMBULATORY SURGICAL SERVICES

■ 3. The authority citation for part 416 continues to read as follows:

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

■ 4. Section 416.2 is amended by—
■ a. Revising the definition of ''ASC services.''
■ b. Adding a definition of ''Covered ancillary services'' in alphabetical order.
■ c. Revising the definition of ''Covered surgical procedures.''
■ d. Revising the definition of ''Facility services.''

The revisions and addition read as follows:

§ 416.2 Definitions.

* * * * *

ASC services means, for the period before January 1, 2008, facility services that are furnished in an ASC, and beginning January 1, 2008, means the combined facility services and covered ancillary services that are furnished in an ASC in connection with covered surgical procedures.

Covered ancillary services means items and services that are integral to a covered surgical procedure performed in an ASC as provided in § 416.164(b), for which payment may be made under § 416.171 in addition to the payment for the facility services.

Covered surgical procedures means those surgical procedures furnished before January 1, 2008, that meet the criteria specified in § 416.65 and those surgical procedures furnished on or after January 1, 2008, that meet the criteria specified in § 416.166.

Facility services means for the period before January 1, 2008, services that are furnished in connection with covered surgical procedures performed in an ASC, and beginning January 1, 2008, means services that are furnished in connection with covered surgical procedures performed in an ASC as provided in § 416.164(a) for which payment is included in the ASC payment established under § 416.171 for the covered surgical procedure.

■ 5. A new Subpart F is added to read as follows:

Subpart F—Coverage, Scope of ASC Services, and Prospective Payment System for ASC Services Furnished on or After January 1, 2008

Sec.

Subpart F—Coverage, Scope of ASC Services, and Prospective Payment System for ASC Services Furnished on or After January 1, 2008

§ 416.160 Basis and scope.

(a) *Statutory basis.* (1) Section 1833(i)(2)(D) of the Act requires the Secretary to implement a revised payment system for payment of surgical services furnished in ASCs. The statute requires that, in the year such system is implemented, the system shall be designed to result in the same amount of aggregate expenditures for such services as would be made if there was no requirement for a revised payment system. The revised payment system shall be implemented no earlier than January 1, 2006, and no later than January 1, 2008. There shall be no administrative or judicial review under section 1869 of the Act, section 1878 of the Act, or otherwise of the classification system, the relative weights, payment amounts, and the geographic adjustment factor, if any, of the revised payment system.

(2) Section 1833(a)(1)(G) of the Act provides that, beginning with the implementation date of a revised payment system for ASC facility services furnished in connection with a surgical procedure pursuant to section 1833(i)(1)(A) of the Act, the amount paid shall be 80 percent of the lesser of the actual charge for such services or the amount determined by the Secretary under the revised payment system.

(3) Section 1833(i)(1)(A) of the Act requires the Secretary to specify the surgical procedures that can be performed safely on an ambulatory basis in an ASC.

(4) Section 1834(d) of the Act specifies that, when screening colonoscopies or screening flexible sigmoidoscopies are performed in an ASC or hospital outpatient department, payment shall be based on the lesser of the amount under the fee schedule that would apply to such services if they were performed in a hospital outpatient department in an area or the amount under the fee schedule that would apply to such services if they were performed in an ambulatory surgical center in the same area. Section 1834(d) of the Act further specifies that the coinsurance for screening flexible sigmoidoscopy and screening colonoscopy procedures is 25 percent of the payment amount. Section 1834(d) of the Act also specifies that, in the case of screening flexible sigmoidoscopy and screening colonoscopy services, their payment amounts must not exceed the payment rates established for the related diagnostic services. Section 1833(b)(8) of the Act specifies that the Part B deductible shall not apply with respect to colorectal screening tests as described in section 1861(pp)(1) of the Act, which include screening colonoscopies and screening flexible sigmoidoscopies.

(b) *Scope.* This subpart sets forth—

(1) The scope of ASC services and the criteria for determining the covered surgical procedures for which Medicare provides payment for the associated facility services and covered ancillary services;

(2) The basis of payment for facility services and for covered ancillary services furnished in an ASC in connection with a covered surgical procedure;

(3) The methodologies by which Medicare determines payment amounts for ASC services.

§ 416.161 Applicability of this subpart.

The provisions of this subpart apply to ASC services furnished on or after January 1, 2008.

§ 416.163 General rules.

(a) Payment is made under this subpart for ASC services specified in §§ 416.164(a) and (b) furnished to Medicare beneficiaries by a participating ASC in connection with covered surgical procedures as determined by the Secretary in accordance with § 416.166.

(b) Payment for physicians' services and payment for anesthetists' services are made in accordance with Part 414 of this subchapter.

(c) Payment for items and services other than physicians' and anesthetists' services, as specified in § 416.164(c), is made in accordance with § 410.152 of this subchapter.

§ 416.164 Scope of ASC services.

(a) *Included facility services.* ASC services for which payment is packaged into the ASC payment for a covered surgical procedure under § 416.166 include, but are not limited to—

(1) Nursing, technician, and related services;

(2) Use of the facility where the surgical procedures are performed;

(3) Any laboratory testing performed under a Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate of waiver;

(4) Drugs and biologicals for which separate payment is not allowed under the hospital outpatient prospective payment system (OPPS);

(5) Medical and surgical supplies not on pass-through status under Subpart G of Part 419 of this subchapter;

(6) Equipment;

(7) Surgical dressings;

(8) Implanted prosthetic devices, including intraocular lenses (IOLs), and related accessories and supplies not on pass-through status under Subpart G of Part 419 of this subchapter;

(9) Implanted DME and related accessories and supplies not on pass-through status under Subpart G of Part 419 of this subchapter;

(10) Splints and casts and related devices;

(11) Radiology services for which separate payment is not allowed under the OPPS, and other diagnostic tests or interpretive services that are integral to a surgical procedure;

(12) Administrative, recordkeeping and housekeeping items and services;

(13) Materials, including supplies and equipment for the administration and monitoring of anesthesia; and

(14) Supervision of the services of an anesthetist by the operating surgeon.

(b) *Covered ancillary services.* Ancillary items and services that are integral to a covered surgical procedure, as defined in § 416.166, and for which separate payment is allowed include:

(1) Brachytherapy sources;

(2) Certain implantable items that have pass-through status under the OPPS;

(3) Certain items and services that CMS designates as contractor-priced,

including, but not limited to, the procurement of corneal tissue;

(4) Certain drugs and biologicals for which separate payment is allowed under the OPPS;

(5) Certain radiology services for which separate payment is allowed under the OPPS.

(c) *Excluded services.* ASC services do not include items and services outside the scope of ASC services for which payment may be made under Part 414 of this subchapter in accordance with § 410.152, including, but not limited to—

(1) Physicians' services (including surgical procedures and all preoperative and postoperative services that are performed by a physician);

(2) Anesthetists' services;

(3) Radiology services (other than those integral to performance of a covered surgical procedure);

(4) Diagnostic procedures (other than those directly related to performance of a covered surgical procedure);

(5) Ambulance services;

(6) Leg, arm, back, and neck braces other than those that serve the function of a cast or splint;

(7) Artificial limbs;

(8) Nonimplantable prosthetic devices and DME.

§ 416.166 Covered surgical procedures.

(a) *Covered surgical procedures.* Effective for services furnished on or after January 1, 2008, covered surgical procedures are those procedures that meet the general standards described in paragraph (b) of this section (whether commonly furnished in an ASC or a physician's office) and are not excluded under paragraph (c) of this section.

(b) *General standards.* Subject to the exclusions in paragraph (c) of this section, covered surgical procedures are surgical procedures specified by the Secretary and published in the **Federal Register** that are separately paid under the OPPS, that would not be expected to pose a significant safety risk to a Medicare beneficiary when performed in an ASC, and for which standard medical practice dictates that the beneficiary would not typically be expected to require active medical monitoring and care at midnight following the procedure.

(c) *General exclusions.* Notwithstanding paragraph (b) of this section, covered surgical procedures do not include those surgical procedures that—

(1) Generally result in extensive blood loss;

(2) Require major or prolonged invasion of body cavities;

(3) Directly involve major blood vessels;

(4) Are generally emergent or life-threatening in nature;

(5) Commonly require systemic thrombolytic therapy;

(6) Are designated as requiring inpatient care under § 419.22(n) of this subchapter;

(7) Can only be reported using a CPT unlisted surgical procedure code; or

(8) Are otherwise excluded under § 411.15 of this subchapter.

§ 416.167 Basis of payment.

(a) *Unit of payment.* Under the ASC payment system, prospectively determined amounts are paid for ASC services furnished to Medicare beneficiaries in connection with covered surgical procedures. Covered surgical procedures and covered ancillary services are identified by codes established under the Healthcare Common Procedure Coding System (HCPCS). The unadjusted national payment rate is determined according to the methodology described in § 416.171. The manner in which the Medicare payment amount and the beneficiary coinsurance amount for each ASC service is determined is described in § 416.172.

(b) *Ambulatory payment classification (APC) groups and payment weights.*

(1) ASC covered surgical procedures are classified using the APC groups described in § 419.31 of this subchapter.

(2) For purposes of calculating ASC national payment rates under the methodology described in § 416.171, except as specified in paragraph (b)(3) of this section, an ASC relative payment weight is determined based on the APC relative payment weight for each covered surgical procedure and covered ancillary service that has an applicable APC relative payment weight described in § 419.31 of this subchapter.

(3) Notwithstanding paragraph (b)(2) of this section, the relative payment weights for services paid in accordance with § 416.171(d) are determined so that the national ASC payment rate does not exceed the unadjusted nonfacility practice expense amount paid under the Medicare physician fee schedule for such procedures under Subpart B of Part 414 of this subchapter.

§ 416.171 Determination of payment rates for ASC services.

(a) *Standard methodology.* The standard methodology for determining the national unadjusted payment rate for ASC services is to calculate the product of the applicable conversion factor and the relative payment weight established under § 416.167(b), unless otherwise indicated in this section.

(1) *Conversion factor for CY 2008.* CMS calculates a conversion factor so that payment for ASC services furnished in CY 2008 would result in the same aggregate amount of expenditures as would be made if the provisions in this Subpart F did not apply, as estimated by CMS.

(2) *Conversion factor for CY 2009 and subsequent calendar years.* The conversion factor for a calendar year is equal to the conversion factor calculated for the previous year, updated as follows:

(i) For CY 2009, the update is equal to zero percent.

(ii) For CY 2010 and subsequent calendar years, the update is the Consumer Price Index for All Urban Consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved.

(b) *Exception.* The national ASC payment rates for the following items and services are not determined in accordance with paragraph (a) of this section but are paid an amount derived from the payment rate for the equivalent item or service set under the payment system established in Part 419 of this subchapter as updated annually in the **Federal Register**. If a payment rate is not available, the following items and services are designated as contractor-priced:

(1) Covered ancillary services specified in § 416.164(b), with the exception of radiology services as provided in § 416.164(b)(5);

(2) Device-intensive procedures assigned to device-dependent APCs under the OPPS with device costs greater than 50 percent of the APC cost;

(3) Procedures using certain separately paid implantable devices that are approved for transitional pass-through payment in accordance with § 419.66 of this subchapter.

(c) *Transitional payment rates.* (1) ASC payment rates for CY 2008 are a transitional blend of 75 percent of the CY 2007 ASC payment rate for a covered surgical procedure on the CY 2007 ASC list of surgical procedures and 25 percent of the payment rate for the procedure calculated under the methodology described in paragraph (a) of this section.

(2) ASC payment rates for CY 2009 are a transitional blend of 50 percent of the CY 2007 ASC payment rate for a covered surgical procedure on the CY 2007 ASC list of surgical procedures and 50 percent of the payment rate for the procedure calculated under the methodology described in paragraph (a) of this section.

(3) ASC payment rates for CY 2010 are a transitional blend of 25 percent of the CY 2007 ASC payment rate for a

covered surgical procedure on the CY 2007 ASC list of surgical procedures and 75 percent of the payment rate for the procedure calculated under the methodology described in paragraph (a) of this section.

(4) The national ASC payment rate for CY 2011 and subsequent calendar years for a covered surgical procedure designated in accordance with § 416.166 is the payment rates for the procedure calculated under the methodology described in paragraph (a) of this section.

(5) Covered ancillary services described in § 416.164(b) and surgical procedures identified as covered when performed in an ASC under § 416.166 for the first time beginning on or after January 1, 2008, are not subject to the transitional payment rates applicable in CYs 2008 through 2010 for ASC facility services.

(d) *Limitation on payment rates for office-based surgical procedures and covered ancillary radiology services.* Notwithstanding the provisions of paragraph (a) of this section, for any covered surgical procedure under § 416.166 that CMS determines is commonly performed in physicians' offices or for any covered ancillary radiology service, the national unadjusted ASC payment rates for these procedures and services will be the lesser of the amount determined under paragraph (a) of this section or the amount calculated at the nonfacility practice expense relative value units under § 414.22(b)(5)(i)(B) of this subchapter multiplied by the conversion factor described in § 414.20(a)(3) of this subchapter.

(e) *Budget neutrality.* (1) For CY 2008, CMS establishes the conversion factor to result in budget neutrality as estimated by CMS in accordance with paragraph (a)(1) of this section.

(2) For CY 2009 and subsequent calendar years, CMS adjusts the ASC relative payment weights under § 416.167(b)(2) as needed so that any updates and adjustments made under § 419.50(a) of this subchapter are budget neutral as estimated by CMS.

§ 416.172 Adjustments to national payment rates.

(a) *General rule.* Contractors adjust the payment rates established for ASC services to determine Medicare program payment and beneficiary coinsurance amounts in accordance with paragraphs (b) through (g) of this section.

(b) *Lesser of actual charge or geographically adjusted payment rate.* Payments to ASCs equal 80 percent of the lesser of—

(1) The actual charge for the service; or

(2) The geographically adjusted payment rate determined under this subpart.

(c) *Geographic adjustment.*—(1) *General rule.* Except as provided in paragraph (c)(2) of this section, the national ASC payment rates established under § 416.171 for covered surgical procedures are adjusted for variations in ASC labor costs across geographic areas using wage index values, labor and nonlabor percentages, and localities specified by the Secretary.

(2) *Exception.* The geographic adjustment is not applied to the payment rates set for drugs, biologicals, devices with OPPS transitional pass-through payment status, and brachytherapy sources.

(d) *Deductibles and coinsurance.* Part B deductible and coinsurance amounts apply as specified in §§ 410.152(a) and (i)(2) of this subchapter.

(e) *Payment reductions for multiple surgical procedures.*—(1) *General rule.* Except as provided in paragraph (e)(2) of this section, when more than one covered surgical procedure for which payment is made under the ASC payment system is performed during an operative session, the Medicare program payment amount and the beneficiary coinsurance amount are based on—

(i) 100 percent of the applicable ASC payment amount for the procedure with the highest national unadjusted ASC payment rate; and

(ii) 50 percent of the applicable ASC payment amount for all other covered surgical procedures.

(2) *Exception: Procedures not subject to multiple procedure discounting.* CMS may apply any policies or procedures used with respect to multiple procedures under the prospective payment system for hospital outpatient department services under Part 419 of this subchapter as may be consistent with the equitable and efficient administration of this part.

(f) *Interrupted procedures.* When a covered surgical procedure or covered ancillary service is terminated prior to completion due to extenuating circumstances or circumstances that threaten the well-being of the patient, the Medicare program payment amount and the beneficiary coinsurance amount are based on one of the following—

(1) The full program and beneficiary coinsurance amounts if the procedure for which anesthesia is planned is discontinued after the induction of anesthesia or after the procedure is started;

(2) One-half of the full program and beneficiary coinsurance amounts if the procedure for which anesthesia is planned is discontinued after the patient is prepared for surgery and taken to the room where the procedure is to be performed but before the anesthesia is induced; or

(3) One-half of the full program and beneficiary coinsurance amounts if a covered surgical procedure or covered ancillary service for which anesthesia is not planned is discontinued after the patient is prepared and taken to the room where the service is to be provided.

(g) *Payment adjustment for new technology intraocular lenses (NTIOLs).* A payment adjustment will be made for insertion of an IOL approved as belonging to a class of NTIOLs as defined in Subpart G.

§ 416.173 Publication of revised payment methodologies and payment rates.

CMS publishes annually, through notice and comment rulemaking in the **Federal Register**, the payment methodologies and payment rates for ASC services and designates the covered surgical procedures and covered ancillary services for which CMS will make an ASC payment and other revisions as appropriate.

§ 416.178 Limitations on administrative and judicial review.

There is no administrative or judicial review under section 1869 of the Act, section 1878 of the Act, or otherwise of the following:

(a) The classification system;

(b) Relative weights;

(c) Payment amounts; and

(d) Geographic adjustment factors.

§ 416.179 Payment and coinsurance reduction for devices replaced without cost or when full credit is received.

(a) *General rule.* CMS reduces the amount of payment for a covered surgical procedure for which CMS determines that a significant portion of the payment is attributable to the cost of an implanted device not on pass-through status under Subpart G of Part 419 of this subchapter when one of the following situations occur:

(1) The device is replaced without cost to the ASC or the beneficiary; or

(2) The ASC receives full credit for the cost of a replaced device.

(b) *Amount of reduction to the ASC payment for the covered surgical procedure.* The amount of the reduction to the ASC payment made under paragraph (a) of this section is calculated in the same manner as the device payment reduction that would be applied to the ASC payment for the covered surgical procedure in order to remove predecessor device costs so that

the ASC payment amount for a device with pass-through status under § 419.66 of this subchapter represents the full cost of the device, and no packaged device payment is provided through the ASC payment for the covered surgical procedure.

(c) *Amount of beneficiary coinsurance.* The beneficiary coinsurance is calculated based on the ASC payment for the covered surgical procedure after application of the reduction under paragraph (b) of this section.

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

Dated: April 24, 2007.

Leslie Norwalk,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: May 31, 2007.

Michael O. Leavitt,

Secretary.

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
0016T	Thermotx choroids vasc lesion	Y	R2		3.9333	$167.33	$167.33
0017T	Photocoagulat macular drusen	Y	R2		3.9333	$167.33	$167.33
0027T	Endoscopic epidural lysis	Y	G2		17.8499	$759.39	$759.39
0031T	Speculoscopy		N1				
0032T	Speculoscopy w/direct sample		N1				
0046T	Cath lavage, mammary duct(s)	Y	R2		15.1024	$642.50	$642.50
0047T	Cath lavage, mammary duct(s)	Y	R2		15.1024	$642.50	$642.50
0062T	Rep intradisc annulus;1 lev	Y	G2		25.1296	$1,069.09	$1,069.09
0063T	Rep intradisc annulus;>1lev	Y	G2		25.1296	$1,069.09	$1,069.09
0084T	Temp prostate urethral stent	Y	G2		2.1393	$91.01	$91.01
0099T*	Implant corneal ring	Y	R2		15.2259	$647.76	$647.76
0100T	Prosth retina receive&gen	Y	G2		37.4290	$1,592.34	$1,592.34
0101T	Extracorp shockwv tx,hi enrg	Y	G2		25.1296	$1,069.09	$1,069.09
0102T	Extracorp shockwv tx,anesth	Y	G2		25.1296	$1,069.09	$1,069.09
0123T	Scleral fistulization	Y	G2		22.9970	$978.36	$978.36
0124T*	Conjunctival drug placement	Y	R2		6.0673	$258.12	$258.12
0133T	Esophageal implant injexn	Y	G2		25.7552	$1,095.70	$1,095.70
0176T	Aqu canal dilat w/o retent	Y	A2	$1,339.00	37.8967	$1,612.24	$1,407.31
0177T	Aqu canal dilat w retent	Y	A2	$1,339.00	37.8967	$1,612.24	$1,407.31
10021	Fna w/o image	Y	P2		1.0995	$46.78	$46.78
10022	Fna w/image	Y	G2		2.0738	$88.23	$88.23
10040	Acne surgery	Y	P2		0.4760	$20.25	$20.25
10060	Drainage of skin abscess	Y	P3		1.0944	$46.56	$46.56
10061	Drainage of skin abscess	Y	P2		1.4392	$61.23	$61.23
10080	Drainage of pilonidal cyst	Y	P2		1.4392	$61.23	$61.23
10081	Drainage of pilonidal cyst	Y	P3		3.0339	$129.07	$129.07
10120	Remove foreign body	Y	P2		1.4392	$61.23	$61.23
10121	Remove foreign body	Y	A2	$446.00	15.1024	$642.50	$495.13
10140	Drainage of hematoma/fluid	Y	P3		1.6174	$68.81	$68.81
10160	Puncture drainage of lesion	Y	P2		1.0259	$43.64	$43.64
10180	Complex drainage, wound	Y	A2	$446.00	17.5086	$744.87	$520.72
11000	Debride infected skin	Y	P3		0.5312	$22.60	$22.60
11001	Debride infected skin add-on	Y	P3		0.1850	$7.87	$7.87
11010	Debride skin, fx	Y	A2	$251.52	4.0919	$174.08	$232.16
11011	Debride skin/muscle, fx	Y	A2	$251.52	4.0919	$174.08	$232.16
11012	Debride skin/muscle/bone, fx	Y	A2	$251.52	4.0919	$174.08	$232.16
11040	Debride skin, partial	Y	P3		0.4828	$20.54	$20.54
11041	Debride skin, full	Y	P3		0.5632	$23.96	$23.96
11042	Debride skin/tissue	Y	A2	$164.42	2.6749	$113.80	$151.77
11043	Debride tissue/muscle	Y	A2	$164.42	2.6749	$113.80	$151.77
11044	Debride tissue/muscle/bone	Y	A2	$423.10	6.8832	$292.83	$390.53
11055	Trim skin lesion	Y	P3		0.5552	$23.62	$23.62
11056	Trim skin lesions, 2 to 4	Y	P3		0.6116	$26.02	$26.02
11057	Trim skin lesions, over 4	Y	P3		0.7000	$29.78	$29.78
11100	Biopsy, skin lesion	Y	P2		1.0259	$43.64	$43.64
11101	Biopsy, skin add-on	Y	P3		0.2978	$12.67	$12.67
11200	Removal of skin tags	Y	P3		0.9174	$39.03	$39.03
11201	Remove skin tags add-on	Y	P3		0.1288	$5.48	$5.48
11300	Shave skin lesion	Y	P2		0.8432	$35.87	$35.87
11301	Shave skin lesion	Y	P2		0.8432	$35.87	$35.87
11302	Shave skin lesion	Y	P2		1.0918	$46.45	$46.45
11303	Shave skin lesion	Y	P3		1.4484	$61.62	$61.62
11305	Shave skin lesion	Y	P3		0.7726	$32.87	$32.87
11306	Shave skin lesion	Y	P3		1.0140	$43.14	$43.14
11307	Shave skin lesion	Y	P2		1.0918	$46.45	$46.45
11308	Shave skin lesion	Y	P2		1.0918	$46.45	$46.45
11310	Shave skin lesion	Y	P3		1.0058	$42.79	$42.79
11311	Shave skin lesion	Y	P2		1.0918	$46.45	$46.45
11312	Shave skin lesion	Y	P2		1.0918	$46.45	$46.45
11313	Shave skin lesion	Y	P3		1.6094	$68.47	$68.47
11400	Exc tr-ext b9+marg 0.5 <cm	Y	P3		1.5530	$66.07	$66.07
11401	Exc tr-ext b9+marg 0.6–1 cm	Y	P3		1.6980	$72.24	$72.24
11402	Exc tr-ext b9+marg 1.1–2 cm	Y	P3		1.8508	$78.74	$78.74

Note: The Medicare program payment is 80 percent of the total payment amount and beneficiary coinsurance is 20 percent of the total payment amount, except for screening flexible sigmoidoscopies and screening colonoscopies for which the program payment is 75 percent and the beneficiary coinsurance is 25 percent.

* Refers to codes designated as ''office-based'', whose designation as office-based is temporary because we have insufficient claims data. We will reconsider this designation when new claims data become available.

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
11403	Exc tr-ext b9+marg 2.1–3 cm	Y	P3		1.9876	$84.56	$84.56
11404	Exc tr-ext b9+marg 3.1–4 cm	Y	A2	$333.00	15.1024	$642.50	$410.38
11406	Exc tr-ext b9+marg > 4.0 cm	Y	A2	$446.00	15.1024	$642.50	$495.13
11420	Exc h-f-nk-sp b9+marg 0.5<	Y	P3		1.4484	$61.62	$61.62
11421	Exc h-f-nk-sp b9+marg 0.6–1	Y	P3		1.7220	$73.26	$73.26
11422	Exc h-f-nk-sp b9+marg 1.1–2	Y	P3		1.8750	$79.77	$79.77
11423	Exc h-f-nk-sp b9+marg 2.1–3	Y	P3		2.1085	$89.70	$89.70
11424	Exc h-f-nk-sp b9+marg 3.1–4	Y	A2	$446.00	15.1024	$642.50	$495.13
11426	Exc h-f-nk-sp b9+marg > 4 cm	Y	A2	$446.00	20.0656	$853.65	$547.91
11440	Exc face-mm b9+marg 0.5 < cm	Y	P3		1.6898	$71.89	$71.89
11441	Exc face-mm b9+marg 0.6–1 cm	Y	P3		1.8993	$80.80	$80.80
11442	Exc face-mm b9+marg 1.1–2 cm	Y	P3		2.0763	$88.33	$88.33
11443	Exc face-mm b9+marg 2.1-3 cm	Y	P3		2.3256	$98.94	$98.94
11444	Exc face-mm b9+marg 3.1–4 cm	Y	A2	$333.00	6.8083	$289.65	$322.16
11446	Exc face-mm b9+marg > 4 cm	Y	A2	$446.00	20.0656	$853.65	$547.91
11450	Removal, sweat gland lesion	Y	A2	$446.00	20.0656	$853.65	$547.91
11451	Removal, sweat gland lesion	Y	A2	$446.00	20.0656	$853.65	$547.91
11462	Removal, sweat gland lesion	Y	A2	$446.00	20.0656	$853.65	$547.91
11463	Removal, sweat gland lesion	Y	A2	$446.00	20.0656	$853.65	$547.91
11470	Removal, sweat gland lesion	Y	A2	$446.00	20.0656	$853.65	$547.91
11471	Removal, sweat gland lesion	Y	A2	$446.00	20.0656	$853.65	$547.91
11600	Exc tr-ext mlg+marg 0.5 < cm	Y	P3		2.1646	$92.09	$92.09
11601	Exc tr-ext mlg+marg 0.6–1 cm	Y	P3		2.4787	$105.45	$105.45
11602	Exc tr-ext mlg+marg 1.1-2 cm	Y	P3		2.6879	$114.35	$114.35
11603	Exc tr-ext mlg+marg 2.1–3 cm	Y	P3		2.8729	$122.22	$122.22
11604	Exc tr-ext mlg+marg 3.1–4 cm	Y	A2	$418.49	6.8083	$289.65	$386.28
11606	Exc tr-ext mlg+marg > 4 cm	Y	A2	$446.00	15.1024	$642.50	$495.13
11620	Exc h-f-nk-sp mlg+marg 0.5	Y	P3		2.1888	$93.12	$93.12
11621	Exc h-f-nk-sp mlg+marg 0.6–1	Y	P3		2.4947	$106.13	$106.13
11622	Exc h-f-nk-sp mlg+marg 1.1–2	Y	P3		2.7683	$117.77	$117.77
11623	Exc h-f-nk-sp mlg+marg 2.1–3	Y	P3		3.0017	$127.70	$127.70
11624	Exc h-f-nk-sp mlg+marg 3.1–4	Y	A2	$446.00	15.1024	$642.50	$495.13
11626	Exc h-f-nk-sp mlg+mar > 4 cm	Y	A2	$446.00	20.0656	$853.65	$547.91
11640	Exc face-mm malig+marg 0.5<	Y	P3		2.2934	$97.57	$97.57
11641	Exc face-mm malig+marg 0.6–1	Y	P3		2.6796	$114.00	$114.00
11642	Exc face-mm malig+marg 1.1–2	Y	P3		2.9937	$127.36	$127.36
11643	Exc face-mm malig+marg 2.1–3	Y	P3		3.2511	$138.31	$138.31
11644	Exc face-mm malig+marg 3.1–4	Y	A2	$446.00	15.1024	$642.50	$495.13
11646	Exc face-mm mlg+marg > 4 cm	Y	A2	$446.00	20.0656	$853.65	$547.91
11719	Trim nail(s)	Y	P3		0.2494	$10.61	$10.61
11720	Debride nail, 1–5	Y	P3		0.3218	$13.69	$13.69
11721	Debride nail, 6 or more	Y	P3		0.4024	$17.12	$17.12
11730	Removal of nail plate	Y	P3		0.9576	$40.74	$40.74
11732	Remove nail plate, add-on	Y	P3		0.4024	$17.12	$17.12
11740	Drain blood from under nail	Y	P3		0.5392	$22.94	$22.94
11750	Removal of nail bed	Y	P3		2.0763	$88.33	$88.33
11752	Remove nail bed/finger tip	Y	P3		2.8729	$122.22	$122.22
11755	Biopsy, nail unit	Y	P3		1.4566	$61.97	$61.97
11760	Repair of nail bed	Y	G2		1.4843	$63.15	$63.15
11762	Reconstruction of nail bed	Y	P2		1.4843	$63.15	$63.15
11765	Excision of nail fold, toe	Y	P2		1.6241	$69.09	$69.09
11770	Removal of pilonidal lesion	Y	A2	$510.00	20.0656	$853.65	$595.91
11771	Removal of pilonidal lesion	Y	A2	$510.00	20.0656	$853.65	$595.91
11772	Removal of pilonidal lesion	Y	A2	$510.00	20.0656	$853.65	$595.91
11900	Injection into skin lesions	Y	P3		0.6358	$27.05	$27.05
11901	Added skin lesions injection	Y	P3		0.6760	$28.76	$28.76
11920	Correct skin color defects	Y	P2		1.4843	$63.15	$63.15
11921	Correct skin color defects	Y	P2		1.4843	$63.15	$63.15
11922	Correct skin color defects	Y	P3		0.8368	$35.60	$35.60
11950	Therapy for contour defects	Y	P3		0.8048	$34.24	$34.24
11951	Therapy for contour defects	Y	P3		1.0784	$45.88	$45.88
11952	Therapy for contour defects	Y	P3		1.4484	$61.62	$61.62
11954	Therapy for contour defects	Y	P2		1.4843	$63.15	$63.15

Note: The Medicare program payment is 80 percent of the total payment amount and beneficiary coinsurance is 20 percent of the total payment amount, except for screening flexible sigmoidoscopies and screening colonoscopies for which the program payment is 75 percent and the beneficiary coinsurance is 25 percent.

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
11960	Insert tissue expander(s)	Y	A2	$446.00	21.4302	$911.71	$562.43
11970	Replace tissue expander	Y	A2	$510.00	41.0893	$1,748.06	$819.52
11971	Remove tissue expander(s)	Y	A2	$333.00	20.0656	$853.65	$463.16
11976	Removal of contraceptive cap	Y	P3		1.3760	$58.54	$58.54
11980	Implant hormone pellet(s)	N	P2		0.6102	$25.96	$25.96
11981	Insert drug implant device	N	P2		0.6102	$25.96	$25.96
11982	Remove drug implant device	N	P2		0.6102	$25.96	$25.96
11983	Remove/insert drug implant	N	P2		0.6102	$25.96	$25.96
12001	Repair superficial wound(s)	Y	P2		1.4843	$63.15	$63.15
12002	Repair superficial wound(s)	Y	P2		1.4843	$63.15	$63.15
12004	Repair superficial wound(s)	Y	P2		1.4843	$63.15	$63.15
12005	Repair superficial wound(s)	Y	A2	$91.24	1.4843	$63.15	$84.22
12006	Repair superficial wound(s)	Y	A2	$91.24	1.4843	$63.15	$84.22
12007	Repair superficial wound(s)	Y	A2	$91.24	1.4843	$63.15	$84.22
12011	Repair superficial wound(s)	Y	P2		1.4843	$63.15	$63.15
12013	Repair superficial wound(s)	Y	P2		1.4843	$63.15	$63.15
12014	Repair superficial wound(s)	Y	P2		1.4843	$63.15	$63.15
12015	Repair superficial wound(s)	Y	G2		1.4843	$63.15	$63.15
12016	Repair superficial wound(s)	Y	A2	$91.24	1.4843	$63.15	$84.22
12017	Repair superficial wound(s)	Y	A2	$91.24	1.4843	$63.15	$84.22
12018	Repair superficial wound(s)	Y	A2	$91.24	1.4843	$63.15	$84.22
12020	Closure of split wound	Y	A2	$91.24	1.4843	$63.15	$84.22
12021	Closure of split wound	Y	A2	$91.24	1.4843	$63.15	$84.22
12031	Layer closure of wound(s)	Y	P2		1.4843	$63.15	$63.15
12032	Layer closure of wound(s)	Y	P2		1.4843	$63.15	$63.15
12034	Layer closure of wound(s)	Y	A2	$91.24	1.4843	$63.15	$84.22
12035	Layer closure of wound(s)	Y	A2	$91.24	1.4843	$63.15	$84.22
12036	Layer closure of wound(s)	Y	A2	$91.24	1.4843	$63.15	$84.22
12037	Layer closure of wound(s)	Y	A2	$323.28	5.2594	$223.75	$298.40
12041	Layer closure of wound(s)	Y	P2		1.4843	$63.15	$63.15
12042	Layer closure of wound(s)	Y	P2		1.4843	$63.15	$63.15
12044	Layer closure of wound(s)	Y	A2	$91.24	1.4843	$63.15	$84.22
12045	Layer closure of wound(s)	Y	A2	$91.24	1.4843	$63.15	$84.22
12046	Layer closure of wound(s)	Y	A2	$91.24	1.4843	$63.15	$84.22
12047	Layer closure of wound(s)	Y	A2	$323.28	5.2594	$223.75	$298.40
12051	Layer closure of wound(s)	Y	P2		1.4843	$63.15	$63.15
12052	Layer closure of wound(s)	Y	P2		1.4843	$63.15	$63.15
12053	Layer closure of wound(s)	Y	P2		1.4843	$63.15	$63.15
12054	Layer closure of wound(s)	Y	A2	$91.24	1.4843	$63.15	$84.22
12055	Layer closure of wound(s)	Y	A2	$91.24	1.4843	$63.15	$84.22
12056	Layer closure of wound(s)	Y	A2	$91.24	1.4843	$63.15	$84.22
12057	Layer closure of wound(s)	Y	A2	$323.28	5.2594	$223.75	$298.40
13100	Repair of wound or lesion	Y	A2	$323.28	5.2594	$223.75	$298.40
13101	Repair of wound or lesion	Y	A2	$323.28	5.2594	$223.75	$298.40
13102	Repair wound/lesion add-on	Y	A2	$91.24	1.4843	$63.15	$84.22
13120	Repair of wound or lesion	Y	A2	$91.24	1.4843	$63.15	$84.22
13121	Repair of wound or lesion	Y	A2	$91.24	1.4843	$63.15	$84.22
13122	Repair wound/lesion add-on	Y	A2	$91.24	1.4843	$63.15	$84.22
13131	Repair of wound or lesion	Y	A2	$91.24	1.4843	$63.15	$84.22
13132	Repair of wound or lesion	Y	A2	$91.24	1.4843	$63.15	$84.22
13133	Repair wound/lesion add-on	Y	A2	$91.24	1.4843	$63.15	$84.22
13150	Repair of wound or lesion	Y	A2	$323.28	5.2594	$223.75	$298.40
13151	Repair of wound or lesion	Y	A2	$323.28	5.2594	$223.75	$298.40
13152	Repair of wound or lesion	Y	A2	$323.28	5.2594	$223.75	$298.40
13153	Repair wound/lesion add-on	Y	A2	$91.24	1.4843	$63.15	$84.22
13160	Late closure of wound	Y	A2	$446.00	21.4302	$911.71	$562.43
14000	Skin tissue rearrangement	Y	A2	$446.00	14.0346	$597.07	$483.77
14001	Skin tissue rearrangement	Y	A2	$510.00	21.4302	$911.71	$610.43
14020	Skin tissue rearrangement	Y	A2	$510.00	14.0346	$597.07	$531.77
14021	Skin tissue rearrangement	Y	A2	$510.00	14.0346	$597.07	$531.77
14040	Skin tissue rearrangement	Y	A2	$446.00	14.0346	$597.07	$483.77
14041	Skin tissue rearrangement	Y	A2	$510.00	14.0346	$597.07	$531.77
14060	Skin tissue rearrangement	Y	A2	$510.00	14.0346	$597.07	$531.77

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
14061	Skin tissue rearrangement	Y	A2	$510.00	14.0346	$597.07	$531.77
14300	Skin tissue rearrangement	Y	A2	$630.00	21.4302	$911.71	$700.43
14350	Skin tissue rearrangement	Y	A2	$510.00	21.4302	$911.71	$610.43
15002	Wnd prep, ch/inf, trk/arm/lg	Y	A2	$323.28	5.2594	$223.75	$298.40
15003	Wnd prep, ch/inf addl 100 cm	Y	A2	$323.28	5.2594	$223.75	$298.40
15004	Wnd prep ch/inf, f/n/hf/g	Y	A2	$323.28	5.2594	$223.75	$298.40
15005	Wnd prep, f/n/hf/g, addl cm	Y	A2	$323.28	5.2594	$223.75	$298.40
15040	Harvest cultured skin graft	Y	A2	$91.24	1.4843	$63.15	$84.22
15050	Skin pinch graft	Y	A2	$323.28	5.2594	$223.75	$298.40
15100	Skin splt grft, trnk/arm/leg	Y	A2	$446.00	21.4302	$911.71	$562.43
15101	Skin splt grft t/a/l, add-on	Y	A2	$510.00	21.4302	$911.71	$610.43
15110	Epidrm autogrft trnk/arm/leg	Y	A2	$446.00	21.4302	$911.71	$562.43
15111	Epidrm autogrft t/a/l add-on	Y	A2	$333.00	21.4302	$911.71	$477.68
15115	Epidrm a-grft face/nck/hf/g	Y	A2	$446.00	21.4302	$911.71	$562.43
15116	Epidrm a-grft f/n/hf/g addl	Y	A2	$333.00	21.4302	$911.71	$477.68
15120	Skn splt a-grft fac/nck/hf/g	Y	A2	$446.00	21.4302	$911.71	$562.43
15121	Skn splt a-grft f/n/hf/g add	Y	A2	$510.00	21.4302	$911.71	$610.43
15130	Derm autograft, trnk/arm/leg	Y	A2	$446.00	21.4302	$911.71	$562.43
15131	Derm autograft t/a/l add-on	Y	A2	$333.00	21.4302	$911.71	$477.68
15135	Derm autograft face/nck/hf/g	Y	A2	$446.00	21.4302	$911.71	$562.43
15136	Derm autograft, f/n/hf/g add	Y	A2	$333.00	21.4302	$911.71	$477.68
15150	Cult epiderm grft t/arm/leg	Y	A2	$446.00	21.4302	$911.71	$562.43
15151	Cult epiderm grft t/a/l addl	Y	A2	$333.00	21.4302	$911.71	$477.68
15152	Cult epiderm graft t/a/l +%	Y	A2	$333.00	21.4302	$911.71	$477.68
15155	Cult epiderm graft, f/n/hf/g	Y	A2	$446.00	21.4302	$911.71	$562.43
15156	Cult epidrm grft f/n/hfg add	Y	A2	$333.00	21.4302	$911.71	$477.68
15157	Cult epiderm grft f/n/hfg +%	Y	A2	$333.00	21.4302	$911.71	$477.68
15200	Skin full graft, trunk	Y	A2	$510.00	14.0346	$597.07	$531.77
15201	Skin full graft trunk add-on	Y	A2	$323.28	5.2594	$223.75	$298.40
15220	Skin full graft sclp/arm/leg	Y	A2	$446.00	14.0346	$597.07	$483.77
15221	Skin full graft add-on	Y	A2	$323.28	5.2594	$223.75	$298.40
15240	Skin full grft face/genit/hf	Y	A2	$510.00	14.0346	$597.07	$531.77
15241	Skin full graft add-on	Y	A2	$323.28	5.2594	$223.75	$298.40
15260	Skin full graft een & lips	Y	A2	$446.00	14.0346	$597.07	$483.77
15261	Skin full graft add-on	Y	A2	$323.28	5.2594	$223.75	$298.40
15300	Apply skinallogrft, t/arm/lg	Y	A2	$323.28	5.2594	$223.75	$298.40
15301	Apply sknallogrft t/a/l addl	Y	A2	$323.28	5.2594	$223.75	$298.40
15320	Apply skin allogrft f/n/hf/g	Y	A2	$323.28	5.2594	$223.75	$298.40
15321	Aply sknallogrft f/n/hfg add	Y	A2	$323.28	5.2594	$223.75	$298.40
15330	Aply acell alogrft t/arm/leg	Y	A2	$323.28	5.2594	$223.75	$298.40
15331	Aply acell grft t/a/l add-on	Y	A2	$323.28	5.2594	$223.75	$298.40
15335	Apply acell graft, f/n/hf/g	Y	A2	$323.28	5.2594	$223.75	$298.40
15336	Aply acell grft f/n/hf/g add	Y	A2	$323.28	5.2594	$223.75	$298.40
15340	Apply cult skin substitute	Y	P3	.....	3.1385	$133.52	$133.52
15341	Apply cult skin sub add-on	Y	G2	.....	5.2594	$223.75	$223.75
15360	Apply cult derm sub, t/a/l	Y	G2	.....	5.2594	$223.75	$223.75
15361	Aply cult derm sub t/a/l add	Y	G2	.....	5.2594	$223.75	$223.75
15365	Apply cult derm sub f/n/hf/g	Y	G2	.....	5.2594	$223.75	$223.75
15366	Apply cult derm f/hf/g add	Y	G2	.....	5.2594	$223.75	$223.75
15400	Apply skin xenograft, t/a/l	Y	A2	$323.28	5.2594	$223.75	$298.40
15401	Apply skn xenogrft t/a/l add	Y	A2	$323.28	5.2594	$223.75	$298.40
15420	Apply skin xgraft, f/n/hf/g	Y	A2	$323.28	5.2594	$223.75	$298.40
15421	Apply skn xgrft f/n/hf/g add	Y	A2	$323.28	5.2594	$223.75	$298.40
15430	Apply acellular xenograft	Y	A2	$323.28	5.2594	$223.75	$298.40
15431	Apply acellular xgraft add	Y	A2	$323.28	5.2594	$223.75	$298.40
15570	Form skin pedicle flap	Y	A2	$510.00	21.4302	$911.71	$610.43
15572	Form skin pedicle flap	Y	A2	$510.00	21.4302	$911.71	$610.43
15574	Form skin pedicle flap	Y	A2	$510.00	21.4302	$911.71	$610.43
15576	Form skin pedicle flap	Y	A2	$510.00	14.0346	$597.07	$531.77
15600	Skin graft	Y	A2	$510.00	21.4302	$911.71	$610.43
15610	Skin graft	Y	A2	$510.00	21.4302	$911.71	$610.43
15620	Skin graft	Y	A2	$630.00	21.4302	$911.71	$700.43
15630	Skin graft	Y	A2	$510.00	21.4302	$911.71	$610.43

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
15650	Transfer skin pedicle flap	Y	A2	$717.00	21.4302	$911.71	$765.68
15731	Forehead flap w/vasc pedicle	Y	A2	$510.00	14.0346	$597.07	$531.77
15732	Muscle-skin graft, head/neck	Y	A2	$510.00	21.4302	$911.71	$610.43
15734	Muscle-skin graft, trunk	Y	A2	$510.00	21.4302	$911.71	$610.43
15736	Muscle-skin graft, arm	Y	A2	$510.00	21.4302	$911.71	$610.43
15738	Muscle-skin graft, leg	Y	A2	$510.00	21.4302	$911.71	$610.43
15740	Island pedicle flap graft	Y	A2	$446.00	14.0346	$597.07	$483.77
15750	Neurovascular pedicle graft	Y	A2	$446.00	21.4302	$911.71	$562.43
15760	Composite skin graft	Y	A2	$446.00	21.4302	$911.71	$562.43
15770	Derma-fat-fascia graft	Y	A2	$510.00	21.4302	$911.71	$610.43
15775	Hair transplant punch grafts	Y	A2	$323.28	5.2594	$223.75	$298.40
15776	Hair transplant punch grafts	Y	A2	$323.28	5.2594	$223.75	$298.40
15780	Abrasion treatment of skin	Y	P3	.....	9.3992	$399.87	$399.87
15781	Abrasion treatment of skin	Y	P2	.....	4.0919	$174.08	$174.08
15782	Abrasion treatment of skin	Y	P2	.....	4.0919	$174.08	$174.08
15783	Abrasion treatment of skin	Y	P2	.....	2.6749	$113.80	$113.80
15786	Abrasion, lesion, single	Y	P2	.....	1.0918	$46.45	$46.45
15787	Abrasion, lesions, add-on	Y	P3	.....	0.7726	$32.87	$32.87
15788	Chemical peel, face, epiderm	Y	P2	.....	0.8432	$35.87	$35.87
15789	Chemical peel, face, dermal	Y	P2	.....	1.6241	$69.09	$69.09
15792	Chemical peel, nonfacial	Y	P2	.....	1.0918	$46.45	$46.45
15793	Chemical peel, nonfacial	Y	P2	.....	0.8432	$35.87	$35.87
15819	Plastic surgery, neck	Y	G2	.....	5.2594	$223.75	$223.75
15820	Revision of lower eyelid	Y	A2	$510.00	21.4302	$911.71	$610.43
15821	Revision of lower eyelid	Y	A2	$510.00	21.4302	$911.71	$610.43
15822	Revision of upper eyelid	Y	A2	$510.00	21.4302	$911.71	$610.43
15823	Revision of upper eyelid	Y	A2	$717.00	14.0346	$597.07	$687.02
15824	Removal of forehead wrinkles	Y	A2	$510.00	21.4302	$911.71	$610.43
15825	Removal of neck wrinkles	Y	A2	$510.00	21.4302	$911.71	$610.43
15826	Removal of brow wrinkles	Y	A2	$510.00	21.4302	$911.71	$610.43
15828	Removal of face wrinkles	Y	A2	$510.00	21.4302	$911.71	$610.43
15829	Removal of skin wrinkles	Y	A2	$717.00	21.4302	$911.71	$765.68
15830	Exc skin abd	Y	A2	$510.00	20.0656	$853.65	$595.91
15832	Excise excessive skin tissue	Y	A2	$510.00	20.0656	$853.65	$595.91
15833	Excise excessive skin tissue	Y	A2	$510.00	20.0656	$853.65	$595.91
15834	Excise excessive skin tissue	Y	A2	$510.00	20.0656	$853.65	$595.91
15835	Excise excessive skin tissue	Y	A2	$323.28	5.2594	$223.75	$298.40
15836	Excise excessive skin tissue	Y	A2	$510.00	15.1024	$642.50	$543.13
15837	Excise excessive skin tissue	Y	G2	.....	15.1024	$642.50	$642.50
15838	Excise excessive skin tissue	Y	G2	.....	15.1024	$642.50	$642.50
15839	Excise excessive skin tissue	Y	A2	$510.00	15.1024	$642.50	$543.13
15840	Graft for face nerve palsy	Y	A2	$630.00	21.4302	$911.71	$700.43
15841	Graft for face nerve palsy	Y	A2	$630.00	21.4302	$911.71	$700.43
15842	Flap for face nerve palsy	Y	G2	.....	14.0346	$597.07	$597.07
15845	Skin and muscle repair, face	Y	A2	$630.00	21.4302	$911.71	$700.43
15847	Exc skin abd add-on	Y	A2	$510.00	20.0656	$853.65	$595.91
15850	Removal of sutures	Y	G2	.....	2.6749	$113.80	$113.80
15851	Removal of sutures	Y	P3	.....	1.2070	$51.35	$51.35
15852	Dressing change not for burn	N	G2	.....	0.6102	$25.96	$25.96
15860	Test for blood flow in graft	N	G2	.....	0.6102	$25.96	$25.96
15876	Suction assisted lipectomy	Y	A2	$510.00	21.4302	$911.71	$610.43
15877	Suction assisted lipectomy	Y	A2	$510.00	21.4302	$911.71	$610.43
15878	Suction assisted lipectomy	Y	A2	$510.00	14.0346	$597.07	$531.77
15879	Suction assisted lipectomy	Y	A2	$510.00	21.4302	$911.71	$610.43
15920	Removal of tail bone ulcer	Y	A2	$251.52	4.0919	$174.08	$232.16
15922	Removal of tail bone ulcer	Y	A2	$630.00	21.4302	$911.71	$700.43
15931	Remove sacrum pressure sore	Y	A2	$510.00	20.0656	$853.65	$595.91
15933	Remove sacrum pressure sore	Y	A2	$510.00	20.0656	$853.65	$595.91
15934	Remove sacrum pressure sore	Y	A2	$510.00	21.4302	$911.71	$610.43
15935	Remove sacrum pressure sore	Y	A2	$630.00	21.4302	$911.71	$700.43
15936	Remove sacrum pressure sore	Y	A2	$630.00	21.4302	$911.71	$700.43
15937	Remove sacrum pressure sore	Y	A2	$630.00	21.4302	$911.71	$700.43
15940	Remove hip pressure sore	Y	A2	$510.00	20.0656	$853.65	$595.91

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
15941	Remove hip pressure sore	Y	A2	$510.00	20.0656	$853.65	$595.91
15944	Remove hip pressure sore	Y	A2	$510.00	21.4302	$911.71	$610.43
15945	Remove hip pressure sore	Y	A2	$630.00	21.4302	$911.71	$700.43
15946	Remove hip pressure sore	Y	A2	$630.00	21.4302	$911.71	$700.43
15950	Remove thigh pressure sore	Y	A2	$510.00	20.0656	$853.65	$595.91
15951	Remove thigh pressure sore	Y	A2	$630.00	20.0656	$853.65	$685.91
15952	Remove thigh pressure sore	Y	A2	$510.00	21.4302	$911.71	$610.43
15953	Remove thigh pressure sore	Y	A2	$630.00	21.4302	$911.71	$700.43
15956	Remove thigh pressure sore	Y	A2	$510.00	21.4302	$911.71	$610.43
15958	Remove thigh pressure sore	Y	A2	$630.00	21.4302	$911.71	$700.43
16000	Initial treatment of burn(s)	Y	P3		0.6438	$27.39	$27.39
16020	Dress/debrid p-thick burn, s	Y	P3		0.9656	$41.08	$41.08
16025	Dress/debrid p-thick burn, m	Y	A2	$67.11	1.0918	$46.45	$61.95
16030	Dress/debrid p-thick burn, l	Y	A2	$99.83	1.6241	$69.09	$92.15
16035	Incision of burn scab, initi	Y	G2		2.6749	$113.80	$113.80
17000	Destruct premalg lesion	Y	P2		0.4760	$20.25	$20.25
17003	Destruct premalg les, 2–14	Y	P3		0.0886	$3.77	$3.77
17004	Destroy premlg lesions 15+	Y	P3		1.8993	$80.80	$80.80
17106	Destruction of skin lesions	Y	P2		2.5665	$109.19	$109.19
17107	Destruction of skin lesions	Y	P2		2.5665	$109.19	$109.19
17108	Destruction of skin lesions	Y	P2		2.5665	$109.19	$109.19
17110	Destruct b9 lesion, 1–14	Y	P2		0.8432	$35.87	$35.87
17111	Destruct lesion, 15 or more	Y	P2		1.0918	$46.45	$46.45
17250	Chemical cautery, tissue	Y	P3		1.0220	$43.48	$43.48
17260	Destruction of skin lesions	Y	P3		1.0944	$46.56	$46.56
17261	Destruction of skin lesions	Y	P2		1.6241	$69.09	$69.09
17262	Destruction of skin lesions	Y	P2		1.6241	$69.09	$69.09
17263	Destruction of skin lesions	Y	P2		1.6241	$69.09	$69.09
17264	Destruction of skin lesions	Y	P2		1.6241	$69.09	$69.09
17266	Destruction of skin lesions	Y	P3		2.4382	$103.73	$103.73
17270	Destruction of skin lesions	Y	P2		1.6241	$69.09	$69.09
17271	Destruction of skin lesions	Y	P2		1.0918	$46.45	$46.45
17272	Destruction of skin lesions	Y	P2		1.6241	$69.09	$69.09
17273	Destruction of skin lesions	Y	P2		1.6241	$69.09	$69.09
17274	Destruction of skin lesions	Y	P3		2.5026	$106.47	$106.47
17276	Destruction of skin lesions	Y	P2		2.6749	$113.80	$113.80
17280	Destruction of skin lesions	Y	P3		1.6014	$68.13	$68.13
17281	Destruction of skin lesions	Y	P2		1.6241	$69.09	$69.09
17282	Destruction of skin lesions	Y	P2		1.6241	$69.09	$69.09
17283	Destruction of skin lesions	Y	P2		1.6241	$69.09	$69.09
17284	Destruction of skin lesions	Y	P2		2.6749	$113.80	$113.80
17286	Destruction of skin lesions	Y	P2		1.6241	$69.09	$69.09
17311	Mohs, 1 stage, h/n/hf/g	Y	P2		3.7292	$158.65	$158.65
17312	Mohs addl stage	Y	P2		3.7292	$158.65	$158.65
17313	Mohs, 1 stage, t/a/l	Y	P2		3.7292	$158.65	$158.65
17314	Mohs, addl stage, t/a/l	Y	P2		3.7292	$158.65	$158.65
17315	Mohs surg, addl block	Y	P3		0.9254	$39.37	$39.37
17340	Cryotherapy of skin	Y	P3		0.2816	$11.98	$11.98
17360	Skin peel therapy	Y	P2		1.0918	$46.45	$46.45
17380	Hair removal by electrolysis	Y	R2		1.0918	$46.45	$46.45
19000	Drainage of breast lesion	Y	P3		1.5290	$65.05	$65.05
19001	Drain breast lesion add-on	Y	P3		0.1932	$8.22	$8.22
19020	Incision of breast lesion	Y	A2	$446.00	17.5086	$744.87	$520.72
19030	Injection for breast x-ray		N1				
19100	Bx breast percut w/o image	Y	A2	$240.00	3.9045	$166.11	$221.53
19101	Biopsy of breast, open	Y	A2	$446.00	19.2788	$820.18	$539.55
19102	Bx breast percut w/image	Y	A2	$240.00	3.9045	$166.11	$221.53
19103	Bx breast percut w/device	Y	A2	$395.77	6.4387	$273.92	$365.31
19105	Cryosurg ablate fa, each	Y	G2		28.0166	$1,191.91	$1,191.91
19110	Nipple exploration	Y	A2	$446.00	19.2788	$820.18	$539.55
19112	Excise breast duct fistula	Y	A2	$510.00	19.2788	$820.18	$587.55
19120	Removal of breast lesion	Y	A2	$510.00	19.2788	$820.18	$587.55
19125	Excision, breast lesion	Y	A2	$510.00	19.2788	$820.18	$587.55

Note: The Medicare program payment is 80 percent of the total payment amount and beneficiary coinsurance is 20 percent of the total payment amount, except for screening flexible sigmoidoscopies and screening colonoscopies for which the program payment is 75 percent and the beneficiary coinsurance is 25 percent.

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
19126	Excision, addl breast lesion	Y	A2	$510.00	19.2788	$820.18	$587.55
19290	Place needle wire, breast		N1	$333.00			
19291	Place needle wire, breast		N1	$333.00			
19295	Place breast clip, percut	N	A2	$106.76	1.7369	$73.89	$98.54
19296	Place po breast cath for rad	Y	A2	$1,339.00	51.2269	$2,179.35	$1,549.09
19297	Place breast cath for rad	Y	A2	$1,339.00	51.2269	$2,179.35	$1,549.09
19298	Place breast rad tube/caths	N	A2	$1,339.00	52.8730	$2,249.38	$1,566.60
19300	Removal of breast tissue	Y	A2	$630.00	19.2788	$820.18	$677.55
19301	Partical mastectomy	Y	A2	$510.00	19.2788	$820.18	$587.55
19302	P-mastectomy w/ln removal	Y	A2	$995.00	36.9988	$1,574.04	$1,139.76
19303	Mast, simple, complete	Y	A2	$630.00	28.0166	$1,191.91	$770.48
19304	Mast, subq	Y	A2	$630.00	28.0166	$1,191.91	$770.48
19316	Suspension of breast	Y	A2	$630.00	28.0166	$1,191.91	$770.48
19318	Reduction of large breast	Y	A2	$630.00	36.9988	$1,574.04	$866.01
19324	Enlarge breast	Y	A2	$630.00	36.9988	$1,574.04	$866.01
19325	Enlarge breast with implant	Y	A2	$1,339.00	51.2269	$2,179.35	$1,549.09
19328	Removal of breast implant	Y	A2	$333.00	28.0166	$1,191.91	$547.73
19330	Removal of implant material	Y	A2	$333.00	28.0166	$1,191.91	$547.73
19340	Immediate breast prosthesis	Y	A2	$446.00	37.8692	$1,611.07	$737.27
19342	Delayed breast prosthesis	Y	A2	$510.00	51.2269	$2,179.35	$927.34
19350	Breast reconstruction	Y	A2	$630.00	19.2788	$820.18	$677.55
19355	Correct inverted nipple(s)	Y	A2	$630.00	28.0166	$1,191.91	$770.48
19357	Breast reconstruction	Y	A2	$717.00	51.2269	$2,179.35	$1,082.59
19366	Breast reconstruction	Y	A2	$717.00	28.0166	$1,191.91	$835.73
19370	Surgery of breast capsule	Y	A2	$630.00	28.0166	$1,191.91	$770.48
19371	Removal of breast capsule	Y	A2	$630.00	28.0166	$1,191.91	$770.48
19380	Revise breast reconstruction	Y	A2	$717.00	37.8692	$1,611.07	$940.52
19396	Design custom breast implant	Y	G2		28.0166	$1,191.91	$1,191.91
20000	Incision of abscess	Y	P2		1.4392	$61.23	$61.23
20005	Incision of deep abscess	Y	A2	$446.00	20.8706	$887.90	$556.48
20103	Explore wound, extremity	Y	G2		4.2212	$179.58	$179.58
20150	Excise epiphyseal bar	Y	G2		41.0893	$1,748.06	$1,748.06
20200	Muscle biopsy	Y	A2	$446.00	15.1024	$642.50	$495.13
20205	Deep muscle biopsy	Y	A2	$510.00	15.1024	$642.50	$543.13
20206	Needle biopsy, muscle	Y	A2	$240.00	3.9045	$166.11	$221.53
20220	Bone biopsy, trocar/needle	Y	A2	$251.52	4.0919	$174.08	$232.16
20225	Bone biopsy, trocar/needle	Y	A2	$418.49	6.8083	$289.65	$386.28
20240	Bone biopsy, excisional	Y	A2	$446.00	20.0656	$853.65	$547.91
20245	Bone biopsy, excisional	Y	A2	$510.00	20.0656	$853.65	$595.91
20250	Open bone biopsy	Y	A2	$510.00	20.8706	$887.90	$604.48
20251	Open bone biopsy	Y	A2	$510.00	20.8706	$887.90	$604.48
20500	Injection of sinus tract	Y	P3		1.4162	$60.25	$60.25
20501	Inject sinus tract for x-ray		N1				
20520	Removal of foreign body	Y	P3		2.2131	$94.15	$94.15
20525	Removal of foreign body	Y	A2	$510.00	20.0656	$853.65	$595.91
20526	Ther injection, carp tunnel	Y	P3		0.7162	$30.47	$30.47
20550	Inj tendon sheath/ligament	Y	P3		0.5392	$22.94	$22.94
20551	Inj tendon origin/insertion	Y	P3		0.5312	$22.60	$22.60
20552	Inj trigger point, 1/2 muscl	Y	P3		0.5230	$22.25	$22.25
20553	Inject trigger points, =/> 3	Y	P3		0.5874	$24.99	$24.99
20600	Drain/inject, joint/bursa	Y	P3		0.5312	$22.60	$22.60
20605	Drain/inject, joint/bursa	Y	P3		0.6036	$25.68	$25.68
20610	Drain/inject, joint/bursa	Y	P3		0.8128	$34.58	$34.58
20612	Aspirate/inj ganglion cyst	Y	P3		0.5714	$24.31	$24.31
20615	Treatment of bone cyst	Y	P2		2.0687	$88.01	$88.01
20650	Insert and remove bone pin	Y	A2	$510.00	20.8706	$887.90	$604.48
20662	Application of pelvis brace	Y	R2		20.8706	$887.90	$887.90
20663	Application of thigh brace	Y	R2		20.8706	$887.90	$887.90
20665	Removal of fixation device	N	G2		0.6102	$25.96	$25.96
20670	Removal of support implant	Y	A2	$333.00	15.1024	$642.50	$410.38
20680	Removal of support implant	Y	A2	$510.00	20.0656	$853.65	$595.91
20690	Apply bone fixation device	Y	A2	$446.00	25.1296	$1,069.09	$601.77
20692	Apply bone fixation device	Y	A2	$510.00	25.1296	$1,069.09	$649.77

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
20693	Adjust bone fixation device	Y	A2	$510.00	20.8706	$887.90	$604.48
20694	Remove bone fixation device	Y	A2	$333.00	20.8706	$887.90	$471.73
20822	Replantation digit, complete	Y	G2		25.8758	$1,100.83	$1,100.83
20900	Removal of bone for graft	Y	A2	$510.00	25.1296	$1,069.09	$649.77
20902	Removal of bone for graft	Y	A2	$630.00	25.1296	$1,069.09	$739.77
20910	Remove cartilage for graft	Y	A2	$510.00	21.4302	$911.71	$610.43
20912	Remove cartilage for graft	Y	A2	$510.00	21.4302	$911.71	$610.43
20920	Removal of fascia for graft	Y	A2	$630.00	14.0346	$597.07	$621.77
20922	Removal of fascia for graft	Y	A2	$510.00	21.4302	$911.71	$610.43
20924	Removal of tendon for graft	Y	A2	$630.00	25.1296	$1,069.09	$739.77
20926	Removal of tissue for graft	Y	A2	$630.00	14.0346	$597.07	$621.77
20950	Fluid pressure, muscle	Y	G2		1.4392	$61.23	$61.23
20972	Bone/skin graft, metatarsal	Y	G2		40.8559	$1,738.13	$1,738.13
20973	Bone/skin graft, great toe	Y	R2		40.8559	$1,738.13	$1,738.13
20975	Electrical bone stimulation	N	A2	$37.51	0.6102	$25.96	$34.62
20979	Us bone stimulation	N	P3		0.5552	$23.62	$23.62
20982	Ablate, bone tumor(s) perq	Y	G2		41.0893	$1,748.06	$1,748.06
21010	Incision of jaw joint	Y	A2	$446.00	23.3299	$992.52	$582.63
21015	Resection of facial tumor	Y	A2	$510.00	16.4266	$698.84	$557.21
21025	Excision of bone, lower jaw	Y	A2	$446.00	38.1991	$1,625.10	$740.78
21026	Excision of facial bone(s)	Y	A2	$446.00	38.1991	$1,625.10	$740.78
21029	Contour of face bone lesion	Y	A2	$446.00	38.1991	$1,625.10	$740.78
21030	Excise max/zygoma b9 tumor	Y	P3		5.4479	$231.77	$231.77
21031	Remove exostosis, mandible	Y	P3		4.4823	$190.69	$190.69
21032	Remove exostosis, maxilla	Y	P3		4.5869	$195.14	$195.14
21034	Excise max/zygoma mlg tumor	Y	A2	$510.00	38.1991	$1,625.10	$788.78
21040	Excise mandible lesion	Y	A2	$446.00	23.3299	$992.52	$582.63
21044	Removal of jaw bone lesion	Y	A2	$446.00	38.1991	$1,625.10	$740.78
21046	Remove mandible cyst complex	Y	A2	$446.00	38.1991	$1,625.10	$740.78
21047	Excise lwr jaw cyst w/repair	Y	A2	$446.00	38.1991	$1,625.10	$740.78
21048	Remove maxilla cyst complex	Y	R2		38.1991	$1,625.10	$1,625.10
21050	Removal of jaw joint	Y	A2	$510.00	38.1991	$1,625.10	$788.78
21060	Remove jaw joint cartilage	Y	A2	$446.00	38.1991	$1,625.10	$740.78
21070	Remove coronoid process	Y	A2	$510.00	38.1991	$1,625.10	$788.78
21076	Prepare face/oral prosthesis	Y	P3		8.1760	$347.83	$347.83
21077	Prepare face/oral prosthesis	Y	P3		20.1504	$857.26	$857.26
21079	Prepare face/oral prosthesis	Y	P3		14.2437	$605.97	$605.97
21080	Prepare face/oral prosthesis	Y	P3		16.3280	$694.64	$694.64
21081	Prepare face/oral prosthesis	Y	P3		14.9437	$635.75	$635.75
21082	Prepare face/oral prosthesis	Y	P3		13.8253	$588.17	$588.17
21083	Prepare face/oral prosthesis	Y	P3		13.5113	$574.81	$574.81
21084	Prepare face/oral prosthesis	Y	P3		15.6117	$664.17	$664.17
21085	Prepare face/oral prosthesis	Y	P3		6.1079	$259.85	$259.85
21086	Prepare face/oral prosthesis	Y	P3		14.7587	$627.88	$627.88
21087	Prepare face/oral prosthesis	Y	P3		14.6621	$623.77	$623.77
21088	Prepare face/oral prosthesis	Y	R2		38.1991	$1,625.10	$1,625.10
21100	Maxillofacial fixation	Y	A2	$446.00	38.1991	$1,625.10	$740.78
21110	Interdental fixation	Y	P2		7.5511	$321.25	$321.25
21116	Injection, jaw joint x-ray		N1				
21120	Reconstruction of chin	Y	A2	$995.00	23.3299	$992.52	$994.38
21121	Reconstruction of chin	Y	A2	$995.00	23.3299	$992.52	$994.38
21122	Reconstruction of chin	Y	A2	$995.00	23.3299	$992.52	$994.38
21123	Reconstruction of chin	Y	A2	$995.00	23.3299	$992.52	$994.38
21125	Augmentation, lower jaw bone	Y	A2	$995.00	23.3299	$992.52	$994.38
21127	Augmentation, lower jaw bone	Y	A2	$1,339.00	38.1991	$1,625.10	$1,410.53
21137	Reduction of forehead	Y	G2		23.3299	$992.52	$992.52
21138	Reduction of forehead	Y	G2		38.1991	$1,625.10	$1,625.10
21139	Reduction of forehead	Y	G2		38.1991	$1,625.10	$1,625.10
21150	Reconstruct midface, lefort	Y	G2		38.1991	$1,625.10	$1,625.10
21181	Contour cranial bone lesion	Y	A2	$995.00	23.3299	$992.52	$994.38
21198	Reconstr lwr jaw segment	Y	G2		38.1991	$1,625.10	$1,625.10
21199	Reconstr lwr jaw w/advance	Y	G2		38.1991	$1,625.10	$1,625.10
21206	Reconstruct upper jaw bone	Y	A2	$717.00	38.1991	$1,625.10	$944.03

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
21208	Augmentation of facial bones	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
21209	Reduction of facial bones	Y	A2	$717.00	38.1991	$1,625.10	$944.03
21210	Face bone graft	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
21215	Lower jaw bone graft	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
21230	Rib cartilage graft	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
21235	Ear cartilage graft	Y	A2	$995.00	23.3299	$992.52	$994.38
21240	Reconstruction of jaw joint	Y	A2	$630.00	38.1991	$1,625.10	$878.78
21242	Reconstruction of jaw joint	Y	A2	$717.00	38.1991	$1,625.10	$944.03
21243	Reconstruction of jaw joint	Y	A2	$717.00	38.1991	$1,625.10	$944.03
21244	Reconstruction of lower jaw	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
21245	Reconstruction of jaw	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
21246	Reconstruction of jaw	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
21248	Reconstruction of jaw	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
21249	Reconstruction of jaw	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
21260	Revise eye sockets	Y	G2	.....	38.1991	$1,625.10	$1,625.10
21267	Revise eye sockets	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
21270	Augmentation, cheek bone	Y	A2	$717.00	38.1991	$1,625.10	$944.03
21275	Revision, orbitofacial bones	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
21280	Revision of eyelid	Y	A2	$717.00	38.1991	$1,625.10	$944.03
21282	Revision of eyelid	Y	A2	$717.00	16.4266	$698.84	$712.46
21295	Revision of jaw muscle/bone	Y	A2	$333.00	7.5511	$321.25	$330.06
21296	Revision of jaw muscle/bone	Y	A2	$333.00	23.3299	$992.52	$497.88
21310	Treatment of nose fracture	Y	A2	$150.72	2.4520	$104.32	$139.12
21315	Treatment of nose fracture	Y	A2	$150.72	2.4520	$104.32	$139.12
21320	Treatment of nose fracture	Y	A2	$446.00	7.5511	$321.25	$414.81
21325	Treatment of nose fracture	Y	A2	$630.00	23.3299	$992.52	$720.63
21330	Treatment of nose fracture	Y	A2	$717.00	23.3299	$992.52	$785.88
21335	Treatment of nose fracture	Y	A2	$995.00	23.3299	$992.52	$994.38
21336	Treat nasal septal fracture	Y	A2	$630.00	37.5382	$1,596.99	$871.75
21337	Treat nasal septal fracture	Y	A2	$446.00	16.4266	$698.84	$509.21
21338	Treat nasoethmoid fracture	Y	A2	$630.00	23.3299	$992.52	$720.63
21339	Treat nasoethmoid fracture	Y	A2	$717.00	23.3299	$992.52	$785.88
21340	Treatment of nose fracture	Y	A2	$630.00	38.1991	$1,625.10	$878.78
21345	Treat nose/jaw fracture	Y	A2	$995.00	23.3299	$992.52	$994.38
21355	Treat cheek bone fracture	Y	A2	$510.00	38.1991	$1,625.10	$788.78
21356	Treat cheek bone fracture	Y	A2	$510.00	23.3299	$992.52	$630.63
21390	Treat eye socket fracture	Y	G2	.....	38.1991	$1,625.10	$1,625.10
21400	Treat eye socket fracture	Y	A2	$446.00	7.5511	$321.25	$414.81
21401	Treat eye socket fracture	Y	A2	$510.00	16.4266	$698.84	$557.21
21406	Treat eye socket fracture	Y	G2	.....	38.1991	$1,625.10	$1,625.10
21407	Treat eye socket fracture	Y	G2	.....	38.1991	$1,625.10	$1,625.10
21421	Treat mouth roof fracture	Y	A2	$630.00	23.3299	$992.52	$720.63
21440	Treat dental ridge fracture	Y	P3	.....	7.0012	$297.85	$297.85
21445	Treat dental ridge fracture	Y	A2	$630.00	23.3299	$992.52	$720.63
21450	Treat lower jaw fracture	Y	A2	$150.72	2.4520	$104.32	$139.12
21451	Treat lower jaw fracture	Y	A2	$464.15	7.5511	$321.25	$428.43
21452	Treat lower jaw fracture	Y	A2	$446.00	16.4266	$698.84	$509.21
21453	Treat lower jaw fracture	Y	A2	$510.00	38.1991	$1,625.10	$788.78
21454	Treat lower jaw fracture	Y	A2	$717.00	23.3299	$992.52	$785.88
21461	Treat lower jaw fracture	Y	A2	$630.00	38.1991	$1,625.10	$878.78
21462	Treat lower jaw fracture	Y	A2	$717.00	38.1991	$1,625.10	$944.03
21465	Treat lower jaw fracture	Y	A2	$630.00	38.1991	$1,625.10	$878.78
21480	Reset dislocated jaw	Y	A2	$150.72	2.4520	$104.32	$139.12
21485	Reset dislocated jaw	Y	A2	$446.00	16.4266	$698.84	$509.21
21490	Repair dislocated jaw	Y	A2	$510.00	38.1991	$1,625.10	$788.78
21495	Treat hyoid bone fracture	Y	G2	.....	16.4266	$698.84	$698.84
21497	Interdental wiring	Y	A2	$446.00	16.4266	$698.84	$509.21
21501	Drain neck/chest lesion	Y	A2	$446.00	17.5086	$744.87	$520.72
21502	Drain chest lesion	Y	A2	$446.00	20.8706	$887.90	$556.48
21550	Biopsy of neck/chest	Y	G2	.....	6.8083	$289.65	$289.65
21555	Remove lesion, neck/chest	Y	A2	$446.00	20.0656	$853.65	$547.91
21556	Remove lesion, neck/chest	Y	A2	$446.00	20.0656	$853.65	$547.91
21557	Remove tumor, neck/chest	Y	G2	.....	20.0656	$853.65	$853.65

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
21600	Partial removal of rib	Y	A2	$446.00	25.1296	$1,069.09	$601.77
21610	Partial removal of rib	Y	A2	$446.00	25.1296	$1,069.09	$601.77
21685	Hyoid myotomy & suspension	Y	G2	.....	7.5511	$321.25	$321.25
21700	Revision of neck muscle	Y	A2	$446.00	20.8706	$887.90	$556.48
21720	Revision of neck muscle	Y	A2	$510.00	20.8706	$887.90	$604.48
21725	Revision of neck muscle	Y	A2	$88.46	1.4392	$61.23	$81.65
21800	Treatment of rib fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
21805	Treatment of rib fracture	Y	A2	$446.00	25.5264	$1,085.97	$605.99
21820	Treat sternum fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
21920	Biopsy soft tissue of back	Y	P3	.....	3.0983	$131.81	$131.81
21925	Biopsy soft tissue of back	Y	A2	$446.00	20.0656	$853.65	$547.91
21930	Remove lesion, back or flank	Y	A2	$446.00	20.0656	$853.65	$547.91
21935	Remove tumor, back	Y	A2	$510.00	20.0656	$853.65	$595.91
22102	Remove part, lumbar vertebra	Y	G2	.....	44.1489	$1,878.23	$1,878.23
22103	Remove extra spine segment	Y	G2	.....	44.1489	$1,878.23	$1,878.23
22305	Treat spine process fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
22310	Treat spine fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
22315	Treat spine fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
22505	Manipulation of spine	Y	A2	$446.00	14.5947	$620.90	$489.73
22520	Percut vertebroplasty thor	Y	A2	$1,339.00	25.1296	$1,069.09	$1,271.52
22521	Percut vertebroplasty lumb	Y	A2	$1,339.00	25.1296	$1,069.09	$1,271.52
22522	Percut vertebroplasty add-on	Y	A2	$1,339.00	25.1296	$1,069.09	$1,271.52
22523	Percut kyphoplasty, thor	Y	G2	.....	66.5800	$2,832.51	$2,832.51
22524	Percut kyphoplasty, lumbar	Y	G2	.....	66.5800	$2,832.51	$2,832.51
22525	Percut kyphoplasty, add-on	Y	G2	.....	66.5800	$2,832.51	$2,832.51
22900	Remove abdominal wall lesion	Y	A2	$630.00	20.0656	$853.65	$685.91
23000	Removal of calcium deposits	Y	A2	$446.00	15.1024	$642.50	$495.13
23020	Release shoulder joint	Y	A2	$446.00	41.0893	$1,748.06	$771.52
23030	Drain shoulder lesion	Y	A2	$333.00	17.5086	$744.87	$435.97
23031	Drain shoulder bursa	Y	A2	$510.00	17.5086	$744.87	$568.72
23035	Drain shoulder bone lesion	Y	A2	$510.00	20.8706	$887.90	$604.48
23040	Exploratory shoulder surgery	Y	A2	$510.00	25.1296	$1,069.09	$649.77
23044	Exploratory shoulder surgery	Y	A2	$630.00	25.1296	$1,069.09	$739.77
23065	Biopsy shoulder tissues	Y	P3	.....	2.1888	$93.12	$93.12
23066	Biopsy shoulder tissues	Y	A2	$446.00	20.0656	$853.65	$547.91
23075	Removal of shoulder lesion	Y	A2	$446.00	15.1024	$642.50	$495.13
23076	Removal of shoulder lesion	Y	A2	$446.00	20.0656	$853.65	$547.91
23077	Remove tumor of shoulder	Y	A2	$510.00	20.0656	$853.65	$595.91
23100	Biopsy of shoulder joint	Y	A2	$446.00	20.8706	$887.90	$556.48
23101	Shoulder joint surgery	Y	A2	$995.00	25.1296	$1,069.09	$1,013.52
23105	Remove shoulder joint lining	Y	A2	$630.00	25.1296	$1,069.09	$739.77
23106	Incision of collarbone joint	Y	A2	$630.00	25.1296	$1,069.09	$739.77
23107	Explore treat shoulder joint	Y	A2	$630.00	25.1296	$1,069.09	$739.77
23120	Partial removal, collar bone	Y	A2	$717.00	41.0893	$1,748.06	$974.77
23125	Removal of collar bone	Y	A2	$717.00	41.0893	$1,748.06	$974.77
23130	Remove shoulder bone, part	Y	A2	$717.00	41.0893	$1,748.06	$974.77
23140	Removal of bone lesion	Y	A2	$630.00	20.8706	$887.90	$694.48
23145	Removal of bone lesion	Y	A2	$717.00	25.1296	$1,069.09	$805.02
23146	Removal of bone lesion	Y	A2	$717.00	25.1296	$1,069.09	$805.02
23150	Removal of humerus lesion	Y	A2	$630.00	25.1296	$1,069.09	$739.77
23155	Removal of humerus lesion	Y	A2	$717.00	25.1296	$1,069.09	$805.02
23156	Removal of humerus lesion	Y	A2	$717.00	25.1296	$1,069.09	$805.02
23170	Remove collar bone lesion	Y	A2	$446.00	25.1296	$1,069.09	$601.77
23172	Remove shoulder blade lesion	Y	A2	$446.00	25.1296	$1,069.09	$601.77
23174	Remove humerus lesion	Y	A2	$446.00	25.1296	$1,069.09	$601.77
23180	Remove collar bone lesion	Y	A2	$630.00	25.1296	$1,069.09	$739.77
23182	Remove shoulder blade lesion	Y	A2	$630.00	25.1296	$1,069.09	$739.77
23184	Remove humerus lesion	Y	A2	$630.00	25.1296	$1,069.09	$739.77
23190	Partial removal of scapula	Y	A2	$630.00	25.1296	$1,069.09	$739.77
23195	Removal of head of humerus	Y	A2	$717.00	25.1296	$1,069.09	$805.02
23330	Remove shoulder foreign body	Y	A2	$333.00	6.8083	$289.65	$322.16
23331	Remove shoulder foreign body	Y	A2	$333.00	20.0656	$853.65	$463.16
23350	Injection for shoulder x-ray	.....	N1	.....	.....	.....	.....

Note: The Medicare program payment is 80 percent of the total payment amount and beneficiary coinsurance is 20 percent of the total payment amount, except for screening flexible sigmoidoscopies and screening colonoscopies for which the program payment is 75 percent and the beneficiary coinsurance is 25 percent.

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
23395	Muscle transfer,shoulder/arm	Y	A2	$717.00	41.0893	$1,748.06	$974.77
23397	Muscle transfers	Y	A2	$995.00	66.5800	$2,832.51	$1,454.38
23400	Fixation of shoulder blade	Y	A2	$995.00	25.1296	$1,069.09	$1,013.52
23405	Incision of tendon & muscle	Y	A2	$446.00	25.1296	$1,069.09	$601.77
23406	Incise tendon(s) & muscle(s)	Y	A2	$446.00	25.1296	$1,069.09	$601.77
23410	Repair rotator cuff, acute	Y	A2	$717.00	41.0893	$1,748.06	$974.77
23412	Repair rotator cuff, chronic	Y	A2	$995.00	41.0893	$1,748.06	$1,183.27
23415	Release of shoulder ligament	Y	A2	$717.00	41.0893	$1,748.06	$974.77
23420	Repair of shoulder	Y	A2	$995.00	41.0893	$1,748.06	$1,183.27
23430	Repair biceps tendon	Y	A2	$630.00	41.0893	$1,748.06	$909.52
23440	Remove/transplant tendon	Y	A2	$630.00	41.0893	$1,748.06	$909.52
23450	Repair shoulder capsule	Y	A2	$717.00	66.5800	$2,832.51	$1,245.88
23455	Repair shoulder capsule	Y	A2	$995.00	66.5800	$2,832.51	$1,454.38
23460	Repair shoulder capsule	Y	A2	$717.00	66.5800	$2,832.51	$1,245.88
23462	Repair shoulder capsule	Y	A2	$995.00	41.0893	$1,748.06	$1,183.27
23465	Repair shoulder capsule	Y	A2	$717.00	66.5800	$2,832.51	$1,245.88
23466	Repair shoulder capsule	Y	A2	$995.00	41.0893	$1,748.06	$1,183.27
23480	Revision of collar bone	Y	A2	$630.00	41.0893	$1,748.06	$909.52
23485	Revision of collar bone	Y	A2	$995.00	66.5800	$2,832.51	$1,454.38
23490	Reinforce clavicle	Y	A2	$510.00	41.0893	$1,748.06	$819.52
23491	Reinforce shoulder bones	Y	A2	$510.00	66.5800	$2,832.51	$1,090.63
23500	Treat clavicle fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
23505	Treat clavicle fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
23515	Treat clavicle fracture	Y	A2	$510.00	57.2172	$2,434.19	$991.05
23520	Treat clavicle dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
23525	Treat clavicle dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
23530	Treat clavicle dislocation	Y	A2	$510.00	37.5382	$1,596.99	$781.75
23532	Treat clavicle dislocation	Y	A2	$630.00	25.5264	$1,085.97	$743.99
23540	Treat clavicle dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
23545	Treat clavicle dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
23550	Treat clavicle dislocation	Y	A2	$510.00	37.5382	$1,596.99	$781.75
23552	Treat clavicle dislocation	Y	A2	$630.00	37.5382	$1,596.99	$871.75
23570	Treat shoulder blade fx	Y	A2	$103.62	1.6857	$71.71	$95.64
23575	Treat shoulder blade fx	Y	A2	$103.62	1.6857	$71.71	$95.64
23585	Treat scapula fracture	Y	A2	$510.00	57.2172	$2,434.19	$991.05
23600	Treat humerus fracture	Y	P2	.....	1.6857	$71.71	$71.71
23605	Treat humerus fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
23615	Treat humerus fracture	Y	A2	$630.00	57.2172	$2,434.19	$1,081.05
23616	Treat humerus fracture	Y	A2	$630.00	57.2172	$2,434.19	$1,081.05
23620	Treat humerus fracture	Y	P2	.....	1.6857	$71.71	$71.71
23625	Treat humerus fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
23630	Treat humerus fracture	Y	A2	$717.00	57.2172	$2,434.19	$1,146.30
23650	Treat shoulder dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
23655	Treat shoulder dislocation	Y	A2	$333.00	14.5947	$620.90	$404.98
23660	Treat shoulder dislocation	Y	A2	$510.00	37.5382	$1,596.99	$781.75
23665	Treat dislocation/fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
23670	Treat dislocation/fracture	Y	A2	$510.00	57.2172	$2,434.19	$991.05
23675	Treat dislocation/fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
23680	Treat dislocation/fracture	Y	A2	$510.00	37.5382	$1,596.99	$781.75
23700	Fixation of shoulder	Y	A2	$333.00	14.5947	$620.90	$404.98
23800	Fusion of shoulder joint	Y	A2	$630.00	66.5800	$2,832.51	$1,180.63
23802	Fusion of shoulder joint	Y	A2	$995.00	41.0893	$1,748.06	$1,183.27
23921	Amputation follow-up surgery	Y	A2	$323.28	5.2594	$223.75	$298.40
23930	Drainage of arm lesion	Y	A2	$333.00	17.5086	$744.87	$435.97
23931	Drainage of arm bursa	Y	A2	$446.00	17.5086	$744.87	$520.72
23935	Drain arm/elbow bone lesion	Y	A2	$446.00	20.8706	$887.90	$556.48
24000	Exploratory elbow surgery	Y	A2	$630.00	25.1296	$1,069.09	$739.77
24006	Release elbow joint	Y	A2	$630.00	25.1296	$1,069.09	$739.77
24065	Biopsy arm/elbow soft tissue	Y	P3	.....	2.9695	$126.33	$126.33
24066	Biopsy arm/elbow soft tissue	Y	A2	$446.00	15.1024	$642.50	$495.13
24075	Remove arm/elbow lesion	Y	A2	$446.00	15.1024	$642.50	$495.13
24076	Remove arm/elbow lesion	Y	A2	$446.00	20.0656	$853.65	$547.91
24077	Remove tumor of arm/elbow	Y	A2	$510.00	20.0656	$853.65	$595.91

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
24100	Biopsy elbow joint lining	Y	A2	$333.00	20.8706	$887.90	$471.73
24101	Explore/treat elbow joint	Y	A2	$630.00	25.1296	$1,069.09	$739.77
24102	Remove elbow joint lining	Y	A2	$630.00	25.1296	$1,069.09	$739.77
24105	Removal of elbow bursa	Y	A2	$510.00	20.8706	$887.90	$604.48
24110	Remove humerus lesion	Y	A2	$446.00	20.8706	$887.90	$556.48
24115	Remove/graft bone lesion	Y	A2	$510.00	25.1296	$1,069.09	$649.77
24116	Remove/graft bone lesion	Y	A2	$510.00	25.1296	$1,069.09	$649.77
24120	Remove elbow lesion	Y	A2	$510.00	20.8706	$887.90	$604.48
24125	Remove/graft bone lesion	Y	A2	$510.00	25.1296	$1,069.09	$649.77
24126	Remove/graft bone lesion	Y	A2	$510.00	25.1296	$1,069.09	$649.77
24130	Removal of head of radius	Y	A2	$510.00	25.1296	$1,069.09	$649.77
24134	Removal of arm bone lesion	Y	A2	$446.00	25.1296	$1,069.09	$601.77
24136	Remove radius bone lesion	Y	A2	$446.00	25.1296	$1,069.09	$601.77
24138	Remove elbow bone lesion	Y	A2	$446.00	25.1296	$1,069.09	$601.77
24140	Partial removal of arm bone	Y	A2	$510.00	25.1296	$1,069.09	$649.77
24145	Partial removal of radius	Y	A2	$510.00	25.1296	$1,069.09	$649.77
24147	Partial removal of elbow	Y	A2	$446.00	25.1296	$1,069.09	$601.77
24149	Radical resection of elbow	Y	G2	.....	25.1296	$1,069.09	$1,069.09
24152	Extensive radius surgery	Y	G2	.....	41.0893	$1,748.06	$1,748.06
24153	Extensive radius surgery	Y	G2	.....	66.5800	$2,832.51	$2,832.51
24155	Removal of elbow joint	Y	A2	$510.00	41.0893	$1,748.06	$819.52
24160	Remove elbow joint implant	Y	A2	$446.00	25.1296	$1,069.09	$601.77
24164	Remove radius head implant	Y	A2	$510.00	25.1296	$1,069.09	$649.77
24200	Removal of arm foreign body	Y	P3	.....	2.4867	$105.79	$105.79
24201	Removal of arm foreign body	Y	A2	$446.00	15.1024	$642.50	$495.13
24220	Injection for elbow x-ray		N1	.....	.....	.....	.....
24300	Manipulate elbow w/anesth	Y	G2	.....	14.5947	$620.90	$620.90
24301	Muscle/tendon transfer	Y	A2	$630.00	25.1296	$1,069.09	$739.77
24305	Arm tendon lengthening	Y	A2	$630.00	25.1296	$1,069.09	$739.77
24310	Revision of arm tendon	Y	A2	$510.00	20.8706	$887.90	$604.48
24320	Repair of arm tendon	Y	A2	$510.00	41.0893	$1,748.06	$819.52
24330	Revision of arm muscles	Y	A2	$510.00	66.5800	$2,832.51	$1,090.63
24331	Revision of arm muscles	Y	A2	$510.00	41.0893	$1,748.06	$819.52
24332	Tenolysis, triceps	Y	G2	.....	20.8706	$887.90	$887.90
24340	Repair of biceps tendon	Y	A2	$510.00	41.0893	$1,748.06	$819.52
24341	Repair arm tendon/muscle	Y	A2	$510.00	41.0893	$1,748.06	$819.52
24342	Repair of ruptured tendon	Y	A2	$510.00	41.0893	$1,748.06	$819.52
24343	Repr elbow lat ligmnt w/tiss	Y	G2	.....	25.1296	$1,069.09	$1,069.09
24344	Reconstruct elbow lat ligmnt	Y	G2	.....	66.5800	$2,832.51	$2,832.51
24345	Repr elbw med ligmnt w/tissu	Y	A2	$446.00	25.1296	$1,069.09	$601.77
24346	Reconstruct elbow med ligmnt	Y	G2	.....	41.0893	$1,748.06	$1,748.06
24350	Repair of tennis elbow	Y	A2	$510.00	25.1296	$1,069.09	$649.77
24351	Repair of tennis elbow	Y	A2	$510.00	25.1296	$1,069.09	$649.77
24352	Repair of tennis elbow	Y	A2	$510.00	25.1296	$1,069.09	$649.77
24354	Repair of tennis elbow	Y	A2	$510.00	25.1296	$1,069.09	$649.77
24356	Revision of tennis elbow	Y	A2	$510.00	25.1296	$1,069.09	$649.77
24360	Reconstruct elbow joint	Y	A2	$717.00	33.4505	$1,423.08	$893.52
24361	Reconstruct elbow joint	Y	A2	$717.00	107.1942	$4,560.36	$1,677.84
24362	Reconstruct elbow joint	Y	A2	$717.00	47.4378	$2,018.15	$1,042.29
24363	Replace elbow joint	Y	A2	$995.00	107.1942	$4,560.36	$1,886.34
24365	Reconstruct head of radius	Y	A2	$717.00	33.4505	$1,423.08	$893.52
24366	Reconstruct head of radius	Y	A2	$717.00	107.1942	$4,560.36	$1,677.84
24400	Revision of humerus	Y	A2	$630.00	25.1296	$1,069.09	$739.77
24410	Revision of humerus	Y	A2	$630.00	25.1296	$1,069.09	$739.77
24420	Revision of humerus	Y	A2	$510.00	41.0893	$1,748.06	$819.52
24430	Repair of humerus	Y	A2	$510.00	66.5800	$2,832.51	$1,090.63
24435	Repair humerus with graft	Y	A2	$630.00	66.5800	$2,832.51	$1,180.63
24470	Revision of elbow joint	Y	A2	$510.00	41.0893	$1,748.06	$819.52
24495	Decompression of forearm	Y	A2	$446.00	25.1296	$1,069.09	$601.77
24498	Reinforce humerus	Y	A2	$510.00	66.5800	$2,832.51	$1,090.63
24500	Treat humerus fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
24505	Treat humerus fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
24515	Treat humerus fracture	Y	A2	$630.00	57.2172	$2,434.19	$1,081.05

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
24516	Treat humerus fracture	Y	A2	$630.00	57.2172	$2,434.19	$1,081.05
24530	Treat humerus fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
24535	Treat humerus fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
24538	Treat humerus fracture	Y	A2	$446.00	25.5264	$1,085.97	$605.99
24545	Treat humerus fracture	Y	A2	$630.00	57.2172	$2,434.19	$1,081.05
24546	Treat humerus fracture	Y	A2	$717.00	57.2172	$2,434.19	$1,146.30
24560	Treat humerus fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
24565	Treat humerus fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
24566	Treat humerus fracture	Y	A2	$446.00	25.5264	$1,085.97	$605.99
24575	Treat humerus fracture	Y	A2	$510.00	57.2172	$2,434.19	$991.05
24576	Treat humerus fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
24577	Treat humerus fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
24579	Treat humerus fracture	Y	A2	$510.00	57.2172	$2,434.19	$991.05
24582	Treat humerus fracture	Y	A2	$446.00	25.5264	$1,085.97	$605.99
24586	Treat elbow fracture	Y	A2	$630.00	57.2172	$2,434.19	$1,081.05
24587	Treat elbow fracture	Y	A2	$717.00	57.2172	$2,434.19	$1,146.30
24600	Treat elbow dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
24605	Treat elbow dislocation	Y	A2	$446.00	14.5947	$620.90	$489.73
24615	Treat elbow dislocation	Y	A2	$510.00	57.2172	$2,434.19	$991.05
24620	Treat elbow fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
24635	Treat elbow fracture	Y	A2	$510.00	57.2172	$2,434.19	$991.05
24640	Treat elbow dislocation	Y	G2	.....	1.6857	$71.71	$71.71
24650	Treat radius fracture	Y	P2	.....	1.6857	$71.71	$71.71
24655	Treat radius fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
24665	Treat radius fracture	Y	A2	$630.00	37.5382	$1,596.99	$871.75
24666	Treat radius fracture	Y	A2	$630.00	57.2172	$2,434.19	$1,081.05
24670	Treat ulnar fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
24675	Treat ulnar fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
24685	Treat ulnar fracture	Y	A2	$510.00	37.5382	$1,596.99	$781.75
24800	Fusion of elbow joint	Y	A2	$630.00	41.0893	$1,748.06	$909.52
24802	Fusion/graft of elbow joint	Y	A2	$717.00	41.0893	$1,748.06	$974.77
24925	Amputation follow-up surgery	Y	A2	$510.00	20.8706	$887.90	$604.48
25000	Incision of tendon sheath	Y	A2	$510.00	20.8706	$887.90	$604.48
25001	Incise flexor carpi radialis	Y	G2	.....	20.8706	$887.90	$887.90
25020	Decompress forearm 1 space	Y	A2	$510.00	20.8706	$887.90	$604.48
25023	Decompress forearm 1 space	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25024	Decompress forearm 2 spaces	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25025	Decompress forearm 2 spaces	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25028	Drainage of forearm lesion	Y	A2	$333.00	20.8706	$887.90	$471.73
25031	Drainage of forearm bursa	Y	A2	$446.00	20.8706	$887.90	$556.48
25035	Treat forearm bone lesion	Y	A2	$446.00	20.8706	$887.90	$556.48
25040	Explore/treat wrist joint	Y	A2	$717.00	25.1296	$1,069.09	$805.02
25065	Biopsy forearm soft tissues	Y	P3	.....	3.0259	$128.73	$128.73
25066	Biopsy forearm soft tissues	Y	A2	$446.00	20.0656	$853.65	$547.91
25075	Removal forearm lesion subcu	Y	A2	$446.00	15.1024	$642.50	$495.13
25076	Removal forearm lesion deep	Y	A2	$510.00	20.0656	$853.65	$595.91
25077	Remove tumor, forearm/wrist	Y	A2	$510.00	20.0656	$853.65	$595.91
25085	Incision of wrist capsule	Y	A2	$510.00	20.8706	$887.90	$604.48
25100	Biopsy of wrist joint	Y	A2	$446.00	20.8706	$887.90	$556.48
25101	Explore/treat wrist joint	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25105	Remove wrist joint lining	Y	A2	$630.00	25.1296	$1,069.09	$739.77
25107	Remove wrist joint cartilage	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25109	Excise tendon forearm/wrist	Y	G2	.....	20.8706	$887.90	$887.90
25110	Remove wrist tendon lesion	Y	A2	$510.00	20.8706	$887.90	$604.48
25111	Remove wrist tendon lesion	Y	A2	$510.00	16.1540	$687.24	$554.31
25112	Reremove wrist tendon lesion	Y	A2	$630.00	16.1540	$687.24	$644.31
25115	Remove wrist/forearm lesion	Y	A2	$630.00	20.8706	$887.90	$694.48
25116	Remove wrist/forearm lesion	Y	A2	$630.00	20.8706	$887.90	$694.48
25118	Excise wrist tendon sheath	Y	A2	$446.00	25.1296	$1,069.09	$601.77
25119	Partial removal of ulna	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25120	Removal of forearm lesion	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25125	Remove/graft forearm lesion	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25126	Remove/graft forearm lesion	Y	A2	$510.00	25.1296	$1,069.09	$649.77

Note: The Medicare program payment is 80 percent of the total payment amount and beneficiary coinsurance is 20 percent of the total payment amount, except for screening flexible sigmoidoscopies and screening colonoscopies for which the program payment is 75 percent and the beneficiary coinsurance is 25 percent.

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
25130	Removal of wrist lesion	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25135	Remove & graft wrist lesion	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25136	Remove & graft wrist lesion	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25145	Remove forearm bone lesion	Y	A2	$446.00	25.1296	$1,069.09	$601.77
25150	Partial removal of ulna	Y	A2	$446.00	25.1296	$1,069.09	$601.77
25151	Partial removal of radius	Y	A2	$446.00	25.1296	$1,069.09	$601.77
25210	Removal of wrist bone	Y	A2	$510.00	25.8758	$1,100.83	$657.71
25215	Removal of wrist bones	Y	A2	$630.00	25.8758	$1,100.83	$747.71
25230	Partial removal of radius	Y	A2	$630.00	25.1296	$1,069.09	$739.77
25240	Partial removal of ulna	Y	A2	$630.00	25.1296	$1,069.09	$739.77
25246	Injection for wrist x-ray		N1				
25248	Remove forearm foreign body	Y	A2	$446.00	20.8706	$887.90	$556.48
25250	Removal of wrist prosthesis	Y	A2	$333.00	25.1296	$1,069.09	$517.02
25251	Removal of wrist prosthesis	Y	A2	$333.00	25.1296	$1,069.09	$517.02
25259	Manipulate wrist w/anesthes	Y	G2		1.6857	$71.71	$71.71
25260	Repair forearm tendon/muscle	Y	A2	$630.00	25.1296	$1,069.09	$739.77
25263	Repair forearm tendon/muscle	Y	A2	$446.00	25.1296	$1,069.09	$601.77
25265	Repair forearm tendon/muscle	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25270	Repair forearm tendon/muscle	Y	A2	$630.00	25.1296	$1,069.09	$739.77
25272	Repair forearm tendon/muscle	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25274	Repair forearm tendon/muscle	Y	A2	$630.00	25.1296	$1,069.09	$739.77
25275	Repair forearm tendon sheath	Y	A2	$630.00	25.1296	$1,069.09	$739.77
25280	Revise wrist/forearm tendon	Y	A2	$630.00	25.1296	$1,069.09	$739.77
25290	Incise wrist/forearm tendon	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25295	Release wrist/forearm tendon	Y	A2	$510.00	20.8706	$887.90	$604.48
25300	Fusion of tendons at wrist	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25301	Fusion of tendons at wrist	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25310	Transplant forearm tendon	Y	A2	$510.00	41.0893	$1,748.06	$819.52
25312	Transplant forearm tendon	Y	A2	$630.00	41.0893	$1,748.06	$909.52
25315	Revise palsy hand tendon(s)	Y	A2	$510.00	41.0893	$1,748.06	$819.52
25316	Revise palsy hand tendon(s)	Y	A2	$510.00	66.5800	$2,832.51	$1,090.63
25320	Repair/revise wrist joint	Y	A2	$510.00	41.0893	$1,748.06	$819.52
25332	Revise wrist joint	Y	A2	$717.00	33.4505	$1,423.08	$893.52
25335	Realignment of hand	Y	A2	$510.00	41.0893	$1,748.06	$819.52
25337	Reconstruct ulna/radioulnar	Y	A2	$717.00	41.0893	$1,748.06	$974.77
25350	Revision of radius	Y	A2	$510.00	66.5800	$2,832.51	$1,090.63
25355	Revision of radius	Y	A2	$510.00	41.0893	$1,748.06	$819.52
25360	Revision of ulna	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25365	Revise radius & ulna	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25370	Revise radius or ulna	Y	A2	$510.00	41.0893	$1,748.06	$819.52
25375	Revise radius & ulna	Y	A2	$630.00	41.0893	$1,748.06	$909.52
25390	Shorten radius or ulna	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25391	Lengthen radius or ulna	Y	A2	$630.00	41.0893	$1,748.06	$909.52
25392	Shorten radius & ulna	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25393	Lengthen radius & ulna	Y	A2	$630.00	41.0893	$1,748.06	$909.52
25394	Repair carpal bone, shorten	Y	G2		16.1540	$687.24	$687.24
25400	Repair radius or ulna	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25405	Repair/graft radius or ulna	Y	A2	$630.00	25.1296	$1,069.09	$739.77
25415	Repair radius & ulna	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25420	Repair/graft radius & ulna	Y	A2	$630.00	66.5800	$2,832.51	$1,180.63
25425	Repair/graft radius or ulna	Y	A2	$510.00	41.0893	$1,748.06	$819.52
25426	Repair/graft radius & ulna	Y	A2	$630.00	41.0893	$1,748.06	$909.52
25430	Vasc graft into carpal bone	Y	G2		25.8758	$1,100.83	$1,100.83
25431	Repair nonunion carpal bone	Y	G2		25.8758	$1,100.83	$1,100.83
25440	Repair/graft wrist bone	Y	A2	$630.00	66.5800	$2,832.51	$1,180.63
25441	Reconstruct wrist joint	Y	A2	$717.00	107.1942	$4,560.36	$1,677.84
25442	Reconstruct wrist joint	Y	A2	$717.00	107.1942	$4,560.36	$1,677.84
25443	Reconstruct wrist joint	Y	A2	$717.00	47.4378	$2,018.15	$1,042.29
25444	Reconstruct wrist joint	Y	A2	$717.00	47.4378	$2,018.15	$1,042.29
25445	Reconstruct wrist joint	Y	A2	$717.00	47.4378	$2,018.15	$1,042.29
25446	Wrist replacement	Y	A2	$995.00	107.1942	$4,560.36	$1,886.34
25447	Repair wrist joint(s)	Y	A2	$717.00	33.4505	$1,423.08	$893.52
25449	Remove wrist joint implant	Y	A2	$717.00	33.4505	$1,423.08	$893.52

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
25450	Revision of wrist joint	Y	A2	$510.00	41.0893	$1,748.06	$819.52
25455	Revision of wrist joint	Y	A2	$510.00	41.0893	$1,748.06	$819.52
25490	Reinforce radius	Y	A2	$510.00	41.0893	$1,748.06	$819.52
25491	Reinforce ulna	Y	A2	$510.00	41.0893	$1,748.06	$819.52
25492	Reinforce radius and ulna	Y	A2	$510.00	41.0893	$1,748.06	$819.52
25500	Treat fracture of radius	Y	P2	.....	1.6857	$71.71	$71.71
25505	Treat fracture of radius	Y	A2	$103.62	1.6857	$71.71	$95.64
25515	Treat fracture of radius	Y	A2	$510.00	37.5382	$1,596.99	$781.75
25520	Treat fracture of radius	Y	A2	$103.62	1.6857	$71.71	$95.64
25525	Treat fracture of radius	Y	A2	$630.00	37.5382	$1,596.99	$871.75
25526	Treat fracture of radius	Y	A2	$717.00	37.5382	$1,596.99	$937.00
25530	Treat fracture of ulna	Y	P2	.....	1.6857	$71.71	$71.71
25535	Treat fracture of ulna	Y	A2	$103.62	1.6857	$71.71	$95.64
25545	Treat fracture of ulna	Y	A2	$510.00	37.5382	$1,596.99	$781.75
25560	Treat fracture radius & ulna	Y	P2	.....	1.6857	$71.71	$71.71
25565	Treat fracture radius & ulna	Y	A2	$103.62	1.6857	$71.71	$95.64
25574	Treat fracture radius & ulna	Y	A2	$510.00	57.2172	$2,434.19	$991.05
25575	Treat fracture radius/ulna	Y	A2	$510.00	57.2172	$2,434.19	$991.05
25600	Treat fracture radius/ulna	Y	P2	.....	1.6857	$71.71	$71.71
25605	Treat fracture radius/ulna	Y	A2	$103.62	1.6857	$71.71	$95.64
25606	Treat fx distal radial	Y	A2	$510.00	25.5264	$1,085.97	$653.99
25607	Treat fx rad extra-articul	Y	A2	$717.00	57.2172	$2,434.19	$1,146.30
25608	Treat fx rad intra-articul	Y	A2	$717.00	57.2172	$2,434.19	$1,146.30
25609	Treat fx radial 3+ frag	Y	A2	$717.00	57.2172	$2,434.19	$1,146.30
25622	Treat wrist bone fracture	Y	P2	.....	1.6857	$71.71	$71.71
25624	Treat wrist bone fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
25628	Treat wrist bone fracture	Y	A2	$510.00	37.5382	$1,596.99	$781.75
25630	Treat wrist bone fracture	Y	P2	.....	1.6857	$71.71	$71.71
25635	Treat wrist bone fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
25645	Treat wrist bone fracture	Y	A2	$510.00	37.5382	$1,596.99	$781.75
25650	Treat wrist bone fracture	Y	P2	.....	1.6857	$71.71	$71.71
25651	Pin ulnar styloid fracture	Y	G2	.....	25.5264	$1,085.97	$1,085.97
25652	Treat fracture ulnar styloid	Y	G2	.....	37.5382	$1,596.99	$1,596.99
25660	Treat wrist dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
25670	Treat wrist dislocation	Y	A2	$510.00	25.5264	$1,085.97	$653.99
25671	Pin radioulnar dislocation	Y	A2	$333.00	25.5264	$1,085.97	$521.24
25675	Treat wrist dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
25676	Treat wrist dislocation	Y	A2	$446.00	25.5264	$1,085.97	$605.99
25680	Treat wrist fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
25685	Treat wrist fracture	Y	A2	$510.00	25.5264	$1,085.97	$653.99
25690	Treat wrist dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
25695	Treat wrist dislocation	Y	A2	$446.00	25.5264	$1,085.97	$605.99
25800	Fusion of wrist joint	Y	A2	$630.00	66.5800	$2,832.51	$1,180.63
25805	Fusion/graft of wrist joint	Y	A2	$717.00	41.0893	$1,748.06	$974.77
25810	Fusion/graft of wrist joint	Y	A2	$717.00	66.5800	$2,832.51	$1,245.88
25820	Fusion of hand bones	Y	A2	$630.00	16.1540	$687.24	$644.31
25825	Fuse hand bones with graft	Y	A2	$717.00	25.8758	$1,100.83	$812.96
25830	Fusion, radioulnar jnt/ulna	Y	A2	$717.00	66.5800	$2,832.51	$1,245.88
25907	Amputation follow-up surgery	Y	A2	$510.00	20.8706	$887.90	$604.48
25922	Amputate hand at wrist	Y	A2	$510.00	20.8706	$887.90	$604.48
25929	Amputation follow-up surgery	Y	A2	$510.00	14.0346	$597.07	$531.77
26010	Drainage of finger abscess	Y	P2	.....	1.4392	$61.23	$61.23
26011	Drainage of finger abscess	Y	A2	$333.00	11.1535	$474.50	$368.38
26020	Drain hand tendon sheath	Y	A2	$446.00	16.1540	$687.24	$506.31
26025	Drainage of palm bursa	Y	A2	$333.00	16.1540	$687.24	$421.56
26030	Drainage of palm bursa(s)	Y	A2	$446.00	16.1540	$687.24	$506.31
26034	Treat hand bone lesion	Y	A2	$446.00	16.1540	$687.24	$506.31
26035	Decompress fingers/hand	Y	G2	.....	16.1540	$687.24	$687.24
26040	Release palm contracture	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26045	Release palm contracture	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26055	Incise finger tendon sheath	Y	A2	$446.00	16.1540	$687.24	$506.31
26060	Incision of finger tendon	Y	A2	$446.00	16.1540	$687.24	$506.31
26070	Explore/treat hand joint	Y	A2	$446.00	16.1540	$687.24	$506.31

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
26075	Explore/treat finger joint	Y	A2	$630.00	16.1540	$687.24	$644.31
26080	Explore/treat finger joint	Y	A2	$630.00	16.1540	$687.24	$644.31
26100	Biopsy hand joint lining	Y	A2	$446.00	16.1540	$687.24	$506.31
26105	Biopsy finger joint lining	Y	A2	$333.00	16.1540	$687.24	$421.56
26110	Biopsy finger joint lining	Y	A2	$333.00	16.1540	$687.24	$421.56
26115	Removal hand lesion subcut	Y	A2	$446.00	20.0656	$853.65	$547.91
26116	Removal hand lesion, deep	Y	A2	$446.00	20.0656	$853.65	$547.91
26117	Remove tumor, hand/finger	Y	A2	$510.00	20.0656	$853.65	$595.91
26121	Release palm contracture	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26123	Release palm contracture	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26125	Release palm contracture	Y	A2	$630.00	16.1540	$687.24	$644.31
26130	Remove wrist joint lining	Y	A2	$510.00	16.1540	$687.24	$554.31
26135	Revise finger joint, each	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26140	Revise finger joint, each	Y	A2	$446.00	16.1540	$687.24	$506.31
26145	Tendon excision, palm/finger	Y	A2	$510.00	16.1540	$687.24	$554.31
26160	Remove tendon sheath lesion	Y	A2	$510.00	16.1540	$687.24	$554.31
26170	Removal of palm tendon, each	Y	A2	$510.00	16.1540	$687.24	$554.31
26180	Removal of finger tendon	Y	A2	$510.00	16.1540	$687.24	$554.31
26185	Remove finger bone	Y	A2	$630.00	16.1540	$687.24	$644.31
26200	Remove hand bone lesion	Y	A2	$446.00	16.1540	$687.24	$506.31
26205	Remove/graft bone lesion	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26210	Removal of finger lesion	Y	A2	$446.00	16.1540	$687.24	$506.31
26215	Remove/graft finger lesion	Y	A2	$510.00	16.1540	$687.24	$554.31
26230	Partial removal of hand bone	Y	A2	$992.95	16.1540	$687.24	$916.52
26235	Partial removal, finger bone	Y	A2	$510.00	16.1540	$687.24	$554.31
26236	Partial removal, finger bone	Y	A2	$510.00	16.1540	$687.24	$554.31
26250	Extensive hand surgery	Y	A2	$510.00	16.1540	$687.24	$554.31
26255	Extensive hand surgery	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26260	Extensive finger surgery	Y	A2	$510.00	16.1540	$687.24	$554.31
26261	Extensive finger surgery	Y	A2	$510.00	16.1540	$687.24	$554.31
26262	Partial removal of finger	Y	A2	$446.00	16.1540	$687.24	$506.31
26320	Removal of implant from hand	Y	A2	$446.00	15.1024	$642.50	$495.13
26340	Manipulate finger w/anesth	Y	G2	.....	1.6857	$71.71	$71.71
26350	Repair finger/hand tendon	Y	A2	$333.00	25.8758	$1,100.83	$524.96
26352	Repair/graft hand tendon	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26356	Repair finger/hand tendon	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26357	Repair finger/hand tendon	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26358	Repair/graft hand tendon	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26370	Repair finger/hand tendon	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26372	Repair/graft hand tendon	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26373	Repair finger/hand tendon	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26390	Revise hand/finger tendon	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26392	Repair/graft hand tendon	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26410	Repair hand tendon	Y	A2	$510.00	16.1540	$687.24	$554.31
26412	Repair/graft hand tendon	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26415	Excision, hand/finger tendon	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26416	Graft hand or finger tendon	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26418	Repair finger tendon	Y	A2	$630.00	16.1540	$687.24	$644.31
26420	Repair/graft finger tendon	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26426	Repair finger/hand tendon	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26428	Repair/graft finger tendon	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26432	Repair finger tendon	Y	A2	$510.00	16.1540	$687.24	$554.31
26433	Repair finger tendon	Y	A2	$510.00	16.1540	$687.24	$554.31
26434	Repair/graft finger tendon	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26437	Realignment of tendons	Y	A2	$510.00	16.1540	$687.24	$554.31
26440	Release palm/finger tendon	Y	A2	$510.00	16.1540	$687.24	$554.31
26442	Release palm & finger tendon	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26445	Release hand/finger tendon	Y	A2	$510.00	16.1540	$687.24	$554.31
26449	Release forearm/hand tendon	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26450	Incision of palm tendon	Y	A2	$510.00	16.1540	$687.24	$554.31
26455	Incision of finger tendon	Y	A2	$510.00	16.1540	$687.24	$554.31
26460	Incise hand/finger tendon	Y	A2	$510.00	16.1540	$687.24	$554.31
26471	Fusion of finger tendons	Y	A2	$446.00	16.1540	$687.24	$506.31

Note: The Medicare program payment is 80 percent of the total payment amount and beneficiary coinsurance is 20 percent of the total payment amount, except for screening flexible sigmoidoscopies and screening colonoscopies for which the program payment is 75 percent and the beneficiary coinsurance is 25 percent.

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
26474	Fusion of finger tendons	Y	A2	$446.00	16.1540	$687.24	$506.31
26476	Tendon lengthening	Y	A2	$333.00	16.1540	$687.24	$421.56
26477	Tendon shortening	Y	A2	$333.00	16.1540	$687.24	$421.56
26478	Lengthening of hand tendon	Y	A2	$333.00	16.1540	$687.24	$421.56
26479	Shortening of hand tendon	Y	A2	$333.00	16.1540	$687.24	$421.56
26480	Transplant hand tendon	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26483	Transplant/graft hand tendon	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26485	Transplant palm tendon	Y	A2	$446.00	25.8758	$1,100.83	$609.71
26489	Transplant/graft palm tendon	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26490	Revise thumb tendon	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26492	Tendon transfer with graft	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26494	Hand tendon/muscle transfer	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26496	Revise thumb tendon	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26497	Finger tendon transfer	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26498	Finger tendon transfer	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26499	Revision of finger	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26500	Hand tendon reconstruction	Y	A2	$630.00	16.1540	$687.24	$644.31
26502	Hand tendon reconstruction	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26508	Release thumb contracture	Y	A2	$510.00	16.1540	$687.24	$554.31
26510	Thumb tendon transfer	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26516	Fusion of knuckle joint	Y	A2	$333.00	25.8758	$1,100.83	$524.96
26517	Fusion of knuckle joints	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26518	Fusion of knuckle joints	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26520	Release knuckle contracture	Y	A2	$510.00	16.1540	$687.24	$554.31
26525	Release finger contracture	Y	A2	$510.00	16.1540	$687.24	$554.31
26530	Revise knuckle joint	Y	A2	$510.00	33.4505	$1,423.08	$738.27
26531	Revise knuckle with implant	Y	A2	$995.00	47.4378	$2,018.15	$1,250.79
26535	Revise finger joint	Y	A2	$717.00	33.4505	$1,423.08	$893.52
26536	Revise/implant finger joint	Y	A2	$717.00	47.4378	$2,018.15	$1,042.29
26540	Repair hand joint	Y	A2	$630.00	16.1540	$687.24	$644.31
26541	Repair hand joint with graft	Y	A2	$995.00	25.8758	$1,100.83	$1,021.46
26542	Repair hand joint with graft	Y	A2	$630.00	16.1540	$687.24	$644.31
26545	Reconstruct finger joint	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26546	Repair nonunion hand	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26548	Reconstruct finger joint	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26550	Construct thumb replacement	Y	A2	$446.00	25.8758	$1,100.83	$609.71
26555	Positional change of finger	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26560	Repair of web finger	Y	A2	$446.00	16.1540	$687.24	$506.31
26561	Repair of web finger	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26562	Repair of web finger	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26565	Correct metacarpal flaw	Y	A2	$717.00	25.8758	$1,100.83	$812.96
26567	Correct finger deformity	Y	A2	$717.00	25.8758	$1,100.83	$812.96
26568	Lengthen metacarpal/finger	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26580	Repair hand deformity	Y	A2	$717.00	16.1540	$687.24	$709.56
26587	Reconstruct extra finger	Y	A2	$717.00	16.1540	$687.24	$709.56
26590	Repair finger deformity	Y	A2	$717.00	16.1540	$687.24	$709.56
26591	Repair muscles of hand	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26593	Release muscles of hand	Y	A2	$510.00	16.1540	$687.24	$554.31
26596	Excision constricting tissue	Y	A2	$446.00	16.1540	$687.24	$506.31
26600	Treat metacarpal fracture	Y	P2	.....	1.6857	$71.71	$71.71
26605	Treat metacarpal fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
26607	Treat metacarpal fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
26608	Treat metacarpal fracture	Y	A2	$630.00	25.5264	$1,085.97	$743.99
26615	Treat metacarpal fracture	Y	A2	$630.00	37.5382	$1,596.99	$871.75
26641	Treat thumb dislocation	Y	G2	.....	1.6857	$71.71	$71.71
26645	Treat thumb fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
26650	Treat thumb fracture	Y	A2	$446.00	25.5264	$1,085.97	$605.99
26665	Treat thumb fracture	Y	A2	$630.00	37.5382	$1,596.99	$871.75
26670	Treat hand dislocation	Y	G2	.....	1.6857	$71.71	$71.71
26675	Treat hand dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
26676	Pin hand dislocation	Y	A2	$446.00	25.5264	$1,085.97	$605.99
26685	Treat hand dislocation	Y	A2	$510.00	37.5382	$1,596.99	$781.75
26686	Treat hand dislocation	Y	A2	$510.00	57.2172	$2,434.19	$991.05

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
26700	Treat knuckle dislocation	Y	G2		1.6857	$71.71	$71.71
26705	Treat knuckle dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
26706	Pin knuckle dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
26715	Treat knuckle dislocation	Y	A2	$630.00	37.5382	$1,596.99	$871.75
26720	Treat finger fracture, each	Y	P2		1.6857	$71.71	$71.71
26725	Treat finger fracture, each	Y	P2		1.6857	$71.71	$71.71
26727	Treat finger fracture, each	Y	A2	$995.00	25.5264	$1,085.97	$1,017.74
26735	Treat finger fracture, each	Y	A2	$630.00	37.5382	$1,596.99	$871.75
26740	Treat finger fracture, each	Y	P2		1.6857	$71.71	$71.71
26742	Treat finger fracture, each	Y	A2	$103.62	1.6857	$71.71	$95.64
26746	Treat finger fracture, each	Y	A2	$717.00	37.5382	$1,596.99	$937.00
26750	Treat finger fracture, each	Y	P2		1.6857	$71.71	$71.71
26755	Treat finger fracture, each	Y	G2		1.6857	$71.71	$71.71
26756	Pin finger fracture, each	Y	A2	$446.00	25.5264	$1,085.97	$605.99
26765	Treat finger fracture, each	Y	A2	$630.00	37.5382	$1,596.99	$871.75
26770	Treat finger dislocation	Y	G2		1.6857	$71.71	$71.71
26775	Treat finger dislocation	Y	G2		14.5947	$620.90	$620.90
26776	Pin finger dislocation	Y	A2	$446.00	25.5264	$1,085.97	$605.99
26785	Treat finger dislocation	Y	A2	$446.00	25.5264	$1,085.97	$605.99
26820	Thumb fusion with graft	Y	A2	$717.00	25.8758	$1,100.83	$812.96
26841	Fusion of thumb	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26842	Thumb fusion with graft	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26843	Fusion of hand joint	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26844	Fusion/graft of hand joint	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26850	Fusion of knuckle	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26852	Fusion of knuckle with graft	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26860	Fusion of finger joint	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26861	Fusion of finger jnt, add-on	Y	A2	$446.00	25.8758	$1,100.83	$609.71
26862	Fusion/graft of finger joint	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26863	Fuse/graft added joint	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26910	Amputate metacarpal bone	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26951	Amputation of finger/thumb	Y	A2	$446.00	16.1540	$687.24	$506.31
26952	Amputation of finger/thumb	Y	A2	$630.00	16.1540	$687.24	$644.31
26990	Drainage of pelvis lesion	Y	A2	$333.00	20.8706	$887.90	$471.73
26991	Drainage of pelvis bursa	Y	A2	$333.00	20.8706	$887.90	$471.73
27000	Incision of hip tendon	Y	A2	$446.00	20.8706	$887.90	$556.48
27001	Incision of hip tendon	Y	A2	$510.00	25.1296	$1,069.09	$649.77
27003	Incision of hip tendon	Y	A2	$510.00	25.1296	$1,069.09	$649.77
27033	Exploration of hip joint	Y	A2	$510.00	41.0893	$1,748.06	$819.52
27035	Denervation of hip joint	Y	A2	$630.00	41.0893	$1,748.06	$909.52
27040	Biopsy of soft tissues	Y	A2	$333.00	6.8083	$289.65	$322.16
27041	Biopsy of soft tissues	Y	A2	$418.49	6.8083	$289.65	$386.28
27047	Remove hip/pelvis lesion	Y	A2	$446.00	20.0656	$853.65	$547.91
27048	Remove hip/pelvis lesion	Y	A2	$510.00	20.0656	$853.65	$595.91
27049	Remove tumor, hip/pelvis	Y	A2	$510.00	20.0656	$853.65	$595.91
27050	Biopsy of sacroiliac joint	Y	A2	$510.00	20.8706	$887.90	$604.48
27052	Biopsy of hip joint	Y	A2	$510.00	20.8706	$887.90	$604.48
27060	Removal of ischial bursa	Y	A2	$717.00	20.8706	$887.90	$759.73
27062	Remove femur lesion/bursa	Y	A2	$717.00	20.8706	$887.90	$759.73
27065	Removal of hip bone lesion	Y	A2	$717.00	20.8706	$887.90	$759.73
27066	Removal of hip bone lesion	Y	A2	$717.00	25.1296	$1,069.09	$805.02
27067	Remove/graft hip bone lesion	Y	A2	$717.00	25.1296	$1,069.09	$805.02
27080	Removal of tail bone	Y	A2	$446.00	25.1296	$1,069.09	$601.77
27086	Remove hip foreign body	Y	A2	$333.00	6.8083	$289.65	$322.16
27087	Remove hip foreign body	Y	A2	$510.00	20.8706	$887.90	$604.48
27093	Injection for hip x-ray		N1				
27095	Injection for hip x-ray		N1				
27097	Revision of hip tendon	Y	A2	$510.00	25.1296	$1,069.09	$649.77
27098	Transfer tendon to pelvis	Y	A2	$510.00	25.1296	$1,069.09	$649.77
27100	Transfer of abdominal muscle	Y	A2	$630.00	41.0893	$1,748.06	$909.52
27105	Transfer of spinal muscle	Y	A2	$630.00	41.0893	$1,748.06	$909.52
27110	Transfer of iliopsoas muscle	Y	A2	$630.00	41.0893	$1,748.06	$909.52
27111	Transfer of iliopsoas muscle	Y	A2	$630.00	41.0893	$1,748.06	$909.52

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
27193	Treat pelvic ring fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27194	Treat pelvic ring fracture	Y	A2	$446.00	14.5947	$620.90	$489.73
27200	Treat tail bone fracture	Y	P2	.....	1.6857	$71.71	$71.71
27202	Treat tail bone fracture	Y	A2	$446.00	37.5382	$1,596.99	$733.75
27220	Treat hip socket fracture	Y	G2	.....	1.6857	$71.71	$71.71
27230	Treat thigh fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27238	Treat thigh fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27246	Treat thigh fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27250	Treat hip dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
27252	Treat hip dislocation	Y	A2	$446.00	14.5947	$620.90	$489.73
27256	Treat hip dislocation	Y	G2	.....	1.6857	$71.71	$71.71
27257	Treat hip dislocation	Y	A2	$510.00	14.5947	$620.90	$537.73
27265	Treat hip dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
27266	Treat hip dislocation	Y	A2	$446.00	14.5947	$620.90	$489.73
27275	Manipulation of hip joint	Y	A2	$446.00	14.5947	$620.90	$489.73
27301	Drain thigh/knee lesion	Y	A2	$510.00	17.5086	$744.87	$568.72
27305	Incise thigh tendon & fascia	Y	A2	$446.00	20.8706	$887.90	$556.48
27306	Incision of thigh tendon	Y	A2	$510.00	20.8706	$887.90	$604.48
27307	Incision of thigh tendons	Y	A2	$510.00	20.8706	$887.90	$604.48
27310	Exploration of knee joint	Y	A2	$630.00	25.1296	$1,069.09	$739.77
27323	Biopsy, thigh soft tissues	Y	A2	$333.00	6.8083	$289.65	$322.16
27324	Biopsy, thigh soft tissues	Y	A2	$333.00	20.0656	$853.65	$463.16
27325	Neurectomy, hamstring	Y	A2	$446.00	17.8499	$759.39	$524.35
27326	Neurectomy, popliteal	Y	A2	$446.00	17.8499	$759.39	$524.35
27327	Removal of thigh lesion	Y	A2	$446.00	20.0656	$853.65	$547.91
27328	Removal of thigh lesion	Y	A2	$510.00	20.0656	$853.65	$595.91
27329	Remove tumor, thigh/knee	Y	A2	$630.00	20.0656	$853.65	$685.91
27330	Biopsy, knee joint lining	Y	A2	$630.00	25.1296	$1,069.09	$739.77
27331	Explore/treat knee joint	Y	A2	$630.00	25.1296	$1,069.09	$739.77
27332	Removal of knee cartilage	Y	A2	$630.00	25.1296	$1,069.09	$739.77
27333	Removal of knee cartilage	Y	A2	$630.00	25.1296	$1,069.09	$739.77
27334	Remove knee joint lining	Y	A2	$630.00	25.1296	$1,069.09	$739.77
27335	Remove knee joint lining	Y	A2	$630.00	25.1296	$1,069.09	$739.77
27340	Removal of kneecap bursa	Y	A2	$510.00	20.8706	$887.90	$604.48
27345	Removal of knee cyst	Y	A2	$630.00	20.8706	$887.90	$694.48
27347	Remove knee cyst	Y	A2	$630.00	20.8706	$887.90	$694.48
27350	Removal of kneecap	Y	A2	$630.00	25.1296	$1,069.09	$739.77
27355	Remove femur lesion	Y	A2	$510.00	25.1296	$1,069.09	$649.77
27356	Remove femur lesion/graft	Y	A2	$630.00	25.1296	$1,069.09	$739.77
27357	Remove femur lesion/graft	Y	A2	$717.00	25.1296	$1,069.09	$805.02
27358	Remove femur lesion/fixation	Y	A2	$717.00	25.1296	$1,069.09	$805.02
27360	Partial removal, leg bone(s)	Y	A2	$717.00	25.1296	$1,069.09	$805.02
27370	Injection for knee x-ray	.....	N1	.....	.....	.....	.....
27372	Removal of foreign body	Y	A2	$995.00	20.0656	$853.65	$959.66
27380	Repair of kneecap tendon	Y	A2	$333.00	20.8706	$887.90	$471.73
27381	Repair/graft kneecap tendon	Y	A2	$510.00	20.8706	$887.90	$604.48
27385	Repair of thigh muscle	Y	A2	$510.00	20.8706	$887.90	$604.48
27386	Repair/graft of thigh muscle	Y	A2	$510.00	20.8706	$887.90	$604.48
27390	Incision of thigh tendon	Y	A2	$333.00	20.8706	$887.90	$471.73
27391	Incision of thigh tendons	Y	A2	$446.00	20.8706	$887.90	$556.48
27392	Incision of thigh tendons	Y	A2	$510.00	20.8706	$887.90	$604.48
27393	Lengthening of thigh tendon	Y	A2	$446.00	25.1296	$1,069.09	$601.77
27394	Lengthening of thigh tendons	Y	A2	$510.00	25.1296	$1,069.09	$649.77
27395	Lengthening of thigh tendons	Y	A2	$510.00	41.0893	$1,748.06	$819.52
27396	Transplant of thigh tendon	Y	A2	$510.00	25.1296	$1,069.09	$649.77
27397	Transplants of thigh tendons	Y	A2	$510.00	41.0893	$1,748.06	$819.52
27400	Revise thigh muscles/tendons	Y	A2	$510.00	41.0893	$1,748.06	$819.52
27403	Repair of knee cartilage	Y	A2	$630.00	25.1296	$1,069.09	$739.77
27405	Repair of knee ligament	Y	A2	$630.00	41.0893	$1,748.06	$909.52
27407	Repair of knee ligament	Y	A2	$630.00	66.5800	$2,832.51	$1,180.63
27409	Repair of knee ligaments	Y	A2	$630.00	41.0893	$1,748.06	$909.52
27418	Repair degenerated kneecap	Y	A2	$510.00	41.0893	$1,748.06	$819.52
27420	Revision of unstable kneecap	Y	A2	$510.00	41.0893	$1,748.06	$819.52

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
27422	Revision of unstable kneecap	Y	A2	$995.00	41.0893	$1,748.06	$1,183.27
27424	Revision/removal of kneecap	Y	A2	$510.00	41.0893	$1,748.06	$819.52
27425	Lat retinacular release open	Y	A2	$995.00	25.1296	$1,069.09	$1,013.52
27427	Reconstruction, knee	Y	A2	$510.00	41.0893	$1,748.06	$819.52
27428	Reconstruction, knee	Y	A2	$630.00	66.5800	$2,832.51	$1,180.63
27429	Reconstruction, knee	Y	A2	$630.00	66.5800	$2,832.51	$1,180.63
27430	Revision of thigh muscles	Y	A2	$630.00	41.0893	$1,748.06	$909.52
27435	Incision of knee joint	Y	A2	$630.00	41.0893	$1,748.06	$909.52
27437	Revise kneecap	Y	A2	$630.00	33.4505	$1,423.08	$828.27
27438	Revise kneecap with implant	Y	A2	$717.00	47.4378	$2,018.15	$1,042.29
27440	Revision of knee joint	Y	G2	.....	33.4505	$1,423.08	$1,423.08
27441	Revision of knee joint	Y	A2	$717.00	33.4505	$1,423.08	$893.52
27442	Revision of knee joint	Y	A2	$717.00	33.4505	$1,423.08	$893.52
27443	Revision of knee joint	Y	A2	$717.00	33.4505	$1,423.08	$893.52
27446	Revision of knee joint	Y	G2	.....	205.6815	$8,750.31	$8,750.31
27496	Decompression of thigh/knee	Y	A2	$717.00	20.8706	$887.90	$759.73
27497	Decompression of thigh/knee	Y	A2	$510.00	20.8706	$887.90	$604.48
27498	Decompression of thigh/knee	Y	A2	$510.00	20.8706	$887.90	$604.48
27499	Decompression of thigh/knee	Y	A2	$510.00	20.8706	$887.90	$604.48
27500	Treatment of thigh fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27501	Treatment of thigh fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27502	Treatment of thigh fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27503	Treatment of thigh fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27508	Treatment of thigh fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27509	Treatment of thigh fracture	Y	A2	$510.00	25.5264	$1,085.97	$653.99
27510	Treatment of thigh fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27516	Treat thigh fx growth plate	Y	A2	$103.62	1.6857	$71.71	$95.64
27517	Treat thigh fx growth plate	Y	A2	$103.62	1.6857	$71.71	$95.64
27520	Treat kneecap fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27530	Treat knee fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27532	Treat knee fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27538	Treat knee fracture(s)	Y	A2	$103.62	1.6857	$71.71	$95.64
27550	Treat knee dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
27552	Treat knee dislocation	Y	A2	$333.00	14.5947	$620.90	$404.98
27560	Treat kneecap dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
27562	Treat kneecap dislocation	Y	A2	$333.00	14.5947	$620.90	$404.98
27566	Treat kneecap dislocation	Y	A2	$446.00	37.5382	$1,596.99	$733.75
27570	Fixation of knee joint	Y	A2	$333.00	14.5947	$620.90	$404.98
27594	Amputation follow-up surgery	Y	A2	$510.00	20.8706	$887.90	$604.48
27600	Decompression of lower leg	Y	A2	$510.00	20.8706	$887.90	$604.48
27601	Decompression of lower leg	Y	A2	$510.00	20.8706	$887.90	$604.48
27602	Decompression of lower leg	Y	A2	$510.00	20.8706	$887.90	$604.48
27603	Drain lower leg lesion	Y	A2	$446.00	17.5086	$744.87	$520.72
27604	Drain lower leg bursa	Y	A2	$446.00	20.8706	$887.90	$556.48
27605	Incision of achilles tendon	Y	A2	$333.00	20.4263	$869.00	$467.00
27606	Incision of achilles tendon	Y	A2	$333.00	20.8706	$887.90	$471.73
27607	Treat lower leg bone lesion	Y	A2	$446.00	20.8706	$887.90	$556.48
27610	Explore/treat ankle joint	Y	A2	$446.00	25.1296	$1,069.09	$601.77
27612	Exploration of ankle joint	Y	A2	$510.00	25.1296	$1,069.09	$649.77
27613	Biopsy lower leg soft tissue	Y	P3	.....	2.8569	$121.54	$121.54
27614	Biopsy lower leg soft tissue	Y	A2	$446.00	20.0656	$853.65	$547.91
27615	Remove tumor, lower leg	Y	A2	$510.00	25.1296	$1,069.09	$649.77
27618	Remove lower leg lesion	Y	A2	$446.00	15.1024	$642.50	$495.13
27619	Remove lower leg lesion	Y	A2	$510.00	20.0656	$853.65	$595.91
27620	Explore/treat ankle joint	Y	A2	$630.00	25.1296	$1,069.09	$739.77
27625	Remove ankle joint lining	Y	A2	$630.00	25.1296	$1,069.09	$739.77
27626	Remove ankle joint lining	Y	A2	$630.00	25.1296	$1,069.09	$739.77
27630	Removal of tendon lesion	Y	A2	$510.00	20.8706	$887.90	$604.48
27635	Remove lower leg bone lesion	Y	A2	$510.00	25.1296	$1,069.09	$649.77
27637	Remove/graft leg bone lesion	Y	A2	$510.00	25.1296	$1,069.09	$649.77
27638	Remove/graft leg bone lesion	Y	A2	$510.00	25.1296	$1,069.09	$649.77
27640	Partial removal of tibia	Y	A2	$446.00	41.0893	$1,748.06	$771.52
27641	Partial removal of fibula	Y	A2	$446.00	25.1296	$1,069.09	$601.77

Note: The Medicare program payment is 80 percent of the total payment amount and beneficiary coinsurance is 20 percent of the total payment amount, except for screening flexible sigmoidoscopies and screening colonoscopies for which the program payment is 75 percent and the beneficiary coinsurance is 25 percent.

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
27647	Extensive ankle/heel surgery	Y	A2	$510.00	41.0893	$1,748.06	$819.52
27648	Injection for ankle x-ray		N1				
27650	Repair achilles tendon	Y	A2	$510.00	41.0893	$1,748.06	$819.52
27652	Repair/graft achilles tendon	Y	A2	$510.00	66.5800	$2,832.51	$1,090.63
27654	Repair of achilles tendon	Y	A2	$510.00	41.0893	$1,748.06	$819.52
27656	Repair leg fascia defect	Y	A2	$446.00	20.8706	$887.90	$556.48
27658	Repair of leg tendon, each	Y	A2	$333.00	20.8706	$887.90	$471.73
27659	Repair of leg tendon, each	Y	A2	$446.00	20.8706	$887.90	$556.48
27664	Repair of leg tendon, each	Y	A2	$446.00	20.8706	$887.90	$556.48
27665	Repair of leg tendon, each	Y	A2	$446.00	25.1296	$1,069.09	$601.77
27675	Repair lower leg tendons	Y	A2	$446.00	20.8706	$887.90	$556.48
27676	Repair lower leg tendons	Y	A2	$510.00	25.1296	$1,069.09	$649.77
27680	Release of lower leg tendon	Y	A2	$510.00	25.1296	$1,069.09	$649.77
27681	Release of lower leg tendons	Y	A2	$446.00	25.1296	$1,069.09	$601.77
27685	Revision of lower leg tendon	Y	A2	$510.00	25.1296	$1,069.09	$649.77
27686	Revise lower leg tendons	Y	A2	$510.00	25.1296	$1,069.09	$649.77
27687	Revision of calf tendon	Y	A2	$510.00	25.1296	$1,069.09	$649.77
27690	Revise lower leg tendon	Y	A2	$630.00	41.0893	$1,748.06	$909.52
27691	Revise lower leg tendon	Y	A2	$630.00	41.0893	$1,748.06	$909.52
27692	Revise additional leg tendon	Y	A2	$510.00	41.0893	$1,748.06	$819.52
27695	Repair of ankle ligament	Y	A2	$446.00	25.1296	$1,069.09	$601.77
27696	Repair of ankle ligaments	Y	A2	$446.00	25.1296	$1,069.09	$601.77
27698	Repair of ankle ligament	Y	A2	$446.00	25.1296	$1,069.09	$601.77
27700	Revision of ankle joint	Y	A2	$717.00	33.4505	$1,423.08	$893.52
27704	Removal of ankle implant	Y	A2	$446.00	20.8706	$887.90	$556.48
27705	Incision of tibia	Y	A2	$446.00	41.0893	$1,748.06	$771.52
27707	Incision of fibula	Y	A2	$446.00	20.8706	$887.90	$556.48
27709	Incision of tibia & fibula	Y	A2	$446.00	25.1296	$1,069.09	$601.77
27730	Repair of tibia epiphysis	Y	A2	$446.00	25.1296	$1,069.09	$601.77
27732	Repair of fibula epiphysis	Y	A2	$446.00	25.1296	$1,069.09	$601.77
27734	Repair lower leg epiphyses	Y	A2	$446.00	25.1296	$1,069.09	$601.77
27740	Repair of leg epiphyses	Y	A2	$446.00	25.1296	$1,069.09	$601.77
27742	Repair of leg epiphyses	Y	A2	$446.00	41.0893	$1,748.06	$771.52
27745	Reinforce tibia	Y	A2	$510.00	66.5800	$2,832.51	$1,090.63
27750	Treatment of tibia fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27752	Treatment of tibia fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27756	Treatment of tibia fracture	Y	A2	$510.00	25.5264	$1,085.97	$653.99
27758	Treatment of tibia fracture	Y	A2	$630.00	37.5382	$1,596.99	$871.75
27759	Treatment of tibia fracture	Y	A2	$630.00	57.2172	$2,434.19	$1,081.05
27760	Treatment of ankle fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27762	Treatment of ankle fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27766	Treatment of ankle fracture	Y	A2	$510.00	37.5382	$1,596.99	$781.75
27780	Treatment of fibula fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27781	Treatment of fibula fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27784	Treatment of fibula fracture	Y	A2	$510.00	37.5382	$1,596.99	$781.75
27786	Treatment of ankle fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27788	Treatment of ankle fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27792	Treatment of ankle fracture	Y	A2	$510.00	37.5382	$1,596.99	$781.75
27808	Treatment of ankle fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27810	Treatment of ankle fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27814	Treatment of ankle fracture	Y	A2	$510.00	37.5382	$1,596.99	$781.75
27816	Treatment of ankle fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27818	Treatment of ankle fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27822	Treatment of ankle fracture	Y	A2	$510.00	37.5382	$1,596.99	$781.75
27823	Treatment of ankle fracture	Y	A2	$510.00	57.2172	$2,434.19	$991.05
27824	Treat lower leg fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27825	Treat lower leg fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27826	Treat lower leg fracture	Y	A2	$510.00	37.5382	$1,596.99	$781.75
27827	Treat lower leg fracture	Y	A2	$510.00	57.2172	$2,434.19	$991.05
27828	Treat lower leg fracture	Y	A2	$630.00	57.2172	$2,434.19	$1,081.05
27829	Treat lower leg joint	Y	A2	$446.00	37.5382	$1,596.99	$733.75
27830	Treat lower leg dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
27831	Treat lower leg dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
27832	Treat lower leg dislocation	Y	A2	$446.00	37.5382	$1,596.99	$733.75
27840	Treat ankle dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
27842	Treat ankle dislocation	Y	A2	$333.00	14.5947	$620.90	$404.98
27846	Treat ankle dislocation	Y	A2	$510.00	37.5382	$1,596.99	$781.75
27848	Treat ankle dislocation	Y	A2	$510.00	37.5382	$1,596.99	$781.75
27860	Fixation of ankle joint	Y	A2	$333.00	14.5947	$620.90	$404.98
27870	Fusion of ankle joint, open	Y	A2	$630.00	66.5800	$2,832.51	$1,180.63
27871	Fusion of tibiofibular joint	Y	A2	$630.00	66.5800	$2,832.51	$1,180.63
27884	Amputation follow-up surgery	Y	A2	$510.00	20.8706	$887.90	$604.48
27889	Amputation of foot at ankle	Y	A2	$510.00	25.1296	$1,069.09	$649.77
27892	Decompression of leg	Y	A2	$510.00	20.8706	$887.90	$604.48
27893	Decompression of leg	Y	A2	$510.00	20.8706	$887.90	$604.48
27894	Decompression of leg	Y	A2	$510.00	20.8706	$887.90	$604.48
28001	Drainage of bursa of foot	Y	P3	.....	2.8327	$120.51	$120.51
28002	Treatment of foot infection	Y	A2	$510.00	20.8706	$887.90	$604.48
28003	Treatment of foot infection	Y	A2	$510.00	20.8706	$887.90	$604.48
28005	Treat foot bone lesion	Y	A2	$510.00	20.4263	$869.00	$599.75
28008	Incision of foot fascia	Y	A2	$510.00	20.4263	$869.00	$599.75
28010	Incision of toe tendon	Y	P3	.....	2.1164	$90.04	$90.04
28011	Incision of toe tendons	Y	A2	$510.00	20.4263	$869.00	$599.75
28020	Exploration of foot joint	Y	A2	$446.00	20.4263	$869.00	$551.75
28022	Exploration of foot joint	Y	A2	$446.00	20.4263	$869.00	$551.75
28024	Exploration of toe joint	Y	A2	$446.00	20.4263	$869.00	$551.75
28035	Decompression of tibia nerve	Y	A2	$630.00	17.8499	$759.39	$662.35
28043	Excision of foot lesion	Y	A2	$446.00	20.0656	$853.65	$547.91
28045	Excision of foot lesion	Y	A2	$510.00	20.4263	$869.00	$599.75
28046	Resection of tumor, foot	Y	A2	$510.00	20.4263	$869.00	$599.75
28050	Biopsy of foot joint lining	Y	A2	$446.00	20.4263	$869.00	$551.75
28052	Biopsy of foot joint lining	Y	A2	$446.00	20.4263	$869.00	$551.75
28054	Biopsy of toe joint lining	Y	A2	$446.00	20.4263	$869.00	$551.75
28055	Neurectomy, foot	Y	A2	$630.00	17.8499	$759.39	$662.35
28060	Partial removal, foot fascia	Y	A2	$446.00	20.4263	$869.00	$551.75
28062	Removal of foot fascia	Y	A2	$510.00	20.4263	$869.00	$599.75
28070	Removal of foot joint lining	Y	A2	$510.00	20.4263	$869.00	$599.75
28072	Removal of foot joint lining	Y	A2	$510.00	20.4263	$869.00	$599.75
28080	Removal of foot lesion	Y	A2	$510.00	20.4263	$869.00	$599.75
28086	Excise foot tendon sheath	Y	A2	$446.00	20.4263	$869.00	$551.75
28088	Excise foot tendon sheath	Y	A2	$446.00	20.4263	$869.00	$551.75
28090	Removal of foot lesion	Y	A2	$510.00	20.4263	$869.00	$599.75
28092	Removal of toe lesions	Y	A2	$510.00	20.4263	$869.00	$599.75
28100	Removal of ankle/heel lesion	Y	A2	$446.00	20.4263	$869.00	$551.75
28102	Remove/graft foot lesion	Y	A2	$510.00	40.8559	$1,738.13	$817.03
28103	Remove/graft foot lesion	Y	A2	$510.00	40.8559	$1,738.13	$817.03
28104	Removal of foot lesion	Y	A2	$446.00	20.4263	$869.00	$551.75
28106	Remove/graft foot lesion	Y	A2	$510.00	40.8559	$1,738.13	$817.03
28107	Remove/graft foot lesion	Y	A2	$510.00	40.8559	$1,738.13	$817.03
28108	Removal of toe lesions	Y	A2	$446.00	20.4263	$869.00	$551.75
28110	Part removal of metatarsal	Y	A2	$510.00	20.4263	$869.00	$599.75
28111	Part removal of metatarsal	Y	A2	$510.00	20.4263	$869.00	$599.75
28112	Part removal of metatarsal	Y	A2	$510.00	20.4263	$869.00	$599.75
28113	Part removal of metatarsal	Y	A2	$510.00	20.4263	$869.00	$599.75
28114	Removal of metatarsal heads	Y	A2	$510.00	20.4263	$869.00	$599.75
28116	Revision of foot	Y	A2	$510.00	20.4263	$869.00	$599.75
28118	Removal of heel bone	Y	A2	$630.00	20.4263	$869.00	$689.75
28119	Removal of heel spur	Y	A2	$630.00	20.4263	$869.00	$689.75
28120	Part removal of ankle/heel	Y	A2	$995.00	20.4263	$869.00	$963.50
28122	Partial removal of foot bone	Y	A2	$510.00	20.4263	$869.00	$599.75
28124	Partial removal of toe	Y	P3	.....	4.7639	$202.67	$202.67
28126	Partial removal of toe	Y	A2	$510.00	20.4263	$869.00	$599.75
28130	Removal of ankle bone	Y	A2	$510.00	20.4263	$869.00	$599.75
28140	Removal of metatarsal	Y	A2	$510.00	20.4263	$869.00	$599.75
28150	Removal of toe	Y	A2	$510.00	20.4263	$869.00	$599.75
28153	Partial removal of toe	Y	A2	$510.00	20.4263	$869.00	$599.75

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
28160	Partial removal of toe	Y	A2	$510.00	20.4263	$869.00	$599.75
28171	Extensive foot surgery	Y	A2	$510.00	20.4263	$869.00	$599.75
28173	Extensive foot surgery	Y	A2	$510.00	20.4263	$869.00	$599.75
28175	Extensive foot surgery	Y	A2	$510.00	20.4263	$869.00	$599.75
28190	Removal of foot foreign body	Y	P3	.....	2.9855	$127.01	$127.01
28192	Removal of foot foreign body	Y	A2	$446.00	15.1024	$642.50	$495.13
28193	Removal of foot foreign body	Y	A2	$418.49	6.8083	$289.65	$386.28
28200	Repair of foot tendon	Y	A2	$510.00	20.4263	$869.00	$599.75
28202	Repair/graft of foot tendon	Y	A2	$510.00	20.4263	$869.00	$599.75
28208	Repair of foot tendon	Y	A2	$510.00	20.4263	$869.00	$599.75
28210	Repair/graft of foot tendon	Y	A2	$510.00	40.8559	$1,738.13	$817.03
28220	Release of foot tendon	Y	P3	.....	4.4823	$190.69	$190.69
28222	Release of foot tendons	Y	A2	$333.00	20.4263	$869.00	$467.00
28225	Release of foot tendon	Y	A2	$333.00	20.4263	$869.00	$467.00
28226	Release of foot tendons	Y	A2	$333.00	20.4263	$869.00	$467.00
28230	Incision of foot tendon(s)	Y	P3	.....	4.4341	$188.64	$188.64
28232	Incision of toe tendon	Y	P3	.....	4.2329	$180.08	$180.08
28234	Incision of foot tendon	Y	A2	$446.00	20.4263	$869.00	$551.75
28238	Revision of foot tendon	Y	A2	$510.00	40.8559	$1,738.13	$817.03
28240	Release of big toe	Y	A2	$446.00	20.4263	$869.00	$551.75
28250	Revision of foot fascia	Y	A2	$510.00	20.4263	$869.00	$599.75
28260	Release of midfoot joint	Y	A2	$510.00	20.4263	$869.00	$599.75
28261	Revision of foot tendon	Y	A2	$510.00	20.4263	$869.00	$599.75
28262	Revision of foot and ankle	Y	A2	$630.00	20.4263	$869.00	$689.75
28264	Release of midfoot joint	Y	A2	$333.00	40.8559	$1,738.13	$684.28
28270	Release of foot contracture	Y	A2	$510.00	20.4263	$869.00	$599.75
28272	Release of toe joint, each	Y	P3	.....	4.0559	$172.55	$172.55
28280	Fusion of toes	Y	A2	$446.00	20.4263	$869.00	$551.75
28285	Repair of hammertoe	Y	A2	$510.00	20.4263	$869.00	$599.75
28286	Repair of hammertoe	Y	A2	$630.00	20.4263	$869.00	$689.75
28288	Partial removal of foot bone	Y	A2	$510.00	20.4263	$869.00	$599.75
28289	Repair hallux rigidus	Y	A2	$510.00	20.4263	$869.00	$599.75
28290	Correction of bunion	Y	A2	$446.00	28.2349	$1,201.20	$634.80
28292	Correction of bunion	Y	A2	$446.00	28.2349	$1,201.20	$634.80
28293	Correction of bunion	Y	A2	$510.00	28.2349	$1,201.20	$682.80
28294	Correction of bunion	Y	A2	$510.00	28.2349	$1,201.20	$682.80
28296	Correction of bunion	Y	A2	$510.00	28.2349	$1,201.20	$682.80
28297	Correction of bunion	Y	A2	$510.00	28.2349	$1,201.20	$682.80
28298	Correction of bunion	Y	A2	$510.00	28.2349	$1,201.20	$682.80
28299	Correction of bunion	Y	A2	$717.00	28.2349	$1,201.20	$838.05
28300	Incision of heel bone	Y	A2	$446.00	40.8559	$1,738.13	$769.03
28302	Incision of ankle bone	Y	A2	$446.00	20.4263	$869.00	$551.75
28304	Incision of midfoot bones	Y	A2	$446.00	40.8559	$1,738.13	$769.03
28305	Incise/graft midfoot bones	Y	A2	$510.00	40.8559	$1,738.13	$817.03
28306	Incision of metatarsal	Y	A2	$630.00	20.4263	$869.00	$689.75
28307	Incision of metatarsal	Y	A2	$630.00	20.4263	$869.00	$689.75
28308	Incision of metatarsal	Y	A2	$446.00	20.4263	$869.00	$551.75
28309	Incision of metatarsals	Y	A2	$630.00	40.8559	$1,738.13	$907.03
28310	Revision of big toe	Y	A2	$510.00	20.4263	$869.00	$599.75
28312	Revision of toe	Y	A2	$510.00	20.4263	$869.00	$599.75
28313	Repair deformity of toe	Y	A2	$446.00	20.4263	$869.00	$551.75
28315	Removal of sesamoid bone	Y	A2	$630.00	20.4263	$869.00	$689.75
28320	Repair of foot bones	Y	A2	$630.00	40.8559	$1,738.13	$907.03
28322	Repair of metatarsals	Y	A2	$630.00	40.8559	$1,738.13	$907.03
28340	Resect enlarged toe tissue	Y	A2	$630.00	20.4263	$869.00	$689.75
28341	Resect enlarged toe	Y	A2	$630.00	20.4263	$869.00	$689.75
28344	Repair extra toe(s)	Y	A2	$630.00	20.4263	$869.00	$689.75
28345	Repair webbed toe(s)	Y	A2	$630.00	20.4263	$869.00	$689.75
28400	Treatment of heel fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
28405	Treatment of heel fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
28406	Treatment of heel fracture	Y	A2	$446.00	25.5264	$1,085.97	$605.99
28415	Treat heel fracture	Y	A2	$510.00	37.5382	$1,596.99	$781.75
28420	Treat/graft heel fracture	Y	A2	$630.00	37.5382	$1,596.99	$871.75

Note: The Medicare program payment is 80 percent of the total payment amount and beneficiary coinsurance is 20 percent of the total payment amount, except for screening flexible sigmoidoscopies and screening colonoscopies for which the program payment is 75 percent and the beneficiary coinsurance is 25 percent.

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
28430	Treatment of ankle fracture	Y	P2		1.6857	$71.71	$71.71
28435	Treatment of ankle fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
28436	Treatment of ankle fracture	Y	A2	$446.00	25.5264	$1,085.97	$605.99
28445	Treat ankle fracture	Y	A2	$510.00	37.5382	$1,596.99	$781.75
28450	Treat midfoot fracture, each	Y	P2		1.6857	$71.71	$71.71
28455	Treat midfoot fracture, each	Y	P2		1.6857	$71.71	$71.71
28456	Treat midfoot fracture	Y	A2	$446.00	25.5264	$1,085.97	$605.99
28465	Treat midfoot fracture, each	Y	A2	$510.00	37.5382	$1,596.99	$781.75
28470	Treat metatarsal fracture	Y	P2		1.6857	$71.71	$71.71
28475	Treat metatarsal fracture	Y	P2		1.6857	$71.71	$71.71
28476	Treat metatarsal fracture	Y	A2	$446.00	25.5264	$1,085.97	$605.99
28485	Treat metatarsal fracture	Y	A2	$630.00	37.5382	$1,596.99	$871.75
28490	Treat big toe fracture	Y	P3		1.6579	$70.53	$70.53
28495	Treat big toe fracture	Y	P2		1.6857	$71.71	$71.71
28496	Treat big toe fracture	Y	A2	$446.00	25.5264	$1,085.97	$605.99
28505	Treat big toe fracture	Y	A2	$510.00	37.5382	$1,596.99	$781.75
28510	Treatment of toe fracture	Y	P3		1.2956	$55.12	$55.12
28515	Treatment of toe fracture	Y	P3		1.6658	$70.87	$70.87
28525	Treat toe fracture	Y	A2	$510.00	37.5382	$1,596.99	$781.75
28530	Treat sesamoid bone fracture	Y	P3		1.2392	$52.72	$52.72
28531	Treat sesamoid bone fracture	Y	A2	$510.00	37.5382	$1,596.99	$781.75
28540	Treat foot dislocation	Y	P2		1.6857	$71.71	$71.71
28545	Treat foot dislocation	Y	A2	$333.00	25.5264	$1,085.97	$521.24
28546	Treat foot dislocation	Y	A2	$446.00	25.5264	$1,085.97	$605.99
28555	Repair foot dislocation	Y	A2	$446.00	37.5382	$1,596.99	$733.75
28570	Treat foot dislocation	Y	P2		1.6857	$71.71	$71.71
28575	Treat foot dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
28576	Treat foot dislocation	Y	A2	$510.00	25.5264	$1,085.97	$653.99
28585	Repair foot dislocation	Y	A2	$510.00	37.5382	$1,596.99	$781.75
28600	Treat foot dislocation	Y	P2		1.6857	$71.71	$71.71
28605	Treat foot dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
28606	Treat foot dislocation	Y	A2	$446.00	25.5264	$1,085.97	$605.99
28615	Repair foot dislocation	Y	A2	$510.00	37.5382	$1,596.99	$781.75
28630	Treat toe dislocation	Y	G2		1.6857	$71.71	$71.71
28635	Treat toe dislocation	Y	A2	$333.00	14.5947	$620.90	$404.98
28636	Treat toe dislocation	Y	A2	$510.00	25.5264	$1,085.97	$653.99
28645	Repair toe dislocation	Y	A2	$510.00	37.5382	$1,596.99	$781.75
28660	Treat toe dislocation	Y	G2		1.6857	$71.71	$71.71
28665	Treat toe dislocation	Y	A2	$333.00	14.5947	$620.90	$404.98
28666	Treat toe dislocation	Y	A2	$510.00	25.5264	$1,085.97	$653.99
28675	Repair of toe dislocation	Y	A2	$510.00	37.5382	$1,596.99	$781.75
28705	Fusion of foot bones	Y	A2	$630.00	40.8559	$1,738.13	$907.03
28715	Fusion of foot bones	Y	A2	$630.00	40.8559	$1,738.13	$907.03
28725	Fusion of foot bones	Y	A2	$630.00	40.8559	$1,738.13	$907.03
28730	Fusion of foot bones	Y	A2	$630.00	40.8559	$1,738.13	$907.03
28735	Fusion of foot bones	Y	A2	$630.00	40.8559	$1,738.13	$907.03
28737	Revision of foot bones	Y	A2	$717.00	40.8559	$1,738.13	$972.28
28740	Fusion of foot bones	Y	A2	$630.00	40.8559	$1,738.13	$907.03
28750	Fusion of big toe joint	Y	A2	$630.00	40.8559	$1,738.13	$907.03
28755	Fusion of big toe joint	Y	A2	$630.00	20.4263	$869.00	$689.75
28760	Fusion of big toe joint	Y	A2	$630.00	40.8559	$1,738.13	$907.03
28810	Amputation toe & metatarsal	Y	A2	$446.00	20.4263	$869.00	$551.75
28820	Amputation of toe	Y	A2	$446.00	20.4263	$869.00	$551.75
28825	Partial amputation of toe	Y	A2	$446.00	20.4263	$869.00	$551.75
28890	High energy eswt, plantar f	Y	G2		25.1296	$1,069.09	$1,069.09
29000	Application of body cast	N	G2		1.0607	$45.13	$45.13
29010	Application of body cast	N	P2		2.2777	$96.90	$96.90
29015	Application of body cast	N	P2		2.2777	$96.90	$96.90
29020	Application of body cast	N	G2		1.0607	$45.13	$45.13
29025	Application of body cast	N	P2		1.0607	$45.13	$45.13
29035	Application of body cast	N	G2		2.2777	$96.90	$96.90
29040	Application of body cast	N	G2		1.0607	$45.13	$45.13
29044	Application of body cast	N	P2		2.2777	$96.90	$96.90

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
29046	Application of body cast	N	G2		2.2777	$96.90	$96.90
29049	Application of figure eight	N	P3		0.9736	$41.42	$41.42
29055	Application of shoulder cast	N	P2		2.2777	$96.90	$96.90
29058	Application of shoulder cast	N	P2		1.0607	$45.13	$45.13
29065	Application of long arm cast	N	P3		1.0462	$44.51	$44.51
29075	Application of forearm cast	N	P3		0.9978	$42.45	$42.45
29085	Apply hand/wrist cast	N	P3		1.0220	$43.48	$43.48
29086	Apply finger cast	N	P3		0.8048	$34.24	$34.24
29105	Apply long arm splint	N	P3		0.9334	$39.71	$39.71
29125	Apply forearm splint	N	P3		0.7966	$33.89	$33.89
29126	Apply forearm splint	N	P3		0.8932	$38.00	$38.00
29130	Application of finger splint	N	P3		0.3622	$15.41	$15.41
29131	Application of finger splint	N	P3		0.5472	$23.28	$23.28
29200	Strapping of chest	N	P3		0.5312	$22.60	$22.60
29220	Strapping of low back	N	P3		0.5312	$22.60	$22.60
29240	Strapping of shoulder	N	P3		0.6116	$26.02	$26.02
29260	Strapping of elbow or wrist	N	P3		0.5632	$23.96	$23.96
29280	Strapping of hand or finger	N	P3		0.5874	$24.99	$24.99
29305	Application of hip cast	N	G2		2.2777	$96.90	$96.90
29325	Application of hip casts	N	G2		2.2777	$96.90	$96.90
29345	Application of long leg cast	N	P3		1.3760	$58.54	$58.54
29355	Application of long leg cast	N	P3		1.3438	$57.17	$57.17
29358	Apply long leg cast brace	N	P3		1.6496	$70.18	$70.18
29365	Application of long leg cast	N	P3		1.3036	$55.46	$55.46
29405	Apply short leg cast	N	P3		0.9736	$41.42	$41.42
29425	Apply short leg cast	N	P3		0.9898	$42.11	$42.11
29435	Apply short leg cast	N	P3		1.2392	$52.72	$52.72
29440	Addition of walker to cast	N	P3		0.5230	$22.25	$22.25
29445	Apply rigid leg cast	N	P3		1.3760	$58.54	$58.54
29450	Application of leg cast	N	P2		1.0607	$45.13	$45.13
29505	Application, long leg splint	N	G2		1.0607	$45.13	$45.13
29515	Application lower leg splint	N	G2		1.0607	$45.13	$45.13
29520	Strapping of hip	N	P3		0.6116	$26.02	$26.02
29530	Strapping of knee	N	P3		0.5714	$24.31	$24.31
29540	Strapping of ankle and/or ft	N	P3		0.3862	$16.43	$16.43
29550	Strapping of toes	N	P3		0.4024	$17.12	$17.12
29580	Application of paste boot	N	P3		0.5552	$23.62	$23.62
29590	Application of foot splint	N	P3		0.4506	$19.17	$19.17
29700	Removal/revision of cast	N	P3		0.7484	$31.84	$31.84
29705	Removal/revision of cast	N	P3		0.6438	$27.39	$27.39
29710	Removal/revision of cast	N	P3		1.1990	$51.01	$51.01
29715	Removal/revision of cast	N	P3		0.9254	$39.37	$39.37
29720	Repair of body cast	N	P3		0.9254	$39.37	$39.37
29730	Windowing of cast	N	P3		0.6276	$26.70	$26.70
29740	Wedging of cast	N	P3		0.8852	$37.66	$37.66
29750	Wedging of clubfoot cast	N	P3		0.7966	$33.89	$33.89
29800	Jaw arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29804	Jaw arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29805	Shoulder arthroscopy, dx	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29806	Shoulder arthroscopy/surgery	Y	A2	$510.00	45.5027	$1,935.82	$866.46
29807	Shoulder arthroscopy/surgery	Y	A2	$510.00	45.5027	$1,935.82	$866.46
29819	Shoulder arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29820	Shoulder arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29821	Shoulder arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29822	Shoulder arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29823	Shoulder arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29824	Shoulder arthroscopy/surgery	Y	A2	$717.00	28.6245	$1,217.77	$842.19
29825	Shoulder arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29826	Shoulder arthroscopy/surgery	Y	A2	$510.00	45.5027	$1,935.82	$866.46
29827	Arthroscop rotator cuff repr	Y	A2	$717.00	45.5027	$1,935.82	$1,021.71
29830	Elbow arthroscopy	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29834	Elbow arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29835	Elbow arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
29836	Elbow arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29837	Elbow arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29838	Elbow arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29840	Wrist arthroscopy	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29843	Wrist arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29844	Wrist arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29845	Wrist arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29846	Wrist arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29847	Wrist arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29848	Wrist endoscopy/surgery	Y	A2	$1,339.00	28.6245	$1,217.77	$1,308.69
29850	Knee arthroscopy/surgery	Y	A2	$630.00	28.6245	$1,217.77	$776.94
29851	Knee arthroscopy/surgery	Y	A2	$630.00	45.5027	$1,935.82	$956.46
29855	Tibial arthroscopy/surgery	Y	A2	$630.00	45.5027	$1,935.82	$956.46
29856	Tibial arthroscopy/surgery	Y	A2	$630.00	28.6245	$1,217.77	$776.94
29860	Hip arthroscopy, dx	Y	A2	$630.00	28.6245	$1,217.77	$776.94
29861	Hip arthroscopy/surgery	Y	A2	$630.00	28.6245	$1,217.77	$776.94
29862	Hip arthroscopy/surgery	Y	A2	$1,339.00	45.5027	$1,935.82	$1,488.21
29863	Hip arthroscopy/surgery	Y	A2	$630.00	45.5027	$1,935.82	$956.46
29870	Knee arthroscopy, dx	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29871	Knee arthroscopy/drainage	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29873	Knee arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29874	Knee arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29875	Knee arthroscopy/surgery	Y	A2	$630.00	28.6245	$1,217.77	$776.94
29876	Knee arthroscopy/surgery	Y	A2	$630.00	28.6245	$1,217.77	$776.94
29877	Knee arthroscopy/surgery	Y	A2	$630.00	28.6245	$1,217.77	$776.94
29879	Knee arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29880	Knee arthroscopy/surgery	Y	A2	$630.00	28.6245	$1,217.77	$776.94
29881	Knee arthroscopy/surgery	Y	A2	$630.00	28.6245	$1,217.77	$776.94
29882	Knee arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29883	Knee arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29884	Knee arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29885	Knee arthroscopy/surgery	Y	A2	$510.00	45.5027	$1,935.82	$866.46
29886	Knee arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29887	Knee arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29888	Knee arthroscopy/surgery	Y	A2	$510.00	45.5027	$1,935.82	$866.46
29889	Knee arthroscopy/surgery	Y	A2	$510.00	45.5027	$1,935.82	$866.46
29891	Ankle arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29892	Ankle arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29893	Scope, plantar fasciotomy	Y	A2	$1,255.56	20.4263	$869.00	$1,158.92
29894	Ankle arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29895	Ankle arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29897	Ankle arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29898	Ankle arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29899	Ankle arthroscopy/surgery	Y	A2	$510.00	45.5027	$1,935.82	$866.46
29900	Mcp joint arthroscopy, dx	Y	A2	$510.00	16.1540	$687.24	$554.31
29901	Mcp joint arthroscopy, surg	Y	A2	$510.00	16.1540	$687.24	$554.31
29902	Mcp joint arthroscopy, surg	Y	A2	$510.00	16.1540	$687.24	$554.31
30000	Drainage of nose lesion	Y	P2	.....	2.4520	$104.32	$104.32
30020	Drainage of nose lesion	Y	P2	.....	2.4520	$104.32	$104.32
30100	Intranasal biopsy	Y	P3	.....	1.7625	$74.98	$74.98
30110	Removal of nose polyp(s)	Y	P3	.....	2.7683	$117.77	$117.77
30115	Removal of nose polyp(s)	Y	A2	$446.00	16.4266	$698.84	$509.21
30117	Removal of intranasal lesion	Y	A2	$510.00	16.4266	$698.84	$557.21
30118	Removal of intranasal lesion	Y	A2	$510.00	23.3299	$992.52	$630.63
30120	Revision of nose	Y	A2	$333.00	16.4266	$698.84	$424.46
30124	Removal of nose lesion	Y	R2	.....	7.5511	$321.25	$321.25
30125	Removal of nose lesion	Y	A2	$446.00	38.1991	$1,625.10	$740.78
30130	Excise inferior turbinate	Y	A2	$510.00	16.4266	$698.84	$557.21
30140	Resect inferior turbinate	Y	A2	$446.00	23.3299	$992.52	$582.63
30150	Partial removal of nose	Y	A2	$510.00	38.1991	$1,625.10	$788.78
30160	Removal of nose	Y	A2	$630.00	38.1991	$1,625.10	$878.78
30200	Injection treatment of nose	Y	P3	.....	1.4082	$59.91	$59.91
30210	Nasal sinus therapy	Y	P3	.....	1.7784	$75.66	$75.66

Note: The Medicare program payment is 80 percent of the total payment amount and beneficiary coinsurance is 20 percent of the total payment amount, except for screening flexible sigmoidoscopies and screening colonoscopies for which the program payment is 75 percent and the beneficiary coinsurance is 25 percent.

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
30220	Insert nasal septal button	Y	A2	$464.15	7.5511	$321.25	$428.43
30300	Remove nasal foreign body	N	P2		0.6102	$25.96	$25.96
30310	Remove nasal foreign body	Y	A2	$333.00	16.4266	$698.84	$424.46
30320	Remove nasal foreign body	Y	A2	$446.00	16.4266	$698.84	$509.21
30400	Reconstruction of nose	Y	A2	$630.00	38.1991	$1,625.10	$878.78
30410	Reconstruction of nose	Y	A2	$717.00	38.1991	$1,625.10	$944.03
30420	Reconstruction of nose	Y	A2	$717.00	38.1991	$1,625.10	$944.03
30430	Revision of nose	Y	A2	$510.00	23.3299	$992.52	$630.63
30435	Revision of nose	Y	A2	$717.00	38.1991	$1,625.10	$944.03
30450	Revision of nose	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
30460	Revision of nose	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
30462	Revision of nose	Y	A2	$1,339.00	38.1991	$1,625.10	$1,410.53
30465	Repair nasal stenosis	Y	A2	$1,339.00	38.1991	$1,625.10	$1,410.53
30520	Repair of nasal septum	Y	A2	$630.00	23.3299	$992.52	$720.63
30540	Repair nasal defect	Y	A2	$717.00	38.1991	$1,625.10	$944.03
30545	Repair nasal defect	Y	A2	$717.00	38.1991	$1,625.10	$944.03
30560	Release of nasal adhesions	Y	A2	$150.72	2.4520	$104.32	$139.12
30580	Repair upper jaw fistula	Y	A2	$630.00	38.1991	$1,625.10	$878.78
30600	Repair mouth/nose fistula	Y	A2	$630.00	38.1991	$1,625.10	$878.78
30620	Intranasal reconstruction	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
30630	Repair nasal septum defect	Y	A2	$995.00	23.3299	$992.52	$994.38
30801	Ablate inf turbinate, superf	Y	A2	$333.00	7.5511	$321.25	$330.06
30802	Cauterization, inner nose	Y	A2	$333.00	7.5511	$321.25	$330.06
30901	Control of nosebleed	Y	P3		1.0300	$43.82	$43.82
30903	Control of nosebleed	Y	A2	$72.48	1.1791	$50.16	$66.90
30905	Control of nosebleed	Y	A2	$72.48	1.1791	$50.16	$66.90
30906	Repeat control of nosebleed	Y	A2	$72.48	1.1791	$50.16	$66.90
30915	Ligation, nasal sinus artery	Y	A2	$446.00	24.8809	$1,058.51	$599.13
30920	Ligation, upper jaw artery	Y	A2	$510.00	24.8809	$1,058.51	$647.13
30930	Ther fx, nasal inf turbinate	Y	A2	$630.00	16.4266	$698.84	$647.21
31000	Irrigation, maxillary sinus	Y	P3		2.3499	$99.97	$99.97
31002	Irrigation, sphenoid sinus	Y	R2		7.5511	$321.25	$321.25
31020	Exploration, maxillary sinus	Y	A2	$446.00	23.3299	$992.52	$582.63
31030	Exploration, maxillary sinus	Y	A2	$510.00	38.1991	$1,625.10	$788.78
31032	Explore sinus, remove polyps	Y	A2	$630.00	38.1991	$1,625.10	$878.78
31040	Exploration behind upper jaw	Y	R2		23.3299	$992.52	$992.52
31050	Exploration, sphenoid sinus	Y	A2	$446.00	38.1991	$1,625.10	$740.78
31051	Sphenoid sinus surgery	Y	A2	$630.00	38.1991	$1,625.10	$878.78
31070	Exploration of frontal sinus	Y	A2	$446.00	23.3299	$992.52	$582.63
31075	Exploration of frontal sinus	Y	A2	$630.00	38.1991	$1,625.10	$878.78
31080	Removal of frontal sinus	Y	A2	$630.00	38.1991	$1,625.10	$878.78
31081	Removal of frontal sinus	Y	A2	$630.00	38.1991	$1,625.10	$878.78
31084	Removal of frontal sinus	Y	A2	$630.00	38.1991	$1,625.10	$878.78
31085	Removal of frontal sinus	Y	A2	$630.00	38.1991	$1,625.10	$878.78
31086	Removal of frontal sinus	Y	A2	$630.00	38.1991	$1,625.10	$878.78
31087	Removal of frontal sinus	Y	A2	$630.00	38.1991	$1,625.10	$878.78
31090	Exploration of sinuses	Y	A2	$717.00	38.1991	$1,625.10	$944.03
31200	Removal of ethmoid sinus	Y	A2	$446.00	38.1991	$1,625.10	$740.78
31201	Removal of ethmoid sinus	Y	A2	$717.00	38.1991	$1,625.10	$944.03
31205	Removal of ethmoid sinus	Y	A2	$510.00	38.1991	$1,625.10	$788.78
31231	Nasal endoscopy, dx	Y	P2		1.4054	$59.79	$59.79
31233	Nasal/sinus endoscopy, dx	Y	A2	$86.39	1.4054	$59.79	$79.74
31235	Nasal/sinus endoscopy, dx	Y	A2	$333.00	14.7928	$629.33	$407.08
31237	Nasal/sinus endoscopy, surg	Y	A2	$446.00	14.7928	$629.33	$491.83
31238	Nasal/sinus endoscopy, surg	Y	A2	$333.00	14.7928	$629.33	$407.08
31239	Nasal/sinus endoscopy, surg	Y	A2	$630.00	21.9512	$933.87	$705.97
31240	Nasal/sinus endoscopy, surg	Y	A2	$446.00	14.7928	$629.33	$491.83
31254	Revision of ethmoid sinus	Y	A2	$510.00	21.9512	$933.87	$615.97
31255	Removal of ethmoid sinus	Y	A2	$717.00	21.9512	$933.87	$771.22
31256	Exploration maxillary sinus	Y	A2	$510.00	21.9512	$933.87	$615.97
31267	Endoscopy, maxillary sinus	Y	A2	$510.00	21.9512	$933.87	$615.97
31276	Sinus endoscopy, surgical	Y	A2	$510.00	21.9512	$933.87	$615.97
31287	Nasal/sinus endoscopy, surg	Y	A2	$510.00	21.9512	$933.87	$615.97

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
31288	Nasal/sinus endoscopy, surg	Y	A2	$510.00	21.9512	$933.87	$615.97
31300	Removal of larynx lesion	Y	A2	$717.00	23.3299	$992.52	$785.88
31320	Diagnostic incision, larynx	Y	A2	$446.00	38.1991	$1,625.10	$740.78
31400	Revision of larynx	Y	A2	$446.00	38.1991	$1,625.10	$740.78
31420	Removal of epiglottis	Y	A2	$446.00	38.1991	$1,625.10	$740.78
31500	Insert emergency airway	N	G2	.....	2.4233	$103.09	$103.09
31502	Change of windpipe airway	Y	G2	.....	2.3587	$100.35	$100.35
31505	Diagnostic laryngoscopy	Y	P2	.....	0.7698	$32.75	$32.75
31510	Laryngoscopy with biopsy	Y	A2	$446.00	14.7928	$629.33	$491.83
31511	Remove foreign body, larynx	Y	A2	$86.39	1.4054	$59.79	$79.74
31512	Removal of larynx lesion	Y	A2	$446.00	14.7928	$629.33	$491.83
31513	Injection into vocal cord	Y	A2	$86.39	1.4054	$59.79	$79.74
31515	Laryngoscopy for aspiration	Y	A2	$333.00	14.7928	$629.33	$407.08
31520	Dx laryngoscopy, newborn	Y	G2	.....	1.4054	$59.79	$59.79
31525	Dx laryngoscopy excl nb	Y	A2	$333.00	14.7928	$629.33	$407.08
31526	Dx laryngoscopy w/oper scope	Y	A2	$446.00	21.9512	$933.87	$567.97
31527	Laryngoscopy for treatment	Y	A2	$333.00	21.9512	$933.87	$483.22
31528	Laryngoscopy and dilation	Y	A2	$446.00	14.7928	$629.33	$491.83
31529	Laryngoscopy and dilation	Y	A2	$446.00	14.7928	$629.33	$491.83
31530	Laryngoscopy w/fb removal	Y	A2	$446.00	21.9512	$933.87	$567.97
31531	Laryngoscopy w/fb & op scope	Y	A2	$510.00	21.9512	$933.87	$615.97
31535	Laryngoscopy w/biopsy	Y	A2	$446.00	21.9512	$933.87	$567.97
31536	Laryngoscopy w/bx & op scope	Y	A2	$510.00	21.9512	$933.87	$615.97
31540	Laryngoscopy w/exc of tumor	Y	A2	$510.00	21.9512	$933.87	$615.97
31541	Larynscop w/tumr exc + scope	Y	A2	$630.00	21.9512	$933.87	$705.97
31545	Remove vc lesion w/scope	Y	A2	$630.00	21.9512	$933.87	$705.97
31546	Remove vc lesion scope/graft	Y	A2	$630.00	21.9512	$933.87	$705.97
31560	Laryngoscop w/arytenoidectom	Y	A2	$717.00	21.9512	$933.87	$771.22
31561	Larynscop, remve cart + scop	Y	A2	$717.00	21.9512	$933.87	$771.22
31570	Laryngoscope w/vc inj	Y	A2	$446.00	14.7928	$629.33	$491.83
31571	Laryngoscop w/vc inj + scope	Y	A2	$446.00	21.9512	$933.87	$567.97
31575	Diagnostic laryngoscopy	Y	P3	.....	1.4002	$59.57	$59.57
31576	Laryngoscopy with biopsy	Y	A2	$446.00	21.9512	$933.87	$567.97
31577	Remove foreign body, larynx	Y	A2	$236.42	3.8463	$163.63	$218.22
31578	Removal of larynx lesion	Y	A2	$446.00	21.9512	$933.87	$567.97
31579	Diagnostic laryngoscopy	Y	P3	.....	2.5833	$109.90	$109.90
31580	Revision of larynx	Y	A2	$717.00	38.1991	$1,625.10	$944.03
31582	Revision of larynx	Y	A2	$717.00	38.1991	$1,625.10	$944.03
31588	Revision of larynx	Y	A2	$717.00	38.1991	$1,625.10	$944.03
31590	Reinnervate larynx	Y	A2	$717.00	38.1991	$1,625.10	$944.03
31595	Larynx nerve surgery	Y	A2	$446.00	38.1991	$1,625.10	$740.78
31603	Incision of windpipe	Y	A2	$333.00	7.5511	$321.25	$330.06
31605	Incision of windpipe	Y	G2	.....	7.5511	$321.25	$321.25
31611	Surgery/speech prosthesis	Y	A2	$510.00	23.3299	$992.52	$630.63
31612	Puncture/clear windpipe	Y	A2	$333.00	23.3299	$992.52	$497.88
31613	Repair windpipe opening	Y	A2	$446.00	23.3299	$992.52	$582.63
31614	Repair windpipe opening	Y	A2	$446.00	38.1991	$1,625.10	$740.78
31615	Visualization of windpipe	Y	A2	$333.00	9.5228	$405.13	$351.03
31620	Endobronchial us add-on	N	A2	$333.00	32.2854	$1,373.52	$593.13
31622	Dx bronchoscope/wash	Y	A2	$333.00	9.5228	$405.13	$351.03
31623	Dx bronchoscope/brush	Y	A2	$446.00	9.5228	$405.13	$435.78
31624	Dx bronchoscope/lavage	Y	A2	$446.00	9.5228	$405.13	$435.78
31625	Bronchoscopy w/biopsy(s)	Y	A2	$446.00	9.5228	$405.13	$435.78
31628	Bronchoscopy/lung bx, each	Y	A2	$446.00	9.5228	$405.13	$435.78
31629	Bronchoscopy/needle bx, each	Y	A2	$446.00	9.5228	$405.13	$435.78
31630	Bronchoscopy dilate/fx repr	Y	A2	$446.00	22.0099	$936.37	$568.59
31631	Bronchoscopy, dilate w/stent	Y	A2	$446.00	22.0099	$936.37	$568.59
31632	Bronchoscopy/lung bx, add'l	Y	G2	.....	9.5228	$405.13	$405.13
31633	Bronchoscopy/needle bx add'l	Y	G2	.....	9.5228	$405.13	$405.13
31635	Bronchoscopy w/fb removal	Y	A2	$446.00	9.5228	$405.13	$435.78
31636	Bronchoscopy, bronch stents	Y	A2	$446.00	22.0099	$936.37	$568.59
31637	Bronchoscopy, stent add-on	Y	A2	$333.00	9.5228	$405.13	$351.03
31638	Bronchoscopy, revise stent	Y	A2	$446.00	22.0099	$936.37	$568.59

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
31640	Bronchoscopy w/tumor excise	Y	A2	$446.00	22.0099	$936.37	$568.59
31641	Bronchoscopy, treat blockage	Y	A2	$446.00	22.0099	$936.37	$568.59
31643	Diag bronchoscope/catheter	Y	A2	$446.00	9.5228	$405.13	$435.78
31645	Bronchoscopy, clear airways	Y	A2	$333.00	9.5228	$405.13	$351.03
31646	Bronchoscopy, reclear airway	Y	A2	$333.00	9.5228	$405.13	$351.03
31656	Bronchoscopy, inj for x-ray	Y	A2	$333.00	9.5228	$405.13	$351.03
31715	Injection for bronchus x-ray		N1				
31717	Bronchial brush biopsy	Y	A2	$236.42	3.8463	$163.63	$218.22
31720	Clearance of airways	Y	A2	$47.32	0.7698	$32.75	$43.68
31730	Intro, windpipe wire/tube	Y	A2	$236.42	3.8463	$163.63	$218.22
31750	Repair of windpipe	Y	A2	$717.00	38.1991	$1,625.10	$944.03
31755	Repair of windpipe	Y	A2	$446.00	38.1991	$1,625.10	$740.78
31820	Closure of windpipe lesion	Y	A2	$333.00	16.4266	$698.84	$424.46
31825	Repair of windpipe defect	Y	A2	$446.00	23.3299	$992.52	$582.63
31830	Revise windpipe scar	Y	A2	$446.00	23.3299	$992.52	$582.63
32000	Drainage of chest	Y	A2	$222.78	3.6244	$154.19	$205.63
32002	Treatment of collapsed lung	Y	G2		3.6244	$154.19	$154.19
32019	Insert pleural catheter	Y	G2		29.5416	$1,256.79	$1,256.79
32400	Needle biopsy chest lining	Y	A2	$333.00	6.1384	$261.15	$315.04
32405	Biopsy, lung or mediastinum	Y	A2	$333.00	6.1384	$261.15	$315.04
32420	Puncture/clear lung	Y	A2	$222.78	3.6244	$154.19	$205.63
32960	Therapeutic pneumothorax	Y	G2		3.6244	$154.19	$154.19
33010	Drainage of heart sac	Y	A2	$222.78	3.6244	$154.19	$205.63
33011	Repeat drainage of heart sac	Y	A2	$222.78	3.6244	$154.19	$205.63
33206	Insertion of heart pacemaker	Y	J8		170.6370	$7,259.41	$7,259.41
33207	Insertion of heart pacemaker	Y	J8		170.6370	$7,259.41	$7,259.41
33208	Insertion of heart pacemaker	Y	J8		210.2184	$8,943.32	$8,943.32
33210	Insertion of heart electrode	Y	G2		58.8594	$2,504.06	$2,504.06
33211	Insertion of heart electrode	Y	G2		58.8594	$2,504.06	$2,504.06
33212	Insertion of pulse generator	Y	H8	$510.00	134.4886	$5,721.55	$5,311.76
33213	Insertion of pulse generator	Y	H8	$510.00	155.7342	$6,625.40	$6,192.90
33214	Upgrade of pacemaker system	Y	J8		210.2184	$8,943.32	$8,943.32
33215	Reposition pacing-defib lead	Y	G2		25.6142	$1,089.70	$1,089.70
33216	Insert lead pace-defib, one	Y	G2		58.8594	$2,504.06	$2,504.06
33217	Insert lead pace-defib, dual	Y	G2		58.8594	$2,504.06	$2,504.06
33218	Repair lead pace-defib, one	Y	G2		25.6142	$1,089.70	$1,089.70
33220	Repair lead pace-defib, dual	Y	G2		25.6142	$1,089.70	$1,089.70
33222	Revise pocket, pacemaker	Y	A2	$446.00	21.4302	$911.71	$562.43
33223	Revise pocket, pacing-defib	Y	A2	$446.00	21.4302	$911.71	$562.43
33224	Insert pacing lead & connect	Y	J8		439.4366	$18,694.95	$18,694.95
33225	Lventric pacing lead add-on	Y	J8		439.4366	$18,694.95	$18,694.95
33226	Reposition 1 ventric lead	Y	G2		25.6142	$1,089.70	$1,089.70
33233	Removal of pacemaker system	Y	A2	$446.00	25.6142	$1,089.70	$606.93
33234	Removal of pacemaker system	Y	G2		25.6142	$1,089.70	$1,089.70
33235	Removal pacemaker electrode	Y	G2		25.6142	$1,089.70	$1,089.70
33241	Remove pulse generator	Y	G2		25.6142	$1,089.70	$1,089.70
33282	Implant pat-active ht record	N	J8		99.9215	$4,250.96	$4,250.96
33284	Remove pat-active ht record	Y	G2		10.9918	$467.62	$467.62
33508	Endoscopic vein harvest		N1				
35188	Repair blood vessel lesion	Y	A2	$630.00	37.7391	$1,605.53	$873.88
35207	Repair blood vessel lesion	Y	A2	$630.00	37.7391	$1,605.53	$873.88
35473	Repair arterial blockage	Y	G2		42.9360	$1,826.63	$1,826.63
35474	Repair arterial blockage	Y	G2		42.9360	$1,826.63	$1,826.63
35476	Repair venous blockage	Y	G2		42.9360	$1,826.63	$1,826.63
35492	Atherectomy, percutaneous	Y	G2		42.9360	$1,826.63	$1,826.63
35572	Harvest femoropopliteal vein		N1				
35761	Exploration of artery/vein	Y	G2		29.2133	$1,242.82	$1,242.82
35875	Removal of clot in graft	Y	A2	$1,339.00	37.7391	$1,605.53	$1,405.63
35876	Removal of clot in graft	Y	A2	$1,339.00	37.7391	$1,605.53	$1,405.63
36000	Place needle in vein		N1				
36002	Pseudoaneurysm injection trt	N	G2		2.4606	$104.68	$104.68
36005	Injection ext venography		N1				
36010	Place catheter in vein		N1				

Note: The Medicare program payment is 80 percent of the total payment amount and beneficiary coinsurance is 20 percent of the total payment amount, except for screening flexible sigmoidoscopies and screening colonoscopies for which the program payment is 75 percent and the beneficiary coinsurance is 25 percent.

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
36011	Place catheter in vein		N1				
36012	Place catheter in vein		N1				
36013	Place catheter in artery		N1				
36014	Place catheter in artery		N1				
36015	Place catheter in artery		N1				
36100	Establish access to artery		N1				
36120	Establish access to artery		N1				
36140	Establish access to artery		N1				
36145	Artery to vein shunt		N1				
36160	Establish access to aorta		N1				
36200	Place catheter in aorta		N1				
36215	Place catheter in artery		N1				
36216	Place catheter in artery		N1				
36217	Place catheter in artery		N1				
36218	Place catheter in artery		N1				
36245	Place catheter in artery		N1				
36246	Place catheter in artery		N1				
36247	Place catheter in artery		N1				
36248	Place catheter in artery		N1				
36260	Insertion of infusion pump	Y	A2	$510.00	28.5032	$1,212.61	$685.65
36261	Revision of infusion pump	Y	A2	$446.00	28.5032	$1,212.61	$637.65
36262	Removal of infusion pump	Y	A2	$333.00	22.6665	$964.30	$490.83
36400	Bl draw <3 yrs fem/jugular		N1				
36405	Bl draw <3 yrs scalp vein		N1				
36406	Bl draw <3 yrs other vein		N1				
36410	Non-routine bl draw >3 yrs		N1				
36416	Capillary blood draw		N1				
36420	Vein access cutdown <1 yr	Y	G2		0.1999	$8.50	$8.50
36425	Vein access cutdown >1 yr	Y	R2		0.1999	$8.50	$8.50
36430	Blood transfusion service	N	P3		0.7806	$33.21	$33.21
36440	Bl push transfuse, 2 yr or <	N	R2		3.4584	$147.13	$147.13
36450	Bl exchange/transfuse, nb	N	R2		3.4584	$147.13	$147.13
36468	Injection(s), spider veins	Y	R2		1.0798	$45.94	$45.94
36469	Injection(s), spider veins	Y	G2		1.0798	$45.94	$45.94
36470	Injection therapy of vein	Y	P2		1.0798	$45.94	$45.94
36471	Injection therapy of veins	Y	P2		1.0798	$45.94	$45.94
36475	Endovenous rf, 1st vein	Y	A2	$1,339.00	34.7288	$1,477.47	$1,373.62
36476	Endovenous rf, vein add-on	Y	A2	$1,339.00	34.7288	$1,477.47	$1,373.62
36478	Endovenous laser, 1st vein	Y	A2	$1,339.00	24.8809	$1,058.51	$1,268.88
36479	Endovenous laser vein addon	Y	A2	$1,339.00	24.8809	$1,058.51	$1,268.88
36481	Insertion of catheter, vein		N1				
36500	Insertion of catheter, vein		N1				
36510	Insertion of catheter, vein		N1				
36511	Apheresis wbc	N	G2		11.7134	$498.32	$498.32
36512	Apheresis rbc	N	G2		11.7134	$498.32	$498.32
36513	Apheresis platelets	N	G2		11.7134	$498.32	$498.32
36514	Apheresis plasma	N	G2		11.7134	$498.32	$498.32
36515	Apheresis, adsorp/reinfuse	N	G2		30.2231	$1,285.78	$1,285.78
36516	Apheresis, selective	N	G2		30.2231	$1,285.78	$1,285.78
36522	Photopheresis	N	G2		30.2231	$1,285.78	$1,285.78
36540	Collect blood venous device		N1				
36550	Declot vascular device	Y	P3		0.2816	$11.98	$11.98
36555	Insert non-tunnel cv cath	Y	A2	$333.00	8.7846	$373.72	$343.18
36556	Insert non-tunnel cv cath	Y	A2	$333.00	8.7846	$373.72	$343.18
36557	Insert tunneled cv cath	Y	A2	$446.00	22.6665	$964.30	$575.58
36558	Insert tunneled cv cath	Y	A2	$446.00	22.6665	$964.30	$575.58
36560	Insert tunneled cv cath	Y	A2	$510.00	28.5032	$1,212.61	$685.65
36561	Insert tunneled cv cath	Y	A2	$510.00	28.5032	$1,212.61	$685.65
36563	Insert tunneled cv cath	Y	A2	$510.00	28.5032	$1,212.61	$685.65
36565	Insert tunneled cv cath	Y	A2	$510.00	28.5032	$1,212.61	$685.65
36566	Insert tunneled cv cath	Y	H8	$510.00	107.1217	$4,557.28	$3,809.60
36568	Insert picc cath	Y	A2	$333.00	8.7846	$373.72	$343.18
36569	Insert picc cath	Y	A2	$333.00	8.7846	$373.72	$343.18

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
36570	Insert picvad cath	Y	A2	$510.00	22.6665	$964.30	$623.58
36571	Insert picvad cath	Y	A2	$510.00	22.6665	$964.30	$623.58
36575	Repair tunneled cv cath	Y	A2	$446.00	8.7846	$373.72	$427.93
36576	Repair tunneled cv cath	Y	A2	$446.00	8.7846	$373.72	$427.93
36578	Replace tunneled cv cath	Y	A2	$446.00	22.6665	$964.30	$575.58
36580	Replace cvad cath	Y	A2	$333.00	8.7846	$373.72	$343.18
36581	Replace tunneled cv cath	Y	A2	$446.00	22.6665	$964.30	$575.58
36582	Replace tunneled cv cath	Y	A2	$510.00	28.5032	$1,212.61	$685.65
36583	Replace tunneled cv cath	Y	A2	$510.00	28.5032	$1,212.61	$685.65
36584	Replace picc cath	Y	A2	$333.00	8.7846	$373.72	$343.18
36585	Replace picvad cath	Y	A2	$510.00	22.6665	$964.30	$623.58
36589	Removal tunneled cv cath	Y	A2	$333.00	8.7846	$373.72	$343.18
36590	Removal tunneled cv cath	Y	A2	$333.00	8.7846	$373.72	$343.18
36595	Mech remov tunneled cv cath	Y	G2	.....	22.6665	$964.30	$964.30
36596	Mech remov tunneled cv cath	Y	G2	.....	8.7846	$373.72	$373.72
36597	Reposition venous catheter	Y	G2	.....	8.7846	$373.72	$373.72
36598*	Inj w/fluor, eval cv device	N	P2	.....	0.6102	$25.96	$25.96
36600	Withdrawal of arterial blood	.....	N1	.....	.....	.....	.....
36620	Insertion catheter, artery	.....	N1	.....	.....	.....	.....
36625	Insertion catheter, artery	.....	N1	.....	.....	.....	.....
36640	Insertion catheter, artery	Y	A2	$333.00	28.5032	$1,212.61	$552.90
36680	Insert needle, bone cavity	Y	G2	.....	1.0995	$46.78	$46.78
36800	Insertion of cannula	Y	A2	$510.00	29.2133	$1,242.82	$693.21
36810	Insertion of cannula	Y	A2	$510.00	29.2133	$1,242.82	$693.21
36815	Insertion of cannula	Y	A2	$510.00	29.2133	$1,242.82	$693.21
36818	Av fuse, uppr arm, cephalic	Y	A2	$510.00	37.7391	$1,605.53	$783.88
36819	Av fuse, uppr arm, basilic	Y	A2	$510.00	37.7391	$1,605.53	$783.88
36820	Av fusion/forearm vein	Y	A2	$510.00	37.7391	$1,605.53	$783.88
36821	Av fusion direct any site	Y	A2	$510.00	37.7391	$1,605.53	$783.88
36825	Artery-vein autograft	Y	A2	$630.00	37.7391	$1,605.53	$873.88
36830	Artery-vein nonautograft	Y	A2	$630.00	37.7391	$1,605.53	$873.88
36831	Open thrombect av fistula	Y	A2	$1,339.00	37.7391	$1,605.53	$1,405.63
36832	Av fistula revision, open	Y	A2	$630.00	37.7391	$1,605.53	$873.88
36833	Av fistula revision	Y	A2	$630.00	37.7391	$1,605.53	$873.88
36834	Repair A-V aneurysm	Y	A2	$510.00	37.7391	$1,605.53	$783.88
36835	Artery to vein shunt	Y	A2	$630.00	29.2133	$1,242.82	$783.21
36860	External cannula declotting	Y	A2	$127.40	2.0726	$88.17	$117.59
36861	Cannula declotting	Y	A2	$510.00	29.2133	$1,242.82	$693.21
36870	Percut thrombect av fistula	Y	A2	$1,339.00	32.3818	$1,377.62	$1,348.66
37184	Prim art mech thrombectomy	Y	G2	.....	37.7391	$1,605.53	$1,605.53
37185	Prim art m-thrombect add-on	Y	G2	.....	37.7391	$1,605.53	$1,605.53
37186	Sec art m-thrombect add-on	Y	G2	.....	37.7391	$1,605.53	$1,605.53
37187	Venous mech thrombectomy	Y	G2	.....	37.7391	$1,605.53	$1,605.53
37188	Venous m-thrombectomy add-on	Y	G2	.....	37.7391	$1,605.53	$1,605.53
37200	Transcatheter biopsy	Y	G2	.....	6.1384	$261.15	$261.15
37203	Transcatheter retrieval	Y	G2	.....	16.2375	$690.79	$690.79
37250	Iv us first vessel add-on	N	G2	.....	32.5472	$1,384.66	$1,384.66
37251	Iv us each add vessel add-on	N	G2	.....	32.5472	$1,384.66	$1,384.66
37500	Endoscopy ligate perf veins	Y	A2	$510.00	34.7288	$1,477.47	$751.87
37607	Ligation of a-v fistula	Y	A2	$510.00	24.8809	$1,058.51	$647.13
37609	Temporal artery procedure	Y	A2	$446.00	15.1024	$642.50	$495.13
37650	Revision of major vein	Y	A2	$446.00	24.8809	$1,058.51	$599.13
37700	Revise leg vein	Y	A2	$446.00	34.7288	$1,477.47	$703.87
37718	Ligate/strip short leg vein	Y	A2	$510.00	34.7288	$1,477.47	$751.87
37722	Ligate/strip long leg vein	Y	A2	$510.00	34.7288	$1,477.47	$751.87
37735	Removal of leg veins/lesion	Y	A2	$510.00	34.7288	$1,477.47	$751.87
37760	Ligation, leg veins, open	Y	A2	$510.00	24.8809	$1,058.51	$647.13
37765	Phleb veins - extrem - to 20	Y	R2	.....	24.8809	$1,058.51	$1,058.51
37766	Phleb veins - extrem 20+	Y	R2	.....	24.8809	$1,058.51	$1,058.51
37780	Revision of leg vein	Y	A2	$510.00	24.8809	$1,058.51	$647.13
37785	Ligate/divide/excise vein	Y	A2	$510.00	24.8809	$1,058.51	$647.13
37790	Penile venous occlusion	Y	A2	$510.00	32.9873	$1,403.38	$733.35
38200	Injection for spleen x-ray	.....	N1	.....	.....	.....	.....

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
38204	Bl donor search management		N1				
38205	Harvest allogenic stem cells	N	G2		11.7134	$498.32	$498.32
38206	Harvest auto stem cells	N	G2		11.7134	$498.32	$498.32
38220	Bone marrow aspiration	Y	P2		2.4011	$102.15	$102.15
38221	Bone marrow biopsy	Y	P2		2.4011	$102.15	$102.15
38230	Bone marrow collection	N	G2		20.3582	$866.10	$866.10
38241	Bone marrow/stem transplant	N	G2		20.3582	$866.10	$866.10
38242	Lymphocyte infuse transplant	N	R2		11.7134	$498.32	$498.32
38300	Drainage, lymph node lesion	Y	A2	$333.00	11.1535	$474.50	$368.38
38305	Drainage, lymph node lesion	Y	A2	$446.00	17.5086	$744.87	$520.72
38308	Incision of lymph channels	Y	A2	$446.00	21.2621	$904.55	$560.64
38500	Biopsy/removal, lymph nodes	Y	A2	$446.00	21.2621	$904.55	$560.64
38505	Needle biopsy, lymph nodes	Y	A2	$240.00	3.9045	$166.11	$221.53
38510	Biopsy/removal, lymph nodes	Y	A2	$446.00	21.2621	$904.55	$560.64
38520	Biopsy/removal, lymph nodes	Y	A2	$446.00	21.2621	$904.55	$560.64
38525	Biopsy/removal, lymph nodes	Y	A2	$446.00	21.2621	$904.55	$560.64
38530	Biopsy/removal, lymph nodes	Y	A2	$446.00	21.2621	$904.55	$560.64
38542	Explore deep node(s), neck	Y	A2	$446.00	37.7224	$1,604.82	$735.71
38550	Removal, neck/armpit lesion	Y	A2	$510.00	21.2621	$904.55	$608.64
38555	Removal, neck/armpit lesion	Y	A2	$630.00	21.2621	$904.55	$698.64
38570	Laparoscopy, lymph node biop	Y	A2	$1,339.00	43.5488	$1,852.70	$1,467.43
38571	Laparoscopy, lymphadenectomy	Y	A2	$1,339.00	70.5066	$2,999.56	$1,754.14
38572	Laparoscopy, lymphadenectomy	Y	A2	$1,339.00	43.5488	$1,852.70	$1,467.43
38700	Removal of lymph nodes, neck	Y	G2		21.2621	$904.55	$904.55
38740	Remove armpit lymph nodes	Y	A2	$446.00	37.7224	$1,604.82	$735.71
38745	Remove armpit lymph nodes	Y	A2	$630.00	37.7224	$1,604.82	$873.71
38760	Remove groin lymph nodes	Y	A2	$446.00	21.2621	$904.55	$560.64
38790	Inject for lymphatic x-ray		N1				
38792	Identify sentinel node		N1				
38794	Access thoracic lymph duct		N1				
40490	Biopsy of lip	Y	P3		1.4968	$63.68	$63.68
40500	Partial excision of lip	Y	A2	$446.00	16.4266	$698.84	$509.21
40510	Partial excision of lip	Y	A2	$446.00	23.3299	$992.52	$582.63
40520	Partial excision of lip	Y	A2	$446.00	16.4266	$698.84	$509.21
40525	Reconstruct lip with flap	Y	A2	$446.00	23.3299	$992.52	$582.63
40527	Reconstruct lip with flap	Y	A2	$446.00	23.3299	$992.52	$582.63
40530	Partial removal of lip	Y	A2	$446.00	23.3299	$992.52	$582.63
40650	Repair lip	Y	A2	$464.15	7.5511	$321.25	$428.43
40652	Repair lip	Y	A2	$464.15	7.5511	$321.25	$428.43
40654	Repair lip	Y	A2	$464.15	7.5511	$321.25	$428.43
40700	Repair cleft lip/nasal	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
40701	Repair cleft lip/nasal	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
40702	Repair cleft lip/nasal	Y	R2		38.1991	$1,625.10	$1,625.10
40720	Repair cleft lip/nasal	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
40761	Repair cleft lip/nasal	Y	A2	$510.00	38.1991	$1,625.10	$788.78
40800	Drainage of mouth lesion	Y	P2		1.4392	$61.23	$61.23
40801	Drainage of mouth lesion	Y	A2	$446.00	7.5511	$321.25	$414.81
40804	Removal, foreign body, mouth	N	P2		0.6102	$25.96	$25.96
40805	Removal, foreign body, mouth	Y	P3		3.8385	$163.30	$163.30
40806	Incision of lip fold	Y	P3		1.6898	$71.89	$71.89
40808	Biopsy of mouth lesion	Y	P2		2.4520	$104.32	$104.32
40810	Excision of mouth lesion	Y	P3		2.5913	$110.24	$110.24
40812	Excise/repair mouth lesion	Y	P3		3.3155	$141.05	$141.05
40814	Excise/repair mouth lesion	Y	A2	$446.00	16.4266	$698.84	$509.21
40816	Excision of mouth lesion	Y	A2	$446.00	23.3299	$992.52	$582.63
40818	Excise oral mucosa for graft	Y	A2	$150.72	2.4520	$104.32	$139.12
40819	Excise lip or cheek fold	Y	A2	$333.00	7.5511	$321.25	$330.06
40820	Treatment of mouth lesion	Y	P3		3.6455	$155.09	$155.09
40830	Repair mouth laceration	Y	G2		2.4520	$104.32	$104.32
40831	Repair mouth laceration	Y	A2	$333.00	7.5511	$321.25	$330.06
40840	Reconstruction of mouth	Y	A2	$446.00	23.3299	$992.52	$582.63
40842	Reconstruction of mouth	Y	A2	$510.00	23.3299	$992.52	$630.63
40843	Reconstruction of mouth	Y	A2	$510.00	23.3299	$992.52	$630.63

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
40844	Reconstruction of mouth	Y	A2	$717.00	38.1991	$1,625.10	$944.03
40845	Reconstruction of mouth	Y	A2	$717.00	38.1991	$1,625.10	$944.03
41000	Drainage of mouth lesion	Y	P3		1.9394	$82.51	$82.51
41005	Drainage of mouth lesion	Y	A2	$150.72	2.4520	$104.32	$139.12
41006	Drainage of mouth lesion	Y	A2	$333.00	23.3299	$992.52	$497.88
41007	Drainage of mouth lesion	Y	A2	$333.00	16.4266	$698.84	$424.46
41008	Drainage of mouth lesion	Y	A2	$333.00	16.4266	$698.84	$424.46
41009	Drainage of mouth lesion	Y	A2	$150.72	2.4520	$104.32	$139.12
41010	Incision of tongue fold	Y	A2	$333.00	7.5511	$321.25	$330.06
41015	Drainage of mouth lesion	Y	A2	$150.72	2.4520	$104.32	$139.12
41016	Drainage of mouth lesion	Y	A2	$333.00	7.5511	$321.25	$330.06
41017	Drainage of mouth lesion	Y	A2	$333.00	7.5511	$321.25	$330.06
41018	Drainage of mouth lesion	Y	A2	$333.00	7.5511	$321.25	$330.06
41100	Biopsy of tongue	Y	P3		2.0118	$85.59	$85.59
41105	Biopsy of tongue	Y	P3		1.9634	$83.53	$83.53
41108	Biopsy of floor of mouth	Y	P3		1.7947	$76.35	$76.35
41110	Excision of tongue lesion	Y	P3		2.5913	$110.24	$110.24
41112	Excision of tongue lesion	Y	A2	$446.00	16.4266	$698.84	$509.21
41113	Excision of tongue lesion	Y	A2	$446.00	16.4266	$698.84	$509.21
41114	Excision of tongue lesion	Y	A2	$446.00	23.3299	$992.52	$582.63
41115	Excision of tongue fold	Y	P3		3.0339	$129.07	$129.07
41116	Excision of mouth lesion	Y	A2	$333.00	16.4266	$698.84	$424.46
41120	Partial removal of tongue	Y	A2	$717.00	23.3299	$992.52	$785.88
41250	Repair tongue laceration	Y	A2	$150.72	2.4520	$104.32	$139.12
41251	Repair tongue laceration	Y	A2	$150.72	2.4520	$104.32	$139.12
41252	Repair tongue laceration	Y	A2	$446.00	7.5511	$321.25	$414.81
41500	Fixation of tongue	Y	A2	$333.00	23.3299	$992.52	$497.88
41510	Tongue to lip surgery	Y	A2	$333.00	16.4266	$698.84	$424.46
41520	Reconstruction, tongue fold	Y	A2	$446.00	7.5511	$321.25	$414.81
41800	Drainage of gum lesion	Y	A2	$88.46	1.4392	$61.23	$81.65
41805	Removal of foreign body, gum	Y	P3		2.9695	$126.33	$126.33
41806	Removal of foreign body, jawbone	Y	P3		3.8145	$162.28	$162.28
41820	Excision, gum, each quadrant	Y	R2		7.5511	$321.25	$321.25
41821	Excision of gum flap	Y	G2		7.5511	$321.25	$321.25
41822	Excision of gum lesion	Y	P3		3.4363	$146.19	$146.19
41823	Excision of gum lesion	Y	P3		4.8525	$206.44	$206.44
41825	Excision of gum lesion	Y	P3		2.6879	$114.35	$114.35
41826	Excision of gum lesion	Y	P3		3.0339	$129.07	$129.07
41827	Excision of gum lesion	Y	A2	$446.00	23.3299	$992.52	$582.63
41828	Excision of gum lesion	Y	P3		3.1867	$135.57	$135.57
41830	Removal of gum tissue	Y	P3		4.4261	$188.30	$188.30
41850	Treatment of gum lesion	Y	R2		16.4266	$698.84	$698.84
41870	Gum graft	Y	G2		23.3299	$992.52	$992.52
41872	Repair gum	Y	P3		4.3939	$186.93	$186.93
41874	Repair tooth socket	Y	P3		4.2651	$181.45	$181.45
42000	Drainage mouth roof lesion	Y	A2	$150.72	2.4520	$104.32	$139.12
42100	Biopsy roof of mouth	Y	P3		1.7220	$73.26	$73.26
42104	Excision lesion, mouth roof	Y	P3		2.3980	$102.02	$102.02
42106	Excision lesion, mouth roof	Y	P3		3.0741	$130.78	$130.78
42107	Excision lesion, mouth roof	Y	A2	$446.00	23.3299	$992.52	$582.63
42120	Remove palate/lesion	Y	A2	$630.00	38.1991	$1,625.10	$878.78
42140	Excision of uvula	Y	A2	$446.00	7.5511	$321.25	$414.81
42145	Repair palate, pharynx/uvula	Y	A2	$717.00	23.3299	$992.52	$785.88
42160	Treatment mouth roof lesion	Y	P3		3.1707	$134.89	$134.89
42180	Repair palate	Y	A2	$150.72	2.4520	$104.32	$139.12
42182	Repair palate	Y	A2	$446.00	38.1991	$1,625.10	$740.78
42200	Reconstruct cleft palate	Y	A2	$717.00	38.1991	$1,625.10	$944.03
42205	Reconstruct cleft palate	Y	A2	$717.00	38.1991	$1,625.10	$944.03
42210	Reconstruct cleft palate	Y	A2	$717.00	38.1991	$1,625.10	$944.03
42215	Reconstruct cleft palate	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
42220	Reconstruct cleft palate	Y	A2	$717.00	38.1991	$1,625.10	$944.03
42226	Lengthening of palate	Y	A2	$717.00	38.1991	$1,625.10	$944.03
42235	Repair palate	Y	A2	$717.00	16.4266	$698.84	$712.46

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
42260	Repair nose to lip fistula	Y	A2	$630.00	23.3299	$992.52	$720.63
42280	Preparation, palate mold	Y	P3		1.6898	$71.89	$71.89
42281	Insertion, palate prosthesis	Y	G2		16.4266	$698.84	$698.84
42300	Drainage of salivary gland	Y	A2	$333.00	16.4266	$698.84	$424.46
42305	Drainage of salivary gland	Y	A2	$446.00	16.4266	$698.84	$509.21
42310	Drainage of salivary gland	Y	A2	$150.72	2.4520	$104.32	$139.12
42320	Drainage of salivary gland	Y	A2	$150.72	2.4520	$104.32	$139.12
42330	Removal of salivary stone	Y	P3		2.5511	$108.53	$108.53
42335	Removal of salivary stone	Y	P3		4.1685	$177.34	$177.34
42340	Removal of salivary stone	Y	A2	$446.00	16.4266	$698.84	$509.21
42400	Biopsy of salivary gland	Y	P3		1.4244	$60.60	$60.60
42405	Biopsy of salivary gland	Y	A2	$446.00	16.4266	$698.84	$509.21
42408	Excision of salivary cyst	Y	A2	$510.00	16.4266	$698.84	$557.21
42409	Drainage of salivary cyst	Y	A2	$510.00	16.4266	$698.84	$557.21
42410	Excise parotid gland/lesion	Y	A2	$510.00	38.1991	$1,625.10	$788.78
42415	Excise parotid gland/lesion	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
42420	Excise parotid gland/lesion	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
42425	Excise parotid gland/lesion	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
42440	Excise submaxillary gland	Y	A2	$510.00	38.1991	$1,625.10	$788.78
42450	Excise sublingual gland	Y	A2	$446.00	23.3299	$992.52	$582.63
42500	Repair salivary duct	Y	A2	$510.00	23.3299	$992.52	$630.63
42505	Repair salivary duct	Y	A2	$630.00	38.1991	$1,625.10	$878.78
42507	Parotid duct diversion	Y	A2	$510.00	38.1991	$1,625.10	$788.78
42508	Parotid duct diversion	Y	A2	$630.00	38.1991	$1,625.10	$878.78
42509	Parotid duct diversion	Y	A2	$630.00	38.1991	$1,625.10	$878.78
42510	Parotid duct diversion	Y	A2	$630.00	38.1991	$1,625.10	$878.78
42550	Injection for salivary x-ray		N1				
42600	Closure of salivary fistula	Y	A2	$333.00	16.4266	$698.84	$424.46
42650	Dilation of salivary duct	Y	P3		0.9254	$39.37	$39.37
42660	Dilation of salivary duct	Y	P3		1.1186	$47.59	$47.59
42665	Ligation of salivary duct	Y	A2	$995.00	23.3299	$992.52	$994.38
42700	Drainage of tonsil abscess	Y	A2	$150.72	2.4520	$104.32	$139.12
42720	Drainage of throat abscess	Y	A2	$333.00	16.4266	$698.84	$424.46
42725	Drainage of throat abscess	Y	A2	$446.00	38.1991	$1,625.10	$740.78
42800	Biopsy of throat	Y	P3		1.7947	$76.35	$76.35
42802	Biopsy of throat	Y	A2	$333.00	16.4266	$698.84	$424.46
42804	Biopsy of upper nose/throat	Y	A2	$333.00	16.4266	$698.84	$424.46
42806	Biopsy of upper nose/throat	Y	A2	$446.00	23.3299	$992.52	$582.63
42808	Excise pharynx lesion	Y	A2	$446.00	16.4266	$698.84	$509.21
42809	Remove pharynx foreign body	N	G2		0.6102	$25.96	$25.96
42810	Excision of neck cyst	Y	A2	$510.00	23.3299	$992.52	$630.63
42815	Excision of neck cyst	Y	A2	$717.00	38.1991	$1,625.10	$944.03
42820	Remove tonsils and adenoids	Y	A2	$510.00	22.1165	$940.90	$617.73
42821	Remove tonsils and adenoids	Y	A2	$717.00	22.1165	$940.90	$772.98
42825	Removal of tonsils	Y	A2	$630.00	22.1165	$940.90	$707.73
42826	Removal of tonsils	Y	A2	$630.00	22.1165	$940.90	$707.73
42830	Removal of adenoids	Y	A2	$630.00	22.1165	$940.90	$707.73
42831	Removal of adenoids	Y	A2	$630.00	22.1165	$940.90	$707.73
42835	Removal of adenoids	Y	A2	$630.00	22.1165	$940.90	$707.73
42836	Removal of adenoids	Y	A2	$630.00	22.1165	$940.90	$707.73
42860	Excision of tonsil tags	Y	A2	$510.00	22.1165	$940.90	$617.73
42870	Excision of lingual tonsil	Y	A2	$510.00	22.1165	$940.90	$617.73
42890	Partial removal of pharynx	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
42892	Revision of pharyngeal walls	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
42900	Repair throat wound	Y	A2	$333.00	7.5511	$321.25	$330.06
42950	Reconstruction of throat	Y	A2	$446.00	23.3299	$992.52	$582.63
42955	Surgical opening of throat	Y	A2	$446.00	23.3299	$992.52	$582.63
42960	Control throat bleeding	Y	A2	$72.48	1.1791	$50.16	$66.90
42962	Control throat bleeding	Y	A2	$446.00	38.1991	$1,625.10	$740.78
42970	Control nose/throat bleeding	Y	R2		1.1791	$50.16	$50.16
42972	Control nose/throat bleeding	Y	A2	$510.00	16.4266	$698.84	$557.21
43030	Throat muscle surgery	Y	G2		16.4266	$698.84	$698.84
43200	Esophagus endoscopy	Y	A2	$333.00	8.3175	$353.85	$338.21

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
43201	Esoph scope w/submucous inj	Y	A2	$333.00	8.3175	$353.85	$338.21
43202	Esophagus endoscopy, biopsy	Y	A2	$333.00	8.3175	$353.85	$338.21
43204	Esoph scope w/sclerosis inj	Y	A2	$333.00	8.3175	$353.85	$338.21
43205	Esophagus endoscopy/ligation	Y	A2	$333.00	8.3175	$353.85	$338.21
43215	Esophagus endoscopy	Y	A2	$333.00	8.3175	$353.85	$338.21
43216	Esophagus endoscopy/lesion	Y	A2	$333.00	8.3175	$353.85	$338.21
43217	Esophagus endoscopy	Y	A2	$333.00	8.3175	$353.85	$338.21
43219	Esophagus endoscopy	Y	A2	$333.00	22.9475	$976.26	$493.82
43220	Esoph endoscopy, dilation	Y	A2	$333.00	8.3175	$353.85	$338.21
43226	Esoph endoscopy, dilation	Y	A2	$333.00	8.3175	$353.85	$338.21
43227	Esoph endoscopy, repair	Y	A2	$446.00	8.3175	$353.85	$422.96
43228	Esoph endoscopy, ablation	Y	A2	$446.00	25.7552	$1,095.70	$608.43
43231	Esoph endoscopy w/us exam	Y	A2	$446.00	8.3175	$353.85	$422.96
43232	Esoph endoscopy w/us fn bx	Y	A2	$446.00	8.3175	$353.85	$422.96
43234	Upper GI endoscopy, exam	Y	A2	$333.00	8.3175	$353.85	$338.21
43235	Uppr gi endoscopy, diagnosis	Y	A2	$333.00	8.3175	$353.85	$338.21
43236	Uppr gi scope w/submuc inj	Y	A2	$446.00	8.3175	$353.85	$422.96
43237	Endoscopic us exam, esoph	Y	A2	$446.00	8.3175	$353.85	$422.96
43238	Uppr gi endoscopy w/us fn bx	Y	A2	$446.00	8.3175	$353.85	$422.96
43239	Upper GI endoscopy, biopsy	Y	A2	$446.00	8.3175	$353.85	$422.96
43240	Esoph endoscope w/drain cyst	Y	A2	$446.00	8.3175	$353.85	$422.96
43241	Upper GI endoscopy with tube	Y	A2	$446.00	8.3175	$353.85	$422.96
43242	Uppr gi endoscopy w/us fn bx	Y	A2	$446.00	8.3175	$353.85	$422.96
43243	Upper gi endoscopy & inject	Y	A2	$446.00	8.3175	$353.85	$422.96
43244	Upper GI endoscopy/ligation	Y	A2	$446.00	8.3175	$353.85	$422.96
43245	Uppr gi scope dilate strictr	Y	A2	$446.00	8.3175	$353.85	$422.96
43246	Place gastrostomy tube	Y	A2	$446.00	8.3175	$353.85	$422.96
43247	Operative upper GI endoscopy	Y	A2	$446.00	8.3175	$353.85	$422.96
43248	Uppr gi endoscopy/guide wire	Y	A2	$446.00	8.3175	$353.85	$422.96
43249	Esoph endoscopy, dilation	Y	A2	$446.00	8.3175	$353.85	$422.96
43250	Upper GI endoscopy/tumor	Y	A2	$446.00	8.3175	$353.85	$422.96
43251	Operative upper GI endoscopy	Y	A2	$446.00	8.3175	$353.85	$422.96
43255	Operative upper GI endoscopy	Y	A2	$446.00	8.3175	$353.85	$422.96
43256	Uppr gi endoscopy w/stent	Y	A2	$510.00	22.9475	$976.26	$626.57
43257	Uppr gi scope w/thrml txmnt	Y	A2	$510.00	25.7552	$1,095.70	$656.43
43258	Operative upper GI endoscopy	Y	A2	$510.00	8.3175	$353.85	$470.96
43259	Endoscopic ultrasound exam	Y	A2	$510.00	8.3175	$353.85	$470.96
43260	Endo cholangiopancreatograph	Y	A2	$446.00	19.8381	$843.97	$545.49
43261	Endo cholangiopancreatograph	Y	A2	$446.00	19.8381	$843.97	$545.49
43262	Endo cholangiopancreatograph	Y	A2	$446.00	19.8381	$843.97	$545.49
43263	Endo cholangiopancreatograph	Y	A2	$446.00	19.8381	$843.97	$545.49
43264	Endo cholangiopancreatograph	Y	A2	$446.00	19.8381	$843.97	$545.49
43265	Endo cholangiopancreatograph	Y	A2	$446.00	19.8381	$843.97	$545.49
43267	Endo cholangiopancreatograph	Y	A2	$446.00	19.8381	$843.97	$545.49
43268	Endo cholangiopancreatograph	Y	A2	$446.00	22.9475	$976.26	$578.57
43269	Endo cholangiopancreatograph	Y	A2	$446.00	22.9475	$976.26	$578.57
43271	Endo cholangiopancreatograph	Y	A2	$446.00	19.8381	$843.97	$545.49
43272	Endo cholangiopancreatograph	Y	A2	$446.00	19.8381	$843.97	$545.49
43450	Dilate esophagus	Y	A2	$333.00	5.4566	$232.14	$307.79
43453	Dilate esophagus	Y	A2	$333.00	5.4566	$232.14	$307.79
43456	Dilate esophagus	Y	A2	$335.41	5.4566	$232.14	$309.59
43458	Dilate esophagus	Y	A2	$335.41	5.4566	$232.14	$309.59
43600	Biopsy of stomach	Y	A2	$333.00	8.3175	$353.85	$338.21
43653	Laparoscopy, gastrostomy	Y	A2	$1,339.00	43.5488	$1,852.70	$1,467.43
43750	Place gastrostomy tube	Y	A2	$446.00	8.3175	$353.85	$422.96
43760	Change gastrostomy tube	Y	A2	$144.98	2.3587	$100.35	$133.82
43761	Reposition gastrostomy tube	Y	A2	$333.00	7.4800	$318.22	$329.31
43870	Repair stomach opening	Y	A2	$333.00	8.3175	$353.85	$338.21
43886	Revise gastric port, open	Y	G2	.....	5.2594	$223.75	$223.75
43887	Remove gastric port, open	Y	G2	.....	5.2594	$223.75	$223.75
43888	Change gastric port, open	Y	G2	.....	14.0346	$597.07	$597.07
44100	Biopsy of bowel	Y	A2	$333.00	8.3175	$353.85	$338.21
44312	Revision of ileostomy	Y	A2	$333.00	21.4302	$911.71	$477.68

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
44340	Revision of colostomy	Y	A2	$510.00	21.4302	$911.71	$610.43
44360	Small bowel endoscopy	Y	A2	$446.00	9.4946	$403.93	$435.48
44361	Small bowel endoscopy/biopsy	Y	A2	$446.00	9.4946	$403.93	$435.48
44363	Small bowel endoscopy	Y	A2	$446.00	9.4946	$403.93	$435.48
44364	Small bowel endoscopy	Y	A2	$446.00	9.4946	$403.93	$435.48
44365	Small bowel endoscopy	Y	A2	$446.00	9.4946	$403.93	$435.48
44366	Small bowel endoscopy	Y	A2	$446.00	9.4946	$403.93	$435.48
44369	Small bowel endoscopy	Y	A2	$446.00	9.4946	$403.93	$435.48
44370	Small bowel endoscopy/stent	Y	A2	$1,339.00	22.9475	$976.26	$1,248.32
44372	Small bowel endoscopy	Y	A2	$446.00	9.4946	$403.93	$435.48
44373	Small bowel endoscopy	Y	A2	$446.00	9.4946	$403.93	$435.48
44376	Small bowel endoscopy	Y	A2	$446.00	9.4946	$403.93	$435.48
44377	Small bowel endoscopy/biopsy	Y	A2	$446.00	9.4946	$403.93	$435.48
44378	Small bowel endoscopy	Y	A2	$446.00	9.4946	$403.93	$435.48
44379	Sbowel endoscope w/stent	Y	A2	$1,339.00	22.9475	$976.26	$1,248.32
44380	Small bowel endoscopy	Y	A2	$333.00	9.4946	$403.93	$350.73
44382	Small bowel endoscopy	Y	A2	$333.00	9.4946	$403.93	$350.73
44383	Ileoscopy w/stent	Y	A2	$1,339.00	22.9475	$976.26	$1,248.32
44385	Endoscopy of bowel pouch	Y	A2	$333.00	8.7686	$373.04	$343.01
44386	Endoscopy, bowel pouch/biop	Y	A2	$333.00	8.7686	$373.04	$343.01
44388	Colonoscopy	Y	A2	$333.00	8.7686	$373.04	$343.01
44389	Colonoscopy with biopsy	Y	A2	$333.00	8.7686	$373.04	$343.01
44390	Colonoscopy for foreign body	Y	A2	$333.00	8.7686	$373.04	$343.01
44391	Colonoscopy for bleeding	Y	A2	$333.00	8.7686	$373.04	$343.01
44392	Colonoscopy & polypectomy	Y	A2	$333.00	8.7686	$373.04	$343.01
44393	Colonoscopy, lesion removal	Y	A2	$333.00	8.7686	$373.04	$343.01
44394	Colonoscopy w/snare	Y	A2	$333.00	8.7686	$373.04	$343.01
44397	Colonoscopy w/stent	Y	A2	$333.00	22.9475	$976.26	$493.82
44701	Intraop colon lavage add-on		N1				
45000	Drainage of pelvic abscess	Y	A2	$312.07	5.0770	$215.99	$288.05
45005	Drainage of rectal abscess	Y	A2	$446.00	12.7389	$541.95	$469.99
45020	Drainage of rectal abscess	Y	A2	$446.00	12.7389	$541.95	$469.99
45100	Biopsy of rectum	Y	A2	$333.00	22.2682	$947.36	$486.59
45108	Removal of anorectal lesion	Y	A2	$446.00	22.2682	$947.36	$571.34
45150	Excision of rectal stricture	Y	A2	$446.00	22.2682	$947.36	$571.34
45160	Excision of rectal lesion	Y	A2	$446.00	22.2682	$947.36	$571.34
45170	Excision of rectal lesion	Y	A2	$446.00	22.2682	$947.36	$571.34
45190	Destruction, rectal tumor	Y	A2	$1,339.00	22.2682	$947.36	$1,241.09
45300	Proctosigmoidoscopy dx	Y	P3		1.3922	$59.23	$59.23
45303	Proctosigmoidoscopy dilate	Y	P2		8.5477	$363.64	$363.64
45305	Proctosigmoidoscopy w/bx	Y	A2	$333.00	8.5477	$363.64	$340.66
45307	Proctosigmoidoscopy fb	Y	A2	$333.00	20.6375	$877.98	$469.25
45308	Proctosigmoidoscopy removal	Y	A2	$333.00	8.5477	$363.64	$340.66
45309	Proctosigmoidoscopy removal	Y	A2	$333.00	8.5477	$363.64	$340.66
45315	Proctosigmoidoscopy removal	Y	A2	$333.00	8.5477	$363.64	$340.66
45317	Proctosigmoidoscopy bleed	Y	A2	$333.00	8.5477	$363.64	$340.66
45320	Proctosigmoidoscopy ablate	Y	A2	$333.00	20.6375	$877.98	$469.25
45321	Proctosigmoidoscopy volvul	Y	A2	$333.00	20.6375	$877.98	$469.25
45327	Proctosigmoidoscopy w/stent	Y	A2	$333.00	22.9475	$976.26	$493.82
45330	Diagnostic sigmoidoscopy	Y	P3		1.9152	$81.48	$81.48
45331	Sigmoidoscopy and biopsy	Y	A2	$299.24	4.8683	$207.11	$276.21
45332	Sigmoidoscopy w/fb removal	Y	A2	$299.24	4.8683	$207.11	$276.21
45333	Sigmoidoscopy & polypectomy	Y	A2	$333.00	8.5477	$363.64	$340.66
45334	Sigmoidoscopy for bleeding	Y	A2	$333.00	8.5477	$363.64	$340.66
45335	Sigmoidoscopy w/submuc inj	Y	A2	$299.24	4.8683	$207.11	$276.21
45337	Sigmoidoscopy & decompress	Y	A2	$299.24	4.8683	$207.11	$276.21
45338	Sigmoidoscopy w/tumr remove	Y	A2	$333.00	8.5477	$363.64	$340.66
45339	Sigmoidoscopy w/ablate tumr	Y	A2	$333.00	8.5477	$363.64	$340.66
45340	Sig w/balloon dilation	Y	A2	$333.00	8.5477	$363.64	$340.66
45341	Sigmoidoscopy w/ultrasound	Y	A2	$333.00	8.5477	$363.64	$340.66
45342	Sigmoidoscopy w/us guide bx	Y	A2	$333.00	8.5477	$363.64	$340.66
45345	Sigmoidoscopy w/stent	Y	A2	$333.00	22.9475	$976.26	$493.82
45355	Surgical colonoscopy	Y	A2	$333.00	8.7686	$373.04	$343.01

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
45378	Diagnostic colonoscopy	Y	A2	$446.00	8.7686	$373.04	$427.76
45379	Colonoscopy w/fb removal	Y	A2	$446.00	8.7686	$373.04	$427.76
45380	Colonoscopy and biopsy	Y	A2	$446.00	8.7686	$373.04	$427.76
45381	Colonoscopy, submucous inj	Y	A2	$446.00	8.7686	$373.04	$427.76
45382	Colonoscopy/control bleeding	Y	A2	$446.00	8.7686	$373.04	$427.76
45383	Lesion removal colonoscopy	Y	A2	$446.00	8.7686	$373.04	$427.76
45384	Lesion remove colonoscopy	Y	A2	$446.00	8.7686	$373.04	$427.76
45385	Lesion removal colonoscopy	Y	A2	$446.00	8.7686	$373.04	$427.76
45386	Colonoscopy dilate stricture	Y	A2	$446.00	8.7686	$373.04	$427.76
45387	Colonoscopy w/stent	Y	A2	$333.00	22.9475	$976.26	$493.82
45391	Colonoscopy w/endoscope us	Y	A2	$446.00	8.7686	$373.04	$427.76
45392	Colonoscopy w/endoscopic fnb	Y	A2	$446.00	8.7686	$373.04	$427.76
45500	Repair of rectum	Y	A2	$446.00	22.2682	$947.36	$571.34
45505	Repair of rectum	Y	A2	$446.00	29.6189	$1,260.08	$649.52
45520	Treatment of rectal prolapse	Y	P2	.....	1.0798	$45.94	$45.94
45560	Repair of rectocele	Y	A2	$446.00	29.6189	$1,260.08	$649.52
45900	Reduction of rectal prolapse	Y	A2	$312.07	5.0770	$215.99	$288.05
45905	Dilation of anal sphincter	Y	A2	$333.00	22.2682	$947.36	$486.59
45910	Dilation of rectal narrowing	Y	A2	$333.00	22.2682	$947.36	$486.59
45915	Remove rectal obstruction	Y	A2	$312.07	5.0770	$215.99	$288.05
45990	Surg dx exam, anorectal	Y	A2	$312.07	5.0770	$215.99	$288.05
46020	Placement of seton	Y	A2	$510.00	22.2682	$947.36	$619.34
46030	Removal of rectal marker	Y	A2	$312.07	5.0770	$215.99	$288.05
46040	Incision of rectal abscess	Y	A2	$510.00	22.2682	$947.36	$619.34
46045	Incision of rectal abscess	Y	A2	$446.00	22.2682	$947.36	$571.34
46050	Incision of anal abscess	Y	A2	$312.07	5.0770	$215.99	$288.05
46060	Incision of rectal abscess	Y	A2	$446.00	22.2682	$947.36	$571.34
46070	Incision of anal septum	Y	G2	.....	12.7389	$541.95	$541.95
46080	Incision of anal sphincter	Y	A2	$510.00	22.2682	$947.36	$619.34
46083	Incise external hemorrhoid	Y	P3	.....	1.9554	$83.19	$83.19
46200	Removal of anal fissure	Y	A2	$446.00	22.2682	$947.36	$571.34
46210	Removal of anal crypt	Y	A2	$446.00	22.2682	$947.36	$571.34
46211	Removal of anal crypts	Y	A2	$446.00	22.2682	$947.36	$571.34
46220	Removal of anal tag	Y	A2	$333.00	22.2682	$947.36	$486.59
46221	Ligation of hemorrhoid(s)	Y	P3	.....	2.5591	$108.87	$108.87
46230	Removal of anal tags	Y	A2	$333.00	22.2682	$947.36	$486.59
46250	Hemorrhoidectomy	Y	A2	$510.00	22.2682	$947.36	$619.34
46255	Hemorrhoidectomy	Y	A2	$510.00	22.2682	$947.36	$619.34
46257	Remove hemorrhoids & fissure	Y	A2	$510.00	22.2682	$947.36	$619.34
46258	Remove hemorrhoids & fistula	Y	A2	$510.00	22.2682	$947.36	$619.34
46260	Hemorrhoidectomy	Y	A2	$510.00	22.2682	$947.36	$619.34
46261	Remove hemorrhoids & fissure	Y	A2	$630.00	22.2682	$947.36	$709.34
46262	Remove hemorrhoids & fistula	Y	A2	$630.00	22.2682	$947.36	$709.34
46270	Removal of anal fistula	Y	A2	$510.00	22.2682	$947.36	$619.34
46275	Removal of anal fistula	Y	A2	$510.00	22.2682	$947.36	$619.34
46280	Removal of anal fistula	Y	A2	$630.00	22.2682	$947.36	$709.34
46285	Removal of anal fistula	Y	A2	$333.00	22.2682	$947.36	$486.59
46288	Repair anal fistula	Y	A2	$630.00	22.2682	$947.36	$709.34
46320	Removal of hemorrhoid clot	Y	P3	.....	1.8186	$77.37	$77.37
46500	Injection into hemorrhoid(s)	Y	P3	.....	2.2934	$97.57	$97.57
46505	Chemodenervation anal musc	Y	G2	.....	5.0770	$215.99	$215.99
46600	Diagnostic anoscopy	N	P2	.....	0.6102	$25.96	$25.96
46604	Anoscopy and dilation	Y	P2	.....	8.5477	$363.64	$363.64
46606	Anoscopy and biopsy	Y	P3	.....	3.0821	$131.12	$131.12
46608	Anoscopy, remove for body	Y	A2	$333.00	8.5477	$363.64	$340.66
46610	Anoscopy, remove lesion	Y	A2	$333.00	20.6375	$877.98	$469.25
46611	Anoscopy	Y	A2	$333.00	8.5477	$363.64	$340.66
46612	Anoscopy, remove lesions	Y	A2	$333.00	20.6375	$877.98	$469.25
46614	Anoscopy, control bleeding	Y	P3	.....	1.9634	$83.53	$83.53
46615	Anoscopy	Y	A2	$446.00	20.6375	$877.98	$554.00
46700	Repair of anal stricture	Y	A2	$510.00	22.2682	$947.36	$619.34
46706	Repr of anal fistula w/glue	Y	A2	$333.00	29.6189	$1,260.08	$564.77
46750	Repair of anal sphincter	Y	A2	$510.00	37.8991	$1,612.34	$785.59

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
46753	Reconstruction of anus	Y	A2	$510.00	22.2682	$947.36	$619.34
46754	Removal of suture from anus	Y	A2	$446.00	22.2682	$947.36	$571.34
46760	Repair of anal sphincter	Y	A2	$446.00	37.8991	$1,612.34	$737.59
46761	Repair of anal sphincter	Y	A2	$510.00	37.8991	$1,612.34	$785.59
46762	Implant artificial sphincter	Y	A2	$995.00	37.8991	$1,612.34	$1,149.34
46900	Destruction, anal lesion(s)	Y	P3		2.4947	$106.13	$106.13
46910	Destruction, anal lesion(s)	Y	P3		2.7281	$116.06	$116.06
46916	Cryosurgery, anal lesion(s)	Y	P2		1.0918	$46.45	$46.45
46917	Laser surgery, anal lesions	Y	A2	$333.00	20.4276	$869.05	$467.01
46922	Excision of anal lesion(s)	Y	A2	$333.00	20.4276	$869.05	$467.01
46924	Destruction, anal lesion(s)	Y	A2	$333.00	20.4276	$869.05	$467.01
46934	Destruction of hemorrhoids	Y	P3		4.2087	$179.05	$179.05
46935	Destruction of hemorrhoids	Y	P3		2.8729	$122.22	$122.22
46936	Destruction of hemorrhoids	Y	P3		4.4341	$188.64	$188.64
46937	Cryotherapy of rectal lesion	Y	A2	$446.00	22.2682	$947.36	$571.34
46938	Cryotherapy of rectal lesion	Y	A2	$446.00	29.6189	$1,260.08	$649.52
46940	Treatment of anal fissure	Y	P3		1.9394	$82.51	$82.51
46942	Treatment of anal fissure	Y	P3		1.8588	$79.08	$79.08
46945	Ligation of hemorrhoids	Y	P3		3.2511	$138.31	$138.31
46946	Ligation of hemorrhoids	Y	A2	$333.00	12.7389	$541.95	$385.24
46947	Hemorrhoidopexy by stapling	Y	A2	$995.00	29.6189	$1,260.08	$1,061.27
47000	Needle biopsy of liver	Y	A2	$333.00	6.1384	$261.15	$315.04
47001	Needle biopsy, liver add-on		N1				
47382	Percut ablate liver rf	Y	G2		37.3604	$1,589.42	$1,589.42
47500	Injection for liver x-rays		N1				
47505	Injection for liver x-rays		N1				
47510	Insert catheter, bile duct	Y	A2	$446.00	20.2682	$862.27	$550.07
47511	Insert bile duct drain	Y	A2	$1,245.85	20.2682	$862.27	$1,149.96
47525	Change bile duct catheter	Y	A2	$333.00	11.6575	$495.95	$373.74
47530	Revise/reinsert bile tube	Y	A2	$333.00	11.6575	$495.95	$373.74
47552	Biliary endoscopy thru skin	Y	A2	$446.00	20.2682	$862.27	$550.07
47553	Biliary endoscopy thru skin	Y	A2	$510.00	20.2682	$862.27	$598.07
47554	Biliary endoscopy thru skin	Y	A2	$510.00	20.2682	$862.27	$598.07
47555	Biliary endoscopy thru skin	Y	A2	$510.00	20.2682	$862.27	$598.07
47556	Biliary endoscopy thru skin	Y	A2	$1,245.85	20.2682	$862.27	$1,149.96
47560	Laparoscopy w/cholangio	Y	A2	$510.00	32.1241	$1,366.66	$724.17
47561	Laparo w/cholangio/biopsy	Y	A2	$510.00	32.1241	$1,366.66	$724.17
47562	Laparoscopic cholecystectomy	Y	G2		43.5488	$1,852.70	$1,852.70
47563	Laparo cholecystectomy/graph	Y	G2		43.5488	$1,852.70	$1,852.70
47564	Laparo cholecystectomy/explr	Y	G2		43.5488	$1,852.70	$1,852.70
47630	Remove bile duct stone	Y	A2	$510.00	20.2682	$862.27	$598.07
48102	Needle biopsy, pancreas	Y	A2	$333.00	6.1384	$261.15	$315.04
49080	Puncture, peritoneal cavity	Y	A2	$222.78	3.6244	$154.19	$205.63
49081	Removal of abdominal fluid	Y	A2	$222.78	3.6244	$154.19	$205.63
49180	Biopsy, abdominal mass	Y	A2	$333.00	6.1384	$261.15	$315.04
49250	Excision of umbilicus	Y	A2	$630.00	22.0832	$939.49	$707.37
49320	Diag laparo separate proc	Y	A2	$510.00	32.1241	$1,366.66	$724.17
49321	Laparoscopy, biopsy	Y	A2	$630.00	32.1241	$1,366.66	$814.17
49322	Laparoscopy, aspiration	Y	A2	$630.00	32.1241	$1,366.66	$814.17
49400	Air injection into abdomen		N1				
49402	Remove foreign body, adbomen	Y	A2	$446.00	22.0832	$939.49	$569.37
49419	Insrt abdom cath for chemotx	Y	A2	$333.00	29.2133	$1,242.82	$560.46
49420	Insert abdom drain, temp	Y	A2	$333.00	29.5416	$1,256.79	$563.95
49421	Insert abdom drain, perm	Y	A2	$333.00	29.5416	$1,256.79	$563.95
49422	Remove perm cannula/catheter	Y	A2	$333.00	25.6142	$1,089.70	$522.18
49423	Exchange drainage catheter	Y	G2		11.6575	$495.95	$495.95
49424	Assess cyst, contrast inject		N1				
49426	Revise abdomen-venous shunt	Y	A2	$446.00	22.0832	$939.49	$569.37
49427	Injection, abdominal shunt		N1				
49429	Removal of shunt	Y	G2		25.6142	$1,089.70	$1,089.70
49495	Rpr ing hernia baby, reduc	Y	A2	$630.00	29.2182	$1,243.03	$783.26
49496	Rpr ing hernia baby, blocked	Y	A2	$630.00	29.2182	$1,243.03	$783.26
49500	Rpr ing hernia, init, reduce	Y	A2	$630.00	29.2182	$1,243.03	$783.26

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
49501	Rpr ing hernia, init blocked	Y	A2	$1,339.00	29.2182	$1,243.03	$1,315.01
49505	Prp i/hern init reduc > 5 yr	Y	A2	$630.00	29.2182	$1,243.03	$783.26
49507	Prp i/hern init block > 5 yr	Y	A2	$1,339.00	29.2182	$1,243.03	$1,315.01
49520	Rerepair ing hernia, reduce	Y	A2	$995.00	29.2182	$1,243.03	$1,057.01
49521	Rerepair ing hernia, blocked	Y	A2	$1,339.00	29.2182	$1,243.03	$1,315.01
49525	Repair ing hernia, sliding	Y	A2	$630.00	29.2182	$1,243.03	$783.26
49540	Repair lumbar hernia	Y	A2	$446.00	29.2182	$1,243.03	$645.26
49550	Rpr rem hernia, init, reduce	Y	A2	$717.00	29.2182	$1,243.03	$848.51
49553	Rpr fem hernia, init blocked	Y	A2	$1,339.00	29.2182	$1,243.03	$1,315.01
49555	Rerepair fem hernia, reduce	Y	A2	$717.00	29.2182	$1,243.03	$848.51
49557	Rerepair fem hernia, blocked	Y	A2	$1,339.00	29.2182	$1,243.03	$1,315.01
49560	Rpr ventral hern init, reduc	Y	A2	$630.00	29.2182	$1,243.03	$783.26
49561	Rpr ventral hern init, block	Y	A2	$1,339.00	29.2182	$1,243.03	$1,315.01
49565	Rerepair ventrl hern, reduce	Y	A2	$630.00	29.2182	$1,243.03	$783.26
49566	Rerepair ventrl hern, block	Y	A2	$1,339.00	29.2182	$1,243.03	$1,315.01
49568	Hernia repair w/mesh	Y	A2	$995.00	29.2182	$1,243.03	$1,057.01
49570	Rpr epigastric hern, reduce	Y	A2	$630.00	29.2182	$1,243.03	$783.26
49572	Rpr epigastric hern, blocked	Y	A2	$1,339.00	29.2182	$1,243.03	$1,315.01
49580	Rpr umbil hern, reduc < 5 yr	Y	A2	$630.00	29.2182	$1,243.03	$783.26
49582	Rpr umbil hern, block < 5 yr	Y	A2	$1,339.00	29.2182	$1,243.03	$1,315.01
49585	Rpr umbil hern, reduc > 5 yr	Y	A2	$630.00	29.2182	$1,243.03	$783.26
49587	Rpr umbil hern, block > 5 yr	Y	A2	$1,339.00	29.2182	$1,243.03	$1,315.01
49590	Repair spigelian hernia	Y	A2	$510.00	29.2182	$1,243.03	$693.26
49600	Repair umbilical lesion	Y	A2	$630.00	29.2182	$1,243.03	$783.26
49650	Laparo hernia repair initial	Y	A2	$630.00	43.5488	$1,852.70	$935.68
49651	Laparo hernia repair recur	Y	A2	$995.00	43.5488	$1,852.70	$1,209.43
50200	Biopsy of kidney	Y	A2	$333.00	6.1384	$261.15	$315.04
50382	Change ureter stent, percut	Y	G2	.....	19.2251	$817.89	$817.89
50384	Remove ureter stent, percut	Y	G2	.....	19.2251	$817.89	$817.89
50387	Change ext/int ureter stent	Y	G2	.....	7.4800	$318.22	$318.22
50389	Remove renal tube w/fluoro	Y	G2	.....	3.4079	$144.98	$144.98
50390	Drainage of kidney lesion	Y	A2	$333.00	6.1384	$261.15	$315.04
50391	Instll rx agnt into rnal tub	Y	P2	.....	1.0887	$46.32	$46.32
50392	Insert kidney drain	Y	A2	$333.00	19.2251	$817.89	$454.22
50393	Insert ureteral tube	Y	A2	$333.00	19.2251	$817.89	$454.22
50394	Injection for kidney x-ray	.....	N1	.....	.....	.....	.....
50395	Create passage to kidney	Y	A2	$333.00	19.2251	$817.89	$454.22
50396	Measure kidney pressure	Y	A2	$131.50	2.1393	$91.01	$121.38
50398	Change kidney tube	Y	A2	$333.00	7.4800	$318.22	$329.31
50551	Kidney endoscopy	Y	A2	$333.00	6.4951	$276.32	$318.83
50553	Kidney endoscopy	Y	A2	$333.00	19.2251	$817.89	$454.22
50555	Kidney endoscopy & biopsy	Y	A2	$333.00	6.4951	$276.32	$318.83
50557	Kidney endoscopy & treatment	Y	A2	$333.00	23.8700	$1,015.50	$503.63
50561	Kidney endoscopy & treatment	Y	A2	$333.00	19.2251	$817.89	$454.22
50562	Renal scope w/tumor resect	Y	G2	.....	6.4951	$276.32	$276.32
50570	Kidney endoscopy	Y	G2	.....	6.4951	$276.32	$276.32
50572	Kidney endoscopy	Y	G2	.....	6.4951	$276.32	$276.32
50574	Kidney endoscopy & biopsy	Y	G2	.....	6.4951	$276.32	$276.32
50575	Kidney endoscopy	Y	G2	.....	34.9261	$1,485.86	$1,485.86
50576	Kidney endoscopy & treatment	Y	G2	.....	19.2251	$817.89	$817.89
50590	Fragmenting of kidney stone	Y	G2	.....	43.5398	$1,852.31	$1,852.31
50592	Perc rf ablate renal tumor	Y	G2	.....	37.3604	$1,589.42	$1,589.42
50684	Injection for ureter x-ray	.....	N1	.....	.....	.....	.....
50686	Measure ureter pressure	Y	P2	.....	1.0887	$46.32	$46.32
50688	Change of ureter tube/stent	Y	A2	$333.00	7.4800	$318.22	$329.31
50690	Injection for ureter x-ray	.....	N1	.....	.....	.....	.....
50947	Laparo new ureter/bladder	Y	A2	$1,339.00	43.5488	$1,852.70	$1,467.43
50948	Laparo new ureter/bladder	Y	A2	$1,339.00	43.5488	$1,852.70	$1,467.43
50951	Endoscopy of ureter	Y	A2	$333.00	6.4951	$276.32	$318.83
50953	Endoscopy of ureter	Y	A2	$333.00	6.4951	$276.32	$318.83
50955	Ureter endoscopy & biopsy	Y	A2	$333.00	19.2251	$817.89	$454.22
50957	Ureter endoscopy & treatment	Y	A2	$333.00	19.2251	$817.89	$454.22
50961	Ureter endoscopy & treatment	Y	A2	$333.00	19.2251	$817.89	$454.22

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
50970	Ureter endoscopy	Y	A2	$333.00	6.4951	$276.32	$318.83
50972	Ureter endoscopy & catheter	Y	A2	$333.00	6.4951	$276.32	$318.83
50974	Ureter endoscopy & biopsy	Y	A2	$333.00	19.2251	$817.89	$454.22
50976	Ureter endoscopy & treatment	Y	A2	$333.00	19.2251	$817.89	$454.22
50980	Ureter endoscopy & treatment	Y	A2	$333.00	19.2251	$817.89	$454.22
51000	Drainage of bladder	Y	P3	.....	1.1588	$49.30	$49.30
51005	Drainage of bladder	Y	P2	.....	1.0887	$46.32	$46.32
51010	Drainage of bladder	Y	A2	$333.00	18.1679	$772.92	$442.98
51020	Incise & treat bladder	Y	A2	$630.00	23.8700	$1,015.50	$726.38
51030	Incise & treat bladder	Y	A2	$630.00	23.8700	$1,015.50	$726.38
51040	Incise & drain bladder	Y	A2	$630.00	23.8700	$1,015.50	$726.38
51045	Incise bladder/drain ureter	Y	A2	$399.24	6.4951	$276.32	$368.51
51050	Removal of bladder stone	Y	A2	$630.00	23.8700	$1,015.50	$726.38
51065	Remove ureter calculus	Y	A2	$630.00	23.8700	$1,015.50	$726.38
51080	Drainage of bladder abscess	Y	A2	$333.00	17.5086	$744.87	$435.97
51500	Removal of bladder cyst	Y	A2	$630.00	29.2182	$1,243.03	$783.26
51520	Removal of bladder lesion	Y	A2	$630.00	23.8700	$1,015.50	$726.38
51600	Injection for bladder x-ray	.....	N1	.....	.....	.....	.....
51605	Preparation for bladder xray	.....	N1	.....	.....	.....	.....
51610	Injection for bladder x-ray	.....	N1	.....	.....	.....	.....
51700	Irrigation of bladder	Y	P3	.....	1.2554	$53.41	$53.41
51701	Insert bladder catheter	N	P2	.....	0.6102	$25.96	$25.96
51702	Insert temp bladder cath	N	P2	.....	0.6102	$25.96	$25.96
51703	Insert bladder cath, complex	Y	P2	.....	1.0887	$46.32	$46.32
51705	Change of bladder tube	Y	P3	.....	1.7302	$73.61	$73.61
51710	Change of bladder tube	Y	A2	$333.00	7.4800	$318.22	$329.31
51715	Endoscopic injection/implant	Y	A2	$510.00	29.0253	$1,234.82	$691.21
51720	Treatment of bladder lesion	Y	P3	.....	1.3600	$57.86	$57.86
51725	Simple cystometrogram	Y	P2	.....	2.1393	$91.01	$91.01
51726	Complex cystometrogram	Y	A2	$209.48	3.4079	$144.98	$193.36
51736	Urine flow measurement	Y	P3	.....	0.4264	$18.14	$18.14
51741	Electro-uroflowmetry, first	Y	P3	.....	0.4990	$21.23	$21.23
51772	Urethra pressure profile	Y	A2	$131.50	2.1393	$91.01	$121.38
51784	Anal/urinary muscle study	Y	P2	.....	1.0887	$46.32	$46.32
51785	Anal/urinary muscle study	Y	A2	$66.92	1.0887	$46.32	$61.77
51792	Urinary reflex study	Y	P2	.....	1.0887	$46.32	$46.32
51795	Urine voiding pressure study	Y	P2	.....	2.1393	$91.01	$91.01
51797	Intraabdominal pressure test	Y	P2	.....	2.1393	$91.01	$91.01
51798	Us urine capacity measure	N	P3	.....	0.3702	$15.75	$15.75
51880	Repair of bladder opening	Y	A2	$333.00	23.8700	$1,015.50	$503.63
51992	Laparo sling operation	Y	A2	$717.00	43.5488	$1,852.70	$1,000.93
52000	Cystoscopy	Y	A2	$333.00	6.4951	$276.32	$318.83
52001	Cystoscopy, removal of clots	Y	A2	$399.24	6.4951	$276.32	$368.51
52005	Cystoscopy & ureter catheter	Y	A2	$446.00	19.2251	$817.89	$538.97
52007	Cystoscopy and biopsy	Y	A2	$446.00	19.2251	$817.89	$538.97
52010	Cystoscopy & duct catheter	Y	A2	$399.24	6.4951	$276.32	$368.51
52204	Cystoscopy w/biopsy(s)	Y	A2	$446.00	19.2251	$817.89	$538.97
52214	Cystoscopy and treatment	Y	A2	$446.00	23.8700	$1,015.50	$588.38
52224	Cystoscopy and treatment	Y	A2	$446.00	23.8700	$1,015.50	$588.38
52234	Cystoscopy and treatment	Y	A2	$446.00	23.8700	$1,015.50	$588.38
52235	Cystoscopy and treatment	Y	A2	$510.00	23.8700	$1,015.50	$636.38
52240	Cystoscopy and treatment	Y	A2	$510.00	23.8700	$1,015.50	$636.38
52250	Cystoscopy and radiotracer	Y	A2	$630.00	23.8700	$1,015.50	$726.38
52260	Cystoscopy and treatment	Y	A2	$446.00	19.2251	$817.89	$538.97
52265	Cystoscopy and treatment	Y	P2	.....	6.4951	$276.32	$276.32
52270	Cystoscopy & revise urethra	Y	A2	$446.00	19.2251	$817.89	$538.97
52275	Cystoscopy & revise urethra	Y	A2	$446.00	19.2251	$817.89	$538.97
52276	Cystoscopy and treatment	Y	A2	$510.00	19.2251	$817.89	$586.97
52277	Cystoscopy and treatment	Y	A2	$446.00	23.8700	$1,015.50	$588.38
52281	Cystoscopy and treatment	Y	A2	$446.00	19.2251	$817.89	$538.97
52282	Cystoscopy, implant stent	Y	A2	$1,339.00	34.9261	$1,485.86	$1,375.72
52283	Cystoscopy and treatment	Y	A2	$446.00	19.2251	$817.89	$538.97
52285	Cystoscopy and treatment	Y	A2	$446.00	19.2251	$817.89	$538.97

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
52290	Cystoscopy and treatment	Y	A2	$446.00	19.2251	$817.89	$538.97
52300	Cystoscopy and treatment	Y	A2	$446.00	19.2251	$817.89	$538.97
52301	Cystoscopy and treatment	Y	A2	$510.00	19.2251	$817.89	$586.97
52305	Cystoscopy and treatment	Y	A2	$446.00	19.2251	$817.89	$538.97
52310	Cystoscopy and treatment	Y	A2	$399.24	6.4951	$276.32	$368.51
52315	Cystoscopy and treatment	Y	A2	$446.00	19.2251	$817.89	$538.97
52317	Remove bladder stone	Y	A2	$333.00	23.8700	$1,015.50	$503.63
52318	Remove bladder stone	Y	A2	$446.00	23.8700	$1,015.50	$588.38
52320	Cystoscopy and treatment	Y	A2	$717.00	23.8700	$1,015.50	$791.63
52325	Cystoscopy, stone removal	Y	A2	$630.00	23.8700	$1,015.50	$726.38
52327	Cystoscopy, inject material	Y	A2	$446.00	23.8700	$1,015.50	$588.38
52330	Cystoscopy and treatment	Y	A2	$446.00	23.8700	$1,015.50	$588.38
52332	Cystoscopy and treatment	Y	A2	$446.00	23.8700	$1,015.50	$588.38
52334	Create passage to kidney	Y	A2	$510.00	23.8700	$1,015.50	$636.38
52341	Cysto w/ureter stricture tx	Y	A2	$510.00	23.8700	$1,015.50	$636.38
52342	Cysto w/up stricture tx	Y	A2	$510.00	23.8700	$1,015.50	$636.38
52343	Cysto w/renal stricture tx	Y	A2	$510.00	23.8700	$1,015.50	$636.38
52344	Cysto/uretero, stricture tx	Y	A2	$510.00	23.8700	$1,015.50	$636.38
52345	Cysto/uretero w/up stricture	Y	A2	$510.00	23.8700	$1,015.50	$636.38
52346	Cystouretero w/renal strict	Y	A2	$510.00	23.8700	$1,015.50	$636.38
52351	Cystouretero & or pyeloscope	Y	A2	$510.00	19.2251	$817.89	$586.97
52352	Cystouretero w/stone remove	Y	A2	$630.00	23.8700	$1,015.50	$726.38
52353	Cystouretero w/lithotripsy	Y	A2	$630.00	34.9261	$1,485.86	$843.97
52354	Cystouretero w/biopsy	Y	A2	$630.00	23.8700	$1,015.50	$726.38
52355	Cystouretero w/excise tumor	Y	A2	$630.00	23.8700	$1,015.50	$726.38
52400	Cystouretero w/congen repr	Y	A2	$510.00	23.8700	$1,015.50	$636.38
52402	Cystourethro cut ejacul duct	Y	A2	$510.00	23.8700	$1,015.50	$636.38
52450	Incision of prostate	Y	A2	$510.00	23.8700	$1,015.50	$636.38
52500	Revision of bladder neck	Y	A2	$510.00	23.8700	$1,015.50	$636.38
52510	Dilation prostatic urethra	Y	A2	$510.00	19.2251	$817.89	$586.97
52601	Prostatectomy (TURP)	Y	A2	$630.00	34.9261	$1,485.86	$843.97
52606	Control postop bleeding	Y	A2	$333.00	23.8700	$1,015.50	$503.63
52612	Prostatectomy, first stage	Y	A2	$446.00	34.9261	$1,485.86	$705.97
52614	Prostatectomy, second stage	Y	A2	$333.00	34.9261	$1,485.86	$621.22
52620	Remove residual prostate	Y	A2	$333.00	34.9261	$1,485.86	$621.22
52630	Remove prostate regrowth	Y	A2	$446.00	34.9261	$1,485.86	$705.97
52640	Relieve bladder contracture	Y	A2	$446.00	23.8700	$1,015.50	$588.38
52647	Laser surgery of prostate	Y	A2	$1,339.00	43.1004	$1,833.62	$1,462.66
52648	Laser surgery of prostate	Y	A2	$1,339.00	43.1004	$1,833.62	$1,462.66
52700	Drainage of prostate abscess	Y	A2	$446.00	23.8700	$1,015.50	$588.38
53000	Incision of urethra	Y	A2	$333.00	18.3960	$782.62	$445.41
53010	Incision of urethra	Y	A2	$333.00	18.3960	$782.62	$445.41
53020	Incision of urethra	Y	A2	$333.00	18.3960	$782.62	$445.41
53025	Incision of urethra	Y	R2	.....	18.3960	$782.62	$782.62
53040	Drainage of urethra abscess	Y	A2	$446.00	18.3960	$782.62	$530.16
53060	Drainage of urethra abscess	Y	P3	.....	1.6416	$69.84	$69.84
53080	Drainage of urinary leakage	Y	A2	$510.00	18.3960	$782.62	$578.16
53085	Drainage of urinary leakage	Y	G2	.....	18.3960	$782.62	$782.62
53200	Biopsy of urethra	Y	A2	$333.00	18.3960	$782.62	$445.41
53210	Removal of urethra	Y	A2	$717.00	29.0253	$1,234.82	$846.46
53215	Removal of urethra	Y	A2	$717.00	18.3960	$782.62	$733.41
53220	Treatment of urethra lesion	Y	A2	$446.00	29.0253	$1,234.82	$643.21
53230	Removal of urethra lesion	Y	A2	$446.00	29.0253	$1,234.82	$643.21
53235	Removal of urethra lesion	Y	A2	$510.00	18.3960	$782.62	$578.16
53240	Surgery for urethra pouch	Y	A2	$446.00	29.0253	$1,234.82	$643.21
53250	Removal of urethra gland	Y	A2	$446.00	18.3960	$782.62	$530.16
53260	Treatment of urethra lesion	Y	A2	$446.00	18.3960	$782.62	$530.16
53265	Treatment of urethra lesion	Y	A2	$446.00	18.3960	$782.62	$530.16
53270	Removal of urethra gland	Y	A2	$446.00	18.3960	$782.62	$530.16
53275	Repair of urethra defect	Y	A2	$446.00	18.3960	$782.62	$530.16
53400	Revise urethra, stage 1	Y	A2	$510.00	29.0253	$1,234.82	$691.21
53405	Revise urethra, stage 2	Y	A2	$446.00	29.0253	$1,234.82	$643.21
53410	Reconstruction of urethra	Y	A2	$446.00	29.0253	$1,234.82	$643.21

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
53420	Reconstruct urethra, stage 1	Y	A2	$510.00	29.0253	$1,234.82	$691.21
53425	Reconstruct urethra, stage 2	Y	A2	$446.00	29.0253	$1,234.82	$643.21
53430	Reconstruction of urethra	Y	A2	$446.00	29.0253	$1,234.82	$643.21
53431	Reconstruct urethra/bladder	Y	A2	$446.00	29.0253	$1,234.82	$643.21
53440	Male sling procedure	N	A2	$446.00	79.2092	$3,369.80	$1,176.95
53442	Remove/revise male sling	Y	A2	$333.00	29.0253	$1,234.82	$558.46
53444	Insert tandem cuff	N	A2	$446.00	79.2092	$3,369.80	$1,176.95
53445	Insert uro/ves nck sphincter	N	H8	$333.00	178.7754	$7,605.64	$6,152.75
53446	Remove uro sphincter	Y	A2	$333.00	29.0253	$1,234.82	$558.46
53447	Remove/replace ur sphincter	N	H8	$333.00	178.7754	$7,605.64	$6,152.75
53449	Repair uro sphincter	Y	A2	$333.00	29.0253	$1,234.82	$558.46
53450	Revision of urethra	Y	A2	$333.00	29.0253	$1,234.82	$558.46
53460	Revision of urethra	Y	A2	$333.00	18.3960	$782.62	$445.41
53502	Repair of urethra injury	Y	A2	$446.00	18.3960	$782.62	$530.16
53505	Repair of urethra injury	Y	A2	$446.00	29.0253	$1,234.82	$643.21
53510	Repair of urethra injury	Y	A2	$446.00	18.3960	$782.62	$530.16
53515	Repair of urethra injury	Y	A2	$446.00	29.0253	$1,234.82	$643.21
53520	Repair of urethra defect	Y	A2	$446.00	29.0253	$1,234.82	$643.21
53600	Dilate urethra stricture	Y	P3	.....	0.9254	$39.37	$39.37
53601	Dilate urethra stricture	Y	P3	.....	1.0702	$45.53	$45.53
53605	Dilate urethra stricture	Y	A2	$446.00	19.2251	$817.89	$538.97
53620	Dilate urethra stricture	Y	P3	.....	1.4888	$63.34	$63.34
53621	Dilate urethra stricture	Y	P3	.....	1.5692	$66.76	$66.76
53660	Dilation of urethra	Y	P3	.....	1.0542	$44.85	$44.85
53661	Dilation of urethra	Y	P3	.....	1.0462	$44.51	$44.51
53665	Dilation of urethra	Y	A2	$333.00	18.3960	$782.62	$445.41
53850	Prostatic microwave thermotx	Y	P2	.....	41.1375	$1,750.11	$1,750.11
53852	Prostatic rf thermotx	Y	P2	.....	41.1375	$1,750.11	$1,750.11
53853	Prostatic water thermother	Y	P2	.....	23.8700	$1,015.50	$1,015.50
54000	Slitting of prepuce	Y	A2	$446.00	18.3960	$782.62	$530.16
54001	Slitting of prepuce	Y	A2	$446.00	18.3960	$782.62	$530.16
54015	Drain penis lesion	Y	A2	$630.00	17.5086	$744.87	$658.72
54050	Destruction, penis lesion(s)	Y	P2	.....	1.0918	$46.45	$46.45
54055	Destruction, penis lesion(s)	Y	P3	.....	1.4404	$61.28	$61.28
54056	Cryosurgery, penis lesion(s)	Y	P2	.....	0.8432	$35.87	$35.87
54057	Laser surg, penis lesion(s)	Y	A2	$333.00	17.4423	$742.05	$435.26
54060	Excision of penis lesion(s)	Y	A2	$333.00	17.4423	$742.05	$435.26
54065	Destruction, penis lesion(s)	Y	A2	$333.00	20.4276	$869.05	$467.01
54100	Biopsy of penis	Y	A2	$333.00	15.1024	$642.50	$410.38
54105	Biopsy of penis	Y	A2	$333.00	20.0656	$853.65	$463.16
54110	Treatment of penis lesion	Y	A2	$446.00	32.9873	$1,403.38	$685.35
54111	Treat penis lesion, graft	Y	A2	$446.00	32.9873	$1,403.38	$685.35
54112	Treat penis lesion, graft	Y	A2	$446.00	32.9873	$1,403.38	$685.35
54115	Treatment of penis lesion	Y	A2	$333.00	17.5086	$744.87	$435.97
54120	Partial removal of penis	Y	A2	$446.00	32.9873	$1,403.38	$685.35
54150	Circumcision w/regionl block	Y	A2	$333.00	20.5513	$874.31	$468.33
54160	Circumcision, neonate	Y	A2	$446.00	20.5513	$874.31	$553.08
54161	Circum 28 days or older	Y	A2	$446.00	20.5513	$874.31	$553.08
54162	Lysis penil circumic lesion	Y	A2	$446.00	20.5513	$874.31	$553.08
54163	Repair of circumcision	Y	A2	$446.00	20.5513	$874.31	$553.08
54164	Frenulotomy of penis	Y	A2	$446.00	20.5513	$874.31	$553.08
54200	Treatment of penis lesion	Y	P3	.....	1.5370	$65.39	$65.39
54205	Treatment of penis lesion	Y	A2	$630.00	32.9873	$1,403.38	$823.35
54220	Treatment of penis lesion	Y	A2	$131.50	2.1393	$91.01	$121.38
54230	Prepare penis study	.....	N1	.....	.....	.....	.....
54231	Dynamic cavernosometry	Y	P3	.....	1.3036	$55.46	$55.46
54235	Penile injection	Y	P3	.....	0.9496	$40.40	$40.40
54240	Penis study	Y	P3	.....	0.6518	$27.73	$27.73
54250	Penis study	Y	P3	.....	0.2254	$9.59	$9.59
54300	Revision of penis	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54304	Revision of penis	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54308	Reconstruction of urethra	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54312	Reconstruction of urethra	Y	A2	$510.00	32.9873	$1,403.38	$733.35

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
54316	Reconstruction of urethra	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54318	Reconstruction of urethra	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54322	Reconstruction of urethra	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54324	Reconstruction of urethra	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54326	Reconstruction of urethra	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54328	Revise penis/urethra	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54340	Secondary urethral surgery	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54344	Secondary urethral surgery	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54348	Secondary urethral surgery	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54352	Reconstruct urethra/penis	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54360	Penis plastic surgery	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54380	Repair penis	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54385	Repair penis	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54400	Insert semi-rigid prosthesis	N	A2	$510.00	79.2092	$3,369.80	$1,224.95
54401	Insert self-contd prosthesis	N	H8	$510.00	178.7754	$7,605.64	$6,285.50
54405	Insert multi-comp penis pros	N	H8	$510.00	178.7754	$7,605.64	$6,285.50
54406	Remove muti-comp penis pros	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54408	Repair multi-comp penis pros	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54410	Remove/replace penis prosth	N	H8	$510.00	178.7754	$7,605.64	$6,285.50
54415	Remove self-contd penis pros	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54416	Remv/repl penis contain pros	N	H8	$510.00	178.7754	$7,605.64	$6,285.50
54420	Revision of penis	Y	A2	$630.00	32.9873	$1,403.38	$823.35
54435	Revision of penis	Y	A2	$630.00	32.9873	$1,403.38	$823.35
54440	Repair of penis	Y	A2	$630.00	32.9873	$1,403.38	$823.35
54450	Preputial stretching	Y	A2	$209.48	3.4079	$144.98	$193.36
54500	Biopsy of testis	Y	A2	$333.00	10.2655	$436.73	$358.93
54505	Biopsy of testis	Y	A2	$333.00	23.5310	$1,001.08	$500.02
54512	Excise lesion testis	Y	A2	$446.00	23.5310	$1,001.08	$584.77
54520	Removal of testis	Y	A2	$510.00	23.5310	$1,001.08	$632.77
54522	Orchiectomy, partial	Y	A2	$510.00	23.5310	$1,001.08	$632.77
54530	Removal of testis	Y	A2	$630.00	29.2182	$1,243.03	$783.26
54550	Exploration for testis	Y	A2	$630.00	29.2182	$1,243.03	$783.26
54560	Exploration for testis	Y	G2	.....	23.5310	$1,001.08	$1,001.08
54600	Reduce testis torsion	Y	A2	$630.00	23.5310	$1,001.08	$722.77
54620	Suspension of testis	Y	A2	$510.00	23.5310	$1,001.08	$632.77
54640	Suspension of testis	Y	A2	$630.00	29.2182	$1,243.03	$783.26
54660	Revision of testis	Y	A2	$446.00	23.5310	$1,001.08	$584.77
54670	Repair testis injury	Y	A2	$510.00	23.5310	$1,001.08	$632.77
54680	Relocation of testis(es)	Y	A2	$510.00	23.5310	$1,001.08	$632.77
54690	Laparoscopy, orchiectomy	Y	A2	$1,339.00	43.5488	$1,852.70	$1,467.43
54692	Laparoscopy, orchiopexy	Y	G2	.....	70.5066	$2,999.56	$2,999.56
54700	Drainage of scrotum	Y	A2	$446.00	23.5310	$1,001.08	$584.77
54800	Biopsy of epididymis	Y	A2	$127.16	2.0687	$88.01	$117.37
54830	Remove epididymis lesion	Y	A2	$510.00	23.5310	$1,001.08	$632.77
54840	Remove epididymis lesion	Y	A2	$630.00	23.5310	$1,001.08	$722.77
54860	Removal of epididymis	Y	A2	$510.00	23.5310	$1,001.08	$632.77
54861	Removal of epididymis	Y	A2	$630.00	23.5310	$1,001.08	$722.77
54865	Explore epididymis	Y	A2	$333.00	23.5310	$1,001.08	$500.02
54900	Fusion of spermatic ducts	Y	A2	$630.00	23.5310	$1,001.08	$722.77
54901	Fusion of spermatic ducts	Y	A2	$630.00	23.5310	$1,001.08	$722.77
55000	Drainage of hydrocele	Y	P3	.....	1.5772	$67.10	$67.10
55040	Removal of hydrocele	Y	A2	$510.00	29.2182	$1,243.03	$693.26
55041	Removal of hydroceles	Y	A2	$717.00	29.2182	$1,243.03	$848.51
55060	Repair of hydrocele	Y	A2	$630.00	23.5310	$1,001.08	$722.77
55100	Drainage of scrotum abscess	Y	A2	$333.00	11.1535	$474.50	$368.38
55110	Explore scrotum	Y	A2	$446.00	23.5310	$1,001.08	$584.77
55120	Removal of scrotum lesion	Y	A2	$446.00	23.5310	$1,001.08	$584.77
55150	Removal of scrotum	Y	A2	$333.00	23.5310	$1,001.08	$500.02
55175	Revision of scrotum	Y	A2	$333.00	23.5310	$1,001.08	$500.02
55180	Revision of scrotum	Y	A2	$446.00	23.5310	$1,001.08	$584.77
55200	Incision of sperm duct	Y	A2	$446.00	23.5310	$1,001.08	$584.77
55250	Removal of sperm duct(s)	Y	A2	$446.00	23.5310	$1,001.08	$584.77
55300	Prepare, sperm duct x-ray	.....	N1	.....	.....	.....	.....

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
55400	Repair of sperm duct	Y	A2	$333.00	23.5310	$1,001.08	$500.02
55450	Ligation of sperm duct	Y	P3		5.2227	$222.19	$222.19
55500	Removal of hydrocele	Y	A2	$510.00	23.5310	$1,001.08	$632.77
55520	Removal of sperm cord lesion	Y	A2	$630.00	23.5310	$1,001.08	$722.77
55530	Revise spermatic cord veins	Y	A2	$630.00	23.5310	$1,001.08	$722.77
55535	Revise spermatic cord veins	Y	A2	$630.00	29.2182	$1,243.03	$783.26
55540	Revise hernia & sperm veins	Y	A2	$717.00	29.2182	$1,243.03	$848.51
55550	Laparo ligate spermatic vein	Y	A2	$1,339.00	43.5488	$1,852.70	$1,467.43
55600	Incise sperm duct pouch	Y	R2		23.5310	$1,001.08	$1,001.08
55680	Remove sperm pouch lesion	Y	A2	$333.00	23.5310	$1,001.08	$500.02
55700	Biopsy of prostate	Y	A2	$345.83	5.6262	$239.36	$319.21
55705	Biopsy of prostate	Y	A2	$345.83	5.6262	$239.36	$319.21
55720	Drainage of prostate abscess	Y	A2	$333.00	23.8700	$1,015.50	$503.63
55725	Drainage of prostate abscess	Y	A2	$446.00	23.8700	$1,015.50	$588.38
55860	Surgical exposure, prostate	Y	G2		18.1679	$772.92	$772.92
55870	Electroejaculation	Y	P3		1.6094	$68.47	$68.47
55873	Cryoablate prostate	Y	H8	$1,339.00	137.5639	$5,852.38	$5,252.74
55875	Transperi needle place, pros	Y	A2	$1,339.00	34.9261	$1,485.86	$1,375.72
55876*	Place rt device/marker, pros	Y	P3		1.6416	$69.84	$69.84
56405	I & D of vulva/perineum	Y	P3		1.0058	$42.79	$42.79
56420	Drainage of gland abscess	Y	P2		1.2900	$54.88	$54.88
56440	Surgery for vulva lesion	Y	A2	$446.00	20.5081	$872.48	$552.62
56441	Lysis of labial lesion(s)	Y	A2	$333.00	14.8489	$631.72	$407.68
56442	Hymenotomy	Y	A2	$333.00	14.8489	$631.72	$407.68
56501	Destroy, vulva lesions, sim	Y	P3		1.3680	$58.20	$58.20
56515	Destroy vulva lesion/s compl	Y	A2	$510.00	20.4276	$869.05	$599.76
56605	Biopsy of vulva/perineum	Y	P3		0.7966	$33.89	$33.89
56606	Biopsy of vulva/perineum	Y	P3		0.3460	$14.72	$14.72
56620	Partial removal of vulva	Y	A2	$717.00	28.5095	$1,212.88	$840.97
56625	Complete removal of vulva	Y	A2	$995.00	28.5095	$1,212.88	$1,049.47
56700	Partial removal of hymen	Y	A2	$333.00	20.5081	$872.48	$467.87
56740	Remove vagina gland lesion	Y	A2	$510.00	20.5081	$872.48	$600.62
56800	Repair of vagina	Y	A2	$510.00	20.5081	$872.48	$600.62
56805	Repair clitoris	Y	G2		14.8489	$631.72	$631.72
56810	Repair of perineum	Y	A2	$717.00	20.5081	$872.48	$755.87
56820	Exam of vulva w/scope	Y	P3		1.0058	$42.79	$42.79
56821	Exam/biopsy of vulva w/scope	Y	P3		1.3116	$55.80	$55.80
57000	Exploration of vagina	Y	A2	$333.00	14.8489	$631.72	$407.68
57010	Drainage of pelvic abscess	Y	A2	$446.00	14.8489	$631.72	$492.43
57020	Drainage of pelvic fluid	Y	A2	$409.33	6.6592	$283.30	$377.82
57022	I & d vaginal hematoma, pp	Y	G2		11.1535	$474.50	$474.50
57023	I & d vag hematoma, non-ob	Y	A2	$333.00	17.5086	$744.87	$435.97
57061	Destroy vag lesions, simple	Y	P3		1.2634	$53.75	$53.75
57065	Destroy vag lesions, complex	Y	A2	$333.00	20.5081	$872.48	$467.87
57100	Biopsy of vagina	Y	P3		0.8048	$34.24	$34.24
57105	Biopsy of vagina	Y	A2	$446.00	20.5081	$872.48	$552.62
57130	Remove vagina lesion	Y	A2	$446.00	20.5081	$872.48	$552.62
57135	Remove vagina lesion	Y	A2	$446.00	20.5081	$872.48	$552.62
57150	Treat vagina infection	Y	P2		0.1468	$6.25	$6.25
57155	Insert uteri tandems/ovoids	Y	A2	$409.33	6.6592	$283.30	$377.82
57160	Insert pessary/other device	Y	P3		0.8208	$34.92	$34.92
57170	Fitting of diaphragm/cap	Y	P2		0.1468	$6.25	$6.25
57180	Treat vaginal bleeding	Y	A2	$178.05	2.8966	$123.23	$164.35
57200	Repair of vagina	Y	A2	$333.00	20.5081	$872.48	$467.87
57210	Repair vagina/perineum	Y	A2	$446.00	20.5081	$872.48	$552.62
57220	Revision of urethra	Y	A2	$510.00	42.9896	$1,828.91	$839.73
57230	Repair of urethral lesion	Y	A2	$510.00	28.5095	$1,212.88	$685.72
57240	Repair bladder & vagina	Y	A2	$717.00	28.5095	$1,212.88	$840.97
57250	Repair rectum & vagina	Y	A2	$717.00	28.5095	$1,212.88	$840.97
57260	Repair of vagina	Y	A2	$717.00	28.5095	$1,212.88	$840.97
57265	Extensive repair of vagina	Y	A2	$995.00	42.9896	$1,828.91	$1,203.48
57267	Insert mesh/pelvic flr addon	Y	A2	$995.00	28.5095	$1,212.88	$1,049.47
57268	Repair of bowel bulge	Y	A2	$510.00	28.5095	$1,212.88	$685.72

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
57287	Revise/remove sling repair	Y	G2		28.5095	$1,212.88	$1,212.88
57288	Repair bladder defect	Y	A2	$717.00	42.9896	$1,828.91	$994.98
57289	Repair bladder & vagina	Y	A2	$717.00	28.5095	$1,212.88	$840.97
57291	Construction of vagina	Y	A2	$717.00	28.5095	$1,212.88	$840.97
57300	Repair rectum-vagina fistula	Y	A2	$510.00	28.5095	$1,212.88	$685.72
57320	Repair bladder-vagina lesion	Y	G2		28.5095	$1,212.88	$1,212.88
57400	Dilation of vagina	Y	A2	$446.00	20.5081	$872.48	$552.62
57410	Pelvic examination	Y	A2	$446.00	14.8489	$631.72	$492.43
57415	Remove vaginal foreign body	Y	A2	$446.00	20.5081	$872.48	$552.62
57420	Exam of vagina w/scope	Y	P3		1.0380	$44.16	$44.16
57421	Exam/biopsy of vag w/scope	Y	P3		1.3842	$58.89	$58.89
57452	Exam of cervix w/scope	Y	P3		0.9818	$41.77	$41.77
57454	Bx/curett of cervix w/scope	Y	P3		1.2232	$52.04	$52.04
57455	Biopsy of cervix w/scope	Y	P3		1.2876	$54.78	$54.78
57456	Endocerv curettage w/scope	Y	P3		1.2474	$53.07	$53.07
57460	Bx of cervix w/scope, leep	Y	P3		4.0639	$172.89	$172.89
57461	Conz of cervix w/scope, leep	Y	P3		4.2811	$182.13	$182.13
57500	Biopsy of cervix	Y	P3		1.8186	$77.37	$77.37
57505	Endocervical curettage	Y	P3		1.1104	$47.24	$47.24
57510	Cauterization of cervix	Y	P3		1.1508	$48.96	$48.96
57511	Cryocautery of cervix	Y	P2		1.2900	$54.88	$54.88
57513	Laser surgery of cervix	Y	A2	$446.00	14.8489	$631.72	$492.43
57520	Conization of cervix	Y	A2	$446.00	20.5081	$872.48	$552.62
57522	Conization of cervix	Y	A2	$446.00	28.5095	$1,212.88	$637.72
57530	Removal of cervix	Y	A2	$510.00	28.5095	$1,212.88	$685.72
57550	Removal of residual cervix	Y	A2	$510.00	28.5095	$1,212.88	$685.72
57556	Remove cervix, repair bowel	Y	A2	$717.00	42.9896	$1,828.91	$994.98
57558	D&c of cervical stump	Y	A2	$510.00	17.7499	$755.13	$571.28
57700	Revision of cervix	Y	A2	$333.00	20.5081	$872.48	$467.87
57720	Revision of cervix	Y	A2	$510.00	20.5081	$872.48	$600.62
57800	Dilation of cervical canal	Y	P3		0.5874	$24.99	$24.99
58100	Biopsy of uterus lining	Y	P3		0.9818	$41.77	$41.77
58110*	Bx done w/colposcopy add-on	Y	P3		0.3782	$16.09	$16.09
58120	Dilation and curettage	Y	A2	$446.00	17.7499	$755.13	$523.28
58145	Myomectomy vag method	Y	A2	$717.00	28.5095	$1,212.88	$840.97
58301	Remove intrauterine device	Y	P3		0.9496	$40.40	$40.40
58321	Artificial insemination	Y	P3		0.8450	$35.95	$35.95
58322	Artificial insemination	Y	P3		0.9012	$38.34	$38.34
58323	Sperm washing	Y	P3		0.2736	$11.64	$11.64
58340	Catheter for hysterography		N1				
58345	Reopen fallopian tube	Y	R2		14.8489	$631.72	$631.72
58346	Insert heyman uteri capsule	Y	A2	$446.00	14.8489	$631.72	$492.43
58350	Reopen fallopian tube	Y	A2	$510.00	28.5095	$1,212.88	$685.72
58353	Endometr ablate, thermal	Y	A2	$995.00	28.5095	$1,212.88	$1,049.47
58356	Endometrial cryoablation	Y	P3		41.9827	$1,786.07	$1,786.07
58545	Laparoscopic myomectomy	Y	A2	$1,339.00	32.1241	$1,366.66	$1,345.92
58546	Laparo-myomectomy, complex	Y	A2	$1,339.00	43.5488	$1,852.70	$1,467.43
58550	Laparo-asst vag hysterectomy	Y	A2	$1,339.00	70.5066	$2,999.56	$1,754.14
58552	Laparo-vag hyst incl t/o	Y	G2		43.5488	$1,852.70	$1,852.70
58555	Hysteroscopy, dx, sep proc	Y	A2	$333.00	21.3586	$908.66	$476.92
58558	Hysteroscopy, biopsy	Y	A2	$510.00	21.3586	$908.66	$609.67
58559	Hysteroscopy, lysis	Y	A2	$446.00	21.3586	$908.66	$561.67
58560	Hysteroscopy, resect septum	Y	A2	$510.00	34.0155	$1,447.12	$744.28
58561	Hysteroscopy, remove myoma	Y	A2	$510.00	34.0155	$1,447.12	$744.28
58562	Hysteroscopy, remove fb	Y	A2	$510.00	21.3586	$908.66	$609.67
58563	Hysteroscopy, ablation	Y	A2	$1,339.00	34.0155	$1,447.12	$1,366.03
58565	Hysteroscopy, sterilization	Y	A2	$1,339.00	42.9896	$1,828.91	$1,461.48
58600	Division of fallopian tube	Y	G2		28.5095	$1,212.88	$1,212.88
58615	Occlude fallopian tube(s)	Y	G2		20.5081	$872.48	$872.48
58660	Laparoscopy, lysis	Y	A2	$717.00	43.5488	$1,852.70	$1,000.93
58661	Laparoscopy, remove adnexa	Y	A2	$717.00	43.5488	$1,852.70	$1,000.93
58662	Laparoscopy, excise lesions	Y	A2	$717.00	43.5488	$1,852.70	$1,000.93
58670	Laparoscopy, tubal cautery	Y	A2	$510.00	43.5488	$1,852.70	$845.68

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
58671	Laparoscopy, tubal block	Y	A2	$510.00	43.5488	$1,852.70	$845.68
58672	Laparoscopy, fimbrioplasty	Y	A2	$717.00	43.5488	$1,852.70	$1,000.93
58673	Laparoscopy, salpingostomy	Y	A2	$717.00	43.5488	$1,852.70	$1,000.93
58800	Drainage of ovarian cyst(s)	Y	A2	$510.00	14.8489	$631.72	$540.43
58820	Drain ovary abscess, open	Y	A2	$510.00	28.5095	$1,212.88	$685.72
58900	Biopsy of ovary(s)	Y	A2	$510.00	14.8489	$631.72	$540.43
58970	Retrieval of oocyte	Y	A2	$245.92	4.0007	$170.20	$226.99
58974	Transfer of embryo	Y	A2	$245.92	4.0007	$170.20	$226.99
58976	Transfer of embryo	Y	A2	$245.92	4.0007	$170.20	$226.99
59000	Amniocentesis, diagnostic	Y	P2	.....	1.4222	$60.50	$60.50
59001	Amniocentesis, therapeutic	Y	R2	.....	6.6592	$283.30	$283.30
59012	Fetal cord puncture, prenatal	Y	G2	.....	1.4222	$60.50	$60.50
59015	Chorion biopsy	Y	P3	.....	1.1910	$50.67	$50.67
59020	Fetal contract stress test	Y	P3	.....	0.5632	$23.96	$23.96
59025	Fetal non-stress test	Y	P3	.....	0.2816	$11.98	$11.98
59070	Transabdom amnioinfus w/us	Y	G2	.....	1.4222	$60.50	$60.50
59072	Umbilical cord occlud w/us	Y	G2	.....	1.4222	$60.50	$60.50
59076	Fetal shunt placement, w/us	Y	G2	.....	1.4222	$60.50	$60.50
59100	Remove uterus lesion	Y	R2	.....	28.5095	$1,212.88	$1,212.88
59150	Treat ectopic pregnancy	Y	G2	.....	43.5488	$1,852.70	$1,852.70
59151	Treat ectopic pregnancy	Y	G2	.....	43.5488	$1,852.70	$1,852.70
59160	D& c after delivery	Y	A2	$510.00	17.7499	$755.13	$571.28
59200	Insert cervical dilator	Y	P3	.....	0.8530	$36.29	$36.29
59300	Episiotomy or vaginal repair	Y	P3	.....	1.7542	$74.63	$74.63
59320	Revision of cervix	Y	A2	$333.00	20.5081	$872.48	$467.87
59412	Antepartum manipulation	Y	G2	.....	2.3864	$101.52	$101.52
59414	Deliver placenta	Y	G2	.....	14.8489	$631.72	$631.72
59812	Treatment of miscarriage	Y	A2	$717.00	18.5201	$787.90	$734.73
59820	Care of miscarriage	Y	A2	$717.00	18.5201	$787.90	$734.73
59821	Treatment of miscarriage	Y	A2	$717.00	18.5201	$787.90	$734.73
59840	Abortion	Y	A2	$717.00	16.9328	$720.37	$717.84
59841	Abortion	Y	A2	$717.00	16.9328	$720.37	$717.84
59866	Abortion (mpr)	Y	G2	.....	1.4222	$60.50	$60.50
59870	Evacuate mole of uterus	Y	A2	$717.00	18.5201	$787.90	$734.73
59871	Remove cerclage suture	Y	A2	$717.00	20.5081	$872.48	$755.87
60000	Drain thyroid/tongue cyst	Y	A2	$333.00	7.5511	$321.25	$330.06
60001	Aspirate/inject thyriod cyst	Y	P3	.....	1.3116	$55.80	$55.80
60100	Biopsy of thyroid	Y	P3	.....	1.0462	$44.51	$44.51
60200	Remove thyroid lesion	Y	A2	$446.00	37.7224	$1,604.82	$735.71
60280	Remove thyroid duct lesion	Y	A2	$630.00	37.7224	$1,604.82	$873.71
60281	Remove thyroid duct lesion	Y	A2	$630.00	37.7224	$1,604.82	$873.71
61000	Remove cranial cavity fluid	Y	R2	.....	2.9907	$127.23	$127.23
61001	Remove cranial cavity fluid	Y	R2	.....	2.9907	$127.23	$127.23
61020	Remove brain cavity fluid	Y	A2	$183.83	2.9907	$127.23	$169.68
61026	Injection into brain canal	Y	A2	$183.83	2.9907	$127.23	$169.68
61050	Remove brain canal fluid	Y	A2	$183.83	2.9907	$127.23	$169.68
61055	Injection into brain canal	Y	A2	$183.83	2.9907	$127.23	$169.68
61070	Brain canal shunt procedure	Y	A2	$183.83	2.9907	$127.23	$169.68
61215	Insert brain-fluid device	Y	A2	$510.00	47.0342	$2,000.98	$882.75
61330	Decompress eye socket	Y	G2	.....	38.1991	$1,625.10	$1,625.10
61334	Explore orbit/remove object	Y	G2	.....	38.1991	$1,625.10	$1,625.10
61790	Treat trigeminal nerve	Y	A2	$510.00	17.8499	$759.39	$572.35
61791	Treat trigeminal tract	Y	A2	$351.92	5.7253	$243.57	$324.83
61795	Brain surgery using computer	N	A2	$302.04	4.9138	$209.05	$278.79
61880	Revise/remove neuroelectrode	Y	G2	.....	17.8334	$758.69	$758.69
61885	Insrt/redo neurostim 1 array	N	H8	$446.00	260.1530	$11,067.69	$10,137.66
61886	Implant neurostim arrays	Y	H8	$510.00	342.4747	$14,569.90	$13,649.39
61888	Revise/remove neuroreceiver	Y	A2	$333.00	35.5702	$1,513.26	$628.07
62194	Replace/irrigate catheter	Y	A2	$333.00	11.6575	$495.95	$373.74
62225	Replace/irrigate catheter	Y	A2	$333.00	11.6575	$495.95	$373.74
62230	Replace/revise brain shunt	Y	A2	$446.00	47.0342	$2,000.98	$834.75
62252	Csf shunt reprogram	N	P3	.....	1.0462	$44.51	$44.51
62263	Epidural lysis mult sessions	Y	A2	$333.00	12.1702	$517.76	$379.19

Note: The Medicare program payment is 80 percent of the total payment amount and beneficiary coinsurance is 20 percent of the total payment amount, except for screening flexible sigmoidoscopies and screening colonoscopies for which the program payment is 75 percent and the beneficiary coinsurance is 25 percent.

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
62264	Epidural lysis on single day	Y	A2	$333.00	12.1702	$517.76	$379.19
62268	Drain spinal cord cyst	Y	A2	$183.83	2.9907	$127.23	$169.68
62269	Needle biopsy, spinal cord	Y	A2	$333.00	6.1384	$261.15	$315.04
62270	Spinal fluid tap, diagnostic	Y	A2	$139.00	2.2614	$96.21	$128.30
62272	Drain cerebro spinal fluid	Y	A2	$139.00	2.2614	$96.21	$128.30
62273	Inject epidural patch	Y	A2	$333.00	5.7253	$243.57	$310.64
62280	Treat spinal cord lesion	Y	A2	$333.00	6.3603	$270.59	$317.40
62281	Treat spinal cord lesion	Y	A2	$333.00	6.3603	$270.59	$317.40
62282	Treat spinal canal lesion	Y	A2	$333.00	6.3603	$270.59	$317.40
62284	Injection for myelogram		N1				
62287	Percutaneous diskectomy	Y	A2	$1,339.00	33.1520	$1,410.39	$1,356.85
62290	Inject for spine disk x-ray		N1				
62291	Inject for spine disk x-ray		N1				
62292	Injection into disk lesion	Y	G2		2.9907	$127.23	$127.23
62294	Injection into spinal artery	Y	A2	$183.83	2.9907	$127.23	$169.68
62310	Inject spine c/t	Y	A2	$333.00	6.3603	$270.59	$317.40
62311	Inject spine l/s (cd)	Y	A2	$333.00	6.3603	$270.59	$317.40
62318	Inject spine w/cath, c/t	Y	A2	$333.00	6.3603	$270.59	$317.40
62319	Inject spine w/cath l/s (cd)	Y	A2	$333.00	6.3603	$270.59	$317.40
62350	Implant spinal canal cath	Y	A2	$446.00	30.8394	$1,312.00	$662.50
62355	Remove spinal canal catheter	Y	A2	$446.00	12.1702	$517.76	$463.94
62360	Insert spine infusion device	Y	A2	$446.00	112.6322	$4,791.71	$1,532.43
62361	Implant spine infusion pump	Y	H8	$446.00	243.3568	$10,353.13	$9,589.69
62362	Implant spine infusion pump	Y	H8	$446.00	243.3568	$10,353.13	$9,589.69
62365	Remove spine infusion device	Y	A2	$446.00	33.1520	$1,410.39	$687.10
62367	Analyze spine infusion pump	N	P3		0.4104	$17.46	$17.46
62368	Analyze spine infusion pump	N	P3		0.5150	$21.91	$21.91
63600	Remove spinal cord lesion	Y	A2	$446.00	17.8499	$759.39	$524.35
63610	Stimulation of spinal cord	Y	A2	$333.00	17.8499	$759.39	$439.60
63615	Remove lesion of spinal cord	Y	R2		17.8499	$759.39	$759.39
63650	Implant neuroelectrodes	N	H8	$446.00	71.6329	$3,047.48	$2,552.76
63655	Implant neuroelectrodes	N	J8		109.1028	$4,641.56	$4,641.56
63660	Revise/remove neuroelectrode	Y	A2	$333.00	17.8334	$758.69	$439.42
63685	Insrt/redo spine n generator	Y	H8	$446.00	251.0862	$10,681.96	$9,721.25
63688	Revise/remove neuroreceiver	Y	A2	$333.00	35.5702	$1,513.26	$628.07
63744	Revision of spinal shunt	Y	A2	$510.00	39.2633	$1,670.38	$800.10
63746	Removal of spinal shunt	Y	A2	$446.00	10.9918	$467.62	$451.41
64400	Nblock inj, trigeminal	Y	P3		1.3198	$56.15	$56.15
64402	Nblock inj, facial	Y	P3		1.2312	$52.38	$52.38
64405	Nblock inj, occipital	Y	P3		1.0542	$44.85	$44.85
64408	Nblock inj, vagus	Y	P3		1.2232	$52.04	$52.04
64410	Nblock inj, phrenic	Y	A2	$333.00	5.7253	$243.57	$310.64
64412	Nblock inj, spinal accessor	Y	P3		1.8830	$80.11	$80.11
64413	Nblock inj, cervical plexus	Y	P3		1.2554	$53.41	$53.41
64415	Nblock inj, brachial plexus	Y	A2	$139.00	2.2614	$96.21	$128.30
64416	Nblock cont infuse, b plex	Y	G2		2.2614	$96.21	$96.21
64417	Nblock inj, axillary	Y	A2	$139.00	2.2614	$96.21	$128.30
64418	Nblock inj, suprascapular	Y	P3		1.8026	$76.69	$76.69
64420	Nblock inj, intercost, sng	Y	A2	$139.00	2.2614	$96.21	$128.30
64421	Nblock inj, intercost, mlt	Y	A2	$333.00	5.7253	$243.57	$310.64
64425	Nblock inj, ilio-ing/hypogi	Y	P3		1.1990	$51.01	$51.01
64430	Nblock inj, pudendal	Y	A2	$139.00	2.2614	$96.21	$128.30
64435	Nblock inj, paracervical	Y	P3		1.8026	$76.69	$76.69
64445	Nblock inj, sciatic, sng	Y	P3		1.7382	$73.95	$73.95
64446	Nblk inj, sciatic, cont inf	Y	G2		5.7253	$243.57	$243.57
64447	Nblock inj fem, single	Y	G2		2.2614	$96.21	$96.21
64450	Nblock, other peripheral	Y	P3		1.0140	$43.14	$43.14
64470	Inj paravertebral c/t	Y	A2	$333.00	6.3603	$270.59	$317.40
64472	Inj paravertebral c/t add-on	Y	A2	$333.00	5.7253	$243.57	$310.64
64475	Inj paravertebral l/s	Y	A2	$333.00	6.3603	$270.59	$317.40
64476	Inj paravertebral l/s add-on	Y	A2	$333.00	5.7253	$243.57	$310.64
64479	Inj foramen epidural c/t	Y	A2	$333.00	6.3603	$270.59	$317.40
64480	Inj foramen epidural add-on	Y	A2	$333.00	6.3603	$270.59	$317.40

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
64483	Inj foramen epidural l/s	Y	A2	$333.00	6.3603	$270.59	$317.40
64484	Inj foramen epidural add-on	Y	A2	$333.00	6.3603	$270.59	$317.40
64505	Nblock, spenopalatine gangl	Y	P3		0.9416	$40.06	$40.06
64508	Nblock, carotid sinus s/p	Y	P3		2.0922	$89.01	$89.01
64510	Nblock, stellate ganglion	Y	A2	$333.00	6.3603	$270.59	$317.40
64517	Nblock inj, hypogas plxs	Y	A2	$139.00	2.2614	$96.21	$128.30
64520	Nblock, lumbar/thoracic	Y	A2	$333.00	6.3603	$270.59	$317.40
64530	Nblock inj, celiac pelus	Y	A2	$333.00	6.3603	$270.59	$317.40
64553	Implant neuroelectrodes	N	H8	$333.00	307.2433	$13,071.05	$11,841.79
64555	Implant neuroelectrodes	N	J8		71.6329	$3,047.48	$3,047.48
64560	Implant neuroelectrodes	N	J8		71.6329	$3,047.48	$3,047.48
64561	Implant neuroelectrodes	N	H8	$510.00	71.6329	$3,047.48	$2,600.76
64565	Implant neuroelectrodes	N	J8		71.6329	$3,047.48	$3,047.48
64573	Implant neuroelectrodes	N	H8	$333.00	307.2433	$13,071.05	$11,841.79
64575	Implant neuroelectrodes	N	H8	$333.00	109.1028	$4,641.56	$3,818.33
64577	Implant neuroelectrodes	N	H8	$333.00	109.1028	$4,641.56	$3,818.33
64580	Implant neuroelectrodes	N	H8	$333.00	109.1028	$4,641.56	$3,818.33
64581	Implant neuroelectrodes	N	H8	$510.00	109.1028	$4,641.56	$3,951.08
64585	Revise/remove neuroelectrode	Y	A2	$333.00	17.8334	$758.69	$439.42
64590	Insrt/redo pn/gastr stimul	Y	H8	$446.00	251.0862	$10,681.96	$9,721.25
64595	Revise/rmv pn/gastr stimul	Y	A2	$333.00	35.5702	$1,513.26	$628.07
64600	Injection treatment of nerve	Y	A2	$333.00	12.1702	$517.76	$379.19
64605	Injection treatment of nerve	Y	A2	$333.00	12.1702	$517.76	$379.19
64610	Injection treatment of nerve	Y	A2	$333.00	12.1702	$517.76	$379.19
64612	Destroy nerve, face muscle	Y	P3		1.6579	$70.53	$70.53
64613	Destroy nerve, neck muscle	Y	P3		1.7302	$73.61	$73.61
64614	Destroy nerve, extrem musc	Y	P3		1.9474	$82.85	$82.85
64620	Injection treatment of nerve	Y	A2	$333.00	12.1702	$517.76	$379.19
64622	Destr paravertebrl nerve l/s	Y	A2	$333.00	12.1702	$517.76	$379.19
64623	Destr paravertebral n add-on	Y	A2	$333.00	6.3603	$270.59	$317.40
64626	Destr paravertebrl nerve c/t	Y	A2	$333.00	12.1702	$517.76	$379.19
64627	Destr paravertebral n add-on	Y	A2	$333.00	6.3603	$270.59	$317.40
64630	Injection treatment of nerve	Y	A2	$351.92	5.7253	$243.57	$324.83
64640	Injection treatment of nerve	Y	P3		2.6716	$113.66	$113.66
64650	Chemodenerv eccrine glands	Y	G2		2.2614	$96.21	$96.21
64653	Chemodenerv eccrine glands	Y	G2		2.2614	$96.21	$96.21
64680	Injection treatment of nerve	Y	A2	$390.95	6.3603	$270.59	$360.86
64681	Injection treatment of nerve	Y	A2	$446.00	12.1702	$517.76	$463.94
64702	Revise finger/toe nerve	Y	A2	$333.00	17.8499	$759.39	$439.60
64704	Revise hand/foot nerve	Y	A2	$333.00	17.8499	$759.39	$439.60
64708	Revise arm/leg nerve	Y	A2	$446.00	17.8499	$759.39	$524.35
64712	Revision of sciatic nerve	Y	A2	$446.00	17.8499	$759.39	$524.35
64713	Revision of arm nerve(s)	Y	A2	$446.00	17.8499	$759.39	$524.35
64714	Revise low back nerve(s)	Y	A2	$446.00	17.8499	$759.39	$524.35
64716	Revision of cranial nerve	Y	A2	$510.00	17.8499	$759.39	$572.35
64718	Revise ulnar nerve at elbow	Y	A2	$446.00	17.8499	$759.39	$524.35
64719	Revise ulnar nerve at wrist	Y	A2	$446.00	17.8499	$759.39	$524.35
64721	Carpal tunnel surgery	Y	A2	$446.00	17.8499	$759.39	$524.35
64722	Relieve pressure on nerve(s)	Y	A2	$333.00	17.8499	$759.39	$439.60
64726	Release foot/toe nerve	Y	A2	$333.00	17.8499	$759.39	$439.60
64727	Internal nerve revision	Y	A2	$333.00	17.8499	$759.39	$439.60
64732	Incision of brow nerve	Y	A2	$446.00	17.8499	$759.39	$524.35
64734	Incision of cheek nerve	Y	A2	$446.00	17.8499	$759.39	$524.35
64736	Incision of chin nerve	Y	A2	$446.00	17.8499	$759.39	$524.35
64738	Incision of jaw nerve	Y	A2	$446.00	17.8499	$759.39	$524.35
64740	Incision of tongue nerve	Y	A2	$446.00	17.8499	$759.39	$524.35
64742	Incision of facial nerve	Y	A2	$446.00	17.8499	$759.39	$524.35
64744	Incise nerve, back of head	Y	A2	$446.00	17.8499	$759.39	$524.35
64746	Incise diaphragm nerve	Y	A2	$446.00	17.8499	$759.39	$524.35
64761	Incision of pelvis nerve	Y	G2		17.8499	$759.39	$759.39
64763	Incise hip/thigh nerve	Y	G2		17.8499	$759.39	$759.39
64766	Incise hip/thigh nerve	Y	G2		33.1520	$1,410.39	$1,410.39
64771	Sever cranial nerve	Y	A2	$446.00	17.8499	$759.39	$524.35

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
64772	Incision of spinal nerve	Y	A2	$446.00	17.8499	$759.39	$524.35
64774	Remove skin nerve lesion	Y	A2	$446.00	17.8499	$759.39	$524.35
64776	Remove digit nerve lesion	Y	A2	$510.00	17.8499	$759.39	$572.35
64778	Digit nerve surgery add-on	Y	A2	$446.00	17.8499	$759.39	$524.35
64782	Remove limb nerve lesion	Y	A2	$510.00	17.8499	$759.39	$572.35
64783	Limb nerve surgery add-on	Y	A2	$446.00	17.8499	$759.39	$524.35
64784	Remove nerve lesion	Y	A2	$510.00	17.8499	$759.39	$572.35
64786	Remove sciatic nerve lesion	Y	A2	$510.00	33.1520	$1,410.39	$735.10
64787	Implant nerve end	Y	A2	$446.00	17.8499	$759.39	$524.35
64788	Remove skin nerve lesion	Y	A2	$510.00	17.8499	$759.39	$572.35
64790	Removal of nerve lesion	Y	A2	$510.00	17.8499	$759.39	$572.35
64792	Removal of nerve lesion	Y	A2	$510.00	33.1520	$1,410.39	$735.10
64795	Biopsy of nerve	Y	A2	$446.00	17.8499	$759.39	$524.35
64802	Remove sympathetic nerves	Y	A2	$446.00	17.8499	$759.39	$524.35
64820	Remove sympathetic nerves	Y	G2	.....	17.8499	$759.39	$759.39
64821	Remove sympathetic nerves	Y	A2	$630.00	25.8758	$1,100.83	$747.71
64822	Remove sympathetic nerves	Y	G2	.....	25.8758	$1,100.83	$1,100.83
64823	Remove sympathetic nerves	Y	G2	.....	25.8758	$1,100.83	$1,100.83
64831	Repair of digit nerve	Y	A2	$630.00	33.1520	$1,410.39	$825.10
64832	Repair nerve add-on	Y	A2	$333.00	33.1520	$1,410.39	$602.35
64834	Repair of hand or foot nerve	Y	A2	$446.00	33.1520	$1,410.39	$687.10
64835	Repair of hand or foot nerve	Y	A2	$510.00	33.1520	$1,410.39	$735.10
64836	Repair of hand or foot nerve	Y	A2	$510.00	33.1520	$1,410.39	$735.10
64837	Repair nerve add-on	Y	A2	$333.00	33.1520	$1,410.39	$602.35
64840	Repair of leg nerve	Y	A2	$446.00	33.1520	$1,410.39	$687.10
64856	Repair/transpose nerve	Y	A2	$446.00	33.1520	$1,410.39	$687.10
64857	Repair arm/leg nerve	Y	A2	$446.00	33.1520	$1,410.39	$687.10
64858	Repair sciatic nerve	Y	A2	$446.00	33.1520	$1,410.39	$687.10
64859	Nerve surgery	Y	A2	$333.00	33.1520	$1,410.39	$602.35
64861	Repair of arm nerves	Y	A2	$510.00	33.1520	$1,410.39	$735.10
64862	Repair of low back nerves	Y	A2	$510.00	33.1520	$1,410.39	$735.10
64864	Repair of facial nerve	Y	A2	$510.00	33.1520	$1,410.39	$735.10
64865	Repair of facial nerve	Y	A2	$630.00	33.1520	$1,410.39	$825.10
64870	Fusion of facial/other nerve	Y	A2	$630.00	33.1520	$1,410.39	$825.10
64872	Subsequent repair of nerve	Y	A2	$446.00	33.1520	$1,410.39	$687.10
64874	Repair & revise nerve add-on	Y	A2	$510.00	33.1520	$1,410.39	$735.10
64876	Repair nerve/shorten bone	Y	A2	$510.00	33.1520	$1,410.39	$735.10
64885	Nerve graft, head or neck	Y	A2	$446.00	33.1520	$1,410.39	$687.10
64886	Nerve graft, head or neck	Y	A2	$446.00	33.1520	$1,410.39	$687.10
64890	Nerve graft, hand or foot	Y	A2	$446.00	33.1520	$1,410.39	$687.10
64891	Nerve graft, hand or foot	Y	A2	$446.00	33.1520	$1,410.39	$687.10
64892	Nerve graft, arm or leg	Y	A2	$446.00	33.1520	$1,410.39	$687.10
64893	Nerve graft, arm or leg	Y	A2	$446.00	33.1520	$1,410.39	$687.10
64895	Nerve graft, hand or foot	Y	A2	$510.00	33.1520	$1,410.39	$735.10
64896	Nerve graft, hand or foot	Y	A2	$510.00	33.1520	$1,410.39	$735.10
64897	Nerve graft, arm or leg	Y	A2	$510.00	33.1520	$1,410.39	$735.10
64898	Nerve graft, arm or leg	Y	A2	$510.00	33.1520	$1,410.39	$735.10
64901	Nerve graft add-on	Y	A2	$446.00	33.1520	$1,410.39	$687.10
64902	Nerve graft add-on	Y	A2	$446.00	33.1520	$1,410.39	$687.10
64905	Nerve pedicle transfer	Y	A2	$446.00	33.1520	$1,410.39	$687.10
64907	Nerve pedicle transfer	Y	A2	$333.00	33.1520	$1,410.39	$602.35
65091	Revise eye	Y	A2	$510.00	35.2292	$1,498.76	$757.19
65093	Revise eye with implant	Y	A2	$510.00	35.2292	$1,498.76	$757.19
65101	Removal of eye	Y	A2	$510.00	35.2292	$1,498.76	$757.19
65103	Remove eye/insert implant	Y	A2	$510.00	35.2292	$1,498.76	$757.19
65105	Remove eye/attach implant	Y	A2	$630.00	35.2292	$1,498.76	$847.19
65110	Removal of eye	Y	A2	$717.00	35.2292	$1,498.76	$912.44
65112	Remove eye/revise socket	Y	A2	$995.00	35.2292	$1,498.76	$1,120.94
65114	Remove eye/revise socket	Y	A2	$995.00	35.2292	$1,498.76	$1,120.94
65125	Revise ocular implant	Y	G2	.....	17.1243	$728.52	$728.52
65130	Insert ocular implant	Y	A2	$510.00	25.2550	$1,074.42	$651.11
65135	Insert ocular implant	Y	A2	$446.00	25.2550	$1,074.42	$603.11
65140	Attach ocular implant	Y	A2	$510.00	35.2292	$1,498.76	$757.19

Note: The Medicare program payment is 80 percent of the total payment amount and beneficiary coinsurance is 20 percent of the total payment amount, except for screening flexible sigmoidoscopies and screening colonoscopies for which the program payment is 75 percent and the beneficiary coinsurance is 25 percent.

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
65150	Revise ocular implant	Y	A2	$446.00	25.2550	$1,074.42	$603.11
65155	Reinsert ocular implant	Y	A2	$510.00	35.2292	$1,498.76	$757.19
65175	Removal of ocular implant	Y	A2	$333.00	17.1243	$728.52	$431.88
65205	Remove foreign body from eye	N	P3	.....	0.4990	$21.23	$21.23
65210	Remove foreign body from eye	N	P3	.....	0.6196	$26.36	$26.36
65220	Remove foreign body from eye	N	G2	.....	1.1607	$49.38	$49.38
65222	Remove foreign body from eye	N	P3	.....	0.6840	$29.10	$29.10
65235	Remove foreign body from eye	Y	A2	$446.00	15.2259	$647.76	$496.44
65260	Remove foreign body from eye	Y	A2	$510.00	16.5239	$702.98	$558.25
65265	Remove foreign body from eye	Y	A2	$630.00	27.6020	$1,174.27	$766.07
65270	Repair of eye wound	Y	A2	$446.00	17.1243	$728.52	$516.63
65272	Repair of eye wound	Y	A2	$446.00	22.9970	$978.36	$579.09
65275	Repair of eye wound	Y	A2	$630.00	22.9970	$978.36	$717.09
65280	Repair of eye wound	Y	A2	$630.00	16.5239	$702.98	$648.25
65285	Repair of eye wound	Y	A2	$630.00	37.4290	$1,592.34	$870.59
65286	Repair of eye wound	Y	P2	.....	6.0673	$258.12	$258.12
65290	Repair of eye socket wound	Y	A2	$510.00	21.2801	$905.32	$608.83
65400	Removal of eye lesion	Y	A2	$333.00	15.2259	$647.76	$411.69
65410	Biopsy of cornea	Y	A2	$446.00	15.2259	$647.76	$496.44
65420	Removal of eye lesion	Y	A2	$446.00	15.2259	$647.76	$496.44
65426	Removal of eye lesion	Y	A2	$717.00	22.9970	$978.36	$782.34
65430	Corneal smear	N	P3	.....	0.9736	$41.42	$41.42
65435	Curette/treat cornea	Y	P3	.....	0.7564	$32.18	$32.18
65436	Curette/treat cornea	Y	G2	.....	15.2259	$647.76	$647.76
65450	Treatment of corneal lesion	N	G2	.....	2.1451	$91.26	$91.26
65600	Revision of cornea	Y	P3	.....	3.8707	$164.67	$164.67
65710	Corneal transplant	Y	A2	$995.00	38.2707	$1,628.15	$1,153.29
65730	Corneal transplant	Y	A2	$995.00	38.2707	$1,628.15	$1,153.29
65750	Corneal transplant	Y	A2	$995.00	38.2707	$1,628.15	$1,153.29
65755	Corneal transplant	Y	A2	$995.00	38.2707	$1,628.15	$1,153.29
65770	Revise cornea with implant	Y	A2	$995.00	51.9894	$2,211.78	$1,299.20
65772	Correction of astigmatism	Y	A2	$630.00	15.2259	$647.76	$634.44
65775	Correction of astigmatism	Y	A2	$630.00	15.2259	$647.76	$634.44
65780	Ocular reconst, transplant	Y	A2	$717.00	38.2707	$1,628.15	$944.79
65781	Ocular reconst, transplant	Y	A2	$717.00	38.2707	$1,628.15	$944.79
65782	Ocular reconst, transplant	Y	A2	$717.00	38.2707	$1,628.15	$944.79
65800	Drainage of eye	Y	A2	$333.00	15.2259	$647.76	$411.69
65805	Drainage of eye	Y	A2	$333.00	15.2259	$647.76	$411.69
65810	Drainage of eye	Y	A2	$510.00	22.9970	$978.36	$627.09
65815	Drainage of eye	Y	A2	$446.00	22.9970	$978.36	$579.09
65820	Relieve inner eye pressure	Y	A2	$333.00	6.0673	$258.12	$314.28
65850	Incision of eye	Y	A2	$630.00	22.9970	$978.36	$717.09
65855	Laser surgery of eye	Y	P3	.....	3.1947	$135.91	$135.91
65860	Incise inner eye adhesions	Y	P3	.....	2.9855	$127.01	$127.01
65865	Incise inner eye adhesions	Y	A2	$333.00	15.2259	$647.76	$411.69
65870	Incise inner eye adhesions	Y	A2	$630.00	22.9970	$978.36	$717.09
65875	Incise inner eye adhesions	Y	A2	$630.00	22.9970	$978.36	$717.09
65880	Incise inner eye adhesions	Y	A2	$630.00	15.2259	$647.76	$634.44
65900	Remove eye lesion	Y	A2	$717.00	15.2259	$647.76	$699.69
65920	Remove implant of eye	Y	A2	$995.00	22.9970	$978.36	$990.84
65930	Remove blood clot from eye	Y	A2	$717.00	22.9970	$978.36	$782.34
66020	Injection treatment of eye	Y	A2	$333.00	15.2259	$647.76	$411.69
66030	Injection treatment of eye	Y	A2	$333.00	6.0673	$258.12	$314.28
66130	Remove eye lesion	Y	A2	$995.00	22.9970	$978.36	$990.84
66150	Glaucoma surgery	Y	A2	$630.00	22.9970	$978.36	$717.09
66155	Glaucoma surgery	Y	A2	$630.00	22.9970	$978.36	$717.09
66160	Glaucoma surgery	Y	A2	$446.00	22.9970	$978.36	$579.09
66165	Glaucoma surgery	Y	A2	$630.00	22.9970	$978.36	$717.09
66170	Glaucoma surgery	Y	A2	$630.00	22.9970	$978.36	$717.09
66172	Incision of eye	Y	A2	$630.00	22.9970	$978.36	$717.09
66180	Implant eye shunt	Y	A2	$717.00	37.8967	$1,612.24	$940.81
66185	Revise eye shunt	Y	A2	$446.00	37.8967	$1,612.24	$737.56
66220	Repair eye lesion	Y	A2	$510.00	37.4290	$1,592.34	$780.59

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
66225	Repair/graft eye lesion	Y	A2	$630.00	37.8967	$1,612.24	$875.56
66250	Follow-up surgery of eye	Y	A2	$446.00	15.2259	$647.76	$496.44
66500	Incision of iris	Y	A2	$333.00	6.0673	$258.12	$314.28
66505	Incision of iris	Y	A2	$333.00	6.0673	$258.12	$314.28
66600	Remove iris and lesion	Y	A2	$510.00	22.9970	$978.36	$627.09
66605	Removal of iris	Y	A2	$510.00	22.9970	$978.36	$627.09
66625	Removal of iris	Y	A2	$372.94	6.0673	$258.12	$344.24
66630	Removal of iris	Y	A2	$510.00	22.9970	$978.36	$627.09
66635	Removal of iris	Y	A2	$510.00	22.9970	$978.36	$627.09
66680	Repair iris & ciliary body	Y	A2	$510.00	22.9970	$978.36	$627.09
66682	Repair iris & ciliary body	Y	A2	$446.00	22.9970	$978.36	$579.09
66700	Destruction, ciliary body	Y	A2	$446.00	15.2259	$647.76	$496.44
66710	Ciliary transscleral therapy	Y	A2	$446.00	15.2259	$647.76	$496.44
66711	Ciliary endoscopic ablation	Y	A2	$446.00	15.2259	$647.76	$496.44
66720	Destruction, ciliary body	Y	A2	$446.00	15.2259	$647.76	$496.44
66740	Destruction, ciliary body	Y	A2	$446.00	22.9970	$978.36	$579.09
66761	Revision of iris	Y	P3	.....	4.3375	$184.53	$184.53
66762	Revision of iris	Y	P3	.....	4.4019	$187.27	$187.27
66770	Removal of inner eye lesion	Y	P3	.....	4.7639	$202.67	$202.67
66820	Incision, secondary cataract	Y	G2	.....	6.0673	$258.12	$258.12
66821	After cataract laser surgery	Y	A2	$312.50	5.0839	$216.28	$288.45
66825	Reposition intraocular lens	Y	A2	$630.00	22.9970	$978.36	$717.09
66830	Removal of lens lesion	Y	A2	$372.94	6.0673	$258.12	$344.24
66840	Removal of lens material	Y	A2	$630.00	14.8702	$632.62	$630.66
66850	Removal of lens material	Y	A2	$995.00	29.2281	$1,243.45	$1,057.11
66852	Removal of lens material	Y	A2	$630.00	29.2281	$1,243.45	$783.36
66920	Extraction of lens	Y	A2	$630.00	29.2281	$1,243.45	$783.36
66930	Extraction of lens	Y	A2	$717.00	29.2281	$1,243.45	$848.61
66940	Extraction of lens	Y	A2	$717.00	14.8702	$632.62	$695.91
66982	Cataract surgery, complex	Y	A2	$973.00	23.6313	$1,005.35	$981.09
66983	Cataract surg w/iol, 1 stage	Y	A2	$973.00	23.6313	$1,005.35	$981.09
66984	Cataract surg w/iol, 1 stage	Y	A2	$973.00	23.6313	$1,005.35	$981.09
66985	Insert lens prosthesis	Y	A2	$826.00	23.6313	$1,005.35	$870.84
66986	Exchange lens prosthesis	Y	A2	$826.00	23.6313	$1,005.35	$870.84
66990	Ophthalmic endoscope add-on	.....	N1	.....	.....	.....	.....
67005	Partial removal of eye fluid	Y	A2	$630.00	27.6020	$1,174.27	$766.07
67010	Partial removal of eye fluid	Y	A2	$630.00	27.6020	$1,174.27	$766.07
67015	Release of eye fluid	Y	A2	$333.00	27.6020	$1,174.27	$543.32
67025	Replace eye fluid	Y	A2	$333.00	27.6020	$1,174.27	$543.32
67027	Implant eye drug system	Y	A2	$630.00	37.4290	$1,592.34	$870.59
67028	Injection eye drug	Y	P3	.....	1.9876	$84.56	$84.56
67030	Incise inner eye strands	Y	A2	$333.00	16.5239	$702.98	$425.50
67031	Laser surgery, eye strands	Y	A2	$312.50	5.0839	$216.28	$288.45
67036	Removal of inner eye fluid	Y	A2	$630.00	37.4290	$1,592.34	$870.59
67038	Strip retinal membrane	Y	A2	$717.00	37.4290	$1,592.34	$935.84
67039	Laser treatment of retina	Y	A2	$995.00	37.4290	$1,592.34	$1,144.34
67040	Laser treatment of retina	Y	A2	$995.00	37.4290	$1,592.34	$1,144.34
67101	Repair detached retina	Y	P3	.....	7.2104	$306.75	$306.75
67105	Repair detached retina	Y	P2	.....	5.0841	$216.29	$216.29
67107	Repair detached retina	Y	A2	$717.00	37.4290	$1,592.34	$935.84
67108	Repair detached retina	Y	A2	$995.00	37.4290	$1,592.34	$1,144.34
67110	Repair detached retina	Y	P3	.....	7.8462	$333.80	$333.80
67112	Rerepair detached retina	Y	A2	$995.00	37.4290	$1,592.34	$1,144.34
67115	Release encircling material	Y	A2	$446.00	16.5239	$702.98	$510.25
67120	Remove eye implant material	Y	A2	$446.00	16.5239	$702.98	$510.25
67121	Remove eye implant material	Y	A2	$446.00	27.6020	$1,174.27	$628.07
67141	Treatment of retina	Y	A2	$241.77	3.9333	$167.33	$223.16
67145	Treatment of retina	Y	P3	.....	4.5387	$193.09	$193.09
67208	Treatment of retinal lesion	Y	P3	.....	4.8283	$205.41	$205.41
67210	Treatment of retinal lesion	Y	P2	.....	5.0841	$216.29	$216.29
67218	Treatment of retinal lesion	Y	A2	$717.00	16.5239	$702.98	$713.50
67220	Treatment of choroid lesion	Y	P2	.....	3.9333	$167.33	$167.33
67221	Ocular photodynamic ther	Y	P3	.....	2.9695	$126.33	$126.33

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
67225	Eye photodynamic ther add-on	Y	P3		0.2012	$8.56	$8.56
67227	Treatment of retinal lesion	Y	A2	$333.00	27.6020	$1,174.27	$543.32
67228	Treatment of retinal lesion	Y	P2		5.0841	$216.29	$216.29
67250	Reinforce eye wall	Y	A2	$510.00	17.1243	$728.52	$564.63
67255	Reinforce/graft eye wall	Y	A2	$510.00	27.6020	$1,174.27	$676.07
67311	Revise eye muscle	Y	A2	$510.00	21.2801	$905.32	$608.83
67312	Revise two eye muscles	Y	A2	$630.00	21.2801	$905.32	$698.83
67314	Revise eye muscle	Y	A2	$630.00	21.2801	$905.32	$698.83
67316	Revise two eye muscles	Y	A2	$630.00	21.2801	$905.32	$698.83
67318	Revise eye muscle(s)	Y	A2	$630.00	21.2801	$905.32	$698.83
67320	Revise eye muscle(s) add-on	Y	A2	$630.00	21.2801	$905.32	$698.83
67331	Eye surgery follow-up add-on	Y	A2	$630.00	21.2801	$905.32	$698.83
67332	Rerevise eye muscles add-on	Y	A2	$630.00	21.2801	$905.32	$698.83
67334	Revise eye muscle w/suture	Y	A2	$630.00	21.2801	$905.32	$698.83
67335	Eye suture during surgery	Y	A2	$630.00	21.2801	$905.32	$698.83
67340	Revise eye muscle add-on	Y	A2	$630.00	21.2801	$905.32	$698.83
67343	Release eye tissue	Y	A2	$995.00	21.2801	$905.32	$972.58
67345	Destroy nerve of eye muscle	Y	P3		1.9634	$83.53	$83.53
67346	Biopsy, eye muscle	Y	A2	$333.00	14.3845	$611.96	$402.74
67400	Explore/biopsy eye socket	Y	A2	$510.00	25.2550	$1,074.42	$651.11
67405	Explore/drain eye socket	Y	A2	$630.00	25.2550	$1,074.42	$741.11
67412	Explore/treat eye socket	Y	A2	$717.00	25.2550	$1,074.42	$806.36
67413	Explore/treat eye socket	Y	A2	$717.00	25.2550	$1,074.42	$806.36
67414	Explr/decompress eye socket	Y	G2		35.2292	$1,498.76	$1,498.76
67415	Aspiration, orbital contents	Y	A2	$333.00	17.1243	$728.52	$431.88
67420	Explore/treat eye socket	Y	A2	$717.00	35.2292	$1,498.76	$912.44
67430	Explore/treat eye socket	Y	A2	$717.00	35.2292	$1,498.76	$912.44
67440	Explore/drain eye socket	Y	A2	$717.00	35.2292	$1,498.76	$912.44
67445	Explr/decompress eye socket	Y	A2	$717.00	35.2292	$1,498.76	$912.44
67450	Explore/biopsy eye socket	Y	A2	$717.00	35.2292	$1,498.76	$912.44
67500	Inject/treat eye socket	N	G2		2.1451	$91.26	$91.26
67505	Inject/treat eye socket	Y	G2		2.8954	$123.18	$123.18
67515	Inject/treat eye socket	Y	P3		0.5714	$24.31	$24.31
67550	Insert eye socket implant	Y	A2	$630.00	35.2292	$1,498.76	$847.19
67560	Revise eye socket implant	Y	A2	$446.00	25.2550	$1,074.42	$603.11
67570	Decompress optic nerve	Y	A2	$630.00	35.2292	$1,498.76	$847.19
67700	Drainage of eyelid abscess	Y	P2		2.8954	$123.18	$123.18
67710	Incision of eyelid	Y	P3		3.6777	$156.46	$156.46
67715	Incision of eyelid fold	Y	A2	$333.00	17.1243	$728.52	$431.88
67800	Remove eyelid lesion	Y	P3		1.2312	$52.38	$52.38
67801	Remove eyelid lesions	Y	P3		1.4888	$63.34	$63.34
67805	Remove eyelid lesions	Y	P3		1.9232	$81.82	$81.82
67808	Remove eyelid lesion(s)	Y	A2	$446.00	17.1243	$728.52	$516.63
67810	Biopsy of eyelid	Y	P2		2.8954	$123.18	$123.18
67820	Revise eyelashes	N	P3		0.4264	$18.14	$18.14
67825	Revise eyelashes	Y	P3		1.2794	$54.43	$54.43
67830	Revise eyelashes	Y	A2	$446.00	7.2819	$309.79	$411.95
67835	Revise eyelashes	Y	A2	$446.00	17.1243	$728.52	$516.63
67840	Remove eyelid lesion	Y	P3		3.8063	$161.93	$161.93
67850	Treat eyelid lesion	Y	P3		2.6879	$114.35	$114.35
67875	Closure of eyelid by suture	Y	G2		7.2819	$309.79	$309.79
67880	Revision of eyelid	Y	A2	$510.00	15.2259	$647.76	$544.44
67882	Revision of eyelid	Y	A2	$510.00	17.1243	$728.52	$564.63
67900	Repair brow defect	Y	A2	$630.00	17.1243	$728.52	$654.63
67901	Repair eyelid defect	Y	A2	$717.00	17.1243	$728.52	$719.88
67902	Repair eyelid defect	Y	A2	$717.00	17.1243	$728.52	$719.88
67903	Repair eyelid defect	Y	A2	$630.00	17.1243	$728.52	$654.63
67904	Repair eyelid defect	Y	A2	$630.00	17.1243	$728.52	$654.63
67906	Repair eyelid defect	Y	A2	$717.00	17.1243	$728.52	$719.88
67908	Repair eyelid defect	Y	A2	$630.00	17.1243	$728.52	$654.63
67909	Revise eyelid defect	Y	A2	$630.00	17.1243	$728.52	$654.63
67911	Revise eyelid defect	Y	A2	$510.00	17.1243	$728.52	$564.63
67912	Correction eyelid w/implant	Y	A2	$510.00	17.1243	$728.52	$564.63

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
67914	Repair eyelid defect	Y	A2	$510.00	17.1243	$728.52	$564.63
67915	Repair eyelid defect	Y	P3		4.2329	$180.08	$180.08
67916	Repair eyelid defect	Y	A2	$630.00	17.1243	$728.52	$654.63
67917	Repair eyelid defect	Y	A2	$630.00	17.1243	$728.52	$654.63
67921	Repair eyelid defect	Y	A2	$510.00	17.1243	$728.52	$564.63
67922	Repair eyelid defect	Y	P3		4.1685	$177.34	$177.34
67923	Repair eyelid defect	Y	A2	$630.00	17.1243	$728.52	$654.63
67924	Repair eyelid defect	Y	A2	$630.00	17.1243	$728.52	$654.63
67930	Repair eyelid wound	Y	P3		4.1121	$174.94	$174.94
67935	Repair eyelid wound	Y	A2	$446.00	17.1243	$728.52	$516.63
67938	Remove eyelid foreign body	N	P2		1.1607	$49.38	$49.38
67950	Revision of eyelid	Y	A2	$446.00	17.1243	$728.52	$516.63
67961	Revision of eyelid	Y	A2	$510.00	17.1243	$728.52	$564.63
67966	Revision of eyelid	Y	A2	$510.00	17.1243	$728.52	$564.63
67971	Reconstruction of eyelid	Y	A2	$510.00	25.2550	$1,074.42	$651.11
67973	Reconstruction of eyelid	Y	A2	$510.00	25.2550	$1,074.42	$651.11
67974	Reconstruction of eyelid	Y	A2	$510.00	25.2550	$1,074.42	$651.11
67975	Reconstruction of eyelid	Y	A2	$510.00	17.1243	$728.52	$564.63
68020	Incise/drain eyelid lining	Y	P3		1.0864	$46.22	$46.22
68040	Treatment of eyelid lesions	N	P3		0.5392	$22.94	$22.94
68100	Biopsy of eyelid lining	Y	P3		2.2775	$96.89	$96.89
68110	Remove eyelid lining lesion	Y	P3		2.9131	$123.93	$123.93
68115	Remove eyelid lining lesion	Y	A2	$446.00	17.1243	$728.52	$516.63
68130	Remove eyelid lining lesion	Y	A2	$446.00	15.2259	$647.76	$496.44
68135	Remove eyelid lining lesion	Y	P3		1.3922	$59.23	$59.23
68200	Treat eyelid by injection	N	P3		0.4024	$17.12	$17.12
68320	Revise/graft eyelid lining	Y	A2	$630.00	17.1243	$728.52	$654.63
68325	Revise/graft eyelid lining	Y	A2	$630.00	25.2550	$1,074.42	$741.11
68326	Revise/graft eyelid lining	Y	A2	$630.00	25.2550	$1,074.42	$741.11
68328	Revise/graft eyelid lining	Y	A2	$630.00	25.2550	$1,074.42	$741.11
68330	Revise eyelid lining	Y	A2	$630.00	22.9970	$978.36	$717.09
68335	Revise/graft eyelid lining	Y	A2	$630.00	25.2550	$1,074.42	$741.11
68340	Separate eyelid adhesions	Y	A2	$630.00	17.1243	$728.52	$654.63
68360	Revise eyelid lining	Y	A2	$446.00	22.9970	$978.36	$579.09
68362	Revise eyelid lining	Y	A2	$446.00	22.9970	$978.36	$579.09
68371	Harvest eye tissue, alograft	Y	A2	$446.00	15.2259	$647.76	$496.44
68400	Incise/drain tear gland	Y	P2		2.8954	$123.18	$123.18
68420	Incise/drain tear sac	Y	P3		4.3777	$186.24	$186.24
68440	Incise tear duct opening	Y	P3		1.3520	$57.52	$57.52
68500	Removal of tear gland	Y	A2	$510.00	25.2550	$1,074.42	$651.11
68505	Partial removal, tear gland	Y	A2	$510.00	25.2550	$1,074.42	$651.11
68510	Biopsy of tear gland	Y	A2	$333.00	17.1243	$728.52	$431.88
68520	Removal of tear sac	Y	A2	$510.00	25.2550	$1,074.42	$651.11
68525	Biopsy of tear sac	Y	A2	$333.00	17.1243	$728.52	$431.88
68530	Clearance of tear duct	Y	P3		5.5929	$237.94	$237.94
68540	Remove tear gland lesion	Y	A2	$510.00	25.2550	$1,074.42	$651.11
68550	Remove tear gland lesion	Y	A2	$510.00	25.2550	$1,074.42	$651.11
68700	Repair tear ducts	Y	A2	$446.00	25.2550	$1,074.42	$603.11
68705	Revise tear duct opening	Y	P2		2.8954	$123.18	$123.18
68720	Create tear sac drain	Y	A2	$630.00	25.2550	$1,074.42	$741.11
68745	Create tear duct drain	Y	A2	$630.00	25.2550	$1,074.42	$741.11
68750	Create tear duct drain	Y	A2	$630.00	25.2550	$1,074.42	$741.11
68760	Close tear duct opening	N	P2		2.1451	$91.26	$91.26
68761	Close tear duct opening	N	P3		1.6658	$70.87	$70.87
68770	Close tear system fistula	Y	A2	$630.00	17.1243	$728.52	$654.63
68801	Dilate tear duct opening	N	P2		1.1607	$49.38	$49.38
68810	Probe nasolacrimal duct	N	A2	$131.86	2.1451	$91.26	$121.71
68811	Probe nasolacrimal duct	Y	A2	$446.00	17.1243	$728.52	$516.63
68815	Probe nasolacrimal duct	Y	A2	$446.00	17.1243	$728.52	$516.63
68840	Explore/irrigate tear ducts	N	P2		1.1607	$49.38	$49.38
68850	Injection for tear sac x-ray		N1				
69000	Drain external ear lesion	Y	P2		1.4392	$61.23	$61.23
69005	Drain external ear lesion	Y	P3		2.2934	$97.57	$97.57

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
69020	Drain outer ear canal lesion	Y	P2		1.4392	$61.23	$61.23
69100	Biopsy of external ear	Y	P3		1.4404	$61.28	$61.28
69105	Biopsy of external ear canal	Y	P3		1.9474	$82.85	$82.85
69110	Remove external ear, partial	Y	A2	$333.00	15.1024	$642.50	$410.38
69120	Removal of external ear	Y	A2	$446.00	23.3299	$992.52	$582.63
69140	Remove ear canal lesion(s)	Y	A2	$446.00	23.3299	$992.52	$582.63
69145	Remove ear canal lesion(s)	Y	A2	$446.00	15.1024	$642.50	$495.13
69150	Extensive ear canal surgery	Y	A2	$464.15	7.5511	$321.25	$428.43
69200	Clear outer ear canal	N	P2		0.6102	$25.96	$25.96
69205	Clear outer ear canal	Y	A2	$333.00	20.0656	$853.65	$463.16
69210	Remove impacted ear wax	N	P3		0.4748	$20.20	$20.20
69220	Clean out mastoid cavity	Y	P2		0.8432	$35.87	$35.87
69222	Clean out mastoid cavity	Y	P3		3.0339	$129.07	$129.07
69300	Revise external ear	Y	A2	$510.00	23.3299	$992.52	$630.63
69310	Rebuild outer ear canal	Y	A2	$510.00	38.1991	$1,625.10	$788.78
69320	Rebuild outer ear canal	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69400	Inflate middle ear canal	Y	P3		1.9152	$81.48	$81.48
69401	Inflate middle ear canal	Y	P3		1.0944	$46.56	$46.56
69405	Catheterize middle ear canal	Y	P3		2.7842	$118.45	$118.45
69420	Incision of eardrum	Y	P2		2.4520	$104.32	$104.32
69421	Incision of eardrum	Y	A2	$510.00	16.4266	$698.84	$557.21
69424	Remove ventilating tube	Y	P3		1.7542	$74.63	$74.63
69433	Create eardrum opening	Y	P3		2.4787	$105.45	$105.45
69436	Create eardrum opening	Y	A2	$510.00	16.4266	$698.84	$557.21
69440	Exploration of middle ear	Y	A2	$510.00	23.3299	$992.52	$630.63
69450	Eardrum revision	Y	A2	$333.00	38.1991	$1,625.10	$656.03
69501	Mastoidectomy	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69502	Mastoidectomy	Y	A2	$995.00	23.3299	$992.52	$994.38
69505	Remove mastoid structures	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69511	Extensive mastoid surgery	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69530	Extensive mastoid surgery	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69540	Remove ear lesion	Y	P3		2.9615	$125.99	$125.99
69550	Remove ear lesion	Y	A2	$717.00	38.1991	$1,625.10	$944.03
69552	Remove ear lesion	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69601	Mastoid surgery revision	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69602	Mastoid surgery revision	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69603	Mastoid surgery revision	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69604	Mastoid surgery revision	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69605	Mastoid surgery revision	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69610	Repair of eardrum	Y	P3		4.0477	$172.20	$172.20
69620	Repair of eardrum	Y	A2	$446.00	23.3299	$992.52	$582.63
69631	Repair eardrum structures	Y	A2	$717.00	38.1991	$1,625.10	$944.03
69632	Rebuild eardrum structures	Y	A2	$717.00	38.1991	$1,625.10	$944.03
69633	Rebuild eardrum structures	Y	A2	$717.00	38.1991	$1,625.10	$944.03
69635	Repair eardrum structures	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69636	Rebuild eardrum structures	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69637	Rebuild eardrum structures	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69641	Revise middle ear & mastoid	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69642	Revise middle ear & mastoid	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69643	Revise middle ear & mastoid	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69644	Revise middle ear & mastoid	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69645	Revise middle ear & mastoid	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69646	Revise middle ear & mastoid	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69650	Release middle ear bone	Y	A2	$995.00	23.3299	$992.52	$994.38
69660	Revise middle ear bone	Y	A2	$717.00	38.1991	$1,625.10	$944.03
69661	Revise middle ear bone	Y	A2	$717.00	38.1991	$1,625.10	$944.03
69662	Revise middle ear bone	Y	A2	$717.00	38.1991	$1,625.10	$944.03
69666	Repair middle ear structures	Y	A2	$630.00	38.1991	$1,625.10	$878.78
69667	Repair middle ear structures	Y	A2	$630.00	38.1991	$1,625.10	$878.78
69670	Remove mastoid air cells	Y	A2	$510.00	38.1991	$1,625.10	$788.78
69676	Remove middle ear nerve	Y	A2	$510.00	38.1991	$1,625.10	$788.78
69700	Close mastoid fistula	Y	A2	$510.00	38.1991	$1,625.10	$788.78
69711	Remove/repair hearing aid	Y	A2	$333.00	38.1991	$1,625.10	$656.03

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
69714	Implant temple bone w/stimul	Y	A2	$1,339.00	38.1991	$1,625.10	$1,410.53
69715	Temple bne implnt w/stimulat	Y	A2	$1,339.00	38.1991	$1,625.10	$1,410.53
69717	Temple bone implant revision	Y	A2	$1,339.00	38.1991	$1,625.10	$1,410.53
69718	Revise temple bone implant	Y	A2	$1,339.00	38.1991	$1,625.10	$1,410.53
69720	Release facial nerve	Y	A2	$717.00	38.1991	$1,625.10	$944.03
69740	Repair facial nerve	Y	A2	$717.00	38.1991	$1,625.10	$944.03
69745	Repair facial nerve	Y	A2	$717.00	38.1991	$1,625.10	$944.03
69801	Incise inner ear	Y	A2	$717.00	38.1991	$1,625.10	$944.03
69802	Incise inner ear	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69805	Explore inner ear	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69806	Explore inner ear	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69820	Establish inner ear window	Y	A2	$717.00	38.1991	$1,625.10	$944.03
69840	Revise inner ear window	Y	A2	$717.00	38.1991	$1,625.10	$944.03
69905	Remove inner ear	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69910	Remove inner ear & mastoid	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69915	Incise inner ear nerve	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69930	Implant cochlear device	Y	H8	$995.00	587.7216	$25,003.44	$23,712.58
69990	Microsurgery add-on		N1				
C9716	Radiofrequency energy to anu	Y	G2		29.6189	$1,260.08	$1,260.08
C9724	EPS gast cardia plic	Y	G2		25.7552	$1,095.70	$1,095.70
C9725	Place endorectal app	N	G2		8.9477	$380.66	$380.66
C9726	Rxt breast appl place/remov	N	G2		10.5746	$449.88	$449.88
C9727	Insert palate implants	N	G2		13.8283	$588.30	$588.30
G0104	CA screen;flexi sigmoidscope	N	P3		1.9152	$81.48	$81.48
G0105	Colorectal scrn; hi risk ind	Y	A2	$446.00	7.8492	$333.93	$417.98
G0121	Colon ca scrn not hi rsk ind	Y	A2	$446.00	7.8492	$333.93	$417.98
G0127	Trim nail(s)	Y	P3		0.2494	$10.61	$10.61
G0186	Dstry eye lesn,fdr vssl tech	Y	R2		3.9333	$167.33	$167.33
G0247	Routine footcare pt w lops	Y	P3		0.4828	$20.54	$20.54
G0259	Inject for sacroiliac joint		N1				
G0260	Inj for sacroiliac jt anesth	Y	A2	$333.00	5.7253	$243.57	$310.64
G0268	Removal of impacted wax md	N	P3		0.4990	$21.23	$21.23
G0269	Occlusive device in vein art		N1				
G0289	Arthro, loose body + chondro		N1				
G0297	Insert single chamber/cd	Y	J8		440.1206	$18,724.05	$18,724.05
G0298	Insert dual chamber/cd	Y	J8		440.1206	$18,724.05	$18,724.05
G0299	Inser/repos single icd+leads	Y	J8		546.9370	$23,268.34	$23,268.34
G0300	Insert reposit lead dual+gen	Y	J8		546.9370	$23,268.34	$23,268.34
G0364	Bone marrow aspirate & biopsy	Y	P3		0.1208	$5.14	$5.14
G0392	AV fistula or graft arterial	Y	A2	$1,339.00	42.9360	$1,826.63	$1,460.91
G0393	AV fistula or graft venous	Y	A2	$1,339.00	42.9360	$1,826.63	$1,460.91

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
0028T	Dexa body composition study	N1		
0042T	Ct perfusion w/contrast, cbf	N1		
0054T	Bone surgery using computer	Z2	4.9138	$209.05
0055T	Bone surgery using computer	Z2	4.9138	$209.05
0056T	Bone surgery using computer	Z2	4.9138	$209.05
0067T	Ct colonography;dx	Z2	4.8405	$205.93
0071T	U/s leiomyomata ablate <200	Z2	28.5095	$1,212.88
0072T	U/s leiomyomata ablate >200	Z2	42.9896	$1,828.91
0073T	Delivery, comp imrt	Z2	5.4731	$232.84
0126T	Chd risk imt study	N1		
0144T	CT heart wo dye; qual calc	Z2	4.1265	$175.55
0145T	CT heart w/wo dye funct	Z2	4.9832	$212.00
0146T	CCTA w/wo dye	Z2	4.9832	$212.00
0147T	CCTA w/wo, quan calcium	Z2	4.9832	$212.00
0148T	CCTA w/wo, strxr	Z2	6.5012	$276.58
0149T	CCTA w/wo, strxr quan calc	Z2	6.5012	$276.58
0150T	CCTA w/wo, disease strxr	Z2	4.1265	$175.55
0151T	CT heart funct add-on	Z2	1.5379	$65.43
0159T	Cad breast mri	N1		
0174T	Cad cxr with interp	N1		
0175T	Cad cxr remote	N1		
70010	Contrast x-ray of brain	Z2	2.5544	$108.67
70015	Contrast x-ray of brain	Z3	1.4806	$62.99
70030	X-ray eye for foreign body	Z3	0.3782	$16.09
70100	X-ray exam of jaw	Z3	0.4346	$18.49
70110	X-ray exam of jaw	Z3	0.5230	$22.25
70120	X-ray exam of mastoids	Z3	0.4990	$21.23
70130	X-ray exam of mastoids	Z2	0.7093	$30.18
70134	X-ray exam of middle ear	Z3	0.6036	$25.68
70140	X-ray exam of facial bones	Z3	0.4346	$18.49
70150	X-ray exam of facial bones	Z3	0.6116	$26.02
70160	X-ray exam of nasal bones	Z3	0.4506	$19.17
70170	X-ray exam of tear duct	Z2	2.9586	$125.87
70190	X-ray exam of eye sockets	Z3	0.4990	$21.23
70200	X-ray exam of eye sockets	Z3	0.6116	$26.02
70210	X-ray exam of sinuses	Z3	0.4506	$19.17
70220	X-ray exam of sinuses	Z3	0.5632	$23.96
70240	X-ray exam, pituitary saddle	Z3	0.3862	$16.43
70250	X-ray exam of skull	Z3	0.4908	$20.88
70260	X-ray exam of skull	Z3	0.6518	$27.73
70300	X-ray exam of teeth	Z3	0.1932	$8.22
70310	X-ray exam of teeth	Z3	0.4828	$20.54
70320	Full mouth x-ray of teeth	Z2	0.6550	$27.87
70328	X-ray exam of jaw joint	Z3	0.4104	$17.46
70330	X-ray exam of jaw joints	Z3	0.6920	$29.44
70332	X-ray exam of jaw joint	Z3	1.3520	$57.52
70336	Magnetic image, jaw joint	Z2	4.5523	$193.67
70350	X-ray head for orthodontia	Z3	0.2576	$10.96
70355	Panoramic x-ray of jaws	Z3	0.3218	$13.69
70360	X-ray exam of neck	Z3	0.3622	$15.41
70370	Throat x-ray & fluoroscopy	Z3	1.1346	$48.27
70371	Speech evaluation, complex	Z2	1.2908	$54.91
70373	Contrast x-ray of larynx	Z3	1.3036	$55.46
70380	X-ray exam of salivary gland	Z3	0.5714	$24.31
70390	X-ray exam of salivary duct	Z3	1.5612	$66.42
70450	Ct head/brain w/o dye	Z2	3.0908	$131.49
70460	Ct head/brain w/dye	Z2	4.0825	$173.68
70470	Ct head/brain w/o & w/dye	Z2	4.8405	$205.93
70480	Ct orbit/ear/fossa w/o dye	Z2	3.0908	$131.49
70481	Ct orbit/ear/fossa w/dye	Z2	4.0825	$173.68
70482	Ct orbit/ear/fossa w/o & w/dye	Z2	4.8405	$205.93
70486	Ct maxillofacial w/o dye	Z2	3.0908	$131.49
70487	Ct maxillofacial w/dye	Z2	4.0825	$173.68
70488	Ct maxillofacial w/o & w/dye	Z2	4.8405	$205.93

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
70490	Ct soft tissue neck w/o dye	Z2	3.0908	$131.49
70491	Ct soft tissue neck w/dye	Z2	4.0825	$173.68
70492	Ct sft tsue nck w/o & w/dye	Z2	4.8405	$205.93
70496	Ct angiography, head	Z2	4.8552	$206.55
70498	Ct angiography, neck	Z2	4.8552	$206.55
70540	Mri orbit/face/neck w/o dye	Z2	5.6745	$241.41
70542	Mri orbit/face/neck w/dye	Z2	6.1231	$260.50
70543	Mri orbt/fac/nck w/o & w/dye	Z2	8.1155	$345.26
70544	Mr angiography head w/o dye	Z2	5.6745	$241.41
70545	Mr angiography head w/dye	Z2	6.1231	$260.50
70546	Mr angiograph head w/o & w/dye	Z2	8.1155	$345.26
70547	Mr angiography neck w/o dye	Z2	5.6745	$241.41
70548	Mr angiography neck w/dye	Z2	6.1231	$260.50
70549	Mr angiograph neck w/o & w/dye	Z2	8.1155	$345.26
70551	Mri brain w/o dye	Z2	5.6745	$241.41
70552	Mri brain w/dye	Z2	6.1231	$260.50
70553	Mri brain w/o & w/dye	Z2	8.1155	$345.26
70554	Fmri brain by tech	Z2	5.6745	$241.41
70555	Fmri brain by phys/psych	Z2	5.6745	$241.41
70557	Mri brain w/o dye	Z2	5.6745	$241.41
70558	Mri brain w/dye	Z2	6.1231	$260.50
70559	Mri brain w/o & w/dye	Z2	8.1155	$345.26
71010	Chest x-ray	Z3	0.3300	$14.04
71015	Chest x-ray	Z3	0.4024	$17.12
71020	Chest x-ray	Z3	0.4426	$18.83
71021	Chest x-ray	Z3	0.5392	$22.94
71022	Chest x-ray	Z3	0.6036	$25.68
71023	Chest x-ray and fluoroscopy	Z3	0.8690	$36.97
71030	Chest x-ray	Z3	0.6276	$26.70
71034	Chest x-ray and fluoroscopy	Z2	1.2908	$54.91
71035	Chest x-ray	Z3	0.4828	$20.54
71040	Contrast x-ray of bronchi	Z3	1.3278	$56.49
71060	Contrast x-ray of bronchi	Z2	1.6956	$72.14
71090	X-ray & pacemaker insertion	Z2	1.2908	$54.91
71100	X-ray exam of ribs	Z3	0.4426	$18.83
71101	X-ray exam of ribs/chest	Z3	0.5230	$22.25
71110	X-ray exam of ribs	Z3	0.5794	$24.65
71111	X-ray exam of ribs/chest	Z3	0.7322	$31.15
71120	X-ray exam of breastbone	Z3	0.4748	$20.20
71130	X-ray exam of breastbone	Z3	0.5472	$23.28
71250	Ct thorax w/o dye	Z2	3.0908	$131.49
71260	Ct thorax w/dye	Z2	4.0825	$173.68
71270	Ct thorax w/o & w/dye	Z2	4.8405	$205.93
71275	Ct angiography, chest	Z2	4.8552	$206.55
71550	Mri chest w/o dye	Z2	5.6745	$241.41
71551	Mri chest w/dye	Z2	6.1231	$260.50
71552	Mri chest w/o & w/dye	Z2	8.1155	$345.26
72010	X-ray exam of spine	Z2	0.7093	$30.18
72020	X-ray exam of spine	Z3	0.3218	$13.69
72040	X-ray exam of neck spine	Z3	0.5150	$21.91
72050	X-ray exam of neck spine	Z3	0.7322	$31.15
72052	X-ray exam of neck spine	Z3	0.9416	$40.06
72069	X-ray exam of trunk spine	Z3	0.4586	$19.51
72070	X-ray exam of thoracic spine	Z3	0.4748	$20.20
72072	X-ray exam of thoracic spine	Z3	0.5552	$23.62
72074	X-ray exam of thoracic spine	Z3	0.7000	$29.78
72080	X-ray exam of trunk spine	Z3	0.5070	$21.57
72090	X-ray exam of trunk spine	Z3	0.6196	$26.36
72100	X-ray exam of lower spine	Z3	0.5552	$23.62
72110	X-ray exam of lower spine	Z3	0.7644	$32.52
72114	X-ray exam of lower spine	Z3	1.0380	$44.16
72120	X-ray exam of lower spine	Z3	0.7484	$31.84
72125	Ct neck spine w/o dye	Z2	3.0908	$131.49
72126	Ct neck spine w/dye	Z2	4.0825	$173.68

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
72127	Ct neck spine w/o & w/dye	Z2	4.8405	$205.93
72128	Ct chest spine w/o dye	Z2	3.0908	$131.49
72129	Ct chest spine w/dye	Z2	4.0825	$173.68
72130	Ct chest spine w/o & w/dye	Z2	4.8405	$205.93
72131	Ct lumbar spine w/o dye	Z2	3.0908	$131.49
72132	Ct lumbar spine w/dye	Z2	4.0825	$173.68
72133	Ct lumbar spine w/o & w/dye	Z2	4.8405	$205.93
72141	Mri neck spine w/o dye	Z2	5.6745	$241.41
72142	Mri neck spine w/dye	Z2	6.1231	$260.50
72146	Mri chest spine w/o dye	Z2	5.6745	$241.41
72147	Mri chest spine w/dye	Z2	6.1231	$260.50
72148	Mri lumbar spine w/o dye	Z2	5.6745	$241.41
72149	Mri lumbar spine w/dye	Z2	6.1231	$260.50
72156	Mri neck spine w/o & w/dye	Z2	8.1155	$345.26
72157	Mri chest spine w/o & w/dye	Z2	8.1155	$345.26
72158	Mri lumbar spine w/o & w/dye	Z2	8.1155	$345.26
72170	X-ray exam of pelvis	Z3	0.3782	$16.09
72190	X-ray exam of pelvis	Z3	0.5714	$24.31
72191	Ct angiograph pelv w/o & w/dye	Z2	4.8552	$206.55
72192	Ct pelvis w/o dye	Z2	3.0908	$131.49
72193	Ct pelvis w/dye	Z2	4.0825	$173.68
72194	Ct pelvis w/o & w/dye	Z2	4.8405	$205.93
72195	Mri pelvis w/o dye	Z2	5.6745	$241.41
72196	Mri pelvis w/dye	Z2	6.1231	$260.50
72197	Mri pelvis w/o & w/dye	Z2	8.1155	$345.26
72200	X-ray exam sacroiliac joints	Z3	0.4184	$17.80
72202	X-ray exam sacroiliac joints	Z3	0.5070	$21.57
72220	X-ray exam of tailbone	Z3	0.4264	$18.14
72240	Contrast x-ray of neck spine	Z2	2.5544	$108.67
72255	Contrast x-ray, thorax spine	Z3	2.5026	$106.47
72265	Contrast x-ray, lower spine	Z3	2.4867	$105.79
72270	Contrast x-ray, spine	Z2	2.5544	$108.67
72275	Epidurography	Z3	1.4404	$61.28
72285	X-ray c/t spine disk	Z3	3.8145	$162.28
72291	Perq vertebroplasty, fluor	Z2	2.5544	$108.67
72292	Perq vertebroplasty, ct	Z2	2.5544	$108.67
72295	X-ray of lower spine disk	Z3	3.6213	$154.06
73000	X-ray exam of collar bone	Z3	0.4024	$17.12
73010	X-ray exam of shoulder blade	Z3	0.4184	$17.80
73020	X-ray exam of shoulder	Z3	0.3460	$14.72
73030	X-ray exam of shoulder	Z3	0.4264	$18.14
73040	Contrast x-ray of shoulder	Z3	1.6256	$69.16
73050	X-ray exam of shoulders	Z3	0.5230	$22.25
73060	X-ray exam of humerus	Z3	0.4264	$18.14
73070	X-ray exam of elbow	Z3	0.4024	$17.12
73080	X-ray exam of elbow	Z3	0.4990	$21.23
73085	Contrast x-ray of elbow	Z3	1.4806	$62.99
73090	X-ray exam of forearm	Z3	0.4024	$17.12
73092	X-ray exam of arm, infant	Z3	0.4024	$17.12
73100	X-ray exam of wrist	Z3	0.4104	$17.46
73110	X-ray exam of wrist	Z3	0.4908	$20.88
73115	Contrast x-ray of wrist	Z3	1.4806	$62.99
73120	X-ray exam of hand	Z3	0.3944	$16.78
73130	X-ray exam of hand	Z3	0.4426	$18.83
73140	X-ray exam of finger(s)	Z3	0.4184	$17.80
73200	Ct upper extremity w/o dye	Z2	3.0908	$131.49
73201	Ct upper extremity w/dye	Z2	4.0825	$173.68
73202	Ct uppr extremity w/o & w/dye	Z2	4.8405	$205.93
73206	Ct angio upr extrm w/o & w/dye	Z2	4.8552	$206.55
73218	Mri upper extremity w/o dye	Z2	5.6745	$241.41
73219	Mri upper extremity w/dye	Z2	6.1231	$260.50
73220	Mri uppr extremity w/o & w/dye	Z2	8.1155	$345.26
73221	Mri joint upr extrem w/o dye	Z2	5.6745	$241.41
73222	Mri joint upr extrem w/dye	Z2	6.1231	$260.50

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
73223	Mri joint upr extr w/o & w/dye	Z2	8.1155	$345.26
73500	X-ray exam of hip	Z3	0.3540	$15.06
73510	X-ray exam of hip	Z3	0.5070	$21.57
73520	X-ray exam of hips	Z3	0.5392	$22.94
73525	Contrast x-ray of hip	Z3	1.4726	$62.65
73530	X-ray exam of hip	Z2	1.2224	$52.00
73540	X-ray exam of pelvis & hips	Z3	0.5150	$21.91
73542	X-ray exam, sacroiliac joint	Z3	1.2312	$52.38
73550	X-ray exam of thigh	Z3	0.4184	$17.80
73560	X-ray exam of knee, 1 or 2	Z3	0.4184	$17.80
73562	X-ray exam of knee, 3	Z3	0.4908	$20.88
73564	X-ray exam, knee, 4 or more	Z3	0.5552	$23.62
73565	X-ray exam of knees	Z3	0.4264	$18.14
73580	Contrast x-ray of knee joint	Z3	1.9152	$81.48
73590	X-ray exam of lower leg	Z3	0.3944	$16.78
73592	X-ray exam of leg, infant	Z3	0.4104	$17.46
73600	X-ray exam of ankle	Z3	0.3944	$16.78
73610	X-ray exam of ankle	Z3	0.4506	$19.17
73615	Contrast x-ray of ankle	Z3	1.5128	$64.36
73620	X-ray exam of foot	Z3	0.3944	$16.78
73630	X-ray exam of foot	Z3	0.4426	$18.83
73650	X-ray exam of heel	Z3	0.3862	$16.43
73660	X-ray exam of toe(s)	Z3	0.4024	$17.12
73700	Ct lower extremity w/o dye	Z2	3.0908	$131.49
73701	Ct lower extremity w/dye	Z2	4.0825	$173.68
73702	Ct lwr extremity w/o & w/dye	Z2	4.8405	$205.93
73706	Ct angio lwr extr w/o & w/dye	Z2	4.8552	$206.55
73718	Mri lower extremity w/o dye	Z2	5.6745	$241.41
73719	Mri lower extremity w/dye	Z2	6.1231	$260.50
73720	Mri lwr extremity w/o & w/dye	Z2	8.1155	$345.26
73721	Mri jnt of lwr extre w/o dye	Z2	5.6745	$241.41
73722	Mri joint of lwr extr w/dye	Z2	6.1231	$260.50
73723	Mri joint lwr extr w/o & w/dye	Z2	8.1155	$345.26
74000	X-ray exam of abdomen	Z3	0.3622	$15.41
74010	X-ray exam of abdomen	Z3	0.5070	$21.57
74020	X-ray exam of abdomen	Z3	0.5150	$21.91
74022	X-ray exam series, abdomen	Z3	0.6196	$26.36
74150	Ct abdomen w/o dye	Z2	3.0908	$131.49
74160	Ct abdomen w/dye	Z2	4.0825	$173.68
74170	Ct abdomen w/o & w/dye	Z2	4.8405	$205.93
74175	Ct angio abdom w/o & w/dye	Z2	4.8552	$206.55
74181	Mri abdomen w/o dye	Z2	5.6745	$241.41
74182	Mri abdomen w/dye	Z2	6.1231	$260.50
74183	Mri abdomen w/o & w/dye	Z2	8.1155	$345.26
74190	X-ray exam of peritoneum	Z2	2.9586	$125.87
74210	Contrst x-ray exam of throat	Z3	1.1024	$46.90
74220	Contrast x-ray, esophagus	Z3	1.1830	$50.33
74230	Cine/vid x-ray, throat/esoph	Z3	1.1990	$51.01
74235	Remove esophagus obstruction	Z2	1.0974	$46.69
74240	X-ray exam, upper gi tract	Z3	1.3680	$58.20
74241	X-ray exam, upper gi tract	Z2	1.4294	$60.81
74245	X-ray exam, upper gi tract	Z2	2.2176	$94.34
74246	Contrst x-ray uppr gi tract	Z2	1.4294	$60.81
74247	Contrst x-ray uppr gi tract	Z2	1.4294	$60.81
74249	Contrst x-ray uppr gi tract	Z2	2.2176	$94.34
74250	X-ray exam of small bowel	Z3	1.4082	$59.91
74251	X-ray exam of small bowel	Z2	2.2176	$94.34
74260	X-ray exam of small bowel	Z2	1.4294	$60.81
74270	Contrast x-ray exam of colon	Z2	1.4294	$60.81
74280	Contrast x-ray exam of colon	Z2	2.2176	$94.34
74283	Contrast x-ray exam of colon	Z2	1.4294	$60.81
74290	Contrast x-ray, gallbladder	Z3	0.8450	$35.95
74291	Contrast x-rays, gallbladder	Z3	0.7726	$32.87
74300	X-ray bile ducts/pancreas	Z2	1.6956	$72.14

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
74301	X-rays at surgery add-on	Z2	1.6956	$72.14
74305	X-ray bile ducts/pancreas	Z2	1.6956	$72.14
74320	Contrast x-ray of bile ducts	Z3	2.0039	$85.25
74327	X-ray bile stone removal	Z3	1.7462	$74.29
74328	X-ray bile duct endoscopy	N1		
74329	X-ray for pancreas endoscopy	N1		
74330	X-ray bile/panc endoscopy	N1		
74340	X-ray guide for GI tube	Z2	1.2908	$54.91
74350	X-ray guide, stomach tube	Z2	1.6956	$72.14
74355	X-ray guide, intestinal tube	Z2	1.6956	$ 72.14
74360	X-ray guide, GI dilation	Z2	1.0974	$46.69
74363	X-ray, bile duct dilation	Z2	3.6392	$154.82
74400	Contrst x-ray, urinary tract	Z3	1.6094	$68.47
74410	Contrst x-ray, urinary tract	Z3	1.7625	$74.98
74415	Contrst x-ray, urinary tract	Z3	2.0440	$86.96
74420	Contrst x-ray, urinary tract	Z2	2.4159	$102.78
74425	Contrst x-ray, urinary tract	Z2	2.4159	$102.78
74430	Contrast x-ray, bladder	Z3	1.1346	$48.27
74440	X-ray, male genital tract	Z3	1.2634	$53.75
74445	X-ray exam of penis	Z2	2.4159	$102.78
74450	X-ray, urethra/bladder	Z2	2.4159	$102.78
74455	X-ray, urethra/bladder	Z3	1.4324	$60.94
74470	X-ray exam of kidney lesion	Z2	1.6956	$72.14
74475	X-ray control, cath insert	Z3	2.3738	$100.99
74480	X-ray control, cath insert	Z3	2.3738	$100.99
74485	X-ray guide, GU dilation	Z3	2.0683	$87.99
74710	X-ray measurement of pelvis	Z3	0.6276	$26.70
74740	X-ray, female genital tract	Z3	1.1508	$48.96
74742	X-ray, fallopian tube	Z2	2.9586	$125.87
74775	X-ray exam of perineum	Z2	2.4159	$102.78
75552	Heart mri for morph w/o dye	Z2	5.6745	$241.41
75553	Heart mri for morph w/dye	Z2	6.1231	$260.50
75554	Cardiac MRI/function	Z2	5.6745	$241.41
75555	Cardiac MRI/limited study	Z2	5.6745	$241.41
75600	Contrast x-ray exam of aorta	Z3	7.5404	$320.79
75605	Contrast x-ray exam of aorta	Z3	6.2929	$267.72
75625	Contrast x-ray exam of aorta	Z3	6.2125	$264.30
75630	X-ray aorta, leg arteries	Z3	6.4941	$276.28
75635	Ct angio abdominal arteries	Z2	4.8552	$206.55
75650	Artery x-rays, head & neck	Z3	6.2125	$264.30
75658	Artery x-rays, arm	Z3	6.3815	$271.49
75660	Artery x-rays, head & neck	Z2	6.2463	$265.74
75662	Artery x-rays, head & neck	Z3	6.7840	$288.61
75665	Artery x-rays, head & neck	Z3	6.4699	$275.25
75671	Artery x-rays, head & neck	Z3	6.7920	$288.95
75676	Artery x-rays, neck	Z3	6.3815	$271.49
75680	Artery x-rays, neck	Z3	6.5987	$280.73
75685	Artery x-rays, spine	Z3	6.3736	$271.15
75705	Artery x-rays, spine	Z2	6.2463	$265.74
75710	Artery x-rays, arm/leg	Z3	6.4619	$274.91
75716	Artery x-rays, arms/legs	Z3	6.7920	$288.95
75722	Artery x-rays, kidney	Z3	6.4055	$272.51
75724	Artery x-rays, kidneys	Z3	6.8242	$290.32
75726	Artery x-rays, abdomen	Z3	6.3413	$269.78
75731	Artery x-rays, adrenal gland	Z3	6.4055	$272.51
75733	Artery x-rays, adrenals	Z2	6.2463	$265.74
75736	Artery x-rays, pelvis	Z3	6.3975	$272.17
75741	Artery x-rays, lung	Z3	6.0999	$259.51
75743	Artery x-rays, lungs	Z3	6.1963	$263.61
75746	Artery x-rays, lung	Z3	6.2607	$266.35
75756	Artery x-rays, chest	Z3	6.5828	$280.05
75774	Artery x-ray, each vessel	Z3	6.0033	$255.40
75790	Visualize A-V shunt	Z3	1.5210	$64.71
75801	Lymph vessel x-ray, arm/leg	Z2	2.9586	$125.87

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
75803	Lymph vessel x-ray, arms/legs	Z2	2.9586	$125.87
75805	Lymph vessel x-ray, trunk	Z2	2.9586	$125.87
75807	Lymph vessel x-ray, trunk	Z2	2.9586	$125.87
75809	Nonvascular shunt, x-ray	Z3	1.0864	$46.22
75810	Vein x-ray, spleen/liver	Z2	9.5061	$404.42
75820	Vein x-ray, arm/leg	Z3	1.4484	$61.62
75822	Vein x-ray, arms/legs	Z3	1.6738	$71.21
75825	Vein x-ray, trunk	Z3	6.0515	$257.45
75827	Vein x-ray, chest	Z3	6.0677	$258.14
75831	Vein x-ray, kidney	Z3	6.0999	$259.51
75833	Vein x-ray, kidneys	Z3	6.3009	$268.06
75840	Vein x-ray, adrenal gland	Z3	6.1723	$262.59
75842	Vein x-ray, adrenal glands	Z3	6.2769	$267.04
75860	Vein x-ray, neck	Z3	6.2285	$264.98
75870	Vein x-ray, skull	Z3	6.1641	$262.24
75872	Vein x-ray, skull	Z3	6.4459	$274.23
75880	Vein x-ray, eye socket	Z3	1.4484	$61.62
75885	Vein x-ray, liver	Z3	6.0837	$258.82
75887	Vein x-ray, liver	Z3	6.1561	$261.90
75889	Vein x-ray, liver	Z3	6.0837	$258.82
75891	Vein x-ray, liver	Z3	6.0837	$258.82
75893	Venous sampling by catheter	N1	.....	.....
75894	X-rays, transcath therapy	Z2	8.3906	$356.96
75896	X-rays, transcath therapy	Z2	8.3906	$356.96
75898	Follow-up angiography	Z2	1.6956	$72.14
75901	Remove cva device obstruct	Z2	1.6956	$72.14
75902	Remove cva lumen obstruct	Z3	1.1024	$46.90
75940	X-ray placement, vein filter	Z2	8.3906	$356.96
75945	Intravascular us	Z2	2.4606	$104.68
75946	Intravascular us add-on	Z2	1.5607	$66.40
75960	Transcath iv stent rs&i	Z2	6.2463	$265.74
75961	Retrieval, broken catheter	Z3	5.4399	$231.43
75962	Repair arterial blockage	Z2	6.2463	$265.74
75964	Repair artery blockage, each	Z3	4.2571	$181.11
75966	Repair arterial blockage	Z2	6.2463	$265.74
75968	Repair artery blockage, each	Z3	4.2731	$181.79
75970	Vascular biopsy	Z2	6.2463	$265.74
75978	Repair venous blockage	Z2	6.2463	$265.74
75980	Contrast xray exam bile duct	Z2	3.6392	$154.82
75982	Contrast xray exam bile duct	Z2	3.6392	$154.82
75984	Xray control catheter change	Z3	1.5692	$66.76
75989	Abscess drainage under x-ray	N1	.....	.....
75992	Atherectomy, x-ray exam	Z2	6.2463	$265.74
75993	Atherectomy, x-ray exam	Z2	6.2463	$265.74
75994	Atherectomy, x-ray exam	Z2	6.2463	$265.74
75995	Atherectomy, x-ray exam	Z2	6.2463	$265.74
75996	Atherectomy, x-ray exam	Z2	6.2463	$265.74
76000	Fluoroscope examination	Z2	1.2908	$54.91
76001	Fluoroscope exam, extensive	N1	.....	.....
76010	X-ray, nose to rectum	Z3	0.3944	$16.78
76080	X-ray exam of fistula	Z3	0.7644	$32.52
76098	X-ray exam, breast specimen	Z3	0.2736	$11.64
76100	X-ray exam of body section	Z2	1.2224	$52.00
76101	Complex body section x-ray	Z2	1.6956	$72.14
76102	Complex body section x-rays	Z2	2.9586	$125.87
76120	Cine/video x-rays	Z3	1.1024	$46.90
76125	Cine/video x-rays add-on	Z2	0.7093	$30.18
76150	X-ray exam, dry process	Z3	0.4346	$18.49
76350	Special x-ray contrast study	N1	.....	.....
76376	3d render w/o postprocess	Z2	0.6102	$25.96
76377	3d rendering w/postprocess	Z2	1.5379	$65.43
76380	CAT scan follow-up study	Z2	1.5379	$65.43
76496	Fluoroscopic procedure	Z2	1.2908	$54.91
76497	Ct procedure	Z2	1.5379	$65.43

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
76498	Mri procedure	Z2	4.5523	$193.67
76499	Radiographic procedure	Z2	0.7093	$30.18
76506	Echo exam of head	Z2	0.9923	$42.22
76510	Ophth us, b & quant a	Z2	1.5607	$66.40
76511	Ophth us, quant a only	Z3	1.2312	$52.38
76512	Ophth us, b w/non-quant a	Z3	1.0702	$45.53
76513	Echo exam of eye, water bath	Z3	1.1426	$48.61
76514	Echo exam of eye, thickness	Z3	0.0644	$2.74
76516	Echo exam of eye	Z3	0.8852	$37.66
76519	Echo exam of eye	Z3	0.9736	$41.42
76529	Echo exam of eye	Z3	0.8450	$35.95
76536	Us exam of head and neck	Z3	1.5290	$65.05
76604	Us exam, chest	Z2	0.9923	$42.22
76645	Us exam, breast(s)	Z2	0.9923	$42.22
76700	Us exam, abdom, complete	Z2	1.5607	$66.40
76705	Echo exam of abdomen	Z3	1.3922	$59.23
76770	Us exam abdo back wall, comp	Z2	1.5607	$66.40
76775	Us exam abdo back wall, lim	Z3	1.4002	$59.57
76776	Us exam k transpl w/doppler	Z2	1.5607	$66.40
76800	Us exam, spinal canal	Z3	1.3680	$58.20
76801	Ob us < 14 wks, single fetus	Z2	1.5607	$66.40
76802	Ob us < 14 wks, add'l fetus	Z3	0.7000	$29.78
76805	Ob us >/= 14 wks, sngl fetus	Z2	1.5607	$66.40
76810	Ob us >/= 14 wks, addl fetus	Z3	0.9576	$40.74
76811	Ob us, detailed, sngl fetus	Z3	2.4060	$102.36
76812	Ob us, detailed, addl fetus	Z2	0.9923	$42.22
76813	Ob us nuchal meas, 1 gest	Z3	1.3922	$59.23
76814	Ob us nuchal meas, add-on	Z3	0.6760	$28.76
76815	Ob us, limited, fetus(s)	Z2	0.9923	$42.22
76816	Ob us, follow-up, per fetus	Z2	0.9923	$42.22
76817	Transvaginal us, obstetric	Z2	0.9923	$42.22
76818	Fetal biophys profile w/nst	Z3	1.3922	$59.23
76819	Fetal biophys profil w/o nst	Z3	1.1990	$51.01
76820	Umbilical artery echo	Z3	0.8128	$34.58
76821	Middle cerebral artery echo	Z3	1.3036	$55.46
76825	Echo exam of fetal heart	Z2	1.5973	$67.95
76826	Echo exam of fetal heart	Z3	1.2794	$54.43
76827	Echo exam of fetal heart	Z3	1.0462	$44.51
76828	Echo exam of fetal heart	Z3	0.6358	$27.05
76830	Transvaginal us, non-ob	Z2	1.5607	$66.40
76831	Echo exam, uterus	Z3	1.6094	$68.47
76856	Us exam, pelvic, complete	Z2	1.5607	$66.40
76857	Us exam, pelvic, limited	Z2	0.9923	$42.22
76870	Us exam, scrotum	Z2	1.5607	$66.40
76872	Us, transrectal	Z2	1.5607	$66.40
76873	Echograp trans r, pros study	Z2	1.5607	$66.40
76880	Us exam, extremity	Z2	1.5607	$66.40
76885	Us exam infant hips, dynamic	Z2	0.9923	$42.22
76886	Us exam infant hips, static	Z2	0.9923	$42.22
76930	Echo guide, cardiocentesis	Z2	1.1882	$50.55
76932	Echo guide for heart biopsy	Z2	2.1012	$89.39
76936	Echo guide for artery repair	Z2	2.1012	$89.39
76937	Us guide, vascular access	N1	.....	.....
76940	Us guide, tissue ablation	Z2	1.1882	$50.55
76941	Echo guide for transfusion	Z2	1.1882	$50.55
76942	Echo guide for biopsy	Z2	1.1882	$50.55
76945	Echo guide, villus sampling	Z2	1.1882	$50.55
76946	Echo guide for amniocentesis	Z3	0.7404	$31.50
76948	Echo guide, ova aspiration	Z3	0.7404	$31.50
76950	Echo guidance radiotherapy	Z3	0.9416	$40.06
76965	Echo guidance radiotherapy	Z2	2.1012	$89.39
76970	Ultrasound exam follow-up	Z2	0.9923	$42.22
76975	GI endoscopic ultrasound	Z2	1.5607	$66.40
76977	Us bone density measure	Z3	0.3702	$15.75

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
76998	Us guide, intraop	Z2	1.5607	$66.40
76999	Echo examination procedure	Z2	0.9923	$42.22
77001	Fluoroguide for vein device	N1		
77002	Needle localization by xray	N1		
77003	Fluoroguide for spine inject	N1		
77011	Ct scan for localization	Z2	4.0825	$173.68
77012	Ct scan for needle biopsy	Z3	4.0559	$172.55
77013	Ct guide for tissue ablation	Z2	4.8405	$205.93
77014	Ct scan for therapy guide	Z2	1.5379	$65.43
77021	Mr guidance for needle place	Z2	4.5523	$193.67
77022	Mri for tissue ablation	Z2	4.5523	$193.67
77031	Stereotact guide for brst bx	Z2	2.9586	$125.87
77032	Guidance for needle, breast	Z3	0.6840	$29.10
77053	X-ray of mammary duct	Z3	1.2554	$53.41
77054	X-ray of mammary ducts	Z2	1.6956	$72.14
77071	X-ray stress view	Z3	0.3782	$16.09
77072	X-rays for bone age	Z3	0.2736	$11.64
77073	X-rays, bone length studies	Z3	0.5312	$22.60
77074	X-rays, bone survey, limited	Z3	0.8852	$37.66
77075	X-rays, bone survey complete	Z2	1.2224	$52.00
77076	X-rays, bone survey, infant	Z2	0.7093	$30.18
77077	Joint survey, single view	Z3	0.6598	$28.07
77078	Ct bone density, axial	Z2	1.1755	$50.01
77079	Ct bone density, peripheral	Z3	1.4566	$61.97
77080	Dxa bone density, axial	Z2	1.1755	$50.01
77081	Dxa bone density/peripheral	Z2	0.5497	$23.39
77082	Dxa bone density, vert fx	Z3	0.4426	$18.83
77083	Radiographic absorptiometry	Z3	0.4264	$18.14
77084	Magnetic image, bone marrow	Z2	4.5523	$193.67
77280	Sbrt management	Z2	1.5735	$66.94
77285	Set radiation therapy field	Z2	3.9723	$168.99
77290	Set radiation therapy field	Z2	3.9723	$168.99
77295	Set radiation therapy field	Z3	13.6401	$580.29
77299	Radiation therapy planning	Z2	1.5735	$66.94
77300	Radiation therapy dose plan	Z3	0.9334	$39.71
77301	Radiotherapy dose plan, imrt	Z2	13.8081	$587.44
77305	Teletx isodose plan simple	Z3	1.0140	$43.14
77310	Teletx isodose plan intermed	Z3	1.3036	$55.46
77315	Teletx isodose plan complex	Z3	1.7060	$72.58
77321	Special teletx port plan	Z3	2.1085	$89.70
77326	Brachytx isodose calc simp	Z2	1.5735	$66.94
77327	Brachytx isodose calc interm	Z3	2.8649	$121.88
77328	Brachytx isodose plan compl	Z3	3.8305	$162.96
77331	Special radiation dosimetry	Z3	0.4104	$17.46
77332	Radiation treatment aid(s)	Z3	1.0944	$46.56
77333	Radiation treatment aid(s)	Z3	0.8610	$36.63
77334	Radiation treatment aid(s)	Z3	2.2453	$95.52
77336	Radiation physics consult	Z2	1.5735	$66.94
77370	Radiation physics consult	Z2	1.5735	$66.94
77371	Srs, multisource	Z3	24.3429	$1,035.62
77399	External radiation dosimetry	Z2	1.5735	$66.94
77401	Radiation treatment delivery	Z3	0.9094	$38.69
77402	Radiation treatment delivery	Z2	1.4826	$63.07
77403	Radiation treatment delivery	Z2	1.4826	$63.07
77404	Radiation treatment delivery	Z2	1.4826	$63.07
77406	Radiation treatment delivery	Z2	1.4826	$63.07
77407	Radiation treatment delivery	Z2	1.4826	$63.07
77408	Radiation treatment delivery	Z2	1.4826	$63.07
77409	Radiation treatment delivery	Z2	1.4826	$63.07
77411	Radiation treatment delivery	Z2	2.2295	$94.85
77412	Radiation treatment delivery	Z2	2.2295	$94.85
77413	Radiation treatment delivery	Z2	2.2295	$94.85
77414	Radiation treatment delivery	Z2	2.2295	$94.85
77416	Radiation treatment delivery	Z2	2.2295	$94.85

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
77417	Radiology port film(s)	Z3	0.3782	$16.09
77418	Radiation tx delivery, imrt	Z2	5.4731	$232.84
77421	Stereoscopic x-ray guidance	Z2	1.0974	$46.69
77422	Neutron beam tx, simple	Z2	2.2295	$94.85
77423	Neutron beam tx, complex	Z2	2.2295	$94.85
77435	Sbrt management	N1	.....	.....
77470	Special radiation treatment	Z3	4.9813	$211.92
77520	Proton trmt, simple w/o comp	Z2	18.8926	$803.75
77522	Proton trmt, simple w/comp	Z2	18.8926	$803.75
77523	Proton trmt, intermediate	Z2	22.6031	$961.60
77525	Proton treatment, complex	Z2	22.6031	$961.60
77600	Hyperthermia treatment	Z2	3.3461	$142.35
77605	Hyperthermia treatment	Z2	3.3461	$142.35
77610	Hyperthermia treatment	Z2	3.3461	$142.35
77615	Hyperthermia treatment	Z2	3.3461	$142.35
77620	Hyperthermia treatment	Z2	3.3461	$142.35
77750	Infuse radioactive materials	Z3	1.7140	$72.92
77761	Apply intrcav radiat simple	Z3	3.0419	$129.41
77762	Apply intrcav radiat interm	Z3	3.7741	$160.56
77763	Apply intrcav radiat compl	Z3	4.8283	$205.41
77776	Apply interstit radiat simpl	Z3	3.2109	$136.60
77777	Apply interstit radiat inter	Z3	3.8707	$164.67
77778	Apply interstit radiat compl	Z3	5.1261	$218.08
77781	High intensity brachytherapy	Z3	9.7854	$416.30
77782	High intensity brachytherapy	Z2	12.8473	$546.56
77783	High intensity brachytherapy	Z2	12.8473	$546.56
77784	High intensity brachytherapy	Z2	12.8473	$546.56
77789	Apply surface radiation	Z3	0.8530	$36.29
77790	Radiation handling	N1	.....	.....
77799	Radium/radioisotope therapy	Z2	4.8569	$206.63
78000	Thyroid, single uptake	Z3	1.0622	$45.19
78001	Thyroid, multiple uptakes	Z3	1.3520	$57.52
78003	Thyroid suppress/stimul	Z3	1.0622	$45.19
78006	Thyroid imaging with uptake	Z2	2.3432	$99.69
78007	Thyroid image, mult uptakes	Z3	2.1085	$89.70
78010	Thyroid imaging	Z3	2.2692	$96.54
78011	Thyroid imaging with flow	Z2	2.3432	$99.69
78015	Thyroid met imaging	Z3	3.0097	$128.04
78016	Thyroid met imaging/studies	Z2	3.9934	$169.89
78018	Thyroid met imaging, body	Z2	3.9934	$169.89
78020	Thyroid met uptake	Z3	1.1346	$48.27
78070	Parathyroid nuclear imaging	Z2	2.7146	$115.49
78075	Adrenal nuclear imaging	Z2	2.7146	$115.49
78099	Endocrine nuclear procedure	Z2	2.3432	$99.69
78102	Bone marrow imaging, ltd	Z3	2.3336	$99.28
78103	Bone marrow imaging, mult	Z3	3.2431	$137.97
78104	Bone marrow imaging, body	Z2	3.9073	$166.23
78110	Plasma volume, single	Z3	1.1830	$50.33
78111	Plasma volume, multiple	Z3	1.8266	$77.71
78120	Red cell mass, single	Z3	1.4566	$61.97
78121	Red cell mass, multiple	Z3	1.9634	$83.53
78122	Blood volume	Z3	2.6394	$112.29
78130	Red cell survival study	Z3	2.4060	$102.36
78135	Red cell survival kinetics	Z2	3.7562	$159.80
78140	Red cell sequestration	Z3	2.5913	$110.24
78185	Spleen imaging	Z3	2.8808	$122.56
78190	Platelet survival, kinetics	Z2	2.0057	$85.33
78191	Platelet survival	Z2	2.0057	$85.33
78195	Lymph system imaging	Z2	3.9073	$166.23
78199	Blood/lymph nuclear exam	Z2	3.9073	$166.23
78201	Liver imaging	Z3	2.7039	$115.03
78202	Liver imaging with flow	Z3	3.1385	$133.52
78205	Liver imaging (3D)	Z3	4.2811	$182.13
78206	Liver image (3d) with flow	Z2	4.3774	$186.23

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
78215	Liver and spleen imaging	Z3	2.9453	$125.30
78216	Liver & spleen image/flow	Z3	2.3980	$102.02
78220	Liver function study	Z3	2.5833	$109.90
78223	Hepatobiliary imaging	Z2	4.3774	$186.23
78230	Salivary gland imaging	Z3	2.3980	$102.02
78231	Serial salivary imaging	Z3	2.2775	$96.89
78232	Salivary gland function exam	Z3	2.4143	$102.71
78258	Esophageal motility study	Z3	3.2995	$140.37
78261	Gastric mucosa imaging	Z2	3.6526	$155.39
78262	Gastroesophageal reflux exam	Z2	3.6526	$155.39
78264	Gastric emptying study	Z2	3.6526	$155.39
78270	Vit B–12 absorption exam	Z3	1.3278	$56.49
78271	Vit B–12 absrp exam, int fac	Z3	1.3760	$58.54
78272	Vit B–12 absorp, combined	Z3	1.6898	$71.89
78278	Acute GI blood loss imaging	Z2	3.6526	$155.39
78282	GI protein loss exam	Z2	3.6526	$155.39
78290	Meckel's divert exam	Z2	3.6526	$155.39
78291	Leveen/shunt patency exam	Z3	3.4765	$147.90
78299	GI nuclear procedure	Z2	3.6526	$155.39
78300	Bone imaging, limited area	Z3	2.5106	$106.81
78305	Bone imaging, multiple areas	Z3	3.4443	$146.53
78306	Bone imaging, whole body	Z3	3.9029	$166.04
78315	Bone imaging, 3 phase	Z2	3.9174	$166.66
78320	Bone imaging (3D)	Z2	3.9174	$166.66
78399	Musculoskeletal nuclear exam	Z2	3.9174	$166.66
78414	Non-imaging heart function	Z2	4.1265	$175.55
78428	Cardiac shunt imaging	Z3	2.8729	$122.22
78445	Vascular flow imaging	Z2	2.4204	$102.97
78456	Acute venous thrombus image	Z2	2.4204	$102.97
78457	Venous thrombosis imaging	Z2	2.4204	$102.97
78458	Ven thrombosis images, bilat	Z2	2.4204	$102.97
78459	Heart muscle imaging (PET)	Z2	11.8963	$506.10
78460	Heart muscle blood, single	Z3	2.6235	$111.61
78461	Heart muscle blood, multiple	Z3	3.2673	$139.00
78464	Heart image (3d), single	Z2	4.1265	$175.55
78465	Heart image (3d), multiple	Z2	6.5012	$276.58
78466	Heart infarct image	Z3	2.7039	$115.03
78468	Heart infarct image (ef)	Z3	3.7099	$157.83
78469	Heart infarct image (3D)	Z2	4.1265	$175.55
78472	Gated heart, planar, single	Z2	4.1265	$175.55
78473	Gated heart, multiple	Z2	4.9832	$212.00
78478	Heart wall motion add-on	Z3	0.8530	$36.29
78480	Heart function add-on	Z3	0.8530	$36.29
78481	Heart first pass, single	Z3	3.9431	$167.75
78483	Heart first pass, multiple	Z2	4.9832	$212.00
78491	Heart image (pet), single	Z2	11.8963	$506.10
78492	Heart image (pet), multiple	Z2	11.8963	$506.10
78494	Heart image, spect	Z2	4.1265	$175.55
78496	Heart first pass add-on	Z2	1.5054	$64.04
78499	Cardiovascular nuclear exam	Z2	4.1265	$175.55
78580	Lung perfusion imaging	Z2	3.1802	$135.30
78584	Lung V/Q image single breath	Z3	2.2775	$96.89
78585	Lung V/Q imaging	Z2	5.0975	$216.86
78586	Aerosol lung image, single	Z3	2.5670	$109.21
78587	Aerosol lung image, multiple	Z3	3.1305	$133.18
78588	Perfusion lung image	Z3	4.4261	$188.30
78591	Vent image, 1 breath, 1 proj	Z3	2.6637	$113.32
78593	Vent image, 1 proj, gas	Z3	3.1465	$133.86
78594	Vent image, mult proj, gas	Z2	3.1802	$135.30
78596	Lung differential function	Z2	5.0975	$216.86
78599	Respiratory nuclear exam	Z2	3.1802	$135.30
78600	Brain imaging, ltd static	Z3	3.8627	$164.33
78601	Brain imaging, ltd w/flow	Z3	3.3315	$141.73
78605	Brain imaging, complete	Z3	3.1063	$132.15

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
78606	Brain imaging, compl w/flow	Z2	4.6418	$197.48
78607	Brain imaging (3D)	Z2	4.6418	$197.48
78608	Brain imaging (PET)	Z2	13.9166	$592.05
78610	Brain flow imaging only	Z3	2.2855	$97.23
78615	Cerebral vascular flow image	Z3	3.5327	$150.29
78630	Cerebrospinal fluid scan	Z2	3.4923	$148.57
78635	CSF ventriculography	Z2	3.4923	$148.57
78645	CSF shunt evaluation	Z2	3.4923	$148.57
78647	Cerebrospinal fluid scan	Z2	3.4923	$148.57
78650	CSF leakage imaging	Z2	3.4923	$148.57
78660	Nuclear exam of tear flow	Z3	2.4143	$102.71
78699	Nervous system nuclear exam	Z2	4.6418	$197.48
78700	Kidney imaging, morphol	Z3	2.8891	$122.91
78701	Kidney imaging with flow	Z3	3.4041	$144.82
78707	Kflow/funct image w/o drug	Z2	3.4209	$145.54
78708	Kflow/funct image w/drug	Z3	2.9373	$124.96
78709	Kflow/funct image, multiple	Z2	4.0378	$171.78
78710	Kidney imaging (3D)	Z2	3.4209	$145.54
78725	Kidney function study	Z2	1.3754	$58.51
78730	Urinary bladder retention	Z2	0.6102	$25.96
78740	Ureteral reflux study	Z3	2.8649	$121.88
78761	Testicular imaging w/flow	Z3	3.0499	$129.75
78799	Genitourinary nuclear exam	Z2	3.4209	$145.54
78800	Tumor imaging, limited area	Z3	2.9293	$124.62
78801	Tumor imaging, mult areas	Z3	3.9271	$167.07
78802	Tumor imaging, whole body	Z2	3.9934	$169.89
78803	Tumor imaging (3D)	Z2	3.9934	$169.89
78804	Tumor imaging, whole body	Z2	5.9245	$252.05
78805	Abscess imaging, ltd area	Z3	2.8729	$122.22
78806	Abscess imaging, whole body	Z2	3.9934	$169.89
78807	Nuclear localization/abscess	Z2	3.9934	$169.89
78811	Tumor imaging (pet), limited	Z2	13.9166	$592.05
78812	Tumor image (pet)/skul-thigh	Z2	13.9166	$592.05
78813	Tumor image (pet) full body	Z2	13.9166	$592.05
78814	Tumor image pet/ct, limited	Z2	15.4552	$657.51
78815	Tumorimage pet/ct skul-thigh	Z2	15.4552	$657.51
78816	Tumor image pet/ct full body	Z2	15.4552	$657.51
78890	Nuclear medicine data proc	N1		
78891	Nuclear med data proc	N1		
78999	Nuclear diagnostic exam	Z2	1.3754	$58.51
79005	Nuclear rx, oral admin	Z3	1.5370	$65.39
79101	Nuclear rx, iv admin	Z3	1.6094	$68.47
79200	Nuclear rx, intracav admin	Z3	1.6738	$71.21
79300	Nuclr rx, interstit colloid	Z2	3.1779	$135.20
79403	Hematopoietic nuclear tx	Z3	2.5591	$108.87
79440	Nuclear rx, intra-articular	Z3	1.4968	$63.68
79445	Nuclear rx, intra-arterial	Z2	3.1779	$135.20
79999	Nuclear medicine therapy	Z2	3.1779	$135.20
90371	Hep b ig, im	K2		$133.69
90375	Rabies ig, im/sc	K2		$65.44
90376	Rabies ig, heat treated	K2		$70.06
90396	Varicella-zoster ig, im	K2		$122.74
90585	Bcg vaccine, precut	K2		$113.63
90675	Rabies vaccine, im	K2		$146.91
90676	Rabies vaccine, id	K2		$119.86
90708	Measles-rubella vaccine, sc	K2		$45.53
90720	Dtp/hib vaccine, im	K2		$58.70
90727	Plague vaccine, im	K2		$7.13
90733	Meningococcal vaccine, sc	K2		$89.43
90734	Meningococcal vaccine, im	K2		$82.00
90735	Encephalitis vaccine, sc	K2		$99.11
A4218	Sterile saline or water	N1		
A4220	Infusion pump refill kit	N1		
A4248	Chlorhexidine antisept	N1		

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
A4262	Temporary tear duct plug	N1		
A4263	Permanent tear duct plug	N1		
A4270	Disposable endoscope sheath	N1		
A4300	Cath impl vasc access portal	N1		
A4301	Implantable access syst perc	N1		
A4305	Drug delivery system ≧50 ML	N1		
A4306	Drug delivery system ≦50 ml	N1		
A9527	Iodine I-125 sodium iodide	H7		
A9698	Non-rad contrast materialNOC	N1		
C1713	Anchor/screw bn/bn,tis/bn	N1		
C1714	Cath, trans atherectomy, dir	N1		
C1715	Brachytherapy needle	N1		
C1716	Brachytx source, Gold 198	H7		
C1717	Brachytx source, HDR Ir-192	H7		
C1718	Brachytx source, Iodine 125	H7		
C1719	Brachytx sour, Non-HDR Ir-192	H7		
C1720	Brachytx sour, Palladium 103	H7		
C1721	AICD, dual chamber	N1		
C1722	AICD, single chamber	N1		
C1724	Cath, trans atherec, rotation	N1		
C1725	Cath, translumin non-laser	N1		
C1726	Cath, bal dil, non-vascular	N1		
C1727	Cath, bal tis dis, non-vas	N1		
C1728	Cath, brachytx seed adm	N1		
C1729	Cath, drainage	N1		
C1730	Cath, EP, 19 or few elect	N1		
C1731	Cath, EP, 20 or more elec	N1		
C1732	Cath, EP, diag/abl, 3D/vect	N1		
C1733	Cath, EP, othr than cool-tip	N1		
C1750	Cath, hemodialysis, long-term	N1		
C1751	Cath, inf, per/cent/midline	N1		
C1752	Cath, hemodialysis, short-term	N1		
C1753	Cath, intravas ultrasound	N1		
C1754	Catheter, intradiscal	N1		
C1755	Catheter, intraspinal	N1		
C1756	Cath, pacing, transesoph	N1		
C1757	Cath, thrombectomy/embolect	N1		
C1758	Catheter, ureteral	N1		
C1759	Cath, intra echocardiography	N1		
C1760	Closure dev, vasc	N1		
C1762	Conn tiss, human (inc fascia)	N1		
C1763	Conn tiss, non-human	N1		
C1764	Event recorder, cardiac	N1		
C1765	Adhesion barrier	N1		
C1766	Intro/sheath, strble, non-peel	N1		
C1767	Generator, neuro non-recharg	N1		
C1768	Graft, vascular	N1		
C1769	Guide wire	N1		
C1770	Imaging coil, MR, insertable	N1		
C1771	Rep dev, urinary, w/sling	N1		
C1772	Infusion pump, programmable	N1		
C1773	Ret dev, insertable	N1		
C1776	Joint device (implantable)	N1		
C1777	Lead, AICD, endo single coil	N1		
C1778	Lead, neurostimulator	N1		
C1779	Lead, pmkr, transvenous VDD	N1		
C1780	Lens, intraocular (new tech)	N1		
C1781	Mesh (implantable)	N1		
C1782	Morcellator	N1		
C1783	Ocular imp, aqueous drain de	N1		
C1784	Ocular dev, intraop, det ret	N1		
C1785	Pmkr, dual, rate-resp	N1		
C1786	Pmkr, single, rate-resp	N1		
C1787	Patient progr, neurostim	N1		

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
C1788	Port, indwelling, imp	N1		
C1789	Prosthesis, breast, imp	N1		
C1813	Prosthesis, penile, inflatab	N1		
C1814	Retinal tamp, silicone oil	N1		
C1815	Pros, urinary sph, imp	N1		
C1816	Receiver/transmitter, neuro	N1		
C1817	Septal defect imp sys	N1		
C1818	Integrated keratoprosthesis	N1		
C1819	Tissue localization-excision	N1		
C1820	Generator neuro rechg bat sy	J7		
C1821	Interspinous implant	J7		
C1874	Stent, coated/cov w/del sys	N1		
C1875	Stent, coated/cov w/o del sy	N1		
C1876	Stent, non-coa/non-cov w/del	N1		
C1877	Stent, non-coat/cov w/o del	N1		
C1878	Matrl for vocal cord	N1		
C1879	Tissue marker, implantable	N1		
C1880	Vena cava filter	N1		
C1881	Dialysis access system	N1		
C1882	AICD, other than sing/dual	N1		
C1883	Adapt/ext, pacing/neuro lead	N1		
C1884	Embolization Protect syst	N1		
C1885	Cath, translumin angio laser	N1		
C1887	Catheter, guiding	N1		
C1888	Endovas non-cardiac abl cath	N1		
C1891	Infusion pump, non-prog, perm	N1		
C1892	Intro/sheath, fixed, peel-away	N1		
C1893	Intro/sheath, fixed, non-peel	N1		
C1894	Intro/sheath, non-laser	N1		
C1895	Lead, AICD, endo dual coil	N1		
C1896	Lead, AICD, non sing/dual	N1		
C1897	Lead, neurostim test kit	N1		
C1898	Lead, pmkr, other than trans	N1		
C1899	Lead, pmkr/AICD combination	N1		
C1900	Lead, coronary venous	N1		
C2614	Probe, perc lumb disc	N1		
C2615	Sealant, pulmonary, liquid	N1		
C2616	Brachytx source, Yttrium-90	H7		
C2617	Stent, non-cor, tem w/o del	N1		
C2618	Probe, cryoablation	N1		
C2619	Pmkr, dual, non rate-resp	N1		
C2620	Pmkr, single, non rate-resp	N1		
C2621	Pmkr, other than sing/dual	N1		
C2622	Prosthesis, penile, non-inf	N1		
C2625	Stent, non-cor, tem w/del sy	N1		
C2626	Infusion pump, non-prog, temp	N1		
C2627	Cath, suprapubic/cystoscopic	N1		
C2628	Catheter, occlusion	N1		
C2629	Intro/sheath, laser	N1		
C2630	Cath, EP, cool-tip	N1		
C2631	Rep dev, urinary, w/o sling	N1		
C2633	Brachytx source, Cesium-131	H7		
C2634	Brachytx source, HA, I-125	H7		
C2635	Brachytx source, HA, P-103	H7		
C2636	Brachytx linear source, P-103	H7		
C2637	Brachytx, Ytterbium–169	H7		
C8900	MRA w/cont, abd	Z2	6.1231	$260.50
C8901	MRA w/o cont, abd	Z2	5.6745	$241.41
C8902	MRA w/o fol w/cont, abd	Z2	8.1155	$345.26
C8903	MRI w/cont, breast, uni	Z2	6.1231	$260.50
C8904	MRI w/o cont, breast, uni	Z2	5.6745	$241.41
C8905	MRI w/o fol w/cont, brst, un	Z2	8.1155	$345.26
C8906	MRI w/cont, breast, bi	Z2	6.1231	$260.50
C8907	MRI w/o cont, breast, bi	Z2	5.6745	$241.41

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
C8908	MRI w/o fol w/cont, breast,	Z2	8.1155	$345.26
C8909	MRA w/cont, chest	Z2	6.1231	$260.50
C8910	MRA w/o cont, chest	Z2	5.6745	$241.41
C8911	MRA w/o fol w/cont, chest	Z2	8.1155	$345.26
C8912	MRA w/cont, lwr ext	Z2	6.1231	$260.50
C8913	MRA w/o cont, lwr ext	Z2	5.6745	$241.41
C8914	MRA w/o fol w/cont, lwr ext	Z2	8.1155	$345.26
C8918	MRA w/cont, pelvis	Z2	6.1231	$260.50
C8919	MRA w/o cont, pelvis	Z2	5.6745	$241.41
C8920	MRA w/o fol w/cont, pelvis	Z2	8.1155	$345.26
C9003	Palivizumab, per 50 mg	K2		$684.43
C9113	Inj pantoprazole sodium, via	N1		
C9121	Injection, argatroban	K2		$18.04
C9232	Injection, idursulfase	K2		$455.03
C9233	Injection, ranibizumab	K2		$2,030.92
C9234	Inj, alglucosidase alfa	K2		$127.20
C9235	Injection, panitumumab	K2		$84.80
C9350	Porous collagen tube per cm	K2		$485.91
C9351	Acellular derm tissue percm2	K2		$41.59
C9399	Unclassified drugs or biolog	K7		
E0616	Cardiac event recorder	N1		
E0749	Elec osteogen stim implanted	N1		
E0782	Non-programble infusion pump	N1		
E0783	Programmable infusion pump	N1		
E0785	Replacement impl pump cathet	N1		
E0786	Implantable pump replacement	N1		
G0130	Single energy x-ray study	Z3	0.5150	$21.91
G0173	Linear acc stereo radsur com	Z2	63.3759	$2,696.20
G0251	Linear acc based stero radio	Z2	20.3224	$864.58
G0288	Recon, CTA for surg plan	Z2	3.2393	$137.81
G0339	Robot lin-radsurg com, first	Z2	63.3759	$2,696.20
G0340	Robt lin-radsurg fractx 2–5	Z2	43.0297	$1,830.61
J0120	Tetracyclin injection	N1		
J0128	Abarelix injection	K2		$68.62
J0129	Abatacept injection	K2		$18.69
J0130	Abciximab injection	K2		$413.16
J0132	Acetylcysteine injection	K2		$1.95
J0133	Acyclovir injection	N1		
J0135	Adalimumab injection	K2		$319.03
J0150	Injection adenosine 6 MG	K2		$22.86
J0152	Adenosine injection	K2		$69.16
J0170	Adrenalin epinephrin inject	N1		
J0180	Agalsidase beta injection	K2		$127.20
J0190	Inj biperiden lactate/5 mg	K2		$88.15
J0200	Alatrofloxacin mesylate	N1		
J0205	Alglucerase injection	K2		$39.22
J0207	Amifostine	K2		$480.64
J0210	Methyldopate hcl injection	K2		$10.11
J0215	Alefacept	K2		$26.07
J0256	Alpha 1 proteinase inhibitor	K2		$3.28
J0278	Amikacin sulfate injection	N1		
J0280	Aminophyllin 250 MG inj	N1		
J0282	Amiodarone HCl	N1		
J0285	Amphotericin B	N1		
J0287	Amphotericin b lipid complex	K2		$10.38
J0288	Ampho b cholesteryl sulfate	K2		$12.00
J0289	Amphotericin b liposome inj	K2		$17.24
J0290	Ampicillin 500 MG inj	N1		
J0295	Ampicillin sodium per 1.5 gm	N1		
J0300	Amobarbital 125 MG inj	N1		
J0330	Succinycholine chloride inj	N1		
J0348	Anadulafungin injection	K2		$1.91
J0350	Injection anistreplase 30 u	K2		$2,693.80
J0360	Hydralazine hcl injection	N1		

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
J0364	Apomorphine hydrochloride	K2		$2.99
J0365	Aprotonin, 10,000 kiu	K2		$2.52
J0380	Inj metaraminol bitartrate	K2		$15.67
J0390	Chloroquine injection	N1		
J0395	Arbutamine HCl injection	K2		$182.40
J0456	Azithromycin	N1		
J0460	Atropine sulfate injection	N1		
J0470	Dimecaprol injection	N1		
J0475	Baclofen 10 MG injection	K2		$197.04
J0476	Baclofen intrathecal trial	K2		$71.59
J0480	Basiliximab	K2		$1,359.97
J0500	Dicyclomine injection	N1		
J0515	Inj benztropine mesylate	N1		
J0520	Bethanechol chloride inject	N1		
J0530	Penicillin g benzathine inj	N1		
J0540	Penicillin g benzathine inj	N1		
J0550	Penicillin g benzathine inj	N1		
J0560	Penicillin g benzathine inj	N1		
J0570	Penicillin g benzathine inj	N1		
J0580	Penicillin g benzathine inj	N1		
J0583	Bivalirudin	K2		$1.74
J0585	Botulinum toxin a per unit	K2		$5.10
J0587	Botulinum toxin type B	K2		$8.37
J0592	Buprenorphine hydrochloride	N1		
J0594	Busulfan injection	K2		$8.89
J0595	Butorphanol tartrate 1 mg	N1		
J0600	Edetate calcium disodium inj	K2		$40.19
J0610	Calcium gluconate injection	N1		
J0620	Calcium glycer & lact/10 ML	N1		
J0630	Calcitonin salmon injection	N1		
J0636	Inj calcitriol per 0.1 mcg	N1		
J0637	Caspofungin acetate	K2		$30.35
J0640	Leucovorin calcium injection	N1		
J0670	Inj mepivacaine HCL/10 ml	N1		
J0690	Cefazolin sodium injection	N1		
J0692	Cefepime HCl for injection	N1		
J0694	Cefoxitin sodium injection	N1		
J0696	Ceftriaxone sodium injection	N1		
J0697	Sterile cefuroxime injection	N1		
J0698	Cefotaxime sodium injection	N1		
J0702	Betamethasone acet&sod phosp	N1		
J0704	Betamethasone sod phosp/4 MG	N1		
J0706	Caffeine citrate injection	K2		$3.36
J0710	Cephapirin sodium injection	N1		
J0713	Inj ceftazidime per 500 mg	N1		
J0715	Ceftizoxime sodium/500 MG	N1		
J0720	Chloramphenicol sodium injec	N1		
J0725	Chorionic gonadotropin/1000u	N1		
J0735	Clonidine hydrochloride	K2		$63.46
J0740	Cidofovir injection	K2		$761.81
J0743	Cilastatin sodium injection	N1		
J0744	Ciprofloxacin iv	N1		
J0745	Inj codeine phosphate /30 MG	N1		
J0760	Colchicine injection	N1		
J0770	Colistimethate sodium inj	N1		
J0780	Prochlorperazine injection	N1		
J0795	Corticorelin ovine triflutal	K2		$4.31
J0800	Corticotropin injection	K2		$127.73
J0835	Inj cosyntropin per 0.25 MG	K2		$63.85
J0850	Cytomegalovirus imm IV /vial	K2		$868.05
J0878	Daptomycin injection	K2		$0.33
J0881	Darbepoetin alfa, non-esrd	K2		$3.14
J0885	Epoetin alfa, non-esrd	K2		$9.45
J0894	Decitabine injection	K2		$26.48

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
J0895	Deferoxamine mesylate inj	K2		$14.52
J0900	Testosterone enanthate inj	N1		
J0945	Brompheniramine maleate inj	N1		
J0970	Estradiol valerate injection	N1		
J1000	Depo-estradiol cypionate inj	N1		
J1020	Methylprednisolone 20 MG inj	N1		
J1030	Methylprednisolone 40 MG inj	N1		
J1040	Methylprednisolone 80 MG inj	N1		
J1051	Medroxyprogesterone inj	N1		
J1060	Testosterone cypionate 1 ML	N1		
J1070	Testosterone cypionat 100 MG	N1		
J1080	Testosterone cypionat 200 MG	N1		
J1094	Inj dexamethasone acetate	N1		
J1100	Dexamethasone sodium phos	N1		
J1110	Inj dihydroergotamine mesylt	N1		
J1120	Acetazolamid sodium injectio	N1		
J1160	Digoxin injection	N1		
J1162	Digoxin immune fab (ovine)	K2		$516.35
J1165	Phenytoin sodium injection	N1		
J1170	Hydromorphone injection	N1		
J1180	Dyphylline injection	N1		
J1190	Dexrazoxane HCl injection	K2		$174.07
J1200	Diphenhydramine hcl injectio	N1		
J1205	Chlorothiazide sodium inj	K2		$123.84
J1212	Dimethyl sulfoxide 50% 50 ML	N1		
J1230	Methadone injection	N1		
J1240	Dimenhydrinate injection	N1		
J1245	Dipyridamole injection	N1		
J1250	Inj dobutamine HCL/250 mg	N1		
J1260	Dolasetron mesylate	K2		$6.11
J1265	Dopamine injection	N1		
J1270	Injection, doxercalciferol	N1		
J1320	Amitriptyline injection	N1		
J1324	Enfuvirtide injection	K2		$22.91
J1325	Epoprostenol injection	N1		
J1327	Eptifibatide injection	K2		$16.05
J1330	Ergonovine maleate injection	K2		$4.00
J1335	Ertapenem injection	N1		
J1364	Erythro lactobionate /500 MG	N1		
J1380	Estradiol valerate 10 MG inj	N1		
J1390	Estradiol valerate 20 MG inj	N1		
J1410	Inj estrogen conjugate 25 MG	K2		$60.90
J1430	Ethanolamine oleate 100 mg	K2		$79.01
J1435	Injection estrone per 1 MG	N1		
J1436	Etidronate disodium inj	K2		$71.41
J1438	Etanercept injection	K2		$161.55
J1440	Filgrastim 300 mcg injection	K2		$189.47
J1441	Filgrastim 480 mcg injection	K2		$300.58
J1450	Fluconazole	N1		
J1451	Fomepizole, 15 mg	K2		$12.39
J1452	Intraocular Fomivirsen na	K2		$237.50
J1455	Foscarnet sodium injection	K2		$10.20
J1457	Gallium nitrate injection	N1		
J1458	Galsulfase injection	K2		$299.92
J1460	Gamma globulin 1 CC inj	K2		$11.42
J1562	Immune globulin subcutaneous	K2		$12.72
J1565	RSV-ivig	K2		$16.18
J1566	Immune globulin, powder	K2		$25.72
J1567	Immune globulin, liquid	K2		$30.57
J1570	Ganciclovir sodium injection	N1		
J1580	Garamycin gentamicin inj	N1		
J1590	Gatifloxacin injection	N1		
J1595	Injection glatiramer acetate	N1		
J1600	Gold sodium thiomaleate inj	N1		

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HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
J1610	Glucagon hydrochloride/1 MG	K2		$66.27
J1620	Gonadorelin hydroch/ 100 mcg	K2		$180.30
J1626	Granisetron HCl injection	K2		$7.50
J1630	Haloperidol injection	N1		
J1631	Haloperidol decanoate inj	N1		
J1640	Hemin, 1 mg	K2		$6.80
J1642	Inj heparin sodium per 10 u	N1		
J1644	Inj heparin sodium per 1000u	N1		
J1645	Dalteparin sodium	N1		
J1650	Inj enoxaparin sodium	N1		
J1652	Fondaparinux sodium	N1		
J1655	Tinzaparin sodium injection	K2		$2.45
J1670	Tetanus immune globulin inj	K2		$97.26
J1700	Hydrocortisone acetate inj	N1		
J1710	Hydrocortisone sodium ph inj	N1		
J1720	Hydrocortisone sodium succ i	N1		
J1730	Diazoxide injection	K2		$114.32
J1740	Ibandronate sodium injection	K2		$138.71
J1742	Ibutilide fumarate injection	K2		$266.92
J1745	Infliximab injection	K2		$53.76
J1751	Iron dextran 165 injection	K2		$11.72
J1752	Iron dextran 267 injection	K2		$10.42
J1756	Iron sucrose injection	K2		$0.37
J1785	Injection imiglucerase /unit	K2		$3.92
J1790	Droperidol injection	N1		
J1800	Propranolol injection	N1		
J1815	Insulin injection	N1		
J1817	Insulin for insulin pump use	N1		
J1830	Interferon beta-1b /.25 MG	K2		$84.92
J1835	Itraconazole injection	K2		$38.41
J1840	Kanamycin sulfate 500 MG inj	N1		
J1850	Kanamycin sulfate 75 MG inj	N1		
J1885	Ketorolac tromethamine inj	N1		
J1890	Cephalothin sodium injection	N1		
J1931	Laronidase injection	K2		$23.87
J1940	Furosemide injection	N1		
J1945	Lepirudin	K2		$154.89
J1950	Leuprolide acetate /3.75 MG	K2		$433.92
J1956	Levofloxacin injection	N1		
J1960	Levorphanol tartrate inj	N1		
J1980	Hyoscyamine sulfate inj	N1		
J1990	Chlordiazepoxide injection	N1		
J2001	Lidocaine injection	N1		
J2010	Lincomycin injection	N1		
J2020	Linezolid injection	K2		$25.17
J2060	Lorazepam injection	N1		
J2150	Mannitol injection	N1		
J2170	Mecasermin injection	K2		$11.93
J2175	Meperidine hydrochl /100 MG	N1		
J2180	Meperidine/promethazine inj	N1		
J2185	Meropenem	K2		$3.71
J2210	Methylergonovin maleate inj	N1		
J2248	Micafungin sodium injection	K2		$1.71
J2250	Inj midazolam hydrochloride	N1		
J2260	Inj milrinone lactate/5 MG	N1		
J2270	Morphine sulfate injection	N1		
J2271	Morphine so4 injection 100 mg	N1		
J2275	Morphine sulfate injection	N1		
J2278	Ziconotide injection	K2		$6.52
J2280	Inj, moxifloxacin 100 mg	N1		
J2300	Inj nalbuphine hydrochloride	N1		
J2310	Inj naloxone hydrochloride	N1		
J2315	Naltrexone, depot form	K2		$1.90
J2320	Nandrolone decanoate 50 MG	N1		

Note: The Medicare program payment is 80 percent of the total payment amount and beneficiary coinsurance is 20 percent of the total payment amount, except for screening flexible sigmoidoscopies and screening colonoscopies for which the program payment is 75 percent and the beneficiary coinsurance is 25 percent.

ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
J2321	Nandrolone decanoate 100 MG	N1		
J2322	Nandrolone decanoate 200 MG	N1		
J2325	Nesiritide injection	K2		$31.66
J2353	Octreotide injection, depot	K2		$96.77
J2354	Octreotide inj, non-depot	N1		
J2355	Oprelvekin injection	K2		$247.31
J2357	Omalizumab injection	K2		$16.95
J2360	Orphenadrine injection	N1		
J2370	Phenylephrine hcl injection	N1		
J2400	Chloroprocaine hcl injection	N1		
J2405	Ondansetron hcl injection	K2		$3.40
J2410	Oxymorphone hcl injection	N1		
J2425	Palifermin injection	K2		$11.43
J2430	Pamidronate disodium/30 MG	K2		$30.78
J2440	Papaverin hcl injection	N1		
J2460	Oxytetracycline injection	N1		
J2469	Palonosetron HCl	K2		$16.00
J2501	Paricalcitol	N1		
J2503	Pegaptanib sodium injection	K2		$1,054.70
J2504	Pegademase bovine, 25 iu	K2		$177.83
J2505	Injection, pegfilgrastim 6mg	K2		$2,163.33
J2510	Penicillin g procaine inj	N1		
J2513	Pentastarch 10% solution	N1		
J2515	Pentobarbital sodium inj	N1		
J2540	Penicillin g potassium inj	N1		
J2543	Piperacillin/tazobactam	N1		
J2550	Promethazine hcl injection	N1		
J2560	Phenobarbital sodium inj	N1		
J2590	Oxytocin injection	N1		
J2597	Inj desmopressin acetate	N1		
J2650	Prednisolone acetate inj	N1		
J2670	Totazoline hcl injection	N1		
J2675	Inj progesterone per 50 MG	N1		
J2680	Fluphenazine decanoate 25 MG	N1		
J2690	Procainamide hcl injection	N1		
J2700	Oxacillin sodium injection	N1		
J2710	Neostigmine methylslfte inj	N1		
J2720	Inj protamine sulfate/10 MG	N1		
J2725	Inj protirelin per 250 mcg	N1		
J2730	Pralidoxime chloride inj	N1		
J2760	Phentolaine mesylate inj	N1		
J2765	Metoclopramide hcl injection	N1		
J2770	Quinupristin/dalfopristin	K2		$117.81
J2780	Ranitidine hydrochloride inj	N1		
J2783	Rasburicase	K2		$132.53
J2788	Rho d immune globulin 50 mcg	K2		$26.66
J2790	Rho d immune globulin inj	K2		$81.48
J2792	Rho(D) immune globulin h, sd	K2		$15.91
J2794	Risperidone, long acting	K2		$4.85
J2795	Ropivacaine HCl injection	N1		
J2800	Methocarbamol injection	N1		
J2805	Sincalide injection	N1		
J2810	Inj theophylline per 40 MG	N1		
J2820	Sargramostim injection	K2		$25.31
J2850	Inj secretin synthetic human	K2		$20.31
J2910	Aurothioglucose injection	N1		
J2916	Na ferric gluconate complex	N1		
J2920	Methylprednisolone injection	N1		
J2930	Methylprednisolone injection	N1		
J2940	Somatrem injection	K2		$168.90
J2941	Somatropin injection	K2		$47.19
J2950	Promazine hcl injection	N1		
J2993	Reteplase injection	K2		$899.51
J2995	Inj streptokinase /250000 IU	K2		$129.75

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
J2997	Alteplase recombinant	K2		$32.79
J3000	Streptomycin injection	N1		
J3010	Fentanyl citrate injeciton	N1		
J3030	Sumatriptan succinate / 6 MG	K2		$59.38
J3070	Pentazocine injection	N1		
J3100	Tenecteplase injection	K2		$2,043.40
J3105	Terbutaline sulfate inj	N1		
J3120	Testosterone enanthate inj	N1		
J3130	Testosterone enanthate inj	N1		
J3140	Testosterone suspension inj	N1		
J3150	Testosterone propionate inj	N1		
J3230	Chlorpromazine hcl injection	N1		
J3240	Thyrotropin injection	K2		$765.38
J3243	Tigecycline injection	K2		$0.91
J3246	Tirofiban HCl	K2		$7.73
J3250	Trimethobenzamide hcl inj	N1		
J3260	Tobramycin sulfate injection	N1		
J3265	Injection torsemide 10 mg/ml	N1		
J3280	Thiethylperazine maleate inj	N1		
J3285	Treprostinil injection	K2		$55.89
J3301	Triamcinolone acetonide inj	N1		
J3302	Triamcinolone diacetate inj	N1		
J3303	Triamcinolone hexacetonl inj	N1		
J3305	Inj trimetrexate glucoronate	K2		$145.26
J3310	Perphenazine injection	N1		
J3315	Triptorelin pamoate	K2		$155.44
J3320	Spectinomycn di-hcl inj	K2		$30.08
J3350	Urea injection	K2		$74.16
J3355	Urofollitropin, 75 iu	K2		$50.70
J3360	Diazepam injection	N1		
J3364	Urokinase 5000 IU injection	N1		
J3365	Urokinase 250,000 IU inj	K2		$457.73
J3370	Vancomycin hcl injection	N1		
J3396	Verteporfin injection	K2		$8.92
J3400	Triflupromazine hcl inj	N1		
J3410	Hydroxyzine hcl injection	N1		
J3411	Thiamine hcl 100 mg	N1		
J3415	Pyridoxine hcl 100 mg	N1		
J3420	Vitamin b12 injection	N1		
J3430	Vitamin k phytonadione inj	N1		
J3465	Injection, voriconazole	K2		$4.99
J3470	Hyaluronidase injection	N1		
J3471	Ovine, up to 999 USP units	N1		
J3472	Ovine, 1000 USP units	K2		$135.04
J3473	Hyaluronidase recombinant	K2		$0.40
J3475	Inj magnesium sulfate	N1		
J3480	Inj potassium chloride	N1		
J3485	Zidovudine	N1		
J3486	Ziprasidone mesylate	N1		
J3487	Zoledronic acid	K2		$206.04
J3490	Drugs unclassified injection	N1		
J3530	Nasal vaccine inhalation	N1		
J3590	Unclassified biologics	N1		
J7030	Normal saline solution infus	N1		
J7040	Normal saline solution infus	N1		
J7042	5% dextrose/normal saline	N1		
J7050	Normal saline solution infus	N1		
J7060	5% dextrose/water	N1		
J7070	D5w infusion	N1		
J7100	Dextran 40 infusion	N1		
J7110	Dextran 75 infusion	N1		
J7120	Ringers lactate infusion	N1		
J7130	Hypertonic saline solution	N1		
J7187	Inj Vonwillebrand factor IU	K2		$0.88

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
J7189	Factor viia	K2		$1.12
J7190	Factor viii	K2		$0.70
J7191	Factor VIII (porcine)	K2		$0.75
J7192	Factor viii recombinant	K2		$1.07
J7193	Factor IX non-recombinant	K2		$0.89
J7194	Factor ix complex	K2		$0.75
J7195	Factor IX recombinant	K2		$0.99
J7197	Antithrombin iii injection	K2		$1.64
J7198	Anti-inhibitor	K2		$1.36
J7308	Aminolevulinic acid hcl top	K2		$105.43
J7310	Ganciclovir long act implant	K2		$4,752.26
J7311	Fluocinolone acetonide implt	K2		$19,345.00
J7340	Metabolic active D/E tissue	K2		$28.78
J7341	Non-human, metabolic tissue	K2		$1.82
J7342	Metabolically active tissue	K2		$31.66
J7343	Nonmetabolic act d/e tissue	K2		$18.30
J7344	Nonmetabolic active tissue	K2		$89.21
J7345	Non-human, non-metab tissue	K2		$36.10
J7346	Injectable human tissue	K2		$735.38
J7500	Azathioprine oral 50 mg	N1		
J7501	Azathioprine parenteral	K2		$48.44
J7502	Cyclosporine oral 100 mg	K2		$3.60
J7504	Lymphocyte immune globulin	K2		$317.18
J7505	Monoclonal antibodies	K2		$895.15
J7506	Prednisone oral	N1		
J7507	Tacrolimus oral per 1 MG	K2		$3.66
J7509	Methylprednisolone oral	N1		
J7510	Prednisolone oral per 5 mg	N1		
J7511	Antithymocyte globuln rabbit	K2		$327.75
J7513	Daclizumab, parenteral	K2		$299.86
J7515	Cyclosporine oral 25 mg	N1		
J7516	Cyclosporin parenteral 250 mg	N1		
J7517	Mycophenolate mofetil oral	K2		$2.62
J7518	Mycophenolic acid	K2		$2.27
J7520	Sirolimus, oral	K2		$7.22
J7525	Tacrolimus injection	K2		$140.44
J7599	Immunosuppressive drug noc	N1		
J7674	Methacholine chloride, neb	N1		
J7799	Non-inhalation drug for DME	N1		
J8501	Oral aprepitant	K2		$5.07
J8510	Oral busulfan	K2		$2.14
J8520	Capecitabine, oral, 150 mg	K2		$3.97
J8530	Cyclophosphamide oral 25 MG	N1		
J8540	Oral dexamethasone	N1		
J8560	Etoposide oral 50 MG	K2		$29.60
J8597	Antiemetic drug oral NOS	N1		
J8600	Melphalan oral 2 MG	N1		
J8610	Methotrexate oral 2.5 MG	N1		
J8650	Nabilone oral	K2		$16.96
J8700	Temozolomide	K2		$7.41
J9000	Doxorubic hcl 10 MG vl chemo	K2		$6.31
J9001	Doxorubicin hcl liposome inj	K2		$389.48
J9010	Alemtuzumab injection	K2		$541.20
J9015	Aldesleukin/single use vial	K2		$762.98
J9017	Arsenic trioxide	K2		$34.17
J9020	Asparaginase injection	K2		$54.72
J9025	Azacitidine injection	K2		$4.30
J9027	Clofarabine injection	K2		$116.75
J9031	Bcg live intravesical vac	K2		$110.67
J9035	Bevacizumab injection	K2		$57.53
J9040	Bleomycin sulfate injection	K2		$35.85
J9041	Bortezomib injection	K2		$32.68
J9045	Carboplatin injection	K2		$8.46
J9050	Carmus bischl nitro inj	K2		$139.84

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
J9055	Cetuximab injection	K2		$49.81
J9060	Cisplatin 10 MG injection	N1		
J9065	Inj cladribine per 1 MG	K2		$36.12
J9070	Cyclophosphamide 100 MG inj	N1		
J9093	Cyclophosphamide lyophilized	K2		$1.99
J9098	Cytarabine liposome	K2		$395.04
J9100	Cytarabine hcl 100 MG inj	N1		
J9120	Dactinomycin actinomycin d	K2		$493.43
J9130	Dacarbazine 100 mg inj	K2		$5.25
J9150	Daunorubicin	K2		$20.47
J9151	Daunorubicin citrate liposom	K2		$55.92
J9160	Denileukin diftitox, 300 mcg	K2		$1,406.59
J9165	Diethylstilbestrol injection	N1		
J9170	Docetaxel	K2		$306.81
J9175	Elliotts b solution per ml	N1		
J9178	Inj, epirubicin hcl, 2 mg	K2		$21.21
J9181	Etoposide 10 MG inj	N1		
J9185	Fludarabine phosphate inj	K2		$236.44
J9190	Fluorouracil injection	N1		
J9200	Floxuridine injection	K2		$51.31
J9201	Gemcitabine HCl	K2		$125.16
J9202	Goserelin acetate implant	K2		$198.68
J9206	Irinotecan injection	K2		$126.00
J9208	Ifosfomide injection	K2		$46.59
J9209	Mesna injection	K2		$8.97
J9211	Idarubicin hcl injection	K2		$304.61
J9212	Interferon alfacon–1	K2		$4.65
J9213	Interferon alfa–2a inj	K2		$37.89
J9214	Interferon alfa–2b inj	K2		$13.88
J9215	Interferon alfa–n3 inj	K2		$9.12
J9216	Interferon gamma 1–b inj	K2		$289.87
J9217	Leuprolide acetate suspnsion	K2		$229.50
J9218	Leuprolide acetate injeciton	K2		$8.88
J9219	Leuprolide acetate implant	K2		$1,713.12
J9225	Histrelin implant	K2		$1,460.77
J9230	Mechlorethamine hcl inj	K2		$141.61
J9245	Inj melphalan hydrochl 50 MG	K2		$1,284.12
J9250	Methotrexate sodium inj	N1		
J9261	Nelarabine injection	K2		$83.33
J9263	Oxaliplatin	K2		$8.97
J9264	Paclitaxel protein bound	K2		$8.73
J9265	Paclitaxel injection	K2		$12.59
J9266	Pegaspargase/singl dose vial	K2		$1,683.49
J9268	Pentostatin injection	K2		$1,934.91
J9270	Plicamycin (mithramycin) inj	K2		$172.41
J9280	Mitomycin 5 MG inj	K2		$16.13
J9293	Mitoxantrone hydrochl / 5 MG	K2		$168.23
J9300	Gemtuzumab ozogamicin	K2		$2,356.98
J9305	Pemetrexed injection	K2		$43.79
J9310	Rituximab cancer treatment	K2		$496.22
J9320	Streptozocin injection	K2		$153.73
J9340	Thiotepa injection	K2		$40.70
J9350	Topotecan	K2		$830.74
J9355	Trastuzumab	K2		$57.87
J9357	Valrubicin, 200 mg	K2		$77.96
J9360	Vinblastine sulfate inj	N1		
J9370	Vincristine sulfate 1 MG inj	N1		
J9390	Vinorelbine tartrate/10 mg	K2		$20.07
J9395	Injection, Fulvestrant	K2		$80.56
J9600	Porfimer sodium	K2		$2,563.31
J9999	Chemotherapy drug	N1		
L8600	Implant breast silicone/eq	N1		
L8603	Collagen imp urinary 2.5 ml	N1		
L8606	Synthetic implnt urinary 1ml	N1		

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
L8609	Artificial cornea	N1		
L8610	Ocular implant	N1		
L8612	Aqueous shunt prosthesis	N1		
L8613	Ossicular implant	N1		
L8614	Cochlear device	N1		
L8630	Metacarpophalangeal implant	N1		
L8631	MCP joint repl 2 pc or more	N1		
L8641	Metatarsal joint implant	N1		
L8642	Hallux implant	N1		
L8658	Interphalangeal joint spacer	N1		
L8659	Interphalangeal joint repl	N1		
L8670	Vascular graft, synthetic	N1		
L8682	Implt neurostim radiofq rec	N1		
L8690	Aud osseo dev, int/ext comp	J7		
L8699	Prosthetic implant NOS	N1		
Q0163	Diphenhydramine HCl 50mg	N1		
Q0164	Prochlorperazine maleate 5mg	N1		
Q0166	Granisetron HCl 1 mg oral	K2		$44.87
Q0167	Dronabinol 2.5 mg oral	N1		
Q0169	Promethazine HCl 12.5 mg oral	N1		
Q0171	Chlorpromazine HCl 10 mg oral	N1		
Q0173	Trimethobenzamide HCl 250 mg	N1		
Q0174	Thiethylperazine maleate 10 mg	N1		
Q0175	Perphenazine 4 mg oral	N1		
Q0177	Hydroxyzine pamoate 25 mg	N1		
Q0179	Ondansetron HCl 8 mg oral	K2		$36.55
Q0180	Dolasetron mesylate oral	K2		$47.52
Q0515	Sermorelin acetate injection	K2		$1.75
Q1003	Ntiol category 3	L6		$50.00
Q2004	Bladder calculi irrig sol	N1		
Q2009	Fosphenytoin, 50 mg	K2		$5.66
Q2017	Teniposide, 50 mg	K2		$264.09
Q3025	IM inj interferon beta 1–a	K2		$114.57
Q4079	Natalizumab injection	K2		$7.52
Q4083	Hyalgan/supartz inj per dose	K2		$104.85
Q4084	Synvisc inj per dose	K2		$186.66
Q4085	Euflexxa inj per dose	K2		$115.16
Q4086	Orthovisc inj per dose	K2		$198.34
Q9945	LOCM ≦149 mg/ml iodine, 1 ml	K2		$0.42
Q9946	LOCM 150–199 mg/ml iodine,1 ml	K2		$1.95
Q9947	LOCM 200–249 mg/ml iodine,1 ml	K2		$1.33
Q9948	LOCM 250–299 mg/ml iodine,1 ml	K2		$0.36
Q9949	LOCM 300–349 mg/ml iodine,1 ml	K2		$0.37
Q9950	LOCM 350–399 mg/ml iodine,1 ml	K2		$0.22
Q9951	LOCM ≧ 400 mg/ml iodine,1 ml	K2		$0.22
Q9952	Inj Gad-base MR contrast,1 ml	K2		$2.82
Q9953	Inj Fe-based MR contrast,1 ml	K2		$30.41
Q9954	Oral MR contrast, 100 ml	K2		$8.82
Q9955	Inj perflexane lip micros, ml	K2		$12.96
Q9956	Inj octafluoropropane mic, ml	K2		$49.61
Q9957	Inj perflutren lip micros, ml	K2		$61.55
Q9958	HOCM ≦149 mg/ml iodine, 1ml	N1		
Q9959	HOCM 150–199 mg/ml iodine, 1ml	N1		
Q9960	HOCM 200–249 mg/ml iodine, 1 ml	N1		
Q9961	HOCM 250–299 mg/ml iodine, 1ml	N1		
Q9962	HOCM 300–349 mg/ml iodine, 1 ml	N1		
Q9963	HOCM 350–399 mg/ml iodine, 1ml	N1		
Q9964	HOCM≧ 400 mg/ml iodine, 1 ml	N1		
V2630	Anter chamber intraocul lens	N1		
V2631	Iris support intraoclr lens	N1		
V2632	Post chmbr intraocular lens	N1		
V2785	Corneal tissue processing	F4		

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
V2790	Amniotic membrane	N1	.....	.....

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ADDENDUM DD1.—ILLUSTRATIVE ASC PAYMENT INDICATORS

Indicator	Payment indicator definition
A2	Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight.
F4	Corneal tissue acquisition; paid at reasonable cost.
G2	Non office-based surgical procedure added to ASC list in CY 2008 or later; payment based on OPPS relative payment weight.
H7	Brachytherapy source paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced.
H8	Device-intensive procedure on ASC list in CY 2007; paid at adjusted rate.
J7	OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced.
J8	Device-intensive procedure added to ASC list in CY 2008 or later; paid at adjusted rate.
K2	Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.
K7	Unclassified drugs and biologicals; payment contractor-priced.
L6	New Technology Intraocular Lens (NTIOL); special payment.
N1	Packaged procedure/item; no separate payment made.
P2	Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight.
P3	Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs.
R2	Office-based surgical procedure added to ASC list in CY 2008 or later without MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight.
Z2	Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS relative payment weight.
Z3	Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on MPFS nonfacility PE RVUs.

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Book 2 of 2 Books
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Part III

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 410, 411, 414 et al.
Medicare and Medicaid Programs: CY 2008 Proposed Changes; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 410, 411, 414, 416, 419, 482, and 485

[CMS–1392–P]

RIN 0938–AO71

Medicare Program: Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2008 Payment Rates; Proposed Changes to the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates; Medicare and Medicaid Programs: Proposed Changes to Hospital Conditions of Participation; Proposed Changes Affecting Necessary Provider Designations of Critical Access Hospitals

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would revise the Medicare hospital outpatient prospective payment system to implement applicable statutory requirements and changes arising from our continuing experience with this system. In this proposed rule, we describe the proposed changes to the amounts and factors used to determine the payment rates for Medicare hospital outpatient services paid under the prospective payment system. These changes would be applicable to services furnished on or after January 1, 2008.

In addition, this proposed rule would update the revised Medicare ambulatory surgical center (ASC) payment system to implement certain related provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). In this proposed rule, we propose the applicable relative payment weights and amounts for services furnished in ASCs, specific HCPCS codes to which the final policies of the ASC payment system would apply, and other pertinent ratesetting information for the CY 2008 ASC payment system. These changes would be applicable to services furnished on or after January 1, 2008.

In this proposed rule, we also are proposing changes to the policies relating to the necessary provider designations of critical access hospitals (CAHs) that are being recertified when a CAH enters into a new co-location arrangement with another hospital or CAH or when the CAH creates or acquires an off-campus location.

Further, we are proposing changes to several of the current conditions of participation that hospitals must meet to participate in the Medicare and Medicaid programs to require the completion and documentation in the medical record of medical histories and physical examinations of patients conducted after admission and prior to surgery or a procedure requiring anesthesia services and for postanesthesia evaluations of patients before discharge or transfer from the postanesthesia recovery area.

DATES: To be assured consideration, comments on all sections of the preamble of this proposed rule must be received at one of the addresses provided in the **ADDRESSES** section no later than 5 p.m. on September 14, 2007.

ADDRESSES: In commenting, please refer to file code CMS–1392–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to *http://www.cms.hhs.gov/eRulemaking.* Click on the link ''Submit electronic comments on CMS regulations with an open comment period.'' (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By regular mail.* You may mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1392–P, P.O. Box 8011, Baltimore, MD 21244–1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1392–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses: Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–9994 in advance to schedule your arrival with one of our staff members.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT:
Alberta Dwivedi, (410) 786–0378, Hospital outpatient prospective payment issues.
Dana Burley, (410) 786–0378, Ambulatory surgical center issues.
Suzanne Asplen, (410) 786–4558, Partial hospitalization and community mental health centers issues.
Sheila Blackstock, (410) 786–3502, Reporting of quality data issues.
Mary Collins, (410) 786–3189, and Jeannie Miller, (410) 786–3164, Necessary provider designations for CAHs Issues.
Scott Cooper, (410) 786–9465, and Jeannie Miller, (410) 786–3164, Hospital conditions of participation Issues.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this proposed rule to assist us in fully considering issues and developing policies. You can assist us by referencing file code CMS–1392–P and the specific ''issue identifier'' that precedes the section on which you choose to comment.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.cms.hhs.gov/eRulemaking.* Click on the link ''Electronic Comments on CMS Regulations'' on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication

of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, on Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

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Alphabetical List of Acronyms Appearing in the Proposed Rule

ACEP American College of Emergency Physicians
AHA American Hospital Association
AHIMA American Health Information Management Association
AMA American Medical Association
APC Ambulatory payment classification
AMP Average manufacturer price
ASC Ambulatory Surgical Center
ASP Average sales price
AWP Average wholesale price
BBA Balanced Budget Act of 1997, Pub. L. 105–33
BBRA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, Pub. L. 106–113
BCA Blue Cross Association
BCBSA Blue Cross and Blue Shield Association
BIPA Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. 106–554
CAH Critical access hospital
CAP Competitive Acquisition Program
CBSA Core-Based Statistical Area
CCR Cost-to-charge ratio
CERT Comprehensive Error Rate Testing
CMHC Community mental health center
CMS Centers for Medicare & Medicaid Services
CoP [Hospital] Condition of participation
CORF Comprehensive outpatient rehabilitation facility
CPT [Physicians'] Current Procedural Terminology, Fourth Edition, 2007, copyrighted by the American Medical Association
CRNA Certified registered nurse anesthetist
CY Calendar year
DMEPOS Durable medical equipment, prosthetics, orthotics, and supplies
DMERC Durable medical equipment regional carrier
DRA Deficit Reduction Act of 2005, Pub. L. 109–171
DSH Disproportionate share hospital
EACH Essential Access Community Hospital
E/M Evaluation and management
EPO Erythropoietin
ESRD End-stage renal disease
FACA Federal Advisory Committee Act, Pub. L. 92–463
FAR Federal Acquisition Regulations
FDA Food and Drug Administration
FFS Fee-for-service
FSS Federal Supply Schedule
FTE Full-time equivalent
FY Federal fiscal year
GAO Government Accountability Office
HCPCS Healthcare Common Procedure Coding System
HCRIS Hospital Cost Report Information System
HHA Home health agency
HIPAA Health Insurance Portability and Accountability Act of 1996, Pub. L. 104–191
HOPD Hospital outpatient department
HOP QDRP Hospital Outpatient Quality Data Reporting Program
ICD–9–CM International Classification of Diseases, Ninth Edition, Clinical Modification
IDE Investigational device exemption
IOL Intraocular lens
IPPS [Hospital] Inpatient prospective payment system
IVIG Intravenous immune globulin
MAC Medicare Administrative Contractors
MedPAC Medicare Payment Advisory Commission
MDH Medicare-dependent, small rural hospital
MIEA–TRHCA Medicare Improvements and Extension Act under Division B, Title I of the Tax Relief Health Care Act of 2006, Pub. L. 109–432
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108–173
MPFS Medicare Physician Fee Schedule
MSA Metropolitan Statistical Area
NCCI National Correct Coding Initiative
NCD National Coverage Determination
NTIOL New technology intraocular lens
OCE Outpatient Code Editor
OMB Office of Management and Budget
OPD [Hospital] Outpatient department
OPPS [Hospital] Outpatient prospective payment system
PHP Partial hospitalization program
PM Program memorandum
PPI Producer Price Index
PPS Prospective payment system
PPV Pneumococcal pneumonia (virus)
PRA Paperwork Reduction Act
QIO Quality Improvement Organization
RFA Regulatory Flexibility Act
RHQDAPU Reporting Hospital Quality Data for Annual Payment Update [Program]
RHHI Regional home health intermediary
SBA Small Business Administration
SCH Sole community hospital
SDP Single Drug Pricer
SI Status indicator
TEFRA Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248
TOPS Transitional outpatient payments
USPDI United States Pharmacopoeia Drug Information
WAC Wholesale acquisition cost

In this document, we address two payment systems under the Medicare program: the hospital outpatient prospective payment system (OPPS) and the revised ambulatory surgical center (ASC) revised payment system. The provisions relating to the OPPS are included in sections I. through XV., XVII., and XIX. through XXII. of this proposed rule and in Addenda A, B, C (Addendum C is available on the Internet only; see section XIX. of this proposed rule), D1, D2, E, L, and M to this proposed rule. The provisions related to the revised ASC payment system are included in sections XVI., XVII., and XIX. through XXII. of this proposed rule and in Addenda AA, BB, DD1, and DD2 to this proposed rule.

Table of Contents

I. Background for the OPPS

A. Legislative and Regulatory Authority for the Hospital Outpatient Prospective Payment System

When the Medicare statute was originally enacted, Medicare payment for hospital outpatient services was based on hospital-specific costs. In an effort to ensure that Medicare and its beneficiaries pay appropriately for services and to encourage more efficient delivery of care, the Congress mandated replacement of the reasonable cost-based payment methodology with a prospective payment system (PPS). The Balanced Budget Act (BBA) of 1997 (Pub. L. 105–33) added section 1833(t) to the Social Security Act (the Act) authorizing implementation of a PPS for hospital outpatient services (OPPS).

The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999 (Pub. L. 106–113) made major changes in the hospital OPPS. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 (Pub. L. 106–554) made further changes in the OPPS. Section 1833(t) of the Act was also amended by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Pub. L. 108–173). The Deficit Reduction Act (DRA) of 2005 (Pub. L. 109–171), enacted on February 8, 2006, made additional changes in the OPPS. In addition, the Medicare Improvements and Extension Act under Division B of Title I of the Tax Relief and Health Care Act (MIEA–TRHCA) of 2006 (Pub. L. 109–432), enacted on December 20, 2006, made further changes in the OPPS. A discussion of these provisions is included in sections I.E., VII., and XVII. of this proposed rule.

The OPPS was first implemented for services furnished on or after August 1, 2000. Implementing regulations for the OPPS are located at 42 CFR Part 419.

Under the OPPS, we pay for hospital outpatient services on a rate-per-service basis that varies according to the ambulatory payment classification (APC) group to which the service is assigned. We use the Healthcare Common Procedure Coding System (HCPCS) codes (which include certain Current Procedural Terminology (CPT) codes) and descriptors to identify and group the services within each APC group. The OPPS includes payment for most hospital outpatient services, except those identified in section I.B. of this proposed rule. Section 1833(t)(1)(B)(ii) of the Act provides for Medicare payment under the OPPS for hospital outpatient services designated by the Secretary (which includes partial hospitalization services furnished by community mental health centers (CMHCs)) and hospital outpatient services that are furnished to inpatients who have exhausted their Part A benefits, or who are otherwise not in a covered Part A stay. Section 611 of Pub. L. 108–173 added provisions for Medicare coverage of an initial preventive physical examination, subject to the applicable deductible and coinsurance, as an outpatient department service, payable under the OPPS.

The OPPS rate is an unadjusted national payment amount that includes the Medicare payment and the beneficiary copayment. This rate is divided into a labor-related amount and a nonlabor-related amount. The labor-related amount is adjusted for area wage differences using the hospital inpatient wage index value for the locality in which the hospital or CMHC is located.

All services and items within an APC group are comparable clinically and with respect to resource use (section 1833(t)(2)(B) of the Act). In accordance with section 1833(t)(2) of the Act, subject to certain exceptions, services and items within an APC group cannot be considered comparable with respect to the use of resources if the highest median (or mean cost, if elected by the Secretary) for an item or service in the APC group is more than 2 times greater than the lowest median cost for an item or service within the same APC group (referred to as the ''2 times rule''). In implementing this provision, we use the median cost of the item or service assigned to an APC group.

Special payments under the OPPS may be made for New Technology items and services in one of two ways. Section 1833(t)(6) of the Act provides for temporary additional payments, which we refer to as ''transitional pass-through payments,'' for at least 2 but not more than 3 years for certain drugs, biological agents, brachytherapy devices used for the treatment of cancer, and categories of other medical devices. For New Technology services that are not eligible for transitional pass-through payments, and for which we lack sufficient data to appropriately assign them to a clinical APC group, we have established special APC groups based on costs, which we refer to as New Technology APCs. These New Technology APCs are designated by cost bands which allow us to provide appropriate and consistent payment for designated new procedures that are not yet reflected in our claims data. Similar to pass-through payments, an assignment to a New Technology APC is temporary; that is, we retain a service within a New Technology APC until we acquire sufficient data to assign it to a clinically appropriate APC group.

B. Excluded OPPS Services and Hospitals

Section 1833(t)(1)(B)(i) of the Act authorizes the Secretary to designate the hospital outpatient services that are paid under the OPPS. While most hospital outpatient services are payable under the OPPS, section

1833(t)(1)(B)(iv) of the Act excludes payment for ambulance, physical and occupational therapy, and speech-language pathology services, for which payment is made under a fee schedule. Section 614 of Pub. L. 108–173 amended section 1833(t)(1)(B)(iv) of the Act to exclude OPPS payment for screening and diagnostic mammography services. The Secretary exercised the authority granted under the statute to exclude from the OPPS those services that are paid under fee schedules or other payment systems. Such excluded services include, for example, the professional services of physicians and nonphysician practitioners paid under the Medicare Physician Fee Schedule (MPFS); laboratory services paid under the clinical diagnostic laboratory fee schedule (CLFS); services for beneficiaries with end-stage renal disease (ESRD) that are paid under the ESRD composite rate; and services and procedures that require an inpatient stay that are paid under the hospital inpatient prospective payment system (IPPS). We set forth the services that are excluded from payment under the OPPS in § 419.22 of the regulations.

Under § 419.20(b) of the regulations, we specify the types of hospitals and entities that are excluded from payment under the OPPS. These excluded entities include Maryland hospitals, but only for services that are paid under a cost containment waiver in accordance with section 1814(b)(3) of the Act; critical access hospitals (CAHs); hospitals located outside of the 50 States, the District of Columbia, and Puerto Rico; and Indian Health Service hospitals.

C. Prior Rulemaking

On April 7, 2000, we published in the **Federal Register** a final rule with comment period (65 FR 18434) to implement a prospective payment system for hospital outpatient services. The hospital OPPS was first implemented for services furnished on or after August 1, 2000. Section 1833(t)(9) of the Act requires the Secretary to review certain components of the OPPS, no less often than annually, and to revise the groups, relative payment weights, and other adjustments that take into account changes in medical practices, changes in technologies, and the addition of new services, new cost data, and other relevant information and factors.

Since initially implementing the OPPS, we have published final rules in the **Federal Register** annually to implement statutory requirements and changes arising from our continuing experience with this system. We published in the **Federal Register** on November 24, 2006 the CY 2007 OPPS/ASC final rule with comment period (71 FR 67960). In that final rule with comment period, we revised the OPPS to update the payment weights and conversion factor for services payable under the CY 2007 OPPS on the basis of claims data from January 1, 2005, through December 31, 2005, and to implement certain provisions of Pub. L. 108–173 and Pub. L. 109–171. In addition, we responded to public comments received on the provisions of the November 10, 2005 final rule with comment period (70 FR 86516) pertaining to the APC assignment of HCPCS codes identified in Addendum B of that rule with the new interim (NI) comment indicator; and public comments received on the August 23, 2006 OPPS/ASC proposed rule for CY 2007 (71 FR 49506).

D. APC Advisory Panel

1. Authority of the APC Panel

Section 1833(t)(9)(A) of the Act, as amended by section 201(h) of the BBRA, and redesignated by section 202(a)(2) of the BBRA, requires that we consult with an outside panel of experts to review the clinical integrity of the payment groups and their weights under the OPPS. The Act further specifies that the panel will act in an advisory capacity. The Advisory Panel on Ambulatory Payment Classification (APC) Groups (the APC Panel), discussed under section I.D.2. of this proposed rule, fulfills these requirements. The APC Panel is not restricted to using data compiled by CMS, and may use data collected or developed by organizations outside the Department in conducting its review.

2. Establishment of the APC Panel

On November 21, 2000, the Secretary signed the initial charter establishing the APC Panel. This expert panel, which may be composed of up to 15 representatives of providers subject to the OPPS (currently employed full-time, not as consultants, in their respective areas of expertise), reviews clinical data and advises CMS about the clinical integrity of the APC groups and their weights. For purposes of this Panel, consultants or independent contractors are not considered to be full-time employees. The APC Panel is technical in nature, and is governed by the provisions of the Federal Advisory Committee Act (FACA). Since its initial chartering, the Secretary has renewed the APC Panel's charter three times: on November 1, 2002; on November 1, 2004; and effective November 21, 2006. The current charter specifies, among other requirements, that the APC Panel continue to be technical in nature; be governed by the provisions of the FACA; may convene up to three meetings per year; has a Designated Federal Officer (DFO); and is chaired by a Federal official designated by the Secretary.

The current APC Panel membership and other information pertaining to the APC Panel, including its charter, **Federal Register** notices, meeting dates, agenda topics, and meeting reports can be viewed on the CMS Web site at: *http://www.cms.hhs.gov/FACA/05_AdvisoryPanelonAmbulatoryPaymentClassificationGroups.asp#TopOfPage.*

3. APC Panel Meetings and Organizational Structure

The APC Panel first met on February 27, February 28, and March 1, 2001. Since the initial meeting, the APC Panel has held 11 subsequent meetings, with the last meeting taking place on March 7 and 8, 2007. Prior to each meeting, we publish a notice in the **Federal Register** to announce the meeting, and when necessary to solicit and announce nominations for the APC Panel's membership.

The APC Panel has established an operational structure that, in part, includes the use of three subcommittees to facilitate its required APC review process. The three current subcommittees are the Data Subcommittee, the Observation and Visit Subcommittee, and the Packaging Subcommittee. The Data Subcommittee is responsible for studying the data issues confronting the APC Panel, and for recommending options for resolving them. The Observation and Visit Subcommittee reviews and makes recommendations to the APC Panel on all technical issues pertaining to observation services and hospital outpatient visits paid under the OPPS (for example, APC configurations and APC payment weights). The Packaging Subcommittee studies and makes recommendations on issues pertaining to services that are not separately payable under the OPPS, but whose payments are bundled or packaged into APC payments. Each of these subcommittees was established by a majority vote from the full APC Panel during a scheduled APC Panel meeting, and their continuation as subcommittees was approved at the March 2007 APC Panel meeting. All subcommittee recommendations are discussed and voted upon by the full APC Panel.

Discussions of the recommendations resulting from the APC Panel's March

2007 meeting are included in the sections of this proposed rule that are specific to each recommendation. For discussions of earlier APC Panel meetings and recommendations, we reference previous hospital OPPS final rules or the Web site mentioned earlier in this section.

E. Provisions of the Medicare Improvements and Extension Act Under Division B of Title I of the Tax Relief and Health Care Act of 2006

The Medicare Improvements and Extension Act under Division B of Title I of the Tax Relief and Health Care Act (MIEA–TRHCA) of 2006, Pub. L. 109–432, enacted on December 20, 2006, included the following provisions affecting the OPPS:

1. Section 107(a) of the MIEA–TRHCA amended section 1833(t)(16)(C) of the Act to extend the period for payment of brachytherapy devices based on the hospital's charges adjusted to cost for 1 additional year, through December 31, 2007.

2. Section 107(b)(1) of the MIEA–TRHCA amended section 1833(t)(2)(H) of the Act by adding stranded and non-stranded devices furnished on or after July 1, 2007, as additional classifications of brachytherapy devices for which separate payment groups must be established for payment under the OPPS. Section 107(b)(2) of the MIEA–TRCHA provides that the Secretary may implement the section 107(b)(1) amendment to section 1833(t)(2)(H) of the Act ''by program instruction or otherwise.''

3. Section 109(a) of the MIEA–TRHCA added new paragraph (17) to section 1833(t) of the Act which authorizes the Secretary, beginning in 2009 and each subsequent year, to reduce the OPPS full annual update by 2.0 percentage points if a hospital paid under the OPPS fails to submit data as required by the Secretary in the form and manner specified on selected measures of quality of care, including medication errors. In accordance with this provision, the selected measures are those that are appropriate for the measurement of quality of care furnished by hospitals in the outpatient setting, that reflect consensus among affected parties and, to the extent feasible and practicable, that include measures set forth by one or more of the national consensus entities, and that may be the same as those required for reporting by hospitals paid under the IPPS. This provision specifies that a reduction for 1 year cannot be taken into account when computing the OPPS update for a subsequent year. In addition, this provision requires the Secretary to establish a process for making the submitted data available for public review.

F. Summary of the Major Contents of This Proposed Rule

In this proposed rule, we are setting forth proposed changes to the Medicare hospital OPPS for CY 2008. These changes would be effective for services furnished on or after January 1, 2008. We are also setting forth proposed changes to the Medicare ASC payment system for CY 2008. These changes would be effective for services furnished on or after January 1, 2008. The following is a summary of the major changes that we are proposing to make:

1. Proposed Updates Affecting OPPS Payments

In section II. of this proposed rule, we set forth—

- The methodology used to recalibrate the proposed APC relative payment weights.
- The proposed payment for partial hospitalization services, including the proposed separate threshold for outlier payments for CMHCs.
- The proposed update to the conversion factor used to determine payment rates under the OPPS.
- The proposed retention of our current policy to use the IPPS wage indices to adjust, for geographic wage differences, the portion of the OPPS payment rate and the copayment standardized amount attributable to labor-related cost.
- The proposed update of statewide average default CCRs.
- The proposed application of hold harmless transitional outpatient payments (TOPs) for certain small rural hospitals.
- The proposed payment adjustment for rural SCHs.
- The proposed calculation of the hospital outpatient outlier payment.
- The calculation of the proposed national unadjusted Medicare OPPS payment.
- The proposed beneficiary copayments for OPPS services.

2. Proposed OPPS Ambulatory Payment Classification (APC) Group Policies

In section III. of this proposed rule, we discuss the proposed additions of new procedure codes to the APCs; our proposal to establish a number of new APCs; and our analyses of Medicare claims data and certain recommendations of the APC Panel. We also discuss the application of the 2 times rule and proposed exceptions to it; proposed changes to specific APCs; and the proposed movement of procedures from New Technology APCs to clinical APCs.

3. Proposed OPPS Payment for Devices

In section IV. of this proposed rule, we discuss proposed payment for device-dependent APCs and the pass-through payment for specific categories of devices.

4. Proposed OPPS Payment for Drugs, Biologicals, and Radiopharmaceuticals

In section V. of this proposed rule, we discuss the proposed CY 2008 OPPS payment for drugs, biologicals, and radiopharmaceuticals, including the proposed payment for drugs, biologicals, and radiopharmaceuticals with and without pass-through status.

5. Proposed Estimate of OPPS Transitional Pass-Through Spending for Drugs, Biologicals, and Devices

In section VI. of this proposed rule, we discuss the estimate of CY 2008 OPPS transitional pass-through spending for drugs, biologicals, and devices.

6. Proposed OPPS Payment for Brachytherapy Sources

In section VII. of this proposed rule, we discuss our proposal concerning coding and payment for brachytherapy sources.

7. Proposed OPPS Coding and Payment for Drug Administration Services

In section VIII. of this proposed rule, we set forth our proposed policy concerning coding and payment for drug administration services.

8. Proposed OPPS Hospital Coding and Payments for Visits

In section IX. of this proposed rule, we set forth our proposed changes to policies for the coding and reporting of clinic and emergency department visits and critical care services on claims paid under the OPPS.

9. Proposed OPPS Payment for Blood and Blood Products

In section X. of this proposed rule, we discuss our proposed payment for blood and blood products.

10. Proposed OPPS Payment for Observation Services

In section XI. of this proposed rule, we discuss the proposed payment policies for observation services furnished to patients on an outpatient basis.

11. Proposed Procedures That Will Be Paid Only as Inpatient Services

In section XII. of this proposed rule, we discuss the procedures that we are

proposing to remove from the inpatient list and assign to APCs.

12. Proposed Nonrecurring Technical and Policy Changes

In section XIII. of this proposed rule, we set forth our proposals for nonrecurring technical and policy changes and clarifications relating to outpatient hospital services and supplies incident to a physician service; payment for interrupted procedures prior to and after the administration of anesthesia; transitional adjustments to payments for covered outpatient services furnished by small rural hospitals and SCHs located in rural areas; and reporting requirements for wound care services, cardiac rehabilitation services, and bone marrow and stem cell processing services.

13. Proposed OPPS Payment Status and Comment Indicators

In section XIV. of this proposed rule, we discuss proposed changes to the definitions of status indicators assigned to APCs and present our proposed comment indicators for the OPPS/ASC final rule with comment period.

14. OPPS Policy and Payment Recommendations

In section XV. of this proposed rule, we address recommendations made by MedPAC and the APC Panel regarding the OPPS for CY 2008.

15. Proposed Update of the Revised ASC Payment System

In section XVI. of this proposed rule, we discuss the proposed update of the revised ASC payment system payment rates for CY 2008. We also discuss our proposed changes to our regulations § 414.22 (b)(5)(i)(A) and (B) regarding physician payment for performing noncovered ASC surgical procedures in ASCs. In addition, we are proposing to revise the definitions of ''radiology and certain other imaging services'' and ''outpatient prescription drugs'' when provided integral to an ASC covered surgical procedure.

16. Reporting Quality Data for Annual Payment Rate Updates

In section XVII. of this proposed rule, we discuss the proposed quality measures for reporting hospital outpatient quality data for CY 2009 and subsequent years and set forth the requirements for data collection and submission for the annual payment update. We also briefly discuss the legislative provisions of the MIEA–TRHCA that give the Secretary authority to develop quality measures for reporting by ASCs.

17. Proposed Changes Affecting Necessary Provider Critical Access Hospitals (CAHs) and Hospital Conditions of Participation (CoPs)

In section XVIII. of this proposed rule, we discuss our proposed changes affecting necessary provider designations for CAHs that are being recertified when the CAH enters into a new co-location arrangement with another hospital or CAH or when the CAH creates or acquires an off-campus location. We also discuss our proposed changes relating to several hospital CoPs to require the completion of physical examinations and medical histories, and documentation in the medical records, for patients after admission and prior to surgery or a procedure requiring anesthesia services and for postanesthesia evaluations of patients before discharge or transfer from the postanesthesia recovery area.

18. Regulatory Impact Analysis

In section XXII. of this proposed rule, we set forth an analysis of the impact the proposed changes will have on affected entities and beneficiaries.

II. Proposed Updates Affecting OPPS Payments

A. Proposed Recalibration of APC Relative Weights

(If you choose to comment on issues in this section, please include the caption ''APC Relative Weights'' at the beginning of your comment.)

1. Database Construction

a. Database Source and Methodology

Section 1833(t)(9)(A) of the Act requires that the Secretary review and revise the relative payment weights for APCs at least annually. In the April 7, 2000 OPPS final rule with comment period (65 FR 18482), we explained in detail how we calculated the relative payment weights that were implemented on August 1, 2000, for each APC group. Except for some reweighting due to a small number of APC changes, these relative payment weights continued to be in effect for CY 2001. This policy is discussed in the November 13, 2000 interim final rule (65 FR 67824 through 67827).

We are proposing to use the same basic methodology that we described in the April 7, 2000 OPPS final rule with comment period to recalibrate the APC relative payment weights for services furnished on or after January 1, 2008, and before January 1, 2009. That is, we are proposing to recalibrate the relative payment weights for each APC based on claims and cost report data for outpatient services. We are proposing to use the most recent available data to construct the database for calculating APC group weights. For the purpose of recalibrating the proposed APC relative payment weights for CY 2008, we used approximately 131 million final action claims for hospital OPD services furnished on or after January 1, 2006, and before January 1, 2007. (For exact counts of claims used, we refer readers to the claims accounting narrative under supporting documentation for this proposed rule on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/HORD/).* Of the 131 million final action claims for services provided in hospital outpatient settings, approximately 101 million claims were of the type of bill potentially appropriate for use in setting rates for OPPS services (but did not necessarily contain services payable under the OPPS). Of the 101 million claims, approximately 46 million were not for services paid under the OPPS or were excluded as not appropriate for use (for example, erroneous cost-to-charge ratios (CCRs) or no HCPCS codes reported on the claim). We were able to use approximately 50 million whole claims of the approximately 54 million claims that remained to set the OPPS APC relative weights we are proposing for the CY 2008 OPPS. From the 50 million whole claims, we created approximately 88 million single records, of which approximately 58 million were ''pseudo'' single claims (created from multiple procedure claims using the process we discuss in this section). Approximately 822,000 claims trimmed out on cost or units in excess of ±3 standard deviations from the geometric mean, yielding approximately 87 million single bills used for median setting. Ultimately, we were able to use for proposed CY 2008 ratesetting some portion of 92 percent of the CY 2006 claims containing services payable under the OPPS.

The proposed APC relative weights and payments for CY 2008 in Addenda A and B to this proposed rule were calculated using claims from this period that were processed before January 1, 2007, and continue to be based on the median hospital costs for services in the APC groups. We selected claims for services paid under the OPPS and matched these claims to the most recent cost report filed by the individual hospitals represented in our claims data. We continue to believe that it is appropriate to use the most current full calendar year claims data and the most

recently submitted cost reports to calculate the median costs which we are proposing to convert to relative payment weights for purposes of calculating the CY 2008 payment rates.

b. Proposed Use of Single and Multiple Procedure Claims

For CY 2008, in general, we are proposing to continue to use single procedure claims to set the medians on which the APC relative payment weights would be based, with some exceptions as discussed below. We have received many requests asking that we ensure that the data from claims that contain charges for multiple procedures are included in the data from which we calculate the relative payment weights. Requesters believe that relying solely on single procedure claims to recalibrate APC relative payment weights fails to take into account data for many frequently performed procedures, particularly those commonly performed in combination with other procedures. They believe that if a service is frequently performed in combination with others, the individual services are more complex and more resource-intensive than if they were performed alone. Stakeholders have suggested that including data from multiple procedure claims could increase the median cost estimates for the individual services. They believe that depending upon single procedure claims alone results in basing relative payment weights on the least costly services that are not representative of the typical services, thereby introducing downward bias to the medians on which the weights are based.

We generally use single procedure claims to set the median costs for APCs because we believe that it is important that the OPPS relative weights on which payment rates are based be appropriate when one and only one procedure is furnished and because we are, so far, unable to ensure that packaged costs can be appropriately allocated across multiple procedures performed on the same date of service. We agree that, optimally, it is desirable to use the data from as many claims as possible to recalibrate the APC relative payment weights, including those claims for multiple procedures. We engaged in several efforts this year to improve our use of multiple procedure claims for ratesetting. As we have for several years, we continue to use date of service stratification and a list of codes to be bypassed to convert multiple procedure claims to ''pseudo'' single procedure claims. We also continued our internal efforts to better understand the patterns of services and costs from multiple bills toward the goal of using more multiple bill information by assessing the amount of packaging in the multiple bills and, specifically, by exploring the amount of packaging for drug administration services in the single and multiple bill claims. Moreover, in many cases, the proposed expansion of packaging also enables the use of more claims data by enabling us to treat claims with multiple procedure codes as single claims. We refer readers to section II.A.4. of this proposed rule for a full discussion of this proposal for CY 2008.

(1) Proposed Use of Date of Service Stratification and a Bypass List To Increase the Amount of Data Used To Determine Medians

By bypassing specified codes that we believe do not have significant packaged costs, we are able to use more data from multiple procedure claims. In many cases, this enables us to create multiple ''pseudo'' single claims from claims that, as submitted, contained multiple separately paid procedures on the same claim. We refer to these newly created single procedure claims as ''pseudo'' single claims because they were submitted by providers as multiple procedure claims. The history of our use of a bypass list to generate ''pseudo'' single claims is well documented, most recently in the CY 2007 OPPS/ASC final rule with comment period (71 FR 67969 through 67970).

The date of service stratification and bypass list process we used for the CY 2007 OPPS (combined with the packaging changes we are proposing in section II.A.4. of this proposed rule) resulted in our being able to use some part of approximately 92 percent of the total claims that are eligible for use in the OPPS ratesetting and modeling for this proposed rule. This process enabled us to create, for CY 2008 approximately 58 million ''pseudo'' singles and approximately 30 million ''natural'' single bills. For this proposed rule, ''pseudo'' single procedure bills represented 66 percent of all single bills used to calculate median costs. This compares favorably to the CY 2007 OPPS final rule data in which ''pseudo'' single bills represented 68 percent of all single bills used to calculate the median costs on which the CY 2007 OPPS payment rates were based. We believe that the reduction in the percent of ''pseudo'' single bills and the corresponding increase in the proportion of ''natural'' single bills occurred largely because of our proposal to increase packaging as discussed in section II.A.4. of this proposed rule. In many cases, the packaging proposal for CY 2008 enabled us to use claims that would otherwise have been considered to be multiple procedure claims and, absent the proposal for additional packaging, could have been used for ratesetting only if we had been able to create ''pseudo'' single claims from them.

For CY 2008, we are proposing to bypass 425 HCPCS codes that are identified in Table 1 of this proposed rule. We are proposing to continue the use of the codes on the CY 2007 OPPS bypass list but to remove codes we are proposing to package for CY 2008. We also are proposing to remove codes that were on the CY 2007 bypass list that ceased to meet the empirical criteria under the proposed packaging changes when clinical review confirmed that their removal would be appropriate in the context of the full proposal for the CY 2008 OPPS. Since the inception of the bypass list, we have calculated the percent of natural single bills that contained packaging for each code and the amount of packaging in each ''natural'' single bill for each code. We retained the codes on the previous year's bypass list and used the update year's data to determine whether it would be appropriate to add additional codes to the previous year's bypass list. The entire list (including the codes that remained on the bypass list from prior years) was open to public comment. For this CY 2008 proposed rule, we explicitly reviewed all ''natural'' single bills against the empirical criteria for all codes on the CY 2007 bypass list because of the proposal for greater packaging discussed in section II.A.4. of this proposed rule, as this effort increased the packaging associated with some codes. We removed 106 HCPCS codes from the CY 2007 bypass list for the CY 2008 proposal. We note also that many of the codes we are proposing to newly package for CY 2008 were on the bypass list used for setting the OPPS payment rates for CY 2007 and are no longer proposed for bypass because we are proposing to package them, as discussed in more detail below. We also are proposing to add to the bypass list HCPCS codes that, using the proposed rule data, meet the same previously established empirical criteria for the bypass list that are reviewed below or which our clinicians believe would have little associated packaging if the services were correctly coded.

The CY 2008 packaging proposal minimally reduced the percentage of total claims that we were able to use, in whole or in part, from 93 percent for CY 2007 to 92 percent for this proposed rule. The proposed packaging approach increased the number of ''natural'' single bills, in spite of reducing the

universe of codes requiring single bills for ratesetting, but reduced the number of ''pseudo'' single bills. More ''natural'' single procedure bills can be created by the packaging of codes that always appear with another procedure because these dependent services are supportive of and ancillary to the primary independent procedures for which payment is being made. A claim containing two independent procedure codes on the same date of service and not on the bypass list previously could not be used for ratesetting, but packaging the cost of one of the codes on the claim frees the claim to be used to calculate the median cost of the procedure that is not packaged. On the other hand, our proposed packaging approach reduced the number of codes eligible for the bypass list because of the limitation on packaging set by our previously established empirical criteria. A smaller bypass list and the presence of greater packaging on claims reduced the final number of ''pseudo'' single claims. In prior years, roughly 68 percent of single bills were ''pseudo'' single bills, but based on the CY 2008 proposed rule data, 66 percent of single bills were ''pseudo'' singles. Moreover, the number of ''natural'' single bills and ''pseudo'' single bills are reduced by the volume of services that we are proposing to package. Hence, our CY 2008 proposal to package payment for some HCPCS codes with relatively high frequencies would eliminate for ratesetting the number of available ''natural'' and ''pseudo'' single bills attributable to the codes that we are proposing to package.

As in prior years, we are proposing to use the following empirical criteria to determine the additional codes to add to the CY 2007 bypass list to create the CY 2008 bypass list. We assume that the representation of packaging on the single claims for any given code is comparable to packaging for that code in the multiple claims:

- There are 100 or more single claims for the code. This number of single claims ensures that observed outcomes are sufficiently representative of packaging that might occur in the multiple claims.
- Five percent or fewer of the single claims for the code have packaged costs on that single claim for the code. This criterion results in limiting the amount of packaging being redistributed to the payable procedure remaining on the claim after the bypass code is removed and ensures that the costs associated with the bypass code represent the cost of the bypassed service.
- The median cost of packaging observed in the single claims is equal to or less than $50. This limits the amount of error in redistributed costs.
- The code is not a code for an unlisted service.

In addition, we are proposing to add to the bypass list codes that our clinicians believe have minimal associated packaging based on their clinical assessment of the full CY 2008 OPPS proposal. We note that this list contains bypass codes that are appropriate to claims for services in CY 2006 and, therefore, includes codes that have been deleted for CY 2007. Moreover, there are codes on the bypass list that are new for CY 2007 and which are appropriate additions to the bypass list in preparation for use of the CY 2007 claims for creation of the CY 2009 OPPS.

In order to keep the established empirical criteria for the bypass list constant, we are seeking public comment on whether we should adjust the $50 packaging cost criterion for inflation each year and, if so, recommendations for the source of the adjustment. Adding an inflation adjustment factor would ensure that the same amount of packaging associated with candidate codes for the bypass list is reviewed each year relative to nominal costs.

TABLE 1.—PROPOSED CY 2008 BYPASS CODES FOR CREATING ''PSEUDO'' SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS

HCPCS code	Short descriptor
11056	Trim skin lesions, 2 to 4.
11057	Trim skin lesions, over 4.
11300	Shave skin lesion.
11301	Shave skin lesion.
11719	Trim nail(s).
11720	Debride nail, 1–5.
11721	Debride nail, 6 or more.
11954	Therapy for contour defects.
17003	Destruct premalg les, 2–14.
31231	Nasal endoscopy, dx.
31579	Diagnostic laryngoscopy.
51798	Us urine capacity measure.
54240	Penis study.
56820	Exam of vulva w/scope.
67820	Revise eyelashes.
69210	Remove impacted ear wax.
69220	Clean out mastoid cavity.
70030	X-ray eye for foreign body.
70100	X-ray exam of jaw.
70110	X-ray exam of jaw.
70120	X-ray exam of mastoids.
70130	X-ray exam of mastoids.
70140	X-ray exam of facial bones.
70150	X-ray exam of facial bones.
70160	X-ray exam of nasal bones.
70200	X-ray exam of eye sockets.
70210	X-ray exam of sinuses.
70220	X-ray exam of sinuses.
70250	X-ray exam of skull.
70260	X-ray exam of skull.

TABLE 1.—PROPOSED CY 2008 BYPASS CODES FOR CREATING ''PSEUDO'' SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS—Continued

HCPCS code	Short descriptor
70328	X-ray exam of jaw joint.
70330	X-ray exam of jaw joints.
70336	Magnetic image, jaw joint.
70355	Panoramic x-ray of jaws.
70360	X-ray exam of neck.
70370	Throat x-ray & fluoroscopy.
70371	Speech evaluation, complex.
70450	Ct head/brain w/o dye.
70480	Ct orbit/ear/fossa w/o dye.
70486	Ct maxillofacial w/o dye.
70490	Ct soft tissue neck w/o dye.
70544	Mr angiography head w/o dye.
70551	Mri brain w/o dye.
71010	Chest x-ray.
71015	Chest x-ray.
71020	Chest x-ray.
71021	Chest x-ray.
71022	Chest x-ray.
71023	Chest x-ray and fluoroscopy.
71030	Chest x-ray.
71034	Chest x-ray and fluoroscopy.
71035	Chest x-ray.
71100	X-ray exam of ribs.
71101	X-ray exam of ribs/chest.
71110	X-ray exam of ribs.
71111	X-ray exam of ribs/chest.
71120	X-ray exam of breastbone.
71130	X-ray exam of breastbone.
71250	Ct thorax w/o dye.
72010	X-ray exam of spine.
72020	X-ray exam of spine.
72040	X-ray exam of neck spine.
72050	X-ray exam of neck spine.
72052	X-ray exam of neck spine.
72069	X-ray exam of trunk spine.
72070	X-ray exam of thoracic spine.
72072	X-ray exam of thoracic spine.
72074	X-ray exam of thoracic spine.
72080	X-ray exam of trunk spine.
72090	X-ray exam of trunk spine.
72100	X-ray exam of lower spine.
72110	X-ray exam of lower spine.
72114	X-ray exam of lower spine.
72120	X-ray exam of lower spine.
72125	Ct neck spine w/o dye.
72128	Ct chest spine w/o dye.
72131	Ct lumbar spine w/o dye.
72141	Mri neck spine w/o dye.
72146	Mri chest spine w/o dye.
72148	Mri lumbar spine w/o dye.
72170	X-ray exam of pelvis.
72190	X-ray exam of pelvis.
72192	Ct pelvis w/o dye.
72202	X-ray exam sacroiliac joints.
72220	X-ray exam of tailbone.
73000	X-ray exam of collar bone.
73010	X-ray exam of shoulder blade.
73020	X-ray exam of shoulder.
73030	X-ray exam of shoulder.
73050	X-ray exam of shoulders.
73060	X-ray exam of humerus.
73070	X-ray exam of elbow.
73080	X-ray exam of elbow.
73090	X-ray exam of forearm.
73100	X-ray exam of wrist.
73110	X-ray exam of wrist.
73120	X-ray exam of hand.

TABLE 1.—PROPOSED CY 2008 BYPASS CODES FOR CREATING ''PSEUDO'' SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS—Continued

HCPCS code	Short descriptor
73130 ...	X-ray exam of hand.
73140 ...	X-ray exam of finger(s).
73200 ...	Ct upper extremity w/o dye.
73218 ...	Mri upper extremity w/o dye.
73221 ...	Mri joint upr extrem w/o dye.
73510 ...	X-ray exam of hip.
73520 ...	X-ray exam of hips.
73540 ...	X-ray exam of pelvis & hips.
73550 ...	X-ray exam of thigh.
73560 ...	X-ray exam of knee, 1 or 2.
73562 ...	X-ray exam of knee, 3.
73564 ...	X-ray exam, knee, 4 or more.
73565 ...	X-ray exam of knees.
73590 ...	X-ray exam of lower leg.
73600 ...	X-ray exam of ankle.
73610 ...	X-ray exam of ankle.
73620 ...	X-ray exam of foot.
73630 ...	X-ray exam of foot.
73650 ...	X-ray exam of heel.
73660 ...	X-ray exam of toe(s).
73700 ...	Ct lower extremity w/o dye.
73718 ...	Mri lower extremity w/o dye.
73721 ...	Mri jnt of lwr extre w/o dye.
74000 ...	X-ray exam of abdomen.
74010 ...	X-ray exam of abdomen.
74020 ...	X-ray exam of abdomen.
74022 ...	X-ray exam series, abdomen.
74150 ...	Ct abdomen w/o dye.
74210 ...	Contrst x-ray exam of throat.
74220 ...	Contrast x-ray, esophagus.
74230 ...	Cine/vid x-ray, throat/esoph.
74246 ...	Contrst x-ray uppr gi tract.
74247 ...	Contrst x-ray uppr gi tract.
74249 ...	Contrst x-ray uppr gi tract.
76020 ...	X-rays for bone age.
76040 ...	X-rays, bone evaluation.
76061 ...	X-rays, bone survey.
76062 ...	X-rays, bone survey.
76065 ...	X-rays, bone evaluation.
76066 ...	Joint survey, single view.
76070 ...	Ct bone density, axial.
76071 ...	Ct bone density, peripheral.
76075 ...	Dxa bone density, axial.
76076 ...	Dxa bone density/peripheral
76077 ...	Dxa bone density/v-fracture.
76078 ...	Radiographic absorptiometry.
76100 ...	X-ray exam of body section.
76400 ...	Magnetic image, bone marrow.
76510 ...	Ophth us, b & quant a.
76511 ...	Ophth us, quant a only.
76512 ...	Ophth us, b w/non-quant a.
76513 ...	Echo exam of eye, water bath.
76514 ...	Echo exam of eye, thickness.
76516 ...	Echo exam of eye.
76519 ...	Echo exam of eye.
76536 ...	Us exam of head and neck.
76645 ...	Us exam, breast(s).
76700 ...	Us exam, abdom, complete.
76705 ...	Echo exam of abdomen.
76770 ...	Us exam abdo back wall, comp.
76775 ...	Us exam abdo back wall, lim.
76778 ...	Us exam kidney transplant.
76801 ...	Ob us < 14 wks, single fetus.
76805 ...	Ob us >/= 14 wks, sngl fetus.
76811 ...	Ob us, detailed, sngl fetus.
76816 ...	Ob us, follow-up, per fetus.
76817 ...	Transvaginal us, obstetric.

TABLE 1.—PROPOSED CY 2008 BYPASS CODES FOR CREATING ''PSEUDO'' SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS—Continued

HCPCS code	Short descriptor
76830 ...	Transvaginal us, non-ob.
76856 ...	Us exam, pelvic, complete.
76857 ...	Us exam, pelvic, limited.
76870 ...	Us exam, scrotum.
76880 ...	Us exam, extremity.
76970 ...	Ultrasound exam follow-up.
76977 ...	Us bone density measure.
76999 ...	Echo examination procedure.
77300 ...	Radiation therapy dose plan.
77301 ...	Radiotherapy dose plan, imrt.
77315 ...	Teletx isodose plan complex.
77326 ...	Brachytx isodose calc simp.
77327 ...	Brachytx isodose calc interm.
77328 ...	Brachytx isodose plan compl.
77331 ...	Special radiation dosimetry.
77336 ...	Radiation physics consult.
77370 ...	Radiation physics consult.
77401 ...	Radiation treatment delivery.
77402 ...	Radiation treatment delivery.
77403 ...	Radiation treatment delivery.
77404 ...	Radiation treatment delivery.
77407 ...	Radiation treatment delivery.
77408 ...	Radiation treatment delivery.
77409 ...	Radiation treatment delivery.
77411 ...	Radiation treatment delivery.
77412 ...	Radiation treatment delivery.
77413 ...	Radiation treatment delivery.
77414 ...	Radiation treatment delivery.
77416 ...	Radiation treatment delivery.
77418 ...	Radiation tx delivery, imrt.
77470 ...	Special radiation treatment.
77520 ...	Proton trmt, simple w/o comp.
77523 ...	Proton trmt, intermediate.
80500 ...	Lab pathology consultation.
80502 ...	Lab pathology consultation.
85097 ...	Bone marrow interpretation.
86510 ...	Histoplasmosis skin test.
86850 ...	RBC antibody screen.
86870 ...	RBC antibody identification.
86880 ...	Coombs test, direct.
86885 ...	Coombs test, indirect, qual.
86886 ...	Coombs test, indirect, titer.
86890 ...	Autologous blood process.
86900 ...	Blood typing, ABO.
86901 ...	Blood typing, Rh (D).
86903 ...	Blood typing, antigen screen.
86904 ...	Blood typing, patient serum.
86905 ...	Blood typing, RBC antigens.
86906 ...	Blood typing, Rh phenotype.
86930 ...	Frozen blood prep.
86970 ...	RBC pretreatment.
88104 ...	Cytopath fl nongyn, smears.
88106 ...	Cytopath fl nongyn, filter.
88107 ...	Cytopath fl nongyn, sm/fltr.
88108 ...	Cytopath, concentrate tech.
88112 ...	Cytopath, cell enhance tech.
88160 ...	Cytopath smear, other source.
88161 ...	Cytopath smear, other source.
88162 ...	Cytopath smear, other source.
88172 ...	Cytopathology eval of fna.
88173 ...	Cytopath eval, fna, report.
88182 ...	Cell marker study.
88184 ...	Flowcytometry/tc, 1 marker.
88185 ...	Flowcytometry/tc, add-on.
88300 ...	Surgical path, gross.
88302 ...	Tissue exam by pathologist.
88304 ...	Tissue exam by pathologist.

TABLE 1.—PROPOSED CY 2008 BYPASS CODES FOR CREATING ''PSEUDO'' SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS—Continued

HCPCS code	Short descriptor
88305 ...	Tissue exam by pathologist.
88307 ...	Tissue exam by pathologist.
88311 ...	Decalcify tissue.
88312 ...	Special stains.
88313 ...	Special stains.
88321 ...	Microslide consultation.
88323 ...	Microslide consultation.
88325 ...	Comprehensive review of data.
88331 ...	Path consult intraop, 1 bloc.
88342 ...	Immunohistochemistry.
88346 ...	Immunofluorescent study.
88347 ...	Immunofluorescent study.
88348 ...	Electron microscopy.
88358 ...	Analysis, tumor.
88360 ...	Tumor immunohistochem/manual.
88365 ...	Insitu hybridization (fish).
88368 ...	Insitu hybridization, manual.
88399 ...	Surgical pathology procedure.
89049 ...	Chct for mal hyperthermia.
89230 ...	Collect sweat for test.
89240 ...	Pathology lab procedure.
90761 ...	Hydrate iv infusion, add-on.
90766 ...	Ther/proph/dg iv inf, add-on.
90801 ...	Psy dx interview.
90802 ...	Intac psy dx interview.
90804 ...	Psytx, office, 20–30 min.
90805 ...	Psytx, off, 20–30 min w/e&m.
90806 ...	Psytx, off, 45–50 min.
90807 ...	Psytx, off, 45–50 min w/e&m.
90808 ...	Psytx, office, 75–80 min.
90809 ...	Psytx, off, 75–80, w/e&m.
90810 ...	Intac psytx, off, 20–30 min.
90812 ...	Intac psytx, off, 45–50 min.
90816 ...	Psytx, hosp, 20–30 min.
90818 ...	Psytx, hosp, 45–50 min.
90826 ...	Intac psytx, hosp, 45–50 min.
90845 ...	Psychoanalysis.
90846 ...	Family psytx w/o patient.
90847 ...	Family psytx w/patient.
90853 ...	Group psychotherapy.
90857 ...	Intac group psytx.
90862 ...	Medication management.
92002 ...	Eye exam, new patient.
92004 ...	Eye exam, new patient.
92012 ...	Eye exam established pat.
92014 ...	Eye exam & treatment.
92020 ...	Special eye evaluation.
92081 ...	Visual field examination(s).
92082 ...	Visual field examination(s).
92083 ...	Visual field examination(s).
92135 ...	Opthalmic dx imaging.
92136 ...	Ophthalmic biometry.
92225 ...	Special eye exam, initial.
92226 ...	Special eye exam, subsequent.
92230 ...	Eye exam with photos.
92240 ...	Icg angiography.
92250 ...	Eye exam with photos.
92275 ...	Electroretinography.
92285 ...	Eye photography.
92286 ...	Internal eye photography.
92520 ...	Laryngeal function studies.
92541 ...	Spontaneous nystagmus test.
92546 ...	Sinusoidal rotational test.
92548 ...	Posturography.
92552 ...	Pure tone audiometry, air.
92553 ...	Audiometry, air & bone.
92555 ...	Speech threshold audiometry.

TABLE 1.—PROPOSED CY 2008 BYPASS CODES FOR CREATING ''PSEUDO'' SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS—Continued

HCPCS code	Short descriptor
92556 ...	Speech audiometry, complete.
92557 ...	Comprehensive hearing test.
92567 ...	Tympanometry.
92582 ...	Conditioning play audiometry.
92585 ...	Auditor evoke potent, compre.
92603 ...	Cochlear implt f/up exam 7 >.
92604 ...	Reprogram cochlear implt 7 >.
92626 ...	Eval aud rehab status.
93005 ...	Electrocardiogram, tracing.
93225 ...	ECG monitor/record, 24 hrs.
93226 ...	ECG monitor/report, 24 hrs.
93231 ...	Ecg monitor/record, 24 hrs.
93232 ...	ECG monitor/report, 24 hrs.
93236 ...	ECG monitor/report, 24 hrs.
93270 ...	ECG recording.
93271 ...	Ecg/monitoring and analysis.
93278 ...	ECG/signal-averaged.
93727 ...	Analyze ilr system.
93731 ...	Analyze pacemaker system.
93732 ...	Analyze pacemaker system.
93733 ...	Telephone analy, pacemaker.
93734 ...	Analyze pacemaker system.
93735 ...	Analyze pacemaker system.
93736 ...	Telephonic analy, pacemaker.
93741 ...	Analyze ht pace device sngl.
93742 ...	Analyze ht pace device sngl.
93743 ...	Analyze ht pace device dual.
93744 ...	Analyze ht pace device dual.
93786 ...	Ambulatory BP recording.
93788 ...	Ambulatory BP analysis.
93797 ...	Cardiac rehab.
93798 ...	Cardiac rehab/monitor.
93875 ...	Extracranial study.
93880 ...	Extracranial study.
93882 ...	Extracranial study.
93886 ...	Intracranial study.
93888 ...	Intracranial study.
93922 ...	Extremity study.
93923 ...	Extremity study.
93924 ...	Extremity study.
93925 ...	Lower extremity study.
93926 ...	Lower extremity study.
93930 ...	Upper extremity study.
93931 ...	Upper extremity study.
93965 ...	Extremity study.
93970 ...	Extremity study.
93971 ...	Extremity study.
93975 ...	Vascular study.
93976 ...	Vascular study.
93978 ...	Vascular study.
93979 ...	Vascular study.
93990 ...	Doppler flow testing.
94015 ...	Patient recorded spirometry.
94690 ...	Exhaled air analysis.
95115 ...	Immunotherapy, one injection.
95117 ...	Immunotherapy injections.
95165 ...	Antigen therapy services.
95805 ...	Multiple sleep latency test.
95806 ...	Sleep study, unattended.
95807 ...	Sleep study, attended.
95808 ...	Polysomnography, 1–3.
95812 ...	Eeg, 41–60 minutes.
95813 ...	Eeg, over 1 hour.
95816 ...	Eeg, awake and drowsy.
95819 ...	Eeg, awake and asleep.
95822 ...	Eeg, coma or sleep only.
95869 ...	Muscle test, thor paraspinal.

TABLE 1.—PROPOSED CY 2008 BYPASS CODES FOR CREATING ''PSEUDO'' SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS—Continued

HCPCS code	Short descriptor
95900 ...	Motor nerve conduction test.
95921 ...	Autonomic nerv function test.
95925 ...	Somatosensory testing.
95930 ...	Visual evoked potential test.
95950 ...	Ambulatory eeg monitoring.
95953 ...	EEG monitoring/computer.
95970 ...	Analyze neurostim, no prog.
95972 ...	Analyze neurostim, complex.
95974 ...	Cranial neurostim, complex.
95978 ...	Analyze neurostim brain/1h.
96000 ...	Motion analysis, video/3d.
96101 ...	Psycho testing by psych/phys.
96111 ...	Developmental test, extend.
96116 ...	Neurobehavioral status exam.
96118 ...	Neuropsych tst by psych/phys.
96119 ...	Neuropsych testing by tec.
96150 ...	Assess hlth/behave, init.
96151 ...	Assess hlth/behave, subseq.
96152 ...	Intervene hlth/behave, indiv.
96153 ...	Intervene hlth/behave, group.
96415 ...	Chemo, iv infusion, addl hr.
96423 ...	Chemo ia infuse each addl hr.
96900 ...	Ultraviolet light therapy.
96910 ...	Photochemotherapy with UV-B.
96912 ...	Photochemotherapy with UV-A.
96913 ...	Photochemotherapy, UV-A or B.
96920 ...	Laser tx, skin < 250 sq cm.
98925 ...	Osteopathic manipulation.
98926 ...	Osteopathic manipulation.
98927 ...	Osteopathic manipulation.
98940 ...	Chiropractic manipulation.
98941 ...	Chiropractic manipulation.
98942 ...	Chiropractic manipulation.
99204 ...	Office/outpatient visit, new.
99212 ...	Office/outpatient visit, est.
99213 ...	Office/outpatient visit, est.
99214 ...	Office/outpatient visit, est.
99241 ...	Office consultation.
99242 ...	Office consultation.
99243 ...	Office consultation.
99244 ...	Office consultation.
99245 ...	Office consultation.
0144T ...	CT heart wo dye; qual calc.
C8951 ..	IV inf, tx/dx, each addl hr.
C8955 ..	Chemotx adm, IV inf, addl hr.
G0008 ..	Admin influenza virus vac.
G0101 ..	CA screen;pelvic/breast exam.
G0127 ..	Trim nail(s).
G0130 ..	Single energy x-ray study.
G0166 ..	Extrnl counterpulse, per tx.
G0175 ..	OPPS Service,sched team conf.
G0332 ..	Preadmin IV immunoglobulin.
G0340 ..	Robt lin-radsurg fractx 2–5.
G0344 ..	Initial preventive exam.
G0365 ..	Vessel mapping hemo access.
G0367 ..	EKG tracing for initial prev.
G0376 ..	Smoke/tobacco counseling >10.
M0064 ..	Visit for drug monitoring.
Q0091 ..	Obtaining screen pap smear.

(2) Exploration of Allocation of Packaged Costs to Separately Paid Procedure Codes

During its August 23–24, 2006 meeting, the APC Panel recommended that CMS provide claims analysis of the contributions of packaged costs (including packaged revenue code charges and charges for packaged HCPCS codes) to the median cost of each drug administration service. (We refer readers to Recommendation #28 in the August 23–24, 2006 meeting recommendation summary on the CMS Web site at: *http://www.cms.hhs.gov/FACA/05_AdvisoryPanelonAmbulatoryPaymentClassificationGroups.asp#TopOfPage*.) In our continued effort to better understand the multiple claims in order to extract single bill information from them, we examined the extent to which the packaging in multiple procedure claims differs from the packaging in the single procedure claims on which we base the median costs both in general and more specifically for drug administration services. We performed this analysis using the claims data on which we based the CY 2007 OPPS/ASC final rule with comment period. We examined the amount of packaging in multiple procedure versus single procedure claims in general and in claims for drug administration services in particular. We conducted this analysis without taking into account the proposed packaging approach presented in this proposed rule. However, we do not expect the services newly proposed for packaged payment to commonly appear with a drug administration service. Therefore, we believe that the analysis conducted on the CY 2007 final rule with comment period data is sufficient to inform our development of this proposed rule.

In general, we do not believe that the proportionate amount of packaged costs in the multiple bills relative to the number of primary services is greater than that in the single bills. The costs in uncoded revenue codes and HCPCS codes with a packaged status indicator account for 22 percent of observed costs in the universe of all CY 2005 claims that we used to model the CY 2007 OPPS (including both the single and multiple procedure bills). Similarly, the costs in uncoded revenue codes and HCPCS codes with a packaged status indicator account for 18 percent of the total cost in the subset of CY 2005 single bills that we used to calculate the median costs on which the relative weights are based.

However, the bypass methodology creates a ''pseudo'' single bill for all claims for services or items on the bypass list, and these ''pseudo'' single bills have no associated packaging, by definition of the application of the bypass list. Excluding the total cost associated with bypass codes, 28 percent of observed costs in the single

bills are attributable to packaged services, and 29 percent of observed costs across all claims are attributable to packaged services. Therefore, we conclude that, in general, the extent of packaging in all bills is similar to the amount of packaging in the single procedure bills we use to set median costs for most APCs.

We recognize that aggregate numbers do not address the packaging associated with single and multiple procedure claims for specific services. We have received comments stating that the amount of packaging in the single bills for drug administration services is not representative of the typical packaged costs of these drug administration services, which are usually performed in combination with one another, because the single bills represent less complex and less resource-intensive services than the usual cases.

We published a study in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68120 through 68121) that discussed the amount of packaging on the single bills for drug administration procedure codes, and we promised to replicate that study for the APC Panel. We discussed the results of this study with the APC Panel at its March 2007 meeting, in accordance with the APC Panel's August 2006 recommendation. Table 2 below shows the drug administration HCPCS codes and their descriptors, status indicators, deleted code status, and CY 2007 APC assignments in columns 1, 2, 3, and 4, respectively. HCPCS codes for additional hours of infusion services are not presented because these codes were included on the CY 2007 bypass list and, therefore, we explicitly associated no packaged costs with them, as discussed in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68117 through 68118). Column 6 of the table contains the number of single bills relative to total occurrences of the code in the CY 2005 claims, and column 8 shows the percentage of single bills used to set payment rates. Drug administration services demonstrate reasonable single bill representation in comparison with other OPPS services. Single bills for drug administration constitute, roughly, 30 percent of all observed occurrences of drug administration services, varying by code from 7 to 55 percent. Columns 10 through 13 of the table show measures of central tendency for packaged costs as a percentage of total cost on each single claim. Columns 10 and 11 show the mean and median of all packaged costs as a percentage of total costs, and columns 12 and 13 break out the costs of packaged drug HCPCS codes and uncoded pharmacy revenue code charges for revenue codes in the 0250 series (Pharmacy), 0260 series (IV Therapy), and 0630 series (Pharmacy—Extension). These columns demonstrate that packaged costs substantially contribute to median cost estimates for the majority of drug administration HCPCS codes.

For all single bills for CPT code 90780 (Intravenous infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; up to one hour), on average, packaged costs were 31 percent of total cost (median 27 percent). For the same code, packaged drug and pharmacy costs comprised, on average, 23 percent of total costs (median 15 percent). Single bills make up 34 percent of all line-item occurrences of the service, suggesting that this single bill median cost was fairly robust and probably captured packaging adequately. On the other hand, CPT code 90784 (Therapeutic, prophylactic or diagnostic injection (specify material injected); subcutaneous or intramuscular) demonstrates limited packaging (median 0 percent and mean 17 percent), and the median cost for the code is derived from only 7 percent of all occurrences of the code. Across all drug administration codes, over half show significant median packaged costs largely attributable to packaged drug and pharmacy costs.

TABLE 2.—PACKAGED COST DATA FOR CY 2005 SINGLE CLAIMS FOR DRUG ADMINISTRATION SERVICES

HCPCS code	Short descriptor	SI	Deleted code	APC	Single bills	Total frequency	Percent single bills	Median cost ($)	All packaged costs as a percent of total cost		Packaged drug and pharmacy costs as a percent of total cost	
									Median	Mean	Median	Mean
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
90780 ..	IV infusion therapy, 1 hour	S ...	X	0440	1,008,055	2,974,785	33.9	110.43	27.1	30.8	15.3	22.6
90782 ..	Injection, sc/im	S ...	X	0437	1,326,094	2,894,231	45.8	24.77	0.0	10.1	0.0	8.7
90783 ..	Injection, ia	S ...	X	0438	427	3,012	14.2	51.35	0.0	10.9	0.0	6.8
90784 ..	Injection, iv	S ...	X	0438	183,096	2,812,204	6.5	49.54	0.0	16.7	0.0	9.7
90788 ..	Injection of antibiotic	S ...	X	0437	19,400	141,293	13.7	45.96	24.6	32.3	20.7	30.4
96400 ..	Chemotherapy, sc/im	S ...	.....	0438	57,472	81,546	70.5	51.98	0.0	6.3	0.0	4.5
96405 ..	Chemo intralesional, up to 7	S ...	.....	0438	142	181	78.5	193.65	0.0	12.0	0.0	10.5
96406 ..	Chemo intralesional over 7	S ...	.....	0438	2	7	28.6	46.42	0.0	0.0	0.0	0.0
96408 ..	Chemotherapy, push technique.	S ...	.....	0439	21,113	134,447	15.7	96.85	10.6	21.3	2.4	13.6
96410 ..	Chemotherapy, infusion method.	S ...	.....	0441	161,872	555,170	29.2	151.55	21.4	27.0	12.4	19.6
96414 ..	Chemo, infuse method add-on.	S ...	.....	0441	2,370	14,561	16.3	182.89	15.4	23.0	8.6	15.6
96420 ..	Chemo, ia, push tecnique ...	S ...	.....	0439	170	933	18.2	99.86	9.6	27.6	4.2	15.4
96422 ..	Chemo ia infusion up to 1 hr.	S ...	.....	0441	556	1,814	30.7	162.94	45.9	46.5	31.0	35.1
96425 ..	Chemotherapy, infusion method.	S ...	.....	0441	149	557	26.8	216.68	29.4	33.5	14.7	24.4
96440 ..	Chemotherapy, intracavitary	S ...	.....	0439	38	104	36.5	37.12	0.0	2.1	0.0	1.5
96445 ..	Chemotherapy, intracavitary	S ...	.....	0439	43	137	31.4	61.98	23.8	25.0	23.7	21.1
96450 ..	Chemotherapy, into CNS	S ...	.....	0441	394	869	45.3	160.03	25.8	28.7	2.0	8.3
96520 ..	Port pump refill & main	S ...	.....	0440	9,771	23,928	40.8	140.66	29.0	31.5	16.8	23.6
96530 ..	Syst pump refill & main	S ...	.....	0440	8,334	19,283	43.2	100.00	7.4	22.2	0.7	13.7
96542 ..	Chemotherapy injection	S ...	.....	0438	511	929	55.0	51.56	0.0	10.8	0.0	6.5

By definition, we are unable to precisely assess the amount of packaging associated with drug administration codes in the multiple bills. As a proxy, we estimated packaging as a percent of total cost on

each claim for two subsets of claims. Both analyses suggest the presence of moderate packaged costs, especially drug and pharmacy costs, associated with drug administration services in the multiple bills. Table 3 below shows measures of central tendency for packaging percentages in the multiple bills or portions of multiple bills remaining after ''pseudo'' singles have been created. We refer to this group of the multiple bills as the ''hardcore'' multiple bills. For the first subset of ''hardcore'' multiple bills with only drug administration codes, that is, where multiple drug administration codes are the only separately paid procedure codes on the claim (defined as procedure codes with a status indicator of ''S,'' ''T,'' ''V,'' ''X,'' or ''P''), we estimate that packaged costs are 22 percent of total costs (27 percent, on average), where total costs consist of costs for all payable codes. Costs for packaged drug HCPCS codes and pharmacy revenue codes comprise 13 percent of total cost at the median (19 percent, on average). For the second subset of ''hardcore'' multiple bills with any drug administration code, that is, where a drug administration code appears with other payable codes (largely radiology services and visits), we estimate packaged costs are 13 percent of total cost at the median (19 percent, on average). Costs for packaged drugs and pharmacy revenue codes comprise 6 percent of total cost at the median (10 percent, on average). The amount of packaging in both proxy measures, but especially the first subset, closely resembles the packaged costs as a percentage of drug administration costs observed in the single bills for drug administration services. While finding a way to accurately use data from the ''hardcore'' multiple bills to estimate drug administration median costs undoubtedly would impact medians, these comparisons suggest that the multiple bill data probably would support current median estimates.

TABLE 3.—PACKAGED COSTS ON MULTIPLE BILL CLAIMS FOR DRUG ADMINISTRATION SERVICES

Total frequency	All packaged costs as a percent of total cost		Packaged drug and pharmacy costs as a percent of total cost	
	Median	Mean	Median	Mean
Subset 1: ''Hardcore'' Multiple Claims with Only Drug Administration Codes				
693,925	21.6	26.8	12.7	19.3
Subset 2: ''Multiple'' Claims with At Least One Drug Administration Code				
4,816,338	13.2	19.4	5.8	10.0

We have received several comments over the past few years offering algorithms for packaging the costs associated with specific revenue codes or packaged drugs with certain drug administration codes. Because of the complexity of even routine OPPS claims, prior research suggests that such algorithms have limited power to generate additional single bill claims and do little to change median cost estimates. We continue to look for simple, but powerful, methodologies like the bypass list and packaging of HCPCS codes for additional ancillary and supportive services to assign packaged costs to all services within the ''hardcore'' multiple bills. Ideally, these methodologies should be intuitive to the provider community, easily integrated into the complexity of OPPS median cost estimation, and simple to maintain from year to year. We solicit and will carefully consider methodologies for creation of single bills that meet these criteria.

c. Proposed Calculation of CCRs

We calculate hospital-specific overall CCRs and hospital-specific departmental CCRs for each hospital for which we have claims data in the period of claims being used to calculate the median costs that we convert to scaled relative weights for purposes of setting the OPPS payment rates. We apply the hospital-specific CCR to the hospital's charges at the most detailed level possible, based on a revenue code-to-cost center crosswalk that contains a hierarchy of CCRs used to estimate costs from charges for each revenue code. That crosswalk is available for review and continuous comment on the CMS Web site at: *http://www.cms.hhs.gov/HospitalOutpatientPPS/03_crosswalk.asp#TopOfPage*. Comments on the proposed configuration of the crosswalk for CY 2008 should be included with comments on this section of this proposed rule. We calculate CCRs for the standard and nonstandard cost centers accepted by the electronic cost report database. In general, the most detailed level at which we calculate CCRs is the hospital-specific departmental level.

Following the expiration of most medical devices from pass-through status in CY 2003, prior to which devices were paid at charges reduced to cost using the hospital's overall CCR, we received comments that our OPPS cost estimates for device implantation procedures systematically underestimate the cost of the devices included in the packaged payment for the procedures. Commenters informed us that hospitals routinely mark up charges for low cost items to a much greater extent than they mark up high cost items, and that these items are often combined in a single cost center on their Medicare cost report. Commenters stated that when items with widely varying costs are combined in a single cost center using that cost center's CCR to estimate costs from charges for those items, this approach will overestimate the cost of low cost items and underestimate the cost of high cost items. This is commonly known as ''charge compression.'' They stated that, in the case of implantable devices, the charges for both high cost devices and low cost supplies typically are reported under the medical supply revenue code series and that the costs of both typically are reported in the medical supply cost center on the cost report. Commenters stated that the application of one medical supply CCR to charges for all items reported under the medical supply revenue code underestimates the cost of expensive medical supplies and overestimates the cost of inexpensive supplies. They indicated that when these costs are packaged into the costs of the procedures in which they are used, the result is inaccurate median costs for the HCPCS codes and APCs, and thus the standard OPPS ratesetting methodology systematically distorts

relative payment weights for procedures using devices.

In CY 2006, the device industry commissioned a study to interpolate a device-specific CCR from the medical supply CCR, using publicly available hospital claim and Medicare cost report data rather than proprietary data on device costs. After reviewing the device industry's data analysis and study model, CMS contracted with RTI International (RTI) to study the impact of charge compression on the cost-based weight methodology adopted in the FY 2007 IPPS final rule, to evaluate this model and to propose solutions. For more information, interested individuals can view RTI's report on the CMS Web site at: *http://www.cms.hhs.gov/reports/downloads/Dalton.pdf*.

Any study of cost estimation in general, and charge compression specifically, has obvious importance for both the OPPS and the IPPS. RTI's research explicitly focused on the IPPS for several reasons, which include greater Medicare expenditure under the IPPS, a desire to evaluate the model quickly given IPPS regulation deadlines, and a focus on other components of the new FY 2007 IPPS cost-based weight methodology (CMS Contract No. 500–00–0024–T012, ''A Study of Charge Compression in Calculating DRG Relative Weights,'' page 5). The study first addressed the possibility of cross-aggregation bias in the CCRs used to estimate costs under the IPPS created by the IPPS methodology of aggregating cost centers into larger departments before calculating CCRs. The report also addressed potential bias created by estimating costs using a CCR that reflects the combined costs and charges of services with wide variation in the amount of hospital markup. In its assessment of the latter, RTI targeted its attempt to identify the presence of charge compression to those cost centers presumably associated with revenue codes demonstrating significant IPPS expenditures and utilization. RTI assessed the correlation between cost report CCRs and the percent of charges in a cost center attributable to a set of similar services represented by a group of revenue codes. RTI did not examine the correlation between CCRs and revenue codes without significant IPPS expenditures or a demonstrated concentration in a specific Diagnosis Related Group (DRG). For example, RTI did not examine revenue code groups within the pharmacy cost center with low proportionate inpatient charges that might be important to the OPPS, such as ''Pharmacy Incident to Radiology.'' RTI states this limitation in its study and specifically recommends that disaggregated CCRs be reestimated for outpatient hospital charges.

Cost report CCRs combine both inpatient and outpatient services. Ideally, RTI would be able to examine the correlation between CCRs for Medicare inpatient services and inpatient claim charges and the correlation between CCRs for Medicare outpatient services and outpatient claim charges. However, the comprehensive nature of the cost report CCR (which combines inpatient and outpatient services) argues for an analysis of the correlation between CCRs and combined inpatient and outpatient claim charges. As noted, the RTI study accepted some measurement error in its analysis by matching an ''all charges'' CCR to inpatient estimates of charges for groups of similar services represented by revenue codes because of short timelines and because inpatient costs dominate outpatient costs in many ancillary cost centers. We believe that CCR adjustments used to calculate payment should be based on the comparison of cost report CCRs to combined inpatient and outpatient charges. An ''all charges'' model would reduce measurement error and estimate adjustments to disaggregated CCRs that could be used in both hospital inpatient and outpatient payment systems.

RTI made several short-term recommendations for improving the accuracy of DRG weight estimates from a cost-based methodology to address bias in combining cost centers and charge compression that could be considered in the context of OPPS policy. We discuss each recommendation within the context of the OPPS and provide our assessment of its application to the OPPS. We do not discuss RTI's recommendations to change cost report policy, which, by definition, would not have an effect on payment weight estimates until several years in the future.

(1) RTI recommends expansion of the number of CCRs used under the IPPS (RTI study, pages 11 and 85). Our OPPS methodology is already more specific than the RTI recommendation. To the extent possible, the OPPS uses hospital-specific cost centers, both standard and nonstandard, to reduce charges to estimated costs and, therefore, the OPPS ratesetting methodology is already more specific than the RTI recommendation.

(2) RTI recommends disaggregation of emergency department and blood products from the ''other services'' CCR used in the IPPS (RTI study, pages 11 and 85). Because we use standard and nonstandard cost center data, our OPPS methodology already comports with this RTI recommendation. Further, we estimate a CCR for blood that is often higher than that in the cost report based on a special methodology that is discussed further in section X of this proposed rule. Therefore, the OPPS is already meeting, and in several cases exceeding, the RTI recommendation for specificity with regard to estimating the costs associated with emergency department and blood product services.

(3) RTI recommends reclassification of intermediate care charges from the intensive care unit to the routine cost center (RTI study, pages 10 and 85). This recommendation is not relevant to the OPPS because our methodology for calculating costs under the OPPS relies solely on ancillary cost centers and does not use either cost center included in the recommendation to estimate costs for hospital outpatient services.

(4) RTI recommends establishment of regression-based estimates as a temporary or permanent method for disaggregating national average CCRs for medical supplies, drugs, and radiology services under the IPPS (RTI study, pages 11 and 86). With regard to radiology services, RTI estimated significantly lower CCRs for the cost centers for computed tomography (CT) scans and magnetic resonance imaging (MRI) services. RTI triangulated its findings with lower observed CCRs for the one-third of providers reporting nonstandard cost centers, specifically MRI Scan and CT Scan. However, in using CCRs for nonstandard cost centers, including MRI Scan and CT Scan, the OPPS already has partially implemented RTI's recommendation to use lower CCRs to estimate costs for those OPPS services allocated to these two imaging cost centers.

For reasons discussed in more detail below, we are proposing to develop an all-charges model that would compare variation in CCRs with variation in combined inpatient and outpatient charges for sets of similar services and establish disaggregated CCRs that could be applied to both inpatient and outpatient charges. We are proposing to evaluate the results of that methodology for purposes of determining whether the resulting disaggregated CCRs should be proposed for use in developing the CY 2009 OPPS payment rates. The revised all-charges model and resulting disaggregated CCRs will not be available in time for use in the CY 2008 OPPS/ASC final rule with comment period.

There are several reasons that we are not proposing to use the intradepartmental CCRs that RTI estimated using IPPS charges for the CY 2008 OPPS estimation of median costs. We agree with RTI that the

intradepartmental CCRs it calculated for the IPPS would not always be appropriate for application to the OPPS (RTI study, pages 34 and 35). While RTI recommends that the model be recalibrated for outpatient charges before it is applied to the OPPS, we believe that the combined nature of the CCRs available from the cost report prevents an accurate outpatient recalibration that would be appropriate for the OPPS alone. The addition of outpatient charges could change the variability of combined charges for some groups of services. For example, if hospitals use a high volume of less complex devices with lower charges in the outpatient department, the inclusion or omission of the outpatient charges for these high volume and lower cost devices could change the estimated disaggregated device CCR. Furthermore, RTI's analysis excluded some revenue codes with extensive outpatient charges because these revenue codes play a minor role in the IPPS. Therefore, we believe that an all-charges model examining an expanded subset of revenue codes is most appropriate, and that this model must be developed before we could apply the resulting disaggregated CCRs to the charges for supplies paid under the OPPS.

Moreover, to implement the disaggregated IPPS-based CCRs in the OPPS that RTI estimated for CY 2008 could result in greater instability in relative payment weights for CY 2008 than would otherwise occur. Significant changes in CCRs, both increases and decreases, could prompt the reassignment of services to different APCs due to the new estimates of median costs and require modification of the overall APC structure. Not only might there be significant fluctuations in payment between the CY 2007 and CY 2008 OPPS, but a subsequent change to application of the disaggregated CCRs resulting from development of an all-charges model might also result in significant fluctuations in median costs and increased instability in payments from CY 2008 to CY 2009. Therefore, these sequential changes could result in significant increases in median costs in one year and significant declines in median costs in the next year.

Therefore, we are not proposing to adopt the RTI disaggregated CCRs under the CY 2008 OPPS. We will consider whether it would be appropriate to adopt disaggregated CCRs for the OPPS after we analyze the results of the use of both inpatient and outpatient charges across all payers to recalculate disaggregated CCRs.

2. Proposed Calculation of Median Costs

In this section of this proposed rule, we discuss the use of claims to calculate the proposed OPPS payment rates for CY 2008. The hospital OPPS page on the CMS Web site on which this proposed rule is posted provides an accounting of claims used in the development of the proposed rates on the CMS Web site at: *http://www.cms.hhs.gov/HospitalOutpatientPPS*. The accounting of claims used in the development of this proposed rule is included on the Web site under supplemental materials for the CY 2008 proposed rule. That accounting provides additional detail regarding the number of claims derived at each stage of the process. In addition, below we discuss the files of claims that comprise the data sets that are available for purchase under a CMS data user contract. Our CMS Web site, *http://www.cms.hhs.gov/HospitalOutpatientPPS*, includes information about purchasing the following two OPPS data files: ''OPPS Limited Data Set'' and ''OPPS Identifiable Data Set.''

We used the following methodology to establish the relative weights we are proposing to use in calculating the OPPS payment rates for CY 2008 shown in Addenda A and B to this proposed rule. This methodology is as follows:

We used outpatient claims for the full CY 2006, processed before January 1, 2007, to set the proposed relative weights for CY 2008. To begin the calculation of the relative weights for CY 2008, we pulled all claims for outpatient services furnished in CY 2006 from the national claims history file. This is not the population of claims paid under the OPPS, but all outpatient claims (including, for example, CAH claims and hospital claims for clinical laboratory services for persons who are neither inpatients nor outpatients of the hospital).

We then excluded claims with condition codes 04, 20, 21, and 77. These are claims that providers submitted to Medicare knowing that no payment will be made. For example, providers submit claims with a condition code 21 to elicit an official denial notice from Medicare and document that a service is not covered. We then excluded claims for services furnished in Maryland, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands because hospitals in those geographic areas are not paid under the OPPS.

We divided the remaining claims into the three groups shown below. Groups 2 and 3 comprise the 101 million claims that contain hospital bill types paid under the OPPS.

1. Claims that were not bill types 12X, 13X, 14X (hospital bill types), or 76X (CMHC bill types). Other bill types are not paid under the OPPS and, therefore, these claims were not used to set OPPS payment.

2. Claims that were bill types 12X, 13X, or 14X (hospital bill types). These claims are hospital outpatient claims.

3. Claims that were bill type 76X (CMHC). (These claims are later combined with any claims in item 2 above with a condition code 41 to set the per diem partial hospitalization rate determined through a separate process.)

For the CCR calculation process, we used the same general approach as we used in developing the final APC rates for CY 2007, using the revised CCR calculation which excluded the costs of paramedical education programs and weighted the outpatient charges by the volume of outpatient services furnished by the hospital. We refer readers to the CY 2007 OPPS/ASC final rule with comment period for more information (71 FR 67983 through 67985). We first limited the population of cost reports to only those for hospitals that filed outpatient claims in CY 2006 before determining whether the CCRs for such hospitals were valid.

We then calculated the CCRs for each cost center and the overall CCR for each hospital for which we had claims data. We did this using hospital-specific data from the Healthcare Cost Report Information System (HCRIS). We used the most recent available cost report data, in most cases, cost reports for CY 2005. We used the most recently submitted cost report to calculate the CCRs to be used to calculate median costs for the proposed CY 2008 OPPS rates. If the most recent available cost report was submitted but not settled, we looked at the last settled cost report to determine the ratio of submitted to settled cost using the overall CCR, and we then adjusted the most recent available submitted but not settled cost report using that ratio. We calculated both an overall CCR and cost center-specific CCRs for each hospital. We used the overall CCR calculation discussed in section II.A.1.c. of this proposed rule for all purposes that require use of an overall CCR.

We then flagged CAH claims, which are not paid under the OPPS, and claims from hospitals with invalid CCRs. The latter included claims from hospitals without a CCR; those from hospitals paid an all-inclusive rate; those from hospitals with obviously erroneous CCRs (greater than 90 or less than .0001); and those from hospitals with

overall CCRs that were identified as outliers (3 standard deviations from the geometric mean after removing error CCRs). In addition, we trimmed the CCRs at the cost center (that is, departmental) level by removing the CCRs for each cost center as outliers if they exceeded ±3 standard deviations from the geometric mean. We used a four-tiered hierarchy of cost center CCRs to match a cost center to every possible revenue code appearing in the outpatient claims, with the top tier being the most common cost center and the last tier being the default CCR. If a hospital's cost center CCR was deleted by trimming, we set the CCR for that cost center to ''missing,'' so that another cost center CCR in the revenue center hierarchy could apply. If no other cost center CCR could apply to the revenue code on the claim, we used the hospital's overall CCR for the revenue code in question. For example, if a visit was reported under the clinic revenue code, but the hospital did not have a clinic cost center, we mapped the hospital-specific overall CCR to the clinic revenue code. The hierarchy of CCRs is available for inspection and comment on the CMS Web site: *http://www.cms.hhs.gov/HospitalOutpatientPPS.*

We then converted the charges to costs on each claim by applying the CCR that we believed was best suited to the revenue code indicated on the line with the charge. Table 4 of this proposed rule contains a list of the allowed revenue codes. Revenue codes not included in Table 4 are those not allowed under the OPPS because their services cannot be paid under the OPPS (for example, inpatient room and board charges), and thus charges with those revenue codes were not packaged for creation of the OPPS median costs. One exception is the calculation of median blood costs, as discussed in section X. of this proposed rule.

Thus, we applied CCRs as described above to claims with bill types 12X, 13X, or 14X, excluding all claims from CAHs and hospitals in Maryland, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands and claims from all hospitals for which CCRs were flagged as invalid.

We identified claims with condition code 41 as partial hospitalization services of hospitals and moved them to another file. These claims were combined with the 76X claims identified previously to calculate the partial hospitalization per diem rate.

We then excluded claims without a HCPCS code. We moved to another file claims that contained nothing but influenza and pneumococcal pneumonia (''PPV'') vaccines. Influenza and PPV vaccines are paid at reasonable cost and, therefore, these claims are not used to set OPPS rates. We note that the separate file containing partial hospitalization claims is included in the files that are available for purchase as discussed above. Unlike years past, we did not create a separate file of claims containing observation services because we are proposing to package all observation care for the CY 2008 OPPS.

We next copied line-item costs for drugs, blood, and devices (the lines stay on the claim, but are copied onto another file) to a separate file. No claims were deleted when we copied these lines onto another file. These line-items are used to calculate a per unit mean and median and a per day mean and median for drugs, radiopharmaceutical agents, blood and blood products, and devices, including, but not limited to, brachytherapy sources, as well as other information used to set payment rates, such as a unit-to-day ratio for drugs.

We then divided the remaining claims into the following five groups:

1. *Single Major Claims:* Claims with a single separately payable procedure (that is, status indicator ''S,'' '' T,'' ''V,'' or ''X'').

2. *Multiple Major Claims:* Claims with more than one separately payable procedure (that is, status indicator ''S,'' ''T,'' ''V,'' or ''X''), or multiple units for one payable procedure. As discussed below, some of these can be used in median setting. We also included in this set claims that contain one unit of one code when the bilateral modifier is appended to the code and the code is one that is conditionally or independently bilateral. In these cases, these claims represent more than one unit of the service described by the code, notwithstanding that only one unit is billed.

3. *Single Minor Claims:* Claims with a single HCPCS code that is assigned to status indicator ''F,'' ''G,'' ''H,'' ''K,'' ''L,'' or ''N.''

4. *Multiple Minor Claims:* Claims with multiple HCPCS codes that are assigned to status indicator ''F,'' ''G,'' ''H,'' ''K,'' ''L,'' or ''N.''

5. *Non-OPPS Claims:* Claims that contain no services payable under the OPPS (that is, all status indicators other than those listed for major or minor status). These claims are excluded from the files used for the OPPS. Non-OPPS claims have codes paid under other fee schedules, for example, durable medical equipment or clinical laboratory tests, and do not contain either a code for a separately paid service or a code for a packaged service.

We use status indicator ''Q'' in Addendum B to this proposed rule to identify services that receive separate HCPCS code-specific payment when specific criteria are met, and payment for the individual service is packaged in all other circumstances. We are proposing several different sets of criteria to determine whether separate payment would be made for specific services. For example, HCPCS code G0379 (Direct admission of patient for hospital observation care) is assigned to status indicator ''Q'' in Addendum B to this proposed rule because we are proposing that it receive separate payment only if it is billed on the same date of service as HCPCS code G0378 (Hospital observation service, per hour), without any services with status indicator ''T'' or ''V,'' or Critical Care (APC 0617). Proposed payment for observation services is discussed in section XI. of this proposed rule. The specific services in the proposed composite APCs discussed in section II.A.4. of this proposed rule also are assigned to status indicator ''Q'' in Addendum B to this proposed rule because we are proposing that their payment would be bundled into a single composite payment for a combination of major procedures under certain circumstances. These services would only receive separate code-specific payment if certain criteria are met. The same is true for those less intensive outpatient mental health treatment services for which payment is limited to the partial hospitalization per diem rate and which also are assigned to status indicator ''Q'' in Addendum B to this proposed rule. According to longstanding OPPS payment policy (65 FR 18455), payment for these individual mental health services is bundled into a single payment, APC 0034 (Mental Health Services Composite), when the sum of the individual mental health service payments for all of these mental health services provided on the same day would exceed payment for a day of partial hospitalization services. However, the largest number of specific HCPCS codes identified by status indicator ''Q'' in Addendum B to this proposed rule are those codes that we identify as ''special'' packaged codes, where we are proposing that a service receives separate payment when it appears on the same day on a claim without another service that is assigned to status indicator ''S,'' ''T,'' ''V,'' or ''X.'' We are proposing to package payment for these HCPCS codes when the code appears on the same date of service with any other service that is

assigned to status indicator ''S,'' ''T,'' ''V,'' or ''X.''

This last and largest subset of conditionally packaged services have to be integrated into the identification of single and multiple bills to ensure that the costs for these services are appropriately packaged when they appear with any other separately paid service. We handle these conditionally packaged services in the data by assigning the HCPCS code an APC and a data status indicator of ''N.'' When the conditionally packaged HCPCS code appears with a HCPCS code with a status indicator of ''S,'' ''T,'' ''V,'' or ''X'' on the same date of service, it is treated as a packaged code. The costs that appear on the line with the code are packaged into the cost of the HCPCS code with a status indicator of ''S,'' ''T,'' ''V,'' or ''X.'' When the conditionally packaged HCPCS code appears by itself, we change the status indicator on the line to the status indicator of the APC to which the conditionally packaged code is assigned, converting the service from a minor to a major procedure. This creates single bills for these conditionally packaged services that are then used to set the median cost for the conditionally packaged code and for the APC to which it is assigned when it is separately paid.

The claims listed in numbers 1, 2, 3, and 4 above are included in the data files that can be purchased as described above.

In years prior to the CY 2007 OPPS, we made a determination of whether each HCPCS code was a major code or a minor code or a code other than a major or minor code. We used those code-specific determinations to sort claims into the five groups identified above. For the CY 2007 OPPS, we used status indicators to sort the claims into these groups. We defined major procedures as any procedure having a status indicator of ''S,'' ''T,'' ''V,'' or ''X;'' defined minor procedures as any code having a status indicator of ''N;'' and classified ''other'' procedures as any code having a status indicator other than ''S,'' ''T,'' ''V,'' ''X,'' or ''N.'' For the CY 2007 OPPS proposed rule limited data set and identifiable data set, these definitions excluded claims on which hospitals billed drugs and devices without also billing separately paid procedure codes and, therefore, these public use files did not contain all claims used to calculate the drug and device frequencies and medians. We corrected this for the CY 2007 OPPS/ASC final rule with comment period limited data set and identifiable data set by extracting claims containing drugs and devices from the set of ''other'' claims and adding them to the public use files.

At its March 2007 meeting, the APC Panel recommended that CMS edit and return for correction claims that contain a HCPCS code for a separately paid drug or device but that also do not contain a HCPCS code assigned to a procedural APC (that is, those not assigned status indicator ''S,'' ''T,'' ''V,'' or ''X''). The APC Panel stated that this edit should improve the claims data and may increase the number of single bills available for ratesetting. We note that such an edit would be broader than the device-to-procedure code edits we implemented for CY 2007 for selected devices. While we encourage hospitals to code correctly in accordance with CPT, CMS, and local contractor guidance, in general we have historically implemented claims processing edits under the OPPS when we believe that these edits help ensure complete claims data for ratesetting. In the case of such Outpatient Code Editor (OCE) edits for drugs and devices that are separately paid, it is unclear to us that these edits would improve our claims data for median cost calculation because the items receive separate payment and do not result in multiple procedure claims when they are reported. We also are uncertain about the clinical circumstances that could result in a hospital submitting an OPPS claim that only reported a separately paid drug or device. We are soliciting comments specifically on the impact of establishing such edits on hospital billing processes and on related potential improvements to claims data used for median setting.

Therefore, in view of the prior public comments and our desire to ensure that the public data files contain all appropriate data, for the CY 2008 OPPS, we are proposing to define major procedures as HCPCS codes that have a status indicator of ''S,'' ''T,'' ''V,'' or ''X.'' We are proposing to define minor procedures as HCPCS codes that have a status indicator of ''F,'' ''G,'' ''H,'' ''K,'' ''L,'' or ''N'' but, as we discuss above, to make single bills out of any claims for single procedures with a minor code that also has an APC assignment. This ensures that the claims that contain only codes for drugs and biologicals or devices but that do not contain codes for procedures are included in the limited data set and the identifiable data set. It also ensures, as discussed above, that conditionally packaged services that receive separate payment only when they are billed without any other separately payable OPPS services are treated appropriately for purposes of median cost calculations. We are proposing to define ''other'' services as HCPCS codes that have a status indicator other than those defined as major or minor procedures.

We continue to believe that using status indicators, with the proposed changes, is an appropriate way to sort the claims into these groups and also to make our process more transparent to the public. We further believe that this proposed method of sorting claims would enhance the public's ability to derive useful information for analysis and public comment on this proposed rule.

We set aside the single minor, multiple minor, and non-OPPS claims (numbers 3, 4, and 5 above) because we did not use these claims in calculating median costs of procedural APCs. We then examined the multiple major claims for dates of service to determine if we could break them into single procedure claims using the dates of service on all lines on the claim. If we could create claims with single major procedures by using date of service, we created a single procedure claim record for each separately paid procedure on a different date of service (that is, a ''pseudo'' single).

We then used the bypass codes listed in Table 1 of this proposed rule and discussed in section II.A.1.b. of this proposed rule to remove separately payable procedures that we determined contain limited costs or no packaged costs or were otherwise suitable for inclusion on the bypass list from a multiple procedure bill. When one of the two separately payable procedures on a multiple procedure claim was on the bypass list, we split the claim into two ''pseudo'' single procedure claims records. The single procedure claim record that contained the bypass code did not retain packaged services. The single procedure claim record that contained the other separately payable procedure (but no bypass code) retained the packaged revenue code charges and the packaged HCPCS code charges.

We also removed lines that contained multiple units of codes on the bypass list and treated them as ''pseudo'' single claims by dividing the cost for the multiple units by the number of units on the line. Where one unit of a single, separately paid procedure code remained on the claim after removal of the multiple units of the bypass code, we created a ''pseudo'' single claim from that residual claim record, which retained the costs of packaged revenue codes and packaged HCPCS codes. This enabled us to use claims that would otherwise be multiple procedure claims and could not be used. We excluded those claims that we were not able to

convert to single claims even after applying all of the techniques for creation of ''pseudo'' singles. Among those excluded were claims that contain codes that are viewed as independently or conditionally bilateral and that contain the bilateral modifier (Modifier 50, Bilateral procedure) because the line-item cost for the code represents the cost of two units of the procedure, notwithstanding that the code appears with a unit of one. Therefore, the charge on the line represents the charge for two services rather than a single service and using the line as reported would overstate the cost of a single procedure. We then packaged the costs of packaged HCPCS codes (codes with status indicator ''N'' listed in Addendum B to this proposed rule) and packaged revenue codes into the cost of the single major procedure remaining on the claim.

The list of packaged revenue codes is shown in Table 4 of this proposed rule. At its March 2007 meeting the APC Panel recommended that CMS review the final list of packaged revenue codes for consistency with OPPS policy and ensure that future versions of the OCE edit accordingly. We compared the packaged revenue codes in the OCE to the finalized list of packaged revenue codes for the CY 2007 OPPS (71 FR 67989 through 67990) that we used for packaging costs in median calculation. As a result of that analysis, we are accepting the APC Panel's recommendation and we are proposing to change the list of packaged revenue codes for the CY 2008 OPPS in the following manner. First, we are proposing to remove revenue codes 0274 (Prosthetic/Orthotic devices) and 0290 (Durable Medical Equipment) from the list of packaged revenue codes because we do not permit hospitals to report implantable devices in these revenue codes (Internet Only Manual 100–4, Chapter 4, section 20.5.1.1). We also are proposing to add revenue code 0273 (Take Home Supplies) to the list of packaged revenue codes because we believe that the charges under this revenue code are for the incidental supplies that hospitals sometimes provide for patients who are discharged at a time when it is not possible to secure the supplies needed for a brief time at home. We are proposing to conform the list of packaged revenue codes in the OCE to the OPPS for CY 2008.

We packaged the costs of the HCPCS codes that are shown with status indicator ''N'' into the cost of the independent service to which the packaged service is ancillary or supportive. We refer readers to section II.A.4. of this proposed rule for a more complete discussion of the packaging changes we are proposing for CY 2008.

After removing claims for hospitals with error CCRs, claims without HCPCS codes, claims for immunizations not covered under the OPPS, and claims for services not paid under the OPPS, approximately 54 million claims were left. Of these 54 million claims, we were able to use some portion of approximately 50 million whole claims (92 percent of approximately 54 million potentially usable claims) to create approximately 88 million single and ''pseudo'' single claims, of which we used 87 million single bills (after trimming out just over 822,000 claims as discussed below) in the CY 2008 median development and for ratesetting.

We also excluded (1) claims that had zero costs after summing all costs on the claim and (2) claims containing packaging flag number 3. Effective for services furnished on or after July 1, 2004, the OCE assigns packaging flag number 3 to claims on which hospitals submit token charges for a service with status indicator ''S'' or ''T'' (a major separately paid service under the OPPS) for which the fiscal intermediary is required to allocate the sum of charges for services with a status indicator equaling ''S'' or ''T'' based on the weight for the APC to which each code is assigned. We do not believe that these charges, which were token charges as submitted by the hospital, are valid reflections of hospital resources. Therefore, we deleted these claims. We also deleted claims for which the charges equal the revenue center payment (that is, the Medicare payment) on the assumption that where the charge equals the payment, to apply a CCR to the charge would not yield a valid estimate of relative provider cost.

For the remaining claims, we then standardized 60 percent of the costs of the claim (which we have previously determined to be the labor-related portion) for geographic differences in labor input costs. We made this adjustment by determining the wage index that applied to the hospital that furnished the service and dividing the cost for the separately paid HCPCS code furnished by the hospital by that wage index. As has been our policy since the inception of the OPPS, we are proposing to use the pre-reclassified wage indices for standardization because we believe that they better reflect the true costs of items and services in the area in which the hospital is located than the post-reclassification wage indices and, therefore, would result in the most accurate unadjusted median costs.

We also excluded claims that were outside 3 standard deviations from the geometric mean of units for each HCPCS code on the bypass list (because, as discussed above, we used claims that contain multiple units of the bypass codes).

We used the remaining claims to calculate the CY 2008 proposed median costs for each separately payable HCPCS code and each APC. The comparison of HCPCS and APC medians determines the applicability of the ''2 times'' rule. Section 1833(t)(2) of the Act provides that, subject to certain exceptions, the items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest median (or mean cost, if elected by the Secretary) for an item or service in the group is more than 2 times greater than the lowest median cost for an item or service within the same group (''the 2 times rule''). Finally, we reviewed the medians and reassigned HCPCS codes to different APCs where we believed that it was appropriate. Section III. of this proposed rule includes a discussion of certain proposed HCPCS code assignment changes that resulted from examination of the medians and for other reasons. The APC medians were recalculated after we reassigned the affected HCPCS codes. Both the HCPCS medians and the APC medians were weighted to account for the inclusion of multiple units of the bypass codes in the creation of ''pseudo'' single bills.

In our review of median costs for HCPCS codes and their assigned APCs, we have frequently noticed that some services are consistently rarely performed in the hospital outpatient setting for the Medicare population. In particular, there are a number of services, such as several procedures related to the care of pregnant women, that have annual Medicare claims volume of 100 or fewer occurrences. By definition, these services also have a small number of single bills from which to estimate median costs. In addition, in some cases, these codes have been historically assigned to clinical APCs where all the services are low volume. Therefore, the median costs for these services and APCs often fluctuate from year to year, in part due to the variability created by such a small number of claims. One of the benefits of basing payment on the median cost of many HCPCS codes with sufficient single bill representation in an APC is that such fluctuation is moderated by the increased number of observations for similar services on which the APC median cost is also based. We considered proposing a distinct methodology for calculation of the

median cost of low total volume APCs in order to provide more stability in payment from year to year for these low total volume services. However, after examination of the low total volume OPPS services and their assigned APCs, we concluded that there were other clinical APCs with higher volumes of total claims to which these low total volume services could be reassigned, while ensuring the continued clinical and resource homogeneity of the clinical APCs to which they would be newly reassigned. Therefore, we believe that it is more appropriate to reconfigure clinical APCs to eliminate most of the low total volume APCs. These low volume services differ from other OPPS services only because they are not often furnished to the Medicare population. Therefore, we are proposing to reconfigure certain clinical APCs for CY 2008 as a way to promote stability and appropriate payment for the services assigned to them, including low total volume services. We believe that these proposed reconfigurations maintain APC clinical and resource homogeneity. We are proposing these changes as an alternative to developing specific quantitative approaches to treating low total volume APCs differently for purposes of median calculation. As a result of this proposal, 3 APCs proposed for CY 2008 (all of which are New Technology APCs) have a total volume of services less than 100, and only 17 APCs have a total volume of less than 1,000, in comparison with CY 2007 where 9 APCs (including 3 New Technology APCs) had a total volume of less than 100 and 36 APCs had a total volume of less than 1,000.

A detailed discussion of the medians for blood and blood products is included in section X. of this proposed rule. A discussion of the medians for APCs that require one or more devices when the service is performed is included in section IV.A. of this proposed rule. A discussion of the median for partial hospitalization is included below in section II.B. of this proposed rule.

TABLE 4.—PROPOSED CY 2008 PACKAGED REVENUE CODES

Revenue code	Description
0250	PHARMACY.
0251	GENERIC.
0252	NONGENERIC.
0254	PHARMACY INCIDENT TO OTHER DIAGNOSTIC.
0255	PHARMACY INCIDENT TO RADIOLOGY.
0257	NONPRESCRIPTION DRUGS.
0258	IV SOLUTIONS.
0259	OTHER PHARMACY.
0260	IV THERAPY, GENERAL CLASS.
0262	IV THERAPY/PHARMACY SERVICES.
0263	SUPPLY/DELIVERY.
0264	IV THERAPY/SUPPLIES.
0269	OTHER IV THERAPY.
0270	M&S SUPPLIES.
0271	NONSTERILE SUPPLIES.
0272	STERILE SUPPLIES.
0273	TAKE HOME SUPPLIES.
0275	PACEMAKER DRUG.
0276	INTRAOCULAR LENS SOURCE DRUG.
0278	OTHER IMPLANTS.
0279	OTHER M&S SUPPLIES.
0280	ONCOLOGY.
0289	OTHER ONCOLOGY.
0343	DIAGNOSTIC RADIOPHARMS.
0344	THERAPEUTIC RADIOPHARMS.
0370	ANESTHESIA.
0371	ANESTHESIA INCIDENT TO RADIOLOGY.
0372	ANESTHESIA INCIDENT TO OTHER DIAGNOSTIC.
0379	OTHER ANESTHESIA.
0390	BLOOD STORAGE AND PROCESSING.
0399	OTHER BLOOD STORAGE AND PROCESSING.
0560	MEDICAL SOCIAL SERVICES.
0569	OTHER MEDICAL SOCIAL SERVICES.
0621	SUPPLIES INCIDENT TO RADIOLOGY.
0622	SUPPLIES INCIDENT TO OTHER DIAGNOSTIC.
0624	INVESTIGATIONAL DEVICE (IDE).
0630	DRUGS REQUIRING SPECIFIC IDENTIFICATION, GENERAL CLASS.
0631	SINGLE SOURCE.
0632	MULTIPLE.
0633	RESTRICTIVE PRESCRIPTION.
0681	TRAUMA RESPONSE, LEVEL I.
0682	TRAUMA RESPONSE, LEVEL II.
0683	TRAUMA RESPONSE, LEVEL III.
0684	TRAUMA RESPONSE, LEVEL IV.
0689	TRAUMA RESPONSE, OTHER.
0700	CAST ROOM.
0709	OTHER CAST ROOM.
0710	RECOVERY ROOM.
0719	OTHER RECOVERY ROOM.
0720	LABOR ROOM.

TABLE 4.—PROPOSED CY 2008 PACKAGED REVENUE CODES—Continued

Revenue code	Description
0721	LABOR.
0762	OBSERVATION ROOM.
0810	ORGAN ACQUISITION.
0819	OTHER ORGAN ACQUISITION.
0942	EDUCATION/TRAINING.

3. Proposed Calculation of OPPS Scaled Payment Weights

Using the median APC costs discussed previously, we calculated the proposed relative payment weights for each APC for CY 2008 shown in Addenda A and B to this proposed rule. In years prior to CY 2007, we standardized all the relative payment weights to APC 0601 (Mid Level Clinic Visit) because it is one of the most frequently performed services in the hospital outpatient setting. We assigned APC 0601 a relative payment weight of 1.00 and divided the median cost for each APC by the median cost for APC 0601 to derive the relative payment weight for each APC.

Beginning with the CY 2007 OPPS, we standardized all of the relative payment weights to APC 0606 (Level 3 Clinic Visits) because we deleted APC 0601 as part of the reconfiguration of the visit APCs. We chose APC 0606 as the base because under our proposal to reconfigure the APCs where clinic visits are assigned for CY 2007, APC 0606 is the middle level clinic visit APC (that is, Level 3 of five levels). We have historically used the median cost of the middle level clinic visit APC (that is APC 0601 through CY 2006) to calculate unscaled weights because mid-level clinic visits are among the most frequently performed services in the hospital outpatient setting. Therefore, to maintain consistency in using a median for calculating unscaled weights representing the median cost of some of the most frequently provided services, we proposed to continue to use the median cost of the mid-level clinic APC, proposed APC 0606, to calculate unscaled weights. Following our standard methodology, but using the CY 2007 median for APC 0606, for CY 2007 we assigned APC 0606 a relative payment weight of 1.00 and divided the median cost of each APC by the median cost for APC 0606 to derive the unscaled relative payment weight for each APC. The choice of the APC on which to base the relative weights for all other APCs does not affect the payments made under the OPPS because we scale the weights for budget neutrality. We are again proposing to use APC 0606 as the base for the CY 2008 OPPS relative weights.

Section 1833(t)(9)(B) of the Act requires that APC reclassification and recalibration changes, wage index changes, and other adjustments be made in a manner that assures that aggregate payments under the OPPS for CY 2008 are neither greater than nor less than the aggregate payments that would have been made without the changes. To comply with this requirement concerning the APC changes, we compared aggregate payments using the CY 2007 relative weights to aggregate payments using the CY 2008 proposed relative weights. This year, we included payments to CMHCs in our comparison. Based on this comparison, we adjusted the relative weights for purposes of budget neutrality. The unscaled relative payment weights were adjusted by a weight scaler of 1.3665 for budget neutrality. In addition to adjusting for increases and decreases in weight due to the recalibration of APC medians, the scaler also accounts for any change in the base, other than changes in volume, which are not a factor in the weight scaler.

The proposed relative payment weights listed in Addenda A and B to this proposed rule incorporate the recalibration adjustments discussed in sections II.A.1. and 2. of this proposed rule.

Section 1833(t)(14)(H) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, states that ''Additional expenditures resulting from this paragraph shall not be taken into account in establishing the conversion factor, weighting and other adjustment factors for 2004 and 2005 under paragraph (9) but shall be taken into account for subsequent years.'' Section 1833(t)(14) of the Act provides the payment rates for certain ''specified covered outpatient drugs.'' Therefore, the cost of those specified covered outpatient drugs (as discussed in section V. of this proposed rule) is included in the budget neutrality calculations for the CY 2008 OPPS.

4. Proposed Changes to Packaged Services

(If you choose to comment on the issues in this section, please include the caption ''OPPS: Packaged Services'' at the beginning of your comment.)

a. Background

When the Medicare program was first implemented, it paid for hospital services (inpatient and outpatient) based on hospital-specific reasonable costs attributable to furnishing services to Medicare beneficiaries. Later the law was amended to limit payment to the lesser of the hospital's reasonable cost or customary charges for services furnished to Medicare beneficiaries. Specific service-based methodologies were then developed for certain types of services, such as clinical laboratory tests and durable medical equipment, while payments for outpatient surgical procedures and other diagnostic tests were based on a blend of the hospital's aggregate Medicare costs for these services and Medicare's payment for similar services in other ambulatory settings. While this mix of different payment methodologies was in use, hospital outpatient services were growing rapidly following the implementation of the IPPS in 1983. The brisk increase in hospital outpatient services led to an interest in creating payment incentives to promote more efficient delivery of hospital outpatient services through a Medicare prospective payment system for hospital outpatient services, and the final statutory requirements for the OPPS were established by the BBA and the BBRA. During the period of time when different approaches to prospective payment for hospital outpatient services were being considered, a variety of reports to Congress (June 1988, September 1990, and March 1995) discussed three major issues related to defining the unit of payment for the payment system, specifically the extent to which clinically similar procedures should be grouped for payment purposes and the logic that should be used for the groupings; the extent to which payment for minor, ancillary services associated with a significant

procedure should be packaged into a single payment for the procedure (which we refer to as ''packaging''); and the extent to which payment for multiple significant procedures related to an outpatient encounter or to an episode of care should be bundled into a single unit of payment (which we refer to as ''bundling''). Both packaging and bundling were presented as approaches to creating incentives for efficiency, with their potential policy disadvantages including inconsistency with other ambulatory fee schedules, reduced transparency of service-specific payment, and the potential for hospitals shifting the delivery of packaged or bundled services to delivery settings other than the hospital outpatient department (HOPD).

The OPPS, like other prospective payment systems, relies on the concept of averaging, where the payment may be more or less than the estimated costs of providing a service or package of services for a particular patient, but with the exception of outlier cases, it is adequate to ensure access to appropriate care. Decisions about packaging and bundling payment involve a balance between ensuring some separate payment for individual services and establishing incentives for efficiency through larger units of payment. In many situations, the final payment rate for a package of services may do a better job of balancing variability in the relative costs of component services compared to individual rates covering a smaller unit of service without packaging or bundling. Packaging payments into larger payment bundles promotes the stability of payment for services over time, a characteristic that reportedly is very important to hospitals. Unlike packaged services, the costs of individual services typically show greater variation because the higher variability for some component items and services cannot be balanced with lower variability for others and because relative weights are typically estimated using a smaller set of claims. When compared to service-specific payment, packaging or bundling payment for component services may change payment at the hospital level to the extent that there are systematic differences across hospitals in their performance of the services included in that unit of payment. Hospitals spending more per case than payment received would be encouraged to review their service patterns to ensure that they furnish services as efficiently as possible. Similarly, we believe that unpackaging services heightens the hospital's focus on pricing individual services, rather than the efficient delivery of those services. Over the past several years of the OPPS, greater unpackaging of payment has occurred simultaneously with continued tremendous growth in OPPS expenditures as a result of increasing volumes of individual services, as discussed in further detail below. Also discussed in further detail below, most recently in its comments to the CY 2007 OPPS/ASC proposed rule and in the context of this rapid spending growth, the Medicare Payment Advisory Commission (MedPAC) encouraged CMS to broaden the payment bundles under the OPPS to encourage providers to use resources efficiently.

As permitted under section 1833(t)(2)(B) of the Act, the OPPS establishes groups of covered HOPD services, namely APC groups, and uses them as the basic unit of payment. During the evolution of the OPPS over the past 7 years, significant attention has been concentrated on service-specific payment for services furnished to particular patients, rather than on creating incentives for the efficient delivery of services through encounter or episode-of-care-based payment. Overall packaging included in the clinical APCs has decreased, and the procedure groupings have become smaller as the focus has shifted to refining service-level payment. Specifically, in the CY 2003 OPPS, there were 569 APCs, but by CY 2007, the number of APCs had grown to 862, a 51-percent increase in 4 years. Similarly, the percentage of CPT codes for procedural services that receive packaged payment declined by over 10 percent between CY 2003 and CY 2007.

Currently, the APC groups reflect a modest degree of packaging, including packaged payment for minor ancillary services, inexpensive drugs, medical supplies, implantable devices, capital-related costs, operating and recovery room use, and anesthesia services. Bundling payment for multiple significant services provided in the same hospital outpatient encounter or during an episode of care is not currently a common OPPS payment practice, because the APC groups generally reflect only the modest packaging associated with individual procedures or services. Unconditionally packaged services with HCPCS codes are identified by the status indicator ''N.'' Conditionally packaged services, specifically those services whose payment is packaged unless specific criteria for separate payment are met, are assigned to status indicator ''Q.'' To the extent possible, hospitals may use HCPCS codes to report any packaged services that were performed, consistent with CPT or CMS coding guidelines, but packaged costs also may be uncoded and included in specific revenue code charges. Hospitals include charges for packaged services on their claims, and the costs associated with those packaged services are then added into the costs of separately payable procedures on the same claims in establishing payment rates for the separately payable services.

Packaging and bundling payment for multiple interrelated services into a single payment creates incentives for providers to furnish services in the most efficient way by enabling hospitals to manage their resources with maximum flexibility, thereby encouraging long-term cost containment. For example, where there are a variety of supplies that could be used to furnish a service, some of which are more expensive than others, packaging encourages hospitals to use the least expensive item that meets the patient's needs, rather than to routinely use a more expensive item. Packaging also encourages hospitals to negotiate carefully with manufacturers and suppliers to reduce the costs of purchased items and services or to explore alternative group purchasing arrangements, thereby encouraging the most economical health care. Similarly, packaging encourages hospitals to establish protocols that ensure that services are furnished only when they are important and to carefully scrutinize the services ordered by practitioners to maximize the efficient use of hospital resources. Finally, packaging payments into larger payment bundles promotes the stability of payment for services over time. Packaging also may reduce the importance of refining service-specific payment because there is more opportunity for hospitals to average payment across higher cost cases requiring many ancillary services and lower cost cases requiring fewer ancillary services.

b. Addressing Growth in OPPS Volume and Spending

Creating additional incentives for providing only necessary services in the most efficient manner is of vital importance to Medicare today, in view of the recent explosion of growth in program expenditures for hospital outpatient services paid under the OPPS. As illustrated in Table 5 below, total spending has been growing at a rate of roughly 10 percent per year under the OPPS, and the Medicare Trustees project that total spending under the OPPS will increase by more than $3 billion from CY 2007 through CY 2008 to nearly $35 billion. Implementation of the OPPS has not

slowed outpatient spending growth over the past few years; in fact, double-digit spending growth has generally been occurring. We are greatly concerned with this rate of increase in program expenditures under the OPPS.

TABLE 5.—GROWTH IN EXPENDITURES UNDER OPPS FROM CY 2001–CY 2008

[Projected Expenditures for CY 2006–CY 2008, in Billions]

OPPS growth	CY 2001	CY 2002	CY 2003	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008
Incurred Cost	17.702	19.561	21.156	23.866	26.572	29.338	31.641	34.960
Percent Increase	.....	10.5	8.2	12.8	11.3	10.4	7.8	10.5

Source: CY 2007 Medicare Trustees' Report.

As with the other Medicare fee-for-service payment systems that are experiencing rapid spending growth, brisk growth in the intensity and utilization of services is the major reason for the current rates of growth in the OPPS, rather than general price or enrollment changes. Table 6 below illustrates the increases in the volume and intensity of hospital outpatient services over the past several years.

TABLE 6.—PERCENT INCREASE IN VOLUME AND INTENSITY OF HOSPITAL OUTPATIENT SERVICES

	CY 2002	CY 2003	CY 2004	CY 2005	CY 2006 (Est.)	CY 2007 (Est.)	CY 2008 (Est.)
Percent Increase	3.5	2.5	7.6	7.4	8.6	6.4	5.8

Source: CY 2007 Medicare Trustees' Report.

For hospital outpatient services, the volume and intensity of services are estimated to have continued to increase significantly in recent years, at a rate of 8.6 percent between CY 2005 and CY 2006, the last two completed calendar years. As we discussed in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68189 through 68190), the rapid growth in utilization of services under the OPPS shows that Medicare is paying mainly for more services each year, regardless of their quality or impact on beneficiary health. In its March 2007 Report to Congress (pages 55 and 56), MedPAC confirmed that much of the growth in service volume from 2003 to 2005 resulted from increases in the number of services per beneficiary who received care, rather than from increases in the number of beneficiaries served. The MedPAC found that while the rate of growth in service volume declined over that time period, the complexity of services, defined as the sum of the relative payment weights of all OPPS services divided by the volume of all services, increased, and that most of the growth was attributable to the insertion of devices and the provision of complex imaging services. The MedPAC further found that regression analysis suggested that relatively complex hospital outpatient services may be more profitable for hospitals than less complex services. In addition, its analysis indicated that favorable payments for complex services give hospitals an incentive to provide more of those complex services rather than fewer basic services, which increases overall service complexity. The MedPAC expressed concern about this relationship and concluded that the historically large increases in outpatient volume and service complexity suggest a need to recalibrate the OPPS. In the future, MedPAC plans to examine options for recalibrating the payment system to accurately match payments to the costs of individual services (Medicare Payment Advisory Commission Report to the Congress: Medicare Payment Policy, March 2007, pages 55 and 56).

As proposed for the CY 2007 OPPS and finalized for the CY 2009 OPPS, we developed a plan to promote higher quality services under the OPPS, so that Medicare spending would be directed toward those higher quality services (71 FR 68189 through 68197). We believe that Medicare payments should encourage physicians and other providers in their efforts to achieve better health outcomes for Medicare beneficiaries at a lower cost. In the CY 2007 OPPS/ASC final rule with comment period, we discussed the concept of ''value-based purchasing'' in the OPPS as well as in other Medicare payment systems. ''Value-based purchasing'' may use a range of incentives to achieve identified quality and efficiency goals, as a means of promoting better quality of care and more effective resource use in the Medicare payment systems. In developing the concept of value-based purchasing for Medicare, we have been working closely with stakeholder partners.

We continue to believe that the collection and submission of performance data and the public reporting of comparative information are strong incentives for hospital accountability in general and quality improvement in particular, while encouraging the most efficient and effective care. Measurement and reporting can focus the attention of hospitals and consumers on specific goals and on hospitals' performance relative to those goals. Development and implementation of performance measurement and reporting by hospitals can thus produce quality improvement in health care delivery. Hospital performance measures may also provide a foundation for performance-based rather than volume-based payments.

In the CY 2007 OPPS/ASC final rule with comment period, as a first step in the OPPS toward value-based purchasing, we finalized a policy that would employ our equitable adjustment authority under section 1833(t)(2)(E) of the Act to establish an OPPS Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program based on measures specifically developed to characterize the quality of outpatient care (71 FR 68197). We finalized implementation of the program for CY 2009, when we would implement a 2.0 point reduction to the OPPS conversion factor update for those hospitals that do not meet the specific requirements of the CY 2009 OPPS RHQDAPU program. We described the

CY 2009 program which would be based upon CY 2008 hospital reporting of appropriate measures of the quality of hospital outpatient care that have been carefully developed and evaluated, and endorsed as appropriate, with significant input from stakeholders. We reiterated our belief that ensuring that Medicare beneficiaries receive the care they need and that such services are of high quality are the necessary initial steps to incorporating value-based purchasing into the OPPS. We explained that we are specifically seeking to encourage care that is both efficient and of high quality in the HOPD.

Subsequent to the publication of the CY 2007 OPPS/ASC final rule with comment period, section 109(b) of the MIEA-TRHCA specifies that in the case of a subsection (d) hospital (defined under section 1886(d)(1)(B) of the Act as hospitals that are located in the 50 States or the District of Columbia other than those categories of hospitals or hospital units that are specifically excluded from the IPPS, including psychiatric, rehabilitation, long-term care, children's, and cancer hospitals or hospital units) that does not submit to the Secretary the quality reporting data required for CY 2009 and each subsequent year, the OPPS annual update factor shall be reduced by 2.0 percentage points. The quality reporting program proposed for CY 2008 according to this provision is referred to as the Hospital Outpatient Quality Data Reporting Program (HOP QDRP) and is discussed in detail in section XVII. of this proposed rule.

As the next step in our movement toward value-based purchasing under the OPPS and to complement the HOP QDRP for CY 2009, with measure reporting beginning in CY 2008, we believe it is important to initiate specific payment approaches to explicitly encourage efficiency in the hospital outpatient setting that we believe will control future growth in the volume of OPPS services. While the HOP QDRP will encourage the provision of higher quality hospital outpatient services that lead to improved health outcomes for Medicare beneficiaries, we believe that more targeted approaches are also necessary to encourage increased hospital efficiency. Two alternatives we have considered that would be feasible under current law include establishing a methodology to measure the growth in volume and reduce OPPS payment rates to account for unnecessary increases in volume or developing payment incentives for hospitals to ensure that they provide necessary services as efficiently as possible.

With respect to the first alternative, section 1833(t)(2)(F) of the Act requires us to establish a methodology for controlling unnecessary increases in the volume of covered OPPS services, and section 1833(t)(9)(C) of the Act authorizes us to adjust the update to the conversion factor if, under section 1833(t)(2)(F) of the Act, we determine that there is growth in volume that exceeds established tolerances. As we indicated in the September 8, 1998 proposed rule proposing the establishment of the OPPS (63 FR 47585), we considered creating a system that mirrors the sustainable growth rate (SGR) methodology applied to the MPFS update to control unnecessary growth in service volume. However, implementing such a system could have the potentially undesirable effect of escalating service volume as payment rates stagnate and hospital costs rise, thus actually resulting in a growth in volume rather than providing an incentive to control volume. Therefore, this approach to addressing the volume growth under the OPPS could inadvertently result in the exact opposite of our desired outcome.

The second alternative we considered is to expand the packaging of supportive ancillary services and ultimately bundle payment for multiple independent services into a single OPPS payment. We believe that this would create incentives for hospitals to monitor and adjust the volume and efficiency of services themselves, by enabling them to manage their resources with maximum flexibility. Instead of external controls on volume, we believe that it is preferable for the OPPS to create payment incentives for hospitals to carefully scrutinize their service patterns to ensure that they furnish only those services that are necessary for high quality care and to ensure that they provide care as efficiently as possible. Specifically, we believe that increased packaging and bundling are the most appropriate payment strategies to establish such incentives in a prospective payment system, and that this approach is clearly preferable to the establishment of an SGR or other methodology that seeks to control spending by addressing significant growth in volume and program spending with lower payments.

In its October 6, 2006 letter of comment on the CY 2007 OPPS/ASC proposed rule, MedPAC urged us to establish broader payment bundles in both the revised ASC and hospital outpatient prospective payment systems to promote efficient resource use and better align the two payment systems. In particular, our proposal for the CY 2008 revised ASC payment system proposed to package payment for all items and services directly related to the provision of covered surgical procedures into the ASC facility payment for the associated surgical procedure (71 FR 49468). These other items and services included all drugs, biologicals, contrast agents, implantable devices, and diagnostic services such as imaging. Because a number of these items and services are separately paid under the OPPS and the proposal included the establishment of most ASC payment weights based on the procedures' corresponding OPPS payment weights, MedPAC encouraged us to align the payment bundles in the two payment systems by increasing the size of the payment bundles under the OPPS.

Moreover, MedPAC staff indicated in testimony at the January 9, 2007 MedPAC public meeting that the growth in OPPS spending and volume raises questions about whether the OPPS should be changed to encourage greater efficiency (page 390 of the January 9, 2007 MedPAC meeting transcript available at *http://www.medpac.gov*). MedPAC staff explained at that time that MedPAC intends to perform a long-term assessment of the design of the OPPS, including considering the bundling of payments for procedures and visits furnished over a period of time into a single payment, assessing whether there should be an expenditure target for hospital outpatient services, evaluating whether payments for multiple imaging services provided in the same session should be discounted, and reviewing the methodology used by CMS to determine relative payment weights for hospital outpatient services. We welcome MedPAC's study of these areas, particularly with regard to how we might develop appropriate payment rates for larger bundles of services.

Because we believe it is important that the OPPS create enhanced incentives for hospitals to provide only necessary, high quality care and to provide that care as efficiently as possible, we have given considerable thought to how we could increase packaging under the OPPS in a manner that would not place hospitals at substantial financial risk but which would create incentives for efficiency and volume control, while providing hospitals with flexibility to provide care in the most appropriate way for each Medicare beneficiary. We are considering the possibility of greater bundling of payment for major hospital outpatient services, which could result in establishing OPPS payments for episodes of care, and for this reason we particularly welcome MedPAC's

exploration of how such an approach might be incorporated into the OPPS payment methodology. We are particularly concerned about the potential for shifting higher cost bundled services to other ambulatory settings, and we welcome ideas on deterring such activity. We are currently considering the complex policy issues related to the possible development and implementation of a bundled payment policy for hospital outpatient services that involves significant services provided over a period of time which could be paid through an episode-based payment methodology, but we consider this possible approach to be a long-term policy objective. We encourage public comments regarding the specific hospital outpatient services, clinical and financial issues, ratesetting methodologies, and operational challenges we should consider in our exploratory work in this area.

We also are examining how we might possibly establish payments for same-day care encounters, building upon the current use of APCs for payment through greater packaging of supportive ancillary services. This could include conditional packaging of supportive ancillary services into payment for the procedure that is the reason for the OPPS encounter (for example, diagnostic tests performed on the day of a scheduled procedure). Another approach could include creation of composite APCs for frequently performed combinations of surgical procedures (for example, one APC payment for multiple cardiac electrophysiologic procedures performed on the same date). Not only could these encounter-based payment groups create enhanced incentives for efficiency, but they may also enable us to utilize for ratesetting many of the multiple procedure claims that are not now used in our establishment of OPPS rates for single procedures. (We refer readers to section II.A.1.b. of this proposed rule for a more detailed discussion of the treatment of multiple procedure claims in the ratesetting process.) For CY 2008, we are proposing two new composite APCs for CY 2008 payment of combinations of services in two clinical care areas, as discussed under section II.A.4.d. of this proposed rule. We look forward to receiving public comment on this proposal as we explore the possibility of moving toward basing OPPS payment on larger packages and bundles of services provided in a single hospital outpatient encounter.

We intend to involve the APC Panel in our future exploration of how we can develop encounter-based and episode-based payment groups, and we look forward to the findings and recommendations of MedPAC in this area. This is a significant change in direction for the OPPS, and we specifically seek the recommendations of all stakeholders with regard to which ancillary services could be packaged and those combinations of services provided in a single encounter or over time that could be bundled together for payment. We are hopeful that expanded packaging and, ultimately, greater bundling under the OPPS may result in sufficient moderation of growth in volume and spending that further controls would not be needed. However, if spending were to continue to escalate at the current rates, even after we have exhausted our options for increased packaging and bundling, we are considering multiple options under our authority to address these issues, including the possibility of imposing external controls that could link growth in volume to reduced payments under the OPPS in the future.

c. Proposed Packaging Approach

With the exception of the two composite APCs that we are proposing for CY 2008 and discuss in detail in section II.A.4.d. of this proposed rule, we are not currently prepared to propose an episode-based or fully developed encounter-based payment methodology for CY 2008 as our next step in value-based purchasing for the OPPS. However, in reviewing our approach to revising payment packages and bundles, we have examined services currently provided under the OPPS, looking for categories of ancillary items and services for which we believe payment could be appropriately packaged into larger payment packages for the encounter. For this first step in creating larger payment groups, we examined the HCPCS code definitions (including CPT code descriptors) to see whether there were categories of codes for which packaging would be a logical expansion of the longstanding packaging policy that has been a part of the OPPS since its inception. In general, we have often packaged the costs of selected HCPCS codes into payment for services reported with other HCPCS codes where we believed that one code reported an item or service that was integral to the provision of care that was reported by another HCPCS code.

As an example of a previous change in the OPPS packaging status for a HCPCS code that is ancillary and supportive, under the CY 2007 OPPS, we note that CPT code 93641 (Electrophysiologic evaluation of single or dual chamber pacing cardioverter defibrillator leads including defibrillation threshold evaluation (induction of arrhythmia, evaluate of sensing an pacing for arrhythmia termination) at the time of initial implantation or replacement; with testing of single chamber or dual chamber cardioverter defibrillator) went from separate to packaged payment. This service is only performed during the course of a surgical procedure for implantation or replacement of implantable cardioverter-defibrillator (ICD) leads, and these surgical implantation procedures are currently assigned to APC 0106 (Insertion/Replacement/Repair of Pacemaker and/or Electrodes) and APC 0108 (Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads). We considered the electrophysiologic evaluation service (CPT code 93641) to be an ancillary supportive service that may be performed only in the same operative session as a procedure that could otherwise be performed independently of the electrophysiologic evaluation service. In this particular case, the APC Panel recommended for CY 2007 that we package payment for this diagnostic test and we adopted that recommendation for the CY 2007 OPPS. Making this payment change in this specific case resulted in the availability of significantly more claims data and, therefore, establishment of more valid and representative estimated median costs for the lead insertion and electrophysiologic evaluation services furnished in the single hospital encounter.

In the case of much of the care furnished in the HOPD, we believe that it is appropriate to view a complete service as potentially being reported by a combination of two or more HCPCS codes, rather than a single code, and to establish payment policy that supports this view. Ideally, we would consider a complete HOPD service to be the totality of care furnished in a hospital outpatient encounter or in an episode of care. In general, we believe that it is particularly appropriate to package payment for those items and services that are typically ancillary and supportive into the payment for the primary diagnostic or therapeutic modalities in which they are used. As a significant first step towards creating payment units that represent larger units of service, we examined whether there are categories of HCPCS codes that are typically ancillary and supportive to diagnostic and therapeutic modalities.

Specifically, as our initial substantial step toward creating larger payment groups for hospital outpatient care, we are proposing to package payment for

items and services in the seven categories listed below into the payment for the primary diagnostic or therapeutic modality to which we believe these items and services are typically ancillary and supportive. We specifically chose these categories of HCPCS codes for packaging because we believe that the items and services described by the codes in these categories are the HCPCS codes that are typically ancillary and supportive to a primary diagnostic or therapeutic modality and, in those cases, are an integral part of the primary service they support. We are proposing to assign status indicator ''N'' to those HCPCS codes that we believe are always integral to the performance of the primary modality and to package their costs into the costs of the separately paid primary services with which they are billed. We are proposing to assign status indicator ''Q'' to those HCPCS codes that we believe are typically integral to the performance of the primary modality and to package payment for their costs into the costs of the separately paid primary services with which they are usually billed but to pay them separately in those uncommon cases in which no other separately paid primary service is furnished in the hospital outpatient encounter.

For ease of reference in our subsequent discussion in each of the seven areas, we refer to the HCPCS codes for which we are proposing to package (or conditionally package) payment as dependent services. We use the term ''independent service'' to refer to the HCPCS codes that represent the primary therapeutic or diagnostic modality into which we are proposing to package payment for the dependent service. We note that, in future years as we consider the development of larger payment groups that more broadly reflect services provided in an encounter or episode of care, it is possible that we might propose to bundle payment for a service that we now refer to as ''independent'' in this proposed rule.

Specifically, we are proposing to package the payment for HCPCS codes describing the dependent items and services in the following seven categories into the payment for the independent services with which they are furnished:

- Guidance services.
- Image processing services.
- Intraoperative services.
- Imaging supervision and interpretation services.
- Diagnostic radiopharmaceuticals.
- Contrast media and.
- Observation services.

We identify the HCPCS codes we are proposing to package for CY 2008, explain our rationale for proposing to package the codes in these categories, provide examples of how HCPCS and APC median costs and payments would change under these proposals, and discuss the impact of these changes in the discussion below under each category.

The median costs of services at the HCPCS level for many separately paid procedures change as a result of this proposal because we are proposing to change the composition of the payment packages associated with the HCPCS codes. Moreover, as a result of changes to the HCPCS median costs, we are proposing to reassign some HCPCS codes to different clinical APCs for CY 2008 to avoid 2 times violations and to ensure continuing clinical and resource homogeneity of the APCs. Therefore, the APC median costs change not only as a result of the increased packaging itself but also as a result of the migration of HCPCS codes into and out of APCs through APC reconfiguration. The file of HCPCS code and APC median costs resulting from our proposal is found under supporting documentation for this proposed rule on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/HORD/list.asp#TopOfPage*.

Review of the HCPCS median costs indicates that, while the proposed median costs rise for some HCPCS codes as a result of increased packaging that expands the costs included in the payment packages, there are also cases in which the proposed median costs decline as a result of these proposed changes. While it seems intuitive to believe that the proposed median costs of the remaining separately paid services should rise when the costs of services previously paid separately are packaged into larger payment groups, it is more challenging to understand why the proposed median costs of separately paid services would not change or would decline when the costs of previously paid services are packaged.

Medians are generally more stable than means because they are less sensitive to extreme observations, but medians typically do not reflect subtle changes in cost distributions. The OPPS' use of medians rather than means usually results in relative weight estimates being less sensitive to packaging decisions. Specifically, the median cost for a particular independent procedure generally will be higher as a result of added packaging, but also could change little or be lower because median costs typically do not reflect small distributional changes and also because changes to the packaged HCPCS codes affect both the number and composition of single bills and the mix of hospitals contributing those single bills. Such a decline, no change, or an increase in the median cost at the HCPCS code level could result from a change in the number of single bills used to set the median cost. With greater packaging, more ''natural'' single bills are created for some codes but fewer ''pseudo'' single bills are created. Thus, some APCs gain single bills and some lose single bills due to packaging changes, as well as to the reassignment of some codes to different APCs. When more claims from a different mix of providers are used to set the median cost for the HCPCS code, the median cost could move higher or lower within the array of per claim costs.

Similarly, proposed revisions to APC assignments that are necessary to resolve 2 times violations that could arise as a result of changes in the HCPCS median cost for one or more codes due to additional packaging may also result in increases or decreases to APC median costs and, therefore, to increases or decreases in the payments for HCPCS codes that would not be otherwise affected except for the CY 2008 proposed packaging approach for the seven categories of items and services.

We have examined the proposed aggregate impact of making these changes on payment for CY 2008. Because the OPPS is a budget neutral payment system in which the amount of payment weight in the system is annually adjusted for changes in expenditures created by changes in APC weights and codes (but is not currently adjusted based on estimated growth in service volume), the effects of the packaging changes we are proposing result in changes to scaled weights and, therefore, to the payment rates for all separately paid procedures. These changes result from both shifts in median costs as a result of increased packaging, changes in multiple procedure discounting patterns, and a higher weight scaler that is applied to all unscaled APC weights. (We refer readers to section II.A.3. of this proposed rule for an explanation of the weight scaler.) In a budget neutral system, the monies previously paid for services that are now proposed to be packaged are not lost, but are redistributed to all other services. A higher weight scaler would increase payment rates relative to observed median costs for independent services by redistributing the lost weight of packaged items that historically have

been paid separately and the lost weight when the median costs of independent services do not completely reflect the full incremental cost of the packaged services. The impact of this proposed change on proposed CY 2008 OPPS payments is discussed in section XXII B. of this proposed rule, and the impact on various classifications of hospitals is shown in Column 2B in Table 67 in that section.

We estimate that our CY 2008 proposal would redistribute approximately 1.2 percent of the estimated CY 2007 base year expenditures under the OPPS. The monies associated with this redistribution would be in addition to any increase that would otherwise occur due to a proposed higher median cost for the APC as a result of the expanded payment package. If the relative weight for a particular APC decreases as a result of the proposed packaging approach, the increased weight scaler may or may not result in a relative weight that is equal to or greater than the relative weight that would occur without the proposed packaging approach. In general, the packaging that we are proposing would have more effect on payment for some services than on payment for others because the dependent items and services that we are proposing for packaging are furnished more often with some independent services than with others. However, because of the amount of payment weight that would be redistributed by this proposal, there would be some impact on payments for all OPPS services whose rates are set based on payment weights, and the impact on any given hospital would vary based on the mix of services furnished by the hospital.

The following discussion separately addresses each of the seven categories of items and services for which we are proposing to package payment under the CY 2008 OPPS as part of our packaging proposal. Many codes that we are proposing to package for CY 2008 could fit into more than one of those seven categories. For example, CPT code 93325 (Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)) could be included in both the intraoperative and image processing categories. Therefore, for organizational purposes, both to ensure that each code appears in only one category and to facilitate discussion of our CY 2008 proposal, we have created a hierarchy of categories that determines which category each code appropriately falls into. This hierarchy is organized from the most clinically specific to the most general type of category. The hierarchy of categories is as follows: guidance services, image processing services, intraoperative services, and imaging supervision and interpretation services. Therefore, while CPT code 93325 may logically be grouped with either imaging processing services or intraoperative services, it is treated as an image processing service because that group is more clinically specific and precedes intraoperative services in the hierarchy. We did not believe it was necessary to include diagnostic radiopharmaceuticals, contrast media, or observation categories in this list because those services generally map to only one of those categories. We note that there is no cost estimation or payment implications related to the assignment of a HCPCS code for purposes of discussion to any specific category.

(1) Guidance Services

We are proposing to package payment for HCPCS guidance codes for CY 2008, specifically those codes that are reported for supportive guidance services, such as ultrasound, fluoroscopic, and stereotactic navigation services, that aid the performance of an independent procedure. We performed a broad search for such services, relying upon the American Medical Association's (AMA's) CY 2007 book of CPT codes and the CY 2007 book of Level II HCPCS codes, which identified specific HCPCS codes as guidance codes. Moreover, we performed a clinical review of all HCPCS codes to capture additional codes that are not necessarily identified as ''guidance'' services but describe services that provide directional information during the course of performing an independent procedure. For example, we are proposing to package CPT code 61795 (Stereotactic computer-assisted volumetric (navigational) procedure, intracranial, extracranial, or spinal (List separately in addition to code for primary procedure)) because we consider it to be a guidance service that provides three-dimensional information to direct the performance of intracranial or other diagnostic or therapeutic procedures. We also included HCPCS codes that existed in CY 2006 but were deleted and were replaced in CY 2007. We included the CY 2006 HCPCS codes because we are proposing to use the CY 2006 claims data to calculate the CY 2008 OPPS median costs on which the CY 2008 payment rates would be based. Many, although not all, of the CPT guidance codes we identified are designated by CPT as add-on codes that are to be reported in addition to the CPT code for the primary procedure. We also note that there are a number of CPT codes describing independent surgical procedures but which the code descriptors indicate that guidance is included in the code reported for the surgical procedure if it is used and, therefore, packaged payment is already made for the associated guidance service under the OPPS. For example, the independent procedure described by CPT code 55873 (Cryosurgical ablation of the prostate (includes ultrasonic guidance for interstitial cryosurgical probe placement)) already includes the ultrasound guidance that may be used. We believe packaging payment for every guidance service under the OPPS would provide consistently packaged payment for all these services that are used to direct independent procedures, even if they are currently separately reported.

Because these dependent guidance procedures support the performance of an independent procedure and they are generally provided in the same operative session as the independent procedure, we believe that it would be appropriate to package their payment into the OPPS payment for the independent procedure performed. However, guidance services differ from some of the other categories of services that we are proposing to package for CY 2008. Hospitals sometimes may have the option of choosing whether to perform a guidance service immediately preceding or during the main independent procedure, or not at all, unlike many of the imaging supervision and interpretation services, for example, which are generally always reported when the independent procedure is performed. Once a hospital decides that guidance is appropriate, the hospital may have several options regarding the type of guidance service that can be performed. For example, when inserting a central venous access device, hospitals have the option of using no guidance, ultrasound guidance, or fluoroscopic guidance, and the selection in any specific case will depend upon the specific clinical circumstances of the device insertion procedure. In fact, the historical hospital claims data demonstrate that various guidance services for the insertion of these devices, which have historically received packaged payment under the OPPS, are used frequently for the insertion of vascular access devices.

Thus, we recognize hospitals have several options regarding the performance and types of guidance services they use. However, we believe that hospitals utilize the most appropriate form of guidance for the specific procedure that is performed.

We do not want to create payment incentives to use guidance for all independent procedures or to provide one form of guidance instead of another. Therefore, by proposing to package payment for all forms of guidance, we are specifically encouraging hospitals to utilize the most cost effective and clinically advantageous method of guidance that is appropriate in each situation by providing them with the maximum flexibility associated with a single payment for the independent procedure. Similarly, hospitals may appropriately not utilize guidance services in certain situations based on clinical indications.

Because guidance services can be appropriately reported in association with many independent procedures, under our proposed packaging of guidance services for CY 2008, the costs associated with guidance services would be mapped to a larger number of independent procedures than some other categories of codes that we are proposing to package. For example, CPT code 76001 (Fluoroscopy, physician time more than one hour, assisting a non-radiologic physician (e.g., nephrostolithotomy, ERCP, bronchoscopy, transbronchial biopsy)) can be reported with a wide range of services. According to the CPT code descriptor, these procedures include nephrostolithotomy, which may be reported with CPT code 50080 (Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; up to 2 cm), and endoscopic retrograde cholangiopancreatography, which may be reported with CPT code 43260 (Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)). Therefore, the cost of the fluoroscopic guidance would be reflected in the payment for each of these independent services, in addition to numerous other procedures, rather than in the payment for only one or two independent services, as is the case for some of the other categories of codes that we are proposing to package for CY 2008.

In addition, because independent procedures such as CPT code 20610 (Arthrocentesis, aspiration and/or injection; major joint or bursa (e.g., shoulder, hip, knee joint, subacromial bursa)) may be reported with or without guidance, the cost for the guidance will be reflected in the median cost for the independent procedure as a function of the frequency that guidance is reported with that procedure. As we stated previously, the median cost for a particular independent procedure generally will be higher as a result of added packaging, but also could change little or be lower because median costs typically do not reflect small distributional changes and because changes to the packaged HCPCS codes affect both the number and composition of single bills and the mix of hospitals contributing those single bills. In fact, the CY 2007 CPT book indicates that if guidance is performed with CPT code 20610, it may be appropriate to bill CPT code 76942 (Ultrasonic guidance for needle placement (e.g. biopsy, aspiration, injection, localization device), imaging supervision and interpretation); 77002 (Fluoroscopic guidance for needle placement (e.g. biopsy, aspiration, injection, localization device)); 77012 (Computed tomography guidance for needle placement (e.g. biopsy, aspiration, injection, localization device), radiological supervision and interpretation); or 77021 (Magnetic resonance guidance for needle placement (e.g., for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation). The CY 2007 CPT book also implies that it is not always clinically necessary to use guidance in performing an arthrocentesis described by CPT code 20610.

The guidance procedures that we are proposing to package for CY 2008 vary in their resource costs. Resource cost was not a factor we considered when proposing to package guidance procedures. Notably, most of the guidance procedures are relatively low cost in comparison to the independent services they frequently accompany.

The codes we are proposing to identify as guidance codes for CY 2008 that would receive packaged payment are listed in Table 8 below.

Several of these codes, including CPT code 76937 (Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)), are already unconditionally (that is, always) packaged under the CY 2007 OPPS, where they have been assigned to status indicator ''N.'' Payment for these services is currently made as part of the payment for the separately payable, independent services with which they are billed. No separate payment is made for services that we have assigned to status indicator ''N.'' We are not proposing status indicator changes for the five guidance procedures that were unconditionally packaged for CY 2007.

We are proposing to change the status indicators for 31 guidance procedures from separately paid to unconditionally packaged (status indicator ''N'') for the CY 2008 OPPS. We believe that these services are always integral to and dependent upon the independent services that they support and, therefore, their payment would be appropriately packaged because they would generally be performed on the same date and in the same hospital as the independent services.

We are proposing to change the status indicator for 1 guidance procedure from separately paid to conditionally packaged (status indicator ''Q''), and we will treat it as a ''special'' packaged code for the CY 2008 OPPS, specifically, CPT code 76000 (Fluoroscopy (separate procedure), up to 1 hour physician time, other than 71023 or 71034 (e.g. cardiac fluoroscopy)). This code was discussed in the past with the Packaging Subcommittee of the APC Panel which determined that, consistent with its code descriptor as a separate procedure, this procedure could sometimes be provided alone, without any other services on the claim. We believe that this procedure would usually be provided by a hospital as guidance in conjunction with another significant independent procedure on the same date of service but may occasionally be provided without another independent service. As a ''special'' packaged code, if the fluoroscopy service were billed without any other service assigned to status indicator ''S,'' ''T,'' ''V,'' or ''X'' reported on the same date of service, under our proposal we would not treat the fluoroscopy procedure as a dependent service for purposes of payment. If we were to unconditionally package payment for this procedure, treating it as a dependent service, hospitals would receive no payment at all when providing this service alone, although the procedure would not be functioning as a guidance service in that case. However, according to our proposal, its conditionally packaged status with its designation as a ''special'' packaged code would allow payment to be provided for this ''Q'' status fluoroscopy procedure, in which case it would be treated as an independent service under these limited circumstances. On the other hand, when the fluoroscopy service is furnished as a guidance procedure on the same day and in the same hospital as independent, separately paid services that are assigned to status indicator ''S,''

''T,'' ''V,'' or ''X,'' we are proposing to package payment for it as a dependent service. In all cases, we are proposing that hospitals that furnish independent services on the same date as dependent guidance services must bill them all on the same claim. We believe that when dependent guidance services and independent services are furnished on the same date and in the same facility, they are part of a single complete hospital outpatient service that is reported with more than one HCPCS code, and no separate payment should be made for the guidance service which supports the independent service.

We have calculated the median costs on which the proposed CY 2008 payment rates are based using the packaging status of each code as provided in Table 8 below. As we discussed earlier in more detail, this has the effect of both changing the median cost for the independent service into which the cost of the dependent service is packaged and also of redistributing payment that would otherwise have been made separately for the service we are proposing to newly package for CY 2008.

For example, CPT code 76940 (Ultrasound guidance for, and monitoring of, parenchymal tissue ablation) is assigned to APC 0268 (Level I Ultrasound Guidance Procedures) for CY 2007. We are proposing to discontinue APC 0268 for CY 2008 and to provide packaged payment for the HCPCS codes that were previously assigned to APC 0268. CPT code 76940 was billed with CPT code 47382 (Ablation, one or more liver tumor(s), percutaneous, radiofrequency) 148 times in the CY 2008 OPPS proposed rule claims data, and 42 percent of the claims for CPT code 76940 reported CPT code 47382 on the same date of service. Similarly, we note that almost 19 percent of the claims for CPT code 47382 also reported the ultrasound guidance service described by CPT code 76940. Under our proposed policy for the CY 2008 OPPS, we are proposing to expand the packaging associated with CPT code 47382 so that payment for the ultrasound guidance, if performed, would be packaged into the payment for the liver tumor ablation. Specifically, we would package payment for CPT code 76940 so that under the CY 2008 OPPS, the dependent procedure, in this case ultrasound guidance, would receive packaged payment through the separate OPPS payment for the independent procedure, in this case, the liver tumor ablation. The payment rates for this example associated with our CY 2008 proposal are outlined in Table 7 below.

In this case, the proposed CY 2008 median cost for APC 0423 (Level II Percutaneous Abdominal and Biliary Procedures) to which CPT code 47382 is assigned is $2,775.33, while the CY 2007 median cost of APC 0423 is $2,283.08 and of APC 0268 is $72.61. However, as discussed in section II.A.4.c. of this proposed rule concerning our general proposed packaging approach, the added effect of the budget neutrality adjustment that would result from the aggregate effects of the CY 2008 packaging proposal (were there no further budget neutrality adjustment for other reasons) significantly changes the final payment rates relative to median cost estimates. Table 7 presents a comparison of the CY 2007 payment for CPT codes 47382 and 76940, where CPT code 76940 is paid separately, to the CY 2008 payment we are proposing for CPT codes 47382 and 76940, where payment for CPT code 76940 would be packaged. This example cannot demonstrate the overall impact of packaging guidance services on payment to any given hospital because each individual hospital's case-mix and billing patterns would be different. The overall impact of packaging payment for CPT code 76940, as well as all the other proposed packaging changes we are proposing for CY 2008, can only be assessed in the aggregate for classes of hospitals. Section XXII.B. of this proposed rule displays the overall impact of APC weight recalibration and packaging changes we are proposing by classes of hospitals, and the OPPS Hospital-Specific Impacts—Provider-Specific Data file presents our estimates of CY 2008 hospital payment for those hospitals we include in our ratesetting and payment simulation database. The hospital-specific impacts file can be found on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/* under supporting documentation for this proposed rule.

TABLE 7.—EXAMPLE OF THE EFFECTS OF THE CY 2008 PACKAGING PROPOSAL ON PAYMENT FOR CPT CODES 76940 AND 47382

HCPCS code	Short descriptor	Sum of CY 2007 payment (76940 paid separately)	Sum of CY 2008 proposed payment (76940 packaged)
76940	Us guide, tissue ablation spine (dependent service)	$73.04	$0.00
47382	Percut ablate liver rf (independent service)	2,296.47	2,810.08
Total Payment		2,369.51	2,810.08

The estimated overall impact of these changes presented in section XXII.B. of this proposed rule is based on the assumption that hospital behavior would not change with regard to when these dependent services are performed on the same date and by the same hospital that performs the independent services. To the extent that hospitals could change their behavior and perform the guidance services more or less frequently, on subsequent dates, or at settings outside of the hospital, the data would show such a change in practice in future years and that change would be reflected in future budget neutrality adjustments. However, with respect to guidance services in particular, we believe that hospitals are limited in the extent to which they could change their behavior with regard to how they furnish these services. By their definition, these guidance services generally must be furnished on the same date and at the same operative location as the independent procedure in order for the guidance service to meaningfully contribute to the treatment of the patient in directing the performance of the independent procedure. We do not believe the clinical characteristics of the guidance services reported with the guidance HCPCS codes listed in Table 8 below will change in the immediate future.

As we indicated earlier, in all cases we are proposing that hospitals that furnish the guidance service on the same date as the independent service

must bill both services on the same claim. We expect to carefully monitor any changes in billing practices on a service-specific and hospital-specific basis to determine whether there is reason to request that Quality Improvement Organizations (QIOs) review the quality of care furnished or to request that Program Safeguard Contractors review the claims against the medical record.

TABLE 8.—GUIDANCE HCPCS CODES PROPOSED FOR PACKAGED PAYMENT IN CY 2008

HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	Proposed CY 2008 SI	Proposed CY 2008 APC	Inactive HCPCS Code effective 1/1/2008 or earlier (listed on the same line as its replacement code)	Short descriptor of the inactive HCPCS code
19295	Place breast clip, precut	S	0657	N	n/a		
61795	Brain surgery using computer	S	0302	N	n/a		
62160	Neuroendoscopy add-on	T	0122	N	n/a		
76000	Fluoroscope examination	X	0272	Q	0272		
76001	Fluoroscope exam, extensive	N	n/a	N	n/a		
76930	Echo guide, cardiocentesis	S	0268	N	n/a		
76932	Echo guide for heart biopsy	S	0309	N	n/a		
76936	Echo guide for artery repair	S	0309	N	n/a		
76937	Us guide, vascular access	N	n/a	N	n/a		
76940	Us guide, tissue ablation	S	0268	N	n/a		
76941	Echo guide for transfusion	S	0268	N	n/a		
76942	Echo guide for biopsy	S	0268	N	n/a		
76945	Echo guide, villus sampling	S	0268	N	n/a		
76946	Echo guide for amniocentesis	S	0268	N	n/a		
76948	Echo guide, ova aspiration	S	0309	N	n/a		
76950	Echo guidance radiotherapy	S	0268	N	n/a		
76965	Echo guidance radiotherapy	S	0308	N	n/a		
76975	GI endoscopic ultrasound	S	0266	N	n/a		
76998	Us guide, intraop	S	0266	N	n/a	76986	Ultrasound guide intraoper.
77001	Fluoro guide for vein device	N	n/a	N	n/a	75998	Fluoro guide for vein device.
77002	Needle localization by xray	N	n/a	N	n/a	76003	Needle localization by xray.
77003	Fluoroguide for spine inject	N	n/a	N	n/a	76005	Fluoroguide for spine inject.
77011	Ct scan for localization	S	0283	N	n/a	76355	Ct scan for localization.
77012	Ct scan for needle biopsy	S	0283	N	n/a	76360	Ct scan for needle biopsy.
77013	Ct guide for tissue ablation	S	0333	N	n/a	76362	Ct guide for tissue ablation.
77014	Ct scan for therapy guide	S	0282	N	n/a	76370	Ct scan for therapy guide.
77021	Mr guidance for needle place	S	0335	N	n/a	76393	Mr guidance for needle place.
77022	Mri for tissue ablation	S	0335	N	n/a	76394	Mri for tissue ablation.
77031	Stereotact guide for brst bx	X	0264	N	n/a	76095	Stereotactic breast biopsy.
77032	Guidance for needle, breast	X	0263	N	n/a		
77417	Radiology port film(s)	X	0260	N	n/a		
77421	Stereoscopic x-ray guidance	S	0257	N	n/a		
95873	Guide nerv destr, elec stim	S	0215	N	n/a		
95874	Guide nerv destr, needle emg	S	0215	N	n/a		
0054T	Bone surgery using computer	S	0302	N	n/a		
0055T	Bone surgery using computer	S	0302	N	n/a		
0056T	Bone surgery using computer	S	0302	N	n/a		

(2) Image Processing Services

We are proposing to package payment for ''image processing'' HCPCS codes for CY 2008, specifically those codes that are reported as supportive dependent services to process and integrate diagnostic test data in the development of images, performed concurrently or after the independent service is complete. We performed a broad search for such services, relying upon the AMA's CY 2007 book of CPT codes and the CY 2007 book of Level II HCPCS codes, which identified specific codes as ''processing'' codes. In addition, we performed a clinical review of all HCPCS codes to capture additional codes that we consider to be image processing. For example, we are proposing to package payment for CPT code 93325 (Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)) because it is an image processing procedure, even though the code descriptor does not specifically indicate it as such.

An image processing service processes and integrates diagnostic test data that were captured during another independent procedure, usually one that is separately payable under the OPPS. The image processing service is not necessarily provided on the same date of service as the independent procedure. In fact, several of the image processing services that we are proposing to package for CY 2008 do not need to be provided face-to-face with the patient in the same encounter as the independent service. While this approach to service delivery may be administratively advantageous from a hospital's perspective, providing separate payment for each image processing service whenever it is performed is not consistent with encouraging value-based purchasing under the OPPS. We believe it is important to package payment for supportive dependent services that accompany independent services but that may not need to be provided face-to-face with the patient in the same

encounter because the supportive services utilize data that were collected during the preceding independent services and packaging their payment encourages the most efficient use of hospital resources. We are particularly concerned with any continuance of current OPPS payment policies that could encourage certain inefficient and more costly service patterns. As stated above, packaging encourages hospitals to establish protocols that ensure that services are furnished only when they are medically necessary and to carefully scrutinize the services ordered by practitioners to minimize unnecessary use of hospital resources. Our standard methodology to calculate median costs packages the costs of dependent services with the costs of independent services on ''natural'' single claims across different dates of service, so we are confident that we would capture the costs of the supportive image processing services for ratesetting when they are packaged according to our CY 2008 proposal, even if they were provided on a different date than the independent procedure.

We list the image processing services that would be packaged for CY 2008 in Table 10 below. As these services support the performance of an independent service, we believe it would be appropriate to package their payment into the OPPS payment for the independent service provided.

As many independent services may be reported with or without image processing services, the cost of the image processing services will be reflected in the median cost for the independent HCPCS code as a function of the frequency that image processing services are reported with that particular HCPCS code. Again, while the median cost for a particular independent procedure generally will be higher as a result of added packaging, it could also change little or be lower because median costs typically do not reflect small distributional changes and because changes to the packaged HCPCS codes affect both the number and composition of single bills and the mix of hospitals contributing those single bills. For example, CPT code 70450 (Computed tomography, head or brain; without contrast material) may be provided alone or in conjunction with CPT code 76376 (3D rendering with interpretation and reporting of computed tomography, magnetic resource imaging, ultrasound, or other tomographic modality; not requiring image postprocessing on an independent workstation). In fact, CPT code 70450 was provided approximately 1.5 million times based on CY 2008 proposed rule claims data. CPT code 76376 was provided with CPT code 70450 less than 2 percent of the total instances that CPT code 70450 was billed. Therefore, as the frequency of CPT code 76376 provided in conjunction with CPT code 70450 increases, the median cost for CPT code 70450 would be more likely to reflect that additional cost.

The image processing services that we are proposing to package vary in their hospital resource costs. Resource cost was not a factor we considered when proposing to package supportive image processing services. Notably, the majority of image processing services that we are proposing to package have modest median costs in relationship to the cost of the independent service that they typically accompany.

Several of these codes, including CPT code 76350 (Subtraction in conjunction with contrast studies), are already unconditionally (that is, always) packaged under the CY 2007 OPPS, where they have been assigned to status indicator ''N.'' Payment for these services is made as part of the payment for the separately payable, independent services with which they are billed. No separate payment is made for services that we have assigned to status indicator ''N.'' We are not proposing status indicator changes for the four image processing services that were unconditionally packaged for CY 2007.

We are proposing to change the status indicator for seven image processing services from separately paid to unconditionally packaged (status indicator ''N'') for the CY 2008 OPPS. We believe that these services are always integral to and dependent upon the independent service that they support and, therefore, their payment would be appropriately packaged. We have calculated the median costs on which the proposed CY 2008 payment rates are based using the packaging status of each code as provided in Table 10 below. As we discuss above in more detail, this has the effect of both changing the median cost for the independent service into which the cost of the dependent service is packaged and also of redistributing payment that would otherwise have been made separately for the service we are proposing to newly package for CY 2008.

For example, CPT code 93325 (Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)) is assigned to APC 0697 (Level I Echocardiogram Except Transesophageal) for CY 2007. The proposed CY 2008 median cost of APC 0697 is $302.40. CPT code 93325 was billed with CPT code 93350 (Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report) approximately 43,000 times in the CY 2008 OPPS proposed rule data, and 5 percent of the claims for CPT code 93325 reported CPT code 93350 on the same date of service. Similarly, we note that almost 35 percent of the claims for CPT code 93350 also reported the image processing service described by CPT code 93325. Because CPT code 93350 is designated by CPT as an add-on code to a stress test service, as would be expected, we also observed that a CPT code for a stress test, most commonly CPT code 93017 (Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report) was also frequently reported on the same claim on the same day as both of the other two CPT codes. CPT code 93017 is assigned to APC 0100 (Cardiac Stress Tests) with a proposed CY 2008 median cost of $180.10. Under our proposed policy for the CY 2008, we are proposing to expand the packaging associated with the independent stress test and echocardiography services so that payment for the echocardiography color flow velocity mapping, if performed, would be packaged. Specifically, we would package payment for CPT code 93325, the echocardiography color flow velocity mapping, so that this dependent procedure would receive packaged payment through the separate OPPS payments for the independent procedures, here the stress test and echocardiography services. The payment rates for this example associated with our CY 2008 proposal are outlined in Table 9 below.

In this case, the proposed CY 2008 median cost for APC 0100 to which CPT code 93017 is assigned is $180.10. The proposed CY 2008 median cost for APC 0697, to which CPT code 93350 is assigned, is $302.40. The CY 2007 median cost for APC 0100 is $154.83 and the median cost for APC 0697 is $97.61. However, as discussed in section II.A.4.c. of this proposed rule concerning our general proposed packaging approach, the added effect of the budget neutrality adjustment that would result from the aggregate effects of the CY 2008 packaging proposal

(were there no further budget neutrality adjustment for other reasons) significantly changes the final payment rates relative to the median cost estimates. Table 9 presents a comparison of payments for CPT codes 93017, 93350, and 93325 in CY 2007, where payment for CPT code 93325 is made separately, to our CY 2008 proposed payments for CPT codes 93017, 93350, and 93325, where payment for CPT code 93325 would be packaged. This example cannot demonstrate the overall impact of packaging image processing services on payment to any given hospital because each individual hospital's case-mix and billing patterns would be different. The overall impact of packaging payment for CPT code 93325, as well as the proposed packaging changes that we are proposing for CY 2008, can only be assessed in the aggregate for classes of hospitals. Section XXII.B. of this proposed rule displays the overall impact of APC weight recalibration and packaging changes that we are proposing by classes of hospitals, and the OPPS Hospital-Specific Impacts—Provider-Specific Data file presents our estimates of CY 2008 hospital payment for those hospitals we include in our ratesetting and payment simulation database. The hospital-specific impacts file can be found on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/* under supporting documentation for this proposed rule.

TABLE 9.—EXAMPLE OF THE EFFECTS OF THE CY 2008 PACKAGING PROPOSAL ON PAYMENT FOR CPT CODES 93325, 93350, AND 93017

HCPCS code	Short descriptor	Sum of CY 2007 payment (93325 paid separately)	Sum of CY 2008 proposed payment (93325 Packaged)
93325	Doppler color flow add-on (dependent service)	$98.18	$0.00
93350	Echo transthoracic (independent service)	197.64	306.18
93017	Cardiovascular stress test (independent service)	155.74	182.36
Total Payment		451.56	488.54

The estimated overall impact of these proposed changes presented in section XXII.B. of this proposed rule is based on the assumption that hospital behavior would not change with regard to how often these dependent image processing services are performed in conjunction with the independent services. To the extent that hospitals could change their behavior and perform the image processing services more or less frequently, the data would show such a change in practice in future years and that change would be reflected in future budget neutrality adjustments.

As we indicated earlier, in all cases we are proposing that hospitals that furnish the image processing procedure in association with the independent service must bill both services on the same claim. We expect to carefully monitor any changes in billing practices on a service-specific and hospital-specific basis to determine whether there is reason to request that QIOs review the quality of care furnished or to request that Program Safeguard Contractors review the claims against the medical record.

TABLE 10.—IMAGE PROCESSING HCPCS CODES PROPOSED FOR PACKAGED PAYMENT IN CY 2008

HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	Proposed CY 2008 SI	Inactive CPT code effective 1/1/08 or earlier (listed on the same line as its replacement code	Short descriptor of the inactive CPT code
76125	Cine/video x-rays add-on	X	0260	N		
76350	Special x-ray contrast study	N	n/a	N		
76376	3d render w/o postprocess	X	0340	N		
76377	3d rendering w/postprocess	S	0282	N		
93325	Doppler color flow add-on	S	0697	N		
93613	Electrophys map 3d, add-on	T	0087	N		
95957	EEG digital analysis	S	0214	N		
0159T	Cad breast MRI	N	n/a	N		
0174T	Cad cxr remote	N	n/a	N	0152T	Computer chest add-on.
0175T	Cad cxr with interp	N	n/a	N	0152T	Computer chest add-on.
G0288	Recon, CTA for surg plan	S	0417	N		

(3) Intraoperative Services

We are proposing to package payment for ''intraoperative'' HCPCS codes for CY 2008, specifically those codes that are reported for supportive dependent diagnostic testing or other minor procedures performed during independent procedures. We performed a broad search for possible intraoperative HCPCS codes, relying upon the AMA's CY 2007 book of CPT codes and the CY 2007 book of Level II HCPCS codes, to identify specific codes as ''intraoperative'' codes. Furthermore, we performed a clinical review of all HCPCS codes to capture additional supportive diagnostic testing or other minor intraoperative or intraprocedural codes that are not necessarily identified as ''intraoperative'' codes. For example, we are proposing to package payment for CPT code 95955 (Electroencephalogram (EEG) during

nonintracranial surgery (e.g., carotid surgery)) because it is a minor intraoperative diagnostic testing procedure even though the code descriptor does not indicate it as such. Although we use the term ''intraoperative'' to categorize these procedures, we also have included supportive dependent services in this group that are provided during an independent procedure, although that procedure may not necessarily be a surgical procedure. These dependent services clearly fit into this category because they are provided during, and are integral to, an independent procedure, like all the other intraoperative codes, but the independent procedure they accompany may not necessarily be a surgical procedure. For example, we are proposing to package HCPCS code G0268 (Removal of impacted cerumen (one or both ears) by physician on same date of service as audiologic function testing). While specific audiologic function testing procedures are not surgical procedures performed in an operating room, they are independent procedures that are separately payable under the OPPS, and HCPCS code G0268 is a supportive dependent service always provided in association with one of these independent services. All references to ''intraoperative'' below refer to services that are usually or always provided during a surgical procedure or other independent procedure.

By definition, a service that is performed intraoperatively is provided during and, therefore, on the same date of service as another procedure that is separately payable under the OPPS. Because these intraoperative services support the performance of an independent procedure and they are provided in the same operative session as the independent procedure, we believe it would be appropriate to package their payment into the OPPS payment for the independent procedure performed. Therefore, we are not proposing to package payment for CY 2008 for those diagnostic services, such as CPT code 93005 (Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report) that are sometimes or only rarely performed and reported as supportive services in association with other independent procedures. Instead, we are proposing to include those HCPCS codes that are usually or always performed intraoperatively, based upon our review of the codes described above. The intraoperative services that we are proposing to package vary in hospital resource costs. Resource cost was not a factor we considered when determining which supportive intraoperative procedures to package.

The codes we are proposing to identify as intraoperative services for CY 2008 that would receive packaged payment under the OPPS are listed in Table 12 below.

Several of these codes, including CPT code 93640 (Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator leads including defibrillation threshold evaluation (induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination) at the time of initial implantation or replacement), are already unconditionally (that is, always) packaged under the CY 2007 OPPS, where they have been assigned to status indicator ''N.'' Payment for these services is made through the payment for the separately payable, independent services with which they are billed. No separate payment is made for services that we have assigned to status indicator ''N.'' We are not proposing status indicator changes for the five diagnostic intraoperative services that were unconditionally packaged for CY 2007.

We are proposing to change the status indicator for 34 intraoperative services from separately paid to unconditionally packaged (status indicator ''N'') for the CY 2008 OPPS. We believe that these services are always integral to and dependent upon the independent services that they support and, therefore, their payment would be appropriately packaged because they would generally be performed on the same date and in the same hospital as the independent services.

We are also proposing to change the status indicator for one intraoperative procedure from unconditionally packaged to conditionally packaged (status indicator ''Q'') as a ''special'' packaged code for the CY 2008 OPPS, specifically, CPT code 0126T (Common carotid intima-media thickness (IMT) study for evaluation of atherosclerotic burden or coronary heart disease risk factor assessment). This code was discussed in the past with the Packaging Subcommittee of the APC Panel which determined that, consistent with its code descriptor as a separate procedure, this procedure could sometimes be provided alone, without any other OPPS services on the claim. We believe that this procedure would usually be provided by a hospital in conjunction with another independent procedure on the same date of service but may occasionally be provided without another independent service. As a ''special'' packaged code, if the study were billed without any other service assigned to status indicator ''S,'' ''T,'' ''V,'' or ''X'' reported on the same date of service, under our proposal we would not treat the IMT study as a dependent service for purposes of payment. If we were to continue to unconditionally package payment for this procedure, treating it as a dependent service, hospitals would receive no payment at all when providing this service alone, although the procedure would not be functioning as an intraoperative service in that case. However, according to our proposal, its conditionally packaged status as a ''special'' packaged code would allow payment to be provided for this ''Q'' status IMT study when provided alone, in which case it would be treated as an independent service under these limited circumstances. On the other hand, when this service is furnished as an intraoperative procedure on the same day and in the same hospital as independent, separately paid services that are assigned to status indicator ''S,'' ''T,'' ''V,'' or ''X,'' we are proposing to package payment for it as a dependent service. In all cases, we are proposing that hospitals that furnish independent services on the same date as this IMT procedure must bill them all on the same claim. We believe that when dependent and independent services are furnished on the same date and in the same facility, they are part of a single complete hospital outpatient service that is reported with more than one HCPCS code, and no separate payment should be made for the intraoperative procedure that supports the independent service.

We have calculated the median costs on which the proposed CY 2008 payment rates are based using the packaging status of each code as provided in Table 12 below. As we discuss above in more detail, this has the effect of both changing the median cost for the independent service into which the cost of the dependent service is packaged and also of redistributing payment that would otherwise have been made separately for the service we are proposing to newly package for CY 2008.

For example, CPT code 92547 (Use of vertical electrodes (List separately in addition to code for primary procedure)) is assigned to APC 0363 (Level I Otorhinolaryngologic Function Tests) for CY 2007. The proposed CY 2008 median cost of APC 0363 is $53.73. CPT code 92547 was billed with CPT code 92541 (Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording) 6,056 times in the CY 2008 OPPS proposed rule data, and 97

percent of the claims for CPT code 92547 reported CPT code 92541 on the same date of service. Similarly, we note that over half of the claims for CPT code 92541 also reported the service described by CPT code 92547. Under our proposed policy for the CY 2008 OPPS, we are proposing to expand the packaging associated with the independent nystagmus test so that payment for the use of vertical electrodes, if used, would be packaged. Specifically, we would package payment for CPT code 92547 so that under the CY 2008 OPPS the commonly billed dependent procedure, the use of vertical electrodes, would receive packaged payment through the separate OPPS payment for the independent procedure, in this case the nystagmus test. The payment rates for this example associated with our CY 2008 proposal are outlined in Table 11 below.

In this case, the proposed CY 2008 median cost for APC 0363, to which CPT code 92541 is assigned, is $53.73, while the CY 2007 median cost of this APC with status indicator ''S'' and to which both CPT codes 92547 and 02541 are assigned is $52.09. However, as discussed in the section II.A.4. of this proposed rule concerning our general proposed packaging approach, the added effect of the budget neutrality adjustment that would result from the aggregate effects of the complete CY 2008 packaging proposal (were there no further budget neutrality adjustment for other reasons) significantly changes the final payment rates relative to median cost estimates. Table 11 presents a comparison of payment for CPT codes 92541 and 92547 in CY 2007, where CPT code 92547 is paid separately, to our CY 2008 proposed payment for CPT codes 92541 and 92547, where payment for CPT code 92547 would be packaged. This example cannot demonstrate the overall impact of packaging intraoperative services on payment to any given hospital because each individual hospital's case-mix and billing patterns would be different. The overall impact of packaging payment for CPT code 92547, as well as all other packaging changes we are proposing for CY 2008, can only be assessed in the aggregate for classes of hospitals. Section XXII.B. of this proposed rule displays the overall impact of APC weight recalibration and packaging changes we are proposing by classes of hospitals, and the OPPS Hospital-Specific Impacts—Provider-Specific Data file presents our estimates of CY 2008 hospital payment for those hospitals we include in our ratesetting and payment simulation database. The hospital-specific impacts file can be found on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/* under supporting documentation for this proposed rule.

TABLE 11.— EXAMPLE OF THE EFFECTS OF THE CY 2008 PACKAGING PROPOSAL ON PAYMENT FOR CPT CODES 92541 AND 92547

HCPCS Code	Short descriptor	Sum of CY 2007 payment (92547 paid separately)	Sum of CY 2008 proposed payment (92547 packaged)
92541	Spontaneous nystagmus study (independent service)	$52.40	$54.41
92547	Supplemental electrical test (dependent service)	52.40	0.00
Total Payment		104.80	54.41

The estimated overall impact of these proposed changes is based on the assumption that hospital behavior would not change with regard to when these dependent intraoperative services are performed on the same date and by the same hospital that performs the independent services. To the extent that hospitals could change their behavior and perform the intraoperative services more or less frequently, on subsequent dates, or at settings outside of the hospital, the data would show such a change in practice in future years and that change would be reflected in future budget neutrality adjustments. However, with respect to intraoperative services in particular, we believe that hospitals are limited in the extent to which they could change their behavior with regard to how they furnish these services. By their definition, these intraoperative services generally must be furnished on the same date and at the same operative location as the independent procedure in order to be considered intraoperative. For these codes, we assume that both the dependent and independent services would be furnished on the same date in the same hospital, and hospitals should bill them on the same claim with the same date of service.

As we indicated earlier, in all cases we are proposing that hospitals that furnish the intraoperative procedure on the same date as the independent service must bill both services on the same claim. We expect to carefully monitor any changes in billing practices on a service-specific and hospital-specific basis to determine whether there is reason to request that QIOs review the quality of care furnished or to request that Program Safeguard Contractors review the claims against the medical record.

TABLE 12.—INTRAOPERATIVE HCPCS CODES PROPOSED FOR PACKAGED PAYMENT IN CY 2008

HCPCS Code	Short descriptor	CY 2007 SI	CY 2007 APC	Proposed CY 2008 SI
20975	Electrical bone stimulation	X	0340	N
31620	Endobronchial us add-on	S	0670	N
37250	Iv us first vessel add-on	S	0416	N
37251	Iv us each add vessel add-on	S	0416	N
58110	Bx done w/colposcopy add-on	T	0188	N
67299	Eye surgery procedure	T	0235	N
73530	X-ray exam of hip	X	0261	N
74300	X-ray bile ducts/pancreas	X	0263	N

TABLE 12.—INTRAOPERATIVE HCPCS CODES PROPOSED FOR PACKAGED PAYMENT IN CY 2008—Continued

HCPCS Code	Short descriptor	CY 2007 SI	CY 2007 APC	Proposed CY 2008 SI
74301	X-rays at surgery add-on	X	0263	N
75898	Follow-up angiography	X	0263	N
78020	Thyroid met uptake	S	0399	N
78478	Heart wall motion add-on	S	0399	N
78480	Heart function add-on	S	0399	N
78496	Heart first pass add-on	S	0399	N
92547	Supplemental electrical test	X	0363	N
92978	Intravasc us, heart add-on	S	0670	N
92979	Intravasc us, heart add-on	S	0416	N
93320	Doppler echo exam, heart	S	0697	N
93321	Doppler echo exam, heart	S	0697	N
93571	Heart flow reserve measure	S	0670	N
93572	Heart flow reserve measure	S	0416	N
93609	Map tachycardia, add-on	T	0087	N
93613	Electrophys map 3d, add-on	T	0087	N
93621	Electrophysiology evaluation	T	0085	N
93622	Electrophysiology evaluation	T	0085	N
93623	Stimulation, pacing heart	T	0087	N
93631	Heart pacing, mapping	T	0087	N
93640	Evaluation heart device	N	n/a	N
93641	Electrophysiology evaluation	N	n/a	N
93662	Intracardiac ecg (ice)	S	0670	N
95829	Surgery electrocorticogram	S	0214	N
95920	Intraop nerve test add-on	S	0216	N
95955	EEG during surgery	S	0213	N
95999	Neurological procedure	S	0215	N
96020	Functional brain mapping	X	0373	N
0126T	Chd risk imt study	N	n/a	Q
0173T	Iop monit io pressure	N	n/a	N
G0268	Removal of impacted wax md	X	0340	N
G0275	Renal angio, cardiac cath	N	n/a	N
G0278	Iliac art angio, cardiac cath	N	n/a	N

(4) Imaging Supervision and Interpretation Services

We are proposing to change the packaging status of many imaging supervision and interpretation codes for CY 2008. We define ''imaging supervision and interpretation codes'' as HCPCS codes for services that are defined as ''radiological supervision and interpretation'' in the radiology series, 70000 through 79999, of the AMA's CY 2007 book of CPT codes, with the addition of some services in other code ranges of CPT, Category III CPT tracking codes, or Level II HCPCS codes that are clinically similar or directly crosswalk to codes defined as radiological supervision and interpretation services in the CPT radiology range. We also included HCPCS codes that existed in CY 2006 but were deleted and were replaced in CY 2007. We included the CY 2006 HCPCS codes because we are proposing to use the CY 2006 claims data to calculate the CY 2008 OPPS median costs on which the CY 2008 payment rates would be based.

In its discussion of ''radiological supervision and interpretation,'' CPT indicates that ''when a procedure is performed by two physicians, the radiologic portion of the procedure is designated as 'radiological supervision and interpretation'.'' In addition, CPT guidance notes that, ''When a physician performs both the procedure and provides imaging supervision and interpretation, a combination of procedure codes outside the 70000 series and imaging supervision and interpretation codes are to be used.'' In the hospital outpatient setting, the concept of one or more than one physician performing related procedures does not apply to the reporting of these codes, but the radiological supervision and interpretation codes clearly are established for reporting in association with other procedural services outside the CPT 70000 series. Because these imaging supervision and interpretation codes are always reported for imaging services that support the performance of an independent procedure and they are, by definition, always provided in the same operative session as the independent procedure, we believe that it would be appropriate to package their payment into the OPPS payment for the independent procedure performed.

In addition to radiological supervision and interpretation codes in the radiology range of CPT codes, there are CPT codes in other series that describe similar procedures that we are proposing to include in the group of imaging supervision and interpretation codes proposed for packaging under the CY 2008 OPPS. For example, CPT code 93555 (Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; ventricular and/or atrial angiography) whose payment under the OPPS is currently packaged, is commonly reported with an injection procedure code, such as CPT code 93543 (Injection procedure during cardiac catheterization; for selective left ventricular or left atrial angiography), whose payment is also currently packaged under the OPPS, and a cardiac catheterization procedure code, such as CPT code 93526 (Combined right heart catheterization and retrograde left heart catheterization), that is separately paid. In the case of cardiac catheterization, CPT code 93555 describes an imaging supervision and interpretation service in support of the cardiac catheterization procedure, and this dependent service is clinically quite similar to radiological supervision and interpretation codes in the radiology range of CPT. Payment for the cardiac catheterization imaging

supervision and interpretation services has been packaged since the beginning of the OPPS. Therefore, in developing this proposal for the CY 2008 proposed rule, we conducted a comprehensive clinical review of all Category I and Category III CPT codes and Level II HCPCS codes to identify all codes that describe imaging supervision and interpretation services. The codes we are proposing to identify as imaging supervision and interpretation codes for CY 2008 that would receive packaged payment are listed in Table 14 below.

Several of these codes, including CPT code 93555 discussed above, are already unconditionally (that is, always) packaged under the CY 2007 OPPS, where they have been assigned to status indicator ''N.'' Payment for these services is made as part of the payment for the separately payable, independent services with which they are billed. No separate payment is made for services that we have assigned to status indicator ''N.'' We are not proposing status indicator changes for the six imaging supervision and interpretation services that were unconditionally packaged for CY 2007.

We are proposing to change the status indicator for 33 imaging supervision and interpretation services from separately paid to unconditionally packaged (status indicator ''N'') for the CY 2008 OPPS. We believe that these services are always integral to and dependent upon the independent services that they support and, therefore, their payment would be appropriately packaged because they would generally be performed on the same date and in the same hospital as the independent services.

We are proposing to change the status indicator for 93 imaging supervision and interpretation services from separately paid to conditionally packaged (status indicator ''Q'') as ''special'' packaged codes for the CY 2008 OPPS. These services may occasionally be provided at the same time and at the same hospital with one or more other procedures for which payment is currently packaged under the OPPS, most commonly injection procedures, and in these cases we would not treat the imaging supervision and interpretation services as dependent services for purposes of payment. If we were to unconditionally package payment for these imaging supervision and interpretation services as dependent services, hospitals would receive no payment at all for providing the imaging supervision and interpretation service and the other minor procedure(s). However, according to our proposal, their conditional packaging status as ''special'' packaged codes would allow payment to be provided for these ''Q'' status imaging supervision and interpretation services as independent services in these limited circumstances, and for which payment for the accompanying minor procedure would be packaged. However, when these imaging supervision and interpretation dependent services are furnished on the same day and in the same hospital as independent separately paid services, specifically, any service assigned to status indicator ''S,'' ''T,'' ''V,'' or ''X,'' we are proposing to package payment for them as dependent services. In all cases, we are proposing that hospitals that furnish the independent services on the same date as the dependent services must bill them all on the same claim. We believe that when the dependent and independent services are furnished on the same date and in the same hospital, they are part of a single complete hospital outpatient service that is reported with more than one HCPCS code, and no separate payment should be made for the imaging supervision and interpretation service that supports the independent service.

In the case of services for which we are proposing conditional packaging, we would expect that, although these services would always be performed in the same session as another procedure, in some cases that other procedure's payment would also be packaged. For example, CPT code 73525 (Radiological examination, hip, arthrography, radiological supervision and interpretation) and CPT code 27093 (Injection procedure for hip arthrography; without anesthesia) could be provided in a single hospital outpatient encounter and reported as the only two services on a claim. In the case where only these two services were performed, the conditionally packaged status of CPT code 73525 would appropriately allow for its separate payment as an independent imaging supervision and interpretation arthrography service, into which payment for the dependent injection procedure would be packaged.

We have calculated the median costs on which the proposed CY 2008 payment rates are based using the packaging status of each code as provided in Table 14 below. As we discuss above in more detail, this has the effect of both changing the median cost for the independent service into which the cost of the dependent service is packaged and also of redistributing payment that would otherwise have been made separately for the service we are proposing to newly package for CY 2008.

For example, CPT code 72265 (Myelography, lumbosacral, radiological supervision and interpretation) is assigned to APC 0274 (Myelography) for CY 2007. The proposed CY 2008 median cost of APC 0274 is $245.38. CPT code 72265 was billed with CPT code 72132 (Computed tomography, lumbar spine; with contrast material) 20,233 times in the CY 2008 OPPS proposed rule data, and 62 percent of the claims for CPT code 72265 reported CPT code 72132 on the same date of service. Similarly, we note that over half of the claims for CPT code 72132 also reported the myelography service described by CPT code 72265. As would be expected, we also observed that a CPT code for the clinically necessary intrathecal injection, specifically CPT code 62284 (Injection procedure for myelography and/or computed tomography, spinal (other than C1–C2 and posterior fossa)) was also frequently reported on the same claim on the same day as both of the other two CPT codes. Payment for CPT code 62284 is already packaged under the OPPS for CY 2007, as is payment for most HCPCS codes that describe dependent injection procedures that accompany independent procedures. Under our proposed policy for the CY 2008 OPPS, we are proposing to expand the packaging associated with the independent spinal computed tomography (CT) scan so that payment for both the associated injection procedure and the related myelography service, if performed, would be packaged. Specifically, we would package payment for CPT code 72265 when it appears on the same claim with a separately paid service such as CPT code 72132, so that, under the CY 2008 OPPS, both commonly billed dependent procedures, the injection procedure and the myelography service, would receive packaged payment through the separate OPPS payment for the independent procedure, the CT scan. The payment rates for this example associated with our CY 2008 proposal are outlined in Table 13 below. The proposed conditionally packaged status for CPT code 72265 would ensure that if lumbosacral myelography was performed alone, separate payment for the myelography service would be made under the OPPS as the myelography service would not be a dependent service in that situation.

The proposed policy would result in no separate payment for CPT code 72265 when it is billed on the same day and by the same hospital as any separately paid service, such as CPT code 72132. Moreover, as discussed

later in this section, the proposed policy would provide packaged payment for the contrast agent that is required to perform the independent computed tomography service. For purposes of the example in Table 13 below, we include the payment for HCPCS code Q9947 (Low osmolar contrast material 200–249 mg/ml iodine concentration, per ml) which was reported on about one-third of the CY 2008 proposed rule claims for CPT code 72132. To calculate the CY 2007 payment for the contrast agent, we multiplied the mean number of units per day from our CY 2008 proposed rule data (48.3) by the April 2007 per unit payment rate for HCPCS code Q9947 ($1.33).

In this case, the proposed CY 2008 median cost for APC 0316 (Level II Computed Tomography with Contrast) to which CPT code 72132 is assigned is $741.80. The CY 2007 median cost for APC 0283 to which CPT code 72132 is assigned is $249.48 and the median cost of APC 0274 to which CPT code 72265 is assigned is $156.10. However, as discussed in section II.A.4.c. of this proposed rule concerning our general proposed packaging approach, the added effect of the budget neutrality adjustment that would result from the aggregate effects of the CY 2008 packaging proposal (were there no further budget neutrality adjustment for other reasons) significantly changes the final payment rates relative to median cost estimates. Table 13 presents a comparison of payment for CPT codes 72132 and 72265 and HCPCS code Q9947 in CY 2007, where CPT code 72265 and HCPCS code Q9947 are paid separately, to our CY 2008 proposed payment for CPT codes 72132 and 77265 and HCPCS code Q9947, where payment for CPT code 72265 and HCPCS code Q9947 would be packaged. This example cannot demonstrate the overall impact of packaging imaging supervision and interpretation services on payment to any given hospital because each individual hospital's case-mix and billing patterns would be different. The overall impact of packaging payment CPT code 77265 when it appears with any other separately paid service, as well as all other packaging changes that we are proposing for CY 2008, can only be assessed in aggregate for classes of hospitals. Section XXII.B. of this proposed rule displays the overall impact of APC weight recalibration and packaging changes we are proposing by classes of hospitals, and the OPPS Hospital-Specific Impacts—Provider-Specific Data file presents our estimates of CY 2008 hospital payment for those hospitals we include in our ratesetting and payment simulation database. The hospital-specific impacts file can be found on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/* under supporting documentation for this proposed rule.

TABLE 13.—EXAMPLE OF THE EFFECTS OF THE CY 2008 PACKAGING PROPOSAL ON PAYMENT FOR CPT CODES 72265 AND 72132 AND HCPCS CODE Q9947

HCPCS code	Short descriptor	Sum of CY 2007 payment (72265 paid separately)	Sum of CY 2008 proposed payment (72265 packaged)
62284	Injection for myelogram (dependent service)	$0.00	$0.00
Q9947*	LOCM 200–249mg/ml iodine, 1ml (dependent service)	64.24	0.00
72265	Contrast x-ray lower spine (dependent service)	157.01	0.00
72132	CT lumbar spine w/dye (independent service)	250.94	751.09
Total Payment		472.14	751.09

*Based on the mean number of units per day from our CY 2008 proposed rule data (48.3) and the April 2007 per unit payment rate for Q9947 ($1.33).

The estimated overall impact of these changes presented in XXII.B. of this proposed rule is based on the assumption that hospital behavior would not change with regard to when these dependent services are performed on the same date and by the same hospital that performs the independent services. To the extent that hospitals could change their behavior and perform the imaging supervision and interpretation services more or less frequently, on subsequent dates, or at settings outside of the hospital, the data would show such a change in practice in future years and that change would be reflected in future budget neutrality adjustments. However, with respect to the imaging supervision and interpretation services in particular, we believe that hospitals are limited in the extent to which they could change their behavior with regard to how they furnish these services. By their definition, these imaging and supervision services generally must be furnished on the same date and at the same operative location as the independent procedure in order for the imaging service to meaningfully contribute to the diagnosis or treatment of the patient. For those radiological supervision and interpretation codes in the radiology range of CPT in particular, if the same physician is able to perform both the procedure and the supervision and interpretation as stated by CPT, we assume that both the dependent and independent services would be furnished on the same date in the same hospital, and hospitals should bill them on the same claim with the same date of service.

As we indicated earlier in this section, in all cases we are proposing that hospitals that furnish the imaging supervision and interpretation service on the same date as the independent service must bill both services on the same claim. We expect to carefully monitor any changes in billing practices on a service-specific and hospital-specific basis to determine whether there is reason to request that QIOs review the quality of care furnished or to request that Program Safeguard Contractors review the claims against the medical record.

TABLE 14.—IMAGING SUPERVISION AND INTERPRETATION HCPCS CODES PROPOSED FOR PACKAGED PAYMENT IN CY 2008

HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	Proposed CY 2008 SI	Proposed CY 2008 APC	Inactive CPT code effective 1/1/2008 or earlier (listed on the same line as its replacement code)	Short descriptor of the inactive CPT code
70010	Contrast x-ray of brain	S	0274	Q	0274		
70015	Contrast x-ray of brain	S	0274	Q	0274		
70170	X-ray exam of tear duct	X	0264	Q	0264		
70332	X-ray exam of jaw joint	S	0275	Q	0275		
70373	Contrast x-ray of larynx	X	0263	Q	0263		
70390	X-ray exam of salivary duct	X	0263	Q	0263		
71040	Contrast x-ray of bronchi	X	0263	Q	0263		
71060	Contrast x-ray of bronchi	X	0263	Q	0263		
71090	X-ray & pacemaker insertion	X	0272	N	n/a		
72240	Contrast x-ray of neck spine	S	0274	Q	0274		
72255	Contrast x-ray, thorax spine	S	0274	Q	0274		
72265	Contrast x-ray, lower spine	S	0274	Q	0274		
72270	Contrast x-ray, spine	S	0274	Q	0274		
72275	Epidurography	S	0274	N	n/a		
72285	X-ray c/t spine disk	S	0388	Q	0388		
72291	Perq vertebroplasty, fluor	S	0274	N	n/a	76012	Perq vertebroplasty, fluor.
72292	Perq vertebroplasty, ct	S	0274	N	n/a	76013	Perq vertebroplasty, ct.
72295	X-ray of lower spine disk	S	0388	Q	0388		
73040	Contrast x-ray of shoulder	S	0275	Q	0275		
73085	Contrast x-ray of elbow	S	0275	Q	0275		
73115	Contrast x-ray of wrist	S	0275	Q	0275		
73525	Contrast x-ray of hip	S	0275	Q	0275		
73542	X-ray exam, sacroiliac joint	S	0275	Q	0275		
73580	Contrast x-ray of knee joint	S	0275	Q	0275		
73615	Contrast x-ray of ankle	S	0275	Q	0275		
74190	X-ray exam of peritoneum	S	0264	Q	0264		
74235	Remove esophagus obstruction	S	0257	N	n/a		
74305	X-ray bile ducts/pancreas	X	0263	N	n/a		
74320	Contrast x-ray of bile ducts	X	0264	Q	0264		
74327	X-ray bile stone removal	S	0296	N	n/a		
74328	X-ray bile duct endoscopy	N	n/a	N	n/a		
74329	X-ray for pancreas endoscopy	N	n/a	N	ma		
74330	X-ray bile/panc endoscopy	N	n/a	N	n/a		
74340	X-ray guide for GI tube	X	0272	N	n/a		
74350	X-ray guide, stomach tube	X	0263	N	n/a		
74355	X-ray guide, intestinal tube	X	0263	N	n/a		
74360	X-ray guide, GI dilation	S	0257	N	n/a		
74363	X-ray, bile duct dilation	S	0297	N	n/a		
74425	Contrast x-ray, urinary tract	S	0278	Q	0278		
74430	Contrast x-ray, bladder	S	0278	Q	0278		
74440	X-ray, male genital tract	S	0278	Q	0278		
74445	X-ray exam of penis	S	0278	Q	0278		
74450	X-ray, urethra/bladder	S	0278	Q	0278		
74455	X-ray, urethra/bladder	S	0278	Q	0278		
74470	X-ray exam of kidney lesion	X	0263	Q	0263		
74475	X-ray control, cath insert	S	0297	Q	0297		
74480	X-ray control, cath insert	S	0296	Q	0296		
74485	X-ray guide, GU dilation	S	0296	Q	0296		
74740	X-ray, female genital tract	X	0264	Q	0264		
74742	X-ray, fallopian tube	X	0264	N.			
75600	Contrast x-ray exam of aorta	S	0280	Q	0280		
75605	Contrast x-ray exam of aorta	S	0280	Q	0280		
75625	Contrast x-ray exam of aorta	S	0280	Q	0280		
75630	X-ray aorta, leg arteries	S	0280	Q	0280		
75635	Ct angio abdominal arteries	S	0662	Q	0662		
75650	Artery x-rays, head & neck	S	0280	Q	0280		
75658	Artery x-rays, arm	S	0279	Q	0279		
75660	Artery x-rays, head & neck	S	0668	Q	0668		
75662	Artery x-rays, head & neck	S	0280	Q	0280		
75665	Artery x-rays, head & neck	S	0280	Q	0280		
75671	Artery x-rays, head & neck	S	0280	Q	0280		

TABLE 14.—IMAGING SUPERVISION AND INTERPRETATION HCPCS CODES PROPOSED FOR PACKAGED PAYMENT IN CY 2008—Continued

HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	Proposed CY 2008 SI	Proposed CY 2008 APC	Inactive CPT code effective 1/1/2008 or earlier (listed on the same line as its replacement code)	Short descriptor of the inactive CPT code
75676	Artery x-rays, neck	S	0280	Q	0280		
75680	Artery x-rays, neck	S	0280	Q	0280		
75685	Artery x-rays, spine	S	0280	Q	0280		
75705	Artery x-rays, spine	S	0668	Q	0668		
75710	Artery x-rays, arm/leg	S	0280	Q	0280		
75716	Artery x-rays, arms/legs	S	0280	Q	0280		
75722	Artery x-rays, kidney	S	0280	Q	0280		
75724	Artery x-rays, kidneys	S	0280	Q	0280		
75726	Artery x-rays, abdomen	S	0280	Q	0280		
75731	Artery x-rays, adrenal gland	S	0280	Q	0280		
75733	Artery x-rays, adrenals	S	0668	Q	0668		
75736	Artery x-rays, pelvis	S	0280	Q	0280		
75741	Artery x-rays, lung	S	0279	Q	0279		
75743	Artery x-rays, lungs	S	0280	Q	0280		
75746	Artery x-rays, lung	S	0279	Q	0279		
75756	Artery x-rays, chest	S	0279	Q	0279		
75774	Artery x-ray, each vessel	S	0279	N	n/a		
75790	Visualize A–V shunt	S	0279	Q	0279		
75801	Lymph vessel x-ray, arm/leg	X	0264	Q	0264		
75803	Lymph vessel x-ray,arms/legs	X	0264	Q	0264		
75805	Lymph vessel x-ray, trunk	X	0264	Q	0264		
75807	Lymph vessel x-ray, trunk	X	0264	Q	0264		
75809	Nonvascular shunt, x-ray	X	0263	Q	0263		
75810	Vein x-ray, spleen/liver	S	0279	Q	0279		
75820	Vein x-ray, arm/leg	S	0668	Q	0668		
75822	Vein x-ray, arms/legs	S	0668	Q	0668		
75825	Vein x-ray, trunk	S	0279	Q	0279		
75827	Vein x-ray, chest	S	0279	Q	0279		
75831	Vein x-ray, kidney	S	0279	Q	0279		
75833	Vein x-ray, kidneys	S	0279	Q	0279		
75840	Vein x-ray, adrenal gland	S	0280	Q	0280		
75842	Vein x-ray, adrenal glands	S	0280	Q	0280		
75860	Vein x-ray, neck	S	0668	Q	0668		
75870	Vein x-ray, skull	S	0668	Q	0668		
75872	Vein x-ray, skull	S	0279	Q	0279		
75880	Vein x-ray, eye socket	S	0668	Q	0668		
75885	Vein x-ray, liver	S	0280	Q	0280		
75887	Vein x-ray, liver	S	0279	Q	0279		
75889	Vein x-ray, liver	S	0280	Q	0280		
75891	Vein x-ray, liver	S	0279	Q	0279		
75893	Venous sampling by catheter	Q	0668	Q	0668		
75894	X-rays, transcath therapy	S	0298	N	n/a		
75896	X-rays, transcath therapy	S	0263	N	n/a		
75901	Remove cva device obstruct	X	0263	N	n/a		
75902	Remove cva lumen obstruct	X	0263	N	n/a		
75940	X-ray placement, vein filter	S	0298	N	n/a		
75945	Intravascular us	S	0267	Q	0267		
75946	Intravascular us add-on	S	0266	N	n/a		
75960	Transcath iv stent rs&i	S	0668	N	n/a		
75961	Retrieval, broken catheter	S	0668	N	n/a		
75962	Repair arterial blockage	S	0668	Q	0668		
75964	Repair Artery blockage, each	S	0668	N	n/a		
75966	Repair arterial blockage	S	0668	Q	0668		
75968	Repair Artery blockage, each	S	0668	N	n/a		
75970	Vascular biopsy	S	0668	N	n/a		
75978	Repair venous blockage	S	0668	Q	0668		
75980	Contrast xray exam bile duct	S	0297	N	n/a		
75982	Contrast xray exam bile duct	S	0297	N	n/a		
75984	Xray control catheter change	X	0263	N	n/a		
75989	Abscess drainage under x-ray	N		N	n/a		
75992	Atherectomy, x-ray exam	S	0668	N	n/a		
75993	Atherectomy, x-ray exam	S	0668	N	n/a		
75994	Atherectomy, x-ray exam	S	0668	N	n/a		

TABLE 14.—IMAGING SUPERVISION AND INTERPRETATION HCPCS CODES PROPOSED FOR PACKAGED PAYMENT IN CY 2008—Continued

HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	Proposed CY 2008 SI	Proposed CY 2008 APC	Inactive CPT code effective 1/1/2008 or earlier (listed on the same line as its replacement code)	Short descriptor of the inactive CPT code
75995	Atherectomy, x-ray exam	S	0668	N	n/a		
75996	Atherectomy, x-ray exam	S	0668	N	n/a		
76080	X-ray exam of fistula	X	0263	Q	0263		
76975	GI endoscopic ultrasound	S	0266	Q	0266		
77053	X-ray of mammary duct	X	0263	Q	0263	76086	X-ray of mammary duct.
77054	X-ray of mammary ducts	X	0263	Q	0263	76088	X-ray of mammary ducts.
93555	Imaging, cardiac cath	N	n/a	N	n/a		
93556	Imaging, cardiac cath	N	n/a	N	n/a		

(5) Diagnostic Radiopharmaceuticals

For CY 2008, we are proposing to change the packaging status of diagnostic radiopharmaceuticals as part of our overall enhanced packaging approach for the CY 2008 OPPS. Packaging costs into a single aggregate payment for a service, encounter, or episode of care is a fundamental principle that distinguishes a prospective payment system from a fee schedule. In general, packaging the costs of supportive items and services into the payment for the independent procedure or service with which they are associated encourages hospital efficiencies and also enables hospitals to manage their resources with maximum flexibility. As we stated in the CY 2007 OPPS/ASC final rule with comment period, we believe that a policy to package payment for additional radiopharmaceuticals (other than those already packaged when their per day costs are below the packaging threshold for OPPS drugs, biologicals, and radiopharmaceuticals based on data for the update year) is consistent with OPPS packaging principles and would provide greater administrative simplicity for hospitals (71 FR 68094).

All nuclear medicine procedures require the use of at least one radiopharmaceutical, and there are only a small number of radiopharmaceuticals that may be appropriately billed with each diagnostic nuclear medicine procedure. While examining the CY 2005 hospital claims data in preparation for the CY 2007 OPPS/ASC proposed rule, we identified a significant number of diagnostic nuclear medicine procedure claims that were missing HCPCS codes for the associated radiopharmaceutical. At that time, we believed that there could be two reasons for the presence of these claims in the data. One reason could be that the radiopharmaceutical used for the procedure was packaged under the OPPS and, therefore, some hospitals may have decided not to include the specific radiopharmaceutical HCPCS code and an associated charge on the claim. A second reason could be that the hospitals may have incorporated the cost of the radiopharmaceutical into the charges for the associated nuclear medicine procedures. A third possibility not offered in the CY 2007 OPPS/ASC proposed rule is that hospitals may have included the charges for radiopharmaceuticals on an uncoded revenue code line.

In the CY 2007 OPPS/ASC proposed rule, we did not propose packaging payment for radiopharmaceuticals with per day costs above the $55 CY 2007 packaging threshold because we indicated that we were concerned that payments for certain nuclear medicine procedures could potentially be less than the costs of some of the packaged radiopharmaceuticals, especially those that are relatively expensive. At the same time, we also noted the GAO's comment in reference to the CY 2006 OPPS proposed rule that stated a methodology that includes packaging all radiopharmaceutical costs into the payments for the nuclear medicine procedures may result in payments that exceed hospitals' acquisition costs for certain radiopharmaceuticals because there may be more than one radiopharmaceutical that may be used for a particular procedure. We also expressed concern that packaging payment for additional radiopharmaceuticals could provoke treatment decisions that may not reflect use of the most clinically appropriate radiopharmaceutical for a particular nuclear medicine procedure in any specific case (71 FR 68094).

After considering this issue further and examining our CY 2006 claims data for the CY 2008 OPPS update, we believe that it is most appropriate to package payment for some radiopharmaceuticals, specifically diagnostic radiopharmaceuticals, into the payment for diagnostic nuclear medicine procedures for CY 2008. We expect that packaging would encourage hospitals to use the most cost efficient diagnostic radiopharmaceutical products that are clinically appropriate. We anticipate that hospitals would continue to provide care that is aligned with the best interests of the patient. Furthermore, we believe that it would be the intent of most hospitals to provide both the diagnostic radiopharmaceutical and the associated diagnostic nuclear medicine procedure at the time the diagnostic radiopharmaceutical is administered and not to send patients to a different provider for administration of the radiopharmaceutical. We do not believe that our packaging proposal would limit beneficiaries' ability to receive clinically appropriate diagnostic procedures. Again, the OPPS is a system of averages, and payment in the aggregate is intended to be adequate, although payment for any one service may be higher or lower than a hospital's actual costs in that case.

For CY 2008, we have separated radiopharmaceuticals into two groupings. The first group includes diagnostic radiopharmaceuticals, while

the second group includes therapeutic radiopharmaceuticals. We identified all diagnostic radiopharmaceuticals as those Level II HCPCS codes that include the term ''diagnostic'' along with a radiopharmaceutical in their long code descriptors. Therefore, we were able to distinguish therapeutic radiopharmaceuticals from diagnostic radiopharmaceuticals as those Level II HCPCS codes that have the term ''therapeutic'' along with a radiopharmaceutical in their long code descriptors. There currently are no HCPCS C-codes used to report radiopharmaceuticals under the OPPS. For CY 2008, we are proposing to package payment for all diagnostic radiopharmaceuticals that are not otherwise packaged according to the proposed CY 2008 packaging threshold for drugs, biologicals, and radiopharmaceuticals. We are proposing this packaging approach for diagnostic radiopharmaceuticals, while we are proposing to continue to pay separately for therapeutic radiopharmaceuticals with an average per day cost of more than $60 as discussed in section V.B.3. of this proposed rule. In that section, we review our reasons for treating diagnostic radiopharmaceuticals (as well as contrast media) differently from other types of specified covered outpatient drugs identified in section 1833(t)(B) of the Act.

Diagnostic radiopharmaceuticals are always intended to be used with a diagnostic nuclear medicine procedure. In examining our CY 2006 claims data, we were able to match most diagnostic radiopharmaceuticals to their associated diagnostic procedures and most diagnostic nuclear medicine procedures to their associated diagnostic radiopharmaceuticals in the vast majority of single bills used for ratesetting. We estimate that less than 5 percent of all claims with a diagnostic radiopharmaceutical had no corresponding diagnostic nuclear medicine procedure. In addition, we found that only about 13 percent of all single bills with a diagnostic nuclear medicine procedure code had no corresponding diagnostic radiopharmaceutical billed. These statistics indicate that, in a majority of our single bills for diagnostic nuclear medicine procedures, a diagnostic radiopharmaceutical HCPCS code is included on the single bill. Table 15 presents the top 20 diagnostic nuclear medicine procedures in terms of the overall frequency with which they are reported in the OPPS claims data. Among these high volume diagnostic nuclear medicine procedures, their single bills include a HCPCS code for a diagnostic radiopharmaceutical at least 84 percent of the time for 19 out of the top 20 procedures. More specifically, 84 to 86 percent of the single bills for 4 diagnostic nuclear medicine procedures include a diagnostic radiopharmaceutical, 87 to 89 percent of the single bills for 8 diagnostic nuclear medicine procedures include a diagnostic radiopharmaceutical, and 90 percent or more of the single bills for 7 diagnostic nuclear medicine procedures include a diagnostic radiopharmaceutical.

TABLE 15.—TOP 20 DIAGNOSTIC NUCLEAR MEDICINE PROCEDURES SORTED BY CY 2006 OPPS TOTAL VOLUME

HCPCS code	Short descriptor	SI	APC	Total line-item frequency	Single bills with a radiopharmaceutical as a percent of all single bills	Single bills as a percent of total line-item frequency
78465	Heart image (3d), multiple	S	0377	566,252	88	9
78306	Bone imaging, whole body	S	0396	368,452	90	76
78815	Tumorimage pet/ct skul-thigh	S	0308	122,126	100	84
78223	Hepatobiliary imaging	S	0394	69,066	85	90
78315	Bone imaging, 3 phase	S	0396	56,524	89	88
78464	Heart image (3d), single	S	0398	35,866	93	29
78472	Gated heart, planar, single	S	0398	32,154	89	80
78264	Gastric emptying study	S	0395	31,190	88	94
78812	Tumor image (pet)/skul-thigh	S	0308	27,345	100	86
78007	Thyroid image, mult uptakes	S	0391	23,703	84	96
78195	Lymph system imaging	S	0400	20,187	89	18
78585	Lung V/Q imaging	S	0378	20,036	91	48
78070	Parathyroid nuclear imaging	S	0391	18,752	94	84
78006	Thyroid imaging with uptake	S	0390	18,613	86	95
78300	Bone imaging, limited area	S	0396	18,333	89	90
78320	Bone imaging (3D)	S	0396	16,710	84	35
78588	Perfusion lung image	S	0378	14,323	88	48
78707	K flow/funct image w/o drug	S	0404	13,820	89	90
78580	Lung perfusion imaging	S	0401	13,011	66	19
78816	Tumor image pet/ct full body	S	0308	12,349	100	86

Among the lower volume diagnostic nuclear medicine procedures (which are outside the top 20 in terms of volume), there is still good representation of diagnostic radiopharmaceutical HCPCS codes on the single bills for most procedures. About 40 percent of the low volume diagnostic nuclear medicine procedures have at least 80 percent of the single bills for that diagnostic procedure that include a diagnostic radiopharmaceutical HCPCS code; about 37 percent of the low volume diagnostic procedures have between 50 to 79 percent of the single bills that include a diagnostic radiopharmaceutical HCPCS code; and about 23 percent of the low volume diagnostic procedures have less than 50 percent of the single bills that include a diagnostic radiopharmaceutical HCPCS code. For the few diagnostic nuclear medicine procedures where less than 50 percent of the single bills include a diagnostic radiopharmaceutical HCPCS code, we believe there could be several reasons why the percentage of single bills for the diagnostic nuclear medicine procedure with a diagnostic radiopharmaceutical HCPCS code is low.

As noted earlier, it is possible that hospitals may be including the charge for the radiopharmaceutical in the

charge for the diagnostic nuclear medicine procedure itself or on an uncoded revenue code line instead of reporting charges for a specific diagnostic radiopharmaceutical HCPCS code. We found that 24 percent of all single bills for a diagnostic nuclear medicine procedure but without a coded diagnostic radiopharmaceutical had uncoded costs in a revenue code that might contain diagnostic radiopharmaceutical costs, specifically, revenue codes 0254 (Drugs Incident to Other Diagnostic Services), 0255 (Drugs Incident to Radiology), 0343 (Diagnostic Radiopharmaceuticals), 0621 (Supplies Incident to Radiology), and 0622 (Supplies Incident to Other Diagnostic Services). In comparison, we found that only 2 percent of diagnostic nuclear medicine single bills with a nuclear medicine procedure and a coded diagnostic radiopharmaceutical had uncoded costs in these revenue codes. It is also possible that some of these procedures typically use a diagnostic radiopharmaceutical subject to packaged payment under the CY 2006 OPPS, and hospitals may have chosen not to report a separate charge for the diagnostic radiopharmaceutical. Payment for diagnostic radiopharmaceuticals commonly used with some diagnostic nuclear medicine procedures would already be packaged because these diagnostic radiopharmaceuticals' average per day cost were less than $50 in CY 2006. The CY 2008 proposal to package additional diagnostic radiopharmaceuticals would have little impact on the payment for those diagnostic procedures that typically use inexpensive diagnostic radiopharmaceuticals that would be packaged under our proposed CY 2008 packaging threshold of $60, except to the extent that the budget neutrality adjustment due to the broader packaging proposal leads to an increase in the scaler and an increase in the payment for procedures in general.

At its March 2007 meeting, the APC Panel recommended that CMS work with stakeholders on issues related to payment for radiopharmaceuticals, including evaluating claims data for different classes of radiopharmaceuticals and ensuring that a nuclear medicine procedure claim always includes at least one reported radiopharmaceutical agent. We are accepting the APC Panel's recommendation, and we specifically welcome public comment on the hospitals' burden involved should we require such precise reporting. We also are seeking comment on the importance of such a requirement in light of our above discussion on the representation of diagnostic radiopharmaceuticals in the single bills for diagnostic nuclear medicine procedures, the presence of uncoded revenue code charges specific to diagnostic radiopharmaceuticals on claims without a coded diagnostic radiopharmaceutical, and our proposal to package payment for all diagnostic radiopharmaceuticals.

It has come to our attention that several diagnostic radiopharmaceuticals may be used for multiple day studies; that is, a particular diagnostic radiopharmaceutical may be administered on one day and a related diagnostic nuclear medicine procedure may be performed on a subsequent day. While we understand that multiple day episodes for diagnostic radiopharmaceuticals and the related diagnostic nuclear medicine procedures occur, we expect that this would be a small proportion of all diagnostic nuclear medicine imaging procedures. We estimate that, roughly, 15 diagnostic radiopharmaceuticals have a half-life longer than one day such that they could support diagnostic nuclear medicine scans on different days. We believe these diagnostic radiopharmaceuticals would be concentrated in a specific set of diagnostic procedures. Excluding the 5 percent of diagnostic radiopharmaceutical claims with no matching diagnostic nuclear medicine scan for the same beneficiary, we found that a diagnostic nuclear medicine scan was reported on the same day as a coded diagnostic radiopharmaceutical 90 percent or more of the time for 10 of these 15 diagnostic radiopharmaceuticals. Further, between 80 and 90 percent single bills for each of the remaining 5 diagnostic radiopharmaceuticals had a diagnostic nuclear medicine scan on the same day. In the ''natural'' single bills we use for ratesetting, we package payment across dates of service. In light of such high percentages of extended half-life diagnostic radiopharmaceuticals with same day diagnostic nuclear medicine scans and the ability of ''natural'' singles to package costs across days, we believe that our standard OPPS ratesetting methodology of using median costs calculated from claims data adequately captures the costs of diagnostic radiopharmaceuticals associated with diagnostic nuclear medicine procedures that are not provided on the same date of service.

This packaging proposal reduces the overall frequency of single bills for diagnostic nuclear medicine procedures, but the percent of single bills out of total claims remains robust for the majority of diagnostic nuclear medicine procedures. Typically, packaging more procedures should improve the number of single bill claims from which to derive median cost estimates because packaging reduces the number of separately paid procedures on a claim, thereby creating more single procedure bills. In the case of diagnostic nuclear medicine procedures, packaging diagnostic radiopharmaceuticals reduces the overall number of single bills available to calculate median costs by increasing packaged costs that previously were ignored in the bypass process. In prior years, we did not consider the costs of radiopharmaceuticals when we used our bypass methodology to extract ''pseudo'' single claims because we assumed that the cost of radiopharmaceutical overhead and handling would be included in the line-item charge for the radiopharmaceutical, and the diagnostic radiopharmaceuticals were subject to potential separate payment if their mean per day cost fell above the packaging threshold. The bypass process sets empirical and clinical criteria for minimal packaging for a specific list of procedures and services in order to assign packaged costs to other procedures on a claim and is discussed at length in section II.A.1. of this proposed rule. Generally, changing the status of diagnostic radiopharmaceuticals to packaged increases packaging on each claim. This could make it both harder for nuclear medicine procedures to qualify for the bypass list and more difficult to assign packaging to individual diagnostic nuclear medicine procedures, resulting in a possible reduction of the number of ''pseudo'' singles that are produced by the bypass process. Notwithstanding this potentiality, diagnostic nuclear medicine procedures continue to have good representation in the single bills. On average, single bills as a percent of total occurrences remains substantial at 55 percent for individual procedures. We discuss our process for ratesetting, including the construction and use of single and multiple bills, in greater detail in section II.A.1. of this proposed rule.

We believe our CY 2006 claims data support our CY 2008 proposal to package payment for all diagnostic radiopharmaceuticals and lead to proposed payment rates for diagnostic nuclear medicine procedures that appropriately reflect payment for the costs of the diagnostic radiopharmaceuticals that are administered to carry out those diagnostic nuclear medicine procedures. Among the top 20 high volume

diagnostic nuclear medicine procedures, at least 84 percent of the single bills for almost every diagnostic nuclear medicine procedure included a diagnostic radiopharmaceutical HCPCS code. While a diagnostic radiopharmaceutical, by definition, would be anticipated to accompany 100 percent of the diagnostic nuclear medicine procedures, it is not unexpected that while percentages in our claims data are high, they are less than 100 percent. As noted previously, we have heard anecdotal reports that some hospitals may include the charges for diagnostic radiopharmaceuticals in their charge for the diagnostic nuclear medicine procedure or on an uncoded revenue code line, rather than reporting a HCPCS code for the diagnostic radiopharmaceutical. Thus, it is likely that the frequency of diagnostic radiopharmaceutical costs reflected in our claims data are even higher than the percentages indicate. Furthermore, we note that the OPPS ratesetting methodology is based on medians, which are less sensitive to extremes than means and typically do not reflect subtle changes in cost distributions. Therefore, to the extent that the vast majority of single bills for a particular diagnostic nuclear medicine procedure include a diagnostic radiopharmaceutical HCPCS code, the fact that the percentage is somewhat less than 100 percent is likely to have minimal impact on the median cost of the procedure in most cases. Even in those few instances where we have a low total number of single bills, largely because of low overall volume, we have ample representation of diagnostic radiopharmaceutical HCPCS codes on the single bills for the majority of lower volume nuclear medicine procedures. We also continue to have reasonable representation of single bills out of total claims in general. Finally, as noted previously, to the extent that the diagnostic radiopharmaceuticals commonly used with a particular diagnostic nuclear medicine procedure are already packaged, the proposal to package additional diagnostic radiopharmaceuticals would have little impact on the payment for these procedures.

We have calculated the median costs on which we are proposing to base the CY 2008 payment rates using the packaging status of each diagnostic radiopharmaceutical HCPCS code as provided in Table 17 below. As we discussed earlier in more detail, this has the effect of both changing the median cost for the independent service (the diagnostic nuclear medicine procedure) into which the cost of the dependent service (the diagnostic radiopharmaceutical) is packaged and also of redistributing payment that would otherwise have been made separately for the service we are proposing to newly package for CY 2008.

For example, HCPCS code A9552 (Fluorodeoxyglucose F–18 FDG, Diagnostic, per study dose, up to 45 millicuries) that describes the diagnostic radiopharmaceutical commonly called FDG is frequently billed with CPT code 78815 (Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; skull base to mid-thigh). HCPCS code A9552 is assigned to APC 1651 (F18 fdg) for CY 2007. HCPCS code A9552 was billed with CPT code 78815 101,242 times in the single bills available for this CY 2008 proposed rule, and 97 percent of the single bills for CPT code 78815 also reported HCPCS code A9552. Under our proposed policy for CY 2008, we are proposing to package payment for HCPCS code A9552 into the payment for separately payable procedures that are provided in conjunction with HCPCS code A9552. In this example, HCPCS code A9552 would receive packaged payment through the separate OPPS payment for CPT code 78815. CPT code 78815 is assigned to APC 1511 (New Technology—Level XI ($900–$1000)) for CY 2007 with a CY 2007 median cost for PET/CT procedures of $850.36 and to APC 0308 (Non-Myocardial Positron Emission Tomography (PET) Imaging) for CY 2008 with a proposed CY 2008 APC median cost of $1,093.52.

The proposed CY 2008 payment rates associated with this example are outlined in Table 16 below. The table indicates that the proposed CY 2008 payment rate for the skull base to mid-thigh PET/CT scan would be substantially higher than the CY 2007 payment amount for that code. The proposed increase for the PET/CT scan is slightly more than the estimated average CY 2007 payment for the separately payable FDG (paid in CY 2007 at charges reduced to cost).

This example cannot demonstrate the overall impact of packaging diagnostic radiopharmaceuticals on payment to any given hospital because each individual hospital's case mix and billing patterns would be different. The overall impact of packaging diagnostic radiopharmaceuticals, as well as all other packaging changes proposed for CY 2008, can only be assessed in the aggregate for each hospital. Section XXII.B. of this proposed rule displays the overall impact of APC weight recalibration and packaging changes that we are proposing by classes of hospitals, and the OPPS Hospital-Specific Impacts—Provider-Specific Data file presents our estimates of CY 2008 hospital payment for those hospitals we include in our ratesetting and payment simulation database. The hospital-specific impacts file can be found on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/* under supporting documentation for this proposed rule.

TABLE 16.—EXAMPLE OF THE EFFECTS OF THE CY 2008 PACKAGING PROPOSAL ON PAYMENT FOR HCPCS CODE A9552 AND CPT CODE 78815

HCPCS code	Short descriptor	Sum of CY 2007 payment (A9552 paid separately at cost)	Sum of CY 2008 proposed payment (A9552 packaged)
A9552	F18 fdg (dependent service)	*$279.29	0.00
78815	Tumor image pet/ct skul-thigh (independent service)	950.00	1,107.22
Total Payment		1,229.29	1,107.22

*Estimated average CY 2007 payment at charges reduced to cost.

The estimated overall impact of these changes that we are proposing for CY 2008 is based on the assumption that hospital behavior would not change with regard to when the dependent diagnostic radiopharmaceuticals are provided by the same hospital that performs the independent services. In order to provide diagnostic nuclear medicine procedures under this proposal, hospitals would either need to administer the necessary diagnostic radiopharmaceuticals themselves or refer patients elsewhere for the administration of the diagnostic radiopharmaceuticals. In the latter case, claims data would show such a change in practice in future years and that change would be reflected in future ratesetting. However, with respect to diagnostic radiopharmaceuticals, we believe that hospitals are limited in the extent to which they could change their behavior with regard to how they furnish these items because diagnostic radiopharmaceuticals are typically provided on the same day as a diagnostic nuclear medicine procedure. It would be difficult for Hospital A to send patients to receive diagnostic radiopharmaceuticals from Hospital B and then have the patients return to Hospital A for the diagnostic nuclear medicine procedure in the appropriate timeframe (given the radiopharmaceutical's half life) to perform a high quality study. We would expect that hospitals would always bill the diagnostic radiopharmaceutical on the same claim as the other independent services for which the radiopharmaceutical was administered.

As we indicate above, in all cases, we are proposing that hospitals that furnish diagnostic radiopharmaceuticals in association with diagnostic nuclear medicine procedures bill both the item and the procedure on the same claim so that the costs of the diagnostic radiopharmaceuticals can be appropriately packaged into payment for the diagnostic nuclear medicine procedure. We expect to carefully monitor any changes in billing practices on a service-specific and hospital-specific basis to determine whether there is reason to request that QIOs review the quality of care furnished or to request that Program Safeguard Contractors review the claims against the medical record.

TABLE 17.—DIAGNOSTIC RADIOPHARMACEUTICAL HCPCS CODES PROPOSED FOR PACKAGED PAYMENT IN CY 2008

HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	CY 2008 proposed SI
A4641	Radiopharm dx agent noc	N	n/a	N
A4642	In111 satumomab	H	0704	N
A9500	Tc99m sestamibi	H	1600	N
A9502	Tc99m tetrofosmin	H	0705	N
A9503	Tc99m medronate	N	n/a	N*
A9504	Tc99m apcitide	N	n/a	N*
A9505	TL201 thallium	H	1603	N
A9507	In111 capromab	H	1604	N
A9508	I131 iodobenguate, dx	H	1045	N
A9510	Tc99m disofenin	N	n/a	N*
A9512	Tc99m pertechnetate	N	n/a	N*
A9516	I123 iodide cap, dx	H	9148	N
A9521	Tc99m exametazime	H	1096	N
A9524	I131 serum albumin, dx	H	9100	N
A9526	Nitrogen N–13 ammonia	H	0737	N
A9528	Iodine I–131 iodide cap, dx	H	1088	N
A9529	I131 iodide sol, dx	N	n/a	N
A9531	I131 max 100uCi	N	n/a	N*
A9532	I125 serum albumin, dx	N	n/a	N
A9536	Tc99m depreotide	H	0739	N
A9537	Tc99m mebrofenin	N	n/a	N*
A9538	Tc99m pyrophosphate	N	n/a	N*
A9539	Tc99m pentetate	H	0722	N*
A9540	Tc99m MAA	N	n/a	N*
A9541	Tc99m sulfur colloid	N	n/a	N*
A9542	In111 ibritumomab, dx	H	1642	N
A9544	I131 tositumomab, dx	H	1644	N
A9546	Co57/58	H	0723	N
A9547	In111 oxyquinoline	H	1646	N
A9548	In111 pentetate	H	1647	N
A9550	Tc99m gluceptate	H	0740	N
A9551	Tc99m succimer	H	1650	N
A9552	F18 fdg	H	1651	N
A9553	Cr51 chromate	H	0741	N
A9554	I125 iothalamate, dx	N	n/a	N
A9555	Rb82 rubidium	H	1654	N
A9556	Ga67 gallium	H	1671	N
A9557	Tc99m bicisate	H	1672	N
A9558	Xe133 xenon 10mci	N	n/a	N*
A9559	Co57 cyano	H	0724	N
A9560	Tc99m labeled rbc	H	0742	N
A9561	Tc99m oxidronate	N	n/a	N*
A9562	Tc99m mertiatide	H	0743	N
A9565	In111 pentetreotide	H	1677	N
A9566	Tc99m fanolesomab	H	1678	N
A9567	Technetium TC–99m aerosol	H	0829	N*

TABLE 17.—DIAGNOSTIC RADIOPHARMACEUTICAL HCPCS CODES PROPOSED FOR PACKAGED PAYMENT IN CY 2008—Continued

HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	CY 2008 proposed SI
A9568	Tc99m arcitumomab	H	1648	N

* Indicates that the radiopharmaceutical would have been packaged under the $60 packaging threshold methodology in CY 2008, even in the absence of the broader packaging proposal for radiopharmaceuticals.

(6) Contrast Agents

For CY 2008, we are proposing to package payment for all contrast media into their associated independent diagnostic and therapeutic procedures as part of our proposed packaging approach for the CY 2008 OPPS. As noted in section II.A.4.c. of this proposed rule, packaging the costs of supportive items and services into the payment for the independent procedure or service with which they are associated encourages hospital efficiencies and also enables hospitals to manage their resources with maximum flexibility. We believe that contrast agents are particularly well suited for packaging because they are always provided in support of an independent diagnostic or therapeutic procedure that involves imaging, and thus payment for contrast agents can be packaged into the payment for the associated separately payable procedures.

Contrast agents are generally considered to be those substances introduced into or around a structure that, because of the differential absorption of x-rays, alteration of magnetic fields, or other effects of the contrast medium in comparison with surrounding tissues, permit visualization of the structure through an imaging modality. The use of certain contrast agents is generally associated with specific imaging modalities, including x-ray, computed tomography (CT), ultrasound, and magnetic resonance imaging (MRI), for purposes of diagnostic testing or treatment. They are most commonly administered through an oral or intravascular route in association with the performance of the independent procedures involving imaging that are the basis for their administration. Even in the absence of this proposal to package payment for all contrast agents, we would propose to package the majority of HCPCS codes for contrast agents recognized under the OPPS in CY 2008. We consider contrast agents to be drugs under the OPPS, and as a result they are packaged if their estimated mean per day cost is equal to or less than $60 for CY 2008. (For more discussion of our drug packaging criteria, we refer readers to section V.B.2 of this proposed rule.) Seventy-five percent of contrast agents HCPCS codes have an estimated mean per day cost equal to or less than $60 based on our CY 2006 claims data.

Contrast agents are described by those Level II HCPCS codes in the range from Q9945 through Q9964. There currently are no HCPCS C-codes or other Level II HCPCS codes outside the range specified above used to report contrast agents under the OPPS. As shown in Table 19, in CY 2007, we packaged 7 out of 20 of these contrast agent HCPCS codes based on the $55 packaging threshold. For CY 2008, we are proposing to package all drugs with a per day mean cost of $60 or less. For CY 2008, the vast majority of contrast agents would be packaged under the traditional OPPS packaging methodology using the $60 packaging threshold, based on the CY 2006 claims data available for this proposed rule. In fact, of the 20 contrast agent HCPCS codes we are including in our proposed packaging approach, 15 would have been proposed to be packaged for CY 2008 under our drug packaging methodology. These 15 codes represent 94 percent of all occurrences of contrast agents billed under the OPPS. We believe that this shift in the packaging status for several of these agents between CYs 2007 and 2008 may be because, in CY 2007, a number of the contrast agents exceeded the $55 threshold by only a small amount and, based on our latest claims data for CY 2008, a number of these products have now fallen below the proposed $60 threshold. Given that the vast majority of contrast agents billed would already be packaged under the OPPS in CY 2008, we believe it would be desirable to package payment for the remaining contrast agents as it promotes efficiency and results in a consistent payment policy across products that may be used in many of the same independent procedures. We also note that the significant costs associated with these 15 contrast agents would already be reflected in the proposed median costs for those independent procedures and, if we were to pay for the 5 remaining agents separately, we would be treating these 5 agents differently than the others. If the 5 agents remained separately payable, there would effectively be two payments for contrast agents when these 5 agents were billed—a separate payment and a payment for packaged contrast agents that was part of the procedure payment. This could potentially provide a payment incentive to administer certain contrast agents that might not be the most clinically appropriate or cost effective. Moreover, as noted previously, contrast agents are always provided with independent procedures and, under a consistent approach to packaging in keeping with our enhanced efforts to encourage hospital efficiency and promote value-based purchasing under the OPPS, their payment would be appropriately packaged for CY 2008.

We have calculated the median costs on which the proposed CY 2008 payment rates are based using the packaging status of each contrast agent HCPCS code as provided in Table 19 below. As we discussed earlier in more detail, this has the effect of both changing the median cost for the independent service (the diagnostic or therapeutic procedure requiring imaging) into which the cost of the dependent service (the contrast agent) is packaged and also of redistributing payment that would otherwise have been made separately for the service we are proposing to newly package for CY 2008.

For example, HCPCS code Q9947 (Low osmolar contrast material, 200–249 mg/ml iodine concentration, per ml) is one of the contrast agents that we are proposing to package that would not otherwise be packaged in CY 2008 under the proposed $60 packaging threshold. HCPCS code Q9947 is sometimes billed with CPT code 71260 (Computed tomography, thorax; with contrast material(s)). HCPCS code Q9947 is assigned to APC 9159 (LOCM 200–249 mg/ml iodine, 1ml) for CY 2007. HCPCS code Q9947 was billed with CPT code 71260 8,172 times in the single bills available for this CY 2008 proposed rule, and 2 percent of the single bills for CPT code 71260 also reported HCPCS code Q9947. Under our proposed policy for CY 2008, we are proposing to package payment for

HCPCS code Q9947 into the payment for separately payable procedures that are provided in conjunction with the contrast agent. Specifically, we would package payment for HCPCS code Q9947 so that, in this example, HCPCS code Q9947 would receive packaged payment through the separate OPPS payment for CPT code 71260. CPT code 71260 is assigned to APC 0283 (Computed Tomography with Contrast) for CY 2007 with a CY 2007 median cost of $249.48. The procedure is assigned to APC 0283, with a proposed APC name change to ''Level I Computed Tomography with Contrast'' for CY 2008 and a proposed CY 2008 median cost of $286.13.

The proposed CY 2008 payment rates associated with this example are outlined in Table 18 below. The table indicates that the CY 2008 payment that we are proposing for CPT code 71260 is higher than the CY 2007 payment amount for that code. The proposed increase in the payment rate for CPT code 71260 in CY 2008 is slightly greater than the estimated CY 2007 payment for the separately payable HCPCS code Q9947. Notably, a number of low osmolar contrast agents other than HCPCS code Q9947 that were separately paid in CY 2007 also are proposed for packaged payment in CY 2008 because their mean per day cost falls below the $60 packaging threshold for drugs, biologicals, and radiopharmaceuticals for CY 2008. Packaging the costs of these contrast media also affects the proposed payment rate for CPT code 71260. For another example of packaging contrast agents, we refer readers to the example included in Table 13 of section II.A.4.c.(4) of this proposed rule on packaging imaging supervision and interpretation services. That example illustrates the effect of packaging both a supervision and interpretation service (CPT code 72265 (Myelography, lumbosacral, radiological supervision and interpretation)) and a contrast agent (HCPCS code Q9947 (low osmolar contrast material, 200–249 mg/ml iodine, per ml)) into the payment for an imaging procedure (CPT code 72132 (Computed tomography, lumbar spine; with contrast material)).

This example cannot demonstrate the overall impact of packaging contrast agents on any given hospital because each individual hospital's case mix and billing pattern differs. The overall impact of packaging contrast agents, as well as all the other proposed packaging changes, can only be assessed in the aggregate for classes of hospitals. Section XXII.B. of this proposed rule displays the overall impact of APC weight recalibration and packaging changes we are proposing by classes of hospitals, and the OPPS Hospital-Specific Impacts—Provider-Specific Data file presents our estimates of CY 2008 hospital payment for those hospitals we include in our ratesetting and payment simulation database. The hospital-specific impact file can be found on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/* under supporting documentation for this proposed rule.

TABLE 18.—EXAMPLE OF THE EFFECTS OF THE CY 2008 PACKAGING PROPOSAL ON PAYMENT FOR CPT CODE 72160 AND HCPCS CODE Q9947

HCPCS code	Short descriptor	Sum of CY 2007 payment (Q9947 paid separately)	Sum of CY 2008 proposed payment (Q9947 packaged)
Q9947	LOCM 200–249 mg/ml iodine, 1 ml (dependent service)	*$64.24	$0.00
71260	Ct thorax w/dye (independent service)	250.94	289.71
Total Payment		315.18	289.71

*Based on the mean number of units per day from our CY 2008 proposed rule data (48.3) and the April 2007 per unit payment rate for Q9947 ($1.33).

The estimated overall impact of these changes that we are proposing for CY 2008 is based on the assumption that hospital behavior would not change with regard to when the contrast agents are provided by the same hospital that performs the imaging procedure. Under this proposal, in order to provide imaging procedures requiring contrast agents, hospitals would either need to administer the necessary contrast agent themselves or refer patients elsewhere for the administration of the contrast agent. In the latter case, claims data would show such a change in practice in future years and that change would be reflected in future ratesetting. However, with respect to contrast agents, we believe that hospitals are limited in the extent to which they could change their behavior with regard to how they furnish these services because contrast agents are typically provided on the same day immediately prior to an imaging procedure being performed. We would expect that hospitals would always bill the contrast agent on the same claim as the other independent services for which the contrast agent was administered.

As we indicated earlier, in all cases we are proposing that hospitals that furnish the supportive contrast agent in association with independent procedures involving imaging must bill both services on the same claim so that the cost of the contrast agent can be appropriately packaged into payment for the significant independent procedure. We expect to carefully monitor any changes in billing practices on a service-specific and hospital specific basis to determine whether there is reason to request that QIOs review the quality of care furnished or to request that Program Safeguard Contractors review the claims against the medical record.

TABLE 19.—CONTRAST MEDIA HCPCS CODES PROPOSED FOR PACKAGED PAYMENT IN CY 2008

HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	Proposed CY 2008 SI
Q9945	LOCM <=149 mg/ml iodine, 1 ml	K	9157	N*
Q9946	LOCM 150–199 mg/ml iodine, 1 ml	K	9158	N*
Q9947	LOCM 200–249 mg/ml iodine, 1 ml	K	9159	N

TABLE 19.—CONTRAST MEDIA HCPCS CODES PROPOSED FOR PACKAGED PAYMENT IN CY 2008—Continued

HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	Proposed CY 2008 SI
Q9948	LOCM 250–299 mg/ml iodine, 1 ml	K	9160	N*
Q9949	LOCM 300–349 mg/ml iodine, 1 ml	K	9161	N*
Q9950	LOCM 350–399 mg/ml iodine, 1 ml	K	9162	N*
Q9951	LOCM >= 400 mg/ml iodine, 1 ml	K	9163	N*
Q9952	Inj Gad-base MR contrast, 1 ml	K	9164	N*
Q9953	Inj Fe-based MR contrast, 1 ml	K	1713	N
Q9954	Oral MR contrast, 100 ml	K	9165	N*
Q9955	Inj perflexane lip micros, ml	K	9203	N*
Q9956	Inj octafluoropropane mic, ml	K	9202	N
Q9957	Inj perflutren lip micros, ml	K	9112	N
Q9958	HOCM <=149 mg/ml iodine, 1 ml	N	n/a	N*
Q9959	HOCM 150–199 mg/ml iodine, 1 ml	N	n/a	N
Q9960	HOCM 200–249 mg/ml iodine, 1 ml	N	n/a	N*
Q9961	HOCM 250–299 mg/ml iodine, 1 ml	N	n/a	N*
Q9962	HOCM 300–349 mg/ml iodine, 1 ml	N	n/a	N*
Q9963	HOCM 350–399 mg/ml iodine, 1 ml	N	n/a	N*
Q9964	HOCM>= 400 mg/ml iodine, 1 ml	N	n/a	N*

*Indicates that the contrast agent would have been packaged under the $60 packaging threshold methodology in CY 2008, even in the absence the broader packaging proposal for contrast agents.

(7) Observation Services

We are proposing to package payment for all observation care, reported under HCPCS code G0378 (Hospital observation services, per hour) for CY 2008. Payment for observation would be packaged as part of the payment for the separately payable services with which it is billed. We have defined observation care as a well-defined set of specific, clinically appropriate services that include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation status is commonly assigned to patients who present to the emergency department and who then require a significant period of treatment or monitoring before a decision is made concerning their next placement or to patients with unexpectedly prolonged recovery after surgery. Throughout this proposed rule, as well as in our manuals and guidance documents, we use both of the terms ''observation services'' and ''observation care'' in reference to the services defined above.

Payment for all observation care under the OPPS was packaged prior to CY 2002. Since CY 2002, separate payment of a single unit of an observation APC for an episode of observation care has been provided in limited circumstances. Effective for services furnished on or after April 1, 2002, separate payment for observation was made if the beneficiary had chest pain, asthma, or congestive heart failure and met additional criteria for diagnostic testing, minimum and maximum limits to observation care time, physician care, and documentation in the medical record (66 FR 59856, 59879). Payment for observation care that did not meet these specified criteria was packaged. Between CY 2003 and CY 2006, several more changes were made to the OPPS policy regarding separate payment for observation services, such as: Clarification that observation is not separately payable when billed with ''T'' status procedures on the day of or day before observation care; development of specific Level II HCPCS codes for hospital observation services and direct admission to observation care; and removal of the initially established diagnostic testing requirements for separately payable observation (67 FR 66794, 69 FR 65828, and 70 FR 68688). Throughout this time period, we maintained separate payment for observation care only for the three specified medical conditions, and OPPS payment for observation for all other clinical conditions remained packaged.

Since January 1, 2006, hospitals have reported observation services based on an hourly unit of care using HCPCS code G0378. This code has a status indicator of ''Q'' under the CY 2007 OPPS, meaning that the OPPS claims processing logic determines whether the observation is packaged or separately payable. The OCE's current logic determines whether observation services billed under HCPCS code G0378 are separately payable through APC 0339 (Observation) or whether payment for observation services will be packaged into the payment for other separately payable services provided by the hospital in the same encounter based on criteria discussed subsequently. (We note that if an HOPD directly admits a patient to observation, Medicare currently pays separately for that direct admission reported under HCPCS code G0379 (Direct admission of patient for hospital observation care) in situations where payment for the actual observation care reported under HCPCS code G0378 is packaged.) For CY 2008, as discussed in more detail later in this proposed rule (section XI.), we are proposing to continue the coding and payment methodology for direct admission to observation status, with the exception of the requirement that HCPCS code G0379 is only eligible for separate payment if observation care reported under HCPCS code G0378 does not qualify for separate payment. This requirement would no longer be applicable under our proposal to package all observation services reported under HCPCS code G0378.

Currently, separate OPPS payment may be made for observation services reported under HCPCS code G0378 provided to a patient when all of the following requirements are met. The hospital would receive a single separate payment for an episode of observation care (APC 0339) when:

1. Diagnosis Requirements

a. The beneficiary must have one of three medical conditions: congestive heart failure, chest pain, or asthma.

b. Qualifying ICD–9–CM diagnosis codes must be reported in Form Locator (FL) 76, Patient Reason for Visit, or FL 67, principal diagnosis, or both in order for the hospital to receive separate payment for APC 0339. If a qualifying ICD–9–CM diagnosis code(s) is reported in the secondary diagnosis field, but is

not reported in either the Patient Reason for Visit field (FL 76) or in the principal diagnosis field (FL 67), separate payment for APC 0339 is not allowed.

2. Observation Time

a. Observation time must be documented in the medical record.

b. A beneficiary's time in observation (and hospital billing) begins with the beneficiary's admission to an observation bed.

c. A beneficiary's time in observation (and hospital billing) ends when all clinical or medical interventions have been completed, including followup care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient.

d. The number of units reported with HCPCS code G0378 must equal or exceed 8 hours.

3. Additional Hospital Services

a. The claim for observation services must include one of the following services in addition to the reported observation services. The additional services listed below must have a line-item date of service on the same day or the day before the date reported for observation:

- An emergency department visit (APC 0609, 0613, 0614, 0615, or 0616); or
- A clinic visit (APC 0604, 0605, 0606, 0607, or 0608); or
- Critical care (APC 0617); or
- Direct admission to observation reported with HCPCS code G0379 (APC 0604).

b. No procedure with a ''T'' status indicator can be reported on the same day or day before observation care is provided.

4. Physician Evaluation

a. The beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.

b. The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.

In the context of our proposed CY 2008 packaging approach, for several reasons we believe that it is appropriate to package payment for all observation services reported with HCPCS code G0378 under the CY 2008 OPPS. Primarily, observation services are ideal for packaging because they are always provided as a supportive service in conjunction with other independent separately payable hospital outpatient services such as an emergency department visit, surgical procedure, or another separately payable service, and thus observation costs can logically be packaged into OPPS payment for independent services. As discussed extensively earlier in this section, packaging payment into larger payment bundles creates incentives for providers to furnish services in the most efficient way that meets the needs of the patient, encouraging long-term cost containment.

As we discussed in the general overview of the CY 2008 packaging approach earlier in this section (section II.A.4.b. of this proposed rule), there has been substantial growth in program expenditures for hospital outpatient services under the OPPS in recent years. The primary reason for this upsurge is growth in the intensity and utilization of services rather than the general price of services or enrollment changes. This observed trend is notably reflected in the frequency and costs of separately payable observation care for the last few years. While median costs for an episode of observation care that would meet the criteria for separate payment have remained relatively stable between CY 2003 and CY 2006, the frequency of claims for separately payable observation services has rapidly increased. Comparing claims data for separately payable observation care available for proposed rules spanning from CY 2005 to CY 2008 (that is, claims data reflecting services furnished from CY 2003 to CY 2006), we see substantial growth in separately payable observation care billed under the OPPS over that time. In CY 2003, the full first year when observation care was separately payable, there were approximately 56,000 claims for separately payable observation care. In CY 2004, there were approximately 77,000 claims for separately payable observation care. In CY 2005, that number increased to approximately 124,300 claims, representing about a 61 percent increase in one year. In addition, in the CY 2006 data available for this proposed rule, the frequency of claims for separately payable observation services increased again, to more than 271,200 claims, about a 118-percent increase over CY 2005 and more than triple the number of claims from 2 years earlier. While it is not possible to discern the specific factors responsible for the growth in claims for separately payable observation services, as there have been minor changes in both the process and criteria for separate payment for these services over this time period, the substantial growth by itself is noteworthy.

We are also concerned that the current criteria for separate payment for observation services may provide disincentives for efficiency. In order for observation services to be separately payable, they must last at least 8 hours. While this criterion was put in place to ensure that separate payment is made only for observation services of a substantial duration, it may create a financial disincentive for an HOPD to make a timely determination regarding a patient's safe disposition after observation care ends. By packaging payment for all observation services, regardless of their duration, we would provide incentives for more efficient delivery of services and timely decision-making. The current criterion also prohibits separate payment for observation services when a ''T'' status procedure (generally a surgical procedure) is provided on the same day or the previous day by the HOPD to the same Medicare beneficiary. Again, this may create a financial disincentive for hospitals to provide minor surgical procedures during a patient's observation stay, unless those procedures are essential to the patient's care during that time period, even if the most efficient and effective performance of those procedures could be during the single HOPD encounter.

Currently, the OPPS pays separately for observation care for only the three original medical conditions designated in CY 2002, specifically chest pain, asthma, and congestive heart failure. As discussed in more detail in the observation section (section XI.) of this proposed rule, the APC Panel recommended at its March 2007 meeting that we consider expanding separate payment for observation services to include two additional diagnoses, syncope and dehydration. As mentioned previously, we have defined observation care as a well-defined set of specific, clinically appropriate services, which include ongoing, short-term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether a patient will require further treatment as a hospital inpatient or if the individual is able to be discharged from the hospital. Given the definition of observation services, it is clear that, in certain circumstances, observation care could be appropriate for patients with a range of diagnoses. Both the APC Panel and numerous commenters to prior OPPS proposed rules have confirmed their agreement with this perspective. In addition, the June 2006

Institute of Medicine (IOM) Report entitled, ''Hospital-Based Emergency Care: At the Breaking Point,'' encourages hospitals to apply tools to improve the flow of patients through emergency departments, including developing clinical decisions units where observation care is provided. The IOM's Committee on the Future of Emergency Care in the United States Health System recommended that CMS remove the current limitations on the medical conditions that are eligible for separate observation care payment in order to encourage the development of such observation units.

As packaging payment provides desirable incentives for greater efficiency in the delivery of health care and provides hospitals with significant flexibility to manage their resources, we believe it is most appropriate to treat observation care for all diagnoses similarly by packaging its costs into payment for the separately payable independent services with which the observation is associated. This consistent payment methodology would provide hospitals with the flexibility to assess their approaches to patient care and patient flow and provide observation care for patients with a variety of clinical conditions when hospitals conclude that observation services would improve their treatment of those patients. Approximately 70 percent of the occurrences of observation care billed under the OPPS are currently packaged, and this proposal would extend the incentives for efficiency already present for the vast majority of observation services that are already packaged under the OPPS to the remaining 30 percent of observation services for which we currently make separate payment.

We have calculated the median costs on which the proposed CY 2008 payment rates are based according to our proposed packaging approach under which payment for HCPCS code G0378 would always be packaged (status indicator ''N''). As we discussed previously in more detail, in this section, this has the effect of both changing the median costs for the independent services into which the costs of the dependent and supportive observation services are packaged and also of redistributing payment that would otherwise have been made separately for the observation services we are proposing to newly package for CY 2008.

For example, separately payable observation care is frequently billed with CPT code 99285 (Emergency department visit for the evaluation and management of a patient (Level 5)). In the CY 2008 OPPS proposed rule claims data, CPT code 99285 was billed 157,668 times on claims with HCPCS code G0378 that meet our current criteria for separate payment for observation care. In addition, about 57 percent of the claims for HCPCS code G0378 that meet our current criteria for separate payment also reported CPT code 99285. Under our proposed policy for CY 2008, we are proposing to package payment for HCPCS code G0378 into the payment for separately payable procedures that are provided in conjunction with HCPCS code G0378. Specifically, we would package payment for HCPCS code G0378 when it is provided with a separately paid service such as CPT code 99285, so that in this example observation would receive packaged payment through the separate OPPS payment for the Level 5 emergency department visit. CPT code 99285 is assigned to APC 0616 (Level 5 Emergency Visits), with a CY 2007 APC median cost of $323.36 and a proposed CY 2008 median cost of $344.50. The CY 2007 median cost of APC 0339 for separately payable observation is $440.22.

The proposed CY 2008 payment rates associated with this example are outlined in Table 20 below. The table indicates that the proposed CY 2008 payment for a Level 5 emergency department visit is higher than the CY 2007 payment amount for that code. However, the proposed increase in the Level 5 emergency department visit payment rate for CY 2008 is significantly less than the CY 2007 payment for separately payable observation. This is due to the fact that, although observation services are commonly billed with a Level 5 emergency department visit, the proportion of all Level 5 emergency department visits that include observation (12 percent) is relatively small. Thus, when observation care that would have met the CY 2007 criteria for separate payment is packaged into payment for separately payable services such as a Level 5 emergency department visit, it raises the payment rate for that separately payable service for all occurrences of the service, even those occurrences where observation care is not provided. As a result, the payment rate for the separately payable service, the Level 5 emergency department visit, does not increase by the full amount of the former payment rate for separately payable observation care as that amount is spread over many more occurrences of Level 5 emergency department visits. In addition, OPPS' use of medians leads relative weight estimates to be less sensitive to packaging decisions.

TABLE 20.—EXAMPLE OF THE EFFECTS OF THE CY 2008 PACKAGING PROPOSAL ON PAYMENT FOR OBSERVATION CARE (HCPCS CODE G0378) AND CPT CODE 99295

HCPCS code	Short descriptor	Sum of CY 2007 payment (some G0378 paid separately)	Sum of CY 2008 proposed payment (G0378 packaged)
G0378 (under criteria for separately paid observation care).	Hospital observation per hr (dependent service)	$442.81	$0.00
99285	Emergency dept visit (independent service)	325.26	348.81
Total Payment	.....	768.07	348.81

This example cannot demonstrate the overall impact of packaging observation services on any given hospital because each individual hospital's case-mix and billing pattern would be different. The overall impact of packaging HCPCS code G0378, as well as all other packaging changes that we are proposing for CY 2008, can only be assessed in the aggregate for classes of hospitals. Section XXII.B. of this proposed rule displays the overall impact of APC weight recalibration and packaging changes that we are proposing by classes of hospitals, and the OPPS Hospital-Specific Impacts—Provider-Specific Data file presents our estimates of CY 2008 hospital payment

for those hospitals we include in our ratesetting and payment simulation database. The hospital-specific impact file can be found at *http://www.cms.hhs.gov/HospitalOutpatientPPS/* under supporting documentation for this proposed rule.

The estimated overall impact of these changes that we are proposing for CY 2008 presented in section XXII.B. of this proposed rule is based on the assumption that hospital behavior would not change with regard to when the dependent observation care is provided in the same encounter and by the same hospital that performs the independent services. To the extent that hospitals could change their behavior and cease providing observation services, refer patients elsewhere for that care, or increase the frequency of observation services, the data would show such a change in practice in future years and that change would be reflected in future budget neutrality adjustments. However, with respect to observation care, we believe that hospitals are limited in the extent to which they could change their behavior with regard to how they furnish these services because observation care, by definition, is short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital after receiving the independent services. We believe it is unlikely that hospitals would cease providing medically necessary observation care or refer patients elsewhere for that care if they were unable to reach a decision that the patient could be safely discharged from the outpatient department. We would expect that hospitals would always bill the supportive observation care on the same claim as the other independent services provided in the single hospital encounter.

As we indicated earlier, in all cases we are proposing that hospitals that furnish the observation care in association with independent services must bill those services on the same claim so that the costs of the observation care can be appropriately packaged into payment for the independent services. We expect to carefully monitor any changes in billing practices on a service-specific and hospital-specific basis to determine whether there is reason to request that QIOs review the quality of care furnished or to request that Program Safeguard Contractors review the claims against the medical record.

In summary, we are proposing to package payment for all observation services reported with HCPCS code G0378 for CY 2008. Payment for observation services would be made as part of the payment for the separately payable independent services with which they are billed. As part of this proposal, we would change the status indicator for HCPCS code G0378 from ''Q'' to ''N.'' In addition, we would no longer require the current criteria for separate payment related to hospital visits and ''T'' status procedures, minimum number of hours, and qualifying diagnoses. However, we would retain as general reporting requirements those criteria related to physician evaluation, documentation, and observation beginning and ending time as listed in sections II.A.2.a., b., and c., and 4.a. and b. of this proposed rule. Those are more general requirements that encourage hospitals to provide medically reasonable and necessary care and help to ensure the proper reporting of observation services on correctly coded hospital claims that reflect the full charges associated with all hospital resources utilized to provide the reported services.

d. Proposed Development of Composite APCs

(1) Background

As we discuss above in regard to our reasons for our proposed packaging approach for the CY 2008 OPPS, we believe that it is crucial that the payment approach of the OPPS create incentives for hospitals to seek ways to provide services more efficiently than exist under the current OPPS structure and allow hospitals maximum flexibility to manage their resources. The current OPPS structure usually provides payment for individual services which are generally defined by individual HCPCS codes. We currently package the costs of some items and services (such as drugs and biologicals with an average per day cost of less than $55) into the payment for separately payable individual services. However, because the extent of packaging in the OPPS is currently modest, furnishing many individual separately payable services increases total payment to the hospital. We believe that this aspect of the current OPPS structure is a significant factor in the growth in volume and spending that we discuss in our general overview and provides a primary rationale for our proposed packaging approach for services in the CY 2008 OPPS. While packaging payment for supportive dependent services into the payment for the independent services which they accompany promotes greater efficiency and gives hospitals some flexibility to manage their resources, we believe that payment for larger bundles of major separately paid services that are commonly performed in the same hospital outpatient encounter or as part of a multi-day episode of care would create even more incentives for efficiency, as discussed earlier. Moreover, defining the ''service'' paid under the OPPS by combinations of HCPCS codes for component services that are commonly performed in the same encounter and that result in the provision of a complete service would enable us to use more claims data and to establish payment rates that we believe more appropriately capture the costs of services paid under the OPPS.

Section 1833(t)(1)(B) of the Act permits us to define what constitutes a ''service'' for purposes of payment under the OPPS and is not restricted to defining a ''service'' as a single HCPCS code. For example, the OPPS currently packages payment for certain items and services reported with HCPCS codes into the payment for other separately payable services on the claim. Consistent with our statutory flexibility to define what constitutes a service under the OPPS, we are proposing to view a service, in some cases, as not just the diagnostic or treatment modality identified by one individual HCPCS code but as the totality of care provided in a hospital outpatient encounter that would be reported with two or more HCPCS codes for component services.

In view of this statutory flexibility to define what constitutes a ''service'' for purposes of OPPS payment, our desire to encourage efficiency in HOPD care, our focus on value-based purchasing, and our desire to use as much claims data as possible to set payment rates under the OPPS, we examined our claims data to determine how we could best use the multiple procedure claims (''hardcore'' multiples) that are otherwise not available for ratesetting because they include multiple separately payable procedures furnished on the same date of service. As discussed in more detail in our discussion of single and multiple procedure claims in section II.A.1.b. of this proposed rule, we have focused in recent years on ways to convert multiple procedure claims to single procedure claims to maximize our use of the claims data in setting median costs for separately payable procedures. We have been successful in using the bypass list to generate ''pseudo'' single procedure claims for use in median setting, but this approach generally does not enable us to use the hardcore multiple claims that contain multiple separately payable

procedures, all with associated packaging that cannot be split among them. We believe that we could use the data from many more multiple procedure claims by creating APCs for payment of those services defined as frequently occurring common combinations of HCPCS codes for component services that we see in correctly coded multiple procedure claims.

Our examination of data for multiple procedure claims identified two specific sets of services that we believe are good candidates for payment based on the naturally occurring common combinations of component codes that we see on the multiple procedure claims. These are low dose rate (LDR) prostate brachytherapy and cardiac electrophysiologic evaluation and ablation services.

Specifically, we have been told (and our data support) that claims for LDR prostate brachytherapy, when correctly coded, report at least two major separately payable procedure codes the majority of the time. For reasons discussed below, we are proposing to use these correctly coded claims that would otherwise be unusable hardcore multiples as the basis for an encounter-based composite APC that would make a single payment when both codes are reported with the same date of service. We also are proposing to pay separately for these procedure codes in cases where only one of the two procedures is provided in a hospital encounter, through the APC associated with that component procedure code that is furnished.

Similarly, we have been told (and our data support) that multiple cardiac electrophysiologic evaluation, mapping, and ablation services are typically furnished on the same date of service and that the correctly coded claims are typically the multiple procedure claims that include several component services and that we are unable to use in our current claims process. The CY 2007 CPT book introductory discussion in the section entitled ''Intracardiac Electrophysiological Procedures/ Studies'' notes that, in many circumstances, patients with arrhythmias are evaluated and treated at the same encounter. Therefore, as discussed in detail below, we are also proposing to establish an encounter based composite APC for these services that would provide a single payment for certain common combinations of component cardiac electrophysiologic services that are reported on the same date of service.

These composite APCs reflect an evolution in our approach to payment under the OPPS. Where the claims data show that combinations of services are commonly furnished together, in the future we will actively examine whether it would be more appropriate to establish a composite APC under which we would pay a single rate for the service reported with a combination of HCPCS codes on the same date of service (or different dates of service) than to continue to pay for these individual services under service-specific APCs. We are proposing these specific encounter-based composite APCs for CY 2008 because we believe that this approach could move the OPPS toward possible payment based on an encounter or episode-of-care basis, enable us to use more valid and complete claims data, create hospital incentives for efficiency, and provide hospitals with significant flexibility to manage their resources that do not exist when we pay for services on a per service basis. As such, these proposed composite APCs may serve as a prototype for future creation of more composite APCs, through which we could provide OPPS payment for other types of services in the future. We note that while these proposed composite APCs for CY 2008 are based on observed combinations of component HCPCS codes reported on the same date of service for a single encounter, we also will be exploring in the future how we could set payments based on episodes of care involving services that extend beyond the same date but which are all supportive of a single, related course of treatment. While we are not proposing to implement multi-day episode-of-care APCs in CY 2008, we welcome comments on the concept of developing these APCs to provide payment for such episodes in order to inform our future analyses in this area.

While we have never previously used the term ''composite'' APC under the OPPS, we do have one historical payment policy that resembles the CY 2008 proposed composite APC policy. Since the inception of the OPPS, CMS has limited the aggregate payment for specified less intensive mental health services furnished on the same date to the payment for a day of partial hospitalization, which we considered to be the most resource intensive of all outpatient mental health treatment (65 FR 18455). The costs associated with administering a partial hospitalization program represent the most resource intensive of all outpatient mental health treatment, and we do not believe that we should pay more for a day of individual mental health services under the OPPS. Through the OCE, when the payment for specified mental health services provided by one hospital to a single beneficiary on one date of service based on the payment rates associated with the APCs for the individual services would exceed the per diem partial hospitalization payment (listed as APC 0033 (Partial Hospitalization)), those specified mental health services are assigned to APC 0034, which has the same payment rate as APC 0033, and the hospital is paid one unit of APC 0034. This longstanding policy regarding payment of APC 0034 for combinations of independent services provided in a single hospital encounter resembles the payment policy for composite APCs that we are proposing for LDR prostate brachytherapy and cardiac electrophysiologic evaluation and ablation services for CY 2008. Similar to the logic for the proposed composite APCs, the OCE determines whether to pay these specified mental health services individually or to make a single payment at the same rate as the per diem rate for partial hospitalization for all of the specified mental health services furnished on that date of service. However, we note this established policy for payment of APC 0034 differs from the proposed policies for the new CY 2008 composite APCs because APC 0034 is only paid if the sum of the individual payment rates for the specified mental health services provided on one date of service exceeds the APC 0034 payment rate, which equals the per diem rate of APC 0033 for partial hospitalization.

We are not proposing to change this mental health services payment policy for CY 2008. However, we are proposing to change the status indicator from ''S'' to ''Q'' for the HCPCS codes for the specified mental health services to which APC 0034 applies because those codes are conditionally packaged when the sum of the payment rates for the single code APCs to which they are assigned exceeds the per diem payment rate for partial hospitalization. While we have not published APC 0034 in Addendum A in the past, we are including it in Addendum A to this proposed rule entitled ''Mental Health Composite,'' consistent with our naming taxonomy and publication of the two other proposed composite APCs. We are also including the mental health composite APC 0034 and its member HCPCS codes in Addendum M to this proposed rule in the same way that we show the HCPCS codes to which the LDR Prostate Brachytherapy Composite APC and Cardiac Electrophysiologic Evaluation and Ablation Composite APC apply.

In summary, we are not proposing a change to the longstanding payment policy under which the OPPS pays one unit of APC 0034 in cases in which the total payments for specified mental health services provided on the same date of service would otherwise exceed the payment rate for APC 0033. However, we are proposing to change the status indicator to ''Q'' for the HCPCS codes for mental health services to which this policy applies and which comprise this existing composite APC, because payment for these services would be packaged unless the sum of the individual payments assigned to the codes would be less than the payment for APC 0034.

We look forward to public comments on the concept of composite APCs in general and, specifically, the two new proposed encounter-based composite APCs for CY 2008, and we hope to involve the public and the APC Panel in the creation of additional composite APCs. Our goal would be to use the many naturally occurring multiple procedure claims that cannot currently be incorporated under the existing APC structure, regardless of whether the naturally occurring pattern of multiple procedure claims prevents the development of single bills.

(2) Proposed Low Dose Rate (LDR) Prostate Brachytherapy Composite APC

(a) Background

LDR prostate brachytherapy is a treatment for prostate cancer in which needles or catheters are inserted into the prostate, and then radioactive sources are permanently implanted into the prostate through the hollow needles or catheters. The needles or catheters are then removed from the body, leaving the radioactive sources in the prostate forever, where they slowly give off radiation to destroy the cancer cells until the sources are no longer radioactive. At least two CPT codes are used to report the composite treatment service because there are separate codes that describe placement of the needles or catheters and application of the brachytherapy sources. LDR prostate brachytherapy cannot be furnished without the services described by both of these codes. Generally, the component services represented by both codes occur in the same operative session in the same hospital on the same date of service. However, we have been told of uncommon cases in which they are furnished in different locations, with the patient being transported from one location to another for application of the sources. In addition, other services, commonly CPT code 76965 (Ultrasonic guidance for interstitial radioelement application) and CPT code 77290 (Therapeutic radiology simulation-aided field setting; complex) are often provided in the same hospital encounter.

CPT code 55875 (Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy) reports the placement of the needles or catheters for services furnished on or after January 1, 2007. Before this date, including in the claims for services furnished in CY 2006 that were used to develop this proposed rule, CPT code 55859 (Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy) reported this service. All of the claims for CPT code 55859 (as reported in the CY 2006 claims data) are for the placement of needles or catheters for prostate brachytherapy, although not all are related to permanent brachytherapy source application.

CPT code 77778 (Interstitial radiation source application; complex) reports the application of brachytherapy sources and, when billed with CPT code 55859 (or CPT code 55875 after January 1, 2007) for the same encounter, reports placement of the sources in the prostate. We have been told that application of brachytherapy sources to the prostate is estimated to be about 85 percent of all occurrences of CPT code 77778 under the OPPS, consistent with our CY 2006 claims data used for CY 2008 ratesetting. CPT code 77778 is also used to report the application of sources of brachytherapy to body sites other than the prostate.

Historical coding, APC assignments, and payment rates for CPT codes 55859 (CPT code 55875 beginning in CY 2007) and 77778 are shown below in Table 21.

TABLE 21.—HISTORICAL PAYMENT RATES FOR COMPLEX INTERSTITIAL APPLICATION OF BRACHYTHERAPY SOURCES

OPPS CY	Combination APC	Payment rate for CPT code 77778	APC for HCPCS code 77778	Payment rate for CPT codes 55859/55875	APC for HCPCS code 55859	Brachytherapy source
2000	N/A	$198.31	APC 0312	$848.04	APC 0162	Pass-through.
2001	N/A	205.49	APC 0312	878.72	APC 0162	Pass-through.
2002	N/A	6,344.67	APC 0312	2,068.23	APC 0163	Pass-through with pro rata reduction.
2003 (prostate brachytherapy with iodine sources).	G0261, APC 648, $5,154.34.	n/a	n/a	n/a	n/a	Packaged.
2003 (prostate brachytherapy with palladium sources).	G0256, APC 649, $5,998.24.	n/a	n/a	n/a	n/a	Packaged.
2003 (not prostate brachytherapy, not including sources).	N/A	2,853.58	APC 0651	1,479.60	APC 0163	Separate payment based on scaled median cost per source.
2004	N/A	558.24	APC 0651	1,848.55	APC 0163	Cost.
2005	N/A	1,248.93	APC 0651	2,055.63	APC 0163	Cost.
2006	N/A	666.21	APC 0651	1,993.35	APC 0163	Cost.
2007	N/A	1,035.50	APC 0651	2,146.84	APC 0163	Cost.

Payment rates for CPT code 77778, in particular, have fluctuated over the years. We have frequently been informed by the public that reliance on single procedure claims to set the median costs for these services results in use of only incorrectly coded claims for LDR prostate brachytherapy because, for application of brachytherapy sources to the prostate, a correctly coded claim is a multiple procedure claim. Specifically, we have been informed that a correctly coded claim for LDR prostate brachytherapy should include, for the same date of service, both CPT

codes 55859 and 77778, brachytherapy sources reported with Level II HCPCS codes, and typically separately coded imaging and radiation therapy planning services, and that we should use correctly coded claims to set the median for APC 0651 (Complex Interstitial Radiation Source Application) in particular (where CPT code 77778 is assigned). In presentations to the APC Panel in its March 2006 meeting, and in response to the CY 2006 and CY 2007 OPPS proposed rules, commenters urged us to set the payment rate for LDR prostate brachytherapy services using only multiple procedure claims. Specifically for CY 2007, they urged us to sum the costs on multiple procedure claims containing CPT codes 77778 and 55859 (and no other separately payable services not on the bypass list) and, excluding the costs of sources, split the resulting aggregate median cost on the multiple procedure claim according to a preestablished attribution ratio between CPT codes 77778 and 55859. They indicated that any claim for a brachytherapy service that did not also report a brachytherapy source should be considered to be incorrectly coded and thus not reflective of the hospital's resources required for the interstitial source application procedure. The presenters to the APC Panel believed that claims that did not contain both brachytherapy source and source application codes should be excluded from use in establishing the median cost for APC 0651. They believed that hospitals that reported the brachytherapy sources on their claims were more likely to report complete charges for the associated brachytherapy source application procedure than hospitals that did not report the separately payable brachytherapy sources.

As a result of those comments, for both CY 2006 and CY 2007, we used multiple procedure claims containing both CPT codes 55859 and 77778 to determine a median cost for the totality of both services (with both packaging and bypassing of the other commonly furnished services). We compared the median calculated from this subset of claims reflecting the most common clinical scenario to the single bill median costs for CPT codes 55859 and 77778 as a method of determining whether the total payment to the hospital for both services furnished to provide LDR prostate brachytherapy would be reasonable. In both years, we found that the sum of the single bill medians was reasonably close to the median cost of both services from multiple claims when they were treated as a single procedure and the supporting services were either packaged or bypassed for purposes of calculating the median for the combined pair of codes. (We refer readers to the CY 2006 final rule with comment period (70 FR 68596) and the CY 2007 final rule with comment period (71 FR 68043) for specific discussion of these findings.) Hence, we concluded that the single bill median costs were reasonable and, for both the CY 2006 OPPS and CY 2007 OPPS, we based payment for CPT codes 55859 and 77778 on single procedure claims.

(b) Proposed Payment for LDR Prostate Brachytherapy

For the CY 2008 OPPS, we are proposing to create a composite APC 8001, titled ''LDR Prostate Brachytherapy Composite,'' that would provide one bundled payment for LDR prostate brachytherapy when the hospital bills both CPT codes 55875 and 77778 as component services provided during the same hospital encounter. It is shown in Addendum A to this proposed rule as APC 8001 (LDR Prostate Brachytherapy Composite). As discussed in detail in section VII. of this proposed rule, we are proposing to continue to pay sources of brachytherapy separately in accordance with the requirements of the statute.

In the CY 2006 claims used to calculate the proposed CY 2008 median costs, CPT code 55859 was reported 14,083 times. The proposed rule median cost for CPT code 55859, calculated from 2,232 single and ''pseudo'' single bills, is $2,328.56. The CY 2008 proposed rule median cost for APC 0163 (Level IV Cystourethroscopy and other Genitourinary Procedures) to which CPT code 55859 was assigned for CY 2006 and to which CPT code 55875 is assigned for CY 2007 is $2,322.30. In the set of claims used to calculate the median cost for APC 0651, to which CPT code 77778 is the only assigned service, CPT code 77778 was reported 11,850 times. The CY 2008 proposed rule median cost for APC 0651 (and, therefore, for CPT code 77778) based on 339 single and ''pseudo'' single procedure bills is $969.73.

In examining the claims data used to calculate the median costs for this proposed rule, we found 9,807 claims on which both CPT code 55859 and CPT code 77778 were billed on the same date of service. These data suggest that LDR prostate brachytherapy constituted at least 70 percent of CY 2006 claims for CPT code 55859, with the remainder of claims representing the insertion of needles or catheters for high dose rate prostate brachytherapy or unusual clinical situations where the LDR sources were not applied in the same operative session as the insertion of the needles or catheters. These data are consistent with our understanding of current clinical practice for prostate brachytherapy, and we believe that those multiple claims are correctly coded claims for this common clinical scenario. Similarly, 83 percent of the claims for complex interstitial brachytherapy source application CPT code 77778 also included the CPT code for inserting needles or catheters into the prostate, consistent with our understanding that the vast majority of cases of complex interstitial brachytherapy source application procedures are specifically for the treatment of prostate cancer, rather than other types of cancer.

Using the proposed packaging approach for imaging supervision and interpretation services and guidance services for CY 2008, we were able to identify 1,343 claims, 14 percent of all OPPS claims that reported these two procedures on the same date, that contain both CPT codes 55859 and 77778 on the same date of service and no other separately paid procedure code. We were not able to use more claims to develop this composite APC median cost because there are several radiation therapy planning codes that are commonly reported with CPT codes 55859 and 77778 and that are both separately paid and not on the bypass list because the amount of their associated packaging exceeds the threshold for inclusion on the bypass list. A complete discussion of the bypass list under our CY 2008 packaging proposal is provided in section II.A. of this proposed rule.

We packaged the costs of packaged revenue codes and packaged HCPCS codes into the sum of the costs for CPT codes 55859 and 77778 to derive a total proposed median cost of $3,127.35 for the composite LDR prostate brachytherapy service based upon the 1,343 claims that contained both CPT codes and no other separately paid procedure codes. This is reasonably comparable to $3,298.29, the sum of the CPT median costs we calculated using the single procedure bills for CPT codes 55859 and 77778 (($2,328.56 plus $969.73). We believe that the difference between the composite APC median cost based upon those claims that contain both codes and the sum of the median costs for the APCs to which the two individual CPT codes map is minimal and may be attributable to efficiencies in furnishing the services together during a single encounter.

We believe that creation of the composite APC for the payment of LDR prostate brachytherapy is consistent with the statute and with our desire to use more claims data for ratesetting, particularly data from correctly coded claims that reflect typical clinical practice, and to make payment for larger packages and bundles of services to provide enhanced incentives for efficiency and cost containment under the OPPS and to maximize hospital flexibility in managing resources.

Under our proposal, hospitals that furnish LDR prostate brachytherapy would report CPT codes 55875 and 77778 and the codes for the applicable brachytherapy sources in the same manner that they currently report these items and services (in addition to reporting any other services provided), using the same HCPCS codes and reporting the same charges. We would require that hospitals report both CPT codes resulting in the composite APC payment on the same claim when they are furnished to a single Medicare beneficiary in the same facility on the same date of service, and we would make any necessary conforming changes to the billing instructions to ensure that they do not present an obstacle to correct reporting. We may implement edits to ensure that hospitals do not submit two separate claims for these two procedures when furnished on the same date in the same facility. When this combination of codes is reported, the OCE would assign the composite APC 8001 and the Pricer would pay based on the payment rate for the composite APC. The OCE would assign APC 0163 or APC 0651 only when both codes are not reported on the same claim with the same date of service, and we would expect this to be the atypical case. The composite APC would have a status indicator of ''T'' so that payment for other procedures also assigned to status indicator ''T'' with lower payment rates would be reduced by 50 percent when furnished on the same date of service as the composite service, in order to reflect the efficiency that occurs when multiple procedures are furnished to a Medicare beneficiary in a single operative session. We would not expect that the composite APC payment would be commonly reduced because we believe that it is unlikely that a higher paid procedure would be performed on the same date.

We are proposing to continue to establish separate payment rates for APC 0651 (to which only CPT code 77778 is assigned) and for APC 0163 (to which we are proposing to continue to assign CPT code 55875). In some cases, CPT 55875 may be reported for the insertion of needles or catheters for high dose rate prostate brachytherapy, and the low dose rate brachytherapy source application procedure (CPT code 77778) would not be reported. In high dose rate prostate brachytherapy, the sources are applied temporarily several times over a few days while the needles or catheters remain in the prostate, and the needles or catheters are removed only after all the treatment fractions have been completed. We have also been told by hospitals that, even when LDR prostate brachytherapy is planned, there are occasions in which the needles or catheters are inserted in one facility and the patient is moved to another facility for the application of the sources. In those cases, we would need to be able to appropriately pay the hospital that inserted the needles or catheters before the patient was discharged prior to source application. Moreover, there are cases in which the needles or catheters are inserted but it is not possible to proceed to the application of the sources and, therefore, the hospital would correctly report only CPT code 55875. Similarly, more than 10 brachytherapy sources can be applied interstitially (as described by CPT code 77778) to sites other than the prostate and it is, therefore, necessary to have a separate payment rate for CPT code 77778. Hence, for CY 2008 we are proposing to continue to pay for CPT code 55875 (the successor to CPT code 55859) through APC 0163 and to pay for CPT code 77778 through APC 0651 when the services are individually furnished other than on the same date of service in the same facility.

In summary, we are proposing to establish a composite APC, shown in Addendum A as APC 8001, to provide payment for LDR prostate brachytherapy when the composite service, billed as CPT codes 55875 and 77778, is furnished in a single hospital encounter and to base the payment for the composite APC on the median cost derived from claims that contain both codes. These two CPT codes are assigned to status indicator ''Q'' in Addendum B to this proposed rule to signify their conditionally packaged status, and their composite APC assignments are noted in Addendum M. This proposal would permit us to base payment on claims for the most common clinical scenario for interstitial radiation source application to the prostate. We note that this payment bundle would also include payment for the commonly associated imaging guidance services, which would be newly packaged under our proposed CY 2008 packaging approach. Most importantly, this composite APC payment methodology that we are proposing would contribute to our goal of providing payment under the OPPS for a larger bundle of component services provided in a single hospital outpatient encounter, creating additional hospital incentives for efficiency and cost containment, while providing hospitals with the most flexibility to manage their resources.

(3) Proposed Cardiac Electrophysiologic Evaluation and Ablation Composite APC

(a) Background

During its March 2007 meeting, members of the APC Panel indicated that the reason we found so few single bills for procedures assigned to APC 0087 (Cardiac Electrophysiologic Recording/Mapping), specifically 72 of 11,834 or 0.61 percent of all proposed rule CY 2006 claims, is that most of the services assigned to APCs 0085 (Level II Electrophysiologic Evaluation), 0086 (Ablate Heart Dysrhythm Focus), and 0087 are performed in varying combinations with one another. Therefore, correctly coded claims would most often include multiple codes for component services that are reported with different CPT codes and that are now paid separately through different APCs. There would never be many single bills and those that are reported as single bills would likely represent atypical cases or incorrectly coded claims.

We examined the combinations of services observed in our claims data across these three APCs to see whether there was the potential for handling the data differently so that we could use more claims data to set the payment rates for these procedures, particularly those services assigned to APC 0087 where we have had a persistent concern regarding the limited and reportedly unrepresentative single bills available for use in calculating the median cost according to our standard OPPS methodology. We initially developed and examined frequency distributions of unique combinations of codes on claims which contained at least one unit of any code assigned to APC 0085, 0086, or 0087 and then broadened these analysis to any combination of an electrophysiologic evaluation and ablation code.

Our initial frequency distributions supported the APC Panel members' description of their experiences. We identified and enumerated the most commonly appearing unique occurrences (either single procedures or combinations) of codes for services

assigned to status indicator ''S,'' ''T,'' ''V,'' or ''X'' that contained at least one code assigned to APC 0085, 0086, or 0087. There were 7,379 claims in the top 100 occurrence types. Table 22 shows the 10 most common unique occurrences from CY 2006 claims available for this proposed rule.

TABLE 22.—TEN MOST FREQUENTLY OCCURRING UNIQUE OCCURRENCES OF CARDIAC ELECTROPHYSIOLOGIC EVALUATION, MAPPING, AND ABLATION PROCEDURES AND OTHER SEPARATELY PAYABLE SERVICES

Combination number	Frequency	HCPCS code	Short descriptor	CY 2007 APC	CY 2007 SI
1	763	93620	Electrophysiology evaluation	0085	T
2	509	93609	Map tachycardia, add-on	0087	T
		93620	Electrophysiology evaluation	0085	T
		93621	Electrophysiology evaluation	0085	T
		93623	Stimulation, pacing heart	0087	T
		93651	Ablate heart dysrhythm focus	0086	T
3	398	93609	Map tachycardia, add-on	0087	T
		93620	Electrophysiology evaluation	0085	T
		93621	Electrophysiology evaluation	0085	T
		93651	Ablate heart dysrhythm focus	0086	T
4	381	93650	Ablate heart dysrhythm focus	0086	T
5	376	93620	Electrophysiology evaluation	0085	T
		93623	Stimulation, pacing heart	0087	T
6	248	93005	Electrocardiogram, tracing	0099	S
		93609	Map tachycardia, add-on	0087	T
		93620	Electrophysiology evaluation	0085	T
		93621	Electrophysiology evaluation	0085	T
		93623	Stimulation, pacing heart	0087	T
		93651	Ablate heart dysrhythm focus	0086	T
7	225	93005	Electrocardiogram, tracing	0099	S
		93609	Map tachycardia, add-on	0087	T
		93620	Electrophysiology evaluation	0085	T
		93621	Electrophysiology evaluation	0085	T
		93651	Ablate heart dysrhythm focus	0086	T
8	225	93613	Electrophys map 3d, add-on	0087	T
		93620	Electrophysiology evaluation	0085	T
		93621	Electrophysiology evaluation	0085	T
		93651	Ablate heart dysrhythm focus	0086	T
9	217	93005	Electrocardiogram, tracing	0099	S
		93620	Electrophysiology evaluation	0085	T
10	185	93613	Electrophys map 3d, add-on	0087	T
		93620	Electrophysiology evaluation	0085	T
		93621	Electrophysiology evaluation	0085	T
		93623	Stimulation, pacing heart	0087	T
		93651	Ablate heart dysrhythm focus	0086	T

Although the number of claims for each unique occurrence was modest, we were able to determine that there were certain combinations of codes that occurred most often together. Based on our review of the most frequently occurring combinations of codes on claims that also contained at least one code assigned to APC 0085, 0086 or 0087 and our clinical review of the codes, we proceeded to study combination claims that contained at least one code from group A for evaluation services and at least one code from group B for ablation services reported on the same date of service on an individual claim, as specified in Table 23 below.

TABLE 23.—GROUPS OF CARDIAC ELECTROPHYSIOLOGIC EVALUATION AND ABLATION PROCEDURES FOR FURTHER ANALYSIS

Codes used in combinations: at least one in Group A and one in Group B	HCPCS code	CY 2007 APC	CY 2007 SI
Group A:			
Electrophysiology evaluation	93619	0085	T
Electrophysiology evaluation	93620	0085	T
Group B:			
Ablate heart dysrhythm focus	93650	0086	T
Ablate heart dysrhythm focus	93651	0086	T
Ablate heart dysrhythm focus	93652	0086	T

When we studied claims that contained a code in group A and also a code in group B, we found that there were 5,118 claims that met these criteria, and that of these 5,118 claims, 4,552 (89 percent) contained both CPT code 93620 (Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple

electrode catheters with induction or attempted induction of arrhythmia; with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording) from APC 0085 and CPT code 93651 (Intracardiac catheter ablation of arrhythmogenic focus; for treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathways, accessory atrioventricular connections or other atrial foci, singly or in combination) from APC 0086 with the same date of service. Given that CPT code 93651 had a total frequency of 8,091, this means that more than 55 percent of the claims for CPT code 93651 also contained CPT code 93620. CPT code 93620 had a total frequency of 12,624, approximately 50 percent higher than the total frequency for CPT code 93651, which is consistent with our expectations because CPT code 93620 describes a diagnostic service and CPT code 93651 is a treatment service that may be provided based upon the findings of the evaluation described by CPT code 93620. In addition to the codes for group A and group B services, the combination claims also contained costs for packaged services that were reported under revenue codes without HCPCS codes and under packaged HCPCS codes. As we discuss in considerable detail above, we lack a methodology that could be used to allocate these packaged costs to major separately paid procedures in a manner which gives us confidence that the costs would be attributed correctly. We have explored and will continue to explore an alternative strategy that would enable us to use these correctly coded multiple procedure claims for ratesetting.

In our review of these claims, not only did we find a high number of claims on which there was one code from group A and one code from group B, but we also found that claims for procedures assigned to APC 0087 for CY 2007 usually appeared on claims that contained a code from APC 0085 or APC 0086, or both. The most frequently appearing CPT codes that were assigned to APC 0087 for CY 2007 were, as shown above, 93609 (Intraventricular and/or intra-atrial mapping of tachycardia site(s), with catheter manipulation to record from multiple sites to identify origin of tachycardia (List separately in addition to code for primary procedure)), 93613 (Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)), 93621 (Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left atrial pacing and recording from coronary sinus or left atrium (List separately in addition to code for primary procedure)), 93622 (Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left ventricular pacing and recording (List separately in addition to code for primary procedure)), and 93623 (Programmed simulation and pacing after intravenous drug infusion (List separately in addition to code for primary procedure)). These codes are all CPT add-on codes that CPT indicates are to be reported in addition to the code for the primary procedure. Our clinical review of the services described by these five CPT codes determined that they are supportive dependent services that are provided most often as supplemental to procedures assigned to APCs 0085 and 0086. The procedures in APCs 0085 and 0086 can be performed without these supportive add-on procedures, but these dependent services cannot be done except as a supplement to another electrophysiologic procedure. Therefore, we are proposing to unconditionally package all of these five CPT codes under the grouping of intraoperative services for the CY 2008 OPPS. We discuss the packaging of intraoperative services in general, including these services, above.

However, packaging these supportive ancillary services that are so often reported with the cardiac electrophysiologic evaluation and ablation services does not enable us to use many more claims because, as we noted previously, the claims on which these codes most commonly appeared typically also contained at least one separately paid code from APC 0085 and one code from APC 0086. Although the most common combination of codes from APCs 0085 and 0086 is the pair of CPT codes 93620 and 93651, there are numerous other combinations of services from APCs 0085 and 0086 that are performed and, while not as frequent, these combinations are also reflected in the multiple claims.

In order to use more claims and adequately reflect the varied, common combinations of electrophysiologic evaluation and ablation CPT codes, we calculated a composite median cost from all claims containing at least one code from group A and at least one code from group B as if they were a single service. We selected multiple procedure claims that contained at least one code in group A and one code in group B on the same date of service and calculated a median cost from the total costs on these claims. Some claims had more than one code from each group. Although the claim was required to contain at least one code from each group to be included, the claim could also contain any number of codes from either group and any number of units of those codes. In addition, the costs of the five supportive intraoperative services previously assigned to APC 0087 that we identify above were packaged, as well as the costs of the other items and services proposed to be packaged for the CY 2008 OPPS. This selection process yielded 5,118 claims to use for the calculation. The proposed composite median cost for these claims using the CY 2008 proposed rule data is $8,528.83. We believe that this cost is attributable largely to the 4,552 claims that contain one unit each of CPT code 93620 and CPT code 93651 (and some unknown numbers and combinations of packaged services). In comparison, the sum of the CY 2008 proposed rule CPT code median costs for CPT code 93620 (which is $3,111.76) and CPT code 93651 (which is $5,643.95) is $8,755.71. If the 50 percent multiple procedure discount is applied to the CPT code median cost for the lower cost procedure based on its assignment to an APC with a ''T'' status, the adjusted sum of the median costs is $7,199.83 ($5,643.95 + $1,555.88). These medians were calculated using only claims that contain correct devices and do not contain token charges or the ''FB'' modifier. We believe the significant positive difference between the composite and discounted costs still reflects efficiencies, as the sum of the discounted median costs does not take into account the cost of other procedures also provided that are assigned to APCs 0085 and 0086, while the composite median cost of $8,528.83 does, to some extent, reflect the cost of other multiple procedures in APCs 0085 and 0086 that were also reported on the claims used to develop the composite median cost. In addition, these two calculations are based upon two different sets of claims, single procedure claims in one case (which do not represent the way the service is typically furnished) and the specified subset of clinically common combination claims in the second case. Moreover, while the 50 percent multiple procedure reduction is our best aggregate estimate of the overall degree of efficiency applicable to multiple surgeries, it may or may not be specifically appropriate to this particular combination of procedures.

By selecting the multiple procedure claims that contained at least one code in each group, we were able to use many more claims than were available to establish the individual APC medians. The percents by CPT code for the composite configuration below in Table 24 represent the sum of the frequency of single bills used to set the medians for APCs 0085 and 0086 with packaging of the five intraoperative services and the frequency of multiple bills used to set the medians for the composite claims containing at least one code from each group and with packaging of the costs of the five intraoperative services, divided by the total frequency of each CPT code.

TABLE 24.—PERCENTAGE OF CLAIMS USED TO CALCULATE MEDIAN COSTS FOR CARDIAC ELECTROPHYSIOLOGIC EVALUATION AND ABLATION PROCEDURES

Codes used in combinations: at least one in group A and one in Group B	HCPCS code	Proposed CY 2008 APC	SI	Standard configuration (with packaging of intraoperative services)		Composite configuration (with packaging of intraoperative services)
				CPT percentage of single claims	Overall APC percentage of single claims	CPT percentage of single and combination claims
Group A:						
Electrophysiology evaluation	93619	0085	T	38.99	25.47	63.96
Electrophysiology evaluation	93620	0085	T	22.30	25.47	61.77
Group B:						
Ablate heart dysrhythm focus	93650	0085	T	39.58	25.47	52.50
Ablate heart dysrhythm focus	93651	0086	T	4.59	4.68	63.30
Ablate heart dysrhythm focus	93652	0086	T	7.53	4.68	58.78

Moreover, by packaging CPT codes 93609, 93613, 93621, 93622, and 93623, we use many more of the claims for these codes from the most common clinical scenarios than would otherwise be possible if the supportive intraoperative services were separately paid. Wherever any of these codes appears on a claim that can be used for median setting, the cost data for these codes are packaged in the calculation of the median cost for the separately paid services on the claim.

(b) Proposed Payment for Cardiac Electrophysiologic Evaluation and Ablation

In view of our findings with regard to how often the codes in groups A and B appear together on the same claim, we are proposing to establish one composite APC, shown in Addendum A as APC 8000 (Cardiac Electrophysiologic Evaluation and Ablation Composite), for CY 2008 that would pay for a composite service made up of any number of services in groups A and B when at least one code from group A and at least one code from group B appear on the same claim with the same date of service. The five CPT codes involved in this composite APC are assigned to status indicator ''Q'' in Addendum B to this proposed rule to identify their conditionally packaged status, and their composite APC assignments are identified in Addendum M. We are proposing to use the composite median cost of $8,528.83 as the basis for establishing the relative weight for this newly created APC for the composite electrophysiologic evaluation and ablation service. Under this composite APC, unlike most other APCs, we would make a single payment for all services reported in groups A and B. We are proposing that hospitals would continue to code using CPT codes to report these services and that the OCE would recognize when the criteria for payment of the composite APC are met and would assign the composite APC instead of the single procedure APCs as currently occurs. The Pricer would make a single payment for the composite APC that would encompass the program payment for the code in group A, the code in group B, and any other codes reported in groups A or B, as well as the packaged services furnished on the same date of service. The proposed composite APC would have a status indicator of ''T'' so that payment for other procedures also assigned to status indicator ''T'' with lower payment rates would be reduced by 50 percent when furnished on the same date of service as the composite service, in order to reflect the efficiency that occurs when multiple procedures are furnished to a Medicare beneficiary in a single operative session. We would not expect that the proposed composite APC payment would be commonly reduced because we believe that it is unlikely that a higher paid procedure would be performed on the same date. We are proposing to continue to pay separately for other separately paid services that are not reported under the codes in groups A and B (such as chest x-rays and electrocardiograms).

Moreover, where a service in group A is furnished on a date of service that is different from the date of service for a code in group B for the same beneficiary, we are proposing that payments would be made under the single procedure APCs and the composite APC would not apply. Given our CY 2008 proposal to unconditionally package payment for five cardiac electrophysiologic CPT codes as members of the category of intraoperative services that were previously assigned to APCs 0085 and 0087, we are also proposing to reconfigure APCs 0084 through 0087, where many of the cardiac electrophysiologic procedures that will be separately paid when they are not paid according to the composite APC are assigned. Specifically, we are proposing to discontinue APC 0087, and reconfigure APCs 0084, 0085, and 0086, with proposed titles and median costs of Level I Electrophysiologic Procedures (APC 0084) at $647.41; Level II Electrophysiologic Procedures (APC 0085) at $3,059.46; and Level III Electrophysiologic Procedures (APC 0086) at $5,709.52, respectively. We refer readers to section IV.A.2. of this proposed rule for a discussion of

calculation of median costs for device-dependent APCs. We believe this reconfiguration improves the clinical and resource homogeneity of these APCs which would provide payment for cardiac electrophysiologic procedures that would be individually paid when they do not meet the criteria for payment of the composite APC.

We believe that creation of the proposed composite APC for cardiac electrophysiologic evaluation and ablation services is the most efficient and effective way to use the claims data for the majority of these services and best represents the hospital resources associated with performing the common combinations of these services that are clinically typical. We believe that this proposed ratesetting methodology results in an appropriate median cost for the composite service when at least one evaluation service in group A is furnished on the same date as at least one ablation service in group B. This approach creates incentives for efficiency by providing a single payment for a larger bundle of major procedures when they are performed together, in contrast to continued separate payment for each of the individual procedures. We expect to develop additional composite APCs in the future as we learn more about major currently separately paid services that are commonly furnished together during the same hospital outpatient encounter.

e. Service-Specific Packaging Issues

As a result of requests from the public, a Packaging Subcommittee to the APC Panel was established to review all the procedural CPT codes with a status indicator of ''N.'' Commenters to past rules have suggested that certain packaged services could be provided alone, without any other separately payable services on the claim, and requested that these codes not be assigned status indicator ''N.'' In deciding whether to package a service or pay for a code separately, we have historically considered a variety of factors, including whether the service is normally provided separately or in conjunction with other services; how likely it is for the costs of the packaged code to be appropriately mapped to the separately payable codes with which it was performed; and whether the expected cost of the service is relatively low. As discussed above regarding our proposed packaging approach for CY 2008, we have modified the historical considerations outlined above in developing our proposal for the CY 2008 OPPS. The Packaging Subcommittee discussed many HCPCS codes during the March 2007 APC Panel meeting, prior to development of the proposed packaging approach discussed above, and we have summarized and responded to the APC Panel's packaging-related recommendations below. Three of the codes reviewed by the Packaging Subcommittee at the March 2007 APC Panel meeting are included in the seven categories of services identified for packaging under the CY 2008 OPPS. For those three codes, we specifically applied the proposed CY 2008 criteria for determining whether a code should be proposed as packaged or separately payable for CY 2008. Specifically, we determined whether the service is a dependent service falling into one of the seven specified categories that is always or almost always provided integral to an independent service. For those four codes that were reviewed during the March 2007 APC Panel meeting but that do not fit into any of the seven categories of codes that are part of our CY 2008 proposed packaging approach, we applied the packaging criteria described above that were historically used under the OPPS. Moreover, we took into consideration our interest in expanding the size of payment groups for component services to provide encounter-based and episode-of-care-based payment in the future in order to encourage hospital efficiency and provide hospitals with maximal flexibility to manage their resources.

In accordance with a recommendation of the APC Panel, for the CY 2007 OPPS, we implemented a new policy that designates certain codes as ''special'' packaged codes, assigned to status indicator ''Q'' under the OPPS, where separate payment is provided if the code is reported without any other services that are separately payable under the OPPS on the same date of service. Otherwise, payment for the ''special'' packaged code is packaged into payment for the separately payable services provided by the hospital on the same date. We note that these ''special'' packaged codes are a subset of those HCPCS codes that are assigned to status indicator ''Q,'' which means that their payment is conditionally packaged under the OPPS. We are proposing to update our criteria to determine packaged versus separate payment for ''special'' packaged HCPCS codes assigned to status indicator ''Q'' for CY 2008. For CY 2008, payment for ''special'' packaged codes would be packaged when these HCPCS codes are billed on the same date of service as a code assigned to status indicator ''S,'' ''T,'' ''V,'' or ''X.'' When one of the ''special'' packaged codes assigned to status indicator ''Q'' is billed on a date of service without a code that is assigned to any of the four status indicators noted above, the ''special'' packaged code assigned to status indicator ''Q'' would be separately payable.

The Packaging Subcommittee identified areas for change for some currently packaged CPT codes that it believed could frequently be provided to patients as the sole service on a given date and that required significant hospital resources as determined from hospital claims data. Based on the comments received, additional issues, and new data that we shared with the Packaging Subcommittee concerning the packaging status of codes for CY 2008, the Packaging Subcommittee reviewed the packaging status of numerous HCPCS codes and reported its findings to the APC Panel at its March 2007 meeting. The APC Panel accepted the report of the Packaging Subcommittee, heard several presentations on certain packaged services, discussed the deliberations of the Packaging Subcommittee, and recommended that—

1. CMS place CPT code 76937 (Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (list separately in addition to code for primary procedure)) on the list of ''special'' packaged codes (status indicator ''Q''). (Recommendation 1)

2. CMS evaluate providing separate payment for trauma activation when it is reported on a claim for an ED visit, regardless of the level of the emergency department visit. (Recommendation 2)

3. CMS place CPT code 0175T (Computer aided detection (CAD) (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation and report, with or without digitization of film radiographic images, chest radiograph(s), performed remote from primary interpretation) on the list of ''special'' packaged codes (status indicator ''Q''). (Recommendation 3)

4. CMS place CPT code 0126T (Common carotid intima-media thickness (IMT) study for evaluation of atherosclerotic burden or coronary heart disease risk factor assessment) on the list of ''special'' packaged codes (status indicator ''Q'') and that CMS consider mapping the code to APC 340 (Minor Ancillary Procedures). (Recommendation 4)

5. CMS place CPT code 0069T (Acoustic heart sound recording and computer analysis only) on the list of ''special'' packaged codes (status indicator ''Q'') and that CMS exclude APC 0096 (Non-Invasive Vascular Studies) as a potential placement for this CPT code. (Recommendation 5)

6. CMS maintain the packaged status of HCPCS code A4306 (Disposable drug delivery system, flow rate of less than 50 ml per hour) and that CMS present additional data on this system to the APC Panel when available. (Recommendation 6)

7. CMS reevaluate the packaged OPPS payment for CPT code 99186 (Hypothermia; total body) based on current research and availability of new therapeutic modalities. (Recommendation 7)

8. The Packaging Subcommittee remains active until the next APC Panel meeting. (Recommendation 8)

We address each of these recommendations in turn in the discussion that follows.

Recommendation 1

For CY 2008, we are proposing to maintain CPT code 76937 as a packaged service. We are not adopting the APC Panel's recommendation to pay separately for this code in some circumstances as a ''special'' packaged code. In the CY 2006 OPPS final rule with comment period (70 FR 68544 through 68545), in response to several public comments, we reviewed in detail the claims data related to CPT code 76937. During its March 2006 APC Panel meeting, after reviewing data pertinent to CPT code 76937, the APC Panel recommended that CMS maintain the packaged status of this code for CY 2007, and we accepted that recommendation. During the March 2007 APC Panel meeting, after reviewing current data and listening to a public presentation, the Panel recommended that we treat this code as a ''special'' packaged code for CY 2008, noting that certain uncommon clinical scenarios could occur where it would be possible to bill this service alone on a claim, without any other separately payable OPPS services.

We are proposing to maintain CPT code 76937 as an unconditionally packaged service for CY 2008, fully consistent with the proposed packaging approach for the CY 2008 OPPS, as discussed above. Because CPT code 76937 is a guidance procedure and we are proposing to package payment for all guidance procedures for CY 2008, we believe it is appropriate to maintain the unconditionally packaged status of this code, which is a CPT designated add-on procedure that we would expect to be generally provided only in association with other independent services. We applied the updated criteria for determining whether this service should receive packaged or separately payment under the CY 2008 OPPS. Specifically, we determined that this service is a supportive ancillary service that is integral to an independent service, resulting in our CY 2008 proposal to packaged payment for the service.

We discussed this code extensively in both the CY 2006 and CY 2007 final rules with comment period (70 FR 68544 through 68545; 71 FR 67996 through 67997). Our hospital claims data demonstrate that guidance services are used frequently for the insertion of vascular access devices, and we have no evidence that patients lack appropriate access to guidance services necessary for the safe insertion of vascular access devices in the hospital outpatient setting. Because we believe that ultrasound guidance would almost always be provided with one or more separately payable independent procedures, its costs would be appropriately bundled with the handful of vascular access device insertion procedures with which it is most commonly performed. We further believe that hospital staff chooses whether to use no guidance or fluoroscopic guidance or ultrasound guidance on an individual basis, depending on the clinical circumstances of the vascular access device insertion procedure.

Therefore, we do not believe that CPT code 76937 is an appropriate candidate for designation as a ''special'' packaged code. The CY 2007 CPT book indicates that this code is an add-on code and should be reported in addition to the code reported for the primary procedure. According to our CY 2006 claims data available for this proposed rule, this code was billed over 60,000 times, yet less than one-tenth of 1 percent of all claims for the procedure were billed without any separately payable OPPS service on the claim. Because this code is provided alone only extremely rarely, we believe this code would not be appropriately treated as a ''special'' packaged code. Therefore, we are proposing to continue to unconditionally package CPT code 76937 for CY 2008.

Recommendation 2

For CY 2008, we are proposing to maintain the packaged status of revenue code 068x, trauma response, when the trauma response is provided without critical care services. During the August 2006 APC Panel meeting, the APC Panel encouraged CMS to pay differentially for critical care services provided with and without trauma activation. For CY 2007, as a result of the APC Panel's August 2006 discussion and our own data analysis, we finalized a policy to pay differentially for critical care provided with and without trauma activation. The CY 2007 payment rate for critical care unassociated with trauma activation is $405.04 (APC 0617, Critical Care), while the payment rate for critical care associated with trauma activation is $899.58 (APC 0617 and APC 0618 (Trauma Response with Critical Care)). During the March 2007 APC Panel meeting, a presenter requested that CMS also pay differentially for emergency department visits provided with and without trauma activation. Two organizations that submitted comment letters for the APC Panel's review specifically requested separate payment for revenue code 068x every time it appears on a claim, regardless of the other services that were billed on that claim. The APC Panel recommended that CMS evaluate providing separate payment for trauma activation when it is reported on a claim for an emergency department visit, regardless of the level of the emergency department visit.

After accepting the APC Panel's recommendation and evaluating this issue, we continue to believe that, while it is currently appropriate to pay separately for trauma activation when billed in association with critical care services, it is also currently appropriate to maintain the packaged payment status of revenue code 068x when trauma response services are provided in association with both clinic and emergency department visits under the CY 2008 OPPS. As mentioned above, it is our general objective to expand the size of the payment groups under the OPPS to move toward encounter-based and episode-of-care-based payments in order to encourage maximum hospital efficiency with a focus on value-based purchasing. Because trauma activation in association with emergency department or clinic visits would always be provided in the same hospital outpatient encounter as the visit for care of the injured Medicare beneficiary, packaging payment for trauma activation when billed in association with both clinic and emergency department visits is most consistent with our proposed packaging approach. We are also concerned that unpackaging payment for trauma activation in those circumstances where the trauma response would be less likely to be essential to appropriately treating a

Medicare beneficiary would reduce the incentive for hospitals to provide the most efficient and cost-effective care. We note that, while we are proposing for CY 2008 to continue to provide separate payment for trauma activation in association with critical care services, we may reconsider this payment policy for future OPPS updates as we further develop encounter-based and episode-of-care-based payment approaches.

Furthermore, continued packaged payment for trauma activation when unassociated with critical care is consistent with the principles of a prospective payment system, where hospitals receive payment based on the median cost related to all of the hospital resources associated with the main service provided. In various situations, each hospital's costs may be higher or lower than the median cost used to set payment rates. In light of our proposed packaging approach for the CY 2008 OPPS, we believe it is particularly important not to make any changes in our payment policies for other services that are not fully aligned with promoting efficient, judicious, and deliberate care decisions by hospitals that allow them maximum flexibility to manage their resources through encouraging the most cost-effective use of hospital resources in providing the care necessary for the treatment of Medicare beneficiaries. Packaging payment encourages hospitals to establish protocols that ensure that services are furnished only when they are medically necessary and to carefully scrutinize the services ordered by practitioners to minimize unnecessary use of hospital resources.

Therefore, we are adopting the APC Panel's recommendation that we evaluate providing separate payment for revenue code 068x when provided in association with emergency department visits. For CY 2008, after our thorough assessment, we are proposing to maintain the packaged status of revenue code 068x, except when revenue code 068x is billed in association with critical care services.

Recommendation 3

For CY 2008, we are proposing to maintain the unconditionally packaged status of CPT codes 0174T (Computer aided detection (CAD) (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation and report, with or without digitization of film radiographic images, chest radiograph(s), performed concurrent with primary interpretation) and 0175T. These services involve the application of computer algorithms and classification technologies to chest x-ray images to acquire and display information regarding chest x-ray regions that may contain indications of cancer. CPT code 0152T (Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; chest radiograph(s) (List separately in addition to code for primary procedure)), the predecessor code to CPT codes 0174T and 0175T, was indicated as an add-on code to chest x-ray CPT codes for CY 2006, according to the AMA's CY 2006 CPT book. However, on July 1, 2006, the AMA released to the public an update that deleted CPT codes 0152T and replaced it with the two new Category III CPT codes 0174T and 0175T.

In its March 2006 presentation to the APC Panel, before the AMA had released the CY 2007 changes to CPT code 0152T, a presenter requested that we pay separately for this service and assign it to a New Technology APC with a payment rate of $15, based on its estimated cost, clinical considerations, and similarity to other image post processing services that are paid separately. We proposed to accept the APC Panel's recommendation to package CPT code 0152T for CY 2007.

In its August 2006 presentation to the APC Panel, after the AMA had released the CY 2007 code changes, the same presenter requested that we assign both of the two new codes to a New Technology APC with a payment rate of $15. The APC Panel members discussed these codes extensively. They considered the possibility of treating CPT code 0175T as a ''special'' packaged code, thereby assigning payment to the code only when it was performed by a hospital without any other separately payable OPPS service also provided on the same day. They questioned the meaning of the word ''remote'' in the code descriptor for CPT code 0175T, noting that was unclear as to whether remote referred to time, geography, or a specific provider. They believed it was likely that a hospital without a CAD system that performed a chest x-ray and sent the x-ray to another hospital for performance of the CAD would be providing the CAD service under arrangement and, therefore, would be providing at least one other service (chest x-ray) that would be separately paid. Thus, even in these cases, payment for the CAD service could be appropriately packaged. After significant and lengthy deliberation, the APC Panel recommended that we package payment for both of the new CPT codes, 0174T and 0175T, for CY 2007.

In its March 2007 presentation to the APC Panel, the same presenter requested that we pay separately for CPT codes 0174T and 0175T, mapping them to New Technology APC 1492, with a payment rate of $15. The presenter indicated that chest x-ray CAD is not a screening tool and should only be billed to Medicare when applied to chest x-rays suspicious for lung cancer. The presenter also explained that additional and distinct hospital resources are required for chest x-ray CAD that are not required for a standard chest x-ray. In addition, remote chest x-ray CAD described by CPT code 0175T can be performed at a different time or location or by a different provider than the chest x-ray service. The presenter expressed concern that if hospitals were not paid separately for this technology, hospitals would not be able to provide it, thereby limiting beneficiary access to chest x-ray CAD. The APC Panel recommended conditional packaging as a ''special'' packaged code for CPT code 0175T, but did not recommend a change to the unconditionally packaged status of CPT code 0174T. We are not adopting the APC Panel's recommendation for designation of CPT code 0175T as a ''special'' packaged code under the CY 2008 OPPS.

We believe that packaged payment for diagnostic chest x-ray CAD under a prospective payment methodology for outpatient hospital services is most appropriate. We are proposing to maintain CPT codes 0174T and 0175T as unconditionally packaged services for CY 2008, fully consistent with the proposed packaging approach for the CY 2008 OPPS, as discussed above. Because CPT codes 0174T and 0175T are supportive ancillary services that fit into the ''image processing'' category, and we are proposing to package payment for all image processing services for CY 2008, we believe it is appropriate to maintain the packaged status of these codes. We applied the updated criteria for determining whether these two CAD services should receive packaged or separate payment. Specifically, we determined that this service is a dependent service that is integral to an independent service, in this case, the chest x-ray or other OPPS service that we would expect to be provided in addition to the CAD service.

After hearing many public presentations and discussions regarding the use of chest x-ray CAD, we continue to believe that even the remote service would almost always be provided by a hospital either in conjunction with other separately payable services or

under arrangement. For example, if a physician orders a chest x-ray and CAD service to be performed at hospital A, and hospital A, which does not have the CAD technology, sends the chest-ray to hospital B for the performance of chest x-ray CAD, hospital B could only provide the CAD service if it were provided under arrangement, to avoid the OPPS unbundling prohibition. Assuming that the CAD service was provided under arrangement, hospital A would bill for the chest x-ray CAD that was performed by hospital B and would pay hospital B for the service provided. In that case, hospital A would also bill the chest x-ray service that it provided. In another scenario that has been described to us, if a physician were to send a patient to a hospital clinic with the patient's chest x-ray for consultation, we believe that the patient would likely receive a visit service, in addition to the chest x-ray CAD. Therefore, in both of these circumstances, payment for the chest x-ray CAD would be appropriately packaged into payment for the separately payable services with which it was provided.

We also do not believe that CPT code 0175T should be treated as a ''special'' packaged code. As discussed earlier in this section with regard to our packaging proposal for image processing services for CY 2008, we are concerned with establishing payment policies that could encourage certain inefficient and more costly service patterns, particularly for those services that do not need to be provided as a face-to-face encounter with the patient. If we were to assign CPT code 0175T to ''special'' packaged status, we would likely create an incentive for hospitals to perform chest x-ray CAD remotely, for example, several days after performance of the initial chest x-ray, rather than immediately following the chest x-ray on the same day, to enable the hospital to receive separate payment for the service. In CY 2005, there were approximately 7.3 million claims for all chest x-ray services in the HOPD, so a payment policy that could induce such changes in service delivery would be problematic in light of our commitment to encouraging the most efficient and cost-effective care for Medicare beneficiaries. Creating such perverse payment incentives through conditional packaging is a particular problem for those services that do not need a face-to-face encounter with the patient. In fact, as part of our proposed CY 2008 packaging approach, we are also proposing to unconditionally package payment in CY 2008 for several other image processing services that are not always performed face-to-face, including HCPCS code G0288 (Reconstruction, computer tomographic angiography of aorta for surgical planning for vascular surgery) and CPT code 76377 (3D rendering with interpretation and reporting of computed tomography, magnetic resource imaging, ultrasound, or other tomographic modality; requiring image postprocessing on an independent workstation).

The proposed unconditionally packaged treatment of the two CPT codes for chest x-ray CAD is fully consistent with the proposed packaging approach for the CY 2008 OPPS, as discussed above, and the principles and incentives for efficiency inherent in a prospective payment system based on groups of services. Packaging these services creates incentives for providers to furnish services in the most cost-effective way and provides them with the most flexibility to manage their resources. As stated above, packaging encourages hospitals to establish protocols that ensure that services are furnished only when they are medically necessary and to carefully scrutinize the services ordered by practitioners to minimize unnecessary use of hospital resources. Therefore, we are proposing to continue to unconditionally package payment for CPT codes 0174T and 0175T for CY 2008.

Recommendation 4

For CY 2008, we are adopting the APC Panel's recommendation and proposing to add CPT code 0126T to the list of ''special'' packaged codes and assign this code to APC 0340 (Minor Ancillary Procedures).

This service describes an ultrasound procedure that measures common carotid intima-media thickness to evaluate a patient's degree of atherosclerosis. This code became effective January 1, 2006. We received a comment to the CY 2007 proposed rule requesting that this code become separately payable for CY 2007. At that point, we had no cost data for the service and, as discussed in the CY 2007 OPPS/ASC final rule with comment period (71 FR 67998), we reviewed this code with the Packaging Subcommittee, as is our standard procedure for codes that we are asked to review during the comment period. The APC Panel noted that this service could sometimes be provided to a patient without any other separately payable services. Therefore, the APC Panel recommended that we add this code to the list of ''special'' packaged codes and pay for it separately when it is provided without any other separately payable services on the same day. For circumstances when this code is paid separately, the APC Panel recommended that we consider assigning this code to APC 0340.

While we continue to believe that this procedure would not commonly be provided alone, we are adopting the APC Panel recommendation and are proposing to treat this code as a ''special'' packaged code subject to conditional packaging, mapping to APC 0340 for CY 2008 when it would be separately paid. This is fully consistent with the proposed packaging approach for the CY 2008 OPPS, as discussed above. Because CPT code 0126T is almost always performed during another procedure, and we are proposing to package payment for all intraoperative procedures for CY 2008, we believe it is appropriate to designate this CPT code as a ''special'' packaged code. We applied the updated criteria for determining whether this service should receive packaged or separate payment. Specifically, we determined that this service is usually a dependent service that is integral to an independent service, but that it could sometimes be provided without an independent service.

As with all ''special'' packaged codes, we will closely monitor cost data and frequency of separate payment for this procedure as soon as we have more claims data available.

Recommendation 5

For CY 2008, we are proposing to maintain the packaged status of CPT code 0069T, and we are not adopting the APC Panel's recommendation to designate this service as a ''special'' packaged code. This service uses signal processing technology to detect, interpret, and document acoustical activities of the heart through special sensors applied to a patient's chest. This code was a new Category III CPT code implemented in the CY 2005 OPPS. CPT code 0069T was an add-on code to an electrocardiography (EKG) service for CYs 2005 and 2006. However, effective January 1, 2007, the AMA changed the code descriptor to remove the add-on code designation for CPT code 0069T. This code has been packaged under the OPPS since CY 2005.

During the August 2005 APC Panel meeting, the APC Panel recommended packaging CPT code 0069T for CY 2005. In its March 2006 presentation to the APC Panel, a presenter requested that we pay separately for CPT code 0069T and assign it to APC 0099 (Electrocardiograms) based on its estimated cost and clinical characteristics. The presenter stated that

the acoustic heart sound recording and analysis service may be provided with or without a separately reportable electrocardiogram. Members of the APC Panel engaged in extensive discussion of clinical scenarios as they considered whether CPT code 0069T could or could not be appropriately reported alone or in conjunction with several different procedure codes. Ultimately, the APC Panel recommended assigning this service to a separately payable status indicator. However, during the August 2006 meeting, the APC Panel further discussed CMS' proposal to package payment for CPT code 0069T for CY 2007 and considered the CY 2007 code descriptor change, finally recommending that CMS continue to package this code for CY 2007.

During the March 2007 APC Panel meeting, the same presenter requested that we pay separately for this service and assign it to APC 0096 (Non-Invasive Vascular Studies) or to APC 0097 (Cardiac and Ambulatory Blood Pressure Monitoring), with CY 2007 payment rates of $94.06 and $62.85, respectively. The presenter stated that the estimated true cost of this service lies between $62 and $94. The presenter clarified that this service is usually provided with an EKG, but noted that the test is sometimes provided without an EKG, according to its revised code descriptor for CY 2007. The presenter agreed that it would be rare for the acoustic heart sound procedure to be performed alone without any other separately payable OPPS services. The APC Panel recommended that we place CPT code on the list of ''special'' packaged codes and that we exclude APC 0096 as a potential placement for this CPT code.

Because this service does not fit into one of the seven identified categories of packaged codes proposed for the CY 2008 OPPS, we followed our historical packaging guidelines to determine whether to maintain the packaged status of this code or to pay for it separately. Based on the clinical uses that were described during the March 2007 and earlier APC Panel meetings, APC Panel discussions, and our claims data review, we continue to believe that it is highly unlikely that CPT code 0069T would be performed in the HOPD as a sole service without other separately payable OPPS services. In addition, our data indicate that this service is estimated to require only minimal hospital resources. Based on CY 2006 claims, we had only 8 single claims for CPT code 0069T, with a median line-item cost of $5.21, consistent with its low expected cost. Therefore, we believe that payment for CPT code 0069T is appropriately packaged because it would usually be closely linked to the performance of an EKG or other separately payable cardiac service, would rarely, if ever, be the only OPPS service provided to a patient in an encounter, and has a low estimated resource cost. The proposed packaged treatment of this code is consistent with the principles and incentives for efficiency inherent in a prospective payment system based on groups of services. Therefore, we are proposing to continue to package payment for CPT code 0069T for CY 2008.

Recommendation 6

For CY 2008, we are proposing to adopt the APC Panel's recommendation and maintain the packaged status of HCPCS code A4306. As requested by the APC Panel, we will also present to the APC Panel additional data on this system when available.

HCPCS code A4306 describes a disposable drug delivery system with a flow rate of less than 50 ml per hour. As discussed in a presentation at the March 2007 APC Panel meeting, there is a particular disposable drug delivery system that is specifically used to treat postoperative pain. Since the implementation of the OPPS, this code was assigned to status indicator ''A,'' indicating that it was payable according to another fee schedule, in this case, the Durable Medical Equipment (DME) fee schedule. There were discussions during CYs 2005 and 2006 between CMS and a manufacturer, and it was determined that this code should be removed from the DME fee schedule as this code does not describe DME. For CY 2007, HCPCS code A4306 is payable under the OPPS, with status indicator ''N'' indicating that its payment is unconditionally packaged.

One presenter to the APC Panel requested that we pay separately for this supply under the OPPS. For CY 2007, we packaged payment for this code because it is considered to be a supply, and since the inception of the OPPS the established payment policy packages payment for supplies because they are directly related and integral to an independent service furnished under the OPPS.

Our CY 2006 claims data indicate that HCPCS code A4306 was billed on OPPS claims 1,773 times, yielding a line-item median cost of approximately $3. The APC Panel and a presenter believe that this code may not always be appropriately billed by hospitals as the data also show that this code was billed together with computed tomography (CT) scans of the thorax, abdomen, and pelvis approximately 40 percent of the time that this supply was reported. The APC Panel speculated that this code may be currently reported when other types of drug delivery devices are utilized for nonsurgical procedures or for purposes other than the treatment of postoperative pain. Therefore, the APC Panel requested that we share additional data when available.

In summary, because HCPCS code A4306 represents a supply and payment of supplies is packaged under the OPPS according to longstanding policy, we are proposing to maintain the packaged status of HCPCS code A4306 for CY 2008.

Recommendation 7

For CY 2008, we are proposing to maintain the packaged status of CPT code 99186, consistent with the APC Panel's recommendation that we reevaluate the packaged OPPS payment for CPT code 99186 based on current research and the availability of new therapeutic modalities.

This service describes induced total body hypothermia that is performed on some post-cardiac arrest patients to avoid or lessen brain damage. The service has been packaged since the implementation of the OPPS. One presenter to the APC Panel at the March 2007 meeting requested that this code be assigned a separately payable status indicator under the OPPS. The presenter expressed concern that hospitals that provide this service and subsequently transfer the patient to another hospital prior to admission are not adequately paid for their services.

Because this service does not fit into one of the seven identified categories of packaged codes proposed for the CY 2008 OPPS, we followed our historical packaging guidelines to determine whether to maintain the packaged status of this code or to pay for it separately. Claims data indicate that this code was billed 39 times under the OPPS in CY 2006 and was never billed without another separately payable service on the same date. The proposed CY 2008 median cost for this code is $35, with individual costs ranging from $17 to $69, likely reflecting the costs associated with traditional methods of inducing total body hypothermia, such as ice packs applied to the body. In fact, the presenter noted that a technologically advanced total body hypothermia system costs $30,000, with an additional cost of $1,600 per disposable body suit. As expected, our claims data show that this service was provided most frequently with high level emergency department visits and critical care services.

We believe that the circumstances in which total body hypothermia would be provided to a Medicare beneficiary and billed under the OPPS are extremely rare, as patients requiring this therapy would almost always be admitted as inpatients if they survive. We believe that, in the uncommon situation where a patient presents to one hospital and then is cooled and transported to another hospital without admission to the first hospital, payment for the hypothermia service would be most appropriately packaged into payment for the many other separately payable services that it most likely accompanied and that would be paid to the first hospital under the OPPS.

In addition, consistent with the principles and incentives for efficiency inherent in a prospective payment system based on groups of services, packaging payment for this procedure that is highly integrated with other services provided in the hospital outpatient encounter creates incentives for providers to furnish services in the most cost-effective way. In situations where there are a variety of supplies that could be used to furnish a service, some of which are more expensive than others, packaging encourages hospitals to use the most cost-effective item that meets the patient's needs.

Recommendation 8

In response to the APC Panel's recommendation for the Packaging Subcommittee to remain active until the next APC meeting, we note that the APC Panel Packaging Subcommittee remains active, and additional issues and new data concerning the packaging status of codes will be shared for its consideration as information becomes available. We continue to encourage submission of common clinical scenarios involving currently packaged HCPCS codes to the Packaging Subcommittee for its ongoing review, and we also encourage recommendations of specific services or procedures whose payment would be most appropriately packaged under the OPPS. Additional detailed suggestions for the Packaging Subcommittee should be submitted to *APCPanel@cms.hhs.gov*, with ''Packaging Subcommittee'' in the subject line.

B. Proposed Payment for Partial Hospitalization

(If you choose to comment on issues in this section, please include the caption ''OPPS: Partial Hospitalization'' at the beginning of your comment.)

1. Background

Partial hospitalization is an intensive outpatient program of psychiatric services provided to patients as an alternative to inpatient psychiatric care for beneficiaries who have an acute mental illness. A partial hospitalization program (PHP) may be provided by a hospital to its outpatients or by a Medicare-certified community mental health center (CMHC). Section 1833(t)(1)(B)(i) of the Act provides the Secretary with the authority to designate the hospital outpatient services to be covered under the OPPS. The Medicare regulations at 42 CFR 419.21 that implement this provision specify that payments under the OPPS will be made for partial hospitalization services furnished by CMHCs as well as those furnished to hospital outpatients. Section 1833(t)(2)(C) of the Act requires that we establish relative payment weights based on median (or mean, at the election of the Secretary) hospital costs determined by 1996 claims data and data from the most recent available cost reports. Payment to providers under the OPPS for PHPs represents the provider's overhead costs associated with the program. Because a day of care is the unit that defines the structure and scheduling of partial hospitalization services, we established a per diem payment methodology for the PHP APC, effective for services furnished on or after August 1, 2000. For a detailed discussion, we refer readers to the April 7, 2000 OPPS final rule with comment period (65 FR 18452).

Historically, the median per diem cost for CMHCs greatly exceeded the median per diem cost for hospital-based PHPs and has fluctuated significantly from year to year, while the median per diem cost for hospital-based PHPs has remained relatively constant ($200–$225). We believe that CMHCs may have increased and decreased their charges in response to Medicare payment policies. As discussed in more detail in section II.B.2. of this proposed rule and in the CY 2004 OPPS final rule with comment period (68 FR 63470), we also believe that some CMHCs manipulated their charges in order to inappropriately receive outlier payments.

For CY 2005, the PHP per diem amount was based on 12 months of hospital and CMHC PHP claims data (for services furnished from January 1, 2003, through December 31, 2003). We used data from all hospital bills reporting condition code 41, which identifies the claim as partial hospitalization, and all bills from CMHCs because CMHCs are Medicare providers only for the purpose of providing partial hospitalization services. We used CCRs from the most recently available hospital and CMHC cost reports to convert each provider's line-item charges as reported on bills to estimate the provider's cost for a day of PHP services. Per diem costs were then computed by summing the line-item costs on each bill and dividing by the number of days on the bill.

In the CY 2005 OPPS update, the CMHC median per diem cost was $310, the hospital-based PHP median per diem cost was $215, and the combined CMHC and hospital-based median per diem cost was $289. We believed that the reduction in the CY 2005 CMHC median per diem cost compared to prior years indicated that the use of updated CCRs had accounted for the previous increase in CMHC charges and represented a more accurate estimate of CMHC per diem costs for PHP.

For the CY 2006 OPPS final rule with comment period, we analyzed 12 months of the most current claims data available for hospital and CMHC PHP services furnished between January 1, 2004, and December 31, 2004. We also used the most currently available CCRs to estimate costs. The median per diem cost for CMHCs dropped to $154, while the median per diem cost for hospital-based PHPs was $201. Based on the CY 2004 claims data, the average charge per day for CMHCs was $760, considerably greater than hospital-based per day costs but significantly lower than what it was in CY 2003 ($1,184). We believed that a combination of reduced charges and slightly lower CCRs for CMHCs resulted in a significant decline in the CMHC median per diem cost between CY 2003 and CY 2004.

Following the methodology used for the CY 2005 OPPS update, the CY 2006 OPPS updated combined hospital-based and CMHC median per diem cost was $161, a decrease of 44 percent compared to the CY 2005 combined median per diem amount.

As we were concerned that this amount may not cover the cost for PHPs, as stated in the CY 2006 OPPS final rule with comment period (70 FR 68548 and 68549), we applied a 15-percent reduction to the combined hospital-based and CMHC median per diem cost to establish the CY 2005 PHP APC. (We refer readers to the CY 2006 OPPS final rule with comment period for a full discussion of how we established the CY 2006 PHP rate (70 FR 68548).) We stated our belief that a reduction in the CY 2005 median per diem cost would strike an appropriate balance between using the best available data and providing adequate payment for a program that often spans 5–6 hours a

day. We stated that 15 percent was an appropriate reduction because it recognized decreases in median per diem costs in both the hospital data and the CMHC data, and also reduced the risk of any adverse impact on access to these services that might result from a large single-year rate reduction. However, we adopted this policy as a transitional measure, and stated in the CY 2006 OPPS final rule with comment period that we would continue to monitor CMHC costs and charges for these services and work with CMHCs to improve their reporting so that payments can be calculated based on better empirical data, consistent with the approach we have used to calculate payments in other areas of the OPPS (70 FR 68548).

To apply this methodology for CY 2006, we reduced the CY 2005 combined unscaled hospital-based and CMHC median per diem cost of $289 by 15 percent, resulting in a combined median per diem cost of $245.65 for CY 2006.

For the CY 2007 final rule with comment period, we analyzed 12 months of more current data for hospital and CMHC PHP claims for services furnished between January 1, 2005, and December 31, 2005. We also used the most currently available CCRs to estimate costs. Using these updated data, we recreated the analysis performed for the CY 2007 proposed rule to determine if the significant factors we used in determining the proposed PHP rate had changed. The median per diem cost for CMHCs increased $8 to $173, while the median per diem cost for hospital-based PHPs decreased $19 to $190. The CY 2005 average charge per day for CMHCs was $675, similar to the figure noted in the CY 2007 proposed rule ($673) but still significantly lower than what was noted as the average charge for CY 2003 ($1,184).

The combined hospital-based and CMHC median per diem cost would have been $175 for CY 2007. Rather than allowing the PHP median per diem cost to drop to this level, we proposed to reduce the PHP median cost by 15 percent, similar to the methodology used for the CY 2006 update. However, after considering all public comments received concerning the proposed CY 2007 PHP per diem rate and results obtained using the more current data, we modified our proposal to continue using the 15 percent reduction methodology as the basis for calculating the combined hospital based and CMHC median per diem cost for CY 2007. Instead, we made a 5 percent reduction to the CY 2006 median per diem rate to provide a transitional path to the per diem cost indicated by the data. We believed that this approach accounted for the downward direction of the data and addressed concerns raised by commenters about the magnitude of another 15 percent reduction in 1 year. Thus, to calculate the CY 2007 APC PHP per diem cost, we reduced $245.65 (the CY 2005 combined hospital-based and CMHC median per diem cost of $289 reduced by 15 percent) by 5 percent, which resulted in a combined per diem cost of $233.37.

2. Proposed PHP APC Update

For the past 2 years, we were concerned that we did not have sufficient evidence to support using the median per diem cost produced by the most current year's PHP data. After extensive analysis, we now believe we have determined the appropriate level of cost for the type of day services that is being provided. This analysis included an examination of revenue-to-cost center mapping, refinements to the per diem methodology, and an in-depth analysis of the number of units of service per day.

In the CY 2006 and CY 2007 OPPS updates, the data have produced median costs that we believe were too low to cover the cost of a program that typically spans 5 to 6 hours per day. However, we continued to observe a clear downward trend in the data. We stated that if the data continue to reflect a low PHP per diem cost in CY 2008, we expect to continue the transition of decreasing the PHP median per diem cost to an amount that is more reflective of the data.

We received a comment on the CY 2007 proposed rates that CMS understated the PHP median cost by not using a hospital-specific CCR for partial hospitalization. In our response to this comment in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68000), we noted that, although most hospitals do not have a cost center for partial hospitalization, we used the CCR as specific to PHP as possible. The following CMS Web site contains the revenue-code-to-cost-center crosswalk: *http://www.cms.hhs.gov/HospitalOutpatientPPS/03_crosswalk.asp#TopOfPage*.

This crosswalk indicates how charges on a claim are mapped to a cost center for the purpose of converting charges to cost. One or more cost centers are listed for most revenue codes that are used in the OPPS median calculations, starting with the most specific, and ending with the most general. Typically, we map the revenue code to the most specific cost center with a provider-specific CCR. However, if the hospital does not have a CCR for any of the listed cost centers, we consider the overall hospital CCR as the default. For partial hospitalization, the revenue center codes billed by PHPs are mapped to Primary Cost Center 3550 ''Psychiatric/Psychological Services''. If that cost center is not available, they are mapped to the Secondary Cost Center 6000 ''Clinic.'' We use the overall facility CCR for CMHCs because PHPs are CMHCs' only Medicare cost, and CMHCs do not have the same cost structure as hospitals. Therefore, for CMHCs, we use the CCR from the outpatient provider-specific file.

Closer examination of the revenue-code-to-cost-center crosswalk revealed that 10 of the revenue center codes (shown in the table below) that are common among hospital based PHP claims did not map to a Primary Cost Center 3550 ''Psychiatric/Psychological Services'' or a Secondary Cost Center of 6000 ''Clinic.''

Revenue center code	Revenue center description
0430	Occupational Therapy.
0431	Occupational Therapy: Visit charge.
0432	Occupational Therapy: Hourly charge.
0433	Occupational Therapy: Group rate.
0434	Occupational Therapy: Evaluation/re-evaluation.
0439	Occupational Therapy: Other occupational therapy.
0904	Psychiatric/Psychological Treatment: Activity therapy.
0940	Other Therapeutic Services.
0941	Other Therapeutic Services: Recreation Rx.
0942	Other Therapeutic Services: Education/training.

We believe these 10 revenue center codes did not map to either a Primary Cost Center 3550 ''Psychiatric/Psychological Services'' or a Secondary Cost Center 6000 ''Clinic'' because these codes may be used for services that are not PHP or psychiatric related. For example, many Occupational Therapy claims are not furnished to PHP patients and, therefore, should be appropriately mapped to a Primary Cost Center 5100 ''Occupation Therapy'' (the general Occupational Therapy Cost Center). Another example would be claims for Diabetes Education, which is also not furnished to PHP patients.

In order to more accurately estimate costs for PHP claims, for purposes of our analysis, we remapped these 10 revenue center codes to a Primary Cost Center 3550 ''Psychiatric/Psychological Services'' or a Secondary Cost Center 6000 ''Clinic''. Once we remapped the

codes, we computed an alternate cost for each line item of the CY 2006 hospital-based PHP claims. There are a total of 638,652 line items in the CY 2006 hospital-based PHP claims. Prior to remapping, there were 282,871 line items where a default CCR was used to estimate costs. After the remapping, there were 141,682 line items left defaulting to the hospitals' overall CCR. While this remapping creates a more accurate estimate of PHP per diem costs for a significant number of claims, there was not a large change in the resulting median per diem cost. The median per diem costs for hospital-based PHPs increased by $5.20 (from $191.80 to $197).

As part of our effort to produce the most accurate per diem cost estimate, we have reexamined our methodology for computing the PHP per diem cost. Section 1833(t)(2)(C) of the Act requires that we establish relative payment weights based on median (or mean, at the election of the Secretary) hospital costs determined by 1996 claims data and data from the most recent available cost reports. As explained in section II.B.1 of this proposed rule, payment to providers under OPPS for PHP services represents the provider's overhead costs associated with the program. Because a day of care is the unit that defines the structure and scheduling of partial hospitalization services, we established a per diem payment methodology for the PHP APC. Other than being a per diem payment, we use the general OPPS ratesetting methodology for determining median cost.

As we have described in prior **Federal Register** notices, our current method for computing per diem costs is as follows: we use data from all hospital bills reporting condition code 41, which identifies the claim as partial hospitalization, and all bills from CMHCs. We use CCRs from the most recently available hospital and CMHC cost reports to convert each provider's line-item charges as reported on bills to estimate the provider's cost for a day of PHP services. Per diem costs are then computed by summing the line-item costs on each bill and dividing by the number of days of PHP care provided on the bill. These computed per diem costs are arrayed from lowest to highest and the middle value of the array is the median per diem cost.

We have developed an alternate way to determine median cost by computing a separate per diem cost for each day rather than for each bill. Under this method, a cost is computed separately for each day of PHP care. When there are multiple days of care entered on a claim, a unique cost is computed for each day of care. All of these costs are then arrayed from lowest to highest and the middle value of the array would be the median per diem cost.

We believe this alternative method of computing a per diem median cost produces a more accurate estimate because each day gets an equal weight towards computing the median. We have considered this alternative method for several years, but in light of the volatility of the data, we have not believed it would provide a reasonable and appropriate median per diem cost. In light of the stabilizing trend in the data, and in light of the robustness of recent data analysis, we now believe it is appropriate to propose the adoption of this method. We believe this method for computing a PHP per diem median cost more accurately reflects the costs of a PHP and uses all available PHP data. Therefore, for CY 2008, we are proposing to adopt this alternate method for computing PHP median per diem costs.

As noted previously, for the past 2 years, the data have produced median costs that we believe were too low to cover the cost of a program that typically spans 5 to 6 hours per day. This length of day would include 5 or 6 services with a break for lunch. We looked at the number of units of service being provided in a day of care, as a possible explanation for the low per diem cost for PHP. Our analysis revealed that both hospital-based and CMHC PHPs have a significant number of days where less than 4 units of service were provided.

Specifically, 64 percent of the days that CMHCs were paid were for days where 3 or less units of services were provided, and 34 percent of the days that hospital-based PHPs were paid were for days where 3 or less units of service were provided. We believe these findings are significant because they may explain a lower per diem cost. Therefore, based on these findings, we computed median per diem costs in two categories:

(a) All days.

(b) Days with 4 units of service or more (removing days with 3 services or less).

These median per diem costs were computed separately for CMHCs and hospital based PHPs and are shown in the table below:

	CMHCs	Hospital-based PHPs
All Days	$178	$186
Days with 4 units or more	$191	$218

As expected, excluding the low unit days resulted in a higher median per diem cost estimate. However, if the programs have many ''low unit days,'' their cost and Medicare payment should reflect this level of service. It would not be appropriate to set the PHP rate to exclude the ''low unit days'' because these days are covered PHP days. We believe the analysis of the number of units of service per day supports a lower per diem cost. Therefore, including all days supports the data trend towards a lower per diem cost and we believe more accurately reflects the costs of providing these PHP services.

Although the minimum number of PHP services required in a PHP day is three, it was never our intention that this represented the typical number of services to be provided in a typical PHP day. Our intention was to cover days that consisted of only three services, generally because a patient was transitioning towards discharge. Rather than set separate rates for half-days and full-days, we believed it was appropriate to set one rate that would be paid for all PHP days, including those for patients transitioning towards discharge. We intend that the PHP benefit is for a full day, with shorter days only occurring while a patient transitions out of the PHP.

However, as indicated in the data, many programs have these ''low unit days,'' and we believe their cost and Medicare payment should reflect this level of service. It would not be appropriate to set the PHP rate excluding the low unit days because these days are covered. Again, we believe the data support the estimated per diem cost under $200 that we have observed in the data.

At this time, we believe the most appropriate payment rate for PHPs is computed using both hospital-based and CMHC PHP data, including the remapped data for all days, resulting in a median per diem cost of $178. Therefore, we are proposing a CY 2008 APC PHP per diem cost of $178.

3. Proposed Separate Threshold for Outlier Payments to CMHCs

In the November 7, 2003 final rule with comment period (68 FR 63469), we indicated that, given the difference in PHP charges between hospitals and CMHCs, we did not believe it was appropriate to make outlier payments to CMHCs using the outlier percentage target amount and threshold established for hospitals. There was a significant difference in the amount of outlier payments made to hospitals and CMHCs for PHP. In addition, further analysis indicated that using the same OPPS

outlier threshold for both hospitals and CMHCs did not limit outlier payments to high cost cases and resulted in excessive outlier payments to CMHCs. Therefore, beginning in CY 2004, we established a separate outlier threshold for CMHCs. For CYs 2004 and 2005, we designated a portion of the estimated 2.0 percent outlier target amount specifically for CMHCs, consistent with the percentage of projected payments to CMHCs under the OPPS in each of those years, excluding outlier payments. For CY 2006, we set the estimated outlier target at 1.0 percent and allocated a portion of that 1.0 percent, 0.6 percent (or 0.006 percent of total OPPS payments), to CMHCs for PHP services. For CY 2007, we set the estimated outlier target at 1.0 percent and allocated a portion of that 1.0 percent, an amount equal to 0.15 percent of outlier payments and 0.0015 percent of total OPPS payments to CMHCS for PHP service outliers. The CY 2007 CMHC outlier threshold is met when the cost of furnishing services by a CMHC exceeds 3.40 times the PHP APC payment amount. The CY 2007 OPPS outlier payment percentage is 50 percent of the amount of costs in excess of the threshold.

The separate outlier threshold for CMHCs became effective January 1, 2004, and has resulted in more commensurate outlier payments. In CY 2004, the separate outlier threshold for CMHCs resulted in $1.8 million in outlier payments to CMHCs. In CY 2005, the separate outlier threshold for CMHCs resulted in $0.5 million in outlier payments to CMHCs. In contrast, in CY 2003, more than $30 million was paid to CMHCs in outlier payments. We believe this difference in outlier payments indicates that the separate outlier threshold for CMHCs has been successful in keeping outlier payments to CMHCs in line with the percentage of OPPS payments made to CMHCs.

As noted in section II.G. of this proposed rule, for CY 2008, we are proposing to continue our policy of setting aside 1.0 percent of the aggregate total payments under the OPPS for outlier payments. We are proposing that a portion of that 1.0 percent, an amount equal to 0.03 percent of outlier payments and 0.0003 percent of total OPPS payments, would be allocated to CMHCs for PHP service outliers. As discussed in section II.G. of this proposed rule, we again are proposing to set a dollar threshold in addition to an APC multiplier threshold for OPPS outlier payments. However, because the PHP is the only APC for which CMHCs may receive payment under the OPPS, we would not expect to redirect outlier payments by imposing a dollar threshold. Therefore, we are not proposing to set a dollar threshold for CMHC outliers. As noted above, we are proposing to set the outlier threshold for CMHCs for CY 2008 at 3.40 times the APC payment amount and the CY 2008 outlier payment percentage applicable to costs in excess of the threshold at 50 percent.

C. Proposed Conversion Factor Update

(If you choose to comment on issues in this section, please include the caption ''OPPS: Conversion Factor'' at the beginning of your comment.)

Section 1833(t)(3)(C)(ii) of the Act requires us to update the conversion factor used to determine payment rates under the OPPS on an annual basis. Section 1833(t)(3)(C)(iv) of the Act provides that, for CY 2008, the update is equal to the hospital inpatient market basket percentage increase applicable to hospital discharges under section 1886(b)(3)(B)(iii) of the Act.

The proposed hospital market basket increase for FY 2008 published in the IPPS proposed rule on May 3, 2007, is 3.3 percent (72 FR 24835). To set the OPPS proposed conversion factor for CY 2008, we increased the CY 2007 conversion factor of $61.468, as specified in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68003), by 3.3 percent.

In accordance with section 1833(t)(9)(B) of the Act, we further adjusted the conversion factor for CY 2007 to ensure that the revisions that we are proposing to make to our updates for a revised wage index and rural adjustment are made on a budget neutral basis. We calculated an overall budget neutrality factor of 1.0025 for wage index changes by comparing total payments from our simulation model using the FY 2008 IPPS proposed wage index values to those payments using the current (FY 2007) IPPS wage index values. This adjustment reflects an adjustment of 1.0009 for changes to the wage index and an additional 1.0016 to accommodate the IPPS budget neutrality adjustment for inclusion of the rural floor. As discussed further in section II.D. of this proposed rule, for the first time, the proposed FY 2008 IPPS wage indices include a blanket budget neutrality adjustment for including the rural floor provision, which previously had been applied to the IPPS standardized amount. For further discussion of this proposed policy in its entirety, we refer readers to the FY 2008 IPPS proposed rule (72 FR 24787 through 24792). This proposed adjustment is specific to the IPPS. For the OPPS, we have increased the conversion factor by the proportional amount of the rural floor budget neutrality adjustment to accommodate this proposed change.

We estimated the rural adjustment for CY 2008 to reflect the proposed extension of the adjustment to payment for brachytherapy sources as discussed in section II.F.2. of this proposed rule, but as the impact of the proposed extension was negligible, we did not change the proposed rural adjustment. Therefore, we calculated a budget neutrality factor of 1.000 for the rural adjustment. For CY 2008, we estimate that allowed pass through spending for both drugs and devices would equal approximately $54 million, which represents 0.15 percent of total OPPS projected spending for CY 2008. The proposed conversion factor also is adjusted by the difference between the 0.21 percent pass through dollars set aside in CY 2007 and the 0.15 percent estimate for CY 2008 pass through spending. Finally, proposed payments for outliers remain at 1.0 percent of total payments for CY 2008.

The proposed market basket increase update factor of 3.3 percent for CY 2008, the required wage index and rural budget neutrality adjustment of approximately 1.0025, and the proposed adjustment of 0.06 percent for the difference in the pass-through set aside result in a proposed standard OPPS conversion factor for CY 2008 of $63.693.

D. Proposed Wage Index Changes

(If you choose to comment on issues in this section, please include the caption ''OPPS: Wage Index'' at the beginning of your comment.)

Section 1833(t)(2)(D) of the Act requires the Secretary to determine a wage adjustment factor to adjust, for geographic wage differences, the portion of the OPPS payment rate and the copayment standardized amount attributable to labor and labor related cost. Since the inception of the OPPS, CMS policy has been to wage adjust 60 percent of the OPPS payment, based on a regression analysis that determined that approximately 60 percent of the costs of services paid under the OPPS were attributable to wage costs. We confirmed that this labor related share for outpatient services is still appropriate during our regression analysis for the payment adjustment for rural hospitals in the CY 2006 OPPS final rule with comment period (70 FR 68553). We are not proposing to revise this policy for the CY 2008 OPPS. We refer readers to section II.H. of this proposed rule for a description and example of how the wage index for a

particular hospital is used to determine the payment for the hospital. This adjustment must be made in a budget neutral manner. (As we have done in prior years, we are proposing to adopt the final IPPS wage indices for the OPPS and to extend these wage indices to hospitals that participate in the OPPS but not the IPPS (referred to in this section as ''non IPPS'' hospitals).)

As discussed in section II.A. of this proposed rule, we standardize 60 percent of estimated costs (labor-related costs) for geographic area wage variation using the IPPS pre-reclassified wage indices in order to remove the effects of differences in area wage levels in determining the national unadjusted OPPS payment rate and the copayment amount.

As published in the original OPPS April 7, 2000 final rule with comment period (65 FR 18545), OPPS has consistently adopted the final IPPS wage indices as the wage indices for adjusting the OPPS standard payment amounts for labor market differences. Thus, the wage index that applies to a particular hospital under the IPPS will also apply to that hospital under the OPPS. As initially explained in the September 8, 1998 OPPS proposed rule, we believed and continue to believe that using the IPPS wage index as the source of an adjustment factor for OPPS is reasonable and logical, given the inseparable, subordinate status of the hospital outpatient within the hospital overall. In accordance with section 1886(d)(3)(E) of the Act, the IPPS wage index is updated annually. In accordance with our established policy, we are proposing to use the final FY 2008 final version of these wage indices to determine the wage adjustments for the OPPS payment rate and copayment standardized amount that would be published in our final rule with comment period for CY 2008.

We note that the proposed FY 2008 IPPS wage indices continue to reflect a number of changes implemented over the past few years as a result of the revised Office of Management and Budget (OMB) standards for defining geographic statistical areas, the implementation of an occupational mix adjustment as part of the wage index, wage adjustments provided for under Pub. L. 105–33 and Pub. L. 108–173, and clarification of our policy for multicampus hospitals. The following is a brief summary of the components of the proposed FY 2008 IPPS wage indices and any adjustments that we are proposing to apply to the OPPS for CY 2008. We refer the reader to the FY 2008 IPPS proposed rule (72 FR 24776 through 24802) for a detailed discussion of the changes to the wage indices and to the correction notice to the FY 2008 IPPS proposed rule published in the **Federal Register** on June 7, 2007 (72 FR 31507). In this proposed rule, we are not reprinting the proposed FY 2008 IPPS wage indices referenced in the discussion below, with the exception of the out-migration wage adjustment table (Addendum L to this proposed rule). We also refer readers to the CMS Web site for the OPPS at *http://www.cms.hhs.gov/providers/hopps*. At this Web site, the reader will find a link to the proposed FY 2008 IPPS wage indices tables and to those tables as corrected in the correction notice to the FY 2008 IPPS proposed rule published in the **Federal Register** on June 7, 2007.

1. *The proposed continued use of the Core Based Statistical Areas (CBSAs) issued by the OMB as revised standards for designating geographical statistical areas based on the 2000 Census data, to define labor market areas for hospitals for purposes of the IPPS wage index.* The OMB revised standards were published in the **Federal Register** on December 27, 2000 (65 FR 82235), and OMB announced the new CBSAs on June 6, 2003, through an OMB bulletin. In the FY 2005 IPPS final rule, CMS adopted the new OMB definitions for wage index purposes. In the FY 2008 IPPS proposed rule, we again stated that hospitals located in Metropolitan Statistical Areas (MSAs) will be urban and hospitals that are located in Micropolitan Areas or outside CBSAs will be rural. We also reiterated our policy that when an MSA is divided into one or more Metropolitan Divisions, we use the Metropolitan Division for purposes of defining the boundaries of a particular labor market area. To help alleviate the decreased payments for previously urban hospitals that became rural under the new geographical definitions, we allowed these hospitals to maintain for the 3-year period from FY 2005 through FY 2007, the wage index of the MSA where they previously had been located. This hold harmless provision expires after FY 2007. We adopted the same policy for OPPS, but because the OPPS operates on a calendar year, wage index policies are in effect through December 31, 2007. To be consistent with the IPPS, as proposed in the FY 2008 IPPS proposed rule, beginning in CY 2008 (January 1, 2008) under the OPPS, these hospitals will receive their statewide rural wage index. Hospitals paid under the IPPS are eligible to apply for reclassification in FY 2008.

As noted above, for purposes of estimating an adjustment for the OPPS payment rates to accommodate geographic differences in labor costs in this proposed rule, we have used the wage indices identified in the FY 2008 IPPS proposed rule and as corrected in the June 7, 2007 correction notice to the FY 2008 IPPS proposed rule, that are fully adjusted for differences in occupational mix using the entire 6-month survey data collected in 2006.

2. *The reclassifications of hospitals to geographic areas for purposes of the wage index.* For purposes of the OPPS wage index, we are proposing to adopt all of the IPPS reclassifications for FY 2008, including reclassifications that the Medicare Geographic Classification Review Board (MGCRB) approved. We note that reclassifications under section 508 of Pub. L. 108–173 were set to terminate March 31, 2007. However, section 106(a) of the MIEA-TRHCA extended any geographic reclassifications of hospitals that were made under section 508 and that would expire on March 31, 2007 until September 30, 2007. On March 23, 2007, we published a notice in the **Federal Register** (72 FR 13799) that indicated how we are implementing section 106 of the MIEA-TRHCA through September 30, 2007. Because the section 508 provision will expire on September 30, 2007, the OPPS wage index will not include any reclassifications under section 508 for CY 2008.

3. *The out-migration wage adjustment to the wage index.* In the FY 2008 IPPS proposed rule (72 FR 24798 through 24799), we discussed the out-migration adjustment under section 505 of Pub. L. 108–173 for counties under this adjustment. Hospitals paid under the IPPS located in the qualifying section 505 ''out-migration'' counties receive a wage index increase unless they have already been otherwise reclassified. We note that in the FY 2008 IPPS proposed rule, we propose using the post-reclassified, rather than the pre-reclassified wage indices, in calculating the out-migration adjustment. (See the FY 2008 IPPS proposed rule for further information on the out-migration adjustment.) For OPPS purposes, we are proposing to continue our policy in CY 2008 to allow non IPPS hospitals paid under the OPPS to qualify for the out-migration adjustment if they are located in a section 505 out-migration county. Because non-IPPS hospitals cannot reclassify, they are eligible for the out migration wage adjustment. Table 4J published in the addendum to the FY 2008 IPPS proposed rule and as corrected in the June 7, 2007 correction notice to the FY 2008 IPPS proposed rule identifies counties eligible for the out-migration adjustment. As stated earlier, we are reprinting the corrected

version of Table 4J in this proposed rule as Addendum L.

4. *Wage Index for Multicampus Hospitals.* We also wish to clarify that the IPPS policy for multicampus wage index payments also applies to OPPS. As a result of the new labor market areas introduced in FY 2005, there are hospitals with multiple campuses previously located in a single MSA that are now in more than one CBSA. A multicampus hospital is an integrated institution. For this reason, the multicampus hospital has one provider number and submits a single cost report that combines the total wages and hours of each of its campuses in the manner described in the FY 2008 IPPS proposed rule (72 FR 24783).

In the FY 2008 IPPS proposed rule, we proposed to apportion wages and hours across multiple campuses using full-time equivalent (FTE) staff data in order to include wage data for the individual campuses of a multicampus hospital in its local wage index calculation. To the extent that a multicampus hospital system has associated outpatient facilities, we would expect the FTEs for those outpatient facilities to be included in the FTE estimate for the closest inpatient facility. As part of this policy, we would fully expect that an OPD that is part of a multicampus hospital system would receive a wage index based on the geographic location of the inpatient campus with which it is associated. This would include cases where one inpatient campus reclassified. Affiliated outpatient facilities would receive the reclassified wage index of the inpatient campus. For further discussion of the FY 2008 IPPS proposed multicampus hospital policy in its entirety, we refer readers to the FY 2008 IPPS proposed rule (72 FR 24783 through 24784).

5. *Rural Floor Provision.* Section 4410 of Pub. L. 105–33 provides that the area wage index applicable to any hospital that is located in an urban area of a State may not be less than the area wage index applicable to hospitals located in rural areas of the State (''the rural floor''). Table 4A in the FY 2008 IPPS proposed rule (72 FR 24924), as corrected in the June 7, 2007 correction notice (72 FR 31507), identifies urban areas where hospitals located in those areas are assigned the rural floor (noted by a superscript ''2''). For CY 2008 under the OPPS, we are proposing to continue our policy to allow non-IPPS hospitals paid under the OPPS to receive the rural floor wage index when applicable under the IPPS for FY 2008. For the first time, the proposed FY 2008 IPPS wage indices include a blanket budget neutrality adjustment for including the rural floor provision, which previously had been applied to the IPPS standardized amount. For further discussion of this proposed policy in its entirety, we refer readers to the FY 2008 IPPS proposed rule (72 FR 24787 through 24792).

We note that all changes to the wage index resulting from geographic labor market area reclassifications or other adjustments must be incorporated in a budget neutral manner. Accordingly, in calculating the OPPS budget neutrality estimates for CY 2008, in this proposed rule, we have included the wage index changes that would result from the MGCRB reclassifications, implementation of sections 4410 of Pub. L. 105–33 and 505 of Pub. L. 108–173, and other refinements proposed in the FY 2008 IPPS proposed rule. For the CY 2008 OPPS final rule, we are proposing to use the final FY 2008 IPPS wage indices, including the budget neutrality adjustment for the rural floor for calculating OPPS payment in CY 2008. We discuss how the proposed OPPS conversion factor compensates for the inclusion of this budget neutrality adjustment in the wage indices in the budget neutrality section (II.C.) of this proposed rule.

E. Proposed Statewide Average Default CCRs

(If you choose to comment on issues in this section, please include the caption ''OPPS: Statewide Cost-to Charge Ratios'' at the beginning of your comment.)

CMS uses CCRs to determine outlier payments, payments for pass-through devices, and monthly interim transitional corridor payments under the OPPS. Some hospitals do not have a valid CCR. These hospitals include, but are not limited to, hospitals that are new and have not yet submitted a cost report, hospitals that have a CCR that falls outside predetermined floor and ceiling thresholds for a valid CCR, or hospitals that have recently given up their all-inclusive rate status. Last year, we updated the default urban and rural CCRs for CY 2007 in our final rule with comment period (71 FR 68006 through 68009). In this proposed rule, we are proposing to update the default ratios for CY 2008 using the most recent cost report data.

We calculated the statewide default CCRs using the same overall CCRs that we use to adjust charges to costs on claims data. Table 25 lists the proposed CY 2008 default urban and rural CCRs by State and compares them to last year's default CCRs. These CCRs are the ratio of total costs to total charges from each provider's most recently submitted cost report, for those cost centers relevant to outpatient services weighted by Medicare Part B charges. We also adjusted these ratios to reflect final settled status by applying the differential between settled to submitted costs and charges from the most recent pair of settled to submitted cost reports.

For this proposed rule, 78.17 percent of the submitted cost reports represented data for CY 2005. We only used valid CCRs to calculate these default ratios. That is, we removed the CCRs for all-inclusive hospitals, CAHs, and hospitals in Guam, and the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands because these entities are not paid under the OPPS, or in the case of all-inclusive hospitals, because their CCRs are suspect. We further identified and removed any obvious error CCRs and trimmed any outliers. We limited the hospitals used in the calculation of the default CCRs to those hospitals that billed for services under the OPPS during CY 2006.

Finally, we calculated an overall average CCR, weighted by a measure of volume for CY 2006, for each state except Maryland. This measure of volume is the total lines on claims and is the same one that we use in our impact tables. For Maryland, we used an overall weighted average CCR for all hospitals in the nation as a substitute for Maryland CCRs. Few providers in Maryland are eligible to receive payment under the OPPS, which limits the data available to calculate an accurate and representative CCR. The observed differences between last year's and this year's default statewide CCRs largely reflect a general decline in the ratio between costs and charges widely observed in the cost report data. However, observed increases in some areas suggest that the decline in CCRs is moderating. Further, the addition of weighting by Part B charges to the overall CCR in CY 2007 slightly increases the variability of the overall CCR calculation.

As stated above, CMS uses default statewide CCRs for several groups of hospitals, including, but not limited to, hospitals that are new and have not yet submitted a cost report, hospitals that have a CCR that falls outside predetermined floor and ceiling thresholds for a valid CCR, and hospitals that have recently given up their all-inclusive rate status. Current OPPS policy also requires hospitals that experience a change of ownership, but that do not accept assignment of the previous hospital's provider agreement, to use the previous provider's CCR.

For CY 2008, we are proposing to continue to apply this treatment of using the default statewide CCR, to include an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18, and that has not yet submitted its first Medicare cost report. This policy is effective for hospitals experiencing a change of ownership on or after January 1, 2007. As stated in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68006), we believe that a hospital that has not accepted assignment of an existing hospital's provider agreement is similar to a new hospital that will establish its own costs and charges. We also believe that the hospital that has chosen not to accept assignment may have different costs and charges than the existing hospital. Furthermore, we believe that the hospital should be provided time to establish its own costs and charges. Therefore, we are proposing to use the default statewide CCR to determine cost-based payments until the hospital has submitted its first Medicare cost report.

TABLE 25.—PROPOSED CY 2008 STATEWIDE AVERAGE CCRS

State	Rural/urban	Proposed CY 2008 default CCR	Previous default CCR (CY 2007 OPPS final rule)
ALASKA	RURAL	0.5389	0.5337
ALASKA	URBAN	0.3851	0.3830
ALABAMA	RURAL	0.2317	0.2321
ALABAMA	URBAN	0.2198	0.2228
ARKANSAS	RURAL	0.2660	0.2645
ARKANSAS	URBAN	0.2776	0.2749
ARIZONA	RURAL	0.2770	0.2823
ARIZONA	URBAN	0.2360	0.2323
CALIFORNIA	RURAL	0.2305	0.2463
CALIFORNIA	URBAN	0.2260	0.2324
COLORADO	RURAL	0.3677	0.3704
COLORADO	URBAN	0.2578	0.2672
CONNECTICUT	RURAL	0.3888	0.3886
CONNECTICUT	URBAN	0.3481	0.3491
DISTRICT OF COLUMBIA	URBAN	0.3364	0.3392
DELAWARE	RURAL	0.3192	0.3230
DELAWARE	URBAN	0.3952	0.3953
FLORIDA	RURAL	0.2175	0.2191
FLORIDA	URBAN	0.1985	0.1990
GEORGIA	RURAL	0.2842	0.2846
GEORGIA	URBAN	0.2786	0.2888
HAWAII	RURAL	0.3781	0.3574
HAWAII	URBAN	0.3171	0.3199
IOWA	RURAL	0.3499	0.3489
IOWA	URBAN	0.3379	0.3428
IDAHO	RURAL	0.4369	0.4360
IDAHO	URBAN	0.4097	0.4159
ILLINOIS	RURAL	0.2910	0.3082
ILLINOIS	URBAN	0.2812	0.2878
INDIANA	RURAL	0.3207	0.3160
INDIANA	URBAN	0.3155	0.3204
KANSAS	RURAL	0.3201	0.3200
KANSAS	URBAN	0.2466	0.2523
KENTUCKY	RURAL	0.2480	0.2508
KENTUCKY	URBAN	0.2666	0.2698
LOUISIANA	RURAL	0.2727	0.2808
LOUISIANA	URBAN	0.2842	0.2730
MARYLAND	RURAL	0.2924	0.3181
MARYLAND	URBAN	0.3140	0.2978
MASSACHUSETTS	URBAN	0.3466	0.3487
MAINE	RURAL	0.4580	0.4568
MAINE	URBAN	0.4261	0.4294
MICHIGAN	RURAL	0.3354	0.3461
MICHIGAN	URBAN	0.3272	0.3286
MINNESOTA	RURAL	0.5094	0.5085
MINNESOTA	URBAN	0.3452	0.3383
MISSOURI	RURAL	0.2916	0.2944
MISSOURI	URBAN	0.2977	0.3034
MISSISSIPPI	RURAL	0.2820	0.2841
MISSISSIPPI	URBAN	0.2300	0.2312
MONTANA	RURAL	0.4664	0.4392
MONTANA	URBAN	0.4646	0.4628
NORTH CAROLINA	RURAL	0.3007	0.3048
NORTH CAROLINA	URBAN	0.3580	0.3700
NORTH DAKOTA	RURAL	0.3831	0.3668
NORTH DAKOTA	URBAN	0.3842	0.3945
NEBRASKA	RURAL	0.3561	0.3756

TABLE 25.—PROPOSED CY 2008 STATEWIDE AVERAGE CCRS—Continued

State	Rural/urban	Proposed CY 2008 default CCR	Previous default CCR (CY 2007 OPPS final rule)
NEBRASKA	URBAN	0.2832	0.2899
NEW HAMPSHIRE	RURAL	0.3646	0.3700
NEW HAMPSHIRE	URBAN	0.3217	0.3249
NEW JERSEY	URBAN	0.2908	0.2972
NEW MEXICO	RURAL	0.2759	0.2741
NEW MEXICO	URBAN	0.3691	0.3978
NEVADA	RURAL	0.3370	0.3348
NEVADA	URBAN	0.1949	0.2141
NEW YORK	RURAL	0.4210	0.4446
NEW YORK	URBAN	0.4177	0.4275
OHIO	RURAL	0.3629	0.3689
OHIO	URBAN	0.2760	0.2834
OKLAHOMA	RURAL	0.2874	0.2949
OKLAHOMA	URBAN	0.2517	0.2608
OREGON	RURAL	0.3344	0.3438
OREGON	URBAN	0.3899	0.4054
PENNSYLVANIA	RURAL	0.2980	0.3052
PENNSYLVANIA	URBAN	0.2448	0.2524
PUERTO RICO	URBAN	0.4718	0.4689
RHODE ISLAND	URBAN	0.3085	0.3087
SOUTH CAROLINA	RURAL	0.2589	0.2546
SOUTH CAROLINA	URBAN	0.2563	0.2479
SOUTH DAKOTA	RURAL	0.3517	0.3479
SOUTH DAKOTA	URBAN	0.2918	0.3035
TENNESSEE	RURAL	0.2607	0.2648
TENNESSEE	URBAN	0.2514	0.2491
TEXAS	RURAL	0.2823	0.2891
TEXAS	URBAN	0.2495	0.2580
UTAH	RURAL	0.4320	0.4410
UTAH	URBAN	0.4218	0.4161
VIRGINIA	RURAL	0.2788	0.2821
VIRGINIA	URBAN	0.2789	0.2805
VERMONT	RURAL	0.4329	0.4325
VERMONT	URBAN	0.3401	0.3376
WASHINGTON	RURAL	0.3796	0.3742
WASHINGTON	URBAN	0.3574	0.3717
WISCONSIN	RURAL	0.3633	0.3670
WISCONSIN	URBAN	0.3648	0.3638
WEST VIRGINIA	RURAL	0.3134	0.3162
WEST VIRGINIA	URBAN	0.3677	0.3691
WYOMING	RURAL	0.4655	0.4714
WYOMING	URBAN	0.3592	0.3520

F. Proposed OPPS Payments to Certain Rural Hospitals

1. Hold Harmless Transitional Payment Changes Made by Pub. L. 109–171 (DRA)

(If you choose to comment on issues in this section, please include the caption ''Rural Hospital Hold Harmless Transitional Payments'' at the beginning of your comment.)

When the OPPS was implemented, every provider was eligible to receive an additional payment adjustment (transitional corridor payment) if the payments it received for covered OPD services under the OPPS were less than the payments it would have received for the same services under the prior reasonable cost-based system. Section 1833(t)(7) of the Act provides that the transitional corridor payments are temporary payments for most providers, with two exceptions, to ease their transition from the prior reasonable cost-based payment system to the OPPS system. Cancer hospitals and children's hospitals receive the transitional corridor payments on a permanent basis. Section 1833(t)(7)(D)(i) of the Act originally provided for transitional corridor payments to rural hospitals with 100 or fewer beds for covered OPD services furnished before January 1, 2004. However, section 411 of Pub. L. 108–173 amended section 1833(t)(7)(D)(i) of the Act to extend these payments through December 31, 2005, for rural hospitals with 100 or fewer beds. Section 411 also extended the transitional corridor payments to SCHs located in rural areas for services furnished during the period that begins with the provider's first cost reporting period beginning on or after January 1, 2004, and ends on December 31, 2005. Accordingly, the authority for making transitional corridor payments under section 1833(t)(7)(D)(i) of the Act, as amended by section 411 of Pub. L. 108–173, expired for rural hospitals having 100 or fewer beds and SCHs located in rural areas on December 31, 2005.

Section 5105 of Pub. L. 109–171 reinstituted the hold harmless transitional outpatient payments (TOPs) for covered OPD services furnished on or after January 1, 2006, and before January 1, 2009, for rural hospitals having 100 or fewer beds that are not SCHs. When the OPPS payment is less than the payment the provider would have received under the previous

reasonable cost-based system, the amount of payment is increased by 95 percent of the amount of the difference between those two payment systems for CY 2006, by 90 percent of the amount of that difference for CY 2007, and by 85 percent of the amount of that difference for CY 2008.

For CY 2006, we implemented section 5105 of Pub. L. 109–171 through Transmittal 877, issued on February 24, 2006. We did not specifically address whether TOPs payments apply to essential access community hospitals (EACHs), which are considered to be SCHs under section 1886(d)(5)(D)(iii)(III) of the Act. Accordingly, under the statute, EACHs are treated as SCHs. Therefore, we believe that EACHs are not currently eligible for TOPs payment under Pub. L. 109–171. In the CY 2007 OPPS/ASC final rule with comment period, we updated § 419.70(d) to reflect the requirements of Pub. L. 109 171 (71 FR 68010 and 68228).

2. Proposed Adjustment for Rural SCHs Implemented in CY 2006 Related to Public Law 108–173 (MMA)

(If you choose to comment on issues in this section, please include the caption ''OPPS: Rural SCH Payments'' at the beginning of your comment.)

In the CY 2006 OPPS final rule with comment period (70 FR 68556), we finalized a payment increase for rural SCHs of 7.1 percent for all services and procedures paid under the OPPS, excluding drugs, biologicals, brachytherapy seeds, and services paid under pass-through payment policy in accordance with section 1833(t)(13)(B) of the Act, as added by section 411 of Pub. L. 108 173. Section 411 gave the Secretary the authority to make an adjustment to OPPS payments for rural hospitals, effective January 1, 2006, if justified by a study of the difference in costs by APC between hospitals in rural and urban areas. Our analysis showed a difference in costs only for rural SCHs and we implemented a payment adjustment for those hospitals beginning January 1, 2006.

Last year, we became aware that we did not specifically address whether the adjustment applies to EACHs, which are considered to be SCHs under section 1886(d)(5)(D)(iii)(III) of the Act. Thus, under the statute, EACHs are treated as SCHs. Currently, fewer than 10 hospitals are classified as EACHs. As of CY 1998, under section 4201(c) of Pub. L. 105–33, a hospital can no longer become newly classified as an EACH. Therefore, in the CY 2007 OPPS/ASC final rule with comment period for purposes of receiving this rural adjustment, we revised § 419.43(g) to clarify that EACHs are also eligible to receive the rural SCH adjustment, assuming these entities otherwise meet the rural adjustment criteria (71 FR 68010 and 68227).

This adjustment is budget neutral and applied before calculating outliers and coinsurance. As stated in the CY 2006 OPPS final rule with comment period (70 FR 68560), we would not reestablish the adjustment amount on an annual basis, but we might review the adjustment in the future and, if appropriate, would revise the adjustment.

For CY 2008, we are proposing to continue our current policy of a budget neutral 7.1 percent payment increase for rural SCHs, including EACHs, for all services and procedures paid under the OPPS, excluding drugs, biologicals, and services paid under the pass-through payment policy in accordance with section 1833(t)(13)(B) of the Act. For CY 2008, we are proposing to include brachytherapy sources in the group of services eligible for the 7.1 percent payment increase because we are proposing to pay them at prospective rates based on their median costs as calculated from historical claims data. Consequently, we are proposing to revise § 419.43 to reflect our proposal to make brachytherapy sources eligible for the 7.1 percent payment increase for rural SCHs. We plan to reassess the 7.1 percent adjustment in the near future by examining differences between urban and rural costs using updated claims, cost, and provider information. In that process, we will include brachytherapy sources in each hospital's mix of services.

G. Proposed Hospital Outpatient Outlier Payments

(If you choose to comment on issues in this section, please include the caption ''OPPS: Outlier Payments'' at the beginning of your comment.)

Currently, the OPPS pays outlier payments on a service-by-service basis. For CY 2007, the outlier threshold is met when the cost of furnishing a service or procedure by a hospital exceeds 1.75 times the APC payment amount and exceeds the APC payment rate plus a $1,825 fixed-dollar threshold. We introduced a fixed-dollar threshold in CY 2005 in addition to the traditional multiple threshold in order to better target outliers to those high cost and complex procedures where a very costly service could present a hospital with significant financial loss. If a provider meets both of these conditions, the multiple threshold and the fixed-dollar threshold, the outlier payment is calculated as 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment rate.

As explained in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68011 through 68012), we set our projected target for aggregate outlier payments at 1.0 percent of aggregate total payments under the OPPS for CY 2007. The outlier thresholds were set so that estimated CY 2007 aggregate outlier payments would equal 1.0 percent of aggregate total payments under the OPPS. In that final rule with comment period (71 FR 68010), we also published total outlier payments as a percent of total expenditures for CY 2005. In the past, we have received comments asking us to publish estimated outlier payments to provide a context for the proposed outlier thresholds for the update year. Our current estimate, using available CY 2006 claims, is that outlier payments for CY 2006 would be approximately 1.1 percent of total CY 2006 OPPS payment. Using the same set of claims and CY 2007 payment rates, we currently estimate that outlier payments for CY 2007 would be approximately 1.0 percent of total CY 2007 OPPS payments. We note that we provide estimated CY 2008 outlier payments by hospital for hospitals with claims included in the claims data that we used to model impacts on the CMS Web site in the Hospital Specific Impacts—Provider-Specific Data file on the CMS Web site at: *http://www.cms.hhs.gov/HospitalOutpatientPPS/*.

For CY 2008, we are proposing to continue our policy of setting aside 1.0 percent of aggregate total payments under the OPPS for outlier payments. We are proposing that a portion of that 1.0 percent, 0.03 percent, would be allocated to CMHCs for partial hospitalization program service outliers. This amount is the amount of estimated outlier payments resulting from the proposed CMHC outlier threshold of 3.4 times the APC payment rate, as a proportion of all payments dedicated to outlier payments. For further discussion of CMHC outliers, we refer readers to section II.B.3. of this proposed rule.

In order to ensure that estimated CY 2008 aggregate outlier payments would equal 1.0 percent of estimated aggregate total payments under the OPPS, we are proposing that the outlier threshold be set so that outlier payments would be triggered when the cost of furnishing a service or procedure by a hospital exceeds 1.75 times the APC payment amount and exceeds the APC payment rate plus a $2,000 fixed-dollar threshold. This proposed threshold reflects minor changes to the

methodology discussed below as well as APC recalibration, including changes due in part to the CY 2008 packaging proposal discussed in section II.A.4. of this proposed rule.

We calculated the fixed-dollar threshold for this CY 2008 proposed rule using largely the same methodology as we did in CY 2007, except that we are proposing to adjust the overall CCRs to reflect the anticipated annual decline in overall CCRs, discussed below, and to use CCRs from the most recent update to the Outpatient Provider-Specific File (OPSF), rather than CCRs we calculate internally for ratesetting. In November 2006, we issued Transmittal 1030, ''Policy Changes to the Fiscal Intermediary (FI) Calculation of Hospital Outpatient Payment System (OPPS) and Community Mental Health Center (CMHC) Cost-to-Charge Ratios (CCRs),'' instructing fiscal intermediaries (or, if applicable, the MAC) to update the overall CCR calculation for outlier and other cost-based payments using the CCR calculation methodology that we finalized for CY 2007. As discussed in the CY 2007 proposed and final rules, this methodology aligned the fiscal intermediary's CCR calculation and the CCR calculation we previously used to model outlier thresholds by removing allied and nursing health costs for those hospitals with paramedical education programs from the fiscal intermediary's CCR calculation and weighting our ''traditional'' CCR calculation by total Medicare Part B charges. We believe that the OPSF best estimates the CCRs that fiscal intermediaries (or, if applicable, MAC) would use to determine outlier payments in CY 2008. For this proposed rule, we used the April update to the OPSF. We supplemented a CCR calculated internally for the handful of providers with claims in our claims dataset that were not listed in the April update to the OPSF.

The claims that we use to model each OPPS update lag by 2 years. For this proposed rule, we used CY 2006 claims to model the CY 2008 OPPS. In order to estimate CY 2008 outlier payments for this proposed rule, we inflated the charges on the CY 2006 claims using the same inflation factor of 1.1504 that we used to estimate the IPPS fixed dollar outlier threshold for the FY 2008 IPPS proposed rule. For 1 year, the inflation factor is 1.0726. The methodology for determining this charge inflation factor was discussed in the FY 2008 IPPS proposed rule (72 FR 24837). As we stated in the CY 2005 OPPS final rule with comment period, we believe that the use of this charge inflation factor is appropriate for the OPPS because, with the exception of the routine service cost centers, hospitals use the same cost centers to capture costs and charges across inpatient and outpatient services (69 FR 65845).

In comments on the CY 2007 OPPS/ASC proposed rule, a commenter asked that CMS modify the charge methodology used to set the OPPS outlier threshold to account for the change in CCRs over time in a manner similar to that used for the FY 2007 IPPS. The commenter indicated that it would be appropriate to apply an inflation adjustment factor so that the CCRs that CMS uses to simulate OPPS outlier payments would more closely reflect the CCRs that would be used in CY 2007 to determine actual outlier payment. In the CY 2007 OPPS/ASC final rule with comment period, we expressed concern that cost increases between inpatient and outpatient departments could be different and indicated that we would study the issue and address any changes to the outlier methodology through future rulemaking (71 FR 68012).

In assessing the possibility of utilizing a cost inflation adjustment for the OPPS, we determined that we could not calculate an OPPS-specific reliable cost per unit, comparable to the cost per discharge component of the IPPS calculation, because of variability in definition of an OPPS unit of service across calendar years. However, we also believe that the costs and charges reported under the applicable cost centers largely are commingled inpatient and outpatient costs and charges. Notwithstanding fairly accurate estimates of outlier payments as a percent of total payments over the past few years, as discussed above, we do not want to systematically overestimate the OPPS outlier threshold as could occur if we did not apply a CCR inflation adjustment factor. Therefore, we are proposing to apply the CCR inflation adjustment factor that is proposed to be applied for IPPS outlier calculation to the CCRs used to simulate the CY 2008 OPPS outlier payments that determine the fixed dollar threshold. Specifically, for CY 2008, we are proposing to apply an adjustment of 0.9912 to the CCRs that are currently on the OPSF to trend them forward from CY 2007 to CY 2008. The methodology for calculating this adjustment is discussed in the FY 2008 IPPS proposed rule (72 FR 24837).

Therefore, for this CY 2008 proposed rule, we applied the overall CCRs from the April 2007 OPSF file after adjustment to approximate CY 2008 CCRs (using the proposed CCR inflation adjustment factor of 0.9912) to charges on CY 2006 claims that were adjusted to approximate CY 2008 charges (using the proposed charge inflation factor of 1.1504). We simulated aggregated CY 2008 outlier payments using these costs for several different fixed-dollar thresholds, holding the 1.75 multiple constant and assuming that outlier payment would continue to be made at 50 percent of the amount by which the cost of furnishing the service would exceed 1.75 times the APC payment amount, until the total outlier payments equaled 1.0 percent of aggregated estimated total CY 2008 OPPS payments. We estimate that a proposed fixed dollar threshold of $2,000, combined with the proposed multiple threshold of 1.75 times the APC payment rate, would allocate 1.0 percent of aggregated total OPPS payments to outlier payments. We are proposing to continue to make an outlier payment that equals 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment amount when both the 1.75 multiple threshold and the fixed dollar $2,000 threshold are met. For CMHCs, if a CMHC provider's cost for partial hospitalization exceeds 3.4 times the payment rate for APC 0033, the outlier payment is calculated as 50 percent of the amount by which the cost exceeds 3.4 times the APC payment rate.

H. Calculation of the Proposed National Unadjusted Medicare Payment

(If you choose to comment on issues in this section, please include the caption ''OPPS: National Unadjusted Medicare Payment'' at the beginning of your comment.)

The basic methodology for determining prospective payment rates for OPD services under the OPPS is set forth in existing regulations at § 419.31 and § 419.32. The payment rate for services and procedures for which payment is made under the OPPS is the product of the conversion factor calculated in accordance with section II.C. of this proposed rule and the relative weight determined under section II.A. of this proposed rule. Therefore, the national unadjusted payment rate for each APC contained in Addendum A to this proposed rule and for HCPCS codes to which payment under the OPPS has been assigned in Addendum B to this proposed rule (Addendum B is provided as a convenience for readers) was calculated by multiplying the proposed CY 2008 scaled weight for the APC by the proposed CY 2008 conversion factor.

However, to determine the payment that will be made in a calendar year under the OPPS to a specific hospital for

an APC for a service that has a status indicator of ''S,'' ''T,'' ''V,'' or ''X'' in a circumstance in which the multiple procedure discount does not apply, we take the following steps:

Step 1. Calculate 60 percent (the labor-related portion) of the national unadjusted payment rate. Since the initial implementation of the OPPS, we have used 60 percent to represent our estimate of that portion of costs attributable, on average, to labor. (We refer readers to the April 7, 2000 final rule with comment period (65 FR 18496 through 18497) for a detailed discussion of how we derived this percentage.) We confirmed that this labor-related share for hospital outpatient services is still appropriate during our regression analysis for the payment adjustment for rural hospitals in the CY 2006 OPPS final rule with comment period (70 FR 68553).

Step 2. Determine the wage index area in which the hospital is located and identify the wage index level that applies to the specific hospital. The wage index values assigned to each area reflect the new geographic statistical areas as a result of revised OMB standards (urban and rural) to which hospitals are assigned for FY 2008 under the IPPS, reclassifications through the MCGRB, section 1886(d)(8)(B) ''Lugar'' hospitals, and section 401 of Pub. L. 108–173. We note that the reclassifications of hospitals under the one-time appeals process under section 508 of Pub. L. 108–173 expires on September 30, 2007, and is no longer applicable in this determination of appropriate wage values for CY 2008 OPPS. The wage index values include the occupational mix adjustment described in section II.D. of this proposed rule that was developed for the proposed FY 2008 IPPS payment rates published in the **Federal Register** on May 3, 2007 (72 FR 24777 through 27782).

Step 3. Adjust the wage index of hospitals located in certain qualifying counties that have a relatively high percentage of hospital employees who reside in the county, but who work in a different county with a higher wage index, in accordance with section 505 of Pub. L. 108–173. Addendum L to this proposed rule contains the qualifying counties and the proposed wage index increase developed for the FY 2008 IPPS as corrected in the June 7, 2007 correction notice to the FY 2008 IPPS proposed rule (72 FR 31507). This step is to be followed only if the hospital has chosen not to accept reclassification under Step 2 above.

Step 4. Multiply the applicable wage index determined under Steps 2 and 3 by the amount determined under Step 1 that represents the labor-related portion of the national unadjusted payment rate.

Step 5. Calculate 40 percent (the nonlabor-related portion) of the national unadjusted payment rate and add that amount to the resulting product of Step 4. The result is the wage index adjusted payment rate for the relevant wage index area.

Step 6. If a provider is a SCH, as defined in § 412.92, or an EACH, which is considered to be a SCH under section 1886(d)(5)(D)(iii)(III) of the Act, and located in a rural area, as defined in § 412.63(b), or is treated as being located in a rural area under § 412.103, multiply the wage index adjusted payment rate by 1.071 to calculate the total payment.

I. Proposed Beneficiary Copayments

(If you choose to comment on issues in this section, please include the caption ''OPPS: Beneficiary Copayments'' at the beginning of your comment.)

1. Background

Section 1833(t)(3)(B) of the Act requires the Secretary to set rules for determining copayment amounts to be paid by beneficiaries for covered OPD services. Section 1833(t)(8)(C)(ii) of the Act specifies that the Secretary must reduce the national unadjusted copayment amount for a covered OPD service (or group of such services) furnished in a year in a manner so that the effective copayment rate (determined on a national unadjusted basis) for that service in the year does not exceed specified percentages. For all services paid under the OPPS in CY 2008, and in calendar years thereafter, the specified percentage is 40 percent of the APC payment rate (section 1833(t)(8)(C)(ii)(V) of the Act). Section 1833(t)(3)(B)(ii) of the Act provides that, for a covered OPD service (or group of such services) furnished in a year, the national unadjusted coinsurance amount cannot be less than 20 percent of the OPD fee schedule amount. Sections 1834(d)(2)(C)(ii) and (d)(3)(C)(ii) of the Act further requires that the coinsurance for screening flexible sigmoidoscopies and screening colonoscopies be equal to 25 percent of the payment amount. We have applied the 25-percent coinsurance to screening flexible sigmoidoscopies and screening colonoscopies since the beginning of the OPPS.

2. Proposed Copayment

For CY 2008, we are proposing to determine copayment amounts for new and revised APCs using the same methodology that we implemented for CY 2004. (We refer readers to the November 7, 2003 OPPS final rule with comment period (68 FR 63458).) The proposed unadjusted copayment amounts for services payable under the OPPS that would be effective January 1, 2008, are shown in Addendum A and Addendum B to this proposed rule.

We note that we have historically used standard rounding principles to establish a 20 percent copayment for those few circumstances where the copayment rate was between 19.5 and 20 percent using our established copayment rules. For example, the CY 2008 proposed payment and copayment amounts for APC 9228 (Tigecycline injection) are $0.91 and $0.18, respectively. Twenty percent of $0.91 is $0.182. Because it would be impossible to set a copayment rate at exactly 20 percent in this case, that is, $0.182, we rounded the amount, using standard rounding principles, to $0.18. Also using standard rounding principles, 19.78 percent ($0.18 as a percentage of $0.91) rounds to 20 percent and meets the statutory requirement of a copayment amount of at least 20 percent. For CY 2008, APC 9046 (Iron Sucrose Injection) has a proposed payment amount and copayment amount of $0.37 and $0.08, respectively. Using our established copayment rules, 20 percent of $0.37 is $0.074. Normally, we would apply standard rounding principles to achieve an amount that is payable, here $0.07 rather than $0.074. However, if we were to set a copayment amount of $0.07, which is 18.9 percent of $0.37, we would not be setting a copayment rate that is at least 20 percent of the OPPS payment rate. We believe that section 1833(t)(3)(B) of the Act requires us to set a copayment amount that is at least 20 percent of the OPPS payment amount, not less than 20 percent. Therefore, we are proposing to set the copayment rate for APC 9046 at $0.08. Eight cents represents the lowest amount that we could set that would bring the copayment rate to 20 percent or, in this case, just above 20 percent. We are proposing to apply this same methodology in the future to instances where the application of our standard copayment methodology would result in a copayment amount that is under 20 percent and cannot be rounded, under standard rounding principles, to 20 percent.

3. Calculation of a Proposed Adjusted Copayment Amount for an APC Group

To calculate the OPPS adjusted copayment amount for an APC group, take the following steps:

Step 1. Calculate the beneficiary payment percentage for the APC by

dividing the APC's national unadjusted copayment by its payment rate. For example, using APC 0001, $7.00 is 21 percent of $33.15.

Step 2. Calculate the wage adjusted payment rate for the APC, for the provider in question, as indicated in section II.H. of this proposed rule. Calculate the rural adjustment for eligible providers as indicated in section II.H. of this proposed rule.

Step 3. Multiply the percentage calculated in Step 1 by the payment rate calculated in Step 2. The result is the wage-adjusted copayment amount for the APC.

The proposed unadjusted copayments for services payable under the OPPS that would be effective January 1, 2008, are shown in Addendum A and Addendum B to this proposed rule.

III. Proposed OPPS Ambulatory Payment Classification (APC) Group Policies

A. Proposed Treatment of New HCPCS and CPT Codes

(If you choose to comment on issues in this section, please include the caption ''OPPS: New HCPCS and CPT Codes'' at the beginning of your comment.)

1. Proposed Treatment of New HCPCS Codes Included in the April and July Quarterly OPPS Updates for CY 2007

For the July quarter of CY 2007, we created a total of 16 new Level II HCPCS codes, specifically C2638, C2639, C2640, C2641, C2642, C2643, C2698, C2699, C9728, Q4087, Q4088, Q4089, Q4090, Q4091, Q4092, and Q4095 that were not addressed in the CY 2007 OPPS/ASC final rule with comment period that updated the CY 2007 OPPS. We designated the payment status of these codes and added them through the July 2007 update (Change Request 5623, Transmittal 1259, dated June 1, 2007). There were no new Level II HCPCS codes for the April 2007 update. In this CY 2008 OPPS/ASC proposed rule, we are soliciting public comment on the status indicators, APC assignments, and payment rates of these codes, which are listed in Table 26A and Table 26B of this proposed rule. Because of the timing of this proposed rule, the codes implemented through the July 2007 OPPS update are not included in Addendum B to this proposed rule. We are proposing to assign the new HCPCS codes for CY 2008 to the appropriate APCs with the proposed rates as displayed in the tables and incorporate them into our final rule with comment period for CY 2008, which is consistent with our annual APC updating policy.

TABLE 26A.—NEW NON-DRUG HCPCS CODES IMPLEMENTED IN JULY 2007

HCPCS code	Long descriptor	Proposed CY 2008 status indicator	Proposed CY 2008 APC	Proposed CY 2008 payment rate	Implementation date
C2638	Brachytherapy source, stranded, iodine-125, per source	K	2638	$ 42.86	July 1, 2007.
C2639	Brachytherapy source, non-stranded, iodine-125, per source	K	2639	31.91	July 1, 2007.
C2640	Brachytherapy source, stranded, palladium-103, per source	K	2640	62.24	July 1, 2007.
C2641	Brachytherapy source, non-stranded, palladium-103, per source	K	2641	45.29	July 1, 2007.
C2642	Brachytherapy source, stranded, cesium-131, per source	K	2642	97.72	July 1, 2007.
C2643	Brachytherapy source, non stranded, cesium-131, per source	K	2643	51.35	July 1, 2007.
C2698	Brachytherapy source, stranded, not otherwise specified, per source	K	2698	42.86	July 1, 2007.
C2699	Brachytherapy source, non-stranded, not otherwise specified, per source.	K	2699	29.93	July 1, 2007.
C9728	Placement of interstitial device(s) for radiation therapy/surgery guidance (eg, fiducial markers, dosimeter), other than prostate (any approach) single or multiple.	T	0156	194.91	July 1, 2007.

TABLE 26B.—NEW DRUG HCPCS CODES IMPLEMENTED IN JULY 2007

HCPCS code	Long descriptor	Proposed CY 2008 status indicator	Proposed CY 2008 APC	Proposed CY 2008 payment rate	Implementation date
Q4087	Injection, immune globulin, (Octogam), intravenous, non-lyophilized, (e.g. liquid), 500 mg.	K	0943	$ 33.48	July 1, 2007.
Q4088	Injection, immune globulin, (Gammagard), intravenous, non-lyophilized, (e.g. liquid), 500 mg.	K	0944	31.20	July 1, 2007.
Q4089	Injection, rho(d) immune globulin (human), (Rhophylac), intravenous, 100 iu.	K	0945	80.00	July 1, 2007.
Q4090	Injection, hepatitis b immune globulin (Hepagam B), intramuscular, 0.5 ml.	K	0946	64.74	July 1, 2007.
Q4091	Injection, immune globulin, (Flebogamma), intravenous, non-lyophilized, (e.g. liquid), 500 mg.	K	0947	32.61	July 1, 2007.
Q4092	Injection, immune globulin, (Gamunex), intravenous, non-lyophilized, (e.g. liquid), 500 mg.	K	0948	31.86	July 1, 2007.
Q4095	Injection, zoledronic acid (Reclast), 1 mg	K	0951	220.81	July 1, 2007.

2. Proposed Treatment of New Category I and III CPT Codes and Level II HCPCS Codes

As has been our practice in the past, we implement new Category I and III CPT codes and new Level II HCPCS codes, which are released in the summer through the fall of each year for annual updating, effective January 1, in the final rule updating the OPPS for the following calendar year. These codes are flagged with comment indicator ''NI'' in Addendum B to the OPPS/ASC final rule with comment period to indicate that we are assigning them an interim

payment status which is subject to public comment following publication of the final rule that implements the annual OPPS update. (We refer readers to the discussion immediately below concerning our policy for implementing new Category I and III mid-year CPT codes.) We are proposing to continue this recognition and process for CY 2008. New Category I and III CPT codes and new Level II HCPCS codes, effective January 1, 2008, will be listed in Addendum B to the CY 2008 OPPS/ASC final rule with comment period and designated using comment indicator ''NI.'' The status indicator, the APC assignment, or both, for all such codes flagged with comment indicator ''NI'' will be open to public comment. We will respond to all comments received concerning these codes in a subsequent final rule.

In addition, we are proposing to continue our policy of the last 2 years of recognizing new mid-year CPT codes, generally Category III CPT codes, that the AMA releases in January for implementation the following July through the OPPS quarterly update process. Therefore, for CY 2008, we are proposing to include in Addendum B to the CY 2008 OPPS/ASC final rule with comment period the new Category III CPT codes released in January 2007 for implementation on July 1, 2007 (through the OPPS quarterly update process) and the new Category III codes released in July 2007 for implementation on January 1, 2008. However, only those new Category III CPT codes implemented effective January 1, 2008, will be flagged with comment indicator ''NI'' in Addendum B to the CY 2008 OPPS/ASC final rule with comment period, to indicate that we have assigned them an interim payment status which is subject to public comment. Category III CPT codes implemented in July 2007, which appear in Table 27 below, are subject to comment through this proposed rule, and their status will be finalized in the CY 2008 OPPS/ASC final rule with comment period.

TABLE 27.—CATEGORY III CPT CODES IMPLEMENTED IN JULY 2007

HCPCS code	Long descriptor	Proposed CY 2008 status indicator	Proposed CY 2008 APC
0178T	Electrocardiogram, 64 leads or greater, with graphic presentation and analysis; with interpretation and report.	B	Not applicable.
0179T	Electrocardiogram, 64 leads or greater, with graphic presentation and analysis; tracing and graphics only, without interpretation and report.	X	0100.
0180T	Electrocardiogram, 64 leads or greater, with graphic presentation and analysis; interpretation and report only.	B	Not applicable.
0181T	Corneal hysteresis determination, by air impulse stimulation, bilateral, with interpretation and report.	S	0230.
0182T	High dose rate electronic brachytherapy, per fraction	S	1519.

B. Proposed Changes—Variations Within APCs

(If you choose to comment on issues in this section, please include the caption ''OPPS: 2 Times Rule'' at the beginning of your comment.)

1. Background

Section 1833(t)(2)(A) of the Act requires the Secretary to develop a classification system for covered hospital outpatient services. Section 1833(t)(2)(B) of the Act provides that this classification system may be composed of groups of services, so that services within each group are comparable clinically and with respect to the use of resources. In accordance with these provisions, we developed a grouping classification system, referred to as APCs, as set forth in § 419.31 of the regulations. We use Level I and Level II HCPCS codes and descriptors to identify and group the services within each APC. The APCs are organized such that each group is homogeneous both clinically and in terms of resource use. Using this classification system, we have established distinct groups of similar services, as well as medical visits. We also have developed separate APC groups for certain medical devices, drugs, biologicals, radiopharmaceuticals, and brachytherapy devices.

We have packaged into payment for each procedure or service within an APC group the costs associated with those items or services that are directly related to and supportive of performing the main procedures or furnishing services. Therefore, we do not make separate payment for packaged items or services. For example, packaged items and services include: (1) Use of an operating, treatment, or procedure room; (2) use of a recovery room; (3) most observation services; (4) anesthesia; (5) medical/surgical supplies; (6) pharmaceuticals (other than those for which separate payment may be allowed under the provisions discussed in section V. of this proposed rule); and (7) incidental services such as venipuncture. Our proposed packaging approach for CY 2008 is discussed in section II.A.4. of this proposed rule.

Under the OPPS, we pay for hospital outpatient services on a rate-per-service or, as proposed for CY 2008, on a rate-per-encounter basis that varies according to the APC group to which the independent service or combination of services is assigned. Each APC weight represents the hospital median cost of the services included in that APC relative to the hospital median cost of the services included in APC 0606. The APC weights are scaled to APC 0606 because it is the middle level clinic visit APC (that is, where the Level 3 Clinic Visit HCPCS code of five levels of clinic visits is assigned), and because middle level clinic visits are among the most frequently furnished services in the hospital outpatient setting.

Section 1833(t)(9)(A) of the Act requires the Secretary to review the components of the OPPS not less than annually and to revise the groups and relative payment weights and make other adjustments to take into account changes in medical practice, changes in technology, and the addition of new services, new cost data, and other relevant information and factors. Section 1833(t)(9)(A) of the Act, as amended by section 201(h) of the BBRA of 1999, also requires the Secretary, beginning in CY 2001, to consult with an outside panel of experts to review the APC groups and the relative payment weights (the APC Panel recommendations for specific services for the CY 2008 OPPS and our responses to them are discussed in the relevant specific sections throughout this proposed rule).

Finally, as discussed earlier, section 1833(t)(2) of the Act provides that, subject to certain exceptions, the items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest median (or mean cost, if elected by the Secretary) for an item or service in the group is more than 2 times greater than the lowest median cost for an item or service within the same group (referred to as the ''2 times rule''). We use the median cost of the item or service in implementing this provision. The statute authorizes the Secretary to make exceptions to the 2 times rule in unusual cases, such as low-volume items and services.

2. Application of the 2 Times Rule

In accordance with section 1833(t)(2) of the Act and § 419.31 of the regulations, we annually review the items and services within an APC group to determine, with respect to comparability of the use of resources, if the median of the highest cost item or service within an APC group is more than 2 times greater than the median of the lowest cost item or service within that same group (''2 times rule''). We make exceptions to this limit on the variation of costs within each APC group in unusual cases such as low volume items and services.

During the APC Panel's March 2007 meeting, we presented median cost and utilization data for services furnished during the period of January 1, 2006, through September 30, 2006, about which we had concerns or about which the public had raised concerns regarding their APC assignments, status indicator assignments, or payment rates. The discussions of most service-specific issues, the APC Panel recommendations if any, and our proposals for CY 2008 are contained principally in sections III.C. and III.D. of this proposed rule.

In addition to the assignment of specific services to APCs that we discussed with the APC Panel, we also identified APCs with 2 times violations that were not specifically discussed with the APC Panel but for which we are proposing changes to their HCPCS codes' APC assignments in Addendum B to this proposed rule. In these cases, to eliminate a 2 times violation or to improve clinical and resource homogeneity, we are proposing to reassign the codes to APCs that contained services that were similar with regard to both their clinical and resource characteristics. We also are proposing to rename existing APCs, discontinue existing APCs, or create new clinical APCs to complement proposed HCPCS code reassignments. In many cases, the proposed HCPCS code reassignments and associated APC reconfigurations for CY 2008 included in this proposed rule are related to changes in median costs of services and APCs resulting from our proposed packaging approach for CY 2008, as discussed in section II.A.4. of this proposed rule. We also are proposing changes to the status indicators for some codes that are not specifically and separately discussed in this proposed rule. In these cases, we are proposing to change the status indicators for some codes because we believe that another status indicator more accurately describes their payment status from an OPPS perspective based on the policies that we are proposing for CY 2008.

Addendum B to this proposed rule identifies with a comment indicator ''CH'' those HCPCS codes for which we are proposing a change to the APC assignment or status indicator as assigned in the April 2007 Addendum B update.

3. Proposed Exceptions to the 2 Times Rule

As discussed earlier, we may make exceptions to the 2 times limit on the variation of costs within each APC group in unusual cases such as low volume items and services. Taking into account the APC changes that we are proposing for CY 2008 based on the APC Panel recommendations discussed mainly in sections III.C. and III.D. of this proposed rule, the proposed changes to status indicators and APC assignments as identified in Addendum B to this proposed rule, and the use of CY 2006 claims data to calculate the median costs of procedures classified in the APCs, we reviewed all the APCs to determine which APCs would not satisfy the 2 times rule. We used the following criteria to decide whether to propose exceptions to the 2 times rule for affected APCs:

- Resource homogeneity.
- Clinical homogeneity.
- Hospital concentration.
- Frequency of service (volume).
- Opportunity for upcoding and code fragments.

For a detailed discussion of these criteria, we refer readers to the April 7, 2000 OPPS final rule with comment period (65 FR 18457).

Table 28 lists the APCs that we are proposing to exempt from the 2 times rule for CY 2008 based on the criteria cited above. For cases in which a recommendation by the APC Panel appeared to result in or allow a violation of the 2 times rule, we generally accepted the APC Panel's recommendation because those recommendations were based on explicit consideration of resource use, clinical homogeneity, hospital specialization, and the quality of the data used to determine the APC payment rates that we are proposing for CY 2008. The median costs for hospital outpatient services for these and all other APCs that were used in the development of this proposed rule can be found on the CMS Web site at: *http://www.cms.hhs.gov*.

TABLE 28.—PROPOSED APC EXCEPTIONS TO THE 2 TIMES RULE FOR CY 2008

APC	APC title
0033	Partial Hospitalization.
0043	Closed Treatment Fracture Finger/Toe/Trunk.
0060	Manipulation Therapy.
0080	Diagnostic Cardiac Catheterization.
0093	Vascular Reconstruction/Fistula Repair without Device.
0105	Repair/Revision/Removal of Pacemakers, AICDs, or Vascular Devices.
0106	Insertion/Replacement of Pacemaker Leads and/or Electrodes.
0109	Removal/Repair of Implanted Devices.
0235	Level I Posterior Segment Eye Procedures.
0251	Level I ENT Procedures.
0260	Level I Plain Film Except Teeth.
0278	Diagnostic Urography.
0282	Miscellaneous Computed Axial Tomography.
0303	Treatment Device Construction.
0323	Extended Individual Psychotherapy.
0330	Dental Procedures.
0340	Minor Ancillary Procedures.
0368	Level II Pulmonary Tests.
0381	Single Allergy Tests.
0409	Red Blood Cell Tests.
0432	Health and Behavior Services.
0438	Level III Drug Administration.
0604	Level 1 Hospital Clinic Visits.
0664	Level I Proton Beam Radiation Therapy.
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver.

C. New Technology APCs

(If you choose to comment on issues in this section, please include the caption ''New Technology APCs'' at the beginning of your comment.)

1. Introduction

In the November 30, 2001 final rule (66 FR 59903), we finalized changes to the time period a service was eligible for payment under a New Technology APC. Beginning in CY 2002, we retain services within New Technology APC groups until we gather sufficient claims data to enable us to assign the service

to a clinically appropriate APC. This policy allows us to move a service from a New Technology APC in less than 2 years if sufficient data are available. It also allows us to retain a service in a New Technology APC for more than 3 years if sufficient data upon which to base a decision for reassignment have not been collected.

We note that the cost bands for New Technology APCs range from $0 to $50 in increments of $10, from $50 to $100 in increments of $50, from $100 through $2,000 in increments of $100, and from $2,000 through $10,000 in increments of $500. These increments, which are in two parallel sets of New Technology APCs, one with status indicator ''S'' and the other with status indicator ''T,'' allow us to price new technology services more appropriately and consistently.

2. Proposed Movement of Procedures From New Technology APCs to Clinical APCs

As we explained in the November 30, 2001 final rule (66 FR 59897), we generally keep a procedure in the New Technology APC to which it is initially assigned until we have collected data sufficient to enable us to move the procedure to a clinically appropriate APC. However, in cases where we find that our original New Technology APC assignment was based on inaccurate or inadequate information, or where the New Technology APCs are restructured, we may, based on more recent resource utilization information (including claims data) or the availability of refined New Technology APC cost bands, reassign the procedure or service to a different New Technology APC that most appropriately reflects its cost.

At its March 2007 meeting, the APC Panel recommended that CMS keep services in New Technology APCs until sufficient data are available to assign them to clinical APCs, but for no longer than 2 years. We note that because of the potential for quarterly assignment of new services to New Technology APCs and the 2 year time lag in claims data for an OPPS update (that is, CY 2006 data are utilized for this CY 2008 OPPS rulemaking cycle), if we were to accept the APC Panel's recommendation, we would always reassign services from New Technology to clinical APCs based on 1 year or less of claims data. For example, if a new service was first assigned to a New Technology APC in July 2006, we would have 6 months of data for purposes of CY 2008 rulemaking but, in order to ensure that the service was in a New Technology APC for no longer than 2 years, we would need to move the service to a clinical APC for CY 2008. While we might have sufficient claims data from 6 months of CY 2006 to support a proposal for such a reassignment for CY 2008, we are not confident that this would always be the case for all new services, given our understanding of the dissemination of new technology procedures into medical practice and the diverse characteristics of new technology services that treat different clinical conditions. Therefore, we are not accepting the APC Panel's recommendation because we believe that accepting the recommendation would limit our ability to individually assess the OPPS treatment of each new technology service in the context of available hospital claims data. We are particularly concerned about continuing to provide appropriate payment for low volume new technology services that may be expected to continue to be low volume under the OPPS due to the prevalence of the target conditions in the Medicare population. We appreciate the APC Panel's thoughtful discussion of new technology services, and we agree with the APC Panel that it should be our priority to regularly reassign services from New Technology APCs to clinical APCs under the OPPS, so that they are treated like most other OPPS services for purposes of ratesetting once hospitals have had sufficient experience with providing and reporting the new services. Rather, consistent with our current policy, for CY 2008 we are proposing to retain services within New Technology APC groups until we gather sufficient claims data to enable us to assign the service to a clinically appropriate APC. The flexibility associated with this policy allows us to move a service from a New Technology APC in less than 2 years if sufficient data are available. It also allows us to retain a service in a New Technology APC for more than 2 years if sufficient hospital claims data upon which to base a decision for reassignment have not been collected.

The procedures presented below represent services assigned to New Technology APCs for CY 2007 for which we believe we have sufficient data to reassign them to clinically appropriate APCs for CY 2008. Therefore, we are proposing to reassign them to clinically appropriate APCs as indicated specifically in our discussion and in Table 29 of this proposed rule.

a. Positron Emission Tomography (PET)/Computed Tomography (CT) Scans (New Technology APC 1511)

(If you choose to comment on issues in this section, please include the caption ''PET/CT Scans'' at the beginning of your comment.)

From August 2000 through April 2005, we paid separately for PET and CT scans. In CY 2004, the payment rate for nonmyocardial PET scans was $1,450, while it was $193 for typical diagnostic CT scans. Prior to CY 2005, nonmyocardial PET and the PET portion of PET/CT scans were described by G-codes for billing to Medicare. Several commenters to the November 15, 2004 final rule with comment period (69 FR 65682) urged that we replace the G-codes for nonmyocardial PET and PET/CT scan procedures with the established CPT codes. These commenters stated that movement to the established CPT codes would greatly reduce the burden on hospitals of tracking and billing the G-codes which are not recognized by other payers and would allow for more uniform hospital billing of these scans. We agreed with the commenters that movement from the G-codes to the established CPT codes for nonmyocardial PET and PET/CT scans would allow for more uniform billing of these scans. As a result of a Medicare national coverage determination (Publication 100–3, Medicare Claims Processing Manual section 220.6) that was made effective January 28, 2005, we discontinued numerous G-codes that described myocardial PET and nonmyocardial PET procedures and replaced them with the established CPT codes. The CY 2005 payment rate for concurrent PET/CT scans using the CPT codes 78814 (Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; limited area (eg, chest, head/neck); 78815 (Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; skull base to mid-thigh); and 78816 Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; whole body) was $1,250, which was $100 higher than the payment rate for PET scans alone. These PET/CT CPT codes were placed in New Technology APC 1514 (New Technology—Level XIV, $1,200–$1,300) for CY 2005.

We continued with these coding and payment methodologies in CY 2006. For CY 2007, while we proposed to reassign both PET and PET/CT Scans to the same new clinical APC, we finalized a policy that reassigned conventional PET procedures to APC 0308 (Non-

Myocardial Positron Emission Tomography (PET) Imaging) with a final median cost of about $850. We also reassigned PET/CT services to a different New Technology APC for CY 2007, specifically New Technology APC 1511 (New Technology—Level XI, $900–$1000), thereby maintaining the historical payment differential of about $100 between PET and PET/CT procedures. Furthermore, we stated in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68022) that we would wait for a full year of CPT coded claims data prior to assigning the PET/CT services to a clinical APC and that maintaining a modest payment differential between PET and PET/CT procedures was warranted for CY 2007.

For CY 2008, we are proposing the reassignment of concurrent PET/CT scans, specifically CPT codes 78814, 78815, and 78816, to a clinical APC because we believe we have adequate claims data from CY 2006 upon which to determine the median cost of performing these procedures. Based on our analysis of approximately 117,000 CY 2006 single claims, the median cost of PET/CT scans is $1,093.52. In comparison, the median cost of the nonmyocardial PET scans, as described by CPT codes 78608, 78811, 78812, and 78813, is $1,093.51 based on our analysis of approximately 34,000 single claims from CY 2006. We note that a comparison of the median cost of PET/CT scans with the median cost of nonmyocardial PET scans, as derived from CY 2006 claims data, demonstrates that these costs are almost the same, thereby reflecting significant hospital resource equivalency between the two types of services. This result is not unexpected because many newer PET scanners also have the capability of rapidly acquiring CT images for attenuation correction and anatomical localization, sometimes with simultaneous image acquisition. The median costs for both PET and PET/CT scans are significantly higher for CY 2008 than for CY 2007 due to our CY 2008 proposal to package payment for all diagnostic radiopharmaceuticals as described in section II.A.4. of this proposed rule that would package payment for the costs of the radiopharmaceuticals utilized similarly into the payment for both PET and PET/CT scans. We believe that our claims data accurately reflect the comparable hospital resources required to provide nonmyocardial PET and PET/CT procedures, and the scans have obvious clinical similarity as well. Therefore, for CY 2008 we are proposing to reassign the CPT codes for PET/CT scans to the clinical APC where nonmyocardial PET scans are also assigned, specifically APC 0308, with a proposed median cost of $1,093.52.

We note that we have been paying separately for fluorodeoxyglucose (FDG), the radiopharmaceutical described by HCPCS code A9552 (F18 fdg), that is commonly administered during nonmyocardial PET and PET/CT procedures. For CY 2008, consistent with our proposed packaging approach as discussed in section II.A.4. of this proposed rule, we are proposing to package payment for the diagnostic radiopharmaceutical FDG into payment for the associated PET and PET/CT procedures. Because FDG is the most commonly used radiopharmaceutical for both PET and PET/CT scans and our single claims for these procedures include FDG more than 80 percent of the time, the packaging of this radiopharmaceutical fully maintains the clinical and resource homogeneity of the reconfigured APC 0308 that we are proposing.

b. IVIG Preadministration-Related Services (New Technology APC 1502)

(If you choose to comment on issues in this section, please include the caption ''IVIG Preadministration-Related Services'' at the beginning of your comment.)

In CY 2006, we created the temporary HCPCS G-code G0332 (Services for intravenous infusion of immunoglobulin prior to administration (this service is to be billed in conjunction with administration of immunoglobulin)). Based on our estimate of the costs of this service in comparison with other services, HCPCS code G0332 was assigned to New Technology APC 1502 (New Technology—Level II, $50–$100), with a payment rate of $75 effective January 1, 2006. In the CY 2007 OPPS/APC final rule with comment period, we indicated our belief that it was appropriate to continue the temporary IVIG preadministration-related services payment through HCPCS code G0332 and its continued assignment to New Technology APC 1502 for CY 2007, in order to help ensure continued patient access to IVIG (71 FR 68092).

For CY 2008, we are proposing to continue to provide separate payment for IVIG preadministration-related services through the assignment of HCPCS code G0332 to a clinical APC. This service has been assigned to a New Technology APC under the OPPS for 2 full years. As noted previously, under the OPPS, we retain services within New Technology APC groups where they are assigned according to our estimates of their costs until we gather sufficient claims data to enable us to assign the services to clinically appropriate APCs based on hospital resource costs as calculated from claims. According to our analysis of the hospital outpatient claims data, we believe we have adequate claims data from CY 2006 upon which to determine the median cost of performing IVIG preadministration related services and to reassign HCPCS code G0332 to an appropriate clinical APC for CY 2008. Our claims data for this high volume service show a total of over 49,000 services performed, with about 48,000 single claims available for ratesetting. The median cost of this service according to our claims data is $38.52. Therefore, we are proposing to reassign HCPCS code G0332 to new clinical APC 0430 (Drug Preadministration-Related Services) with a median cost of $38.52 for CY 2008, where it would be the only service assigned to the APC at this time.

We note that IVIG preadministration-related services are always provided in conjunction with other separately payable services such as drug administration services, and thus are well suited for packaging into the payment for the separately payable services. While at this time we have not made a determination about the appropriateness of continuing separate OPPS payment for HCPCS code G0332 after CY 2008, we would consider packaging payment for HCPCS code G0332 in future years if we determine separate payment is no longer warranted. We intend to reevaluate the appropriateness of separate payment for preadministration-related services for the CY 2009 OPPS rulemaking cycle, especially as we explore the potential for greater packaging and possible encounter-based or episode-based OPPS payment approaches.

c. Other Services in New Technology APCs

(If you choose to comment on issues in this section, please include the caption ''Other Services in New Technology APCs'' at the beginning of your comment.)

Other than the concurrent PET/CT and IVIG preadministration-related new technology services discussed in sections III.C.2.a. and III.C.2.b. of this proposed rule, there are five procedures currently assigned to New Technology APCs for CY 2007 for which we believe we also have data that are adequate to support their reassignment to clinical APCs. For CY 2008, we are proposing to reassign these procedures to clinically appropriate APCs, applying their CY 2006 claims data to develop their

clinical APC median costs upon which payments would be based. These procedures and their proposed APC assignments are displayed in Table 29 below.

TABLE 29.—PROPOSED CY 2008 APC REASSIGNMENTS OF OTHER NEW TECHNOLOGY PROCEDURES TO CLINICAL APCS

HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	CY 2007 APC payment rate	Proposed CY 2008 SI	Proposed CY 2008 APC	Proposed CY 2008 APC median cost
19298	Place breast rad tube/caths	S	1524	$3,250	T	0648	$3,416.66
G0302	Pre-op service LVRS complete	S	1509	750	S	0209	727.48
G0303	Pre-op service LVRS 10–15dos	S	1507	550	S	0209	727.48
G0304	Pre-op service LVRS 1–9 dos	S	1504	250	S	0213	147.68
G0305	Post op service LVRS min 6	S	1504	250	S	0213	147.68

D. Proposed APC-Specific Policies

1. Hyperbaric Oxygen Therapy (APC 0659)

(If you choose to comment on issues in this section, please include the caption ''Hyperbaric Oxygen Therapy'' at the beginning of your comment.)

When hyperbaric oxygen therapy (HBOT) is prescribed for promoting the healing of chronic wounds, it typically is prescribed for 90 minutes and billed using multiple units of HBOT on a single line or multiple occurrences of HBOT on a claim. In addition to the therapeutic time spent at full hyperbaric oxygen pressure, treatment involves additional time for achieving full pressure (descent), providing air breaks to prevent neurological and other complications from occurring during the course of treatment, and returning the patient to atmospheric pressure (ascent). The OPPS recognizes HCPCS code C1300 (Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval) for HBOT provided in the hospital outpatient setting.

In the CY 2005 final rule with comment period (69 FR 65758 through 65759), we finalized a ''per unit'' median cost calculation for APC 0659 (Hyperbaric Oxygen) using only claims with multiple units or multiple occurrences of HCPCS code C1300 because delivery of a typical HBOT service requires more than 30 minutes. We observed that claims with only a single occurrence of the code were anomalies, either because they reflected terminated sessions or because they were incorrectly coded with a single unit. In the same rule, we also established that HBOT would not generally be furnished with additional services that might be packaged under the standard OPPS APC median cost methodology. This enabled us to use claims with multiple units or multiple occurrences. Finally, we also used each hospital's overall CCR to estimate costs for HCPCS code C1300 from billed charges rather than the CCR for the respiratory therapy cost center. Comments on the CY 2005 proposed rule effectively demonstrated that hospitals report the costs and charges for HBOT in a wide variety of cost centers. We used this methodology to estimate payment for HBOT in CYs 2005, 2006, and 2007. For CY 2008, we are proposing to continue using the same methodology to estimate a ''per unit'' median cost for HCPCS code C1300 of $98.63 using 60,774 claims with multiple units or multiple occurrences.

CY 2008 is the fourth year in which we would have a special methodology to develop the median cost for HBOT services that removed obviously erroneous claims and deviated from our standard methodology of using departmental CCRs, when available, to convert hospitals' charges to costs. Prior to CY 2005, our inclusion of significant numbers of miscoded claims in the median calculation for HBOT and our exclusion of the claims for multiple units of treatment, the typical scenario, resulted in payment rates that were artificially elevated. As explained earlier, beginning in CY 2005 and continuing through the present, we have adjusted the CCR used in the conversion of charges to costs for these services so that claims data would more accurately reflect the relative costs of the services. The median costs of HBOT calculated using this methodology have been reasonably stable for the last 4 years. We believe that this adjustment through use of the hospitals' overall CCRs is all that is necessary to yield a valid median cost for establishing a scaled weight for HBOT services. Therefore, for CY 2008, we are proposing to continue to use the same methodology that we have used since CY 2005 to estimate payment for HBOT.

2. Skin Repair Procedures (APCs 0024, 0025, 0027, and 0686)

For CY 2006, the AMA made comprehensive changes, including code additions, deletions, and revisions, accompanied by new and revised introductory language, parenthetical notes, subheadings and cross-references, to the Integumentary, Repair (Closure) subsection of surgery in the CPT book to facilitate more accurate reporting of skin grafts, skin replacements, skin substitutes, and local wound care. In particular, the section of the CPT book previously titled ''Free Skin Grafts'' and containing codes for skin replacement and skin substitute procedures was renamed, reorganized, and expanded. New and existing CPT codes related to skin replacement surgery and skin substitutes were organized into five subsections: Surgical Preparation, Autograft/Tissue Cultured Autograft, Acellular Dermal Replacement, Allograft/Tissue Cultured Allogeneic Skin Substitute, and Xenograft.

As part of the CY 2006 CPT code update in the newly named ''Skin Replacement Surgery and Skin Substitutes'' section, certain codes were deleted that previously described skin allograft and tissue cultured and acellular skin substitute procedures, including CPT code 15342 (Application of bilaminate skin substitute/neodermis; 25 sq cm), CPT code 15343 (Application of bilaminate skin substitute/neodermis; each additional 25 sq cm), CPT code 15350 (Application of allograft, skin; 100 sq cm or less), and CPT code 15351 (Application of allograft, skin; each additional 100 sq cm). Thirty-seven new CPT codes were created in the ''Skin Replacement Surgery and Skin Substitutes'' section, and these codes received interim final status indicators and APC assignments in the CY 2006 OPPS final rule with comment period and were subject to comment.

In considering the final CY 2007 APC assignments of these 37 ''Skin

Replacement Surgery and Skin Repair'' codes, we reviewed the recommendations made by the APC Panel at its March 2006 meeting; presentations made to the APC Panel; comments received on the CY 2007 proposed rule; the CPT code descriptors, introductory explanations, cross-references, and parenthetical notes; the clinical characteristics of the procedures; and the code-specific median costs for all related CPT codes available from our CY 2005 claims data. A discussion of the final CY 2007 APC assignments of these procedures can be found in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68054 through 68057).

We now have CY 2006 data for the surgical procedures assigned to the 4 CY 2007 skin repair APCs, including the 37 codes considered last year that were new for CY 2006. These APCs are: APC 0024 (Level I Skin Repair); APC 0025 (Level II Skin Repair); APC 0686 (Level III Skin Repair); and APC 0027 (Level IV Skin Repair). Based on CY 2006 data available for this proposed rule, the median costs for the APCs as configured for CY 2007 are approximately: $93 for APC 0024; $251 for APC 0025; $1,027 for APC 0686; and $1,340 for APC 0027. Both APCs 0024 and 0025 have 2 times violations based on CY 2006 claims data. The HCPCS median costs of significant procedures in APC 0024 range from approximately $83 to $255. We note that a number of the procedures currently assigned to APC 0024 are very low volume, with few single claims available for ratesetting. Similarly, the median costs of the significant procedures in APC 0025 range from a low of $119 to a high of about $399. This APC also contains a number of low volume procedures, as well as some new CY 2007 CPT codes without CY 2006 claims data. There is also some variation in the median costs of the HCPCS codes assigned to APCs 0686 and 0027, but no 2 times violations in these two APCs.

At the March 2007 APC Panel meeting, we discussed with the APC Panel one possible reconfiguration of the skin repair APCs in order to address the 2 times violations in APCs 0024 and 0025 for CY 2008 by improving the resource homogeneity of the APCs, as well as ensuring their clinical homogeneity. We reviewed with the APC Panel the potential results associated with adding an additional level in this APC series and reallocating all of the procedures in the original four APCs among five new APCs, taking into account the frequency, resource utilization, and clinical characteristics of each procedure. We also gave particular attention to CPT code families in considering the clinical and resource homogeneity of each APC in the reconfigured series. The new configuration of APCs eliminates the 2 times violations that would otherwise exist in APCs 0024 and 0025. It also more accurately attributes higher cost procedures to the Levels IV and V APCs, which contain the surgical procedures of the greatest intensity and resource requirements, leading to a more balanced distribution of APC median costs across the five new APC levels.

The APC Panel made a recommendation at its March 2007 meeting supporting CMS' reorganization of the skin repair APCs into five levels. This recommendation also asked CMS to give special consideration to the APC assignments of ''add-on'' codes; in the context of skin procedures, these are generally those CPT codes that report treatment of an additional body area and that are reported along with a primary procedure for treatment of the first body area. We are accepting the APC Panel's recommendation through this CY 2008 proposal to reconfigure the skin APCs into five levels, and we have reexamined the placement of each of the add-on codes within the framework of the five APCs. We agree with the APC Panel that, because these skin repair APCs are assigned to status indicator ''T'' so that add-on codes would typically be paid at 50 percent of their APC payment rate, these add-on codes bear special examination with respect to their median costs and their appropriate APC assignments. As a result, several CPT code placements from the draft configuration discussed with the Panel were changed for this proposal.

In summary, for CY 2008 we are proposing to eliminate the four current skin repair APCs and replace them with five new APCs titled: APC 0133 (Level I Skin Repair); APC 0134 (Level II Skin Repair); APC 0135 (Level III Skin Repair); APC 0136 (Level IV Skin Repair); and APC 0137 (Level V Skin Repair). We are proposing to redistribute each of the procedures assigned to the current four levels of skin repair APCs into the five proposed APCs, with one exception. Specifically, we are proposing to reassign CPT code 15835 (Excision, excessive skin and subcutaneous tissue (including lipectomy); buttock) to APC 0022 (Level IV, Excision/Biopsy), where other CPT codes in its code family reside. The median costs of the five proposed APCs are $83.91 (APC 0133), $132.82 (APC 0134), $294.50 (APC 0135), $971.25 (APC 0136), and $1,316.85 (APC 0137). The proposed configurations of these new APCs are listed in Table 30 below.

TABLE 30—PROPOSED CY 2008 SKIN REPAIR APC CONFIGURATIONS

HCPCS code	Short descriptor	Proposed CY 2008 APC	Proposed CY 2008 APC median cost
11950	Therapy for contour defects	0133	$83.91
11951	Therapy for contour defects.		
11952	Therapy for contour defects.		
11954	Therapy for contour defects.		
12001	Repair superficial wound(s).		
12002	Repair superficial wound(s).		
12004	Repair superficial wound(s).		
12005	Repair superficial wound(s).		
12006	Repair superficial wound(s).		
12007	Repair superficial wound(s).		
12011	Repair superficial wound(s).		
12013	Repair superficial wound(s).		
12014	Repair superficial wound(s).		
12015	Repair superficial wound(s).		
12016	Repair superficial wound(s).		
12017	Repair superficial wound(s).		
12018	Repair superficial wound(s).		

TABLE 30—PROPOSED CY 2008 SKIN REPAIR APC CONFIGURATIONS—Continued

HCPCS code	Short descriptor	Proposed CY 2008 APC	Proposed CY 2008 APC median cost
12031	Layer closure of wound(s).		
12041	Layer closure of wound(s).		
12051	Layer closure of wound(s).		
12052	Layer closure of wound(s).		
12053	Layer closure of wound(s).		
15775	Hair transplant punch grafts.		
15776	Hair transplant punch grafts.		
11760	Repair of nail bed	0134	$132.82
11920	Correct skin color defects.		
11921	Correct skin color defects.		
11922	Correct skin color defects.		
12032	Layer closure of wound(s).		
12034	Layer closure of wound(s).		
12035	Layer closure of wound(s).		
12036	Layer closure of wound(s).		
12037	Layer closure of wound(s).		
12042	Layer closure of wound(s).		
12044	Layer closure of wound(s).		
12045	Layer closure of wound(s).		
12046	Layer closure of wound(s).		
12047	Layer closure of wound(s).		
12054	Layer closure of wound(s).		
12055	Layer closure of wound(s).		
12056	Layer closure of wound(s).		
12057	Layer closure of wound(s).		
13120	Repair of wound or lesion.		
13122	Repair wound/lesion add-on.		
13153	Repair wound/lesion add-on.		
15040	Harvest cultured skin graft.		
15170	Acell graft trunk/arms/legs.		
15171	Acell graft t/arm/leg add-on.		
15340	Apply cult skin substitute.		
15341	Apply cult skin sub add-on.		
15360	Apply cult derm sub, t/a/l.		
15361	Aply cult derm sub t/a/l add.		
15365	Apply cult derm sub f/n/hf/g.		
15366	Apply cult derm f/hf/g add.		
15819	Plastic surgery, neck.		
12020	Closure of split wound	0135	$294.50
12021	Closure of split wound.		
13100	Repair of wound or lesion.		
13101	Repair of wound or lesion.		
13102	Repair wound/lesion add-on.		
13121	Repair of wound or lesion.		
13131	Repair of wound or lesion.		
13132	Repair of wound or lesion.		
13133	Repair wound/lesion add-on.		
13150	Repair of wound or lesion.		
13151	Repair of wound or lesion.		
13152	Repair of wound or lesion.		
15000	Wound prep, 1st 100 sq cm.		
15001	Wound prep, addl 100 sq cm.		
15002	Wnd prep, ch/inf, trk/arm/lg.		
15003	Wnd prep, ch/inf addl 100 cm.		
15004	Wnd prep ch/inf, f/n/hf/g.		
15005	Wnd prep, f/n/hf/g, addl cm.		
15050	Skin pinch graft.		
15110	Epidrm autogrft trnk/arm/leg.		
15111	Epidrm autogrft t/a/l add-on.		
15115	Epidrm a-grft face/nck/hf/g.		
15116	Epidrm a-grft f/n/hf/g addl.		
15150	Cult epiderm grft t/arm/leg.		
15151	Cult epiderm grft t/a/l addl.		
15152	Cult epiderm graft t/a/l +%.		
15155	Cult epiderm graft, f/n/hf/g.		
15156	Cult epidrm grft f/n/hfg add.		
15157	Cult epiderm grft f/n/hfg +%.		
15175	Acellular graft, f/n/hf/g.		
15176	Acell graft, f/n/hf/g add-on.		

TABLE 30—PROPOSED CY 2008 SKIN REPAIR APC CONFIGURATIONS—Continued

HCPCS code	Short descriptor	Proposed CY 2008 APC	Proposed CY 2008 APC median cost
15221	Skin full graft add-on.		
15241	Skin full graft add-on.		
15300	Apply skinallogrft, t/arm/lg.		
15301	Apply sknallogrft t/a/l addl.		
15320	Apply skin allogrft f/n/hf/g.		
15321	Apply sknallogrft f/n/hfg add.		
15330	Aply acell alogrft t/arm/leg.		
15331	Aply acell grft t/a/l add-on.		
15335	Apply acell graft, f/n/hf/g.		
15336	Apply acell grft f/n/hf/g add.		
15350	Skin homograft.		
15351	Skin homograft add-on.		
15400	Apply skin xenograft, t/a/l.		
15401	Apply skn xenogrft t/a/l add.		
15420	Apply skin xgraft, f/n/hf/g.		
15421	Apply skn xgrft f/n/hf/g add.		
15430	Apply acellular xenograft.		
15431	Apply acellular xgraft add.		
20926	Removal of tissue for graft.		
43887	Remove gastric port, open.		
11762	Reconstruction of nail bed	0136	$971.25
14000	Skin tissue rearrangement.		
14001	Skin tissue rearrangement.		
14020	Skin tissue rearrangement.		
14021	Skin tissue rearrangement.		
14040	Skin tissue rearrangement.		
14041	Skin tissue rearrangement.		
14060	Skin tissue rearrangement.		
14061	Skin tissue rearrangement.		
15130	Derm autograft, trnk/arm/leg.		
15131	Derm autograft t/a/l add-on.		
15135	Derm autograft face/nck/hf/g.		
15136	Derm autograft, f/n/hf/g add.		
15200	Skin full graft, trunk.		
15201	Skin full graft trunk add-on.		
15220	Skin full graft sclp/arm/leg.		
15240	Skin full grft face/genit/hf.		
15260	Skin full graft een & lips.		
15261	Skin full graft add-on.		
15740	Island pedicle flap graft.		
15936	Remove sacrum pressure sore.		
15952	Remove thigh pressure sore.		
15953	Remove thigh pressure sore.		
15956	Remove thigh pressure sore.		
15958	Remove thigh pressure sore.		
20920	Removal of fascia for graft.		
20922	Removal of fascia for graft.		
23921	Amputation follow-up surgery.		
25929	Amputation follow-up surgery.		
33222	Revise pocket, pacemaker.		
33223	Revise pocket, pacing-defib.		
11960	Insert tissue expander(s)	0137	$1,316.85
13160	Late closure of wound.		
14300	Skin tissue rearrangement.		
14350	Skin tissue rearrangement.		
15100	Skin splt grft, trnk/arm/leg.		
15101	Skin splt grft t/a/l, add-on.		
15120	Skn splt a-grft fac/nck/hf/g.		
15121	Skn splt a-grft f/n/hf/g add.		
15570	Form skin pedicle flap.		
15572	Form skin pedicle flap.		
15574	Form skin pedicle flap.		
15576	Form skin pedicle flap.		
15600	Skin graft.		
15610	Skin graft.		
15620	Skin graft.		
15630	Skin graft.		
15650	Transfer skin pedicle flap.		
15731	Forehead flap w/vasc pedicle.		

TABLE 30—PROPOSED CY 2008 SKIN REPAIR APC CONFIGURATIONS—Continued

HCPCS code	Short descriptor	Proposed CY 2008 APC	Proposed CY 2008 APC median cost
15732	Muscle-skin graft, head/neck.		
15734	Muscle-skin graft, trunk.		
15736	Muscle-skin graft, arm.		
15738	Muscle-skin graft, leg .		
15750	Neurovascular pedicle graft.		
15760	Composite skin graft.		
15770	Derma-fat-fascia graft.		
15820	Revision of lower eyelid.		
15821	Revision of lower eyelid.		
15822	Revision of upper eyelid.		
15823	Revision of upper eyelid.		
15824	Removal of forehead wrinkles.		
15825	Removal of neck wrinkles.		
15826	Removal of brow wrinkles.		
15828	Removal of face wrinkles.		
15829	Removal of skin wrinkles.		
15840	Graft for face nerve palsy.		
15841	Graft for face nerve palsy.		
15842	Flap for face nerve palsy.		
15845	Skin and muscle repair, face.		
15876	Suction assisted lipectomy.		
15877	Suction assisted lipectomy.		
15878	Suction assisted lipectomy.		
15879	Suction assisted lipectomy.		
15922	Removal of tail bone ulcer.		
15934	Remove sacrum pressure sore.		
15935	Remove sacrum pressure sore.		
15937	Remove sacrum pressure sore.		
15944	Remove hip pressure sore.		
15945	Remove hip pressure sore.		
15946	Remove hip pressure sore.		
20101	Explore wound, chest.		
20102	Explore wound, abdomen.		
20910	Remove cartilage for graft.		
20912	Remove cartilage for graft.		
43886	Revise gastric port, open.		
43888	Change gastric port, open.		
44312	Revision of ileostomy.		
44340	Revision of colostomy		

3. Cardiac Computed Tomography and Computed Tomographic Angiography (APCs 0282, 0376, 0377, and 0398)

(If you choose to comment on issues in this section, please include the caption ''Cardiac Computed Tomography and Computed Tomographic Angiography'' at the beginning of your comment.)

Cardiac computed tomography (CCT) and cardiac computed tomography angiography (CCTA) are noninvasive diagnostic procedures that assist physicians in obtaining detailed images of coronary blood vessels. The data obtained from these procedures can be used for further diagnostic evaluations and/or appropriate therapy for coronary patients.

Currently, there are eight Category III CPT codes that describe CCT and CCTA procedures. The CPT codes, which are shown in Table 31, are 0144T through 0151T. These codes were new for CY 2006. In the CY 2006 OPPS final rule with comment period, we assigned the CCT and CCTA procedure codes to interim APCs, which were subject to public comment. We received no comments on the interim APC assignments. Since January 2006, the CCT and CCTA procedure codes have been assigned to four APCs, specifically, APC 0282 (Miscellaneous Computerized Axial Tomography), APC 0376 (Level II Cardiac Imaging), APC 0377 (Level III Cardiac Imaging), and APC 0398 (Level I Cardiac Imaging).

In the CY 2007 OPPS/ASC proposed rule, we proposed to retain the existing APC assignments for the CCT and CCTA procedure codes. We received several comments on the proposed APCs assignments, which we addressed in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68038 and 68039). Several of the commenters requested that we either not assign the CCT and CCTA procedures to any APCs or assign them to appropriate New Technology APCs. In addition, some commenters were also concerned that CCT and CCTA procedures were not clinically homogeneous with other procedures assigned to APCs 0282, 0376, 0377, and 0398, noting that the last three APCs previously contained only nuclear medicine cardiac imaging procedures.

In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68038), we indicated our belief that the clinical characteristics and expected resource use associated with the CCT and CCTA procedures were sufficiently similar to the other procedures assigned to APCs 0282, 0376, 0377, and 0398 that we believed those APC assignments were appropriate. While several of those APCs also contained nuclear medicine imaging procedures, we had never designated those APCs as specific to

nuclear medicine procedures. Therefore, for CY 2007, we continued with the CY 2006 APC assignments for CPT codes 0144T through 0151T. We did not agree with the commenters that use of CT and CTA for cardiac studies was a new technology for which we had no relevant OPPS cost information that could be used to estimate hospital resources for these procedures. We also believed these services could be potentially covered hospital outpatient services, so that it would not be appropriate for us to depart from our standard OPPS policy and not assign them to APCs. As we indicated in our CY 2007 OPPS/ASC proposed rule (71 FR 49549), some Category III CPT codes describe services that we have determined to be similar in clinical characteristics and resource use to HCPCS codes assigned to existing clinical APCs. In these instances, we may assign the Category III CPT code to the appropriate clinical APC. Other Category III CPT codes describe services that we have determined are not compatible with an existing clinical APC, yet are appropriately provided in the hospital outpatient setting. In these cases, we may assign the Category III CPT code to what we estimate is an appropriately priced New Technology APC. In other cases, we may assign a Category III CPT code to one of several nonseparately payable status indicators, including ''N,'' ''C,'' ''B,''' or ''E,''' which we believe is appropriate for the specific code. As we noted in the CY 2007 OPPS/ASC final rule with comment period, we believed that CCT and CCTA procedures were appropriate for separate payment under the OPPS should local contractors provide coverage for these procedures, and, therefore, they warranted status indicator and APC assignments that would provide separate payment under the OPPS (71 FR 68038).

At its March 2007 meeting, the APC Panel recommended that CMS work with stakeholders to determine more appropriate APC placements for CCT and CCTA procedures. The APC Panel made no specific recommendations regarding the appropriate APC assignments for these services, although several different clinical APC configurations were discussed, along with the alternative of assigning these procedures to New Technology APCs.

We note that we generally meet with interested organizations concerning their views about OPPS payment policy issues with respect to specific technologies or services. Following the publication of the CY 2007 OPPS/ASC final rule with comment period, we received such information from interested individuals and organizations regarding the clinical and facility resource characteristics of CCT and CCTA procedures. We will consider the input of any individual or organization to the extent allowed by Federal law, including the Administrative Procedure Act (APA) and the FACA. We establish the OPPS payment rates for services through regulations, during our annual rulemaking cycle. We are required to consider the timely comments of interested organizations, establish the payment policies for the forthcoming year, and respond to the timely comments of all public commenters in the final rule in which we establish the payments for the forthcoming year.

Analysis of our hospital data for claims submitted for CY 2006 indicate that CCT and CCTA procedures are performed relatively frequently on Medicare patients. Our claims data show a total of over 16,000 procedures performed, with about 11,000 single claims available for ratesetting. Based on our analysis of the robust hospital outpatient claims data, we believe we have adequate claims data from CY 2006 upon which to determine the median costs of performing these procedures and to assign them to appropriate clinical APCs. We see no rationale for reassigning these procedures to New Technology APCs in CY 2008, when we have claims-based cost information regarding these procedures, and they are clinically similar to other procedures paid under the OPPS.

We acknowledge the concerns that have been expressed to us regarding the clinical homogeneity of APCs 0376, 0377, and 0398, where some of the CCT and CCTA are assigned for CY 2007 along with nuclear medicine cardiac imaging procedures. Because we are proposing to package payment for diagnostic radiopharmaceuticals into payment for diagnostic nuclear medicine procedures in CY 2008 as discussed in detail in section II.A.4. of this proposed rule, we believe that to ensure the clinical and resource homogeneity of APCs 0376, 0377, and 0398 in CY 2008, it would be most appropriate to reassign the CCT and CCTA services currently residing in those APCs to other clinical APCs for CY 2008.

Therefore, for CY 2008, we are proposing to assign the CCT and CCTA procedures to two clinical APCs, specifically new clinical APC 0383 (Cardiac Computed Tomographic Imaging) and APC 0282, as shown in Table 31. The proposed median cost of $313.81 for APC 0383 is based entirely on claims data for CPT codes 0145T, 0146T, 0147T, 0148T, 0149T, and 0150T that describe CCT and CCTA services, a clinically homogeneous grouping of services. In addition, the individual median costs of these services range from a low of $276.50 to a high of $436.79, reflecting their hospital resource similarity as well. We are proposing to reassign the two other CCT CPT codes, specifically CPT codes 0144T and 0151T, to APC 0282. The inclusion of these two codes in APC 0282 results in a CY 2008 proposed APC median cost of $105.48.

TABLE 31.—PROPOSED CY 2008 APC ASSIGNMENTS OF CCT AND CCTA PROCEDURES

HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	CY 2007 APC median cost	Proposed CY 2008 SI	Proposed CY 2008 APC	Proposed CY 2008 APC median cost
0144T	CT heart wo dye; qual calc	S	0398	$252.17	S	0282	$105.48
0145T	CT heart w/wo dye funct	S	0376	304.52	S	0383	313.81
0146T	CCTA w/wo dye	S	0376	304.52	S	0383	313.81
0147T	CCTA w/wo, quan calcium	S	0376	304.52	S	0383	313.81
0148T	CCTA w/wo, strxr	S	0377	397.29	S	0383	313.81
0149T	CCTA w/wo, strxr quan calc	S	0377	397.29	S	0383	313.81
0150T	CCTA w/wo, disease strxr	S	0398	252.17	S	0383	313.81
0151T	CT heart funct add-on	S	0282	93.98	S	0282	105.48

4. Ultrasound Ablation of Uterine Fibroids With Magnetic Resonance Guidance (MRgFUS) (APCs 0195 and 0202)

(If you choose to comment on issues in this section, please include the caption ''Ultrasound Ablation of Uterine Fibroids with Magnetic Resonance Guidance (MRgFUS)'' at the beginning of your comment.)

Magnetic resonance guided focused ultrasound (MRgFUS) is a noninvasive surgical procedure that uses high intensity focused ultrasound waves to destroy tissue in combination with magnetic resonance imaging (MRI). Currently, the two Category III CPT codes for this procedure are 0071T (Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume less than 200 cc of tissue) and 0072T (Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume greater or equal to 200 cc of tissue), which were implemented on January 1, 2005.

In the CY 2006 OPPS proposed rule, we proposed to continue to assign both codes to APC 0193 (Level V Female Reproductive Proc). However, at the August 2005 APC Panel meeting, the APC Panel recommended that CMS work with stakeholders to assign CPT codes 0071T and 0072T to appropriate New Technology APCs. Based on our review of several factors, which included information presented at the August 2005 APC Panel meeting, the comments received on the CY 2006 OPPS proposed rule, and our analysis of OPPS claims data for different procedures, we reassigned CPT code 0071T from APC 0193 to APC 0195 (Level IX Female Reproductive Proc) and CPT code 0072T from APC 0193 to APC 0202 (Level X Female Reproductive Proc) effective January 1, 2006, to reflect the higher level of resources we estimated were required when performing the MRgFUS procedures.

In the CY 2007 OPPS/ASC proposed rule, we proposed to continue to assign CPT code 0071T to APC 0195 and CPT code 0072T to APC 0202. We received comments on the CY 2007 proposed APC assignments recommending that we revise the APC assignments for CPT codes 0071T and 0072T. The commenters indicated that, while MRgFUS treats anatomical sites that are similar to other procedures assigned to APCs 0195 and 0202, the resources utilized differ dramatically. Several commenters recommended that the most appropriate APC assignment for the MRgFUS procedures would be APC 0127 (Level IV Stereotactic Radiosurgery), based on their analyses of the procedures' resource use and clinical characteristics.

As we stated in both the CY 2006 OPPS final rule with comment period and the CY 2007 OPPS/ASC final rule with comment period, we believe that MRgFUS treatment bears a significant relationship to technologies already in use in hospital outpatient departments (70 FR 68600 and 71 FR 68050, respectively). The use of focused ultrasound for thermal tissue ablation has been in development for decades, and the recent application of MRI to focused ultrasound therapy provides monitoring capabilities that may make the therapy more clinically useful. We continue to believe that, although MRgFUS therapy is relatively new, it is an integrated application of existing technologies (MRI and ultrasound), and its technology resembles other OPPS services that are assigned to clinical APCs for which we have significant OPPS claims data. In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68050), we explained our belief that retaining MRgFUS procedures in clinical APCs with other female reproductive procedures would enable us both to set accurate payment rates and to maintain appropriate clinical homogeneity of the APCs. Furthermore, we did not agree with commenters that MRgFUS procedures shared sufficient clinical and resource characteristics with cobalt-based stereotactic radiosurgery (SRS) to reassign them to that particular clinical APC 0127, where only the single specific SRS procedure was assigned for CY 2007 and which had a CY 2007 APC median cost of $8,460.53. Consequently, in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68051), we finalized payment for these procedures in APCs 0195 and 0202 as proposed.

Analysis of our hospital outpatient data for claims submitted for CY 2006 indicates that MRgFUS procedures are rarely performed on Medicare patients. As we stated in the CY 2006 OPPS final rule with comment period and CY 2007 OPPS/ASC final rule with comment period, because treatment of uterine fibroids is most common among women younger than 65 years of age, we do not expect that there ever will be many Medicare claims for the MRgFUS procedures (70 FR 68600 and 71 FR 68050, respectively). For OPPS claims submitted from CY 2005 through CY 2006, our claims data show that there were only two claims submitted for CPT code 0071T in CY 2005 and one in CY 2006. We have no hospital claims for CPT code 0072T from either of those years.

At its March 2007 meeting, the APC Panel recommended that, for CY 2008, CMS reassign CPT codes 0071T and 0072T from APCs 0195 and 0202 to APC 0067 (Level III Stereotactic Radiosurgery, MRgFUS, and MEG), which has a proposed APC median cost of $3,869.96 for CY 2008. The APC Panel discussed its general belief that while the MRgFUS procedures may not be performed frequently on Medicare patients, CMS should pay appropriately for the procedures to ensure access for Medicare beneficiaries. In addition, following discussion of the potential for reassignment of the CPT codes to New Technology APCs, the APC Panel specifically recommended that the procedures be assigned to a clinical APC at this point in their adoption into clinical practice, instead of a New Technology APC. Furthermore, since publication of the CY 2007 OPPS/ASC final rule with comment period, we have received input from interested individuals and organizations regarding the clinical and resource characteristics of MRgFUS procedures. Based on our consideration of all information available to us regarding the necessary hospital resources for the MRgFUS procedures in comparison with other procedures for which we have historical hospital claims data, for CY 2008 we are proposing to accept the APC Panel's recommendation to reassign these services to clinical APC 0067, an APC that currently contains two linear accelerator-based stereotactic radiosurgery (SRS) procedures that are conducted in a single or first session, rather than procedures for subsequent SRS treatment fractions. We agree with the APC Panel that these SRS procedures share sufficient clinical and resource similarity with the MRgFUS services, including reliance on image guidance in a single treatment session to ablate abnormal tissue, to justify their assignment to the same clinical APC. Unlike the cobalt-based SRS service that we concluded in the CY 2007 OPPS/ASC final rule with comment period was not similar to MRgFUS procedures based on clinical and resource considerations, these linear accelerator-based SRS procedures are not performed solely on intracranial lesions and generally do not require immobilization of the patient's head in a frame that is screwed into the skull, thereby exhibiting characteristics more consistent with MRgFUS treatments. In addition, based on our understanding of the MRgFUS procedures described by the two CPT codes which differ only in the volume of uterine leiomyomata treated, we believe it would be most

appropriate to assign both of these procedures to the same clinical APC, as recommended by the APC Panel. Therefore, for CY 2008 we are proposing to reassign CPT codes 0071T and 0072T to APC 0067, with a proposed APC median cost of $3,869.96, as reflected in Table 32.

TABLE 32.—PROPOSED CY 2008 APC ASSIGNMENTS OF MRGFUS PROCEDURES

HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	CY 2007 APC median cost	Proposed CY 2008 SI	Proposed CY 2008 APC	Proposed CY 2008 APC median cost
0071T	U/s leiomyomata ablate <200	T	0195	$1,742.20	S	0067	$3,869.96
0072T	U/s leiomyomata ablate >200	T	0202	2,534.46	S	0067	3,869.96

5. Single Allergy Tests (APC 0381)

(If you choose to comment on issues in this section, please include the caption ''Single Allergy Tests'' at the beginning of your comment.)

For CY 2008, we are proposing to continue with our methodology of differentiating single allergy tests (''per test'') from multiple allergy tests (''per visit'') by assigning these services to two different APCs to provide accurate payments for these tests in CY 2008. Multiple allergy tests are currently assigned to APC 0370 (Allergy Tests) with a median cost calculated based on the standard OPPS methodology. We provided billing guidance in CY 2006 in Transmittal 804 (issued on January 3, 2006) specifically clarifying that hospitals should report charges for the CPT codes that describe single allergy tests to reflect charges ''per test'' rather than ''per visit'' and should bill the appropriate number of units of these CPT codes to describe all of the tests provided. However, our CY 2006 claims data available for this CY 2008 proposed rule for APC 0381 (Single Allergy Tests) do not reflect improved and more consistent hospital billing practices of ''per test'' for single allergy tests. Using the CY 2006 claims data, the median cost of APC 0381 calculated according to the standard single claims OPPS methodology is $66.17, significantly higher than the CY 2007 median cost of $16.43 for APC 0381 calculated according to the ''per unit'' methodology and greater than we would expect for these procedures that are to be reported ''per test'' with the appropriate number of units. Some claims for single allergy tests still appeared to include charges that represent a ''per visit'' charge, rather than a ''per test'' charge. Therefore, consistent with our payment policy for CYs 2006 and 2007, we are proposing to calculate a ''per unit'' median cost for APC 0381, based upon 276 CY 2006 claims containing multiple units or multiple occurrences of a single CPT code, where packaging on the claims is allocated equally to each unit of the CPT code. Using this methodology, we calculated a proposed median cost of $18.96 for APC 0381 for CY 2008. We will consider whether further instructions to hospitals for reporting these procedures would be beneficial, because we are concerned that our claims data for CY 2006 reflect no apparent change in hospitals' billing practices following our January 2006 clarification. We remain hopeful that better and more accurate hospital reporting and charging practices for these single allergy test CPT codes in future years may allow us to calculate the median cost of APC 0381 using the standard OPPS process for future OPPS updates.

6. Myocardial Positron Emission Tomography (PET) Scans (APC 0307)

(If you choose to comment on issues in this section, please include the caption ''Myocardial PET Scans'' at the beginning of your comment.)

From August 2000 to December 31, 2005, under the OPPS, we assigned one clinical APC to all myocardial positron emission tomography (PET) scan procedures, which were reported with multiple G-codes through March 31, 2005. Under the OPPS, effective April 1, 2005, myocardial PET scans were reported with three CPT codes, specifically CPT codes 78459 (Myocardial imaging, positron emission tomography (PET), metabolic evaluation), 78491 (Myocardial imaging, positron emission tomography (PET), perfusion; single study at rest or stress), and 78492 (Myocardial imaging, positron emission tomography (PET), perfusion; multiple studies at rest and/or stress). From April 1, 2005 through December 31, 2005, these three CPT codes were assigned to one APC, specifically APC 0285 (Myocardial Positron Emission Tomography (PET), with a payment rate of $735.77. In CY 2006, in response to the public comments received on the CY 2006 OPPS proposed rule, and based on our claims information, myocardial PET services were assigned to two clinical APCs for the CY 2006 OPPS. The CPT codes for the single scans, specifically 78459 and 78491, were assigned to APC 0306 (Myocardial Positron Emission Tomography (PET) Imaging, Single Study, Metabolic Evaluation) with a payment rate of $800.55, and the multiple scan CPT code 78492 was assigned to APC 0307 (Myocardial Positron Emission Tomography (PET) Imaging, Multiple Studies) with a payment rate of $2,484.88, effective January 1, 2006. However, analysis of the CY 2005 claims data that were used to set the payment rates for CY 2007 revealed that when all the myocardial PET scan procedure codes were combined into a single clinical APC, as they were prior to CY 2006, the APC median cost for myocardial PET services was very similar to the median cost of their single CY 2005 clinical APC. Further, our analysis revealed that the updated differential median costs of the single and multiple study procedures no longer supported the two-level APC payment structure. Therefore, for CY 2007, CPT codes 78459, 78491, and 78492, were assigned to a single clinical APC, specifically APC 0307, which was renamed ''Myocardial Positron Emission Tomography (PET) Imaging,'' with a median cost of $726.98.

At its March 2007 meeting, the APC Panel recommended that CMS reassign CPT code 78492 to its own clinical APC, to distinguish this multiple study procedure that the APC Panel believed would require greater hospital resources from less resource intensive single study procedures. However, we are not accepting the APC Panel's recommendation because, consistent with our observations from the CY 2005 claims data, our updated CY 2006 claims data do not support the creation of a clinical APC for CPT code 78492 alone. Analysis of the latest CY 2006 claims data continues to support a single level APC payment structure for the myocardial PET scan procedures because very few single scan studies are performed and we believe single and multiple scan procedures are clinically

similar. Our claims data available for this proposed rule show a total of 2,547 procedures reported with the multiple scan CPT code 78492. Alternatively, our claims data show only a combined total of 249 procedures reported with the single scan CPT codes 78459 and 78491, less than 10 percent of all studies reported. A similar distribution is observed in the single bills available for ratesetting.

Similar to last year's findings, our claims data reveal that more hospitals are not only providing multiple myocardial PET scan services, but most myocardial PET scans are multiple studies. We believe that the assignment of CPT codes 78459, 78491, and 78492 to a single clinical APC for CY 2008 remains appropriate because the CY 2006 claims data do not support a resource differential among significant myocardial PET services that would necessitate the placement of single and multiple PET scan procedures into two separate clinical APCs. Therefore, we are proposing to continue to assign both the single and multiple myocardial PET scan procedure codes to APC 0307, with a proposed APC median cost of $2,677.71 for CY 2008. We note that the proposed CY 2008 median cost of APC 0307 is significantly higher than its CY 2007 median cost, in part because of our proposed CY 2008 packaging approach discussed in detail in section II.A.4. of this proposed rule that would package payment for diagnostic radiopharmaceuticals into the payment for their related diagnostic nuclear medicine studies, such as myocardial PET scans. We believe that the proposed median cost appropriately reflects the hospital resources associated with providing myocardial PET scans to Medicare beneficiaries in cost-efficient settings. Furthermore, we believe that the proposed CY 2008 OPPS payment rates are adequate to ensure appropriate access to these services for Medicare beneficiaries. The myocardial PET scan CPT codes and their proposed CY 2008 APC assignments are displayed in Table 33.

TABLE 33.—PROPOSED CY 2008 APC ASSIGNMENTS FOR MYOCARDIAL PET SCANS

HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	CY 2007 APC median cost	Proposed CY 2008 SI	Proposed CY 2008 APC	Proposed CY 2008 APC median cost
78459	Heart muscle imaging (PET)	S	0307	$726.98	S	0307	$2,677.71
78491	Heart image (pet), single	S	0307	726.98	S	0307	2,677.71
78492	Heart image (pet), multiple	S	0307	726.98	S	0307	2,677.71

7. Implantation of Cardioverter-Defibrillators (APCs 0107 and 0108)

(If you choose to comment on issues in this section, please include the caption ''Implantation of Cardioverter-Defibrillators'' at the beginning of your comment.)

In CY 2003, we created four Level II HCPCS codes for implantation of single and dual chamber cardioverter-defibrillators (ICDs) with and without leads because, for the CY 2004 OPPS, we deleted the device HCPCS codes and there was no other way of determining whether the device being implanted was a single chamber or dual chamber device. We were concerned that the costs of inserting single versus dual chamber ICDs could be sufficiently different due to the two types of devices implanted such that separate APC assignments for the insertion procedures could be appropriate in the future. The HCPCS codes are G0297 (Insertion of single chamber pacing cardioverter defibrillator pulse generator); G0298 (Insertion of dual chamber pacing cardioverter defibrillator pulse generator); G0299 (Insertion or repositioning of electrode lead for single chamber pacing cardioverter defibrillator and insertion of pulse generator); and G0300 (Insertion or repositioning of electrode lead for dual chamber pacing cardioverter defibrillator and insertion of pulse generator). The pairs of codes were assigned to two different clinical APCs, depending on whether or not they included the possibility of electrode insertion, specifically APC 0107 (Insertion of Cardioverter-Defibrillator) and APC 0108 (Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads).

In the same year, the OPPS ceased to recognize for payment the two CPT codes for insertion of ICDs with or without ICD leads. These CPT codes are 33240 (Insertion of single or dual chamber pacing cardioverter-defibrillator pulse generator) and 33249 (Insertion or repositioning of electrode lead(s) for single or dual chamber pacing cardioverter-defibrillator and insertion of pulse generator).

We reinstated the device category HCPCS codes on January 1, 2005. Moreover, since January 1, 2005, hospitals have been required to report devices they use or implant when there is a device code that describes the device. We began to edit to ensure that hospitals are correctly billing devices required for certain procedures in April 2005 and implemented the second phase of device edits on October 1, 2005. Therefore, we no longer need different procedural Level II HCPCS codes to identify whether hospitals inserted a single or dual chamber ICD device.

At its March 2007 meeting, the APC Panel recommended that CMS delete the Level II HCPCS codes for implantation of cardioverter-defibrillator pulse generators with or without repositioning or implantation of electrode lead(s) and authorize hospitals to report the CPT codes. The APC Panel indicated that the requirement for reporting device codes would enable CMS to continue to identify costs when different types of devices are implanted if that were to be necessary.

We analyzed the median cost data associated with APCs 0107 and 0108 as part of our preparation for the APC Panel discussion. While there is a difference in the median cost when a single chamber versus a dual chamber device is implanted, the difference has never been great enough to justify differential APC assignments for the procedures. See Table 34 below for a historical summary of all single claim median costs. (For purposes of this analysis, we display the median costs for all single claims without regard to adjustment or to whether the claims meet various selection criteria; these are not the median costs on which payments were based.)

Hospitals have consistently indicated that they would prefer to report the services furnished using the CPT codes that describe them, rather than the alphanumeric G-codes, because many private payers require that they bill the CPT codes. We also prefer to recognize CPT codes for procedures under the OPPS, when possible, to minimize the administrative coding burden on hospitals.

We believe that the differences between the median costs for the two Level II HCPCS codes assigned to each APC (that is, G0297 and G0298 for APC 0107 and G0299 and G0300 for APC 0108) do not currently support differential APC assignments for single and dual chamber ICD insertion procedures. The required device coding would allow us to continue to follow the different costs over time by examining subsets of ICD implantation procedure claims based on the type of device reported on the claims. Moreover, we are sensitive to the benefits of minimizing the reporting burden on hospitals. Therefore, for CY 2008 we are proposing to delete the Level II HCPCS codes for ICD insertion procedures and require hospitals to bill the appropriate CPT codes, along with the applicable device C-codes, for payment under the OPPS.

TABLE 34.—HISTORICAL UNADJUSTED MEDIAN COST DATA FROM ALL SINGLE CLAIMS FOR APCS 0107 AND 0108

HCPCS code	CY 2002 claims (includes 75% of device cost per manufacturer data) (CY 2004 OPPS)	Unadjusted CY 2003 claims (CY 2005 OPPS)	Unadjusted CY 2004 claims (CY 2006 OPPS)	Unadjusted CY 2005 claims (CY 2007 OPPS)	Unadjusted CY 2006 claims (CY 2008 OPPS)
APC 0107:					
33240	$17,025.21	$12,102.28			
G0297		11,886.42	$13,392.82	$10,821.06	$18,470.82
G0298		17,168.67	14,316.54	13,935.35	21,571.88
APC 0108:					
33249	$28,685.29	17,330.96			
G0299		18,561.51	18,425.79	21,367.99	23,060.55
G0300		21,006.03	19,306.96	23,680.34	26,204.89

8. Implantation of Spinal Neurostimulators (APC 0222)

(If you choose to comment on issues in this section, please include the caption ''Implantation of Spinal Neurostimulators'' at the beginning of your comment.)

The CPT code for insertion of a spinal neurostimulator (63685, Insertion or replacement of spinal neurostimulator pulse generation or receiver, direct or inductive coupling), which is assigned to APC 0222 (Implantation of Neurological Device), is reported for both the insertion of a nonrechargeable neurostimulator and a rechargeable neurostimulator. The costs of a nonrechargeable neurostimulator from CY 2005 claims are packaged into the payment for APC 0222 in CY 2007. We believe rechargeable neurostimulators are currently most commonly implanted for spinal neurostimulation, consistent with the information provided during our consideration of the device for pass through designation. However, in response to hospital requests we have recently expanded our procedure-to-device edits to allow device category code C1820 (Generator, neurostimulator (implantable), with rechargeable battery and charging system) to be reported with two other procedures. These procedures are CPT code 64590 (Insertion or replacement of peripheral neurostimulator pulse generator or receiver, direct or inductive coupling), assigned to APC 0222, and CPT code 61885 (Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array), assigned to APC 0039 (Level I Implantation of Neurostimulator).

The rechargeable neurostimulator reported as device category code C1820 has received pass-through payment since January 1, 2006, and its pass-through status will expire on January 1, 2008, as discussed further in section IV.B. of this proposed rule. During the 2 years of pass-through payment when device category code C1820 has been paid at a hospital's charges reduced to cost using the overall hospital CCR, we have applied a device offset when device category code C1820 is reported with a CPT code assigned to APCs 0039 or 0222 in order to remove the costs of the predecessor nonrechargeable device from the cost-based payment of C1820. This device offset ensures that no duplicate device payment is made. As a general policy, under the OPPS we package payment for the costs of devices into the payment for the procedure in which they are used, unless those devices have OPPS pass-through status, such as the case here.

Review of our CY 2007 claims data for APC 0222 shows that the costs of the associated neurostimulator implantation procedures are higher when the rechargeable neurostimulator is implanted rather than the traditional nonrechargeable neurostimulator. We refer readers to Table 35 below for the median costs of APC 0222 under different device packaging scenarios. However, the difference in costs is not so great that retaining the implantation of both types of devices for spinal or peripheral neurostimulation in APC 0222 would cause a 2 times violation, and thereby, justify creating a new clinical APC. In addition, to pay differentially would require us to establish one or more Level II HCPCS codes for reporting under the OPPS, because the three CPT codes for which device category code C1820 is currently an allowed device do not differentiate among the device implantation procedures based on the specific device used. The creation of special Level II HCPCS codes for OPPS reporting is generally undesirable, unless absolutely essential, because it increases hospital administrative burden as the codes may not be accepted by other payers. Establishing separate coding and payment would reduce the size of the APC payment groups in a year where we are proposing to increase packaging under the OPPS through expanded payment groups.

We believe that the principles of a prospective payment system are best served by following our standard practice of retaining a single CPT code for neurostimulator implantation procedures that does not distinguish between rechargeable and nonrechargeable neurostimulators, into which the costs of both types of devices are packaged in relationship to their OPPS utilization. To the extent that the rechargeable neurostimulator may become the dominant device implanted over time for neurostimulation, the median costs of APCs 0222 and 0039 would reflect the change in surgical practice in future years. In the meantime, with the rechargeable neurostimulator coming off pass-through status for CY 2008, by following our standard practice we would be increasing the size of the APC 0222 and

APC 0039 payment bundles for CY 2008, thereby encouraging hospitals to use resources most efficiently.

Therefore, for CY 2008 we are proposing to package the costs of rechargeable neurostimulators into the payment for the CPT codes that describe the services furnished. Our proposed median cost for APC 0222 is $12,161.64, upon which the CY 2008 payment rate for APC 0222 would be based. We believe this approach is the most administratively simple, consistent with OPPS packaging principles, and supportive of encouraging hospital efficiency, yet it also provides appropriate packaged payment for implantable neurostimulators. While we welcome public comment on this issue, we request that commenters address how this specific device implantation situation differs from many other scenarios under the OPPS, where relatively general HCPCS codes describe procedures that may utilize a variety of devices with different costs, and payment for those devices is packaged into the payment for the associated procedures.

TABLE 35.—APC 0222 CY 2006 DATA BASED ON CLAIMS REPORTING DIFFERENT NEUROSTIMULATOR DEVICES

APC 0222 configurations	CY 2006 count of hospitals billing	CY 2006 pass edit, nontoken, no FB single bills	CY 2006 pass edit, nontoken, no FB median cost
APC 0222, including claims with both rechargeable and nonrechargeable neurostimulators ...	868	2,830	$12,161.64
APC 0222A, including only claims with nonrechargeable neurostimulators	781	2,412	11,607.75
APC 0222B, including only claims with rechargeable neurostimulators	238	422	18,088.71

9. Stereotactic Radiosurgery (SRS) Treatment Delivery Services (APCs 0065, 0066, and 0067)

(If you choose to comment on issues in this section, please include the caption ''SRS Treatment Delivery Services'' at the beginning of your comment.)

For CY 2007, the CPT Editorial Panel created four new SRS Category I CPT codes in the Radiation Oncology section of the 2007 CPT manual. Specifically, the CPT Editorial Panel created CPT codes 77371 (Radiation treatment delivery, stereotactic radiosurgery (SRS) (complete course of treatment of cerebral lesion(s) consisting of 1 session); multi-source Cobalt 60 based)); 77372 (Radiation treatment delivery, stereotactic radiosurgery (SRS) (complete course of treatment of cerebral lesion(s) consisting of 1 session); linear accelerator based)), 77373 (Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions); and 77435 (Stereotactic body radiation therapy, treatment management, per treatment course, to one or more lesions, including image guidance, entire course not to exceed 5 fractions).

Of the four CPT codes, CPT codes 77371 and 77435 were recognized under the OPPS effective January 1, 2007, while CPT codes 77372 and 77373 were not. CPT code 77371 was assigned to the same APC and status indicator as its predecessor code, HCPCS code G0243 (Multi-source photon stereotactic radiosurgery, delivery including collimator changes and custom plugging, complete course of treatment, all lesions). For CY 2007, CPT code 77371 was assigned to APC 0127 with a status indicator of ''S.'' Prior to CY 2007, CPT code 77435 was described under CPT code 0083T (Stereotactic body radiation therapy, treatment management, per day), which was assigned to status indicator ''N'' in the OPPS. The CPT Editorial Panel decided to delete CPT code 0083T on December 31, 2006, and replaced it with CPT code 77435. Because the costs of SRS treatment management were already packaged into the OPPS payment rates for SRS treatment delivery, we assigned CPT code 77435 to status indicator ''N'' which was the same status indicator that was assigned to its predecessor Category III CPT code (0083T), under the OPPS, effective January 1, 2007. We note that the OPPS treatment of these new CPT codes was open to comment in the CY 2007 OPPS/ASC final rule with comment period, and we will specifically respond to those comments, according to our usual practice, in the CY 2008 OPPS/ASC final rule with comment period.

As we explained in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68025), we did not recognize CPT codes 77372 and 77373 because they do not accurately and specifically describe the HPCPCS G-codes that we currently use for linear accelerator (LINAC)-based SRS treatment delivery services under the OPPS. During CY 2006, CPT code 77372 was reported under one of two HCPCS codes, depending on the technology used, specifically, G0173 (Linear accelerator based stereotactic radiosurgery, complete course of therapy in one session) and G0339 (Image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session or first session of fractionated treatment). Because HCPCS codes G0173 and G0339 are more specific in their descriptors than CPT code 77372, we decided to continue using HCPCS codes G0173 and G0339 under the OPPS for CY 2007. For CY 2007, we assigned CPT code 77372 to status indicator ''B'' under the OPPS. In addition, during CY 2006, CPT code 77373 was reported under one of three HCPCS codes depending on the circumstances and technology used, specifically, G0251 (Linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, maximum five sessions per course of treatment); G0339 (Image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session or first session of fractionated treatment); and G0340 (Image-guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment). Because HCPCS codes G0251, G0339, and G0340 are more specific in their descriptors than CPT code 77373 and are also assigned to different clinical APCs for CY 2007, we decided to continue recognizing HCPCS codes G0251, G0339, and G0340 under the OPPS for CY 2007. Therefore, for CY 2007 we assigned CPT code 77373 to status indicator ''B'' under the OPPS.

While we have had requests from certain specialty societies and other stakeholders that we recognize CPT codes 77372 and 77373 under the OPPS rather than continuing to use the current Level II HCPCS codes for hospital

outpatient facility reporting of these procedures, we have also heard from others that continued use of the G-codes under the OPPS is the most appropriate way to recognize the facility resource differences between different types of LINAC-based procedures. For the past several years, we have collected information through our claims data regarding the hospital costs associated with the planning and delivery of SRS services. As new technology emerged in the field of SRS several years ago, public commenters urged CMS to recognize cost differences associated with the various methods of SRS planning and delivery. Beginning in CY 2001, we established G-codes to capture any such cost variations associated with the various methods of planning and delivery of SRS. Based on comments received on the CY 2004 OPPS proposed rule regarding the G-codes used for SRS, we made some modifications to the coding for CY 2004 (68 FR 63431 and 63432). First, we received comments regarding the descriptors for HCPCS codes G0173 and G0251, indicating that these codes did not accurately distinguish image-guided robotic SRS systems from other forms of linear accelerator-based SRS systems to account for the cost variation in delivering these services. In response, for CY 2004 we modified the descriptor for G0173 and also created two HCPCS G-codes, G0339 and G0340, to describe complete and fractionated image-guided robotic linear accelerator-based SRS treatment. While all of these LINAC-based SRS procedures were originally assigned to New Technology APCs under the OPPS, we reassigned them to new clinical APCs for CY 2007 based on 2 full years of hospital claims data reflecting stable median costs based on significant volumes of single claims.

HCPCS codes G0173, G0251, G0339, and G0340 are more specific in their descriptors than either CPT code 77372 or 77373. In addition, their hospital claims data continue to reflect significantly different hospital resources that would lead to violations of the 2 times rule were we to reassign certain procedures to the same clinical APCs in order to crosswalk the CY 2006 historical claims data for the 4 G-codes to develop the median costs of the APCs to which the 2 CPT codes would be assigned if we were to recognize them. Therefore, we believe that we should continue to use the G-codes for reporting LINAC-based SRS treatment delivery services for CY 2008 under the OPPS to ensure appropriate payment to hospitals for the different facility resources associated with providing these complex services. That is, we are proposing to continue to assign HCPCS codes G0173 and G0339 to APC 0067 (Level III Stereotactic Radiosurgery, MRgFUS, and MEG), HCPCS code G0251 to APC 0065 (Level I Stereotactic Radiosurgery, MRgFUS, and MEG), and HCPCS code G0340 to APC 0066 (Level II Stereotactic Radiosurgery, MRgFUS, and MEG) for CY 2008.

Since we first established the full group of SRS treatment delivery codes in CY 2004, we now have 3 years of hospital claims data reflecting the costs of each of these services. Based on our latest claims data from CY 2006, the proposed APC median cost for the complete course of therapy in one session or first fraction of image-guided, robotic LINAC-based SRS, as described by HCPCS codes G0173 and G0339 respectively in APC 0067, is $3,869.96 based on 1,946 single claims available for ratesetting. The proposed CY 2008 APC median cost for each fractionated session of LINAC-based SRS, as described by HCPCS code G0251 in APC 0065, is $1,081.92 based on 1,938 single claims. The proposed CY 2008 APC median cost for the second through fifth sessions of image-guided, robotic LINAC-based fractionated SRS treatment, reported by HCPCS code G0340 in APC 0066, is $2,980.24 based on 5,209 single claims.

Therefore, for CY 2008, we are proposing to continue with the CY 2007 HCPCS coding for LINAC-based SRS treatment delivery services under the OPPS. The LINAC based SRS codes and their CY 2008 proposed APC assignments are displayed in Table 36.

TABLE 36.—PROPOSED CY 2008 APC ASSIGNMENTS FOR LINAC-BASED SRS TREATMENT DELIVERY SERVICES

HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	CY 2007 APC median cost	Proposed CY 2008 SI	Proposed CY 2008 APC	Proposed CY 2008 APC median cost
G0173	Linear acc stereo radsur com	S	0067	$3,872.87	S	0067	$ 3,869.96
G0251	Linear acc based stero radio	S	0065	1,241.89	S	0065	1,081.92
G0339	Robot lin-radsurg com, first	S	0067	3,872.87	S	0067	3,869.96
G0340	Robt lin-radsurg fractx 2–5	S	0066	2,629.53	S	0066	2,980.24

10. Blood Transfusion (APC 0110)

(If you choose to comment on issues in this section, please include the caption ''Blood Transfusions'' at the beginning of your comment.)

We have a longstanding policy under the OPPS that transfusion services are billed and paid on a per encounter basis and not by the number of units of blood products transfused (Internet Only Manual 100–4, Chapter 4, Section 231.8). Under this policy, a transfusion APC payment is made to the OPPS provider for transfusing blood products once per day, regardless of the number of units or different types of blood products transfused. The OCE ensures only one payment for APC 0110 (Transfusion), regardless of the number of units of CPT code 36430 (Transfusion, blood or blood components) reported by the hospital on a single date of service. The CPT code 36430 descriptor does not include ''per unit.'' Hence, the median cost for CPT code 36430, which is assigned to APC 0110, represents the costs of transfusion of blood or blood products on the same date of service, regardless of how many units of products are transfused. In addition, for payment of the transfusion service, the OCE also requires the claim to contain a Level II HCPCS P-code for a blood product on the same date of service as the transfusion procedure.

At its March 2007 meeting, the APC Panel recommended that CMS investigate whether CPT code 36430 should identify when multiple units are transfused and trigger a discounted payment for the second and subsequent administration of additional units of blood or blood components. The APC Panel indicated that the current payment for transfusion services does not adequately pay hospitals for the costs of these complex services, and that payment on a per unit basis rather than on a per encounter basis would result in more accurate and appropriate payment.

We do not agree with the APC Panel's recommendation, and we are proposing to not accept this recommendation for

the CY 2008 OPPS. We believe that our current policy of providing a single payment for blood transfusion, regardless of the number of units transfused, is most consistent with the goals of a prospective payment system to encourage and create incentives for efficiency in providing services. Payment for transfusion services on a per encounter basis encourages the transfusion of only those blood products that are necessary for the beneficiary's treatment during the hospital outpatient encounter. Moreover, the current median cost for the transfusion service, associated with the transfusion of all blood products furnished on a date of service, has been set based on the historical reporting of all charges for transfusion on the same date of service and, therefore, represents the full cost of an episode of transfusion, rather than the cost of transfusion of a single unit of blood or blood product. Given our proposed packaging approach for the CY 2008 OPPS, it would be inconsistent for us to revise our current transfusion payment policy to provide separate payment for each unit of blood product transfused, thereby reducing the size of the current transfusion payment bundle.

Therefore, for CY 2008 we are proposing to maintain our current payment policy, which bases payment for transfusion on the costs of all transfusion services furnished on a single date of service and which examines hospital claims to ensure that payment is provided for only one unit of CPT code 36430 on a date of service. However, we remind hospitals that a claim for a single unit of CPT code 36430 should include charges for all of the hospital resource costs associated with the totality of transfusion services furnished on the date of service, so that the payment for one unit of APC 0110 is based on the costs of all transfusion services provided in a hospital outpatient encounter.

11. Screening Colonoscopies and Screening Flexible Sigmoidoscopies (APCs 0158 and 0159)

(If you choose to comment on issues in this section, please include the caption ''Screening Colonoscopies and Screening Flexible Sigmoidoscopies'' at the beginning of your comment.)

Since the implementation of the OPPS in August 2000, screening colonoscopies and screening flexible sigmoidoscopies have been paid separately. In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68013), we implemented certain changes associated with colorectal cancer screening services provided in HOPDs. First, section 5113 of Pub. L. 109–171 amended section 1833(b) of the Act to add colorectal cancer screening to the list of services for which the beneficiary deductible no longer applies. This provision applies to services furnished on or after January 1, 2007. Second, sections 1834(d)(2) and (d)(3) of the Act require Medicare to pay the lesser of the ASC or OPPS payment amount for screening flexible sigmoidoscopies and screening colonoscopies. For CY 2007, the OPPS payment for screening colonoscopies, HCPCS codes G0105 (Colorectal cancer screening; colonoscopy on individual at risk) and G0121 (Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk), developed in accordance with our standard OPPS ratesetting methodology, would have slightly exceeded the CY 2007 ASC payment of $446 for these procedures. Consistent with the requirements set forth in sections 1834(d)(2) and (d)(3) of the Act, the OPPS payment rates for HCPCS codes G0105 and G0121 were set equal to the CY 2007 ASC rate of $446 effective January 1, 2007. This requirement did not impact the OPPS payment rate for screening flexible sigmoidoscopies (G0104, Colorectal cancer screening; flexible sigmoidoscopy) because Medicare did not make payment to ASCs for screening flexible sigmoidoscopies in CY 2007, so there was no payment comparison to be made for those services.

According to the final policy for the revised ASC payment system as described in the final rule for the revised ASC payment system published elsewhere in this issue of the **Federal Register**, ASCs will be paid for screening colonoscopies based on their ASC payment weights derived from the related OPPS APC payment weights and multiplied by the final ASC conversion factor (the product of the OPPS conversion factor and the ASC budget neutrality adjustment). As an office-based procedure added to the ASC list of covered surgical procedures for CY 2008, ASC payment for screening flexible sigmoidoscopies will be capped at the CY 2008 MPFS nonfacility practice expense amount. Sections 1834(d)(2) and (d)(3) of the Act would then require that the CY 2008 OPPS payment rates for these procedures be set equal to their significantly lower ASC payment rates.

However, we are proposing to use the equitable adjustment authority of section 1833(t)(2)(E) of the Act to adjust the OPPS payment rates for screening colonoscopies and screening flexible sigmoidoscopies. Section 1833(t)(2)E) of the Act provides that the Secretary shall establish adjustments, in a budget neutral manner, as determined to be necessary to ensure equitable payments under the OPPS. Sections 1834(d)(2) and (d)(3) of the Act regarding payment for screening flexible sigmoidoscopies and screening colonoscopies under the OPPS and ASC payment systems were established by Congress in 1997, many years prior to the CY 2008 initial implementation of the revised ASC payment system. The payment policies of the revised ASC payment system, as summarized in section XVI. of this proposed rule, make fundamental changes to the methodology for developing ASC payment rates based on certain principles, specifically that the OPPS payment weight relativity is applicable to ASC procedures and that ASC costs are lower than HOPD costs for providing the same procedures, that contradict the original assumptions underlying these provisions. According to the findings of the GAO in its report, released on November 30, 2006, and entitled ''Medicare: Payment for Ambulatory Surgical Centers Should Be Based on the Hospital Outpatient Payment System'' (GAO–07–86), the payment groups of the OPPS accurately reflect the relative costs of procedures performed in ASCs just as well as they reflect the relative costs of the same procedures provided in HOPDs. Screening colonoscopies were among the top 20 ASC procedures in terms of volume whose costs were specifically studied by the GAO in its work that led to this conclusion. We see no clinical or hospital resource explanation for why the OPPS relative costs from CY 2006 OPPS claims data for screening flexible sigmoidoscopies and screening colonoscopies would not provide an appropriate basis for establishing their payment rates under both the OPPS and the revised ASC payment system, according to the standard ratesetting methodologies of each payment system for CY 2008. If we were to pay for these screening procedures under the OPPS according to their ASC rates in CY 2008, we would significantly distort their payment relativity in comparison with other OPPS services. We believe it would be inequitable to pay these screening services in HOPDs at their ASC rates for CY 2008, thereby ignoring the relativity of their costs in comparison with other OPPS services which have similar or different clinical and resource characteristics. Therefore, for CY 2008 when we will be paying for screening colonoscopies and screening flexible sigmoidoscopies performed in ASCs based upon their standard revised ASC payment rates, we are proposing to

adjust the payment rates under the OPPS to pay for the procedures according to the standard OPPS payment rates. We believe that the application of sections 1834(d)(2) and (d)(3) of the Act produces inequitable results because of the revised ASC payment system to be implemented in CY 2008. We believe this proposal would provide the most appropriate payment for these procedures in the context of the contemporary payment policies of the OPPS and the revised ASC payment system.

IV. Proposed OPPS Payment for Devices

A. Proposed Treatment of Device-Dependent APCs

(If you choose to comment on issues in this section, please include the caption ''OPPS: Device-Dependent APCs'' at the beginning of your comment.)

1. Background

Device-dependent APCs are populated by HCPCS codes that usually, but not always, require that a device be implanted or used to perform the procedure. For the CY 2002 OPPS, we used external data, in part, to establish the device-dependent APC medians used for weight setting. At that time, many devices were eligible for pass through payment. For the CY 2002 OPPS, we estimated that the total amount of pass-through payments would far exceed the limit imposed by statute. To reduce the amount of a pro rata adjustment to all pass-through items, we packaged 75 percent of the cost of the devices, using external data furnished by commenters on the August 24, 2001 proposed rule and information furnished on applications for pass-through payment, into the median costs for the device-dependent APCs associated with these pass-through devices. The remaining 25 percent of the cost was considered to be pass through payment.

In the CY 2003 OPPS, we determined APC medians for device-dependent APCs using a three-pronged approach. First, we used only claims with device codes on the claim to set the medians for these APCs. Second, we used external data, in part, to set the medians for selected device-dependent APCs by blending that external data with claims data to establish the APC medians. Finally, we also adjusted the median for any APC (whether device-dependent or not) that declined more than 15 percent. In addition, in the CY 2003 OPPS we deleted the device codes (''C'' codes) from the HCPCS file because we believed that hospitals would include the charges for the devices on their claims, notwithstanding the absence of specific codes for devices used.

In the CY 2004 OPPS, we used only claims containing device codes to set the medians for device-dependent APCs and again used external data in a 50/50 blend with claims data to adjust medians for a few device-dependent codes when it appeared that the adjustments were important to ensure access to care. However, hospital device code reporting was optional.

In the CY 2005 OPPS, which was based on CY 2003 claims data, there were no device codes on the claims and, therefore, we could not use device-coded claims in median calculations as a proxy for completeness of the coding and charges on the claims. For the CY 2005 OPPS, we adjusted device-dependent APC medians for those device-dependent APCs for which the CY 2005 OPPS payment median was less than 95 percent of the CY 2004 OPPS payment median. In these cases, the CY 2005 OPPS payment median was adjusted to 95 percent of the CY 2004 OPPS payment median. We also reinstated the device codes and made the use of the device codes mandatory where an appropriate code exists to describe a device utilized in a procedure. In addition, we implemented HCPCS code edits to facilitate complete reporting of the charges for the devices used in the procedures assigned to the device-dependent APCs.

In the CY 2006 OPPS, which was based on CY 2004 claims data, we set the median costs for device-dependent APCs for CY 2006 at the highest of: (1) The median cost of all single bills; (2) the median cost calculated using only claims that contained pertinent device codes and for which the device cost was greater than $1; or (3) 90 percent of the payment median that was used to set the CY 2005 payment rates. We set 90 percent of the CY 2005 payment median as a floor rather than 85 percent as proposed, in consideration of public comments that stated that a 15-percent reduction from the CY 2005 payment median was too large of a transitional step. We noted in our CY 2006 proposed rule that we viewed our proposed 85 percent payment adjustment as a transitional step from the adjusted medians of past years to the use of unadjusted medians based solely on hospital claims data with device codes in future years (70 FR 42714). We also incorporated, as part of our CY 2006 methodology, the recommendation of commenters to base payment on medians that were calculated using only claims that passed the device edits. As stated in the CY 2006 OPPS final rule with comment period (70 FR 68620), we believed that this policy provided a reasonable transition to full use of claims data in CY 2007, which would include device coding and device editing, while better moderating the amount of decline from the CY 2005 OPPS payment rates.

For CY 2007, we based the device-dependent APC medians on CY 2005 claims, the most current data available at that time. In CY 2005 we reinstated hospital reporting of device codes and made the reporting of device codes mandatory where an appropriate code exists to describe a device utilized. In CY 2005, we also implemented HCPCS code procedure-to-device edits to facilitate complete reporting of the charges for the devices used in the procedures assigned to the device-dependent APCs. For CY 2007 ratesetting, we excluded claims for which the charge for a device was less than $1.01, in part to recognize hospital charging practices due to a recall of cardioverter-defibrillator and pacemaker pulse generators in CY 2005 for which the manufacturers provided replacement devices without cost to the beneficiary or hospital. We also found that there were other devices for which the token charge was less than $1.01, and we removed those claims from the set used to calculate the median costs of device-dependent APCs. In summary, for the CY 2007 OPPS we set the median costs for device-dependent APCs using only claims that passed the device edits and did not contain token charges for the devices. Therefore, the median costs for these APCs for CY 2007 were determined from claims data that generally represented the full cost of the required device.

2. Proposed Payment

For this proposed rule, we calculated the median costs for device-dependent APCs using three different sets of claims. We first calculated a median cost using all single procedure claims that contained appropriate device codes (where there are edits) for the procedure codes in those APCs. We then calculated a second median cost using only claims that contain allowed device HCPCS codes with charges for all device codes that were in excess of $1.00 (nontoken charge device claims). Third, we calculated the APC median cost based only upon nontoken charge device claims with correct devices that did not also contain the HCPCS modifier ''FB,'' reported in CY 2005 to identify that a procedure was performed using an item provided without cost to the provider, supplier, or practitioner, or where a credit was received for a

replaced device (examples include, but are not limited to, devices covered under warranty, devices replaced due to defects, and free samples).

As expected, the median costs calculated based upon single procedure bills that met all three criteria, that is, correct devices, no token charges, and no ''FB'' modifier, were generally higher than the median costs calculated using all single bills. We believe that the claims that meet these three criteria (appropriate device codes, nontoken device charges, and no ''FB'' modifier) reflect the best estimated costs for these device-dependent APCs when the hospital pays the full cost of the device, and we are proposing to base our CY 2008 median costs on the medians calculated based upon these claims.

As a result of the effects of the proposed CY 2008 packaging approach discussed in detail in section II.A.4. of this proposed rule on median costs, we are proposing to make some changes to CY 2007 device-dependent APCs for CY 2008. Specifically, we are proposing to delete APC 0081 (Noncoronary Angioplasty or Atherectomy); APC 0087 (Cardiac Electrophysiologic Recording/Mapping); and APC 0670 (Level II Intravascular and Intracardiac Ultrasound and Flow Reserve) due to the migration of HCPCS codes to other APCs. Some of the HCPCS codes assigned to these APCs in CY 2007 would be unconditionally packaged for CY 2008. The median costs of the remaining HCPCS codes proposed for separate payment in CY 2008 were significantly different than CY 2007 due to the proposed packaging of additional services. We believe that reconfiguration of the APCs is necessary to ensure that the HCPCS codes that would be separately paid in CY 2008 and that are assigned to these APCs in CY 2007 would be assigned to APCs that are homogeneous with regard to clinical characteristics and resource use in CY 2008. The APCs we are proposing for deletion ceased to be appropriate as a result of the reassignment of the HCPCS codes that we are proposing for continued separate payment in CY 2008.

The following seven APCs remain device-dependent APCs for CY 2008, but we are proposing to reassign certain HCPCS codes mapped to these APCs for CY 2007 either to other APCs or among these APCs for CY 2008 to ensure that, in view of the median costs that result from the proposed CY 2008 packaging approach, the HCPCS codes would be assigned to APCs that are homogeneous with regard to clinical characteristics and resource use for CY 2008: APC 0082 (Coronary Atherectomy); APC 0083 (Coronary Angioplasty and Percutaneous Valvuloplasty); APC 0085 (Level II Electrophysiologic Evaluation); APC 0086 (Ablate Heart Dysrhythm Focus); APC 0115 (Cannula/Access Device Procedures); APC 0427 (Level III Tube Changes and Repositioning); and APC 0623 (Level III Vascular Access Procedures). We also are proposing to consider APC 0084 (Level I Electrophysiologic Procedures) to be a device-dependent APC for CY 2008 because we are proposing to reassign many of the HCPCS codes that were previously in APCs 0086 and 0087 to APC 0084.

As a result of the proposed APC reconfigurations resulting from HCPCS code migration, it is not appropriate to compare the proposed CY 2008 OPPS median costs for these eight APCs to the CY 2007 final rule median costs that are the basis for the CY 2007 OPPS payment rates. When we compare the median costs for the other device-dependent APCs with stable proposed CY 2008 configurations in comparison with CY 2007, the median costs for 26 APCs increase, some of them by significant amounts, and the median costs for 5 APCs decrease. We believe that these median costs represent valid estimates of the relative costs of the services in these APCs, both with regard to the increases and the decreases that appear when the proposed CY 2008 median costs are compared to the CY 2007 median costs on which the payment rates for these APCs are based.

The only decline of more than 10 percent is found in APC 0418 (Insertion of Left Ventricular Pacing Electrode). In the case of APC 0418, we have been told that the very large increases in costs that have occurred in the past several years for this APC were the result of claims where hospitals inserted an ICD at the time of insertion of the left ventricular lead but failed to bill for the ICD implantation procedure. This incorrect reporting led to our attributing the costs of the expensive ICD device to the median cost for the insertion of the left ventricular lead, instead of attributing the cost of the ICD to a HCPCS code for the implantation of the device. We believe that the decline in the median cost for APC 0418 is the result of improvements in provider billing and that the median cost we calculated from the CY 2006 data is a reasonable estimate of the cost of the insertion of the left ventricular lead. Moreover, the relatively small number of single bills and the small number of providers furnishing the service (158 hospitals) are likely to cause the median costs to vary more than for services furnished in greater volume by more hospitals. We note that we have put into place reverse device edits for CY 2007, where we require hospitals reporting certain implantable device HCPCS codes to also report an appropriate procedure for the device's use. We believe that these reverse device edits should improve our packaging of device costs into the appropriate procedures for future OPPS updates.

We note that 12 of the APCs for which it is appropriate to compare the proposed CY 2008 APC medians to the CY 2007 final rule medians show increases that are greater than 10 percent. We have examined the data for these APCs and we believe that the increases are attributable to a combination of factors. In some of these cases, the single claims that were usable for establishing the median costs are a small percent of the total bills for the services assigned to the APC and, as we have stated previously, when small percentages of single bills are used, the APC median cost is likely to show greater fluctuation from year to year. In addition, CY 2006 claims, which are the basis for the CY 2008 proposed rule data, were the first set of claims subject to procedure-to-device edits for the entire calendar year. These edits were implemented to ensure that the charges for the necessary devices were reported on the claims. While this editing was phased in during CY 2005, beginning in April and concluding in October, CY 2006 was the first full year of procedure-to-device edits and thus hospitals that had not previously routinely reported separate device codes and charges were required by the edits to do so for all claims submitted in CY 2006. The reporting of device codes and charges for devices has historically resulted in increases in median costs for device-dependent APCs. Thus, we believe that the more complete claims data available for CY 2008 ratesetting likely contribute to the increased proposed median costs observed for some device dependent APCs.

Furthermore, we believe that the proposed increases are also attributable, in part, to our proposal to package the costs of guidance services, intraoperative services, and imaging supervision and interpretation services into the payment for major independent procedures, as described in section II.A.4. of this proposed rule. For example, CPT code 36870 (Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)) is the most commonly reported code in device-dependent APC 0653 (Vascular Reconstruction/Fistula Repair with

Device), representing 25,805 bills of 26,138 total bills in the APC. CPT code 36870 appears with CPT code 75978 (Transluminal balloon angioplasty, venous (*e.g.* subclavian stenosis), radiological supervision and interpretation) 14,679 times and with CPT code 75790 (Angiography, arteriovenous shunt (*e.g.* dialysis patient), radiological supervision and interpretation) 15,623 times in the CY 2006 claims data. We are proposing to package payment for both CPT codes 75978 and 75790 for CY 2008. Moreover, 9 other CPT codes that we are proposing to package for CY 2008 appear with the independent CPT code 36870 more than 100 times each. Therefore, many of the claims for CPT code 36870 proposed to be used for CY 2008 ratesetting include charges for both CPT codes 75790 and 75978 and also contain charges for other CPT codes we are proposing to package, as well as uncoded revenue code charges that are packaged. Therefore, it is not surprising that our proposed median cost for APC 0653 is about 30 percent higher than the CY 2007 median cost for the same APC. Based on our review of patterns of services observed in our claims data for the device-dependent APCs and our clinical review of the procedures assigned to APCs that receive significant increases for CY 2008, we believe that the increases in the proposed median costs for certain device-dependent APCs for CY 2008 are consistent with our general expectations in the context of the comprehensive proposal for the CY 2008 OPPS.

As we have stated in the past, some variation in relative costs from year to year is to be expected in a prospective payment system. We believe that this is particularly true for low volume device-dependent APCs because relatively small numbers of providers furnish the services; the total frequencies of services furnished are low (compared to commonly furnished services like visits); the number of single bills that are available for use in calculating the full median cost of a single unit of a service is also relatively small; and the selection of claims that contain appropriate devices, lack token charges for devices, and lack the ''FB'' modifier further reduces the pool of single bills that can be used to calculate the median cost. However, even in the case of these low volume device-dependent APCs, we continue to believe that the median costs calculated from the single bills that meet the three criteria represent the most valid estimated relative costs of these services to hospitals when they incur the full cost of the devices required to perform the procedures.

Therefore, we are proposing to base the payment rates for CY 2008 for all device dependent APCs on their median costs calculated using only single bills that meet the three selection criteria discussed in detail above. Table 37 below contains the proposed CY 2008 median costs for these APCs. We do not believe that any special payment policies are needed, as we believe that the claims data we are proposing to use for ratesetting will ensure that the costs of the implantable devices are adequately and appropriately reflected in the median costs for these device-dependent APCs.

TABLE 37.—PROPOSED CY 2008 MEDIAN COSTS FOR DEVICE-DEPENDENT APCS

[Note that N/A indicates APCs for which the CY 2007 OPPS medians are not comparable to the CY 2008 medians, due to proposed HCPCS code migration for CY 2008.]

APC	SI	APC title	CY 2007 final rule pass edit, nontoken frequency	CY 2007 final rule pass edit, nontoken median cost	Proposed CY 2008 post cost total frequency	Proposed CY 2008 pass edit, nontoken, no FB frequency	Proposed CY 2008 pass edit, nontoken, no FB median cost	Difference between CY 2007 final rule median and proposed CY 2008 median cost	Count of providers billing in the proposed CY 2008 data
0039	S	Level I Implantation of Neurostimulator.	680	$11,450.84	2893	1035	$12,421.82	8.48	262
0040	S	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	1402	3,457.00	12769	4663	4,010.44	16.01	994
0061	S	Laminectomy or Incision for Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	265	5,145.22	2938	1268	5,115.78	−0.57	440
0082	T	Coronary or Non Coronary Atherectomy.	N/A	N/A	16464	4374	5,584.20	N/A	925
0083	T	Coronary or Non Coronary Angioplasty and Percutaneous Valvuloplasty.	N/A	N/A	140944	37879	2,897.95	N/A	1706
0084	S	Level I Electrophysiologic Procedures.	N/A	N/A	9703	6973	647.41	N/A	600
0085	T	Level II Electrophysiologic Evaluation.	N/A	N/A	15791	3957	3,059.06	N/A	711

TABLE 37.—PROPOSED CY 2008 MEDIAN COSTS FOR DEVICE-DEPENDENT APCS—Continued

[Note that N/A indicates APCs for which the CY 2007 OPPS medians are not comparable to the CY 2008 medians, due to proposed HCPCS code migration for CY 2008.]

APC	SI	APC title	CY 2007 final rule pass edit, nontoken frequency	CY 2007 final rule pass edit, nontoken median cost	Proposed CY 2008 post cost total frequency	Proposed CY 2008 pass edit, nontoken, no FB frequency	Proposed CY 2008 pass edit, nontoken, no FB median cost	Difference between CY 2007 final rule median and proposed CY 2008 median cost	Count of providers billing in the proposed CY 2008 data
0086	T	Level III Electrophysiologic Procedures.	N/A	N/A	8370	384	5,709.52	N/A	157
0089	T	Insertion/Replacement of Permanent Pacemaker and Electrodes.	388	7,557.38	3722	570	7,710.05	N/A	765
0090	T	Insertion/Replacement of Pacemaker Pulse Generator.	505	6,007.21	7426	524	6,279.63	4.53	314
0104	T	Transcatheter Placement of Intracoronary Stents.	396	5,360.43	4638	565	5,599.90	4.47	200
0106	T	Insertion/Replacement of Pacemaker Leads and/or Electrodes.	427	3,138.16	3489	367	4,718.32	50.35	269
0107	T	Insertion of Cardioverter-Defibrillator.	584	18,607.21	9772	448	22,213.36	19.38	230
0108	T	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads.	3045	23,205.37	8732	3267	25,352.27	9.25	585
0115	T	Cannula/Access Device Procedures.	N/A	N/A	2489	1259	1,920.99	N/A	669
0202	T	Level VII Female Reproductive Proc.	4451	2,627.08	17800	10043	2,719.11	3.50	1863
0222	T	Implantation of Neurological Device.	2007	11,099.02	7957	2830	12,161.64	9.57	868
0225	S	Implantation of Neurostimulator Electrodes, Cranial Nerve.	83	13,514.45	1544	239	13,928.36	3.06	159
0227	T	Implantation of Drug Infusion Device.	319	10,657.85	3350	1001	11,242.60	5.49	460
0229	T	Transcatherter Placement of Intravascular Shunts.	882	4,184.15	53470	7225	5,642.77	34.86	1226
0259	T	Level VI ENT Procedures.	472	25,351.03	1311	783	25,434.97	0.33	166
0315	T	Level II Implantation of Neurostimulator.	516	14,845.73	807	648	16,532.22	11.36	195
0384	T	GI Procedures with Stents.	6574	1,402.31	21958	6895	1,587.03	13.17	1428
0385	S	Level I Prosthetic Urological Procedures.	267	4,840.44	881	581	5,368.16	10.90	319
0386	S	Level II Prosthetic Urological Procedures.	1788	8,395.82	4990	3346	9,045.78	7.74	862

TABLE 37.—PROPOSED CY 2008 MEDIAN COSTS FOR DEVICE-DEPENDENT APCS—Continued

[Note that N/A indicates APCs for which the CY 2007 OPPS medians are not comparable to the CY 2008 medians, due to proposed HCPCS code migration for CY 2008.]

APC	SI	APC title	CY 2007 final rule pass edit, nontoken frequency	CY 2007 final rule pass edit, nontoken median cost	Proposed CY 2008 post cost total frequency	Proposed CY 2008 pass edit, nontoken, no FB frequency	Proposed CY 2008 pass edit, nontoken, no FB median cost	Difference between CY 2007 final rule median and proposed CY 2008 median cost	Count of providers billing in the proposed CY 2008 data
0418	T	Insertion of Left Ventricular Pacing Elect.	169	18,777.92	4436	185	15,760.17	−16.07	158
0425	T	Level II Arthroplasty with Prosthesis.	410	6,550.59	1104	489	7,150.52	9.16	330
0427	T	Level III Tube Changes and Repositioning.	N/A	N/A	21092	11368	936.73	N/A	1255
0622	T	Level II Vascular Access Procedures.	25264	1,385.14	55118	33637	1,542.90	11.39	2380
0623	T	Level III Vascular Access Procedures.	N/A	N/A	66747	49861	1844.44	N/A	2701
0625	T	Level IV Vascular Access Procedures.	20	5,100.26	479	8	5,492.89	7.70	154
0648	T	Level IV Breast Surgery.	286	3,130.45	2895	382	3,330.44	6.39	388
0652	T	Insertion of Intraperitoneal and Pleural Catheters.	3676	1,805.28	5407	3138	1,997.86	10.67	996
0653	T	Vascular Reconstruction/Fistula Repair with Device.	702	1,978.84	26138	1573	2,584.62	30.61	682
0654	T	Insertion/Replacement of a permanent dual chamber pacemaker.	1179	6,891.44	29645	1735	6,724.90	−2.42	625
0655	T	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker.	876	9,327.71	12769	1896	9,075.74	−2.70	1247
0656	T	Transcatheter Placement of Intracoronary Drug-Eluting Stents.	2700	6,618.18	24346	3148	7,478.29	13.00	378
0674	T	Prostate Cryoablation.	1737	6,646.07	3182	1997	7,782.75	17.10	366
0680	S	Insertion of Patient Activated Event Recorders.	972	4,436.69	2234	1465	4,506.93	1.58	689
0681	T	Knee Arthroplasty	301	12,569.11	391	286	12,029.91	−4.29	57

3. Proposed Payment When Devices Are Replaced with Partial Credit to the Hospital

As we discuss above in the context of the calculation of median costs for device dependent APCs, in recent years there have been several field actions and recalls with regard to failure of implantable devices. In many of these cases, the manufacturers have offered replacement devices without cost to the hospital or credit for the device being replaced if the patient required a more expensive device. In order to ensure that the payment we are proposing for CY 2008 pays hospitals appropriately when they incur the full cost of the device, we have calculated the proposed median costs for device dependent APCs using only claims that contain the correct device code for the procedure. We are not using claims that contain token charges for these expensive devices or that contain the ''FB'' modifier, which would signify that the device was replaced without cost or with a full credit for the cost of the device being replaced. Similarly, to ensure equitable payment when the hospital receives a device without cost or receives a full credit for the cost of the device being replaced, for CY 2007 we implemented a payment policy that reduces the

payment for selected device-dependent APCs when the hospital receives certain replacement devices without cost or receives a full credit for the device being replaced (71 FR 68077).

Subsequent to the issuance of the CY 2007 OPPS/ASC final rule with comment period, we had many inquiries from hospitals that asked whether the reduction would also apply in cases in which there was a partial credit for the cost of a device that failed or was otherwise covered under a manufacturer warranty. Those inquiring explained that cases of partial credit are the vast majority of cases involving devices that have failed or otherwise must be replaced under warranty. They indicated that in some cases the devices failed, and in other situations the patient's energy needs exceeded the capacity of the device and thus the device ceased to be useful before the end of the warranty period. They told us that a typical industry practice for some types of devices was to provide a 50 percent credit in cases of device failure (including battery depletion) under warranty if a device failed at 3 years of use (failure during the first 3 years would result in a full device credit) and to prorate the credit further over time between 3 and 5 years after the initial device implantation, as the useful life of the device declined. As promulgated in the CY 2007 OPPS/ASC final rule with comment period and codified at § 419.45, the CY 2007 reduction policy does not apply to cases in which there is a partial credit toward the replacement of the device.

In addition to our concern over the replacement of implantable devices at no cost to hospitals due to device recalls, device failure, or other clinical situations, we believe that it is equally as important that timely information be reported and analyzed regarding the performance and longevity of devices replaced in partial credit situations. This issue is particularly timely due to the recent recall of 73,000 ICDs and cardiac resynchronization therapy defibrillators (CRT–Ds) because of a faulty capacitor that can cause the batteries to deplete sooner than expected. In some cases, patients will require more frequent monitoring of their device function and early device replacement. (We refer readers to the Web site: *http://www.fda.gov/cdrh/news* for Questions and Answers posted April 20, 2007 on this recall.) Therefore, we believe that hospitals should report occurrences of devices being replaced under warranty or otherwise with a partial credit granted to the hospital so that we may be able to identify systematic failures of devices or device problems through claims analysis and so that we can make appropriate payment adjustments in these cases. Collecting data on a wider set of device replacements under full and partial credit situations would assist in developing comprehensive summary data, not just a subset of data related to devices replaced without cost or with a full credit to the hospital. We are mindful of the need to use our claims history where possible to promote early awareness of problems with implantable medical devices and to promote high quality medical care with regard to the devices and the services in which they are used.

We also are concerned with the issue of the increased Medicare and beneficiary liability for the monitoring costs that are required as a result of the recall of these 73,000 devices (worldwide, with an unknown portion being applicable to Medicare beneficiaries). Specifically, the manufacturer of the devices that have been most recently recalled recommends that patients with the recalled device consult with their physician in each case and, in some cases, begin a routine of monthly evaluations. We would expect that not only could extra visits to physicians' offices or HOPDs be necessary, but additional diagnostic tests may also be needed to care for the beneficiaries who have the recalled devices. Thus, even when the device does not immediately require replacement, we are concerned that the potential greater costs to Medicare and to the beneficiary or his or her secondary payor for these unforeseen extra services may be substantial and burdensome. We will be actively assessing how we can identify additional health care costs and Medicare expenditures associated with device recall actions and exploring what actions could be appropriate in the case of these additional monitoring and related expenses. We welcome public comment on this issue to inform our future review and analyses.

Moreover, the payment rates for the APCs into which the costs of the most expensive devices are packaged are set based on the assumption that the hospital incurs the full cost of the device. To continue to pay the full APC rate when the hospital receives a partial credit toward the cost of a very expensive device would result in excessive and inappropriate payment for the procedure and its packaged costs. Some hospitals have told us that they do not reduce their charges for the device being implanted or used in the procedure in cases in which they receive a partial credit for the device, even in cases in which the credit is for as much as 50 percent of the cost of an expensive device.

Under the OPPS, we calculate the estimated costs on which the APC payment weights are based by applying a CCR to the charges for the device. When hospitals charge the full amount for the device, although they may have received a substantial credit towards its cost, our methodology may result in median costs that reflect the full costs of these devices in all cases, including those cases in which the hospital incurs much less than the full cost of the device. It is likely that the reduced hospital costs associated with steady, low volume warranty replacements of implantable devices may never be reflected in the CCRs used to adjust charges to costs for devices, because those CCRs are overwhelmed by the volume of other items attributed to the cost centers. Therefore, our median costs for device-dependent APCs would not reflect the reduced hospital costs associated with partial credit replacement procedures and would result in overpayment for the implantation procedures under the OPPS. Moreover, in these cases either the beneficiary or a secondary insurer also would pay a copayment that reflects the full cost of the device, although the hospital may have received a substantial credit under the warranty. We believe that both Medicare and the beneficiary should share in the savings that result from the partial credit that the hospital receives.

We have considered how we might ensure that these cases of device failure or premature replacement are reported and appropriately taken into account in setting OPPS payment rates and beneficiary copayments. We are proposing to create a HCPCS modifier for CY 2008 that would be reported in all cases in which the hospital receives a partial credit toward the replacement of a medical device listed in Table 39 of this proposed rule. These devices are the same devices to which our policy governing payment when the device is furnished to the provider without cost or with full credit applies for CY 2008. As we discussed in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68071), we selected these devices because they have substantial device costs and because the device is implanted in the beneficiary at least temporarily and, therefore, can be associated with an individual beneficiary. This proposed policy would enhance our ability to track the replacement of these implantable medical devices and may permit us to identify trends in device failure or

limited longevity. Moreover, it would enable us to reduce the APC payment in cases in which the hospital receives a partial credit toward the cost of the replacement device being implanted. We believe that this is a logical extension of our policy regarding reduction of the APC payment in cases in which the provider furnishes the device without cost or with a full credit to the hospital.

Specifically, as discussed in more detail below, we are proposing to reduce the payment for the APC into which the device cost is packaged by one half of the amount of the offset amount that would apply if the device were being replaced without cost or with full credit, but only where the amount of the device credit is greater than or equal to 20 percent of the cost of the new replacement device being implanted. We also are proposing to base the beneficiary's copayment on the reduced APC payment rate so that the beneficiary shares in the hospital's reduced costs. We believe that it is inequitable to set the payment rates for the procedures into which payment for these devices is packaged on the assumption that the hospital always incurs the full cost for these expensive devices but to not adjust the payment when the hospital receives a partial credit for a failed or otherwise replaced device. Accordingly, we believe that it is appropriate to make an equitable adjustment to the APC payment to ensure that the Medicare program payment made for the service and the beneficiary's liability are appropriate in these cases in which the hospital's device costs are significantly reduced. We are proposing changes to §§ 419.45(a) and (b) to reflect our proposed policy of reducing the OPPS payment when partial credit for the device cost is received by the hospital for a failed or otherwise replaced device.

Due to the absence of current reporting of the cases in which hospitals receive a partial credit for replaced devices and to our belief, based on conversations with hospital staff, that hospitals do not reduce their device charges to reflect the credits, we have no data for use to empirically determine by how much we should reduce the payment for the procedural APC into which the costs of these devices are packaged. However, device manufacturers and hospitals have told us that a common scenario is that, if a device fails 3 years after implantation, the hospital would receive a 50 percent credit towards a replacement device. Therefore, we are proposing to reduce the payment for these device-dependent APCs by half of the reduction that applies when the hospital receives a device without cost or receives a full credit for a device being replaced. That is, we are proposing to reduce the payment for the APC by half of the offset amount that represents the cost of the device packaged into the APC payment. In the absence of claims data on which to base a reduction factor, but taking into consideration what we have been told is common industry practice, we believe that reducing the amount of payment for the device-dependent APC by half of the estimated cost of the device packaging represents a reasonable and equitable reduction in these cases.

We considered whether to propose to require hospitals to reduce their charges in proportion to the partial credit they receive for the device so that, in future years, we would have cost data reported consistently on which we could consider basing the amount of reduction to the payment for the procedure in cases of a partial device credit. However, we are concerned that such a requirement could impose an administrative burden on hospitals that would outweigh the potential benefit of a more accurate reduction to payment in these cases. We are requesting comments on the extent to which any administrative burden would be balanced or compensated for by the potential payment accuracy benefit of an empirically based reduction to payment in these cases.

In addition, we are proposing to take this reduction only when the credit is for 20 percent or more of the cost of the new replacement device, so that the reduction is not taken in cases in which more than 80 percent of the cost of the replacement device has been incurred by the hospital. We believe that the burden to hospitals of requiring that they report cases in which the partial credit for the device being replaced is less than 20 percent of the cost of the new replacement device is greater than the benefit to the Medicare program and the beneficiary. In addition, if the partial credit is less than 20 percent of the cost of the new replacement device, then we believe that reducing the APC payment for the device implantation procedure by 50 percent of the packaged device cost would provide too low a payment to hospitals providing the necessary device replacement procedures. Therefore, we are proposing that the new HCPCS partial credit modifier would be reported and the partial credit reduction would be taken only in cases in which the credit is equal to or greater than 20 percent of the cost of the new replacement device.

For example, using the proposed CY 2008 offset percents in Table 38 below for illustration only, if a cochlear implant fails under warranty and must be replaced and the manufacturer provides the hospital a 45-percent credit of the cost of the new device used in the implantation procedure, the hospital would bill CPT code 69930 (Cochlear device implantation, with or without mastoidectomy) with the new modifier for partial credit devices, and Medicare would reduce the payment to the hospital by 41.52 percent of the APC payment rate (50 percent of the proposed full offset rate of 83.03 percent that would apply if the device were replaced with no cost to the provider or at full credit for the device being replaced).

Even in the absence of specific instructions from us to reduce the device charges in partial credit cases, we could monitor the charges that are submitted for devices reported with the proposed partial credit modifier to see if hospitals appear to be reflecting partial device credits in their charges for these implantable devices. We believe that we could use pattern analysis to determine if a hospital that is reporting the device with the partial credit modifier is charging at a lower rate for the same device when the modifier appears with the procedure in which the device is used than in cases without reporting of the modifier. If we find that hospitals are adjusting their charges to reflect the reduced costs of these devices, we will explore whether revising the amount of the reduction could be appropriate.

In the course of exploring whether the current regulations apply to partial credit situations, inquirers have told us that they are concerned that hospitals may refrain from returning devices that fail under the warranty period to manufacturers if hospitals would then be required to report the partial credit to Medicare and would receive a reduced Medicare payment as a result. They told us that this hospital practice could delay manufacturers' learning vital information about device failures, longevity, and overall performance. Currently, many device manufacturers encourage the return to them of all implantable devices, once they are taken out of a patient's body for any reason, for evaluation of device performance and survival analysis, which estimates the probability that a device will not malfunction during a specified period of time. We do not believe that hospitals would refrain from returning a device removed from a patient to a manufacturer in order to justify not reporting the partial credit modifier to

Medicare. We believe that hospitals have a strong interest in ensuring that manufacturers know as soon as possible when there are problems with the devices provided to their patients, whether the result would be a full or partial credit for the failed device. In addition, we believe that hospitals, key participants in the broader health care system, are concerned with device performance, patient health, and health care quality from the broader public health perspective and are committed to appropriate reporting to improve the quality of future health care that leads to better health outcomes for patients. Moreover, we do not believe that hospitals would intentionally fail to report to Medicare the service furnished correctly and completely with the partial credit modifier when the modifier applies, because the hospital would then knowingly submit incorrect information on the claim.

In summary, we are proposing to create a HCPCS modifier to be reported on a procedure code in Table 38 below if a device listed in Table 39 below is replaced with partial credit from the manufacturer that is greater than or equal to 20 percent of the cost of the replacement device and to reduce the payment for the procedure by 50 percent of the amount of the estimated packaged cost of the device being replaced when the modifier is reported with a procedure code that is assigned to an APC in Table 38. We believe that this policy is necessary to pay equitably for these services when the hospital receives a partial credit for the cost of the device being implanted.

We note that, of the proposed CY 2008 offset amounts shown in Table 38 that were in effect for CY 2007, 13 decline slightly compared to the CY 2007 final rule offset amounts. Similarly, the proposed CY 2008 offset amounts for eight of these APCs increase somewhat. As with changes in median costs, there may be several different factors that are responsible for the observed changes. With regard to the declines, we believe that it is possible that the increased packaging we are proposing for CY 2008 may cause the nondevice portion of an APC's median cost to increase and, therefore, could result in a decline in the device portion as a percent of total cost. Increases in the offset amounts may be caused by the increases observed in the CCRs, changes in the population of hospitals whose claims were used due to additional packaging, increased packaging of services that have significant device costs, higher costs of new devices, or greater efficiency in the implantation of devices, any of which could result in the device portion of the APC's median cost increasing as a percent of the total cost for the APC as compared to CY 2007. As with APC median costs, the offset amounts are expected to vary from year to year, and we do not see undue variation in the proposed CY 2008 offset amounts compared with the final CY 2007 offset amounts.

The CY 2007 final payment policy when devices are replaced without cost or when a full credit for a replaced device is furnished to the hospital applies to those APCs that met three criteria as described in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68072 through 68077). Specifically, all procedures assigned to the selected APCs must require implantable devices that would be reported if device replacement procedures were performed, the required devices must be surgically inserted or implanted devices that remain in the patient's body after the conclusion of the procedures (at least temporarily), and the device offset amount must be significant, defined as exceeding 40 percent of the APC cost. We also restricted the devices to which the APC payment adjustment would apply to a specific set of costly devices to ensure that the adjustment would not be triggered by the replacement of an inexpensive device whose cost would not constitute a significant proportion of the total payment rate for an APC.

We examined the offset amounts calculated from the CY 2008 proposed rule data and the clinical characteristics of APCs to determine whether the APCs to which the no cost or full credit replacement policy applies in CY 2007 continue to meet the criteria for CY 2008 and to determine whether other APCs to which the policy does not apply in CY 2007 would meet the criteria for CY 2008. We concluded that one additional APC meets the criteria for inclusion under this policy and that one APC currently on the list ceases to meet the criteria. Specifically, we are proposing to add APC 0625 (Level IV Vascular Access Procedures) to the list of APCs to be adjusted in cases of full or partial credit for replaced devices and to add the device described by device code C1881 (Dialysis access system (implantable)) that is implanted in a procedure assigned to APC 0625 to the list of devices to which this policy applies. We are proposing to add APC 0625 and device code C1881 for CY 2008 because they meet the criteria for inclusion in this policy. In particular, the single surgical procedure (CPT code 36566 (Insertion of tunneled centrally inserted central venous access device, requiring two catheters via two separate venous access sites; with subcutaneous port(s)) assigned to APC 0625 always requires an implantable device that is reported, the proposed CY 2008 APC device offset percent is greater than 40 percent, and the device is of a type that is surgically implanted in the patient, where it remains at least temporarily. Furthermore, costly devices described by device code C1881 are implanted in the procedure assigned to APC 0625. We also found that APC 0229 (Transcatheter Placement of Intravascular Shunts) ceases to meet the criteria because the device offset percent for this APC, when calculated from proposed rule data, is less than 40 percent. Moreover, we believe that the devices that would be implanted in the procedures assigned to this APC are not of a type that would be amenable to removal and replacement in a device recall or warranty situation. Therefore, we are proposing to remove APC 0229 from the list of APCs to which the no cost or full credit and proposed partial credit reduction policies are applicable for CY 2008.

Table 38 presents the device offset amounts that we are proposing to apply to the specified APCs in cases of no cost or full or partial credit for replaced devices for the CY 2008 OPPS.

TABLE 38.—PROPOSED ADJUSTMENTS TO APCS IN CASES OF NO COST OR FULL OR PARTIAL CREDIT FOR REPLACED DEVICES

APC	SI	APC title	CY 2007 reduction for full credit case (percent)	Proposed CY 2008 reduction for full credit case (percent)	Proposed CY 2008 reduction for partial credit case (percent)
0039	S	Level I Implantation of Neurostimulator	78.85	82.15	41.07

TABLE 38.—PROPOSED ADJUSTMENTS TO APCS IN CASES OF NO COST OR FULL OR PARTIAL CREDIT FOR REPLACED DEVICES—Continued

APC	SI	APC title	CY 2007 reduction for full credit case (percent)	Proposed CY 2008 reduction for full credit case (percent)	Proposed CY 2008 reduction for partial credit case (percent)
0040	S	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	54.06	55.93	27.97
0061	S	Laminectomy or Incision for Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	60.06	59.32	29.66
0089	T	Insertion/Replacement of Permanent Pacemaker and Electrodes	77.11	74.02	37.01
0090	T	Insertion/Replacement of Pacemaker Pulse Generator	74.74	75.54	37.77
0106	T	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	41.88	57.20	28.60
0107	T	Insertion of Cardioverter-Defibrillator	90.44	89.43	44.72
0108	T	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	89.40	89.26	44.63
0222	T	Implantation of Neurological Device	77.65	83.29	41.64
0225	S	Implantation of Neurostimulator Electrodes, Cranial Nerve	79.04	80.84	40.42
0227	T	Implantation of Drug Infusion Device	80.27	79.69	39.85
0259	T	Level VI ENT Procedures	84.61	83.03	41.52
0315	T	Level II Implantation of Neurostimulator	76.03	86.23	43.12
0385	S	Level I Prosthetic Urological Procedures	83.19	51.67	25.83
0386	S	Level II Prosthetic Urological Procedures	61.16	61.98	30.99
0418	T	Insertion of Left Ventricular Pacing Elect	87.32	81.38	40.69
0625	T	Level IV Vascular Access Procedures	N/A	62.63	32.32
0654	T	Insertion/Replacement of a permanent dual chamber pacemaker	77.35	75.86	37.93
0655	T	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker.	76.59	74.59	37.30
0680	S	Insertion of Patient Activated Event Recorders	76.40	72.14	36.07
0681	T	Knee Arthroplasty	73.37	73.27	36.64

TABLE 39.—PROPOSED DEVICES FOR WHICH THE ''FB MODIFIER'' OR NEW PARTIAL CREDIT MODIFIER MUST BE REPORTED WITH THE PROCEDURE CODE WHEN FURNISHED WITHOUT COST/FULL CREDIT OR PARTIAL CREDIT FOR A REPLACED DEVICE

Device HCPCS code	Short descriptor
C1721	AICD, dual chamber.
C1722	AICD, single chamber.
C1764	Event recorder, cardiac.
C1767	Generator, neurostim, imp.
C1771	Rep dev, urinary, w/sling.
C1772	Infusion pump, programmable.
C1776	Joint device (implantable).
C1777	Lead, AICD, endo single coil.
C1778	Lead, neurostimulator.
C1779	Lead, pmkr, transvenous VDD.
C1785	Pmkr, dual, rate-resp.
C1786	Pmkr, single, rate-resp.
C1813	Prosthesis, penile, inflatab.
C1815	Pros, urinary sph, imp.
C1820	Generator, neuro rechg bat sys.
C1881	Dialysis access system.
C1882	AICD, other than sing/dual.
C1891	Infusion pump, non-prog, perm.
C1895	Lead, AICD, endo dual coil.
C1896	Lead, AICD, non sing/dual.
C1897	Lead, neurostim, test kit.
C1898	Lead, pmkr, other than trans.
C1899	Lead, pmkr/AICD combination.
C1900	Lead coronary venous.
C2619	Pmkr, dual, non rate-resp.
C2620	Pmkr, single, non rate-resp.
C2621	Pmkr, other than sing/dual.
C2622	Prosthesis, penile, non-inf.
C2626	Infusion pump, non-prog, temp.

TABLE 39.—PROPOSED DEVICES FOR WHICH THE ''FB MODIFIER'' OR NEW PARTIAL CREDIT MODIFIER MUST BE REPORTED WITH THE PROCEDURE CODE WHEN FURNISHED WITHOUT COST/FULL CREDIT OR PARTIAL CREDIT FOR A REPLACED DEVICE—Continued

Device HCPCS code	Short descriptor
C2631	Rep dev, urinary, w/o sling.
L8614	Cochlear device/system.

B. Pass-Through Payments for Devices

1. Expiration of Transitional Pass-Through Payments for Certain Devices

(If you choose to comment on issues in this section, please include the caption ''OPPS: Expiring Device Pass-Through Payments'' at the beginning of your comment.)

a. Background

Section 1833(t)(6)(B)(iii) of the Act requires that, under the OPPS, a category of devices be eligible for transitional pass-through payments for at least 2, but not more than 3, years. This period begins with the first date on which a transitional pass-through payment is made for any medical device that is described by the category. The device category codes became effective April 1, 2001, under the provisions of the BIPA. Prior to pass-through device categories, Medicare payments for pass-through devices under the OPPS were made on a brand-specific basis. All of the initial 97 category codes that were established as of April 1, 2001, have expired; 95 categories expired after CY 2002, and 2 categories expired after CY 2003. In addition, nine new categories have expired since their creation. The three categories listed in Table 40, along with their expected expiration dates, were established for pass-through payment in CY 2006 or CY 2007, as noted. Under our established policy, we base the expiration dates for the category codes on the date on which a category was first eligible for pass-through payment.

Of these 3 device categories, there is 1 that would be eligible for pass-through payment for at least 2 years as of December 31, 2007; that is, device category code C1820 (Generator, neurostimulator (implantable), with rechargeable battery and charging system). In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68078), we finalized our proposal to expire device category C1820 from pass-through device payment after December 31, 2007.

In the November 1, 2002 OPPS final rule, we established a policy for payment of devices included in pass-through categories that are due to expire (67 FR 66763). For CY 2003 through CY 2007, we packaged the costs of the

devices no longer eligible for pass-through payments into the costs of the procedures with which the devices were billed in the claims data used to set the payment rates for those years. Brachytherapy sources, which are now separately paid in accordance with section 1833(t)(2)(H) of the Act, are an exception to this established policy (with the exception of brachytherapy sources for prostate brachytherapy, which were packaged in the CY 2003 OPPS only).

b. Proposed Policy

For CY 2008, we are implementing the final decision we discussed in the CY 2007 OPPS/ASC final rule with comment period that finalizes the expiration date for pass-through status for device category C1820. Therefore, as of January 1, 2008, we will discontinue pass-through payment for device category code C1820. In accordance with our established policy, we will package the costs of the device assigned to this device category into the costs of the procedures with which the device was billed in CY 2006, the year of hospital claims data used for this proposed OPPS update.

In addition, the 2 device categories that were established for pass-through payment as of January 1, 2007, C1821 (Interspinous process distraction device (implantable)) and L8690 (Auditory osseointegrated device, includes all internal and external components), would be active categories for pass-through payment for 2 years as of December 31, 2008. Therefore, we are proposing that these categories expire from pass-through device payment as of December 31, 2008.

TABLE 40.—CURRENT PASS-THROUGH DEVICE CATEGORIES BY EXPIRATION DATE

HCPCS code	Category long descriptor	Date(s) populated	Expiration date
C1820	Generator, neurostimulator (implantable)	1/1/06	12/31/07
C1821	Interspinous process distraction device (implantable)	1/1/07	12/31/08
L8690	Auditory osseointegrated device, includes all internal and external components	1/1/07	12/31/08

2. Proposed Provisions for Reducing Transitional Pass-Through Payments To Offset Costs Packaged Into APC Groups

(If you choose to comment on issues in this section, please include the caption ''OPPS: Offset Costs'' at the beginning of your comment.)

a. Background

In the November 30, 2001 OPPS final rule, we explained the methodology we used to estimate the portion of each APC payment rate that could reasonably be attributed to the cost of the associated devices that are eligible for pass-through payments (66 FR 59904). Beginning with the implementation of the CY 2002 OPPS quarterly update (April 1, 2002), we deducted from the pass-through payments for the identified devices an amount that reflected the portion of the APC payment amount that we determined was associated with the cost of the device, as required by section 1833(t)(6)(D)(ii) of the Act. In the November 1, 2002 interim final rule with comment period, we published the applicable offset amounts for CY 2003 (67 FR 66801).

For the CY 2002 and CY 2003 OPPS updates, to estimate the portion of each APC payment rate that could reasonably be attributed to the cost of an associated device eligible for pass-through payment, we used claims data from the period used for recalibration of the APC rates. That is, for CY 2002 OPPS updating, we used CY 2000 claims data, and for CY 2003 OPPS updating, we used CY 2001 claims data. For CY 2002, we used median cost claims data based on specific revenue centers used for device related costs because device C-code cost data were not available until CY 2003. For CY 2003, we calculated a median cost for every APC based on single claims with device codes but without packaging the costs of associated C-codes for device categories that were billed with the APC. We then calculated a median cost for every APC based on single claims with the costs of the associated device category C-codes that were billed with the APC packaged into the median. Comparing the median APC cost without device packaging to the median APC cost including device packaging that was developed from the claims with device codes also reported enabled us to determine the percentage of the median APC cost that was attributable to the associated pass-through devices. By applying those percentages to the APC payment rates, we determined the applicable amount to be deducted from the pass-through payment, the ''offset'' amount. We created an offset list comprised of any APC for which the device cost was at least 1 percent of the APC's cost.

The offset list that we published for CY 2002 through CY 2004 was a list of offset amounts associated with those APCs with identified offset amounts developed using the methodology described above. As a rule, we do not know in advance which procedures residing in certain APCs may be billed with new device categories. Therefore, an offset amount was applied only when a new device category was billed with a HCPCS procedure code that was assigned to an APC appearing on the offset list.

For CY 2004, we modified our policy for applying offsets to device pass-through payments. Specifically, we indicated that we would apply an offset to a new device category only when we could determine that an APC contains costs associated with the device. We continued our existing methodology for determining the offset amount, described earlier. We were able to use this methodology to establish the device offset amounts for CY 2004 because providers reported device codes (generally C-codes) on the CY 2002 claims used for the CY 2004 OPPS update. For the CY 2005 update to the OPPS, our data consisted of CY 2003 claims that did not contain device codes and, therefore, for CY 2005, we utilized the device percentages as developed for CY 2004. In the CY 2004 OPPS update, we reviewed the device categories eligible for continuing pass-through payment in CY 2004 to determine whether the costs associated with the device categories were packaged into the existing APCs. Based on our review of the data for the device categories existing in CY 2004, we determined that there were no close or identifiable costs associated with the devices relating to the respective APCs that were normally billed with them. Therefore, for those device categories, we set the offset amount to $0 for CY 2004. We continued this policy of setting the offset amount to $0 for the device categories that continued to receive pass-through payment in CY 2005.

For the CY 2006 OPPS update, CY 2004 hospital claims were available for analysis. Hospitals billed device C-codes in CY 2004 on a voluntary basis.

We reviewed our CY 2004 data and found that the numbers of claims for services in many of the APCs for which we calculated device percentages using CY 2004 data were quite small. We also found that many of these APCs already had relatively few single claims available for median calculations compared with the total bill frequencies, because of our inability to use many multiple bills in establishing median costs for all APCs. In addition, we found that our claims demonstrated that relatively few hospitals specifically coded for devices utilized in CY 2004. Thus, we were not confident that CY 2004 claims reporting device HCPCS codes represented the typical costs of all hospitals providing the services. Therefore, we did not use CY 2004 claims with device codes to calculate CY 2006 device offset amounts. In addition, we did not use the CY 2005 methodology, for which we utilized the device percentages as developed for CY 2004. Two years had passed since we developed the device offsets for CY 2004, and the device offsets originally calculated from CY 2002 hospital claims data may either have overestimated or underestimated the contributions of device costs to total procedural costs in the outpatient hospital environment of CY 2006. In addition, a number of the APCs on the CY 2004 and CY 2005 device offset percent lists were either no longer in existence or were so significantly reconfigured that the past device offsets likely did not apply.

For CY 2006, we reviewed the single new device category established, C1820, to determine whether device costs associated with the new category were packaged into the existing APC structure based on partial CY 2005 claims data. Under our established policy, if we determine that the device costs associated with the new category are closely identifiable to device costs packaged into existing APCs, we set the offset amount for the new category to an amount greater than $0. Our review of the service indicated that the median cost for the applicable APC 0222 (Implantation of Neurological Device) contained costs for neurostimulators that were similar to neurostimulators described by the new device category C1820. Therefore, we determined that a device offset would be appropriate. We announced a CY 2006 offset amount for that category in Program Transmittal No. 804, dated January 3, 2006. (We subsequently were informed that some rechargeable neurostimulators described by device category C1820 may also be used and billed with a CPT code that maps to APC 0039 (Level I Implantation of Neurostimulator). We announced an offset amount for device category C1820 when billed with a procedure code that maps to APC 0039, in Program Transmittal No. 1209, dated March 21, 2007.)

For CY 2006, we used available partial year CY 2005 hospital claims data to calculate device percentages and potential offsets for CY 2006 applications for new device categories. Effective January 1, 2005, we require hospitals to report device HCPCS codes and their charges when hospitals bill for services that utilize devices described by the existing device category codes. In addition, during CY 2005 we implemented device edits for many services that require devices and for which appropriate device category HCPCS codes exist. Therefore, we expected that the number of claims that included device codes and their respective costs to be much more robust and representative for CY 2005 than for CY 2004.

For CY 2007, we reviewed the two new device categories, C1821 and L8690, to determine whether device costs associated with the new categories were packaged into the existing APC structure based on CY 2005 claims data. As indicated earlier, under our established policy, if we determine that the device costs associated with a new category are closely identifiable to device costs packaged into existing APCs, we set the offset amount for the new category to an amount greater than $0. Our review of the related services indicated that the median costs for the applicable APC 0256 (Level V ENT Procedures (for L8690)) and APC 0050 (Level II Musculoskeletal Procedures Except Hand and Foot (for C1821)) did not contain costs for devices that were similar to those described by the new device categories. Therefore, we set the respective offsets to $0.

We believe that use of the most current claims data to establish offset amounts when they are needed to ensure appropriate payment is consistent with our stated policy; therefore, we are proposing to continue to do so for the CY 2008 OPPS. Specifically, if we create a new device category for payment in CY 2008, to calculate potential offsets we are proposing to examine the most current available claims data, including device costs, to determine whether device costs associated with the new category are already packaged into the existing APC structure, as indicated earlier. If we conclude that some related device costs are packaged into existing APCs, we are proposing to use the methodology described earlier and first used for the CY 2003 OPPS to determine an appropriate device offset percent for those APCs with which the new category would be reported.

b. Proposed Policy

For CY 2008, we are proposing to continue to review each new device category on a case-by-case basis as we have done since CY 2004, to determine whether device costs associated with the new category are packaged into the existing APC structure. If we determine that, for any new device category, no device costs associated with the new category are packaged into existing APCs, we are proposing to continue our current policy of setting the offset amount for the new category to $0 for CY 2008. There are currently two new device categories that will continue for pass through payment in CY 2008. These categories, described by HCPCS codes L8690 and C1821, currently have an offset amount equal to $0 because we could not identify device related costs in the procedural APCs we expect would be billed with either of the two categories L8690 or C1821, that is, in APC 0256 or APC 0050, respectively. We are proposing that the offsets for CY 2008 for L8690 and C1821 remain set to $0, because we cannot identify device costs packaged in the related procedural APCs that are closely identifiable with these device categories, based on the claims data for CY 2006, the claims data year for our CY 2008 OPPS update.

We are proposing to continue our existing policy of establishing new categories in any quarter when we determine that the criteria for granting pass through status for a device category are met. If we create a new device category and determine that our CY 2006 claims data contain a sufficient number of claims with identifiable costs associated with the new category of devices in any APC with which it is billed, we are proposing to establish an offset amount greater than $0 and to reduce the transitional pass through payment for the device by the related procedural APC offset amount. If we determine that a device offset amount greater than $0 is appropriate for any new category that we create, we are proposing to announce the offset amount in the program transmittal that announces the new category.

In summary, for CY 2008, we are proposing to use CY 2006 hospital claims data to calculate device percentages and potential offsets for new device categories established in CY 2008. We are proposing to publish through program transmittals any new or updated offsets that we calculate for CY 2008, corresponding to newly

created categories or existing categories eligible for pass-through payment, respectively.

V. Proposed OPPS Payment Changes for Drugs, Biologicals, and Radiopharmaceuticals

A. Proposed Transitional Pass-Through Payment for Additional Costs of Drugs and Biologicals

(If you choose to comment on issues in this section, please include the caption ''OPPS: Pass-Through Drugs'' at the beginning of your comment.)

1. Background

Section 1833(t)(6) of the Act provides for temporary additional payments or ''transitional pass-through payments'' for certain drugs and biological agents. As originally enacted by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999 (Pub. L. 106–113), this provision requires the Secretary to make additional payments to hospitals for current orphan drugs, as designated under section 526 of the Federal Food, Drug, and Cosmetic Act (Pub. L. 107–186); current drugs and biological agents and brachytherapy sources used for the treatment of cancer; and current radiopharmaceutical drugs and biological products. For those drugs and biological agents referred to as ''current,'' the transitional pass-through payment began on the first date the hospital OPPS was implemented (before enactment of the Medicare, Medicaid, and SCHIP BenefitsImprovement and Protection Act (BIPA) of 2000 (Pub. L. 106–554), on December 21, 2000).

Transitional pass-through payments are also provided for certain ''new'' drugs and biological agents that were not being paid for as an HOPD service as of December 31, 1996, and whose cost is ''not insignificant'' in relation to the OPPS payments for the procedures or services associated with the new drug or biological. Under the statute, transitional pass-through payments can be made for at least 2 years but not more than 3 years. Proposed CY 2008 pass-through drugs and biologicals are assigned status indicator ''G'' in Addenda A and B to this proposed rule.

Section 1833(t)(6)(D)(i) of the Act specifies that the pass-through payment amount, in the case of a drug or biological, is the amount by which the amount determined under section 1842(o) (or, if the drug or biological is covered under a competitive acquisition contract under section 1847B, an amount determined by the Secretary equal to the average price for the drug or biological for all competitive acquisition areas and year established under such section as calculated and adjusted by the Secretary) for the drug or biological exceeds the portion of the otherwise applicable Medicare OPD fee schedule that the Secretary determines is associated with the drug or biological. This methodology for determining the pass-through payment amount is set forth in § 419.64 of the regulations, which specifies that the pass-through payment equals the amount determined under section 1842(o) of the Act minus the portion of the APC payment that CMS determines is associated with the drug or biological. Section 1847A of the Act, as added by section 303(c) of Pub. L. 108–173, establishes the use of the average sales price (ASP) methodology as the basis for payment for drugs and biologicals described in section 1842(o)(1)(C) of the Act that are furnished on or after January 1, 2005. The ASP methodology uses several sources of data as a basis for payment, including ASP, wholesale acquisition cost (WAC), and average wholesale price (AWP). In this proposed rule, the term ''ASP methodology'' and ''ASP based'' are inclusive of all data sources and methodologies described therein. Additional information on the ASP methodology can be found on the CMS Web site at: *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01_overview.asp#TopOfPage.*

As noted above, section 1833(t)(6)(D)(i) of the Act also states that if a drug or biological is covered under a competitive acquisition contract under section 1847B of the Act, the payment rate is equal to the average price for the drug or biological for all competitive acquisition areas and the year established as calculated and adjusted by the Secretary. Section 1847B of the Act, as added by section 303(d) of Pub. L. 108–173, establishes the payment methodology for Medicare Part B drugs and biologicals under the competitive acquisition program (CAP). The Part B drug CAP was implemented July 1, 2006, and includes approximately 180 of the most commonPart B drugs provided in the physician's office setting. The list of drugs and biologicals covered under the Part B drug CAP, their associated payment rates and the Part B drug CAP pricing methodology can be found on the CMS Web site at *http://www.cms.hhs.gov/CompetitiveAcquisforBios.*

For CYs 2005, 2006, and 2007, we estimated the OPPS pass-through payment amount for drugs and biologicals to be zero based on our interpretation that the ''otherwise applicable Medicare OPD fee schedule'' amount was equivalent to the amount to be paid for pass-through drugs and biologicals under section 1842(o) of the Act (or section 1847B of the Act, if the drug or biological is covered under a competitive acquisition contract). We concluded for those years that the resulting difference between these two rates would be zero.

The pass-through application and review process is explained on the CMS Web site at: *http://www.cms.hhs.gov/HospitalOutpatientPPS/04_pass through_payment.asp.*

2. Drugs and Biologicals With Expiring Pass-Through Status in CY 2007

Section 1833(t)(6)(C)(i) of the Act specifies that the duration of transitional pass through payments for drugs and biologicals must be no less than 2 years and no longer than 3 years. In Table 41, we list the seven drugs and biologicals whose pass through status will expire on December 31, 2007, that meet that criterion.

TABLE 41.—PROPOSED DRUGS AND BIOLOGICALS FOR WHICH PASS-THROUGH STATUS EXPIRES DECEMBER 31, 2007

HCPCS code	Short descriptor	CY 2007 and proposed CY 2008 APC	CY 2007 SI	Proposed CY 2008 SI
J2278	Ziconotide injection	1694	G	K
J2503*	Pegaptanib sodium injection	1697	G	K
J7311	Fluocinolone acetonide	9225	G	K
J8501	Oral aprepitant	0868	G	K
J9027	Clofarabine injection	1710	G	K
J9264*	Paclitaxel protein bound	1712	G	K
Q4079	Natalizumab injection	9126	G	K

* Indicates that the drug was paid at a rate determined by the Part B drug CAP methodology while identified as pass-through under the OPPS.

3. Drugs and Biologicals with Proposed Pass-Through Status in CY 2008

We are proposing to continue pass-through status in CY 2008 for 13 drugs and biologicals. These items, which were approved for pass-through status between April 1, 2006 and July 1, 2007, are listed in Table 42. The APCs and HCPCS codes for these drugs and biologicals listed in Table 42 are assigned status indicator ''G'' in Addenda A and B to this proposed rule.

Section 1833(t)(6)(D)(i) of the Act sets the amount of pass-through payment for pass-through drugs and biologicals (the pass-through payment amount). The pass-through payment amount is the difference between the amount authorized under section 1842(o) of the Act (or, if the drug or biological is covered under a competitive acquisition contract under section 1847B, an amount determined by the Secretary equal to the average price for the drug or biological for all competitive acquisition areas and year established under such section as calculated and adjusted by the Secretary) and the portion of the otherwise applicable fee schedule amount that the Secretary determines is associated with the drug or biological. Given our CY 2008 proposal to provide payment for nonpass-through separately payable drugs and biologicals at ASP+5 percent as described further in section V.B.3 of this proposed rule, we believe it would be most consistent with the statute to provide payment for drugs and biologicals with pass through status that are not part of the Part B drug CAP at a rate of ASP+6 percent, compared to ASP+5 percent as the otherwise applicable fee schedule portion associated with the drug or biological. The difference between ASP+6 percent and ASP+5 percent, therefore, would be the CY 2008 pass-through payment amount for these drugs and biologicals. Thus, we are proposing for CY 2008 to pay for pass-through drugs and biologicals that are not part of the Part B drug CAP at ASP+6 percent, equivalent to the rate these drugs and biologicals would receive in the physician's office setting in CY 2008.

Section 1842(o) of the Act also states that if a drug or biological is covered under a competitive acquisition contract under section 1847B of the Act, the payment rate is equal to the average price for the drug or biological for all competitive acquisition areas and year established as calculated and adjusted by the Secretary. For CY 2008, we are proposing to provide payment for drugs and biologicals with pass-through status that are offered under the Part B drug CAP at a rate equal to the Part B drug CAP rate. Therefore, considering ASP+5 percent to be the otherwise applicable fee schedule portion associated with these drugs or biologicals, the difference between the Part B drug CAP rate and ASP+5 percent would be the pass-through payment amount for these drugs and biologicals. HCPCS codes that are offered under the CAP program as of April 1, 2007 are identified in Table 42 with an asterisk.

In section V.B.3.b. of this proposed rule, we discuss our proposal to make separate payment in CY 2008 for new drugs and biologicals with a HCPCS code, consistent with the provisions of section 1842(o) of the Act, at a rate that is equivalent to the payment they would receive in a physician's office setting (or under section 1847B of the Act, if the drug or biological is covered under a competitive acquisition contract) only if we have received a pass-through application for the item and pass-through status has been subsequently granted. Otherwise, we are proposing to pay ASP+5 percent for these products in CY 2008.

We are proposing to use payment rates based on the ASP data from the fourth quarter of CY 2006 for budget neutrality estimates, impact analyses, and completion of Addenda A and B to this proposed rule because these are the most recent data available to us at this time. These payment rates are also the basis for drug payments in the physician's office setting, effective April 1, 2007. As updated data will be available during the development of our final rule, we are proposing to use ASP data from the second quarter of 2007 (which are the basis for drug payments in the physician's office setting, effective October 1, 2007) in budget neutrality estimates, impact analyses, and completion of Addenda A and B to the CY 2008 OPPS/ASC final rule with comment period. In addition, we are proposing to update these pass-through payment rates on a quarterly basis on our Web site during CY 2008 if later quarter ASP submissions (or more recent WAC or AWP information, as applicable) indicate that adjustments to the payment rates for these pass-through drugs and biologicals are necessary. Although there are no pass-through radiopharmaceuticals at this time for CY 2008, the payment rate for a radiopharmaceutical with pass-through status would also be adjusted accordingly.

If a drug that has been granted pass-through status for CY 2008 becomes covered under the Part B drug CAP, we are proposing to make the appropriate adjustments to the payment rates for these drugs and biologicals on a quarterly basis. For drugs and biologicals that are currently covered under the CAP, we are proposing to use the payment rates calculated under that program that are in effect as of April 1, 2007. We are proposing to update these payment rates if the rates change in the future.

TABLE 42.—PROPOSED DRUGS AND BIOLOGICALS WITH PASS-THROUGH STATUS IN CY 2008

HCPCS code	Short descriptor	CY 2007 and proposed CY 2008 APC	CY 2007 and proposed CY 2008 SI
C9232	Injection, idursulfase	9232	G
C9233	Injection, ranibizumab	9233	G
C9235	Injection, panitumumab	9235	G
C9350	Porous collagen tube per cm	9350	G
C9351	Acellular derm tissue percm2	9351	G
J0129	Injection, abatacept	9230	G
J0348	Anadulafungin injection	0760	G
J0894*	Injection, decitabine	9231	G
J1740	Injection ibandronate sodium	9229	G
J2248	Injection, micafungin sodium	9227	G
J3243	Injection, tigecycline	9228	G
J3473	Hyaluronidase recombinant	0806	G
J9261	Nelarabine injection	0825	G

* Indicates that the drug is paid at a rate determined by the Part B drug CAP methodology while identified as pass-through under the OPPS.

B. Proposed Payment for Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Status

1. Background

Under the CY 2007 OPPS, we currently pay for drugs, biologicals, and radiopharmaceuticals that do not have pass-through status in one of two ways: packaged payment within the payment for the associated service or separate payment (individual APCs). We explained in the April 7, 2000 OPPS final rule with comment period (65 FR 18450) that we generally package the cost of drugs and radiopharmaceuticals into the APC payment rate for the procedure or treatment with which the products are usually furnished. Hospitals do not receive separate payment from Medicare for packaged items and supplies, and hospitals may not bill beneficiaries separately for any packaged items and supplies whose costs are recognized and paid within the national OPPS payment rate for the associated procedure or service. (Program Memorandum Transmittal A 01 133, issued on November 20, 2001, explains in greater detail the rules regarding separate payment for packaged services.)

Packaging costs into a single aggregate payment for a service, procedure, or episode of care is a fundamental principle that distinguishes a prospective payment system from a fee schedule. In general, packaging the costs of items and services into the payment for the primary procedure or service with which they are associated encourages hospital efficiencies and also enables hospitals to manage their resources with maximum flexibility.

Section 1833(t)(16)(B) of the Act, as added by section 621(a)(2) of Pub. L. 108–173, sets the threshold for establishing separate APCs for drugs and biologicals at $50 per administration for CYs 2005 and 2006. Therefore, for CYs 2005 and 2006, we paid separately for drugs, biologicals, and radiopharmaceuticals whose per day cost exceeded $50 and packaged the costs of drugs, biologicals, and radiopharmaceuticals whose per day cost was equal to or less than $50 into the procedures with which they were billed. For CY 2007, the packaging threshold for drugs, biologicals, and radiopharmaceuticals that are not new and do not have pass through status was established to be $55. The methodology used to establish the $55 threshold for CY 2007 and our proposed approach for future years are discussed in more detail in section V.B.2. of this proposed rule.

In addition, for CY 2005 to CY 2007, we have provided an exemption to this packaging determination for oral and injectable 5HT3 forms of anti emetic products. We discuss in section V.B.2. of this proposed rule our proposed CY 2008 payment policy for anti emetic products.

2. Proposed Criteria for Packaging Payment for Drugs and Biologicals

(If you choose to comment on issues in this section, please include the caption ''OPPS: Packaging Drugs and Biologicals'' at the beginning of your comment.)

As indicated above, in accordance with section 1833(t)(16)(B) of the Act, the threshold for establishing separate APCs for drugs and biologicals was set to $50 per administration during CYs 2005 and 2006. In CY 2007, we used the fourth quarter moving average Producer Price Index (PPI) levels for prescription preparations to trend the $50 threshold forward from the third quarter of CY 2005 (when the Pub. L. 108–173 mandated threshold became effective) to the third quarter of CY 2007. We then rounded the resulting dollar amount to the nearest $5 increment in order to determine the CY 2007 threshold adjustment amount of $55.

Following the CY 2007 methodology (which is discussed in more detail in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68085 through 68086)), we used updated fourth quarter moving average PPI levels to trend the $50 threshold forward from the third quarter of CY 2005 to the third quarter of CY 2008 and again rounded the resulting dollar amount ($57.78) to the nearest $5 increment, which yielded a figure of $60. In performing this calculation, we used the most up-to-date forecasted, quarterly PPI estimates from CMS' Office of the Actuary (OACT). As actual inflation for past quarters replaced forecasted amounts, the PPI estimates for prior quarters have been revised (compared with those used in the CY 2007 OPPS/ASC proposed rule) and have been incorporated into our calculation for this CY 2008 proposed rule. Based on the calculations described above, we are proposing a packaging threshold for CY 2008 of $60. As stated in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68086), we believe that packaging certain items is a fundamental component of a prospective payment system, that packaging these items does not lead to beneficiary access issues and does not create a problematic site of service differential, that the packaging threshold is reasonable based on the initial establishment in law of a $50 threshold for the CY 2005 OPPS, that updating the $50 threshold is consistent with industry and government practices, and that the PPI is an appropriate mechanism to gauge Part B drug inflation. While we are not proposing for CY 2008 to change this established approach to establishing the general packaging threshold for drugs, biologicals, and radiopharmaceuticals, in view of our proposed packaging approach for the CY 2008 OPPS as outlined in section II.A.4. of this proposed rule and our desire to move the OPPS toward a more encounter-based and episode-based payment in the future, we will consider expanded packaging of payment for drugs, biologicals, and radiopharmaceuticals for a future OPPS update. We believe that consideration of expanded packaging for drugs and biologicals is particularly important given the substantial increase that has occurred in recent years in the proportion of HCPCS codes for drugs, biologicals, and radiopharmaceuticals that are paid separately, from 30 percent in CY 2003 to 50 percent in CY 2007. We are proposing for CY 2008 to expand the packaging of certain drugs and radiopharmaceuticals, specifically contrast agents and diagnostic radiopharmaceuticals as discussed in detail in section II.A.4. of this proposed rule. However, we believe that increased packaging of payment for drugs, biologicals, and radiopharmaceuticals more generally under the OPPS could provide significant incentives for hospital efficiency in adopting the most cost-effective approaches to patient care, while providing hospitals with maximum flexibility in managing their resources. Therefore, we are interested in public comments regarding recommended approaches to increase packaging of these products under the OPPS and issues we should consider as we evaluate alternative methodologies for the future.

To determine their CY 2008 proposed packaging status, we calculated the per day cost of all drugs, biologicals, and radiopharmaceuticals that had a HCPCS code in CY 2006 and were paid (via packaged or separate payment) under the OPPS using claims data from January 1, 2006, to December 31, 2006. In order to calculate the per day costs for drugs, biologicals, and radiopharmaceuticals to determine their packaging status in CY 2008, we are proposing to use the methodology that was described in detail in the CY 2006 OPPS proposed rule (70 FR 42723 through 42724) and finalized in the CY 2006 OPPS final rule with comment period (70 FR 68636 through 70 FR 68638). To calculate the proposed CY

2008 per day costs, we used an estimated payment rate for each drug and biological of ASP+5 percent (which is the payment rate we are proposing for separately payable drugs and biologicals in CY 2008, as discussed in more detail subsequently). As noted in section V.A.3. of this proposed rule, we used the manufacturer submitted ASP data from the fourth quarter of CY 2006 (rates that were used for payment purposes in the physician's office setting, effective April 1, 2007). For items that did not have an ASP based payment rate, we used their mean unit cost derived from the CY 2006 hospital claims data to determine their per day cost. We packaged items with per day cost less than or equal to $60 and identified items with per day cost greater than $60 as separately payable. Consistent with our past practice, we crosswalked historical OPPS claims data from the CY 2006 HCPCS codes that were reported to the CY 2007 HCPCS codes that we display in Addendum B to this proposed rule for payment in CY 2008. We note that HCPCS code A9568 (Technetium Tc–99 arcitumomab, diagnostic, per study dose, up to 45 millicuries), replaced HCPCS code A9549 (Technetium Tc–99 arcitumomab, diagnostic, per study dose, up to 25 millicuries) beginning January 1, 2007. Our CY 2006 claims data indicate that HCPCS code A9549 was billed an average of one time per day. As we do not have claims data available for ratesetting purposes for HCPCS code A9568, we estimated the number of units per day to also be one.

Our policy during previous cycles of the OPPS has been to use updated data to establish final determinations of the packaging status of drugs, biologicals, and radiopharmaceuticals. We note it is also our policy to make an annual packaging determination only when we develop the OPPS final rules. Only items that are identified as separately payable in the final rule will be subject to quarterly updates as discussed in section V.B.3. of this proposed rule. For our calculation of per day costs of drugs, biologicals, and radiopharmaceuticals in the CY 2008 OPPS/ASC final rule with comment period, we are proposing to use ASP data from the first quarter of CY 2007, which would be the basis for calculating payment rates for drugs and biologicals in the physician's office setting using the ASP methodology, effective July 1, 2007, along with the updated hospital claims data from CY 2006.

Consequently, the packaging status for drugs, biologicals, and radiopharmaceuticals for the final rule using the updated data may be different from their packaged status determined based on the data we are using for this proposed rule. Under such circumstances, we are proposing to apply the following policies to these drugs, biologicals, and radiopharmaceuticals whose relationship to the $60 threshold changes based on the final updated data:

- Drugs, biologicals, and radiopharmaceuticals that were paid separately in CY 2007 and that are proposed for separate payment in CY 2008, and then have per day costs equal to or less than $60 based on the updated ASPs and hospital claims data used for the CY 2008 final rule with comment period, would continue to receive separate payment in CY 2008.
- Drugs, biologicals, and radiopharmaceuticals that are packaged in CY 2007 and that are proposed for separate payment in CY 2008, and then have per day costs equal to or less than $60 based on the updated ASPs and hospital claims data used for the CY 2008 final rule with comment period, would remain packaged in CY 2008.
- Drugs, biologicals, and radiopharmaceuticals for which we are proposing packaged payment in CY 2008 but then had per day costs greater than $60 based on the updated ASPs and hospital claims data used for the CY 2008 final rule with comment period, would receive separate payment in CY 2008.

We note that in sections II.A.4.c.(5) and (6) of this proposed rule that we are proposing to package payment for all diagnostic radiopharmaceuticals and contrast agents that would not otherwise be packaged according to the proposed CY 2008 packaging threshold for drugs, biologicals and radiopharmaceuticals. Tables 17 and 19 in sections II.A.4.c.(5) and (6) of this proposed rule list the diagnostic radiopharmaceuticals and contrast agents, respectively, that we are proposing to package in CY 2008. We discuss our reasons for treating diagnostic radiopharmaceuticals and contrast agents differently from other drugs, biologicals, and therapeutic radiopharmaceuticals below.

For CY 2008, we also are proposing to continue exempting the oral and injectable forms of 5HT3 anti-emetic products from packaging, thereby making separate payment for all of the 5HT3 anti-emetic products. As we stated in the CY 2005 OPPS final rule with comment period (69 FR 65779 through 65780), it is our understanding that chemotherapy is very difficult for many patients to tolerate, as the side effects are often debilitating. In order for Medicare beneficiaries to achieve the maximum therapeutic benefit from chemotherapy and other therapies with side effects of nausea and vomiting, anti-emetic use is often an integral part of the treatment regimen. We believe that we should continue to ensure that Medicare payment rules do not impede a beneficiary's access to the particular anti-emetic that is most effective for him or her as determined by the beneficiary and his or her physician.

TABLE 43.—PROPOSED ANTI-EMETICS TO EXEMPT FROM PROPOSED CY 2008 $60 PACKAGING THRESHOLD

HCPCS Code	Short descriptor
J1260	Dolasetron mesylate
J1626	Granisetron HCl injection
J2405	Ondansetron HCl injection
J2469	Palonosetron HCl
Q0166	Granisetron HCl 1 mg oral
Q0179	Ondansetron HCl 8 mg oral
Q0180	Dolasetron mesylate oral

3. Proposed Payment for Drugs and Biologicals Without Pass-Through Status That Are Not Packaged

a. Payment for Specified Covered Outpatient Drugs

(If you choose to comment on issues in this section, please include the caption OPPS: Specified Covered Outpatient Drugs'' at the beginning of your comment.)

(1) Background

Section 1833(t)(14) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, requires special classification of certain separately paid radiopharmaceuticals, drugs, and biologicals and mandates specific payments for these items. Under section 1833(t)(14)(B)(i) of the Act, a ''specified covered outpatient drug'' is a covered outpatient drug, as defined in section 1927(k)(2) of the Act, for which a separate APC exists and that either is a radiopharmaceutical agent or is a drug or biological for which payment was made on a pass through basis on or before December 31, 2002.

Under section 1833(t)(14)(B)(ii) of the Act, certain drugs and biologicals are designated as exceptions and are not included in the definition of ''specified covered outpatient drugs.'' (SCODs) These exceptions are—

- A drug or biological for which payment is first made on or after January 1, 2003, under the transitional pass-through payment provision in section 1833(t)(6) of the Act.
- A drug or biological for which a temporary HCPCS code has not been assigned.

• During CYs 2004 and 2005, an orphan drug (as designated by the Secretary).

Section 1833(t)(14)(A)(iii) of the Act, as added by section 621(a)(1) of Pub. L. 108 173, requires that payment for SCODs in CY 2006 and subsequent years be equal to the average acquisition cost for the drug for that year as determined by the Secretary, subject to any adjustment for overhead costs and taking into account the hospital acquisition cost survey data collected by the Government Accountability Office (GAO) in CYs 2004 and 2005. If hospital acquisition cost data are not available, the law requires that payment be equal to payment rates established under the methodology described in section 1842(o), section 1847A, or section 1847B of the Act as calculated and adjusted by the Secretary as necessary.

In establishing the CY 2006 payment rates, we evaluated the three data sources that were available to us for setting the CY 2006 payment rates for drugs and biologicals. As described in the CY 2006 OPPS final rule with comment period (70 FR 68639 through 68644), these data sources were the GAO reported average purchase prices for 55 specified covered outpatient drug categories for the period July 1, 2003, to June 30, 2004, collected via a survey of 1,400 acute care Medicare-certified hospitals; ASP data; and mean costs derived from CY 2004 hospital claims data. For the CY 2006 OPPS final rule with comment period, we used ASP data from the second quarter of CY 2005, which were used to set payment rates for drugs and biologicals in the physician's office setting effective October 1, 2005, and updated claims data.

In our data analysis for the CY 2006 OPPS final rule with comment period, we compared the payment rates for drugs and biologicals using data from all three sources described above. We estimated aggregate expenditures for all drugs and biologicals that would be separately payable in CY 2006 and for the 55 drugs and biologicals reported by the GAO using mean costs from the claims data, the GAO mean purchase prices, and the ASP-based payment amounts (ASP+6 percent in most cases), and then calculated the equivalent average ASP-based payment rate under each of the three payment methodologies. We excluded radiopharmaceuticals in our analysis because they were paid at hospital charges reduced to cost during CY 2006. The results based on updated ASP and claims data were published in Table 24 of the CY 2006 OPPS final rule with comment period. For a full discussion of our reasons for using these data, we refer readers to section V.B.3.a. of the CY 2006 OPPS final rule with comment period (70 FR 68639 through 68644).

As we noted in the CY 2006 OPPS final rule with comment period, findings from a MedPAC survey of hospital charging practices indicated that hospitals set charges for drugs, biologicals, and radiopharmaceuticals high enough to reflect their pharmacy handling costs as well as their acquisition costs. In consideration of this information, we stated in the CY 2006 OPPS final rule with comment period that payment rates derived from hospital claims data also included acquisition and pharmacy handling costs because they are derived directly from hospital charges (70 FR 68642). In CYs 2006 and 2007, we finalized a policy of providing payment to HOPDs for drugs, biologicals, and associated pharmacy handling costs at a rate of ASP+6 percent. In addition, in CY 2006 we had proposed to collect pharmacy overhead charge data via special pharmacy overhead HCPCS codes that hospitals would report. We did not finalize this proposal for CY 2006 because of hospital concerns regarding the administrative burden associated with reporting pharmacy overhead with these special HCPCS codes (70 FR 68657 through 68665).

(2) Proposed Payment Policy

The provision in section 1833(t)(14)(A)(iii) of the Act, as described above, continues to be applicable to determining payments for SCODs for CY 2008. This provision requires that in CY 2008 payment for SCODs be equal to the average acquisition cost for the drug for that year as determined by the Secretary, subject to any adjustment for overhead costs and taking into account the hospital acquisition cost survey data collected by the GAO in CYs 2004 and 2005. If hospital acquisition cost data are not available, the law requires that payment be equal to payment rates established under the methodology described in section 1842(o), section 1847A, or section 1847B of the Act as calculated and adjusted by the Secretary as necessary. In addition, section 1833(t)(14)(E)(ii) authorizes the Secretary to adjust APC weights for SCODs to take into account the MedPAC report relating to overhead and related expenses, such as pharmacy services and handling costs.

During the March 2007 APC Panel meeting, the APC Panel recommended that CMS implement a three-phase plan to address OPPS payment for pharmacy overhead costs. The first phase of the recommended plan involves CMS working with interested stakeholders to develop a system of defining pharmacy overhead categories for outpatient drugs that require different levels of pharmacy resources. In addition, this phase includes a provision recommending that CMS provide payment for pharmacy overhead costs by setting payment rates for the developed categories through New Technology APCs, presumably while collecting hospital cost data on these services. The second phase of the recommended plan calls for CMS to review estimates of pharmacy overhead costs as identified by the GAO and MedPAC, and to consider external survey data from stakeholders. The third and final phase of the recommended plan calls for specific billing of pharmacy overhead costs using HCPCS codes (corresponding to the categories developed in phase one, with payment rates resulting from submitted hospital claims data) on the same claim as a drug administration service. The APC Panel recommended that the overhead payments be made in addition to the current ASP+6 percent payment rates for separately payable drugs and biologicals that do not have pass-through status. We also have met with interested stakeholders who have presented proposals similar to the APC Panel's recommended plan with various modifications to that recommendation, including suggestions for the assignment of specific drugs and biologicals to various overhead categories and potential overhead payment rates for such categories in the first phase of the APC Panel's recommended plan. In addition, some stakeholders have recommended that CMS conduct a survey of pharmacy overhead costs in the second phase of the APC Panel's recommended plan.

While we appreciate the APC Panel's recommendation, as well as similar suggestions from other stakeholders, we are not proposing to adopt the APC Panel's recommendation for CY 2008. As discussed in section II.A.4. of this proposed rule, for CY 2008, we are proposing to expand packaging for a number of different groups of services. Given our belief that packaging can be helpful in promoting hospital efficiency and long-term cost containment, we do not believe it would be desirable to take steps that would ultimately lead to payment for pharmacy overhead costs being unpackaged under the OPPS. In addition, we note that the APC Panel recommended that CMS establish separate payment amounts for pharmacy overhead in addition to the current combined payment for drug acquisition

costs and pharmacy overhead of ASP+6 percent. As we discussed in the CY 2006 OPPS final rule with comment period (70 FR 68657) and in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68089 through 68092), findings from a MedPAC survey of hospital charging practices indicated that hospitals set charges for drugs, biologicals, and radiopharmaceuticals high enough to reflect their pharmacy handling costs as well as their acquisition costs. We believe that our payment rates for drug acquisition costs and pharmacy overhead should be determined based on the costs reflected in our claims data, as these costs reflect both acquisition costs and overhead costs. We also believe that establishing additional payment for pharmacy overhead beyond our proposed payment rates based on claims data would distort the relative relationship of costs across HOPD services, which is the basis of the OPPS.

While we are not proposing to adopt the APC Panel's recommendation for CY 2008, we considered several other options for payment for drug acquisition costs and pharmacy overhead for CY 2008. First, we considered proposing again the methodology we had proposed for CY 2006, which involved the establishment of three drug overhead categories that hospitals would use to report pharmacy overhead charges associated with a drug provided in the HOPD. Until such data were available for ratesetting purposes, we considered continuing our CY 2007 methodology of bundling average hospital acquisition and pharmacy overhead payments. While this approach has the advantage of not paying separately for pharmacy overhead until we would have claims data on which to establish separate payment rates for drug acquisition costs and pharmacy overhead, its goal would still be to ultimately unpackage OPPS payment for pharmacy overhead. We have decided not to propose this option because we believe it is undesirable to take steps that would ultimately lead to pharmacy overhead being unpackaged at the same time that we are proposing measures to expand packaging under the OPPS and are considering moving toward more episode-based and encounter-based payment. Furthermore, we note that, as we considered this approach, we were mindful of the comments we received in response to our CY 2006 proposed rule expressing concern about the additional administrative burden on staff and coders that this methodology might cause.

Second, we considered continuing our CY 2007 methodology of providing a single bundled payment representing average hospital acquisition costs and associated pharmacy overhead costs. As stated previously, we believe that hospitals are including pharmacy overhead costs in their charges for drugs, consistent with MedPAC's findings. While we continue to believe that a combined payment amount for drug acquisition costs and pharmacy overhead based on our claims data is a reasonable methodology, adequately accounts for acquisition costs and overhead, and is consistent with our broader packaging efforts, we have decided to propose a slight variant of this approach for CY 2008 instead.

For CY 2008, we are proposing to continue our methodology of providing a combined payment rate for drug and biological acquisition costs and pharmacy overhead. However, in addition, we are proposing to instruct hospitals to remove the pharmacy overhead charge from the charge for the drug or biological and instead report the pharmacy overhead charge on an uncoded revenue code line on the claim beginning in CY 2008. This proposed change, from a CY 2007 policy where hospitals include pharmacy overhead in their charges for the drug or biological to a CY 2008 policy of including the pharmacy overhead charges on an uncoded revenue code line, would allow us to package pharmacy overhead costs for drugs and biologicals into payment for the associated procedure, likely a drug administration procedure, in future years when the CY 2008 claims data become available for ratesetting. We are proposing to apply this policy to the reporting of charges for all drugs and biologicals, including contrast agents, irrespective of the item's packaged or separately payable status for the CY 2008 OPPS. We are not proposing to apply this policy to the reporting of overhead charges for radiopharmaceuticals given the explicit instructions we gave hospitals beginning in CY 2006 to include the charges for radiopharmaceutical overhead and handling in the charges for the radiopharmaceutical product.

This proposal would not change our current policy of packaging payment for pharmacy overhead with payment for another item or service. Rather, in future years it would only change the types of items or services with which pharmacy overhead is packaged. Once CY 2008 claims data become available for ratesetting, this proposal would lead to pharmacy overhead for separately payable drugs being packaged with payment for the associated procedure, likely a drug administration procedure, rather than the current policy where pharmacy overhead for separately payable drugs is packaged with the payment for the drug.

We note that, in the case of current OPPS payment for packaged drugs, payment for both the drugs and their associated pharmacy overhead costs is already packaged into payment for the associated separately payable procedures, including drug administration services as discussed in detail in section II.A.1.b.(2) of this proposed rule. Packaging pharmacy overhead for separately payable drugs and biologicals into the payments for drug administration would enhance the accuracy of payments by packaging overhead for similar drugs into the commonly associated separately payable services, for example, by packaging the pharmacy overhead for a chemotherapy drug with the chemotherapy drug administration code also included on the claim. In addition, this methodology is consistent with the increased packaging efforts discussed earlier in this proposed rule. Because we would not expect to have claims data reflecting these reporting changes until CY 2010, we are proposing to continue to provide a combined payment rate for acquisition costs and pharmacy overhead for separately payable drugs and biologicals in CY 2008 similar to the combined payment rate provided in CYs 2006 and 2007 that represents the average hospital acquisition cost and pharmacy overhead cost.

Under our proposal, hospitals would be asked to report pharmacy overhead charges on an uncoded revenue code line. By having hospitals report pharmacy overhead on an uncoded revenue code line, they would have the flexibility to decide whether they reported a pharmacy overhead charge per drug or per episode of drug administration services. The pharmacy overhead charges reported through an uncoded revenue code line would be like any other charge for an uncoded revenue code line on the claim. For example, hospitals may already report charges for some drugs or pharmacy-related services through an uncoded revenue code charge. Our proposal would mean that hospitals would be reporting pharmacy overhead on an uncoded revenue code line, in addition to any drugs or pharmacy-related services that they may already be reporting in that manner. According to our standard OPPS ratesetting methodology, we would package all such uncoded revenue code lines on the claim to develop the median cost for the separately payable service with which the pharmacy charges are reported.

We note that when we proposed establishing specific HCPCS codes for hospitals to report pharmacy overhead for CY 2006, commenters expressed a number of concerns about how this reporting and charging methodology would be different from the approach for other private payers. Some commenters voiced concern that while the proposal would have required hospitals to modify their billing systems to separate the pharmacy overhead charge from the drug charge for Medicare claims, hospitals would need to bill them as a single line item for other payers. Some commenters were concerned that this might require hospitals to charge Medicare differently from all other payers for the same services. With regard to our current proposal for CY 2008 to have hospitals report a charge for the drug and a charge for pharmacy overhead via an uncoded revenue code line, we believe our current approach is consistent with Medicare regulations. So long as hospitals provide the same total charge to all payers, it would be acceptable to report that charge as a line item for one payer and two (or more) line items for another payer.

For this proposed rule, we evaluated two data sources that we have available to us for setting the CY 2008 payment rates for drugs and biologicals. The first source of drug pricing information that we have is the ASP data from the fourth quarter of CY 2006, which were used to set payment rates for drugs and biologicals in the physician's office setting, effective April 1, 2007. We have ASP-based prices for approximately 500 drugs and biologicals (including contrast agents) payable under the OPPS. However, we currently do not have any ASP data on radiopharmaceuticals.

The second source of cost data that we have for drugs, biologicals, and radiopharmaceuticals is the mean and median costs derived from the CY 2006 hospital claims data. As section 1833(t)(14)(A)(iii) of the Act clearly specifies that payment for SCODs in CY 2008 be equal to the ''average'' acquisition cost for the drug, we limited our analysis to the mean costs of drugs determined using the hospital claims data, instead of using median costs.

In our data analysis, we compared the payment rates for drugs and biologicals using data from both sources described above. After determining the proposed CY 2008 packaging status of drugs and biologicals, we estimated aggregate expenditures for all drugs and biologicals (excluding radiopharmaceuticals) that would be separately payable in CY 2008 using mean costs from the hospital claims data and the ASP-based payment amounts, and calculated the equivalent average ASP-based payment rate under both payment methodologies.

The results of our data analysis indicate that using mean unit cost to set the payment rates for the drugs and biologicals that would be separately payable in CY 2008 would be equivalent to basing their payment rates, on average, at ASP+5 percent. Therefore, we are proposing to continue to provide a bundled payment for CY 2008 at ASP+5 percent while hospitals change their charge practices to bill pharmacy overhead charges on an uncoded revenue center line as discussed above. As stated previously, we believe that this methodology would continue to provide accurate payments for average acquisition costs of Part B drugs and pharmacy overhead costs during this transition. In addition, as described in section II.A.4. of this proposed rule, for contrast agents we are proposing a supplemental approach which would package payment for all contrast media under the CY 2008 OPPS, and our specific rationale for this modified approach is described in our discussion of payment for diagnostic radiopharmaceuticals included in section V.A.3.a.(4)(b) of this proposed rule.

(3) Proposed Payment for Blood Clotting Factors

(If you choose to comment on issues in this section, please include the caption ''OPPS: Blood Clotting Factors'' at the beginning of your comment.)

For CY 2007, we are providing payment for blood clotting factors under the OPPS at ASP+6 percent plus an additional payment for the furnishing fee that is also a part of the payment for blood clotting factors furnished in physicians' offices under Medicare Part B. The CY 2007 updated furnishing fee is $0.152 per unit.

For the CY 2008 OPPS, we are proposing to pay for blood clotting factors at ASP+5 percent and to continue our policy for payment of the furnishing fee using the updated amount for CY 2008 as presented in the CY 2008 MPFS final rule.

We have consistently noted that we would update the payment amount for the furnishing fee each year (based on the consumer price index) so that the payment amount for the furnishing fee is equal to the furnishing fee payment amount noted in the MPFS final rule. As discussed in greater detail in the CY 2008 MPFS proposed rule, the CPI data for the 12 month period ending in June 2007 is not yet available. In the CY 2008 MPFS final rule, we will include the actual figure for the percent change in the CPI for medical care for the 12-month period ending June 2007, and the updated furnishing fee for CY 2008 we have calculated based on that figure.

Because the furnishing fee update is based on the percentage increase in the CPI for medical care for the 12 month period ending with June of the previous year and the Bureau of Labor Statistics releases the applicable CPI data after the OPPS and MPFS proposed rules are published, we have not been able to include the actual updated furnishing fee in the CY 2006 through CY 2008 OPPS and MPFS proposed rules. Rather, we announced in these proposed rules that we intended to include the actual figure for the percent change in the applicable CPI, and the updated furnishing fee calculated based on that figure in the associated final rule. Given the timing of the availability of the applicable data and our timeframe for preparing proposed rules, this process is unavoidable and likely to remain unchanged in the future. We believe that including a discussion of the furnishing fee update in annual rulemaking does not provide an advantage over other means of announcing this information, so long as the current statutory update methodology continues in effect. We believe that the public's need for information and adequate notice regarding the updated furnishing fee can be better met by issuing program instructions which will eliminate the discussion of the furnishing fee update annually in rulemaking. In addition, by communicating the updated furnishing fee in program instruction, the actual figure for the percent change in the applicable CPI and the updated furnishing fee calculated based on that figure can be announced more timely than when included as part of the annual rulemaking process. Because the furnishing fee update process is statutorily determined and is based on an index that is not affected by administrative discretion or public comment, we do not believe our proposed means of communicating the update will adversely affect stakeholders or the public. Therefore, for CY 2009 and thereafter, until such time as the update methodology may be modified, we are proposing to announce the blood clotting furnishing fee using applicable program instructions and posting on the CMS Web site. For additional information and instructions on how to submit comments on this proposal, we refer readers to the CY 2008 MPFS proposed rule.

(4) Proposed Payment for Radiopharmaceuticals

(a) Background

Section 303(h) of Pub. L. 108–173 exempted radiopharmaceuticals from ASP pricing in the physician's office setting. Beginning in the CY 2005 OPPS final rule with comment period, we have exempted radiopharmaceutical manufacturers from reporting ASP data for payment purposes under the OPPS (for more information, we refer readers to the CY 2005 OPPS final rule with comment period and the CY 2006 OPPS final rule with comment period, 69 FR 65811 and 70 FR 68655, respectively). Consequently, we do not have ASP data for radiopharmaceuticals for consideration for CY 2008 OPPS ratesetting. In accordance with section 1833(t)(14)(B)(i)(I) of the Act, radiopharmaceuticals are classified under the OPPS as SCODs. Accordingly, payments for radiopharmaceuticals are to be made at average acquisition cost as determined by the Secretary and subject to any adjustment for overhead costs. Radiopharmaceuticals are also subject to the policies affecting all similarly classified OPPS drugs and biologicals, such as pass-through payments and packaging determinations, discussed earlier in this proposed rule.

For CYs 2006 and 2007, we used mean unit cost data from hospital claims to determine each radiopharmaceutical's packaging status, and implemented a temporary policy to pay for separately payable radiopharmaceuticals based on the hospital's charge for each radiopharmaceutical adjusted to cost using the hospital's overall CCR. This methodology was finalized as an interim proxy for average acquisition cost because of the unique circumstances associated with providing radiopharmaceutical products to Medicare beneficiaries. The single OPPS payment represented Medicare payment for both the acquisition cost of the radiopharmaceutical and its associated pharmacy overhead costs. We clearly stated in both the CY 2006 and CY 2007 OPPS final rules with comment period that we did not intend to maintain this methodology permanently (70 FR 68656 and 71 FR 68096, respectively), and that we would continue to actively seek other methodologies for setting payments for radiopharmaceuticals in future years.

During the CY 2006 and CY 2007 rulemaking processes, we encouraged hospitals and the radiopharmaceutical stakeholders to assist us in developing a viable long-term prospective payment methodology for these products under the OPPS. We are pleased to note that we have had many discussions over this past year with interested parties regarding the availability and limitations of radiopharmaceutical cost data. In addition, we have received several suggestions from interested parties on how to structure future payment methodologies. Many of the proposals we have received have suggested that we consider differentiating radiopharmaceutical products into two different categories by cost, at least in part because stakeholders have speculated that charge compression leads to inappropriately low calculated costs for expensive radiopharmaceuticals. For CY 2008, we are making separate payment proposals for diagnostic radiopharmaceuticals and therapeutic radiopharmaceuticals. While we have not grouped radiopharmaceuticals based on cost, we note that the therapeutic radiopharmaceuticals typically are more expensive than the diagnostic radiopharmaceuticals. We identified all diagnostic radiopharmaceuticals specifically as those Level II HCPCS codes that include the term ''diagnostic'' along with a radiopharmaceutical in their long code descriptors. Therefore, we were able to distinguish therapeutic radiopharmaceuticals from diagnostic radiopharmaceuticals as those Level II HCPCS codes that have the term ''therapeutic'' along with a radiopharmaceutical in their long code descriptors. We note that all radiopharmaceutical products fall into one category or the other; their use as a diagnostic radiopharmaceutical or therapeutic radiopharmaceutical is mutually exclusive.

(b) Proposed Payment for Diagnostic Radiopharmaceuticals

(If you choose to comment on issues in this section, please include the caption ''OPPS: Payment for Diagnostic Radiopharmaceuticals'' at the beginning of your comment.)

As discussed in section II.A.4. of this proposed rule, we are proposing to package payment for diagnostic radiopharmaceuticals and contrast agents with per day costs over $60 as part of our packaging proposal for CY 2008. Radiopharmaceuticals and contrast agents currently are defined as SCODs in section 1833(t)(14)(B) of the Act, and we currently package payment for diagnostic radiopharmaceuticals and contrast agents with per day costs of $55 or less. However, our proposal for CY 2008 also includes packaging payment for all diagnostic radiopharmaceuticals and contrast agents, regardless of their per day cost. Packaging costs into a single aggregate payment for a service, encounter, or episode of care is a fundamental principle that distinguishes a prospective payment system from a fee schedule. In general, packaging the costs of items and services into the payment for the primary procedure or service with which they are associated encourages hospital efficiencies and also enables hospitals to manage their resources with maximum flexibility. The proportion of drugs, biologicals, and radiopharmaceuticals that are separately paid has increased in recent years, from 30 percent of HCPCS codes for these products in CY 2003 to 50 percent in CY 2007, a pattern that has been noted previously for procedural services as well. Our proposal to package payment for diagnostic radiopharmaceuticals and contrast agents regardless of per day cost furthers the fundamental principles of a prospective payment system.

We believe our proposal to treat diagnostic radiopharmaceuticals and contrast agents differently from other SCODs is appropriate for several reasons. First, the statutory requirement that we must pay separately for drugs and biologicals for which the per day cost exceeds $50 under section 1833(t)(16)(B) of the Act has expired. Therefore, we are not restricted to the extent to which we can package payment for SCODs and other drugs, nor are we required to treat all classes of drugs in the same manner with regard to whether they are packaged or separately paid. We have used this flexibility to make different packaging determinations for several years with regard to specific anti-emetic drugs. While we are proposing to continue to establish an updated cost threshold for packaging drugs, biologicals, and radiopharmaceuticals, we are also proposing an approach specific to diagnostic radiopharmaceuticals and contrast agents that would otherwise be separately paid.

Second, we see diagnostic radiopharmaceuticals and contrast agents as functioning effectively as supplies that enable the provision of an independent service. More specifically, contrast agents are always provided in support of a diagnostic or therapeutic procedure that involves imaging and diagnostic radiopharmaceuticals are always provided in support of a diagnostic nuclear medicine scan. This is different from many other SCODs, for example, therapeutic radiopharmaceuticals, where the therapeutic radiopharmaceutical itself is the primary therapeutic modality. Given the inherent function of contrast agents and diagnostic radiopharmaceuticals as

supportive to the performance of an independent procedure, we view the packaging of payment for contrast agents and diagnostic radiopharmaceuticals as a logical initial step to expand packaging for SCODs. As we consider moving to additional encounter-based and episode-based payment in future years, we may consider additional options for packaging more SCODs in the future.

Third, section 1833(t)(14)(A)(iii) of the Act requires that payment for SCODs be set prospectively based on a measure of average hospital acquisition cost. While we have ASP data for contrast agents, the lack of ASP data as a source of average acquisition cost for radiopharmaceuticals and the varying inclusion of overhead and handling costs in the charge for a radiopharmaceutical resulted in payment for radiopharmaceuticals at charges reduced to cost on a temporary basis for CYs 2006 and 2007.

We now believe our claims data offer an acceptable proxy for average hospital acquisition cost and associated handling and preparation costs for radiopharmaceuticals. We believe that hospitals have adapted to the CY 2006 coding changes for radiopharmaceuticals and responded to our instructions to include charges for radiopharmaceutical handling in their charges for the radiopharmaceutical products. This issue is discussed in greater detail under section V.B.3.a.(4)(c) of this proposed rule regarding our proposed CY 2008 payment methodology for therapeutic radiopharmaceuticals. We have relied on mean unit costs derived from our claims data as one proxy for average acquisition cost and pharmacy overhead, and we use these data to determine the packaging status for SCODs. However, in light of improved data for radiopharmaceuticals in the CY 2006 claims, we believe that the line item estimated cost for a diagnostic radiopharmaceutical in our claims data is a reasonable approximation of average acquisition and preparation and handling costs for diagnostic radiopharmaceuticals. Further, because the standard OPPS packaging methodology packages the total estimated cost for each radiopharmaceutical on each claim (including the full range costs observed on the claims) with the cost of associated nuclear medicine procedures for ratesetting, this packaging approach is consistent with considering the average cost for radiopharmaceuticals, rather than the median. We also note that we believe our improved claims data could support the establishment of separate, prospective payment rates for diagnostic radiopharmaceuticals with per day costs exceeding our general packaging threshold (analogous to our proposal for therapeutic radiopharmaceuticals). However, we are proposing to package all diagnostic radiopharmaceuticals because we believe additional packaging of payment for supportive and ancillary services, including diagnostic radiopharmaceuticals, would provide additional incentives for efficiency and greater flexibility for hospitals to manage their resources.

In the case of contrast agents, while we have ASP data that can be a proxy for average hospital acquisition cost and associated handling and preparation costs, payment for almost all contrast agents would be packaged under the OPPS for CY 2008 based on the $60 per day packaging threshold. Therefore, as discussed in more detail in section V.B.3.a.(4) of this proposed rule, we believe it would be most appropriate to package payment for all contrast agents for CY 2008, to better provide for accurate payment for the associated tests and procedures that promotes hospital efficiency.

In summary, we view diagnostic radiopharmaceuticals and contrast agents as ancillary and supportive of the diagnostic tests and therapeutic procedures in which they are used. In light of our authority to make different packaging determinations, and the improved reporting of hospital charges for radiopharmaceutical handling in the CY 2006 claims data, we propose to package payment for contrast agents and diagnostic radiopharmaceuticals for CY 2008.

(c) Proposed Payment for Therapeutic Radiopharmaceuticals

(If you choose to comment on issues in this section, please include the caption ''OPPS: Payment for Therapeutic Radiopharmaceuticals'' at the beginning of your comment.)

For CY 2008, we are proposing to continue separate payment for therapeutic radiopharmaceuticals that have a mean per day cost of more than $60, consistent with the packaging methodology applied to other nonpass-through drugs and biologicals. We believe that therapeutic radiopharmaceuticals are distinct from diagnostic radiopharmaceuticals because the primary purpose of providing a therapeutic radiopharmaceutical is the radiopharmaceutical treatment itself, whereas a diagnostic radiopharmaceutical is administered in support of the performance of a diagnostic nuclear medicine study that is the primary service. For separately payable therapeutic radiopharmaceuticals, we are proposing to establish CY 2008 payment rates based on their mean unit costs from our CY 2006 OPPS claims data.

In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68095), we again reiterated our intent to develop a suitable prospective payment methodology for radiopharmaceutical products paid under the OPPS in future years, beginning in CY 2008. Since the start of the temporary cost-based payment methodology for radiopharmaceuticals in CY 2006, we have met with several interested parties on this topic and have received several suggestions from these stakeholders regarding payment methodologies that we could employ for future use under the OPPS.

In considering payment options for therapeutic radiopharmaceuticals for CY 2008, we examined several alternatives. First, we considered retaining the CY 2007 methodology of providing payment for therapeutic radiopharmaceuticals at a hospital's charges reduced to cost using the hospital's overall CCR. While this option would provide consistency in the payment methodology from year to year, we have noted on several occasions, including in the CY 2007 OPPS/ASC final rule with comment period and in various public forums such as the APC Panel meetings, that this methodology was not intended to be the basis of providing payment to hospitals for these products beyond CY 2007. Payment on a claim-specific cost basis is not consistent with the payment of items and services on a prospective basis under the OPPS and may lead to extremely high or low payments to hospitals for radiopharmaceuticals, even when those products would be expected to have relatively predictable and consistent acquisition and handling costs across individual clinical cases and hospitals. In addition, we have stated that we believe that using hospitals' overall CCRs to determine payments could result in an overstatement of radiopharmaceutical costs, which are likely reported in several cost centers, such as diagnostic radiology, that have lower CCRs than hospitals' overall CCRs (71 FR 68095). For these reasons, we are not proposing to use this methodology to set their payment rates for CY 2008.

The second option we considered, and are proposing, as a methodology for providing payment for therapeutic radiopharmaceuticals in CY 2008, is to establish prospective payment rates for

separately payable therapeutic radiopharmaceuticals using mean costs derived from the CY 2006 claims data, where the costs are determined using our standard methodology of applying hospital-specific departmental CCRs to radiopharmaceutical charges, defaulting to hospital-specific overall CCRs only if appropriate departmental CCRs are unavailable. As we stated in the CY 2007 OPPS/ASC proposed rule, we believe this methodology provides us with the most consistent, accurate, and efficient methodology for prospectively establishing payment rates for separately payable therapeutic radiopharmaceuticals (71 FR 49587). We believe that adopting prospective payment based on historical hospital claims data is appropriate because it serves as our most accurate available proxy for the average hospital acquisition cost of separately payable therapeutic radiopharmaceutical products. In addition, we have found that our general prospective payment methodology based on historical hospital claims data results in more consistent, predictable, and equitable payment amounts across hospitals and likely provides incentives to hospitals for efficiently and economically providing these outpatient services. Therefore, we expect that the hospital-specific payment variability found under a charge-reduced-to-cost methodology would no longer affect these products under our CY 2008 proposal.

Although we received comments to our CY 2007 proposed rule indicating that CY 2005 claims data used for that update did not incorporate associated overhead charges into the radiopharmaceutical charge, in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68095) we stated that we expected that hospitals would have adapted to the CY 2006 HCPCS coding changes for some radiopharmaceuticals and responded to our instructions to include their charges for radiopharmaceutical handling in their charges for the radiopharmaceutical products so these costs would be reflected in the CY 2008 ratesetting process. This continues to be our expectation, and we believe that the CY 2006 claims data that we are using to set the CY 2008 OPPS payment rates reflect both the radiopharmaceutical charge and associated overhead charges. As discussed at the March 2007 APC Panel meeting, our CY 2006 claims data show that a greater proportion of radiopharmaceuticals experienced an increase in their median costs from CY 2005 to CY 2006 than experienced a decrease. We indicated that this trend is consistent with the agency's expectations that hospitals would comply with our instructions to include charges for radiopharmaceutical handling in their charges for the radiopharmaceutical products for CY 2006. Therefore, we believe that setting CY 2008 prospective payment rates based on CY 2006 hospital claims data as described above serves as an acceptable combined proxy for average hospital acquisition costs and radiopharmaceutical handling.

During meetings with external stakeholders over the past year, we have been presented with several other suggestions regarding OPPS payment for therapeutic radiopharmaceuticals in CY 2008. One of these options included a suggestion that we employ alternative trimming methodologies in order to produce a claims-based mean cost that would more accurately reflect hospital purchase prices for these products. However, no specific trimming approaches for radiopharmaceuticals were offered for our consideration for CY 2008. We have chosen not to propose a methodology based on special OPPS data trimming for the CY 2008 proposed payment of therapeutic radiopharmaceuticals for the following reasons. First, the OPPS has a standard data trimming methodology to calculate drug, biological, and radiopharmaceutical per day costs from hospital claims data. This includes both a specific trim on units for drugs, biologicals, and radiopharmaceuticals that is ±3 standard deviations from the geometric mean, and a standard trim of any line-item with a cost per unit that is ±3 standard deviations from the geometric mean that is applied across all items and services. Both trims are conducted on the transformed variable, taking the natural log of both units and cost per unit, in order to trim evenly relative to the center of the distribution. Both units and costs per unit are never negative, and there are some therapeutic radiopharmaceuticals with very high units and costs per unit in our hospital claims data. These trims are conservative and typically eliminate only the most egregious observations, ones that could be due to erroneous reporting. For therapeutic radiopharmaceuticals, the unit trim alone removed all items that would have been eliminated under the cost trim, and with the exception of HCPCS code A9563 (Sodium phosphate P–32, therapeutic, per millicurie), this trim removed observations with unit costs below the mean unit cost listed in Table 44 below. That is, overall the result of applying our trimming methodology increased the mean unit cost reported in Table 44.

As a payment system based on relative payment weights, altering the trimming methodology for a particular set of services could unduly influence the relativity of the resulting payment weights for those particular services and could inappropriately redistribute payments in a budget neutral OPPS. We have no reason to believe that hospitals report costs differently for radiopharmaceuticals than they do for other items. As we discuss further in section II.A.1. of this proposed rule, what is important for setting appropriate payment rates under a prospective payment system is accuracy in estimating the relative costliness of services, and not the nominal value of the observed cost. Second, we are not convinced that employing an alternative trimming methodology would result in the most appropriate cost estimates for therapeutic radiopharmaceuticals. We believe that because hospitals were paid in CY 2006 for each therapeutic radiopharmaceutical they reported according to a claim-specific charge that was reduced to cost for payment, hospitals had an incentive to accurately account for the full costs of these products in establishing their charges. In addition, we have no way of knowing the specific clinical scenario that resulted in any given claim with certain reported units and charges for a therapeutic radiopharmaceutical. Therefore, we do not believe it would be appropriate to utilize a ratesetting methodology that could disregard correctly coded claims. While we appreciate this recommendation, we are not proposing a payment methodology that includes additional trimming of hospital claims data for therapeutic radiopharmaceutical products for CY 2008.

Recommendations other than trimming have centered around providing CMS with external data on radiopharmaceutical costs. One specific recommendation that we received from interested stakeholders requested that we allow hospitals to submit their invoices to CMS. With the invoice information, CMS could establish a prospective payment rate for radiopharmaceuticals that would be calculated taking into consideration the total amount invoiced for the radiopharmaceutical, transportation costs, and applicable rebates. While this payment rate would not include payment for certain radiopharmaceutical overhead and handling costs, stakeholders suggested that these costs could be packaged into

the associated procedure payment rather than the payment for the radiopharmaceutical. Stakeholders also generally have recommended that we could collect external data from various sources (such as manufacturers, nuclear pharmacies, and others) to use for therapeutic radiopharmaceutical ratesetting purposes in CY 2008.

We are not proposing a methodology using external data for CY 2008 for the following reasons. First, any approach relying on external data has the same disadvantage previously discussed of differentially influencing the relativity of payment weights for radiopharmaceuticals in the budget neutral OPPS payment system, where we utilize a standard ratesetting methodology for other services. In addition, it is not clear that invoice information from hospitals or cost information from nuclear pharmacies would be more accurate than hospitals' costs for radiopharmaceuticals that we currently calculate based on hospitals' charges reduced to cost by application of a CCR, and such information would generally exclude the costs of the hospital's handling of the radiopharmaceuticals. However, we note that we do not currently identify separate costs for this radiopharmaceutical handling that we could then package into the costs of the associated diagnostic nuclear medicine studies and treatment procedures. Moreover, hospitals currently have the flexibility to set their charges for therapeutic radiopharmaceuticals, taking into account a variety of factors, including acquisition costs and transportation costs, so we believe it is likely that hospitals are already taking this information into consideration when establishing their charges. Further, we have already instructed hospitals to include overhead charges for radiopharmaceuticals in the charge for the radiopharmaceutical product. We have received several reports that hospitals have made these changes, when necessary, and that other changes are in process to conform to our instructions. A ratesetting approach based on external data would likely present a burden to those hospitals that have been working over the past 2 years to align their charging practices with our stated instructions. Adoption of any methodology systematically relying on external data also would be administratively burdensome for CMS because we would need to collect, process, and review external information to ensure that it was valid, reliable, and representative of a diverse group of hospitals so that it could be used to establish rates for all hospitals. For these reasons, we are not proposing to collect hospital invoices or otherwise rely on external data in order to establish prospective payment rates for therapeutic radiopharmaceuticals for CY 2008.

The eight therapeutic radiopharmaceuticals that we are proposing to pay separately in CY 2008 under our proposed methodology of mean units costs calculated from CY 2006 hospitals claims are listed in Table 44 below.

TABLE 44.—THERAPEUTIC RADIOPHARMACEUTICALS PROPOSED FOR PROSPECTIVE PAYMENT IN CY 2008

HCPCS code	Short descriptor	Proposed CY 2008 APC	Proposed CY 2008 SI	Proposed CY 2008 mean cost
A9517	I131 iodide cap, rx	1064	K	$6.22
A9530	I131 iodide sol, rx	1150	K	11.74
A9543	Y90 ibritumomab, rx	1643	K	12,030.02
A9545	I131 tositumomab, rx	1645	K	8,283.41
A9563	P32 Na phosphate	1675	K	118.02
A9564	P32 chromic phosphate	1676	K	122.17
A9600	Sr89 strontium	0701	K	610.07
A9605	Sm 153 lexidronm	0702	K	1,446.05

We note that we have received anecdotal reports from some industry stakeholders asserting that the mean costs for the most expensive radiopharmaceuticals are understated in our claims data. We specifically invite comment on how the CY 2008 OPPS payment rates that we are proposing for therapeutic radiopharmaceuticals compare with the acquisition and associated handling costs of an efficient provider. We also are soliciting suggestions on approaches that could be adopted by Medicare or industry groups to promote improvements in hospital reporting of charges and costs for therapeutic radiopharmaceuticals to the extent that they are warranted and feasible. Some stakeholders have stated that charge compression may be adversely affecting our estimates of the mean cost for expensive radiopharmaceuticals. As discussed in more detail in section II.A.1 of this proposed rule, while we are not proposing to implement adjustments for charge compression for CY 2008 based on the RTI Report, which focused only on inpatient charges, we are proposing steps to explore this issue further for the future. We are proposing to develop an all-charges model that would compare variation in CCRs with variation in charges to establish disaggregated CCRs that could be applied to both inpatient and outpatient charges. We are also proposing to evaluate the results of that methodology for purposes of determining whether the resulting disaggregated CCRs should be proposed for to adjust for charge compressions in developing the CY 2009 OPPS payment rates.

During its March 2007 meeting, the APC Panel made two recommendations regarding radiopharmaceuticals. First, the APC Panel recommended that CMS work with stakeholders on issues related to payment for radiopharmaceuticals, including evaluating claims data for different classes of radiopharmaceuticals and ensuring that a nuclear medicine procedure claim always includes at least one reported radiopharmaceutical agent. As discussed in section II.A.4. of this proposed rule, we are proposing to accept the APC Panel's recommendation, and we welcome public comment on the burden hospitals would experience should we require such precise reporting. We also are seeking comment specifically on the importance of such a requirement in light of our discussion in section II.A.4. of this proposed rule on the representation of radiopharmaceuticals in the single claims for diagnostic nuclear medicine procedures, the presence of uncoded revenue code charges specific to diagnostic radiopharmaceuticals on claims without

a coded radiopharmaceutical, and our proposal to package payment for all diagnostic radiopharmaceuticals for CY 2008.

Second, the APC Panel recommended that we consider the use of external data and work with stakeholders to determine the correct code descriptor units for each radiopharmaceutical, including HCPCS code A9524 (Iodine I–131 iodinated serum albumin, diagnostic, per 5 microcuries). We appreciate the APC Panel's recommendation. We are always open to meeting with interested stakeholders and examining any data they may provide to us. However, we are unable to accept the APC Panel's recommendation concerning the development of specific code descriptors because decisions regarding the creation of permanent HCPCS codes, including code descriptors, are coordinated by the National HCPCS Panel and are outside the scope of the OPPS. For further information on the HCPCS coding process, we refer readers to the CMS Web site at: *http://www.cms.hhs.gov/MedHCPCSGenInfo/01_Overview.asp#TopOfPage*. We encourage interested parties to submit requests for revisions of code descriptors to the National HCPCS Panel for its consideration.

b. Proposed Payment for Nonpass-Through Drugs, Biologicals, and Radiopharmaceuticals with HCPCS Codes, but without OPPS Hospital Claims Data

(If you choose to comment on issues in this section, please include the caption OPPS: Nonpass-Through Coded Drugs, Biologicals, and Radiopharmaceuticals without Claims Data.)

Pub. L. 108–173 does not address the OPPS payment in CY 2005 and after for drugs, biologicals, and radiopharmaceuticals that have assigned HCPCS codes, but that do not have a reference AWP or approval for payment as pass-through drugs or biologicals. Because there is no statutory provision that dictated payment for such drugs and biologicals in CY 2005, and because we had no hospital claims data to use in establishing a payment rate for them, we investigated several payment options for CY 2005 and discussed them in detail in the CY 2005 OPPS final rule with comment period (69 FR 65797 through 65799).

For CYs 2005, 2006, and 2007, we finalized our policy to provide separate payment for new drugs, biologicals, and radiopharmaceuticals with HCPCS codes, but which did not have pass through status at a rate that was equivalent to the payment they received in the physician's office setting, established in accordance with the ASP methodology.

As discussed in the CY 2005 OPPS final rule with comment period (69 FR 65797), and the CY 2006 OPPS final rule with comment period (70 FR 68666), new drugs, biologicals, and radiopharmaceuticals may be expensive, and we are concerned that packaging these new items might jeopardize beneficiary access to them. In addition, we do not want to delay separate payment for these items solely because a pass-through application was not submitted. However, we note that for CY 2008 we are proposing to explicitly account for the pass-through payment amount associated with pass-through drugs and biologicals, in the context of our CY 2008 proposal for the payment of separately payable nonpass-through drugs and biologicals at ASP+5 percent. Therefore, for CY 2008, we are proposing to provide payment for these new drugs and biologicals with HCPCS codes as of January 1, 2008, but which do not have pass-through status and are without OPPS hospital claims data, at ASP+5 percent, consistent with our proposed payment methodology for other nonpass-through drugs and biologicals. This proposal would ensure that we are treating new nonpass-through drugs and biologicals like other drugs and biologicals under the OPPS, unless they are granted pass-through status. Only if they were pass-through drugs and biologicals would they receive a different payment for CY 2008, generally equivalent to the payment these drugs and biologicals would receive in the physician's office setting, consistent with the requirements of the statute.

In accordance with the ASP methodology, in the absence of ASP data, we are proposing to continue the policy we implemented during CYs 2005, 2006, and 2007 of using the WAC for the product to establish the initial payment rate. However, we note that if the WAC is also unavailable, we would make payment at 95 percent of the product's most recent AWP. We are also proposing to assign status indicator ''K'' to HCPCS codes for new drugs and biologicals for which we have not received a pass-through application. We further note that with respect to new items for which we do not have ASP data, once their ASP data become available in later quarter submissions, their payment rates under the OPPS will be adjusted so that the rates are based on the ASP methodology and set to ASP+5 percent. We are also proposing to base payment for new therapeutic radiopharmaceuticals with HCPCS codes as of January 1, 2008, but which do not have pass-through status, on the WACs for these products as ASP data for radiopharmaceuticals are not available. In addition, we note that if the WACs are also unavailable, we would make payment for the therapeutic radiopharmaceuticals at 95 percent of their most recent AWPs. Analogous to new drugs and biologicals, we are proposing to assign status indicator ''K'' to HCPCS codes for new therapeutic radiopharmaceuticals for which we have not received a pass-through application. Consistent with other ASP-based payments, we are proposing to make any appropriate adjustments to the payment amounts for drugs and biologicals in the CY 2008 OPPS/ASC final rule with comment period and also on a quarterly basis on our Web site during CY 2008 if later quarter ASP submissions (or more recent WACs or AWPs) indicate that adjustments to the payment rates for these drugs and biologicals are necessary. The payment rates for new therapeutic radiopharmaceuticals would also be adjusted accordingly. We also are proposing to make appropriate adjustments to the payment rates for new drugs and biologicals in the event that they become covered under the CAP in the future. We note that the new CY 2008 HCPCS codes for drugs, biologicals, and therapeutic radiopharmaceuticals are not available at the time of the development of this proposed rule; however, they will be included in the CY 2008 OPPS/ASC final rule with comment period.

There are several nonpass-through drugs and biologicals that were payable in CY 2006 and/or CY 2007 for which we do not have any CY 2006 hospital claims data. In order to determine the packaging status of these items for CY 2008, we calculated an estimate of the per day cost of each of these items by multiplying the payment rate for each product based on ASP+5 percent, similar to other nonpass-through drugs and biologicals paid under the OPPS, by an estimated average number of units of each product that would typically be furnished to a patient during one administration in the hospital outpatient setting. We are proposing to package items for which we estimate the per administration cost to be less than or equal to $60, which is the general packaging threshold that we are proposing for drugs, biologicals, and radiopharmaceuticals in CY 2008. We are proposing to pay separately for items with an estimated per administration cost greater than $60 (with the

exception of diagnostic radiopharmaceuticals and contrast agents which we are proposing to package regardless of cost, as discussed in more detail above). We are proposing that the CY 2008 payment for separately payable items without CY 2006 claims data would be based on ASP+5 percent, similar to other separately payable nonnpass-through drugs and biologcals under the OPPS. In accordance with the ASP methodology used in the physician office setting, in the absence of ASP data, we would use the WAC for the product to establish the initial payment rate. However, we note that if the WAC is also unavailable, we would make payment at 95 percent of the most recent AWP available.

Table 45A below lists all of the nonpass-through drugs and biologicals without available CY 2006 claims data to which these policies would apply in CY 2008.

TABLE 45A.—DRUGS AND BIOLOGICALS WITHOUT CY 2006 CLAIMS DATA

HCPCS code	Short descriptor	ASP-Based payment rate	Estimated average number of units per administration	Proposed CY 2008 SI
C9234	Inj, alglucosidase alfa	$126.00	130	K
J0288	Ampho b cholesteryl sulfate	11.89	35	K
J0364	Apomorphine hydrochloride	2.96	6	N
J1324	Enfuvirtide injection	22.69	180	K
J1562	Immune globulin subcutaneous	12.60	130	K
J2170	Mecasermin injection	11.81	15.6	K
J2315	Naltrexone, depot form	1.88	380	K
J3355	Urofollitropin, 75 iu	50.22	2	K
J7345	Non-human, non-metab tissue	35.76	16	K
J8650	Nabilone oral	16.80	6	K
J9261	Nelarabine injection	82.54	52.5	K
Q4085	Euflexxa, inj	115.19	1	K

During the March 2007 APC Panel meeting, the APC Panel reiterated its August 2006 recommendation to allow hospitals to report all HCPCS codes for drugs. In general, OPPS recognizes the lowest available administrative dose of a drug if multiple HCPCS codes exist for the drug; for the remainder of the doses, we assign a status indicator ''B'' indicating that another code exists for OPPS purposes. For example, if drug X has 2 HCPCS codes, 1 for a 1 ml dose and a second for a 5 ml dose, the OPPS would assign a payable status indicator to the 1 ml dose and status indicator ''B'' to the 5 ml dose. Hospitals would then need to bill the appropriate number of units for the 1 ml dose in order to receive payment under the OPPS. While we were not prepared to accept this recommendation when we developed the CY 2007 OPP/ASC final rule with comment period, we indicated in that rule that we would continue to consider the APC Panel's recommendation for future OPPS updates (71 FR 68083 through 68084). After further consideration of this issue, we are now accepting the APC Panel's recommendation because we have concluded that recognizing all of these HCPCS codes for payment under the OPPS should not have a significant effect on our payment methodology for drugs. We are proposing to allow hospitals to submit claims by reporting any HCPCS code for a Part B drug that is covered under the OPPS, regardless of the unit determination in the HCPCS code descriptor, beginning in CY 2008. Stakeholders have told us that this policy would reduce the administrative burden associated with our current requirement that hospitals report drugs using only the HCPCS codes with the lowest increments in their code descriptors. Whenever possible, we seek to reduce hospitals' administrative burden in submitting claims for payment under the OPPS, and we appreciate the APC Panel's recommendation in this area.

As these HCPCS codes were previously unrecognized in the OPPS, we do not have claims data to determine the appropriate packaging status. Therefore, we are proposing to assign these HCPCS codes the same status indicator as the associated recognized HCPCS code (that is, the lowest dose), as shown in Table 45B. We believe that this approach is the most appropriate and reasonable way to implement this proposed change without impacting payment. However, once claims data are available for these previously unrecognized HCPCS codes, we would determine the packaging status and resulting status indicator for each HCPCS code according to the general code-specific methodology for determining a code's packaging status for a given update year. We plan to closely follow our claims data to ensure that our annual packaging determinations for the different HCPCS codes describing the same drug do not create inappropriate payment incentives for hospitals to report certain HCPCS codes instead of others. In our analysis for this proposed rule, we also estimated the packaging status of these currently unrecognized HCPCS codes by adjusting the calculated average number of units per day for the associated recognized HCPCS code with claims data to account for the different dosage descriptors. We then multiplied this adjusted average number of units per day value by the most recent ASP data available for the unrecognized HCPCS code (listed in Table 45B). We note this methodology yielded the same packaging determinations and resulting status indicators for the currently unrecognized HCPCS codes for CY 2008 as for the recognized HCPCS code for the same drug.

TABLE 45B.—PREVIOUSLY UNRECOGNIZED HCPCS CODES AND PROPOSED STATUS INDICATORS FOR CY 2008

HCPCS codes not recognized in CY 2007	CY 2007 SI	Short descriptor	Fourth quarter CY 2006 ASP	Associated HCPCS code recognized in CY 2007	Proposed CY 2008 SI
J1470	B	Gamma globulin 2 CC inj	$23.66	J1460	K
J1480	B	Gamma globulin 3 CC inj	35.47		K
J1490	B	Gamma globulin 4 CC inj	47.31		K
J1500	B	Gamma globulin 5 CC inj	59.14		K
J1510	B	Gamma globulin 6 CC inj	71.02		K
J1520	B	Gamma globulin 7 CC inj	82.72		K
J1530	B	Gamma globulin 8 CC inj	94.62		K
J1540	B	Gamma globulin 9 CC inj	106.54		K
J1550	B	Gamma globulin 10 CC inj	118.27		K
J1560	B	Gamma globulin > 10 CC inj	118.24		K
J8521	B	Capecitabine, oral, 500 mg	13.18	J8520	K
J9094	B	Cyclophosphamide lyophilized, 200 mg	3.97	J9093	N
J9095	B	Cyclophosphamide lyophilized, 500 mg	9.93		N
J9096	B	Cyclophosphamide lyophilized, 1g	17.09		N
J9097	B	Cyclophosphamide lyophilized, 2g	39.71		N
J9140	B	Dacarbazine 200 MG inj	9.34	J9130	N
J9290	B	Mitomycin 20 MG inj	68.52	J9280	K
J9291	B	Mitomycin 40 MG inj	137.03		K
J9062	B	Cisplatin 50 MG injection	12.26	J9060	N
J9080	B	Cyclophosphamide 200 MG inj	3.83	J9070	N
J9090	B	Cyclophosphamide 500 MG inj	15.75		N
J9091	B	Cyclophosphamide 1.0 grm inj	19.17		N
J9092	B	Cyclophosphamide 2.0 grm inj	38.34		N
J9110	B	Cytarabine hcl 500 MG inj	8.22	J9100	N
J9182	B	Etoposide 100 MG inj	5.13	J9181	N
J9260	B	Methotrexate sodium inj, 50 mg	2.59	J9250	N
J9375	B	Vincristine sulfate 2 MG inj	15.41	J9370	N
J9380	B	Vincristine sulfate 5 MG inj	38.52		N

There are seven drugs and biologicals, shown in Table 45C below, that were payable in CY 2006 for which we lack CY 2006 claims data and for which we are not able to determine the per day cost based on the ASP methodology. As we are unable to determine the packaging status and subsequent payment rates, if applicable, for these drugs and biologicals for CY 2008 based on the ASP methodology or claims data, we are proposing to package payment for these drugs and biologicals in CY 2008.

TABLE 45C.—DRUGS AND BIOLOGICALS WITHOUT INFORMATION ON PER DAY COST THAT ARE PROPOSED FOR PACKAGING IN CY 2008

HCPCS code	Short descriptor	Proposed CY 2008 SI
90393	Vaccina ig, im	N
90477	Adenovirus vaccine, type 7.	N
90581	Anthrax vaccine, sc	N
90727	Plague vaccine, im	N
J0200	Alatrofloxacin mesylate.	N
J0395	Arbutamine HCl injection.	N

TABLE 45C.—DRUGS AND BIOLOGICALS WITHOUT INFORMATION ON PER DAY COST THAT ARE PROPOSED FOR PACKAGING IN CY 2008—Continued

HCPCS code	Short descriptor	Proposed CY 2008 SI
J1452	Intraocular Fomivirsen na.	N

VI. Proposed Estimate of OPPS Transitional Pass-Through Spending for Drugs, Biologicals, Radiopharmaceuticals, and Devices

(If you choose to comment on issues in this section, please include the caption ''OPPS: Estimated Transitional Pass-Through Spending'' at the beginning of your comment.)

A. Total Allowed Pass-Through Spending

Section 1833(t)(6)(E) of the Act limits the total projected amount of transitional pass-through payments for drugs, biologicals, radiopharmaceuticals, and categories of devices for a given year to an ''applicable percentage'' of projected total Medicare and beneficiary payments under the hospital OPPS. For a year before CY 2004, the applicable percentage was 2.5 percent; for CY 2004 and subsequent years, we specify the applicable percentage up to 2.0 percent.

If we estimate before the beginning of the calendar year that the total amount of pass-through payments in that year would exceed the applicable percentage, section 1833(t)(6)(E)(iii) of the Act requires a uniform reduction in the amount of each of the transitional pass-through payments made in that year to ensure that the limit is not exceeded. We make an estimate of pass-through spending to determine not only whether payments exceed the applicable percentage, but also to determine the appropriate reduction to the conversion factor for the projected level of pass-through spending in the following year.

For devices, developing an estimate of pass-through spending in CY 2008 entails estimating spending for two groups of items. The first group of items consists of those device categories that were eligible for pass-through payment in CY 2006 or CY 2007, or both years, and that would continue to be eligible for pass-through payment in CY 2008. The second group contains items that we know are newly eligible, or project would be newly eligible, for device

pass-through payment in the remainder of CY 2007 or beginning in CY 2008.

For drugs and biologicals, section 1833(t)(6)(D)(i) of the Act establishes the pass-through payment amount for drugs and biologicals eligible for pass-through payment as the amount by which the amount authorized under section 1842(o) of the Act (or, if the drug or biological is covered under a competitive acquisition contract under section 1847B, an amount determined by the Secretary equal to the average price for the drug or biological for all competitive acquisition areas and year established under such section as calculated and adjusted by the Secretary) exceeds the portion of the otherwise applicable fee schedule amount that the Secretary determines is associated with the drug or biological. Because we are proposing to pay for nonpass-through separately payable drugs and biologicals under the CY 2008 OPPS at the ASP+5 percent, which represents the otherwise applicable fee schedule amount associated with a pass-through drug or biological, while we would pay for pass-through drugs and biologicals at the ASP+6 percent or the Part B drug CAP rate, if applicable, our estimate of drug and biological pass-through payment for CY 2008 is not zero. Similar to estimates for devices, the first group of drugs and biologicals requiring a pass-through payment estimate consists of those products that were eligible for pass-through payment in CY 2006 or CY 2007, or both years, and that would continue to be eligible for pass-through payment in CY 2008. The second group contains products that we know are newly eligible, or project would be newly eligible, for drug or biological pass-through payment in the remainder of CY 2007 or beginning in CY 2008. The sum of the CY 2008 pass-through estimates for these two groups of drugs and biologicals would equal the total CY 2008 pass-through spending estimate for drugs and biologicals with pass-through status.

B. Proposed Estimate of Pass-Through Spending

We are proposing to set the applicable percentage limit at 2.0 percent of the total OPPS projected payments for CY 2008, consistent with our OPPS policy from CY 2004 through CY 2007.

As we discuss in section IV.B. of this proposed rule there are two device categories receiving pass-through payment in CY 2007 that would continue for payment during CY 2008. In accordance with the methodology we have used to make estimates in previous years, in cases where we have relevant claims data for the procedures associated with a device category, we are proposing to project these data forward using inflation and utilization factors based on total growth in OPPS services as projected by CMS' Office of the Actuary (OACT) to estimate the upcoming year's pass-through spending for this first group of device categories. As we stated in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68101), we may use an alternate growth factor for any specific device category based on our claims data or the device's clinical characteristics, or both. We developed estimated OPPS utilization of the procedures and costs associated with the two device categories continuing for pass-through payment into CY 2008, based upon examination of our historical claims data, information provided in the pass-through device category applications, and the devices' clinical characteristics. Based on these estimates, we estimate pass-through spending attributable to the first group (that is, the two device categories continuing in CY 2008) described above to be $18.1 million for CY 2008. The two device categories continuing in CY 2008, which are reflected in this $18.1 million estimate for CY 2008 pass-through spending, are listed in Table 46A.

TABLE 46A.—PROPOSED CY 2008 DEVICES WITH CURRENT PASS-THROUGH CATEGORIES CONTINUING INTO CY 2008

HCPCS code	APC	Current pass-through device category
C1821	1821	Interspinous process distraction device (implantable).
L8690	1032	Auditory osseointegrated device, includes all internal and external components.

To estimate CY 2008 pass-through spending for device categories in the second group (that is, device categories that we know at the time of the development of this proposed rule would be newly eligible for pass-through payment in CY 2007 continuing into CY 2008 (of which there are none); additional device categories that we estimate could be approved for pass-through status subsequent to the development of this proposed rule and before January 1, 2008; and projections for new categories that could be established in the second through fourth quarters of CY 2008), we are proposing to use the following approach. In general, as described for the first group of device categories above, if we have relevant claims data, we may project these data forward using OACT inflation and utilization factors based on total growth in OPPS services, or we may use an alternate growth factor for any specific new device category based on our claims data or the device's clinical characteristics, or both. At this time, we anticipate that any new categories for January 1, 2008, would be determined after the publication of this proposed rule, but before publication of the CY 2008 final rule with comment period. If we do not have any relevant CY 2006 claims data upon which to base a spending estimate for CY 2008, we are proposing to use price information and utilization estimates from applicants. To account for the contingency of new device categories that we project could become eligible for pass-through status in the second, third, or fourth quarter of CY 2008, we are proposing to use the general methodology as described above, while also considering the most recent OPPS experience in approving new pass-through device categories.

Therefore, we are proposing that the estimate of pass-through device spending in CY 2008 incorporate both CY 2008 estimates of pass-through spending for device categories made effective January 1, 2007, and estimates for those device categories projected to be approved during subsequent quarters of CY 2007 and CY 2008.

To estimate CY 2008 pass-through spending for drugs and biologicals in the first group, specifically those drugs and biologicals initially eligible for pass-through status in CY 2006 or CY 2007 and proposed for continuation of pass-through payment in CY 2008, we are proposing to utilize the most recent Medicare physician's office data regarding their utilization, information provided in the pass-through applications, historical hospital claims data, pharmaceutical industry information, and clinical information regarding the products, in order to project the CY 2008 OPPS utilization of the products. For the 13 known drugs

and biologicals that are proposed for continuation of pass-through payment in CY 2008, we then estimated the total pass-through payment amount as the difference between ASP+6 percent or the Part B drug CAP rate, as applicable, and ASP+5 percent, aggregated across the projected CY 2008 OPPS utilization of these products. Based on these estimates, we estimate pass-through spending attributable to the first group (that is, the drugs and biological continuing with pass-through eligibility in CY 2008) described above to be about $1.3 million for CY 2008. This $1.3 million estimate of CY 2008 pass-through spending for the first group of pass-through drugs reflects the 13 current pass-through drugs that are continuing on pass-through status into CY 2008, which are listed in Table 46B.

TABLE 46B.—PROPOSED CY 2008 PASS-THROUGH DRUGS WITH CURRENT PASS-THROUGH STATUS CONTINUING INTO CY 2008

HCPCS code	Short descriptor	CY 2007 and proposed CY 2008 APC
C9232	Injection, idursulfase	9232
C9233	Injection, ranibizumab	9233
C9235	Injection, panitumumab	9235
C9350	Porous collagen tube per cm	9350
C9351	Acellular derm tissue per cm2	9351
J0129	Injection, abatacept	9230
J0348	Anadulafungin injection	0760
J0894*	Injection, decitabine	9231
J1740	Injection ibandronate sodium	9229
J2248	Injection, micafungin sodium	9227
J3243	Injection, tigecycline	9228
J3473	Hyaluronidase recombinant	0806
J9261	Nelarabine injection	0825

To estimate CY 2008 pass-through spending for drugs and biologicals in the second group (that is, drugs and biologicals that we know at the time of the development of this proposed rule would be newly eligible for pass-through payment in CY 2007 continuing into CY 2008 (of which there are none); additional drugs and biologicals that we estimate could be approved for pass-through status subsequent to the development of this proposed rule and before January 1, 2008; and projections for new drugs and biologicals that could be initially eligible for pass-through payment in the second through fourth quarters of CY 2008), we are proposing to use the following approach. At this time, we anticipate that any new drugs and biologicals for January 1, 2008, would be determined after the publication of this proposed rule, but before publication of the CY 2008 final rule with comment period. We are proposing to use utilization estimates from applicants, pharmaceutical industry data, and clinical information to base pass through spending estimates for these drugs and biologicals for CY 2008. To account for the contingency of new drugs and biologicals that we project could become eligible for pass through status in the second, third, or fourth quarter of CY 2008, we are proposing to use the general methodology as described above, while also considering the most recent OPPS experience in approving new pass-through drugs and biologicals. Based on these estimates, we estimate pass-through spending attributable to this second group of drugs and biologicals to be about $0.6 million for CY 2008.

Therefore, we are proposing that the estimate of pass through drug and biological spending in CY 2008 incorporate both CY 2008 estimates of pass-through spending for drugs and biologicals with pass-through status in CY 2007 that would continue for CY 2008 and estimates for those drugs and biologicals projected to be approved during subsequent quarters of CY 2007 and CY 2008. The total estimate of pass-through spending for drugs and biologicals under the CY 2008 OPPS is nearly $2 million.

In the CY 2005 OPPS final rule with comment period (69 FR 65810), we indicated that we are accepting pass-through applications for new radiopharmaceuticals that are assigned a HCPCS code on or after January 1, 2005. (Prior to this date, radiopharmaceuticals were not included in the category of drugs paid under the OPPS, and, therefore, were not eligible for pass-through status.) There are no radiopharmaceuticals that were eligible for pass-through payment in CY 2005 or at the time of publication of this proposed rule in CY 2007. In addition, we have no information identifying new radiopharmaceuticals to which a HCPCS code might be assigned on or after January 1, 2008, for which pass through payment status would be sought. We also have no data regarding payment for new radiopharmaceuticals with pass-through status under the methodology that we specified in the CY 2005 OPPS final rule with comment period. However, we do not believe that pass through spending for new radiopharmaceuticals in CY 2008 will be significant enough to materially affect our estimate of total pass-through spending in CY 2008. Therefore, we are not including radiopharmaceuticals in our proposed estimate of pass through spending for CY 2008. We discuss the methodology for determining the CY 2008 payment amount for new radiopharmaceuticals without pass through status in section V.B.3.b. of this proposed rule.

In accordance with the methodology described above, we estimate that total pass-through spending for the 2 device categories and 13 drugs and biologicals that are continuing for pass-through payment into CY 2008 and those that first become eligible for pass-through status subsequent to this proposed rule in CY 2007 or during CY 2008 would equal approximately $54 million, which represents 0.15 percent of total OPPS projected payments for CY 2008.

Because we estimate that pass-through spending in CY 2008 would not amount to 2.0 percent of total projected OPPS CY 2008 spending, we are proposing to return 1.85 percent of the pass-through pool to adjust the conversion factor, as we discuss in section II.C. of this proposed rule.

VII. Proposed Payment for Brachytherapy Sources

(If you choose to comment on issues in this section, please include the caption ''OPPS: Brachytherapy'' at the beginning of your comment.)

A. Background

Section 1833(t)(2)(H) of the Act, as added by section 621(b)(2)(C) of Pub. L. 108–173, mandated the creation of separate groups of covered OPD services that classify brachytherapy devices separately from other services or groups of services. The additional groups must reflect the number, isotope, and radioactive intensity of the devices of brachytherapy furnished, including separate groups for palladium-103 and iodine-125 devices.

Section 1833(t)(16)(C) of the Act, as added by section 621(b)(1) of Pub. L. 108–173, established payment for devices of brachytherapy consisting of a seed or seeds (or radioactive source) based on a hospital's charges for the service, adjusted to cost. The period of payment under this provision is for brachytherapy sources furnished from January 1, 2004, through December 31, 2006. Under section 1833(t)(16)(C) of the Act, charges for the brachytherapy devices may not be used in determining any outlier payments under the OPPS for that period of payment. Consistent with our practice under the OPPS to exclude items paid at cost from budget neutrality consideration, these items were excluded from budget neutrality for that time period as well.

In the OPPS interim final rule with comment period published on January 6, 2004 (69 FR 827), we implemented sections 621(b)(1) and (b)(2)(C) of Pub. L. 108–173. In that rule, we stated that we would pay for the brachytherapy sources (that is, brachytherapy devices) listed in Table 4 of the interim final rule with comment period (69 FR 828) on a cost basis, as required by the statute. Since January 1, 2004, we have used status indicator ''H'' to denote nonpass through brachytherapy sources paid on a cost basis, a policy that we finalized in the CY 2005 final rule with comment period (69 FR 65838).

Furthermore, we adopted a standard policy for brachytherapy code descriptors, beginning January 1, 2005. We included ''per source'' in the HCPCS code descriptors for all those brachytherapy source descriptors for which units of payment were not already delineated.

Section 621(b)(3) of Pub. L. 108–173 required the GAO to conduct a study to determine appropriate payment amounts for devices of brachytherapy, and to submit a report on its study to the Congress and the Secretary, including recommendations on the appropriate payments for such devices. This report was due to Congress and to the Secretary no later than January 1, 2005. The GAO's final report, ''Medicare Outpatient Payments: Rates for Certain Radioactive Sources Used in Brachytherapy Could Be Set Prospectively'' (GAO–06–635), was published on July 24, 2006. We summarized and discussed the report's findings and recommendations in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68103 through 68105). The GAO report principally recommended that we use OPPS historical claims data to determine prospective payment rates for two of the most frequently used brachytherapy sources, iodine-125 and palladium-103, and also recommended that we consider using claims data for the third source studied, high dose rate (HDR) iridium-192.

The GAO report concluded that CMS could set prospective payment rates based on claims data for iodine and palladium sources, because the sources' unit costs are generally stable, both sources have identifiable unit costs that do not vary substantially and unpredictably over time, and reasonably accurate claims data are available. On the other hand, the GAO report explained that it was not able to determine a suitable methodology for paying separately for HDR iridium. The report noted that iridium is reused across multiple patients, making its unit cost more difficult to determine. However, the report also indicated that CMS has outpatient claims data from all hospitals that have used iridium and that in order to identify a suitable methodology for separate payment, CMS would be able to use these data to establish an average cost and evaluate whether that cost varies substantially and unpredictably.

In our CY 2007 annual OPPS rulemaking, we proposed and finalized a policy of prospective payment based on median costs for the 11 brachytherapy sources for which we had claims data. We based the prospective rates on median costs for each source from our CY 2005 claims data (71 FR 68102 through 71 FR 68114). We also indicated that we would assign future new HCPCS codes for new brachytherapy sources to their own APCs, with prospective payment rates set based on our consideration of external data and other relevant information regarding the expected costs of the sources to hospitals (71 FR 68112). We changed the definition of status indicator ''K'' to ensure that ''K'' appropriately describes brachytherapy sources to accommodate the use of ''K'' for prospective payment for brachytherapy sources (71 FR 68110).

Subsequent to publication of the CY 2007 OPPS/ASC final rule with comment period, section 107(a) of the MIEA–TRHCA amended section 1833(t)(16)(C) of the Act by extending the payment period for brachytherapy sources based on a hospital's charges adjusted to cost for one additional year. This requirement for cost-based payment ends after December 31, 2007. Therefore, we have continued payment for sources based on charges reduced to cost through CY 2007. We also have continued using status indicator ''H'' to denote nonpass through brachytherapy sources paid on a cost basis as a result of enactment of this provision rather than using status indicator ''K'' to denote prospective payment for nonpass-through brachytherapy sources, as finalized in the CY 2007 OPPS/ASC final rule with comment period.

Section 107(b)(1) of the MIEA–TRHCA amended section 1833(t)(2)(H) of the Act by adding a requirement for the establishment of separate payment groups for ''stranded and non-stranded'' brachytherapy devices beginning July 1, 2007. Section 107(b)(2) of the MIEA TRHCA authorized the Secretary to implement this new requirement by ''program instruction or otherwise.'' This new requirement is in addition to the requirement for separate payment groups based on the number, isotope, and radioactive intensity of brachytherapy devices previously established by section 1833(t)(2)(H) of the Act. We note that commenters on the CY 2007 proposed rule asserted that stranded sources, which they described as embedded into the stranded suture material and separated within the strand by material of an absorbable nature at specified intervals, had greater production costs than non-stranded sources (71 FR 68113 through 68114).

As a result of the statutory requirement to create separate groups for stranded and non-stranded sources as of July 1, 2007, we established several coding changes via program transmittal, effective July 1, 2007 (Program Transmittal No. 1259, dated June 1, 2007). From comments to our CY 2007 proposed rule and industry input, we are currently aware of three sources that are currently available in stranded and non-stranded forms: iodine-125; palladium-103; and cesium-131.

Therefore, in Program Transmittal No. 1259, we created six new HCPCS codes to differentiate the stranded and non-stranded versions of these three sources.

These six new HCPCS codes replace the three prior brachytherapy source HCPCS codes for iodine, palladium and cesium (C1718, C1720, and C2633, all of which are deleted as of July 1, 2007), respectively, effective July 1, 2007. In this program transmittal, we also provided specific billing instructions to hospitals on how to report stranded sources. We instructed providers, when billing for stranded sources, to bill the number of units of the appropriate source HCPCS C-code according to the number of brachytherapy sources in the strands and specifically *not* to bill as one unit per strand. If a hospital applies both stranded and non-stranded sources to a patient in a single treatment, the hospital should bill the stranded and non-stranded sources separately, according to the differentiated HCPCS codes listed in the table found in that program transmittal and included in Table 48 below. We expect that these instructions will clearly indicate how hospitals are to bill for stranded and non-stranded brachytherapy sources, and that hospital reporting of sources according to these instructions will promote accurate claims data for the various source codes in the future. In Program Transmittal No. 1259, we also added the term ''non-stranded'' to the descriptors for all sources that currently have only non-stranded versions of a source.

In Program Transmittal No. 1259, we indicated that if we receive information that any of the other sources now designated as non-stranded are marketed as a stranded source, we will create coding information for the stranded source. We also established two ''Not Otherwise Specified'' (NOS) codes for billing stranded and non-stranded sources that are not yet known to us and for which we do not have source-specific codes. If a hospital purchases an FDA-approved and marketed radioactive source consisting of a radioactive isotope (consistent with our definition of a brachytherapy source eligible for separate payment as discussed below), for which we do not yet have a separate source code established, it should bill such sources using the appropriate NOS code listed in Program Transmittal No. 1259, that is, C2698 (Brachytherapy source, stranded, not otherwise specified, per source) for stranded NOS sources, or C2699 (Brachytherapy source, non stranded, not otherwise specified, per source) for non-stranded NOS sources, which are also listed in Table 48 below. For example, if a new FDA-approved stranded source comes onto the market and there is currently only a billing code for the non stranded source, the hospital should bill the stranded source under C2698 (stranded NOS source) until a specific stranded billing code for the source is established.

In Program Transmittal No. 1259, we reiterated our longstanding policy that hospitals and other parties are invited to submit recommendations to us for new HCPCS codes to describe new sources consisting of a radioactive isotope, including a detailed rationale to support recommended new sources. We will continue to endeavor to add new brachytherapy source codes and descriptors to our systems for payment on a quarterly basis. Such recommendations should be directed to the Division of Outpatient care, Mail Stop C4–05–17, Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244.

Finally, we note that in the CY 2007 OPPS/ASC final rule with comment period, we established a definition for brachytherapy source for which separate payment under section 1833(t)(2)(H) of the Act is required (71 FR 68113). We considered the definition of ''brachytherapy source'' in the context of current medical practice and in regard to the language in section 1833(t)(2)(H) of the Act, which refers to brachytherapy sources as ''a seed or seeds (or radioactive source).'' We believed that this provision of the Act mandating separate payment refers to sources that are themselves radioactive, meaning that the source contains a radioactive isotope. Furthermore, we indicated that the statutory language is likewise clear that devices of brachytherapy paid separately must reflect the number, isotope, and radioactive intensity of such devices furnished. Accordingly, we further believed that section 1833(t)(2)(H) of the Act applies only to radioactive devices of brachytherapy. In the CY 2007 OPPS/ASC final rule with comment period, we also stated that we would not consider specific devices, beams of radiation, or equipment that do not constitute separate sources that utilize radioactive isotopes to deliver radiation to be brachytherapy sources for separate payment, as such items do not meet the statutory requirements provided in section 1833(t)(2)(H) of the Act (71 FR 68113).

B. Proposed Payments for Brachytherapy Sources

As indicated above, the provision to pay for brachytherapy sources at charges reduced to cost expires after December 31, 2007, in accordance with section 1833(t) (16)(C) of the Act, as amended by section 107(a) of the MIEA–TRHCA. However, under section 1833(t)(2)(H) of the Act, we are still required to create APC groupings that classify devices of brachytherapy separately from other services or groups of services in a manner reflecting the number, isotope, and radioactive intensity of the devices of brachytherapy furnished. In addition, section 1833(t)(2)(H) of the Act, as amended by section 107(b)(1) of the MIEA–TRHCA, requires separate payment groups based on stranded and non-stranded brachytherapy devices on or after July 1, 2007.

We are proposing to pay separately for each of the sources listed in Table 48 below on a prospective basis for CY 2008, with payment rates to be determined using the CY 2006 claims-based median cost per source for each brachytherapy device. Consistent with our policy regarding APC payments made on a prospective basis, we are proposing that the cost of brachytherapy sources be subject to the outlier provision of section 1833(t)(5) of the Act. As indicated in section II.A.2. of this proposed rule, for CY 2008 we are proposing specific prospective payment rates for brachytherapy sources, which will be subject to scaling for budget neutrality.

We believe that adopting prospective payment for brachytherapy sources is appropriate for a number of reasons. The general OPPS payment methodology is a prospective payment system using median costs based on claims data. This prospective payment methodology results in more consistent, predictable and equitable payment amounts per source across hospitals, and it prevents some of the extremely high and low payment amounts found under a charges reduced to cost methodology. The proposed prospective payment would also provide hospitals with incentives for efficiency in the provision of brachytherapy services to Medicare beneficiaries. Moreover, the proposed approach is consistent with our payment methodology for the vast majority of items and services paid under the OPPS. Indeed, section 1833(t)(2)(C) of the Act requires us to establish prospective payment rates for the OPPS system based on median costs (or mean costs if elected by the Secretary). As of CY 2007, only pass-through devices, radiopharmaceuticals, and brachytherapy sources were paid at charges reduced to cost. Based on the proposals in this CY 2008 proposed rule, only pass-through devices would continue to be paid at charges reduced to cost for CY 2008. We note that section 107(a) of the MIEA–TRHCA specifically extended the payment period for brachytherapy sources based on a

hospital's charges adjusted to cost for only one additional year, CY 2007.

Analysis of the CY 2006 claims data suggests that the estimated median cost under the proposed prospective payment approach is higher than the estimated median payment amount under a charges reduced to cost methodology for most brachytherapy sources. We note that estimated median cost under the proposed approach is calculated based on the relevant department CCR whereas payments under a charge reduced to cost methodology are calculated based on each hospital's overall CCR. As shown in Table 47, for 9 of the 11 brachytherapy HCPCS codes that were in existence in CY 2006 and had claims data, the estimated median cost based on the departmental CCR is higher than the median estimated payment under the charges reduced to cost methodology.

TABLE 47.—COMPARISON OF CY 2006 ESTIMATED MEDIAN PAYMENTS UNDER CHARGES REDUCED TO COSTS AND ESTIMATED MEDIAN COSTS

CY 2006 HCPCS code	CY 2006 short descriptor	CY 2006 median estimated payment charges reduced to cost (based on overall CCR)	CY 2006 median cost (based on departmental CCR)
C1716	Brachytx source, Gold 198	$29.30	$31.56
C1717	Brachytx source, HDR Ir-192	143.20	171.26
C1718	Brachytx source, Iodine 125	31.41	37.71
C1719	Brachytx source,Non-HDR Ir-192	18.75	56.69
C1720	Brachytx source, Palladium 103	46.90	55.05
C2616	Brachytx source, Yttrium-90	10,811.30	11,796.07
C2632	Brachytx sol, I–125, per mCi	21.80	28.27
C2633	Brachytx source, Cesium-131	63.67	63.61
C2634	Brachytx source, HA, I–125	26.03	29.56
C2635	Brachytx source, HA, P–103	40.85	46.48
C2636	Brachytx linear source, P–103	56.39	36.64

Note: The short descriptions for some of the HCPCS codes in this table were revised after CY 2006. See Table 48 for the current long descriptions.

With the proposed adoption of prospective payment for brachytherapy sources, there would be opportunities for hospitals to receive additional payments under certain circumstances through the outlier provisions and the 7.1 percent rural adjustment. As noted previously, consistent with our policy regarding APC payments made on a prospective basis, we are proposing that the cost of brachytherapy sources be subject to the outlier provision of section 1833(t)(5) of the Act. Therefore, the source could receive an outlier payment, if the costs of furnishing brachytherapy sources exceed the outlier threshold. Also, as noted in section II.F. of this proposed rule, as a result of our CY 2008 proposal to pay prospectively for brachytherapy sources, we also are proposing to include brachytherapy payments in the group of services eligible for the 7.1 percent payment increase for rural SCHs, including EACHs.

We are proposing a payment methodology for separately paid brachytherapy sources for CY 2008 based upon their median unit costs calculated using CY 2006 claims data. Because we are required to create separate APC groups for stranded and non stranded sources and because our CY 2006 billing codes do not differentiate stranded and non–stranded sources, we are proposing to make certain assumptions when we estimate the median costs for stranded and non–stranded (low activity) iodine–125, palladium–103, and cesium–131 based on our CY 2006 aggregate claims data. As stated above, commenters to our CY 2007 proposed rule stated that the cost of stranded iodine, palladium and cesium sources are higher than non-stranded versions of these sources but provided no data. Given the reported cost differences between stranded and non-stranded sources and the statutory requirement that we establish separate payment groups for stranded and non-stranded sources, we believe it is appropriate to establish different stranded and non-stranded payment rates for iodine-125, palladium-103, and cesium-131 sources. However, in order to establish separate stranded and non-stranded payment rates for these three sources, we are proposing to make the following assumptions in our calculation of their median costs. Assuming that the reportedly lower cost non-stranded sources would be unlikely to be in the top 20 percent of the cost distribution in our aggregate (stranded and non-stranded) CY 2006 claims data, we are proposing to calculate the median cost for these 3 non-stranded sources based on the bottom 80 percent of the cost distribution in our aggregate claims data for each source. Likewise, assuming that the reportedly higher cost stranded sources would be unlikely to be in the bottom 20 percent of the cost distribution in our aggregate CY 2006 claims data, we are proposing to calculate the median cost for these 3 stranded sources based on the top 80 percent of the cost distribution for our aggregate data. This approach to calculating median costs for stranded and non-stranded iodine-125, palladium-103, and cesium-131 sources results in proposed Medicare payment rates based on the 60th percentile of our aggregate data for stranded sources and the 40th percentile of our aggregate data for non-stranded sources, which, after examining the range of our cost data for these sources, appear to provide a reasonable cost differential between stranded and non-stranded sources, until we have claims data reported separately for stranded and non-stranded sources.

We are proposing this approach for stranded and non-stranded iodine-125, palladium-103, and cesium-131 sources as a transitional measure, until we have sufficient claims data for separately coded stranded and non-stranded sources upon which to calculate the median costs for these sources specifically. (The first partial year claims data for separately coded stranded and non-stranded sources will be available in CY 2007 claims data for ratesetting in CY 2009.) This methodology has the benefits of a prospective payment methodology discussed above and complies with the

requirements of the MIEA–TRHCA to recognize separate payment for stranded and non-stranded sources.

Furthermore, we are proposing to pay the two NOS codes, C2698 and C2699, based on a rate equal to the lowest stranded or non-stranded prospective payment rate for such sources, respectively, paid on a per source basis (as opposed, for example, to per mci). This payment methodology for NOS sources provides payment to a hospital for new sources, while encouraging interested parties to quickly bring new sources to our attention, so specific coding and payment can be established. As noted earlier, we may establish new brachytherapy source codes on a quarterly basis.

Because brachytherapy sources will no longer be paid on the basis of their charges reduced to cost after December 31, 2007, we are proposing to discontinue our use of payment status indicator ''H'' for APCs assigned to brachytherapy sources. For CY 2008, we are proposing to use status indicator ''K'' for all brachytherapy source APCs. As indicated earlier, the definition of status indicator ''K'' was changed for CY 2007 to accommodate prospective payment for brachytherapy sources.

For CY 2008, we also are proposing to implement the policy we established in the CY 2007 OPPS/ASC final rule with comment period (which was superseded by section 107 of the MIEA–TRHCA) regarding payment for new brachytherapy sources for which we have no claims data. As discussed above, we are proposing to assign future new HCPCS codes for new brachytherapy sources to their own APCs, with prospective payment rates set based on our consideration of external data and other relevant information regarding the expected costs of the sources to hospitals. Because we are proposing to pay prospectively for brachytherapy sources beginning in CY 2008, we are proposing to implement this policy beginning in CY 2008.

There is currently one brachytherapy source, Ytterbium-169 (HCPCS C2637, Brachytherapy Source, Ytterbium-169, per source), which has its own HCPCS code, but for which we believe we lack claims data on its costs. In the CY 2007 OPPS/ASC proposed rule (71 FR 49598 through 49599), we indicated that it was our understanding that Ytterbium-169 had not yet been marketed, and furthermore that we had no CY 2005 claims data, external data, or other information on its pricing on which to base its payment rate for CY 2007. In response to the CY 2007 proposed rule, we received no cost data or other information that we could use to establish an informed prospective payment rate for Ytterbium-169. Therefore, in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68112), we finalized a policy of assigning HCPCS code C2637, Ytterbium-169, with the nonpayable status indicator ''B'' and indicated that if we later receive relevant information, we could establish a payable status indicator and appropriate payment rate for the Ytterbium source in a future OPPS quarterly update. This policy was superceded by section 107(a) of the MIEA–TRHCA, which required payment for brachytherapy sources in CY 2007 based on charges reduced to costs. For this CY 2008 proposed rule, we believe that we continue to lack claims data or other information on the costs of Ytterbium-169 on which to base an informed prospective payment rate. Our CY 2006 claims data show three claims for HCPCS code C2637, Ytterbium-169, with a median cost of $718.08. We believe these three claims may be incorrectly coded claims that do not represent claims for Ytterbium-169, as the manufacturer of Ytterbium- commented on the CY 2007 OPPS proposed rule that Ytterbium-169 would first become available for market in 2007. Consequently, at this time, we are proposing to not recognize HCPCS code C2637, and again we are assigning it to status indicator ''B'' under the OPPS for CY 2008. However, if in public comments to this proposed rule or later in CY 2007 or CY 2008, we receive relevant and reliable information on the hospital cost for Ytterbium-169 and information that this source is being marketed, we would propose to establish a prospective payment rate for Ytterbium-169 in the CY 2008 final rule or in a quarterly OPPS update, respectively.

Table 48 includes a complete listing of the HCPCS codes, long descriptors, and APC assignments that we currently use for brachytherapy sources paid under the OPPS as of July 1, 2007, and the status indicators, estimated median costs, and payment rates that we are proposing for CY 2008. We note that some of the HCPCS codes for which we are proposing payment rates for CY 2008 are not shown in Addendum B of this proposed rule because that addendum is based on HCPCS codes effective as of April 2007. As indicated earlier, there are some brachytherapy source HCPCS codes that were added as of July 1, 2007. While these HCPCS codes are not shown in Addendum B, the proposed payment rates for all brachytherapy sources are shown in Table 48.

While we are inviting public comment on all aspects of this CY 2008 proposal, we particularly encourage comment on our proposed median costs estimates for stranded and non-stranded iodine-125, palladium-103, and cesium-131, including the submission of any available information or data on cost differences between stranded and non stranded sources. We also are interested in receiving information regarding the historical and current relative market share for stranded versus non-stranded sources, particularly as used in the care of Medicare beneficiaries and with respect to brachytherapy treatments for different clinical conditions.

TABLE 48.—PROPOSED SEPARATELY PAYABLE BRACHYTHERAPY SOURCES FOR CY 2008

HCPCS code	Long descriptor	APC	Proposed CY 2008 median cost	Proposed CY 2008 payment rate	Proposed CY 2008 status indicator
A9527	Iodine I–125, sodium iodide solution, therapeutic, per millicurie	2632	$28.27	$28.62	K
C1716	Brachytherapy source, non-stranded, Gold-198, per source	1716	31.56	31.95	K
C1717	Brachytherapy source, non-stranded, High Dose Rate Iridium-192, per source.	1717	171.26	173.40	K
C1719	Brachytherapy source, non-stranded, Non-High Dose Rate Iridium-192, per source.	1719	56.69	57.40	K
C2616	Brachytherapy source, non-stranded, Yttrium-90, per source	2616	11,796.07	11,943.79	K
C2634	Brachytherapy source, non-stranded, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source.	2634	29.56	29.93	K

TABLE 48.—PROPOSED SEPARATELY PAYABLE BRACHYTHERAPY SOURCES FOR CY 2008—Continued

HCPCS code	Long descriptor	APC	Proposed CY 2008 median cost	Proposed CY 2008 payment rate	Proposed CY 2008 status indicator
C2635	Brachytherapy source, non-stranded, High Activity, Palladium-103, greater than 2.2 mCi (NIST), per source.	2635	46.48	47.06	K
C2636	Brachytherapy linear source, non-stranded, Palladium-103, per 1MM	2636	36.64	37.09	K
C2637	Brachytherapy source, non-stranded, Ytterbium-169, per source	2637	N/A	N/A	B
C2638	Brachytherapy source, stranded, Iodine-125, per source	2638	*42.33	42.86	K
C2639	Brachytherapy source, non-stranded, Iodine-125, per source	2639	**31.51	31.91	K
C2640	Brachytherapy source, stranded, Palladium-103, per source	2640	*61.47	62.24	K
C2641	Brachytherapy source, non-stranded, Palladium-103, per source	2641	**44.73	45.29	K
C2642	Brachytherapy source, stranded, Cesium-131, per source	2642	*96.52	97.72	K
C2643	Brachytherapy source, non-stranded, Cesium-131, per source	2643	**50.72	51.35	K
C2698	Brachytherapy source, stranded, not otherwise specified, per source	2698	42.33	42.86	K
C2699	Brachytherapy source, non-stranded, not otherwise specified, per source ...	2699	29.56	29.93	K

* Estimated median cost for stranded version is based on the 60th percentile of the aggregate (stranded and non stranded) claims data for this source.

** Estimated median cost for non-stranded version is based on the 40th percentile of the aggregate (stranded and non stranded) claims data for this source.

VIII. Proposed OPPS Drug Administration Coding and Payment

(If you choose to comment on issues in this section, please include the caption ''OPPS: Drug Administration'' at the beginning of your comment.)

A. Background

In CY 2005, in response to the recommendations made by commenters and the hospital industry, OPPS transitioned to the use of CPT codes for drug administration services. (For information on coding for drug administration services prior to CY 2005, see 71 FR 68115.) These CPT codes allowed for more specific reporting of services, especially regarding the number of hours for an infusion, and provided consistency in coding between Medicare and other payers. However, at that time, we did not have any data to revise the CY 2005 per-visit APC payment structure for infusion services. In order to collect data for future ratesetting purposes, we implemented claims processing logic that collapsed payments for drug administration services and paid a single APC amount for those services for each visit, unless a modifier was used to identify drug administration services provided in a separate encounter on the same day. Hospitals were instructed to bill all applicable CPT codes for drug administration services provided in a HOPD, without regard to whether or not the CPT code would receive a separate APC payment during OPPS claims processing.

While hospitals just began adopting CPT codes for outpatient drug administration services in CY 2005, physicians paid under the MPFS were using HCPCS G-codes in CY 2005 to report office-based drug administration services. These G-codes were developed in anticipation of substantial revisions to the drug administration CPT codes by the CPT Editorial Panel that were expected for CY 2006.

In CY 2006, as anticipated, the CPT Editorial Panel revised its coding structure for drug administration services, incorporating new concepts such as initial, sequential, and concurrent services into a structure that previously distinguished services based on type of administration (chemotherapy/nonchemotherapy), method of administration (injection/infusion/push), and for infusion services, first hour and additional hours. For CY 2006, we implemented 20 of the 33 CY 2006 drug administration CPT codes that did not reflect the concepts of initial, sequential, and concurrent services, and we created 6 new HCPCS C-codes that generally paralleled the CY 2005 CPT codes for the same services. We chose not to implement the full set of CY 2006 CPT codes because of our concerns regarding the interface between the complex claims processing logic required for correct payments and hospitals' challenges in correctly coding their claims to receive accurate payments for these services.

For CY 2007, as a result of comments to our proposed rule and feedback from the hospital community and the APC Panel, we implemented the full set of CPT codes, including the concepts of initial, sequential and concurrent. In addition, the CY 2007 update process offered us the first opportunity to consider data gathered from the use of CY 2005 CPT codes for purposes of ratesetting. For CY 2007, we used CY 2005 claims data to implement a six-level APC structure for drug administration services. We assigned all CY 2007 HCPCS codes for drug administration services to six new drug administration APCs (as listed in Table 34 of the CY 2007 OPPS/ASC final rule with comment period), with payment rates based on median costs for the APCs as calculated from CY 2005 claims data. In that final rule, we provided a crosswalk that illustrated how we performed our annual payment rate update methodology for these services using CY 2005 data.

As indicated in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68122), because the newly recognized CPT codes discriminate among services more specifically than the CY 2006 C-codes, as was the case when the OPPS transitioned from more general Q-codes to more specific CPT codes for the reporting of drug administration services in CY 2005, for a period of 2 years drug administration services will be paid based on the costs of their predecessor HCPCS codes until updated data are available for review.

B. Proposed Coding and Payment for Drug Administration Services

During the March 2007 APC Panel meeting, the APC Panel recommended that CMS pay separately for CPT code 90768 (Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (list separately in addition to code for primary procedure)) at the same rate as CPT code 90767 (Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion, up to 1 hour (list

separately in addition to code for primary procedure)).

As discussed in section II.A.4. of this proposed rule, in deciding whether to package a service or pay for it separately, we consider a variety of factors, including whether the service is normally provided separately or in conjunction with other services; how likely it is for the costs of the packaged code to be appropriately mapped to the separately payable codes with which it was performed; and whether the expected cost of the service is relatively low. As we discussed in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68122), CPT code 90768 was first introduced in CY 2007 and consistent with our established ratesetting methodology, we do not anticipate OPPS hospital claims data from CY 2007 to be available for ratesetting purposes until CY 2009. In addition, as the services identified with CPT code 90768 were provided in previous years, it is our determination that these costs are already represented in our currently available hospital claims data. Payment for these services was provided in previous years through the billing of more general drug administration codes. Although more exhaustive codes for drug administration services are now available, this does not indicate that these services did not receive OPPS payments in previous years.

As data are not available for drug administration services for purposes of CY 2008 ratesetting, and as we believe that the costs for the drug administration services identified by CPT code 90768 are included in our hospital claims data used for ratesetting purposes, we are not accepting the APC Panel's recommendation to provide a separate APC payment for this service. Furthermore, we note that in section II.A.4. of this proposed rule, we have proposed to expand packaging of certain (nondrug administration) services. We believe that continuing to package CPT code 90786 is consistent with these broader efforts.

For CY 2008, we examined CY 2006 claims data available for this proposed rule and continue to believe the CY 2007 drug administration APC configuration reflects clinically and resource homogeneous groupings of procedures. We note that there is a violation of the 2 times rule in APC 0438 (Level III Drug Administration) as proposed for CY 2008. The violation is related to the comparatively low median cost of CPT code 90773 (Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intra-arterial) for which we have a significantly greater number of CY 2006 single claims available for ratesetting than previous years. The CY 2005 predecessor code for this service, CPT code 90783 (Therapeutic, prophylactic or diagnostic injection (specify material injected); intra-arterial), had a higher median cost that was more similar to the costs of other services also assigned to APC 0438. We continue to believe that this intra-arterial injection procedure is similar from both clinical and hospital resource perspectives to the related intravenous push injection procedures that are assigned to the same clinical APC and, therefore, we are proposing to except APC 0438 from the 2 times rule for CY 2008. We continue to ask hospitals to report all CPT drug administration codes, and we expect hospitals to report CPT codes consistently with CPT coding guidelines and applicable instructions.

We note that in this section of the CY 2007 proposed rule we discussed IVIG preadministration-related services; for CY 2008, this topic is discussed in section III.C.2.b. of this proposed rule.

IX. Proposed Hospital Coding and Payments for Visits

A. Background

Currently, CMS instructs hospitals to use the CY 2007 CPT codes, as well as six HCPCS codes that became effective January 1, 2007, to report clinic and emergency department visits and critical care services on claims paid under the OPPS. The codes are listed below in Table 49.

TABLE 49.—CY 2007 CPT EVALUATION AND MANAGEMENT (E/M) AND LEVEL II HCPCS CODES USED TO REPORT CLINIC AND EMERGENCY DEPARTMENT VISITS AND CRITICAL CARE SERVICES

HCPCS code	Descriptor
	Clinic Visit HCPCS Codes
99201	Office or other outpatient visit for the evaluation and management of a new patient (Level 1).
99202	Office or other outpatient visit for the evaluation and management of a new patient (Level 2).
99203	Office or other outpatient visit for the evaluation and management of a new patient (Level 3).
99204	Office or other outpatient visit for the evaluation and management of a new patient (Level 4).
99205	Office or other outpatient visit for the evaluation and management of a new patient (Level 5).
99211	Office or other outpatient visit for the evaluation and management of an established patient (Level 1).
99212	Office or other outpatient visit for the evaluation and management of an established patient (Level 2).
99213	Office or other outpatient visit for the evaluation and management of an established patient (Level 3).
99214	Office or other outpatient visit for the evaluation and management of an established patient (Level 4).
99215	Office or other outpatient visit for the evaluation and management of an established patient (Level 5).
99241	Office consultation for a new or established patient (Level 1).
99242	Office consultation for a new or established patient (Level 2).
99243	Office consultation for a new or established patient (Level 3).
99244	Office consultation for a new or established patient (Level 4).
99245	Office consultation for a new or established patient (Level 5).
	Emergency Department Visit HCPCS Codes
99281	Emergency department visit for the evaluation and management of a patient (Level 1).
99282	Emergency department visit for the evaluation and management of a patient (Level 2).
99283	Emergency department visit for the evaluation and management of a patient (Level 3).
99284	Emergency department visit for the evaluation and management of a patient (Level 4).
99285	Emergency department visit for the evaluation and management of a patient (Level 5).
G0380	Type B emergency department visit (Level 1).
G0381	Type B emergency department visit (Level 2).
G0382	Type B emergency department visit (Level 3).

TABLE 49.—CY 2007 CPT EVALUATION AND MANAGEMENT (E/M) AND LEVEL II HCPCS CODES USED TO REPORT CLINIC AND EMERGENCY DEPARTMENT VISITS AND CRITICAL CARE SERVICES—Continued

HCPCS code	Descriptor
G0383	Type B emergency department visit (Level 4).
G0384	Type B emergency department visit (Level 5).
	Critical Care Services HCPCS Codes
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30–74 minutes.
99292	Each additional 30 minutes.
G0390	Trauma response associated with hospital critical care services.

Presently, there are three types of visit codes to describe three types of services: Clinic visits, emergency department visits, and critical care services. CPT indicates that office or other outpatient visit codes are used to report E/M services provided in the physician's office or in an outpatient or other ambulatory facility. For OPPS purposes, we refer to these as clinic visit codes. CPT also indicates that emergency department visit codes are used to report E/M services provided in the emergency department, defined as an ''organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day.'' For OPPS purposes, we refer to these as emergency department visit codes that specifically apply to the reporting of visits to Type A emergency departments on or after January 1, 2007, as discussed in further detail later in this section. We established five new Level II HCPCS codes to report visits to Type B emergency departments beginning in CY 2007 because there are currently no CPT codes that fully describe services provided in this type of facility. CPT defines critical care services as the ''direct delivery by a physician(s) of medical care for a critically ill or critically injured patient.'' It also states that ''critical care is usually, but not always, given in a critical care area, such as * * * the emergency care facility.'' In addition to reporting critical care services, hospitals may utilize the new HCPCS code G0390 for the reporting of a trauma response in association with critical care services for the CY 2007 OPPS.

The majority of CPT code descriptors are applicable to both physician and facility resources associated with specific services. However, we have acknowledged from the beginning of the OPPS that we believe that CPT E/M codes were defined to reflect the activities of physicians and do not necessarily describe well the range and mix of services provided by hospitals during visits of clinic and emergency department patients and critical care encounters. In the April 7, 2000 OPPS final rule with comment period (65 FR 18434), we instructed hospitals to report facility resources for clinic and emergency department visits using CPT E/M codes and to develop internal hospital guidelines to determine what level of visit to report for each patient. While awaiting the development of a national set of facility-specific codes and guidelines, we have advised hospitals that each hospital's internal guidelines should follow the intent of the CPT code descriptors, in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the codes.

Critical care services are considered to be outpatient visits, and our current payment policy for trauma activation ties separate payment to the reporting of hospital critical care services. We are not proposing to change our OPPS payment policy for critical care services for CY 2008, and our CY 2008 proposal for payment of trauma activation is described in section II.A.4. of this proposed rule. Therefore, we will no longer include references to critical care services in the sections below that describe hospital outpatient visits.

B. Proposed Policies for Hospital Outpatient Visits

1. Clinic Visits: New and Established Patient Visits and Consultations

As discussed earlier, the majority of all CPT code descriptors are applicable to both physician and facility resources associated with specific services. However, we believe that CPT E/M codes were defined to reflect the activities of physicians and do not describe well the range and mix of services provided by hospitals during visits of clinic and emergency department patients. While awaiting the development of a national set of guidelines, we have advised hospitals that each hospital's internal guidelines should follow the intent of the CPT code descriptors, in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the codes. In the CY 2007 OPPS/ASC proposed rule (71 FR 49607), we proposed to establish five new codes to replace hospitals' reporting of the CPT clinic visit E/M codes for new and established patients listed in Table 49 above. In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68127 through 68128), we specified that we would not create new codes to replace existing CPT E/M codes for reporting hospital visits until national guidelines are developed, in response to commenters who were concerned about implementing hospital-specific Level II HCPCS codes without national guidelines. We also discussed our intention to reconsider whether G-codes would be appropriate for the OPPS once national guidelines are established.

In that same rule (71 FR 68138), we finalized our proposal to pay clinic visits at five payment rates, rather than three payment rates. Prior to CY 2007, under the OPPS, outpatient visits provided by hospitals were paid at three payment levels for clinic visits, even though hospitals reported five resource-based coding levels of clinic visits using CPT E/M codes. Because the three payment rates for clinic visits were based on five levels of CPT codes, in general the two lowest levels of CPT codes (Levels 1 and 2) were assigned to the low level visit APC and the two highest levels of CPT codes (Levels 4 and 5) were assigned to the high level visit APC, while the single middle level CPT code (Level 3) was assigned to the mid-level visit APC. Historical hospital claims data have generally reflected significantly different median costs for the two levels of services assigned to the low and high level visit APCs. We noted that payment at only three levels may not be the most accurate method of payment for those very common

hospital levels of visits that clearly demonstrated differential hospital resources. Consequently, for the CY 2007 OPPS, we mapped the data from the CY 2005 CPT E/M codes and other HCPCS codes assigned previously to the three clinic visit APCs to five new clinic visit APCs to develop median costs for these APCs. We mapped the CPT E/M codes and other HCPCS codes to the clinic visit APCs based on their median costs and clinical homogeneity considerations. Table 50, which includes the median costs based on CY 2006 claims data processed through December 31, 2006, displays the HCPCS code and APC median costs at the five payment levels that we are proposing for the CY 2008 OPPS.

TABLE 50.—PROPOSED ASSIGNMENT OF CLAIMS DATA FROM CY 2006 CPT E/M AND LEVEL II HCPCS CODES TO VISIT APCS FOR CY 2008

CY 2008 APC title	CY 2008 APC	Proposed CY 2008 APC median	APC service frequency (million)	HCPCS code	Short descriptor
Level 1 Hospital Clinic Visits	0604	$52.72	3.8	92012	Eye exam established pat.
				99201	Office/outpatient visit, new (Level 1).
				99211	Office/outpatient visit, est (Level 1).
				99241	Office consultation (Level 1).
				G0101	CA screen; pelvic/breast exam.
				G0245	Initial foot exam pt lops.
				G0379	Direct admit hospital observ.
Level 2 Hospital Clinic Visits	0605	$63.01	7.3	90862	Medication management.
				92002	Eye exam, new patient.
				92014	Eye exam and treatment.
				99202	Office/outpatient visit, new (Level 2).
				99212	Office/outpatient visit, est (Level 2).
				99213	Office/outpatient visit, est (Level 3).
				99242	Office Consultation (Level 2).
				99243	Office Consultation (Level 3).
				99431	Initial care, normal newborn.
				G0246	Followup eval of foot pt lop.
				G0344	Initial preventive exam.
				M0064	Visit for drug monitoring.
Level 3 Hospital Clinic Visits	0606	$85.96	2.9	92004	Eye exam, new patient.
				99203	Office/outpatient visit, new (Level 3).
				99214	Office/outpatient visit, est (Level 4).
				99244	Office consultation (Level 4).
Level 4 Hospital Clinic Visits	0607	$108.08	.8	99204	Office/outpatient visit, new (Level 4).
				99215	Office/outpatient visit, est (Level 5).
				99245	Office consultation (Level 5).
Level 5 Hospital Clinic Visits	0608	$138.88	.08	99205	Office/outpatient visit, new (Level 5).
				G0175	OPPS service, sched team conf.

In the CY 2007 OPPS/ASC proposed rule (71 FR 49617), we solicited comment as to whether a distinction between new and established visits was necessary because we were planning to transition to G-codes and did not want to unnecessarily create codes for both new and established patients. The AMA defines an established patient as ''one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past 3 years.'' To apply this definition to hospital visits, we stated in the April 7, 2000 final rule with comment period (65 FR 18451) that the meanings of ''new'' and ''established'' pertain to whether or not the patient already has a hospital medical record number. If the patient has a hospital medical record that was created within the past 3 years, that patient is considered an established patient to the hospital. The same patient could be ''new'' to the physician but an ''established'' patient to the hospital. The opposite could be true if the physician has a longstanding relationship with the patient, in which case the patient would be an ''established'' patient with respect to the physician and a ''new'' patient to the hospital.

Some commenters who responded to prior OPPS rules have stated that the hospital resources used for new and established patients to provide a specific level of service are very similar, and that it is unnecessary and burdensome from a coding perspective to distinguish between the two types of visits. On the other hand, other commenters have noted, and CY 2005 and CY 2006 claims data have shown, that it may be appropriate to continue using different codes for new and established patients because of the observed median cost differences in the claims data. In addition, during the March 2007 APC Panel meeting, the Observation and Visit Subcommittee of the APC Panel discussed whether the coding distinction between new and established patient visits is necessary. Ultimately, the APC Panel recommended that CMS eliminate the ''new'' and ''established'' patient distinctions in the reporting of hospital clinic visits. During its discussion, the APC Panel suggested that hospitals bill the appropriate level clinic visit code according to the resources expended while treating the beneficiary, based on each hospital's internal guidelines. The APC Panel also suggested that each hospital's internal guidelines reflect resource cost differences (if a difference exists) between new and established patients. For example, a visit that involves certain interventions may be coded as Level 3 for a new patient and Level 2 for an established patient. The APC Panel also made another recommendation which is contingent upon CMS adopting its recommendation

to eliminate the new and established patient distinction reporting requirement. That is, the APC Panel further recommended that CMS map each of the five levels of outpatient clinic visit codes (which do not distinguish between new and established patients) to five separate APCs, thereby paying at five payment rates. For example, the APC Panel recommended mapping the Level 1 patient visit to the Level 1 Clinic Visit APC, mapping the Level 2 patient visit to the Level 2 Clinic Visit APC, and mapping the Level 3 patient visit to the Level 3 Clinic Visit APC. In the current and proposed clinic visit APC configuration, as indicated in Table 50, the APC level assignment does not always correspond to the visit level described by each code. For example, CPT 99213 is a Level 3 clinic visit code for an established patient, which would seem to logically map to the Level 3 Clinic Visit APC. However, because CPT 99213 has a proposed median cost of $64.73, we mapped this code to the Level 2 Clinic Visit APC, which has a proposed median cost of $63.01. The APC Panel indicated that its recommendation would ensure that each visit level would receive its own payment rate, rather than both the Level 2 and 3 patient visit codes receiving the same payment rate.

During CY 2006 and earlier, there was no payment difference between new and established patient visits of the same level, as both were always mapped to the same clinical APC. However, hospital claims data regarding the median costs of the specific CPT clinic visit E/M codes consistently indicate that new patients are more resource-intensive than established patients across all visit levels. The CY 2006 claims data confirm that the cost difference between new and established patient visits increases as the visit level increases.

In both the CY 2007 OPPS/ASC proposed and final rules (71 FR 49617 and 71 FR 68128), respectively, we encouraged public comment that discussed the potential differences in hospital clinic resource consumption between new and established patient visits. We received only a few comments related to this distinction in response to the CY 2007 OPPS/ASC proposed rule and even fewer comments in response to the CY 2007 OPPS/ASC final rule with comment period. For CY 2008, because hospitals will be reporting CPT E/M codes for clinic visits, which distinguish between new and established patients, and because we see meaningful and consistent cost differences between visits for new and established patients, we are proposing to continue to recognize the CPT codes for new and established patient clinic visits under the OPPS, consistent with their CPT code descriptors. Further, we are not adopting the recommendation of the APC Panel to eliminate this differentiation for the reasons noted. We are proposing to reexamine whether the coding distinction between new and established patient visits is necessary as we consider national guidelines. We continue to encourage public comment about hospitals' experiences with assigning visit levels to new and established patients according to their own internal guidelines.

Table 51 lists the CY 2008 proposed median costs of new and established patient clinic visit codes which are based on CY 2006 claims data processed through December 31, 2006.

TABLE 51.—PROPOSED CY 2008 MEDIAN COSTS OF NEW AND ESTABLISHED PATIENT VISIT CPT CODES

Clinic visit level	Proposed CY 2008 new patient visit median cost	Proposed CY 2008 established patient visit median cost
Level 1	$56.08	$50.70
Level 2	63.18	58.84
Level 3	74.99	64.73
Level 4	109.12	84.17
Level 5	138.06	102.89

As noted above, the APC Panel also recommended that CMS map each level of patient visits to its corresponding APC, thereby paying at five payment levels. The APC Panel members noted that this mapping system would eliminate any payment incentive to distinguish between new and established patients but would ensure five payment levels.

For CY 2008, we are proposing to map the clinic visit codes for new patients to the five Clinic Visit APCs, one code to each level, based on the hospital resources observed in historical claims data as they are mapped for CY 2007 and in accordance with the APC Panel's recommendation. However, for CY 2008, we are proposing to maintain the CY 2007 mapping for the clinic visit codes for established patients. As indicated in Table 51 above, we are proposing to map the Level 1 established patient visit to the Level 1 Clinic Visit APC, which results in the Level 1 Clinic Visit APC containing both the Level 1 new and established patient visit codes, in accordance with the APC Panel recommendation. Similarly, we are proposing to map both the Level 2 new and established patient visit codes to the Level 2 Clinic Visit APC. However, we also are proposing to map the Level 3 established patient visit code to the Level 2 Clinic Visit APC because our cost data indicate that the costs associated with a Level 3 established patient visit most closely resemble the costs associated with the Level 2 Clinic Visit APC and the Level 2 new and established patient visits. If CPT code 99213 for an established Level 3 clinic visit was mapped to the Level 3 Clinic Visit APC, which has a proposed median cost of $85.96, we would significantly overpay CPT 99213 every time it was billed. We are proposing to map the Level 3 new patient visit to the Level 3 Clinic Visit APC, consistent with the APC Panel recommendation. We are proposing to map the Level 4 established patient visit to the Level 3 Clinic Visit APC and the Level 5 established patient visit to the Level 4 Clinic Visit APC. The only CPT E/M code that we are proposing to map to the Level 5 Clinic Visit APC for CY 2008 payment is the Level 5 new patient visit. These APC assignments that we are proposing for CY 2008, consistent with the CY 2007 APC assignments, were determined for each HCPCS code based on CY 2008 proposed rule median cost data and clinical considerations. We are not persuaded by the APC Panel recommendation, which would require us to ignore significant cost differences based on resource data that are clinically consistent and instead map each code to its corresponding level APC.

Historical cost data for these frequently provided services are extremely consistent. In addition, from a clinical perspective, we believe that in some cases, in the context of a five level structure for visit reporting, the hospital resources required for a given visit level may only be slightly different from those used for a visit that is one level higher or lower. For example, it is not surprising that particularly among visits for established patients in the middle of the range, such as a Level 2 established patient visit and a Level 3 established patient visit, the hospital resource costs calculated from claims data are similar because these patients would often utilize reasonably comparable hospital resources.

We performed data analyses to determine how the median costs of the clinic visit APCs would change if we fully adopted the APC Panel's recommendation and mapped all of the new and established patient visit codes to the corresponding level of clinic visit APC. Our results are shown in Table 52.

TABLE 52.—CY 2008 MEDIAN COST COMPARISON OF CLINIC VISIT APCS IN TWO DIFFERENT CONFIGURATIONS

APC	APC median cost in the proposed CY 2008 configuration	APC median cost in the recommended APC panel configuration
Level 1 Clinic Visit	$53	$53
Level 2 Clinic Visit	63	60
Level 3 Clinic Visit	86	66
Level 4 Clinic Visit	108	88
Level 5 Clinic Visit	139	110

The APC median cost distribution does not improve when mapping each new and established patient visit code to its corresponding level of APC. In fact, the APC Panel's recommended configuration results in lower payment rates for the Levels 2 through 5 Clinic Visit APCs, and an identical payment rate for the Level 1 Clinic Visit APC because our proposed mapping and the APC Panel's recommendation for this APC are the same. In general, under the OPPS, we rely on resource cost data calculated from hospital claims data to determine appropriate APC mapping of HCPCS codes and to set payment rates. While we acknowledge that it might be more predictable for hospitals to receive the same payment rate for new and established patients of the same visit level, robust cost data clearly indicate that this would not be the most accurate payment method. Historical hospital cost data indicate that new patient visits are costlier than established patient visits of the same level, a finding that is consistent with the perspective of our medical advisors. Because we are proposing that hospitals continue to use CPT E/M codes to report clinic visits for CY 2008, including separate codes for new and established patients, we see no reason to adjust the clinic visit APC configurations. Therefore, for CY 2008, we are proposing to map the CPT E/M codes and other Level II HCPCS codes to the Clinic Visit APCs as configured in Table 50 and not fully adopt the APC Panel's recommendation to map each code to its corresponding APC level. We will reexamine using the claims data for CY 2009 OPPS ratesetting and will also reconsider whether this mapping is appropriate in the future as we continue to work on developing national guidelines.

The APC Panel also recommended that CMS not recognize the CPT consultation codes: CPT 99241 (Office consultation for a new or established patient (Level 1)), CPT 99242 (Office consultation for a new or established patient (Level 2)), CPT 99243 (Office consultation for a new or established patient (Level 3)), CPT 99244 (Office consultation for a new or established patient (Level 4)), and CPT 99245 (Office consultation for a new or established patient (Level 5)). The APC Panel recommended that CMS instruct hospitals to build consultation services into their internal hospital guidelines related to reporting outpatient clinic visit levels based on the complexity and resources used for these outpatient visits.

CPT defines a consultation as ''a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source.'' CPT recognizes two subcategories of consultations, specifically office or other outpatient and inpatient consultations, although only the office consultations would be applicable under the OPPS. Nevertheless, the differentiation of consultations from new and established patient clinic visits would appear to be clinically unnecessary under the OPPS in order to provide proper OPPS payment for hospital outpatient visits.

In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68128), we noted our belief that it may be unnecessary for hospitals to report consultation CPT codes if either a new or established patient visit code accurately describes the service provided. We stated that we were particularly interested in hearing whether consultation codes are a useful measure of hospital resource use under the OPPS, and how consultation visits are different, from a hospital resource perspective, from new patient visits and established patient visits. We observed that we did not want to create an incentive for hospitals to bill a consultation code instead of a new or established patient code because we did not believe that consultation codes necessarily reflected different resource utilization than either new or established patient codes (71 FR 68138). Therefore, for CY 2007, we finalized a payment policy that assigned the consultation code to the same clinical APC as the established patient visit code for each level of service. For example, CPT code 99242, the Level 2 consultation code is mapped to APC 0605 (Level 2 Clinic Visits), which is where CPT code 99212, the Level 2 established patient code, is mapped for CY 2007. Moving the consultation codes to the same APC as the corresponding established patient visit code eliminated any incentive for hospitals to bill a consultation code instead of a new or established patient code.

TABLE 53.—CY 2008 MEDIAN COSTS AND FREQUENCIES OF CPT CONSULTATION VISIT CODES

Code descriptor	Median cost	Frequency
Level 1 Consultation	$66.48	62,000

TABLE 53.—CY 2008 MEDIAN COSTS AND FREQUENCIES OF CPT CONSULTATION VISIT CODES—Continued

Code descriptor	Median cost	Frequency
Level 2 Consultation	65.78	73,000
Level 3 Consultation	81.95	155,000
Level 4 Consultation	109.96	176,000
Level 5 Consultation	139.61	94,000

Consultation services are provided with much less frequency than all levels of established patient visits and low level new patient visits but are provided more frequently than high level new patient visits. The median costs for consultation codes are generally similar to or slightly higher than the corresponding median costs of the same level of new patient visits.

Aside from the APC Panel recommendation, we have received few comments from the public related to this issue. We continue to believe that consultation codes are unnecessary and superfluous in the hospital outpatient setting because hospitals could appropriately bill either a new or established patient visit code, instead of a consultation, as appropriate in these cases. In the interest of simplifying billing, for CY 2008, we are proposing to assign status indicator ''B'' to the consultation codes (that is, not paid under the OPPS) and instruct hospitals to bill a new or established visit code instead of an office consultation code, thereby adopting the APC Panel's recommendation not to recognize these consultation codes. As appropriate, hospitals may build consultation services into their internal hospital guidelines related to reporting clinic visit levels based on the complexity and resources used for these visits.

In summary, for CY 2008, we are proposing that hospitals continue to use the CPT codes to bill for clinic visits and to distinguish between new and established patient visits. For CY 2008, the CPT codes for new and established visits would continue to be payable under the OPPS, but we would reconsider in the future whether there should be a distinction between new and established patient visits as we continue to work on developing national guidelines. For CY 2008, we are proposing to change the status of the consultation codes so that these codes are no longer recognized for payment under the OPPS.

2. Emergency Department Visits

As described above, CPT defines an emergency department as ''an organized hospital based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day.'' Prior to CY 2007, under the OPPS, we restricted the billing of emergency department CPT codes to services furnished at facilities that met this CPT definition. Facilities open less than 24 hours a day should not report the emergency department CPT codes.

Sections 1866(a)(1)(I), 1866(a)(1)(N), and 1867 of the Act impose specific obligations on Medicare-participating hospitals and CAHs that offer emergency services. These obligations concern individuals who come to a hospital's dedicated emergency department and request examination or treatment for medical conditions, and apply to all of these individuals, regardless of whether or not they are beneficiaries of any program under the Act. Section 1867(h) of the Act specifically prohibits a delay in providing required screening or stabilization services in order to inquire about the individual's payment method or insurance status. Section 1867(d) of the Act provides for the imposition of civil monetary penalties on hospitals and physicians responsible for failing to meet the provisions listed above. These provisions, taken together, are frequently referred to as the Emergency Medical Treatment and Labor Act (EMTALA). EMTALA was passed in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99–272 (COBRA).

Section 489.24 of the EMTALA regulations defines ''dedicated emergency department'' as any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under the regulations is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

We believe that every emergency department that meets the CPT definition of emergency department also qualifies as a dedicated emergency department under EMTALA. However, we are aware that there are some departments or facilities of hospitals that meet the definition of a dedicated emergency department under the EMTALA regulations but that do not meet the more restrictive CPT definition of an emergency department. For example, a hospital department or facility that meets the definition of a dedicated emergency department may not be available 24 hours a day, 7 days a week. Nevertheless, hospitals with such departments or facilities incur EMTALA obligations with respect to an individual who presents to the department and requests, or has requested on his or her behalf, examination or treatment for an emergency medical condition. However, because they did not meet the CPT requirements for reporting emergency visit E/M codes, prior to CY 2007, these facilities were required to bill clinic visit codes for the services they furnished under the OPPS. We had no way to distinguish in our hospital claims data the costs of visits provided in dedicated emergency departments that did not meet the CPT definition of emergency department from the costs of clinic visits.

Some hospitals requested that they be permitted to bill emergency department visit codes under the OPPS for services furnished in a facility that met the CPT definition for reporting emergency department visit E/M codes, except that they were not available 24 hours a day. These hospitals believed that their resource costs were more similar to those of emergency departments that met the CPT definition than they were to the resource costs of clinics. Representatives of such facilities argued that emergency department visit payments would be more appropriate, on the grounds that their facilities treated patients with emergency conditions whose costs exceeded the resources reflected in the clinic visit APC payments, even though these emergency departments were not available 24 hours per day. In addition, these hospital representatives indicated that their facilities had EMTALA obligations and should, therefore, be able to receive emergency department visit payments. While these emergency departments may have provided a broader range and intensity of hospital

services and required significant resources to assure their availability and capabilities in comparison with typical hospital outpatient clinics, the fact that they did not operate with all capabilities full-time suggested that hospital resources associated with visits to emergency departments or facilities available less than 24 hours a day might not be as great as the resources associated with emergency departments or facilities that were available 24 hours a day and that fully met the CPT definition.

To determine whether visits to emergency departments or facilities (referred to as Type B emergency departments) that incur EMTALA obligations but do not meet more prescriptive expectations that are consistent with the CPT definition of an emergency department (referred to as Type A emergency departments) have different resource costs than visits to either clinics or Type A emergency departments, in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68132), we finalized a set of five G-codes for use by hospitals to report visits to all entities that meet the definition of a dedicated emergency department under the EMTALA regulations in § 489.24 but that are not Type A emergency departments, as described in Table 54 below. These codes are called ''Type B emergency department visit codes.'' We believed the creation of G-codes for Type B emergency departments was necessary because there were no CPT codes that fully described this type of facility. If we were to continue instructing Type B emergency departments to bill clinic visit codes, we would have no way to track resource costs for Type B emergency department visits as distinct from clinic visits. In that rule we explained that these new G-codes would serve as a vehicle to capture median cost and resource differences among visits provided by Type A emergency departments, Type B emergency departments, and clinics (71 FR 68132).

TABLE 54.—CY 2007 FINAL LEVEL II HCPCS CODES TO BE USED TO REPORT EMERGENCY DEPARTMENT VISITS PROVIDED IN TYPE B EMERGENCY DEPARTMENTS

HCPCS code	Short descriptor	Long descriptor
G0380	Lev 1 hosp type B ED visit	Level 1 hospital emergency department visit provided in a Type B emergency department. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment).
G0381	Lev 2 hosp type B ED visit	Level 2 hospital emergency department visit provided in a Type B emergency department. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment).
G0382	Lev 3 hosp type B ED visit	Level 3 hospital emergency department visit provided in a Type B emergency department. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment).

TABLE 54.—CY 2007 FINAL LEVEL II HCPCS CODES TO BE USED TO REPORT EMERGENCY DEPARTMENT VISITS PROVIDED IN TYPE B EMERGENCY DEPARTMENTS—Continued

HCPCS code	Short descriptor	Long descriptor
G0383	Lev 4 hosp type B ED visit	Level 4 hospital emergency department visit provided in a Type B emergency department. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment).
G0384	Lev 5 hosp type B ED visit	Level 5 hospital emergency department visit provided in a Type B emergency department. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment).

For CY 2007, we assigned the five new Type B emergency department visit codes for services provided in a Type B emergency department to the five newly-established Clinic Visit APCs, 0604, 0605, 0606, 0607, and 0608 (71 FR 68140). This payment policy for Type B emergency department visits is similar to our previous policy which required services furnished in emergency departments that had an EMTALA obligation but did not meet the CPT definition of emergency department to be reported using CPT clinic visit E/M codes, resulting in payments based upon clinic visit APCs. As mentioned above, CPT and CMS required an emergency department to be open 24 hours per day in order for it to be eligible to bill emergency department E/M codes. While maintaining the same payment policy for Type B emergency department visits in CY 2007, we believe the reporting of specific G-codes for emergency department visits provided in Type B emergency departments would permit us to specifically collect and analyze the hospital resource costs of visits to these facilities in order to determine in the future whether a proposal of an alternative payment policy might be warranted. We expected hospitals to adjust their charges appropriately to reflect differences in Type A and Type B emergency departments. The OPPS rulemaking cycle for CY 2009 will be the first year that we will have cost data for these new Type B emergency department HCPCS codes available for analysis.

In the CY 2007 OPPS/ASC proposed rule (71 FR 49609), we proposed to create five G-codes to be reported by the subset of provider-based emergency departments or facilities of the hospital, called Type A emergency departments, that are available to provide services 24 hours a day, 7 days per week and meet one or both of the following requirements related to the EMTALA definition of a dedicated emergency department, specifically: (1) It is licensed by the State in which it is located under the applicable State law as an emergency room or emergency department; or (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment. These codes were called ''Type A emergency visit codes'' and were proposed to replace hospitals' reporting of the CPT emergency department visit E/M codes listed in Table 49 above. Our intention was to allow hospital-based emergency departments or facilities that were historically appropriately reporting CPT emergency department visit E/M codes to bill these new Type A emergency department visit codes. In the CY 2007 OPP/ASC, final rule with comment period (71 FR 68132), we postponed finalizing G-codes to replace CPT codes for Type A emergency department visits until national guidelines are established, and stated that we would again consider their possible utility once the national guidelines are adopted. However, for CY 2007, we finalized the definition of Type A emergency departments to distinguish them from Type B emergency departments. For CY 2007 (71 FR 68140), we assigned the five CPT E/M emergency department visit codes for services provided in a Type A emergency departments to the five newly-created Emergency Department Visit APCs, 0609, 0613, 0614, 0615, and 0616.

We believe that our distinction between Type A and Type B emergency departments refined and clarified the CPT definition of ''emergency department'' for use in the hospital

context. As we have previously noted, the CPT codes were defined to reflect the activities of physicians and do not always describe well the range and mix of services provided by hospitals during visits of emergency department patients. For example, one feature that distinguishes Type A hospital emergency departments from other departments of the hospital is that Type A emergency departments do not generally provide scheduled care, but rather regularly operate to provide immediately available unscheduled services.

We were pleased that the majority of commenters to the CY 2007 OPPS/ASC proposed rule agreed with our general distinction between Type A and Type B emergency departments. We note that after the publication of the CY 2007 OPP/ASC final rule with comment period, numerous readers requested clarification about one paragraph that appeared in that final rule. The paragraph is reprinted below (71 FR 68132).

''We are aware that hospitals operate many types of facilities which they view in aggregate as an integrated healthcare system. For purposes of determining EMTALA obligations, under § 489.24(b) of the regulations, each hospital is evaluated individually to determine its own particular obligations. As we have discussed previously, hospital facilities or departments of the hospital that meet the definition of a dedicated emergency department consistent with the EMTALA regulations may bill Type A emergency department codes (CPT emergency department visit codes) or Type B emergency department codes (HCPCS G-codes), depending on whether or not the dedicated emergency department meets the definition of a Type A emergency department, which includes operating 24 hours per day, 7 days a week. For purposes of determining whether to bill Type A or Type B emergency department codes, each hospital must be evaluated individually and should make a decision specific to each area of the hospital to determine which codes would be appropriate. Where a hospital maintains a separately identifiable area or part of a facility which does not operate on the same schedule (that is, 24 hours per day, 7 days a week) as its emergency department, that area or facility would not be considered an integral part of the emergency department that operates 24 hours per day, 7 days a week for purposes of determining its emergency department type for reporting emergency visit services. Instead, the facility or area would be evaluated separately to determine whether it is a Type A emergency department, Type B emergency department, or clinic. We would expect the hospital providing services in such facilities or areas to evaluate the status of those areas and bill accordingly. In general, it is not appropriate to consider a satellite emergency department or an area of the emergency department as if it were available 24 hours a day simply because the main emergency department is available 24 hours a day. It may be appropriate for a Type A emergency department to 'carve out' portions of the emergency department that are not available 24 hours a day, where visits would be more appropriately billed with Type B emergency department codes.''

In response to the questions we received, we posted on the CMS Web site a ''Frequently Asked Questions'' list that described various examples of treating an emergency department as either a Type A emergency department or a Type B emergency department. In each case, the posted answer stated that hospitals should contact their fiscal intermediary to ensure that the fiscal intermediary and the hospital are in agreement regarding the emergency room status as either Type A or Type B. The response to the posted examples has been positive and the number of inquiries we are receiving has subsided.

Notwithstanding our subsequent clarification, we are not proposing to modify the definitions of Type A or Type B emergency departments for CY 2008 because we believe that our current definition accurately distinguishes between these two types of emergency departments. While we will not know definitively until CY 2009 how the costs of services provided in Type A emergency departments differ from the costs of services provided in Type B emergency departments, we believe that our current distinction between Type A and B emergency departments is appropriate and is most likely to capture any resource cost differences between the two types of emergency departments. However, we are specifically soliciting public comment regarding any additional operational clarifications that we could provide to assist hospitals in determining whether an emergency department is considered to be Type A or Type B.

We specifically indicated for CY 2007 that hospitals should individually consider separately identifiable areas or parts of facilities that did not operate on the same schedule as the main emergency department that was open 24 hours a day, 7 days per week to determine the appropriate codes for reporting services provided in those separately identifiable areas. Because we consider the main distinguishing feature between Type A and Type B emergency departments to be the full-time versus part-time availability of staffed areas for emergency medical care, not the process of care or the site of care (on the hospital's main campus or offsite), our final CY 2007 policy explained that hospitals needed to assess separately identifiable areas individually for their status as Type A or Type B emergency departments. We are interested specifically in comments that describe how this policy could be further clarified in light of hospitals' operational responsibility to efficiently provide emergency services, holding constant the definitions that were developed for CY 2007 and described above. We do not believe a policy change in the reporting of these Type A and Type B emergency department codes would be appropriate for CY 2008, in light of our desire to capture consistent and accurate hospital cost data by HCPCS code for consideration for the CY 2009 OPPS. For CY 2008, we are proposing that Type A emergency department visits would continue to be paid based on the five Emergency Department Visit APCs, while Type B emergency department visits would continue to be paid based on the five Clinic Visit APCs.

C. Proposed Visit Reporting Guidelines

1. Background

As described in section IX.A. of this proposed rule, since April 7, 2000, we have instructed hospitals to report facility resources for clinic and emergency department outpatient hospital visits using the CPT E/M codes and to develop internal hospital guidelines for reporting the appropriate visit level.

During the January 2002 APC Panel meeting, the APC Panel recommended that CMS adopt the American College of Emergency Physicians (ACEP) intervention-based guidelines for facility coding of emergency department visits and develop guidelines for clinic visits that are modeled on the ACEP guidelines.

In the August 9, 2002 OPPS proposed rule (67 FR 52133), we proposed 10 new G-codes (Levels 1–5 Facility Emergency Services and Levels 1–5 Facility Clinic Services) for use in the OPPS to report hospital visits, with the goal of ultimately applying national guidelines to these codes and discontinuing the use of CPT E/M codes under the OPPS. We also solicited public comments regarding national guidelines for hospital coding of emergency department and clinic visits. We discussed different types of models, reflecting on the advantages and disadvantages of each. We reviewed in detail the considerations around various discrete types of specific guidelines, including guidelines based on staff interventions, based upon staff time spent with the patient, based on resource intensity point scoring, and

based on severity acuity point scoring related to patient complexity. In that proposed rule, we also stated that we were concerned about counting separately paid services (for example, intravenous infusions, x-rays, electrocardiograms, and laboratory tests) as ''interventions'' or including their associated ''staff time'' in determining the level of service. We believed that the level of service should be determined by resource consumption that is not otherwise captured in payments for other separately payable services.

In response to comments, in the November 1, 2002 OPPS final rule (67 FR 66793), we stated that we would not create new codes to replace existing CPT E/M codes for reporting hospital visits until national guidelines are developed. We noted that an independent panel of experts would be an appropriate forum to develop codes and guidelines that are simple to understand and implement. We explained that organizations such as the American Hospital Association (AHA) and the American Health Information Management Association (AHIMA) had such expertise and would be capable of creating hospital visit guidelines and providing ongoing provider education. We also articulated a set of principles that any national guidelines for facility visit coding should satisfy, including that coding guidelines should be based on facility resources, should be clear to facilitate accurate payments and be usable for compliance purposes and audits, should meet HIPAA requirements, should only require documentation that is clinically necessary for patient care, and should not facilitate upcoding or gaming. We stated that the distribution of codes reported for each type of hospital outpatient visit (clinic or emergency department) should result in a normal curve. We concluded that we believed the most appropriate forum for development of code definitions and guidelines was an independent expert panel that would make recommendations to CMS.

The AHA and AHIMA originally supported the ACEP model for emergency department visit coding. However, we expressed concern that the ACEP guidelines allowed counting of separately payable services in determining a service level, which could result in the double counting of hospital resources in establishing visit payment rates and payment rates for those separately payable services. Subsequently, on their own initiative, the AHA and AHIMA formed an independent expert panel, the Hospital Evaluation and Management Coding Panel, comprised of members with coding, health information management, documentation, billing, nursing, finance, auditing, and medical experience. This panel included representatives from the AHA, AHIMA, ACEP, Emergency Nurses Association, and American Organization of Nurse Executives. CMS and AMA representatives observed the meetings. On June 24, 2003, the AHA and AHIMA submitted their recommended guidelines, hereafter referred to as the AHA/AHIMA guidelines, for reporting three levels of hospital clinic and emergency department visits and a single level of critical care services to CMS, with the hope that CMS would publish the guidelines in the CY 2004 OPPS proposed rule. The AHA and AHIMA acknowledged that ''continued refinement will be required as in all coding systems. The Panel * * * looks forward to working with CMS to incorporate any recommendations raised during the public comment period'' (AHA/AHIMA guidelines report, page 9). The AHA and AHIMA indicated that the guidelines were field-tested several times by panel members at different stages of their development. The guidelines are based on an intervention model, where the levels are determined by the numbers and types of interventions performed by nursing or ancillary hospital staff. Higher levels of services are reported as the number and/or complexity of staff interventions increase.

Although we did not publish the guidelines, the AHA and AHIMA released the guidelines through their Web sites. Consequently, we received numerous comments from providers and associations, some in favor and some opposed to the guidelines. We undertook a critical review of the recommendations from the AHA and AHIMA and made some modifications to the guidelines based on comments we received from other hospitals and associations on the AHA/AHIMA guidelines, clinical review, and changing payment policies under the OPPS regarding some separately payable services.

In an attempt to validate the modified AHA/AHIMA guidelines and examine the distribution of services that would result from their application to hospital clinic and emergency department visits paid under the OPPS, we contracted for a study that began in September 2004 and concluded in September 2005 to retrospectively code, under the modified AHA/AHIMA guidelines, hospital visits by reviewing hospital visit medical chart documentation gathered through the Comprehensive Error Rate Testing (CERT) work. While a review of documentation and assignment of visit levels based on the modified AHA/AHIMA guidelines to 12,500 clinic and emergency department visits was initially planned, the study was terminated after a pilot review of only 750 visits. The contractor identified a number of elements in the guidelines that were difficult for coders to interpret, poorly defined, nonspecific, or regularly unavailable in the medical records. The contractor's coders were unable to determine any level for about 25 percent of the clinic cases and about 20 percent of the emergency cases reviewed. The only agreement observed between the levels reported on the claims and levels according to the modified AHA/AHIMA guidelines was the classification of Level 1 services, where the review supported the level on the claims 54 to 70 percent of the time. In addition, the vast majority of the clinic and emergency department visits reviewed were assigned to Level 1 during the review. Based on these findings, we believed that it was not necessary to review additional records after the initial sample. The contractor advised that multiple terms in the guidelines required clearer definition and believed that more examples would be helpful. Although we believe that all of the visit documentation for each case was available for the contractor's review, we were unable to determine definitively that this was the case. Thus, there is some possibility that the contractor's assignments would have differed if additional documentation from the medical records were available for the visits. In summary, while testing of the modified AHA/AHIMA guidelines was helpful in illuminating areas of the guidelines that would benefit from refinement, we were unable to draw conclusions about the relationship between the distribution of current hospital reporting of visits using CPT E/M codes that are assigned according to each hospital's internal guidelines and the distribution of codes under the AHA/AHIMA guidelines, nor were we able to demonstrate a normal distribution of visit levels under the modified AHA/AHIMA guidelines. In CY 2007, we posted to the CMS Web site a summary of the contractor's report.

Despite the inconclusive findings from the validation study, after reviewing the AHA/AHIMA guidelines, as well as approximately a dozen other guidelines for outpatient visits submitted by various hospitals and hospital associations, we stated in the CY 2007 OPPS/ASC final rule with

comment period (71 FR 68141) that we believed that the AHA/AHIMA guidelines are the most appropriate and well-developed guidelines for use in the OPPS of which we are aware. Our particular interest in these guidelines is based upon the broad-based input into their development, the desire for CMS to move to promulgate national outpatient hospital visit coding guidelines in the near future, and full consideration of the characteristics of alternative types of guidelines. We also believe that hospitals would react favorably to guidelines developed and supported by the AHA and AHIMA, national organizations that have great interest in hospital coding and payment issues, and possess significant medical, technical and practical expertise due to their broad membership, which includes hospitals and health information management professionals. Anecdotally, we have been told that a number of hospitals are successfully utilizing the AHA/AHIMA guidelines to report levels of hospital visits. However, other organizations have expressed concern that the AHA/AHIMA guidelines may result in a significant redistribution of hospital visits to higher levels, reducing the ability of the OPPS to discriminate among the hospital resources required for various different levels of visits. We, too, remain concerned about the potential redistributive effect on OPPS payments for other services or among levels of hospital visits when national guidelines for outpatient visit coding are adopted. We recognize that there may be difficulty crosswalking historical hospital claims data from current CPT E/M codes reported based on individual internal hospital guidelines to payments for any new coding system developed, in order to provide appropriate payment levels for hospital visits reported based on national guidelines in the future.

There are several types of concerns with the AHA/AHIMA guidelines that have been identified based upon extensive staff review and contractor use of the guidelines during the validation study. We believe the AHA/AHIMA guidelines would require refinement prior to their adoption by the OPPS, as well as continued refinement over time after their implementation. Our modified version of the AHA/AHIMA guidelines provides some possibilities for addressing certain issues. Our eight general areas of concern regarding the AHA/AHIMA model are reviewed below. In addition, we have posted to the CMS Web site both the original AHA/AHIMA guidelines and our modified draft version.

We continue to commit that we would provide a minimum of 6 to 12 months notice to hospitals prior to implementation of national guidelines to provide sufficient time for providers to make the necessary systems changes and educate their staff.

2. CY 2007 Work on Visit Guidelines

There are several areas of the AHA/AHIMA guidelines that we identified in the CY 2007 OPPS/ASC final rule with comment period that would require refinement and further input from the public prior to implementation as national guidelines. These areas include the need for five rather than three levels of codes for clinic and emergency department visits to accommodate the current five levels of OPPS payment; clarification of documentation that would support certain interventions; reconsideration of the inclusion of separately payable services as proxies for hospital resources used in visits; examination of the valuing of certain interventions; assessment of the need for modifications to address the different clinical characteristics of specialty clinic visits; consistency with the Americans with Disabilities Act; reevaluation of the way in which additional hospital resources required for the treatment of new patients are captured; and recommendations for guidelines for the reporting of visits to Type B emergency departments.

We have had a number of meetings and discussions with interested stakeholders over the past several months regarding the AHA/AHIMA guidelines, the CMS modified draft version, the contractor pilot work to test the guidelines, the concerns we identified in the CY 2007 OPPS/ASC final rule, and alternative guidelines. We are aware that the AHA and AHIMA are having an ongoing dialogue with members of their Hospital Evaluation and Management Coding Panel and reviewing their previously recommended model guidelines as well as other models currently in use. We have not received any additional suggestions or modifications from the AHA and AHIMA to date. We have received a number of new suggestions for guidelines from other stakeholders, including individual hospitals and associations, that have engaged in a variety of data collection and pilot application activities in preparing their recommendations. For example, one wound care organization created and presented an independent model that could apply to certain specialty clinics. The organization claimed that several hospital outpatient specialty clinics had already successfully implemented these as their internal guidelines, but requested that CMS designate them as the national wound care clinic guidelines. One provider group tested several sets of guidelines that resembled the ACEP model and compared the results across a set of hospitals. This provider group believes that an ACEP-type model would be the most successful type of national guidelines, assuming that the guidelines were flexible in serving as a guide to visit level reporting. While using several varieties of ACEP-type guidelines in different hospitals, the group noted that across hospitals a specific intervention was almost always assigned to the same clinic visit level. The group concluded that this indicated that the ACEP model and its variations could likely be successfully implemented as national guidelines. Another association reviewed and tested the CMS modified AHA/AHIMA guidelines that were posted to the CMS Web site. This association found it cumbersome to assign the Level 2 and Level 4 Clinic Visit codes because those levels could only be assigned when a certain number of interventions and/or contributory factors were performed. The association suggested changes to the CMS modified AHA/AHIMA guidelines for ease of use and application to specialty clinics, particularly oncology clinics. One developer of national clinic and emergency department visit guidelines noted that many hospitals had successfully used the presenting problem-based guidelines that it had created. The developer noted that its system was easy to use, produced consistent coding decisions resulting in a normal distribution of visits, and even served as a tool to track effectiveness and efficiency.

We appreciate the thoughtful information that has been provided to us so far regarding hospitals' experiences and the insightful responses by the public to our concerns about the AHA/AHIMA model. We are currently actively engaged in evaluating and comparing various guideline models and suggestions that have been provided to us, and we continue to welcome additional public input on this important and complex area of the OPPS. The public input we have received continues to reflect a wide variety of perspectives on the types and content of the guidelines different commenters recommend that we should implement nationally for the OPPS, and no single approach appears to be broadly endorsed by the stakeholder

community. In addition, commenters have described the successful application of many types of internal hospital guidelines with diverse characteristics for the reporting of hospital clinic and emergency department visit levels that they believe accurately capture the required hospital resources.

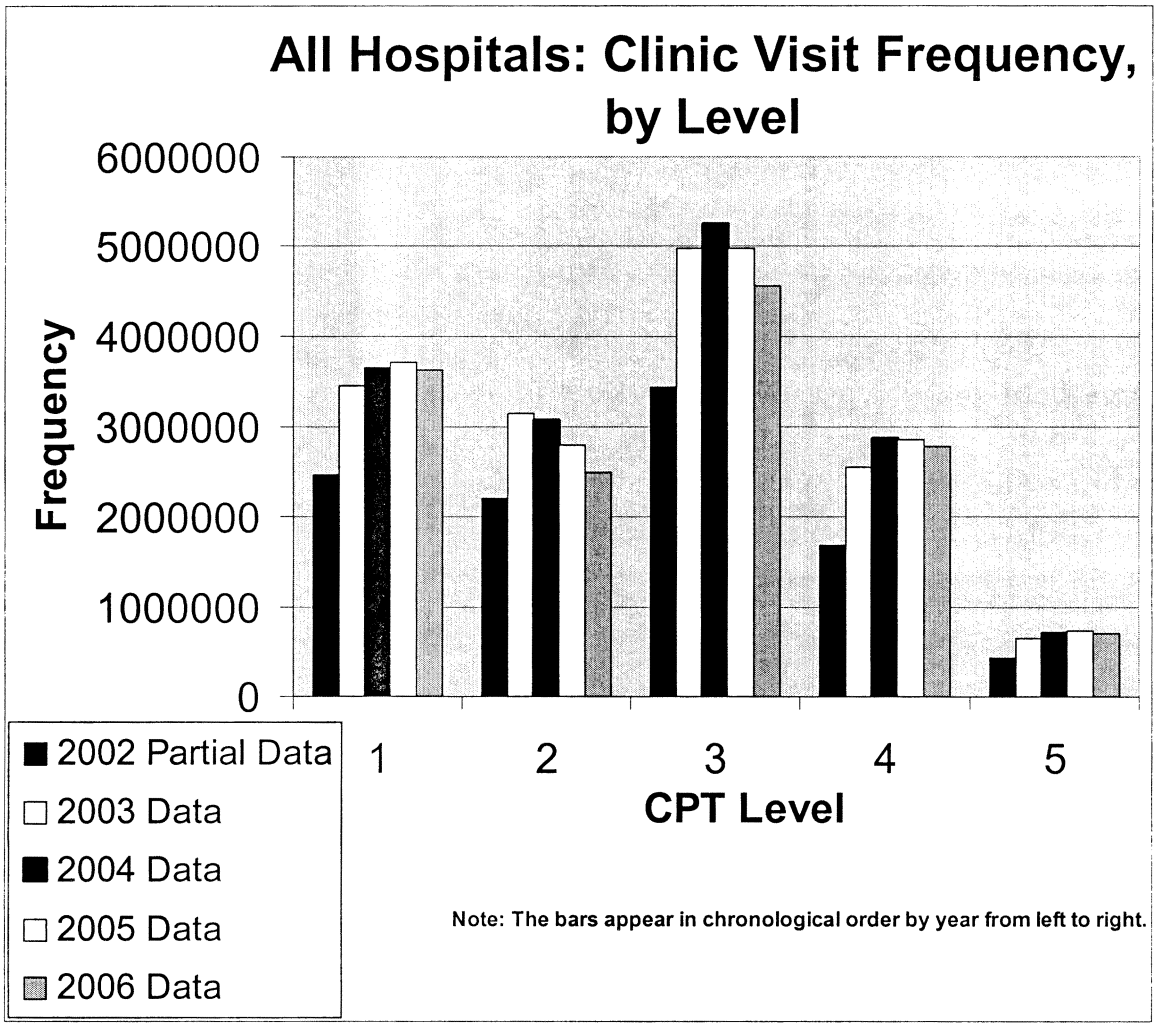
3. Proposed Visit Guidelines

We performed data analyses with the goal of studying the current distribution of each level of clinic and emergency department visit codes billed nationally, as well as the distribution among various classes of hospitals. We analyzed frequency data from claims with dates of service from March 1, 2002, through December 31, 2006, including those claims that were processed through December 31, 2006. To determine the national clinic visit distribution, we reviewed frequency data for each level of new patient visits, established patient visits, and consultation codes. To determine the national emergency department visit distribution, we reviewed frequency data for the five CPT emergency department visit codes. We did not include the five G-codes that describe Type B emergency departments because they became effective January 1, 2007, and we do not yet have a full year of frequency data for those codes.

The clinic visit data, displayed below in Figure 1, revealed a fairly normal national distribution of clinic visits, with the curve somewhat skewed to the left, consistent with our previous analysis of these data in CY 2002 (67 FR 66791). In addition, the visit distributions have been quite stable over the past 5 years.

BILLING CODE 4120–01–P

Figure 1.--Frequency Distribution of New and Established Patient Clinic Visits, by Level of Code



The graph shown in Figure 1 indicates that hospitals, on average, are billing all five levels of visit codes with varying frequency, in a consistent pattern over time. It is striking to note how similar the annual distributions appear from CY 2002 through CY 2006. We are not surprised that hospitals report a relatively high proportion of low level visits, given the typical clinical care provided in HOPDs during these visits. Many Medicare patients are evaluated regularly in clinics by hospitals' clinical staff to determine the status of their chronic medical

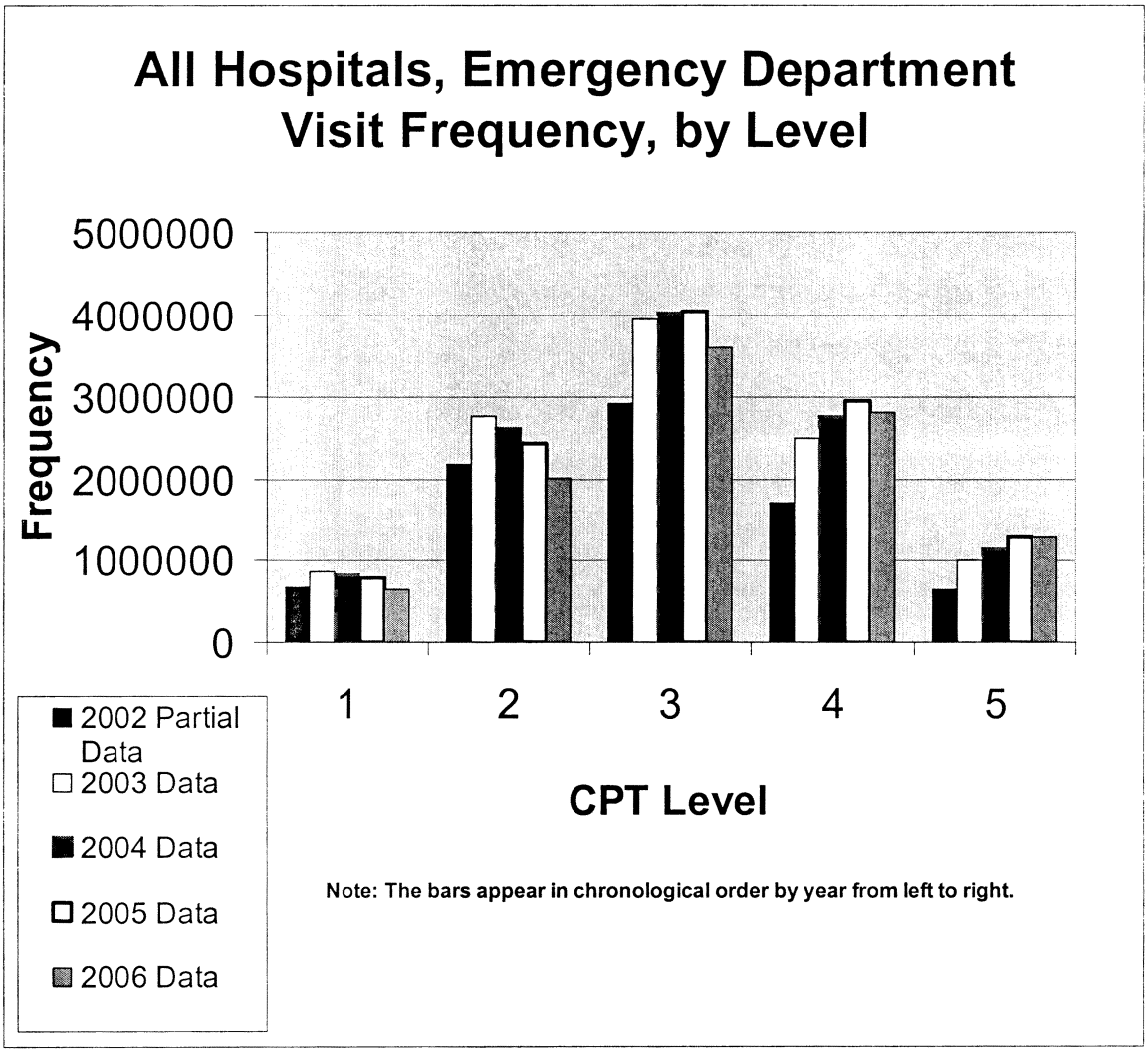
conditions and determine adjustments to treatment plans, and those visits may frequently be reported as a low level visit if that is consistent with the hospital's internal guidelines and fiscal intermediary instructions. Some patients may receive minor services during low level visits that are not described by more specific HCPCS codes. We note that, in general, billing a visit in addition to another service merely because the patient interacted with hospital staff or spent time in a room for that service is inappropriate. If a visit and another service are both billed, such as chemotherapy, a diagnostic test, or a surgical procedure, the visit must be separately identifiable from the other service because the resources used to provide nonvisit services, including staff time, equipment, supplies, among others, are captured in the line item for that service. We believe that hospitals by and large are abiding by this guidance because more than 90 percent of the CY 2006 claims for Level 1 established patient visits available for this proposed rule are single claims.

We also examined the billing patterns for various classes of hospitals, grouped by the hospital categories shown in the impact table (Table 67) in section XXII.B. of this proposed rule, to see how the clinic visit distributions of levels billed for these various categories compared to the national distribution of clinic visit levels. For these subcategories, we specifically focused on the number of established patient visits billed at each level. Generally, the distribution for major teaching hospitals, minor teaching hospitals, and nonteaching hospitals looked remarkably similar to the national distribution of established patient visits. Nonteaching hospitals tended to bill a greater proportion of Level 1 and 2 patient visits as compared to major teaching hospitals, as would be expected if their general patient acuity was slightly lower. Nonteaching hospitals include many community hospitals that treat a wide variety of patients, likely including a larger proportion of patients with minor ailments. Major teaching hospitals reported a slightly higher proportion of Level 4 and 5 visits. This too correlates well with our knowledge of the patient case-mix of large teaching hospitals, which tend to treat a higher proportion of very sick patients than nonteaching hospitals. The distributions for urban and rural hospitals also closely resembled the national distribution, including the rural SCH visit level distribution. The smallest rural hospitals predictably reported a higher proportion of Level 1 and 2 visit codes and a lower proportion of higher level visit codes, as compared to the national average, consistent with their generally lower case-mix severity.

The national emergency department visit data, displayed below in Figure 2, similarly revealed a normal national distribution of emergency department visit levels that was even more symmetrical than the national clinic visit distribution. The national distributions have been stable over the past 5 years as well.

BILLING CODE 4120–01–P

Figure 2.--Frequency Distribution of Emergency Department Visits, by Level of Code



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We also looked at various classes of hospitals, grouped by the hospital categories that we show in the impact table (Table 67) in section XXII. of this proposed rule to see how the emergency department visit distributions of levels billed by hospitals in each of these various categories compared to the national distribution of emergency department visit levels. The emergency department visit distributions for major teaching hospitals, minor teaching hospitals, and nonteaching hospitals were almost identical to the national distribution of emergency department visits. No significant differences were noted. The emergency department visit distributions for urban and rural hospitals also closely resembled the national distribution of emergency department visits. Rural hospitals in the aggregate reported slightly higher proportions of Level 2 and 3 emergency department visits than the national average and slightly fewer Level 4 and 5 visits. When subdividing rural hospitals into groupings based on size, the distribution for small, medium, and large rural hospitals closely mirrored the national average distribution. Large rural hospitals tended to report higher level emergency department visits than smaller rural hospitals. All of these observations regarding the patterns of reporting for rural hospitals are consistent with our expectations for care delivery of those hospitals.

Overall, both the clinic and emergency department visit distributions indicate that hospitals are billing consistently over time and in a manner that distinguishes between visit levels, resulting in relatively normal distributions nationally for the OPPS, as well as for smaller classes of hospitals. These analyses are generally consistent with our understanding of the clinical and resource characteristics of different levels of hospital outpatient clinic and emergency department visits.

We specifically are inviting public comment as to whether a pressing need for national guidelines continues at this point in the maturation of the OPPS or if the current system where hospitals create and apply their own internal guidelines to report visits is currently more practical and appropriately flexible for hospitals. Although we have reiterated our goal since CY 2000 of creating national guidelines, this complex undertaking for these important and common hospital services is proving more challenging than we initially thought as we receive new and expanded information from the public on current hospital reporting practices that lead to appropriate

payment for the hospital resources associated with clinic and emergency department visits. Many hospitals have worked diligently and carefully to develop and implement their own internal guidelines that reflect the scope and types of services they provide throughout the hospital outpatient system. Based on public comments, as well as our own knowledge of how clinics operate, it seems unlikely that one set of straightforward national guidelines could apply to the reporting of visits in all hospitals and specialty clinics. In addition, the stable distribution of clinic and emergency department visits reported under the OPPS over the past several years indicates that hospitals, both nationally in the aggregate and grouped by specific hospital classes, are generally billing in an appropriate and consistent manner as we would expect in a system that accurately distinguishes among different levels of service based on the associated hospital resources.

Therefore, while we continue to evaluate the information and input we have received from the public during CY 2007, as well as invite comments on this proposed rule regarding the necessity and feasibility of implementing different types of national guidelines, we are not proposing to implement national visit guidelines for clinic or emergency department visits for CY 2008. Instead, hospitals will continue to report visits during CY 2008 according to their own internal hospital guidelines.

In the absence of national guidelines, we would continue to regularly reevaluate patterns of hospital outpatient visit reporting at varying levels of disaggregation below the national level to ensure that hospitals continue to bill appropriately and differentially for these services. In addition, we expect that hospitals' internal guidelines will comport with the principles listed below.

- The coding guidelines should follow the intent of the CPT code descriptor in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the code (65 FR 18451).
- The coding guidelines should be based on hospital facility resources. The guidelines should not be based on physician resources (67 FR 66792).
- The coding guidelines should be clear to facilitate accurate payments and be usable for compliance purposes and audits (67 FR 66792).
- The coding guidelines should meet the HIPAA requirements (67 FR 66792).
- The coding guidelines should only require documentation that is clinically necessary for patient care (67 FR 66792).
- The coding guidelines should not facilitate upcoding or gaming (67 FR 66792)

We also are proposing the following five additional principles that should apply to hospital specific guidelines, based on our evolving understanding of the important issues addressed by many hospitals in developing their internal guidelines that now have been used for a number of years. We believe it is reasonable at this time to elaborate upon the standards for hospitals' internal guidelines that we are proposing to apply in CY 2008, based on our knowledge of hospitals' experiences to date with guidelines for visits.

- The coding guidelines should be written or recorded, well-documented and provide the basis for selection of a specific code.
- The coding guidelines should be applied consistently across patients in the clinic or emergency department to which they apply.
- The coding guidelines should not change with great frequency.
- The coding guidelines should be readily available for fiscal intermediary (or, if applicable, MAC) review.
- The coding guidelines should result in coding decisions that could be verified by other hospital staff, as well as outside sources.

We are inviting comment on these principles, specifically, whether hospitals' guidelines currently meet these principles, how difficult it would be for hospitals' guidelines to meet these principles if they do not meet them already, and whether hospitals believe that certain standards should be added or removed. We considered stating that a hospital must use one set of emergency department visit guidelines for all emergency departments in the hospital, but thought that some departments that might be considered emergency departments, such as the obstetrics department, may find it more practical and appropriate to use a different set of guidelines than the general emergency department. Similarly, we find it possible that various specialty clinics in a hospital could have their own set of guidelines, specific to the services offered in those specialty clinics. However, if different guidelines are implemented for different clinics, hospitals should ensure that these guidelines reflect comparable resource use at each level to the other clinic guidelines that the hospital may apply.

We appreciate all the comments we have received in the past from the public on visit guidelines, and we encourage continued submission of comments at any time that will assist us and other stakeholders interested in the development of national guidelines. Until national guidelines are established, hospitals should continue using their own internal guidelines. We would not expect individual hospitals to necessarily experience a normal distribution of visit levels across their claims, although we would expect a normal distribution across all hospitals as observed currently and as we would expect if national guidelines were implemented. We understand that, based on different patterns of care, we could expect that a small community hospital might provide more low level services than high level services, while an academic medical center or trauma center might provide more high level services than low level services. We would also expect national guidelines to provide for five levels of coding, to parallel the five payment levels that currently exist.

We hope to receive additional input from stakeholders over the upcoming months to address whether there is a definite contemporary need for national guidelines, given their potential to redistribute payment under the OPPS and the currently reassuring observed patterns of OPPS visit services. While we understand the interest of some hospitals in our moving quickly to promulgate national guidelines that will ensure standardized reporting of outpatient hospital visit levels, we believe that the issues identified both by us and others that may arise are important and require serious consideration prior to the implementation of national guidelines. Because of our commitment to provide hospitals with 6–12 months notice prior to implementation of national guidelines, we would not implement national guidelines prior to CY 2009. Our goal is to ensure that OPPS national or hospital-specific visit guidelines continue to facilitate consistent and accurate reporting of hospital outpatient visits, in a manner that is resource-based and supportive of appropriate OPPS payments for the efficient and effective provision of visits in hospital outpatient settings.

X. Proposed OPPS Payment for Blood and Blood Products

(If you choose to comment on issues in this section, please include the caption ''OPPS: Blood and Blood Products'' at the beginning of your comment.)

A. Background

Since the implementation of the OPPS in August 2000, separate payments have been made for blood and blood products through APCs rather than packaging them into payments for the procedures with which they were administered. Hospital payments for the costs of blood and blood products, as well as the costs of collecting, processing, and storing blood and blood products, are made through the OPPS payments for specific blood product APCs. On April 12, 2001, CMS issued the original billing guidance for blood products to hospitals (Program Transmittal A–01–50). In response to requests for clarification of these instructions, CMS issued Program Transmittal 496 on March 4, 2005. The comprehensive billing guidelines in Program Transmittal 496 also addressed specific concerns and issues related to billing for blood-related services, which the public had brought to our attention.

In the CY 2000 OPPS, payments for blood and blood products were established based on external data provided by commenters due to limited Medicare claims data. From the CY 2000 OPPS to the CY 2002 OPPS, payment rates for blood and blood products were updated for inflation. For the CY 2003 OPPS, as described in the November 1, 2002 final rule with comment period (67 FR 66773), we applied a special adjustment methodology to blood and blood products that had significant reductions in payment rates from the CY 2002 OPPS to the CY 2003 OPPS, when median costs were first calculated from hospital claims. Using the adjustment methodology, we limited the decrease in payment rates for blood and blood products to approximately 15 percent. For the CY 2004 OPPS, as recommended by the APC Panel, we froze payment rates for blood and blood products at CY 2003 levels as we studied concerns raised by commenters and presenters at the August 2003 and February 2004 APC Panel meetings.

For the CY 2005 OPPS, we established new APCs that allowed each blood product to be assigned to its own separate APC, as several of the previous blood product APCs contained multiple blood products with no clinical homogeneity or whose product specific median costs may not have been similar. Some of the blood product HCPCS codes were reassigned to the new APCs (Table 34 of the November 15, 2004 final rule with comment period (69 FR 65819)).

We also noted in the November 15, 2004 final rule with comment period that public comments on previous OPPS rules had stated that the CCRs that were used to adjust charges to costs for blood products in past years were too low. Past commenters indicated that this approach resulted in an underestimation of the true hospital costs for blood and blood products. In response to these comments and the APC Panel recommendations from its February 2004 and September 2004 meetings, we conducted a thorough analysis of the CY 2003 claims (used to calculate the CY 2005 APC payment rates) to compare CCRs between those hospitals reporting a blood-specific cost center and those hospitals defaulting to the overall hospital CCR in the conversion of their blood product charges to costs. As a result of this analysis, we observed a significant difference in CCRs utilized for conversion of blood product charges to costs for those hospitals with and without blood-specific cost centers. The median hospital blood-specific CCR was almost two times the median overall hospital CCR. As discussed in the November 15, 2004 final rule with comment period, we applied a special methodology for hospitals not reporting a blood-specific cost center, which simulated a blood-specific CCR for each hospital that we then used to convert charges to costs for blood products. Thus, we developed simulated medians for all blood and blood products based on CY 2003 hospital claims data (69 FR 65816).

For the CY 2005 OPPS, we also identified a subset of blood products that had less than 1,000 units billed in CY 2003. For these low-volume blood products, we based the CY 2005 OPPS payment rate on a 50/50 blend of the CY 2004 OPPS product-specific OPPS median costs and the CY 2005 OPPS simulated medians based on the application of blood-specific CCRs to all claims. We were concerned that, given the low frequency in which these products were billed, a few occurrences of coding or billing errors may have led to significant variability in the median calculation. The claims data may not have captured the complete costs of these products to hospitals as fully as possible. This low-volume adjustment methodology also allowed us to further study the issues raised by commenters and by presenters at the September 2004 APC Panel meeting, without putting beneficiary access to these low volume blood products at risk. We have adopted the use of this modified CCR process for calculating unadjusted median costs for blood and blood products each year since the CY 2005 OPPS.

Overall, median costs from CY 2003 (used for the CY 2005 OPPS) to CY 2004 (used for the CY 2006 OPPS) were relatively stable, with a few significant increases and decreases from the CY 2005 adjusted median costs for some specific blood products. For the CY 2006 OPPS, we adopted a payment adjustment policy that limited significant decreases in APC payment rates for blood and blood products from the CY 2005 OPPS to the CY 2006 OPPS to not more than 5 percent. We applied this adjustment to 11 blood and blood product APCs for the CY 2006 OPPS, which we identified in Table 33 of the CY 2006 OPPS final rule with comment period (70 FR 68687). For the CY 2006 OPPS, we set the final median costs for blood and blood products at the greater of: (1) The simulated median costs calculated from the CY 2004 claims data; or (2) 95 percent of the CY 2005 OPPS adjusted median costs for these products, as reflected in Table 33 published in the CY 2006 OPPS final rule with comment period.

In the CY 2007 OPPS, we established payment rates for blood and blood products by using the same simulation methodology described in the November 15, 2004 final rule with comment period (69 FR 65816), which utilizes hospital-specific actual or simulated CCRs for blood cost centers to convert hospital charges for blood and blood products to costs. However, we provided a payment transition for those blood products for which the difference between their CY 2006 adjusted median cost and their CY 2007 simulated median cost was greater than 25 percent. Specifically, we set the CY 2007 median costs upon which payments for blood and blood products are based at the higher of the CY 2007 unadjusted simulated median cost or 75 percent of the CY 2006 adjusted median cost on which the CY 2006 payment is based.

B. Proposed Payment for Blood and Blood Products

We are proposing to set the payment rates for blood and blood products for CY 2008 at the unadjusted median cost for these products, calculated using the hospital specific simulated blood CCR for each hospital that does not have a blood cost center. For this proposed rule, we calculated median costs for blood and blood products using claims for services furnished on or after January 1, 2006, and before January 1, 2007, and using the actual or simulated CCRs from the most recently available hospital cost reports. The median costs derived from this data process are relatively stable compared to the median costs on which payment is based for CY 2007. (See Table 55 below.) Of the 34 blood and blood products, median costs increase for 24

products and decline for 10 products compared to the adjusted medians on which payment is based in CY 2007. Products with the largest declines are, like the products with the greatest increases, mostly those products with low volume use in the hospital outpatient setting. The products whose costs decline more than 5 percent account for less than 1 percent of the total volume of blood and blood products in the claims used to calculate the proposed rates. No product's median cost declines by more than 18 percent in the proposed rule data, and thus no product shows a decline that would have resulted in an adjustment under the final policy in place for CY 2007. The products whose median costs increase account for 79 percent of the total volume of blood and blood products in the claims used to calculate the proposed rates. We note that CY 2006 claims are the first OPPS claims that represent a full year of hospitals' reporting consistent with our detailed blood billing guidelines issued in CY 2005. We are reassured by the relatively stable or slightly increasing median costs from CY 2005 to CY 2006 claims data for most blood products, a pattern that we believe may reflect more accurate and complete hospital reporting and charging practices for these products. Consistent with our billing guidelines, hospitals may now be taking into consideration all appropriate costs associated with providing blood and blood products in charging for those products under the OPPS.

As we indicated in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68147), we believe that the simulated CCR methodology results in accurate reflections of the relative estimated costs of these products for hospitals without blood cost centers and, therefore, for these products in general. Our 1-year adjustment to the median costs for CY 2007, where the median costs for blood and blood products decreased by more than 25 percent from the CY 2006 adjusted median costs, was intended to provide a reasonable transition to use of the simulated median costs for payment of blood and blood products under the OPPS without further adjustment. The medians that result from the use of the simulated CCR process and the CY 2006 claims generally result in median costs that we believe provide an appropriate basis for the relative weights on which the CY 2008 payments for blood and blood products would be based. Therefore, we are proposing to use the median costs derived from the application of blood cost center CCRs for those hospitals that have blood cost centers or simulated blood cost center CCRs for those hospitals that do not have blood cost centers as the basis for the CY 2008 payments for blood and blood products without further adjustment.

TABLE 55.—PROPOSED CY 2008 MEDIAN COSTS FOR BLOOD AND BLOOD PRODUCTS

HCPCS code*	Short descriptor	Proposed CY 2008 units	Proposed CY 2008 simulated CCR median unit cost	CY 2007 payment median: higher of CY 2007 OPPS simulated CCR median unit cost or 75% of CY 2006 adjusted median unit cost	Difference between proposed CY 2008 simulated CCR median unit cost and CY 2007 adjusted simulated CCR median unit cost (percent)
P9010	Whole blood for transfusion	2,467	$279.14	$131.21	112.74%
P9011	Blood split unit	288	133.59	136.42	−2.07
P9012	Cryoprecipitate each unit	4,941	43.05	48.31	−10.89
P9016	RBC leukocytes reduced	558,488	186.14	174.71	6.54
P9017	Plasma 1 donor frz w/in 8 hr	40,750	68.58	69.80	−1.75
P9019	Platelets, each unit	18,466	68.15	58.61	16.28
P9020*	Plaelet rich plasma unit	708	338.08	208.07	62.49
P9021	Red blood cells unit	139,030	127.97	128.78	−0.63
P9022	Washed red blood cells unit	2,220	264.78	209.79	26.21
P9023*	Frozen plasma, pooled, sd	343	75.37	57.11	31.97
P9031	Platelets leukocytes reduced	16,471	108.24	94.53	14.50
P9032	Platelets, irradiated	8,889	130.48	128.81	1.30
P9033	Platelets leukoreduced irrad	4,401	127.57	124.60	2.38
P9034	Platelets, pheresis	8,844	442.89	450.29	−1.64
P9035	Platelet pheres leukoreduced	44,607	502.95	485.89	3.51
P9036	Platelet pheresis irradiated	1,263	440.81	416.08	5.94
P9037	Plate pheres leukoredu irrad	22,378	631.62	613.39	2.97
P9038	RBC irradiated	4,967	209.22	195.85	6.83
P9039	RBC deglycerolized	831	364.46	356.22	2.31
P9040	RBC leukoreduced irradiated	69,722	240.24	216.29	11.07
P9043*	Plasma protein fract, 5%, 50ml	21	90.53	50.96	77.67
P9044	Cryoprecipitate reduced plasma	4,352	82.60	81.91	0.84
P9048*	Plasmaprotein fract, 5%, 250ml	508	245.39	236.78	3.64
P9050*	Granulocytes, pheresis unit	12	978.29	745.98	31.14
P9051*	Blood, l/r, cmv-neg	3,377	150.12	155.79	−3.64
P9052	Platelets, hla-m, l/r, unit	1,618	608.71	667.70	−8.83
P9053	Plt, pher, l/r cmv-neg, irr	1,437	678.13	701.26	−3.30
P9054	Blood, l/r, froz/degly/wash	584	210.86	209.82	0.50
P9055*	Plt, aph/pher, l/r, cmv-neg	789	490.13	394.50	24.24
P9056	Blood, l/r, irradiated	3,634	153.31	143.44	6.88
P9057	RBC, frz/deg/wsh, l/r, irrad	112	406.96	493.32	−17.51
P9058	RBC, l/r, cmv-neg, irrad	3,151	291.16	260.65	11.71
P9059	Plasma, frz between 8–24hour	2,820	78.35	76.32	2.66
P9060	Fr frz plasma donor retested	192	73.17	74.06	−1.20

*Indicates payment median for CY 2007 at 75 percent of the CY 2006 adjusted median.

XI. Proposed OPPS Payment for Observation Services

(If you choose to comment on issues in this section, please include the caption ''OPPS: Observation Services'' at the beginning of your comment.)

Observation care is a well-defined set of specific, clinically appropriate services that include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation status is commonly assigned to patients with unexpectedly prolonged recovery after surgery and to patients who present to the emergency department and who then require a significant period of treatment or monitoring before a decision is made concerning their next placement.

Payment for all observation care under the OPPS was packaged prior to CY 2002. Since CY 2002, separate payment of a single unit of an observation APC for an episode of observation care has been provided in limited circumstances. Effective for services furnished on or after April 1, 2002, separate payment for observation was made if the beneficiary had chest pain, asthma, or congestive heart failure and met additional criteria for diagnostic testing, minimum and maximum limits to observation care time, physician care, and documentation in the medical record (66 FR 59879). Payment for observation care that did not meet these specified criteria was packaged. Between CY 2003 and CY 2006, several more changes were made to the OPPS policy regarding separate payment for observation care, such as: clarification that observation is not separately payable when billed with ''T'' status procedures on the day of or day before observation care; development of specific Level II HCPCS codes for hospital observation care and direct admission to observation care; and removal of the initially established diagnostic testing requirements for separately payable observation (67 FR 66794, 69 FR 65828, and 70 FR 68688). Throughout this time period, we maintained separate payment for observation care only for the three specified medical conditions, and OPPS payment for observation for all other clinical conditions remained packaged.

Since January 1, 2006, hospitals have reported observation services based on an hourly unit of care using HCPCS code G0378 (Hospital observation services, per hour). This code has a status indicator of ''Q'' under the CY 2007 OPPS, meaning that the OPPS claims processing logic determines whether the observation is packaged or separately payable. The OCE's current logic determines whether observation services billed under HCPCS code G0378 is separately payable through APC 0339 (Observation), or whether payment for observation services will be packaged into the payment for other separately payable services provided by the hospital in the same encounter based on criteria discussed below. Also since January 1, 2006, hospitals have reported HCPCS code G0379 (Direct admission of patient for hospital observation care) for a direct admission of a patient to observation care. The OPPS pays separately for that direct admission reported under HCPCS code G0379 in situations where payment for the actual observation services reported under HCPCS G0378 are packaged and where the direct admission meets certain other criteria. The OCE logic determines when HCPCS code G0379 is separately payable under the OPPS.

For CY 2007, we continued to apply the criteria for separate payment for observation care and the coding and payment methodology for observation care that were implemented in CY 2006. Observation care is reported using HCPCS code G0378 and observation that meets the criteria for separate payment maps to APC 0339 (Observation). The current criteria for separate payment for observation (APC 0339) are:

A. Diagnosis Requirements

1. The beneficiary must have one of three medical conditions: congestive heart failure (CHF), chest pain, or asthma.

2. Qualifying ICD–9–CM diagnosis codes must be reported in Form Locator (FL) 76, Patient Reason for Visit, or FL 67, principal diagnosis, or both in order for the hospital to receive separate payment for APC 0339. If a qualifying ICD–9–CM diagnosis code(s) is reported in the secondary diagnosis field, but is not reported in either the Patient Reason for Visit field (FL 76) or in the principal diagnosis field (FL 67), separate payment for APC 0339 is not allowed.

B. Observation Time

1. Observation time must be documented in the medical record.

2. A beneficiary's time in observation (and hospital billing) begins with the beneficiary's admission to an observation bed.

3. A beneficiary's time in observation (and hospital billing) ends when all clinical or medical interventions have been completed, including followup care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient.

4. The number of units reported with HCPCS code G0378 must equal or exceed 8 hours.

C. Additional Hospital Services

1. The claim for observation services must include one of the following services in addition to the reported observation services. The additional services listed below must have a line item date of service on the same day or the day before the date reported for observation:

- An emergency department visit (APC 0609, 0613, 0614, 0615, or 0616); or
- A clinic visit (APC 0604, 0605, 0606, 0607, or 0608); or
- Critical care (APC 0617); or
- Direct admission to observation reported with HCPCS code G0379 (APC 0604).

2. No procedure with a ''T'' status indicator can be reported on the same day or day before observation care is provided.

D. Physician Evaluation

1. The beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.

2. The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.

The CY 2007 list of diagnoses eligible as a criterion for separate payment for observation services may be found in Table 44 of the CY 2007 OPPS/ASC final rule with comment period (71 FR 68152).

For CY 2007, we made one minor change in payment for direct admission to observation. As part of the changes in APC assignments and payments for clinic and emergency department visits, low level clinic visits were moved from APC 0600 (Low Level Clinic Visits) to APC 0604 (Level 1 Clinic Visits), with a CY 2007 payment rate of $50.66. Under the circumstances where direct admission to observation is separately payable, we finalized our CY 2007 assignment of HCPCS code G0379 to APC 0604, consistent with its CY 2006 placement in the APC for Low Level Clinic Visits.

During the APC Panel's August 2006 meeting, the Observation Subcommittee made several recommendations regarding observation services. The first

of these was that CMS should consider adding syncope and dehydration as diagnoses for which observation services would qualify for separate payment. Second, the Observation Subcommittee recommended that CMS perform claims analyses and present data that would allow CMS to consider revising criteria for separately payable observation care when certain procedures that are assigned status indicator ''T,'' for example, insertion of a bladder catheter or laceration repair, are reported on the same claim with an emergency department visit and observation care, and all other criteria for separate observation payment (for example, qualifying diagnosis code, number of hours) are met. The Panel also voted to change the name of the Observation Subcommittee to the Observation and Visit Subcommittee, based on the Panel's interest in expanding the scope of that subcommittee's work.

In response to August 2006 APC Panel recommendations and public comments to the CY 2007 proposed rule, we stated in the CY 2007 OPPS/ASC final rule with comment period that we intended to perform a series of analyses over the upcoming year to explore the potential effects of adding syncope and dehydration as qualifying diagnoses for separately payable observation care, as well as the possibility of allowing separate observation payment for claims for observation care that also include specific minor or routine procedures that have ''T'' status indicators (71 FR 68150).

At the March 2007 meeting of the APC Panel, we discussed with the Observation and Visit Subcommittee and the full Panel the results of the requested data analyses regarding syncope and dehydration, as well as the occurrences of claims for observation care that also include specific minor or routine procedures that have ''T'' status indicators. With respect to the diagnosis analyses, the data presented to the Subcommittee and Panel (consisting of partial year 2006 claims data that are less complete than the claims data available for this proposed rule) showed that there were 136,977 claims for separately payable observation services for the currently eligible conditions of chest pain, asthma, and congestive heart failure, with a median cost of $453. The frequency of claims for observation services for the diagnoses of syncope and dehydration, when all other criteria for separate payment of observation services (other than diagnosis) were met, was 46,961 claims, with a somewhat lower median cost of $416. The effect of adding both syncope and dehydration to the current diagnoses eligible for separate payment would be to lower the median for APC 0339 slightly to $443, using the early partial 2006 data presented to the Subcommittee and Panel. For the study of ''T'' status procedures in relation to observation, we identified relatively few instances (5,162) where observation met all of the criteria for separate payment, including the current three conditions of CHF, asthma, chest pain, except for the presence of a ''T'' status procedure. Of these claims, very few had any significant frequency. The most common procedures are those relating to heart catheterization, angioplasty procedures, and endoscopies. As we have stated in the past, we believe that the observation services in these cases may be related to these procedures and we have no way of discerning from our data whether the procedure happened before or after the observation services.

The APC Panel made three recommendations related to these topics. First, the Panel recommended that CMS add syncope and dehydration to the list of clinical conditions eligible for separate observation payment. Second, the Panel recommended that CMS continue to evaluate the types of diagnostic conditions that might qualify for separate observation payment in the future. Third, the Panel recommended that CMS make no changes to the criteria for separate observation payment related to the performance of ''T'' status procedures. However, the Panel added that if CMS added syncope and dehydration to the list of conditions eligible for separate observation payment, the Panel requested that CMS reexamine the claims data once CMS collects a year of observation claims data, including the additional conditions, so the Panel could reconsider this recommendation at a future meeting.

We have also taken into consideration the June 2006 IOM Report entitled, ''Hospital-Based Emergency Care: At the Breaking Point.'' This report encourages hospitals to apply tools to improve the flow of patients through emergency departments, especially through the use of observation units (clinical decision units). The IOM report also recommends that separate OPPS payment should be made for all conditions for which observation is indicated.

We appreciate the continued work and dedication of the Observation and Visit Subcommittee and the APC Panel, along with the findings and recommendations of the IOM. However, in light of the broader CY 2008 OPPS proposal to move toward expanded packaging of payment for supportive, dependent HOPD services, we are not accepting the Panel's recommendation related to adding syncope and dehydration to the list of diagnoses eligible for separate payment or to consider other clinical conditions for separate payment for observation care. We are proposing to package all observation services (reported with HCPCS code G0378) as part of the proposed changes to packaged services discussed previously in section II.A.4. of this proposed rule. Because we are proposing to package payment for all observation services, we are not proposing to adopt the Panel's recommendation to study claims data for separately payable observation care (including claims for observation for syncope and dehydration) that also include specific minor or routine procedures that have ''T'' status indicators. We agree with the APC Panel and the IOM that there is currently no compelling rationale for a different OPPS payment approach for observation care for only three specific clinical conditions. We recognize that observation care may play an important role in the treatment of many Medicare beneficiaries in the HOPD, decreasing the need for short inpatient admissions and ensuring safe discharges of patients to their homes. Therefore, we believe that our proposed CY 2008 payment policy that would package payment for all observation services consistently for Medicare beneficiaries regardless of their diagnoses is the most appropriate approach in every case of observation care. This proposed methodology encourages hospital efficiency and provides a consistent payment policy that allows hospitals to thoughtfully plan for the role of observation services in the emergency and postsurgical care of patients with many different clinical conditions.

As discussed in section II.A.4. of this proposed rule, observation care is one of seven categories of services for which we are proposing to make packaged payment in CY 2008. In view of the recent rapid growth in HOPD services, we are proposing to move toward larger payment packages and bundles under the OPPS because we believe that packaging creates incentives for providers to furnish services in the most efficient way by maximizing their flexibility to manage their resources, thereby encouraging cost containment. A detailed discussion of this proposal and our rationale for packaging observation care may be found in the section referenced above.

We are proposing to package observation care reported with HCPCS code G0378 for CY 2008 because the

facility portion of observation care is supportive and ancillary to other primary services being furnished in the HOPD. Payment for observation will be made as part of the payment for the separately payable independent services with which it is billed. As part of this proposal, we would change the status indicator for HCPCS code G0378 from ''Q'' to ''N.'' Although we would discontinue recognizing the criteria for separate payment related to hospital visits and qualifying conditions, we would retain as general reporting requirements the criteria related to physician evaluation, documentation and observation beginning and ending time because those are more general requirements that help to ensure proper reporting of observation on hospital claims. The criteria for reporting of observation services under HCPCS code G0378 that we are proposing to retain are:

A. Observation Time

1. Observation time must be documented in the medical record.

2. A beneficiary's time in observation (and hospital billing) begins with the beneficiary's admission to an observation bed.

3. A beneficiary's time in observation (and hospital billing) ends when all clinical or medical interventions have been completed, including followup care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient.

B. Physician Evaluation

1. The beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.

2. The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.

We refer readers to section II.A.4. of this proposed rule for further detailed background on our proposal to package these seven categories of services and for a specific discussion of observation services.

Direct admission to observation (HCPCS code G0379, Direct admission of patient for hospital observation care) is assigned to APC 0604 (Level 1 Hospital Clinic Visits) when the criteria are met for separate payment. For CY 2008, the proposed median cost of APC 0604 is $52.58. We are proposing to continue the current coding and payment methodology for direct admission to observation, with the exception of the prior requirement that HCPCS code G0379 is only eligible for separate payment if observation care reported with HCPCS code G0378 does not qualify for separate payment. That requirement would no longer be applicable, given our CY 2008 proposal to provide packaged payment for all observation care. Hospitals report HCPCS code G0379 when a patient is admitted directly to observation care after being seen by a physician in the community. Thus, for CY 2008, we are proposing that in order to receive separate payment for a direct admission into observation (APC 00604), the claim must show:

1. Both HCPCS codes G0378 (Hospital observation services, per hr) and G0379 (Direct admission of patient for hospital observation care) with the same date of service.

2. That no services with a status indicator ''T'' or ''V'' or Critical Care (APC 0617) were provided on the same day of service as HCPCS code G0379.

Even though we are proposing to package payment for all observation services reported by HCPCS code G0378, we believe it is necessary to continue the OCE claims processing logic in order to make appropriate payment for direct admission.

In summary, we are proposing to package payment for observation care reported with HCPCS code G0378 for CY 2008. Payment for observation would be made as part of the payment for the separately payable independent services with which it is billed. As part of this proposal, we would change the status indicator for HCPCS Code G0378 from ''Q'' to ''N.'' In addition, we would discontinue recognizing the criteria for separate payment related to hospital visits and ''T'' status procedures, minimum number of hours, and qualifying diagnoses. However, we would retain as general requirements the criteria related to physician evaluation, documentation, and observation beginning and ending time. Those are more general requirements that ensure the proper reporting of observation care on correctly coded hospital claims that reflect the charges associated with all hospital resources utilized to provide the reported services. We are proposing to continue the coding and payment methodology for direct admission to observation status, as reported using HCPCS code G0379, with the exception of the prior requirement that HCPCS code G0379 is only eligible for separate payment if observation care reported under HCPCS code G0378 does not qualify for separate payment (since this requirement would no longer be applicable).

XII. Proposed Procedures That Will Be Paid Only as Inpatient Procedures

(If you choose to comment on issues in this section, please include the caption ''OPPS: Inpatient Procedures'' at the beginning of your comment.)

A. Background

Section 1833(t)(1)(B)(i) of the Act gives the Secretary broad authority to determine the services to be covered and paid for under the OPPS. Before implementation of the OPPS in August 2000, Medicare paid reasonable costs for services provided in the outpatient department. The claims submitted were subject to medical review by the fiscal intermediaries to determine the appropriateness of providing certain services in the outpatient setting. We did not specify in regulations those services that were appropriate to provide only in the inpatient setting and that, therefore, should be payable only when provided in that setting.

In the April 7, 2000 final rule with comment period, we identified procedures that are typically provided only in an inpatient setting and, therefore, would not be paid by Medicare under the OPPS (65 FR 18455). These procedures comprise what is referred to as the ''inpatient list.'' The inpatient list specifies those services that are only paid when provided in an inpatient setting because of the nature of the procedure, the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged, or the underlying physical condition of the patient. As we discussed in the April 7, 2000 final rule with comment period (65 FR 18455) and the November 30, 2001 final rule (66 FR 59856), we use the following criteria when reviewing procedures to determine whether or not they should be moved from the inpatient list and assigned to an APC group for payment under the OPPS:

- Most outpatient departments are equipped to provide the services to the Medicare population.
- The simplest procedure described by the code may be performed in most outpatient departments.
- The procedure is related to codes that we have already removed from the inpatient list.

In the November 1, 2002 final rule with comment period (67 FR 66741), we added the following criteria for use in reviewing procedures to determine whether they should be removed from the inpatient list and assigned to an

APC group for payment under the OPPS:

- We have determined that the procedure is being performed in numerous hospitals on an outpatient basis; or
- We have determined that the procedure can be appropriately and safely performed in an ASC and is on the list of approved ASC procedures or proposed by us for addition to the ASC list.

We believe that these additional criteria help us to identify procedures that are appropriate for removal from the inpatient list.

B. Proposed Changes to the Inpatient List

For the CY 2008 OPPS, we used the same methodology as described in the November 15, 2004 final rule with comment period (69 FR 65835) to identify a subset of procedures currently on the inpatient list that are being widely performed on an outpatient basis. These procedures were then clinically reviewed for possible removal from the inpatient list. We solicited input from the APC Panel on the appropriateness of removing 14 procedures from the OPPS inpatient list at its March 2007 meeting. Prior to publishing this OPPS proposed rule, we received one other candidate HCPCS code for removal from the OPPS inpatient list based on a recommendation from the public that was presented to the APC Panel during its meeting on March 8, 2007. The APC Panel recommended that 13 of the 14 procedures that CMS identified for possible removal be removed from the OPPS inpatient list. It also recommended that CMS obtain additional utilization data about 1 of the 14 procedures identified for possible removal from the OPPS inpatient list, specifically CPT code 64818 (Sympathectomy, lumbar); and for another procedure presented for possible removal from the OPPS inpatient list by the public, specifically, CPT code 20660 (Application of cranial tongs caliper, or stereotactic frame, including removal (separate procedure)). The APC Panel requested that CMS provide that additional information to the APC Panel at its next meeting.

Therefore, we are proposing to accept the APC Panel's recommendation to remove the 13 procedures from the OPPS inpatient list for CY 2008 and to assign them to clinically appropriate APCs as shown in Table 56. We also are accepting the recommendation from the APC Panel to gather additional utilization information for CPT codes 20660 and 64818, which we will provide to the APC Panel at its next meeting.

TABLE 56.—PROPOSED HCPCS CODES FOR REMOVAL FROM INPATIENT LIST AND THEIR PROPOSED APC ASSIGNMENTS FOR CY 2008

HCPCS code	Long descriptor	Proposed CY 2008 APC	Proposed CY 2008 SI
21360	Open treatment of depressed malar fracture, including zygomatic arch and malar tripod	0254	T
21365	Open treatment of complicated (eg, comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar tripod; with internal fixation and multiple surgical approaches.	0256	T
21385	Open treatment of orbital floor blowout fracture; transantral approach (Caldwell-Luc type operation)	0256	T
25931	Transmetacarpal amputation; re-amputation	0049	T
27006	Tenotomy, abductors and/or extensor(s) of hip, open (separate procedure)	0050	T
27720	Repair of nonunion or malunion, tibia; without graft, (eg, compression technique)	0063	T
27722	Repair of nonunion or malunion, tibia; with sliding graft	0064	T
50580	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus.	0161	T
51535	Cystotomy for excision, incision, or repair of ureterocele	0162	T
58805	Drainage of ovarian cyst(s), unilateral or bilateral, (separate procedure); abdominal approach	0195	T
60271	Thyroidectomy, including substernal thyroid; cervical approach	0256	T
61770	Stereotactic localization, including burr hole(s), with insertion of catheter(s) or probe(s) for placement of radiation source.	0221	T
69970	Removal of tumor, temporal bone	0256	T

XIII. Proposed Nonrecurring Technical and Policy Changes

A. Outpatient Hospital Services and Supplies Incident to a Physician Service

(If you choose to comment on issues in this section, please include the caption ''Hospital Services Incident to a Physician Service'' at the beginning of your comment.)

We are proposing to make a technical change to §§ 410.27(a)(1)(iii) and (f) of the regulations relating to outpatient hospital services and supplies incident to a physician service to remove an outdated reference to ''designation of a department of a provider'' by CMS and replace it with language that conforms to current policy under the provider based rules as stated in § 413.65 of the regulations. We are proposing to remove from both paragraphs (a)(1)(iii) and (f) the phrase ''at a location (other than an RHC or an FQHC) that CMS designates as a department of a provider under § 413.65 of this chapter'' and replace it with ''at a department of a provider, as defined in § 413.65(a)(2) of this subchapter, that has provider-based status in relation to a hospital under § 413.65 of this subchapter.''

Section 410.27 was codified in the April 7, 2000 OPPS final rule with comment period. The provider based rules at § 413.65 were also codified in the April 7, 2000 rule, but were subsequently amended in the August 1, 2002 IPPS final rule (67 FR 50078 through 50096 and 50114 through 50118). This proposed deletion of the reference in §§ 410.27(a)(1)(iii) and (f) to CMS ''designating'' a department of a provider under § 413.65 would make those sections consistent with the 2002 amendments to the provider-based rules, in that under the amended provider-based rules, a main provider is no longer required to ask CMS to make a determination that a facility or organization is provider-based before the main provider can bill for services of the facility as if the facility were provider-based, or before the main provider can include the costs of those services in its cost report.

We also remind hospitals of the requirements of § 410.27 concerning

services and supplies furnished incident to a physician's service to hospital outpatients. Section 410.27 applies to all ''incident to'' services covered under section 1861(s)(2)(B) of the Act. This provision does not apply to services covered under other benefit categories, such as clinical diagnostic laboratory services covered under section 1833(h)(1) of the Act or diagnostic services covered under section 1861(s)(2)(C) of the Act. Section 410.27(a)(1) currently states that Medicare Part B pays for hospital services and supplies furnished incident to a physician service to outpatients, including drugs and biologicals that cannot be self-administered, if they are furnished by or under arrangements made by a participating hospital, except in the case of a resident of a skilled nursing facility as provided in § 411.15(p); as an integral though incidental part of a physician's services; and in the hospital or at a location (other than a rural health clinic or a Federally qualified health center) that CMS designates as a department of a provider under § 413.65.

We recognize that hospitals consider a variety of business models in their efforts to supply efficient and high quality health care services to Medicare beneficiaries and the general public, and we support such efforts to the extent that they comply with all applicable laws and regulations, including, but not limited to, the Stark law and other anti-kickback laws. Recently, we have received an increasing number of questions about a number of hypothetical business arrangements between hospitals and other entities, including ASCs. We remind hospitals contemplating various business models that involve ''incident to'' services provided to hospital outpatients to consider the requirements of § 410.27. Under § 410.27, ''incident to'' services that are provided to hospital outpatients must be furnished in the hospital or at a department of a provider as described in more detail earlier in our proposed technical update to §§ 410.27(a)(1)(iii) and (f).

With regard to potential for ASCs to provide ''incident to'' services under arrangements with HOPDs, we note that the provider-based rules set forth at § 413.65 do not apply to ASCs. In addition, our longstanding policy codified at § 416.30(f) for ASCs operated by hospitals requires that ''the ASC participates and is paid only as an ASC, without the option of converting to or being paid as a hospital outpatient department, unless CMS determines there is good cause to do otherwise.'' We do not believe good cause exists such that a Medicare-certified ASC would be able to provide ''incident to'' services under arrangement to hospital outpatients under § 410.27. Section 410.27 contains longstanding policy codified in the CY 2000 OPPS final rule with comment period and applies to all ''incident to'' services covered under section1861(s)(2)(B) of the Act. While the hypothetical example we discussed above involves ASCs providing services under arrangement to an HOPD, the provision of § 410.27 applies more broadly to all ''incident to'' services provided either directly or under arrangements made by the hospital with another entity.

B. Interrupted Procedures

(If you choose to comment on issues in this section, please include the caption ''Interrupted Procedures'' at the beginning of your comment.)

Currently, when a procedure is interrupted after its initiation or the administration of anesthesia, hospitals append modifier 74 (Discontinued outpatient procedure after anesthesia administration) to the interrupted procedure, and the full OPPS payment for the procedure is made. In addition, when a procedure requiring anesthesia is discontinued after the beneficiary is prepared for the procedure and taken to the room where the procedure is to be performed, but before the administration of anesthesia, hospitals currently append modifier 73 (Discontinued outpatient procedure prior to anesthesia administration) to the discontinued procedure and receive 50 percent of the OPPS payment for the planned procedure. Hospitals also report modifier 52 to signify that a service that did not require anesthesia was partially reduced or discontinued at the physician's discretion. Modifier 52 is reported under the OPPS for a variety of types of interrupted services, such as radiology services. Under the OPPS, we apply a 50-percent reduction to the facility payment for interrupted procedures and services reported with modifier 52.

We are proposing to amend § 419.44 (Payment reductions for surgical procedures) to more accurately reflect the current OPPS payment policy for interrupted procedures. First, we are proposing to make a technical conforming change to the title of § 419.44 by removing the word ''surgical,'' in order to encompass all the procedures performed in HOPDs. Second, we are proposing to change the heading of § 419.44(b) from ''Terminated procedures'' to ''Interrupted procedures.'' We are proposing to make further technical conforming changes to paragraphs (b)(1) and (b)(2) by removing the words ''surgical'' to encompass all the procedures performed in HOPDs. Finally, we are proposing to add a new paragraph (b)(3) to reflect the current policy of the application of a 50-percent reduction to the OPPS payment when a hospital reports modifier 52 for interrupted or discontinued services that do not require anesthesia.

C. Transitional Adjustments—Hold Harmless Provisions

(If you choose to comment on issues in this section, please include the caption ''Transitional Adjustments—Hold Harmless:'' at the beginning of your comment.)

Section 419.70(d) of the regulations relating to transitional adjustments to payments for covered outpatient services furnished by small rural hospitals and SCHs located in rural areas contains two outdated cross-references to § 412.63(b) (the definition of a hospital located in a ''rural area''). Several years ago, we made § 412.63 applicable from FY 1984 through FY 2004 and established a new § 412.64, effective for FY 2005 and subsequent fiscal years, to incorporate provisions to reflect our adoption of OMB's revised CBSAs as geographic area applicable under Medicare. We are proposing to make a technical correction to the regulations by replacing the cross-reference to § 412.63(b) in §§ 419.70(d)(1)(i), (d)(2)(i), and (d)(4)(ii) with the more current applicable cross-reference to § 412.64(b).

D. Reporting of Wound Care Services

(If you choose to comment on issues in this section, please include the caption ''Wound Care Services'' at the beginning of your comment.)

Section 1834(k) of the Act, as added by section 4541 of the BBA, requires payment under a prospective payment system for all outpatient therapy services, that is, physical therapy services, speech-language pathology services, and occupational therapy services. As provided under section 1834(k)(5) of the Act, we created a therapy code list based on a uniform coding system (that is, the HCPCS) to identify and track these outpatient therapy services paid under the MPFS. We provide this list of therapy codes along with their respective designation in the Medicare Claims Processing Manual Pub. 100–04, Chapter 5, section 20. Two of the designations that we use in that manual denote whether the listed therapy code is an ''always therapy'' service or a ''sometimes therapy'' service. We define an ''always

therapy'' service as a service that must be performed by a qualified therapist under a certified therapy plan of care, and a ''sometimes therapy'' service as a service that may be performed by an individual outside of a certified therapy plan of care.

In the CY 2006 OPPS final rule with comment period (70 FR 68617), we stated that the following CPT codes were classified as ''sometimes therapy'' services that may be appropriately provided under either a certified therapy plan of care or without a certified therapy plan of care: 97597 (Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps) with or without topical application(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 square centimeters); 97598 (Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps) with or without topical application(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area greater than 20 square centimeters); 97602 (Removal of revitalized tissue from wound(s), non-selective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic, abrasion) including topical application(s), wound assessment, and instruction(s) for ongoing care, per session), 97605 (Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters); and 97606 (Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters). We further stated that hospitals would receive separate payment under the OPPS when they bill for wound care services described by CPT codes 97597, 97598, 97602, 97605, and 97606 that are furnished to hospital outpatients by individuals independent of a therapy plan of care. In contrast, when such services are performed by a qualified therapist under a certified therapy plan of care, providers should attach an appropriate therapy modifier (that is, GP for physical therapy, GO for occupational therapy, and GN for speech language pathology) or report their charges under a therapy revenue code (that is, 0420, 0430, or 0440), or both, to receive payment under the MPFS. The OCE logic assigns these services to the appropriate APC for payment under the OPPS if the services are not provided under a certified therapy plan of care, or will direct contractors to the MPFS established payment rates if the services are identified on hospital claims with a therapy modifier or therapy revenue code as therapy services.

For CY 2008, we are proposing to revise the list of therapy revenue codes that may be reported with CPT codes 97597, 97598, 97602, 97605, and 97606 to designate them as services that are performed by a qualified therapist under a certified therapy plan of care, and thus payable under the MPFS, to be consistent with the current billing practices of hospitals and to ensure that we are making separate payment under the OPPS only in appropriate situations. We are proposing to revise the list of therapy revenue codes for reporting these five CPT wound care codes as therapy services to include all revenue codes in the 042X series, which incorporates all revenue codes that begin with 042, such as 0420, 0421, 0422, 0423, 0424, and 0429; the 043X series, which includes all revenue codes that begin with 043, such as 0430, 0431, 0432, 0434, and 0439; and the 044X series, which includes all revenue codes that begin with 044, such as 0440, 0441, 0442, 0443, 0444, and 0449. Therefore, for CY 2008 we are proposing that when services reported with CPT codes 97597, 97598, 97602, 97605, and 97606 are performed by a qualified therapist under a certified therapy plan of care, providers should attach an appropriate therapy modifier (that is, GP for physical therapy, GO for occupational therapy, and GN for speech-language pathology) or report their charge under a therapy revenue code (that is, 042X, 043X, or 044X), or both, to receive payment under the MPFS. Under other circumstances, hospitals would receive separate payment under the OPPS when they bill for wound care services described by CPT codes 97597, 97598, 97602, 97605, and 97606 that are furnished to hospital outpatients by individuals independent of a certified therapy plan of care.

E. Reporting of Cardiac Rehabilitation Services

(If you choose to comment on issues in this section, please include the caption ''Cardiac Rehabilitation Services'' at the beginning of your comment.)

Since the initiation of the OPPS, Medicare has paid for cardiac rehabilitation services in HOPDs using CPT code 93797 (Physician services for outpatient cardiac rehabilitation, without continuous ECG monitoring (per session)) and CPT code 93798 (Physician services for outpatient cardiac rehabilitation, with continuous ECG monitoring (per session)). Both codes are assigned to status indicator ''S'' and are currently mapped to APC 0095 (Cardiac Rehabilitation) for payment.

For CY 2008, we are proposing to discontinue recognizing the current CPT codes for cardiac rehabilitation services and to establish two new Level II HCPCS codes that we believe are more appropriate for specifically reporting cardiac rehabilitation services under the OPPS. The proposed HCPCS codes are: GXXX1 (Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per hour)) and GXXX2 (Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per hour)). In contrast with the current CPT codes, we believe the descriptors of these proposed G-codes more specifically reflect the way cardiac rehabilitation services are provided in HOPDs so that reporting would be more straightforward for hospitals and would result in more accurate data for OPPS ratesetting in 2 years. Consistent with the current APC assignments of the cardiac rehabilitation CPT codes, we are proposing to assign these new HCPCS codes to APC 0095 for CY 2008, with a status indicator of ''S.'' Accordingly, we are proposing to change the status indicators for CPT codes 93797 and 93798 from ''S'' to ''B'' to indicate that alternative codes (GXXX1 and GXXX2) for cardiac rehabilitation services are recognized for payment under the OPPS.

F. Reporting of Bone Marrow and Stem Cell Processing Services

(If you choose to comment on issues in this section, please include the caption ''Bone Marrow and Stem Cell Processing Services'' at the beginning of your comment.)

The OPPS currently recognizes HCPCS code G0267 (Bone marrow or peripheral stem cell harvest, modification or treatment to eliminate cell type(s)) for depletion services for hematopoietic progenitor cells, instead of the more specific CPT codes that describe these services, including CPT codes 38210 (Transplant preparation of hematopoietic progenitor cells; specific

cell depletion within harvest, T-cell depletion); 38211 (Transplant preparation of hematopoietic progenitor cells; tumor cell depletion); 38212 (Transplant preparation of hematopoietic progenitor cells; red blood cell removal); 38213 (Transplant preparation of hematopoietic progenitor cells; platelet depletion); 38214 (Transplant preparation of hematopoietic progenitor cells; plasma (volume) depletion); and 38215 (Transplant preparation of hematopoietic progenitor cells; cell concentration in plasma, mononuclear, of buffy coat layer). These six CPT codes are currently assigned to status indicator ''B,'' while HCPCS code G0267 is assigned to APC 0110 (Transfusion) for payment, with a status indicator of ''S.''

For CY 2008, we are proposing to continue to assign the historical claims data for HCPCS code G0267 to APC 0110. In addition, we are proposing to discontinue recognizing HCPCS code G0267 for CY 2008, assigning it to status indicator ''B,'' and to recognize the six more specific CPT codes, which we are proposing to also assign to APC 0110 with a status indicator of ''S.'' Historically, under the OPPS we recognized the single G-code rather than the CPT codes for the individual transplant cell preparation services because we believed that the services would be uncommonly provided to Medicare beneficiaries in the outpatient setting and would likely require similar resources, so that distinguishing among the services would not be necessary to ensure appropriate OPPS payment. Stakeholders have brought to our attention that the current hospital resources associated with the six different bone marrow and stem cell processing procedures described by these CPT codes may vary widely. While we recognize that the services currently reported with G0267 under the OPPS are not common HOPD procedures, the total volume of these procedures has been increasing over the past several years. Therefore, we believe that recognizing these six CPT codes for bone marrow and stem cell processing services would yield more specific claims data and enable us to pay more appropriately for these services in the future. Consistent with our general OPPS practice, we are proposing to assign the newly recognized CPT codes to the clinical APC that is most appropriate based on historical claims data for the predecessor HCPCS code until we have more specific hospital resource data available to assess the specific CPT codes for possible reassignment.

In addition, we are proposing to discontinue recognition of HCPCS code G0265 (Cyropreservation, freezing and storage of cells for therapeutic use) and G0266 (Thawing and expansion of frozen cells for therapeutic use), currently assigned to status indicator ''A'' under the OPPS and paid according to the Medicare Clinical Laboratory Fee Schedule (CLFS), by assigning them to status indicator ''B'' for CY 2008. We are proposing to recognize, instead, CPT codes 38207 (Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage); 38208 (Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, without washing); and 38209 (Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, with washing) for payment under the OPPS because we believe they are similar to blood processing services that are currently paid under the OPPS, not under the CLFS. We are proposing to assign the single cryopreservation and two thawing CPT codes to APC 0344 (Level IV Pathology) based on their clinical characteristics and resource costs from historical hospital claims data for HCPCS codes G0265 and G0266, which would have been assigned to the same clinical APC if they were paid under the OPPS. Although HCPCS code G0265 and G0266 have not historically been paid under the OPPS, we have a small number of HOPD single claims from CY 2006 for these two predecessor HCPCS codes (when they were paid off the CLFS), respectively, and similar laboratory tissue cryopreservation and thawing services also are proposed for assignment to APC 0344 under the CY 2008 OPPS. We believe this proposal would allow us to pay appropriately for all of these bone marrow and stem cell processing services and to collect more specific hospital resource data.

XIV. Proposed OPPS Payment Status and Comment Indicators

A. Proposed Payment Status Indicator Definitions

(If you choose to comment on issues in this section, please include the caption ''OPPS: Status Indicators'' at the beginning of your comment.)

The OPPS payment status indicators (SIs) that we assign to HCPCS codes and APCs play an important role in determining payment for services under the OPPS. They indicate whether a service represented by a HCPCS code is payable under the OPPS or another payment system and also whether particular OPPS policies apply to the code. Our proposed CY 2008 status indicator assignments for APCs and HCPCS codes are shown in Addendum A and Addendum B, respectively, to this proposed rule. We are proposing to use the status indicators and definitions that are listed in Addendum D1, which we discuss below in greater detail.

1. Proposed Payment Status Indicators to Designate Services That Are Paid under the OPPS

Indicator	Item/code/service	OPPS payment status
G	Pass-Through Drugs and Biologicals	Paid under OPPS; Separate APC payment includes pass through amount.
H	Pass-Through Device Categories	Separate cost-based pass-through payment; Not subject to coinsurance.
K	(1) Non-Pass-Through Drugs and Biologicals	(1) Paid under OPPS; Separate APC payment.
	(2) Therapeutic Radiopharmaceuticals	(2) Paid under OPPS; Separate APC payment.
	(3) Brachytherapy Sources	(3) Paid under OPPS; Separate APC payment.
	(4) Blood and Blood Products	(4) Paid under OPPS; Separate APC payment.
N	Items and Services Packaged into APC Rates	Paid under OPPS; Payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.
P	Partial Hospitalization	Paid under OPPS; Per diem APC payment.

Indicator	Item/code/service	OPPS payment status
Q	Packaged Services Subject to Separate Payment Under OPPS Payment Criteria..	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Separate APC payment based on OPPS payment criteria. (2) If criteria are not met, payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.
S	Significant Procedure, Not Discounted when Multiple.	Paid under OPPS; Separate APC payment.
T	Significant Procedure, Multiple Reduction Applies	Paid under OPPS; Separate APC payment.
V	Clinic or Emergency Department Visit	Paid under OPPS; Separate APC payment.
X	Ancillary Services	Paid under OPPS; Separate APC payment.

As stated in section VII.A. of this proposed rule, subsequent to the publication of the CY 2007 OPPS/ASC final rule with comment period, section 107(a) of the MIEA TRHCA extended the payment period for brachytherapy sources paid under the OPPS based on a hospital's charges adjusted to cost under section 1833(t)(16)(C) of the Act for one additional year. This requirement for cost-based payment ends after December 31, 2007. Therefore, we have continued the OPPS cost-based payment for brachytherapy sources through CY 2007, and have continued using status indicator ''H'' to designate nonpass-through brachytherapy sources paid on a cost basis.

As discussed in section VII.B. of this proposed rule, we are proposing to implement prospective payment for brachytherapy sources paid under the OPPS in CY 2008. In accordance with this proposal, we also are proposing to discontinue our use of payment status indicator ''H'' for APCs assigned to brachytherapy sources. As indicated in section VII.B. of this proposed rule for CY 2008, we are proposing to use payment status indicator ''K'' to designate all brachytherapy source APCs that will be paid under the OPPS.

As discussed in section V.B.3.a.(4) of this proposed rule, we are proposing to implement prospective payment for separately payable therapeutic radiopharmaceuticals under the OPPS in CY 2008. In accordance with this proposal, we also are proposing to discontinue our use of payment status indicator ''H'' for APCs assigned to separately payable therapeutic radiopharmaceuticals. For CY 2008, we are proposing to use payment status indicator ''K'' to designate separately payable therapeutic radiopharmaceuticals that will be paid under the OPPS.

2. Proposed Payment Status Indicators to Designate Services That Are Paid Under a Payment System Other Than the OPPS

Indicator	Item/code/service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS, for example: • Ambulance Services • Clinical Diagnostic Laboratory Services • Non-Implantable Prosthetic and Orthotic Devices • EPO for ESRD Patients • Physical, Occupational, and Speech Therapy • Routine Dialysis Services for ESRD Patients Provided in a Certified Dialysis Unit of a Hospital • Diagnostic Mammography • Screening Mammography	Not paid under OPPS. Paid by fiscal intermediaries under a fee schedule or payment system other than OPPS.
C	Inpatient Procedures	Not paid under OPPS. Admit patient. Bill as inpatient.
F	Corneal Tissue Acquisition; Certain CRNA Services; and Hepatitis B Vaccines.	Not paid under OPPS. Paid at reasonable cost.
L	Influenza Vaccine; Pneumococcal Pneumonia Vaccine	Not paid under OPPS. Paid at reasonable cost; Not subject to deductible or coinsurance.
M	Items and Services Not Billable to the Fiscal Intermediary	Not paid under OPPS.
Y	Non-Implantable Durable Medical Equipment	Not paid under OPPS. All institutional providers other than home health agencies bill to DMERC.

3. Proposed Payment Status Indicators to Designate Services That Are Not Recognized Under the OPPS But That May Be Recognized by Other Institutional Providers

Indicator	Item/code/service	OPPS Payment Status
B	Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and13x).	Not paid under OPPS. • May be paid by intermediaries when submitted on a different bill type, for example, 75x (CORF), but not paid under OPPS. • An alternate code that is recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x) may be available.

4. Proposed Payment Status Indicators to Designate Services That Are Not Payable by Medicare

Indicator	Item/code/service	OPPS Payment Status
D	Discontinued Codes	Not paid under OPPS or any other Medicare payment system.
E	Items, Codes, and Services: ..... • That are not covered by Medicare based on statutory exclusion • That are not covered by Medicare for reasons other than statutory exclusion • That are not recognized by Medicare but for which an alternate code for the same item or service may be available • For which separate payment is not provided by Medicare	Not paid under OPPS or any other Medicare payment system.

To address providers' broader interests and to make the published Addendum B more convenient for public use, we are displaying in Addendum B to this proposed rule all active HCPCS codes that describe items or services that are: (1) Payable under the OPPS; (2) paid under a payment system other than the OPPS; (3) not recognized under the OPPS but that may be recognized by other institutional providers; and (4) not payable by Medicare. The status indicators that we are proposing for CY 2008 for these items and services are listed in the tables above.

A complete listing of HCPCS codes with proposed payment status indicators and APC assignments for CY 2008 is also available electronically on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/HORD/list.asp#TopOfPage.*

B. Proposed Comment Indicator Definitions

(If you choose to comment on issues in this section, please include the caption ''OPPS: Comment Indicators'' at the beginning of your comment.)

In the November 15, 2004 final rule with comment period (69 FR 65827 and 65828), we made final our policy to use two comment indicators to identify in an OPPS final rule the assignment status of a specific HCPCS code to an APC and the timeframe when comments on the HCPCS APC assignment would be accepted. These two comment indicators are listed below.

• ''NF''—New code, final APC assignment; Comments were accepted on a proposed APC assignment in the Proposed Rule; APC assignment is no longer open to comment.

• ''NI''—New code, interim APC assignment; Comments will be accepted on the interim APC assignment for the new code.

In the November 10, 2005 final rule with comment period (70 FR 68702 and 68703), we adopted a new comment indicator:

• ''CH''—Active HCPCS codes in current and next calendar year; status indicator and/or APC assignment have changed.

We implemented comment indicator ''CH'' to designate a change in payment status indicator and/or APC assignment for HCPCS codes in Addendum B of the CY 2006 final rule with comment period. We also stated that codes flagged with the ''CH'' indicator in that final rule would not be open to comment because the changes generally were previously subject to comment during the proposed rule comment period. For CY 2008, we are proposing to continue that policy in the CY 2008 OPPS/ASC final rule with comment period. When used in an OPPS final rule, the ''CH'' indicator is only intended to facilitate the public's review of changes made from one calendar year to another. We are proposing to use the ''CH'' indicator in the CY 2008 OPPS/ASC final rule with comment period to indicate HCPCS codes for which the status indicator or APC assignment, or both, would change in CY 2008 compared to their assignment as of December 31, 2007.

However, only HCPCS codes with comment indicator ''NI'' in the CY 2008 OPPS/ASC final rule with comment period would be subject to comment during the comment period for the final rule with comment period.

We are using the ''CH'' indicator in this proposed rule to call attention to proposed changes in the payment status indicator and/or APC assignment for HCPCS codes for CY 2008. The use of the comment indicator ''CH'' in association with a composite APC indicates that the configuration of the composite APC is proposed for change in this proposed rule.

In this proposed rule, the ''CH'' indicator is appended to HCPCS codes for which we have proposed changes in the payment status indicator and/or APC assignment for CY 2008 compared to their assignment as of June 30, 2007. We believe that using the ''CH'' indicator in this proposed rule will facilitate the public's review of the changes that we are proposing to make final in CY 2008. Use of the ''CH'' indicator in this proposed rule is significant because it highlights changes that are subject to comment during the proposed rule comment period.

We are proposing to terminate comment indicator ''NF'' because its use is no longer relevant in the final rule(s). The two comment indicators, ''NI'' and ''CH,'' that we are proposing to continue using in CY 2008 and their definitions are listed in Addendum D2 to this proposed rule.

XV. OPPS Policy and Payment Recommendations

A. MedPAC Recommendations

The MedPAC submits reports to Congress in March and June that summarize payment policy recommendations. The March 2007 MedPAC report included the following recommendation relating specifically to the hospital OPPS:

Recommendation 2A–1: The Congress should increase payment rates for the outpatient prospective payment system in 2008 by the projected rate-of-increase in the hospital market basket index, concurrent with the implementation of a quality incentive payment program.

CMS Response: We are proposing to increase the payment rates for the CY 2008 OPPS by the projected rate-of-increase in the hospital market basket index (as discussed in section II.C. of this proposed rule) and to implement, effective for CY 2009, the reduction in the annual update factor by 2.0 percentage points for subsection (d) hospitals that do not meet the outpatient hospital quality reporting required by section 1833(t)(17) of the Act, as added by section 109(b) of the MIEA-TRHCA. Our proposal for implementing the hospital quality reporting measures for the CY 2008 OPPS is discussed in detail in section XVII. of this proposed rule.

B. APC Panel Recommendations

Recommendations made by the APC Panel at its March 2007 meeting are discussed in sections of this proposed rule that correspond to topics addressed by the APC Panel. Minutes of the APC Panel's March 7–9, 2007 meeting are available on the CMS Web site at: *http://www.cms.hhs.gov/FACA/05_AdvisoryPanelonAmbulatoryPaymentClassification Groups.asp*.

XVI. Proposed Update of the Revised Ambulatory Surgical Center Payment System

A. Legislative and Regulatory Authority for the ASC Payment System

Section 1832(a)(2)(F)(i) of the Act provides that benefits under the Medicare Part B include payment for facility services furnished in connection with surgical procedures specified by the Secretary that are performed in an ASC. To participate in the Medicare program as an ASC, a facility must meet the standards specified in section 1832(a)(2)(F)(i) of the Act, which are implemented in 42 CFR Part 416, Subpart B and Subpart C of our regulations. The regulations at 42 CFR 416, Subpart B set forth general conditions and requirements for ASCs, and the regulations at Subpart C provide specific conditions for coverage for ASCs.

To establish the reasonable estimated allowances for ASC facility services, section 1833(i)(2)(A)(i) of the Act required us to take into account the audited costs incurred by ASCs to perform a procedure, in accordance with a survey. The ASC services benefit was enacted by Congress through the Omnibus Reconciliation Act of 1980 (Pub. L. 96 499). For a detailed discussion of the legislative history related to ASCs, we refer readers to the June 12, 1998 proposed rule (63 FR 32291).

Section 141(b) of the Social Security Act Amendments of 1994, Pub. L. 103–432, requires us to establish a process for reviewing the appropriateness of the payment amount provided under section 1833(i)(2)(A)(iii) of the Act for intraocular lenses (IOLs) that belong to a class of new technology intraocular lenses (NTIOLs). That process was the subject of a separate final rule entitled ''Adjustment in Payment Amounts for New Technology Intraocular Lenses Furnished by Ambulatory Surgical Centers,'' published on June 16, 1999, in the **Federal Register** (64 FR 32198).

Section 626(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108–173, repealed the requirement formerly found in section 1833(i)(2)(A) of the Act that the Secretary conduct a survey of ASC costs for purposes of updating ASC payment rates and required the Secretary to implement a revised ASC payment system, to be effective not later than January 1, 2008.

Section 5103 of the DRA, Pub. L. 109–171, amended section 1833(i)(2) of the Act by adding a new subparagraph (E) to place a limitation on payments for surgical procedures in ASCs. The amended language provides that if the standard overhead amount under section 1833(i)(2)(A) of the Act for an ASC facility service for such surgical procedures, without application of any geographic adjustment, exceeds the Medicare payment amount under the hospital OPPS for the service for that year, without application of any geographic adjustment, the Secretary shall substitute the OPPS payment amount for the ASC standard overhead amount. This provision applies to surgical procedures furnished in ASCs on or after January 1, 2007, and before the effective date of the revised ASC payment system (see the final rule for the revised ASC payment system published elsewhere in this issue of the **Federal Register**).

Section 109(b) of the MIEA–TRHCA, Pub. L.109–432, amended section 1833(i) of the Act, in part, by adding new clause (iv) to paragraph (2)(D) and by also adding new paragraph (7)(A), which provides that the Secretary may reduce the annual ASC update by 2 percentage points if an ASC fails to submit data as required by the Secretary on selected measures of quality of care, including medication errors. Section 109(b) of MIEA–TRCHA requires that certain quality of care reporting requirements mandated for hospitals paid under the OPPS by section 109(a) of the MIEA–TRCHA be applied in a similar manner to ASCs unless otherwise specified by the Secretary. We refer readers to sections XVII.A. and H. of this proposed rule for further discussion of this provision and our plans for future ASC implementation

B. Rulemaking for the Revised ASC Payment System

On August 23, 2006, we proposed in the **Federal Register** (71 FR 49635) a revised payment system for ASCs to be implemented effective January 1, 2008, in accordance with section 626(b) of Pub. L. 108–173. The proposal included, among other things, revisions to the ASC list of covered surgical procedures for CY 2008 and the payment methodology for the items and services furnished by the ASC.

We are publishing elsewhere in this issue of the **Federal Register** the final rule for the revised ASC payment system, effective January 1, 2008, hereinafter referred to as the July 2007 final rule for the revised ASC payment system. In that final rule, we established that we would address two components of the ASC payment system annually as part of the OPPS rulemaking cycle. Section 1833(i)(1) of the Act requires us to specify, in consultation with appropriate medical organizations, surgical procedures that are appropriately performed on an inpatient basis in a hospital but that can be safely performed in an ASC, CAH, or an HOPD and to review and update the list of ASC procedures at least every 2 years.

In the July 2007 final rule for the revised ASC payment system, we also adopted the method we will use to set payment rates for ASC services furnished in association with covered surgical procedures. Updating covered surgical procedures and covered ancillary services, as well as their payment rates, in association with the annual OPPS rulemaking cycle is particularly important because the OPPS relative payment weights and rates will be used as the basis for the payment of most covered surgical

procedures and covered ancillary services under the revised ASC payment system. This joint update process will ensure that the ASC updates occur in a regular, predictable, and timely manner. The final rule included applicable regulatory changes to 42 CFR Parts 410 and 416.

In this CY 2008 OPPS/ASC proposed rule, we are proposing to update the revised ASC payment system for CY 2008, along with the OPPS. We are also proposing to revise the regulations to make practice expense payment to physicians who perform noncovered ASC procedures in ASCs based on the facility practice expense (PE) relative value units (RVUs) and to exclude covered ancillary radiology services and covered ancillary drugs and biologicals from the categories of designated health services (DHS) that are subject to the physician self-referral prohibition.

C. Revisions to the ASC Payment System Effective January 1, 2008

1. Covered Surgical Procedures Under the Revised ASC Payment System

a. Definition of Surgical Procedure

In order to delineate the scope of procedures that constitute ''outpatient surgical procedures'' for payment under the revised ASC payment system, in the July 2007 final rule for the revised ASC payment system, we clarified what we consider to be a ''surgical'' procedure. Under the ASC payment system existing through CY 2007, we define a surgical procedure as any procedure described within the range of Category I CPT codes that the CPT Editorial Panel of the AMA defines as ''surgery'' (CPT codes 10000 through 69999). Under the revised payment system, we continue to define surgery using that standard. We also include within the scope of surgical procedures payable in an ASC those procedures that are described by Level II HCPCS codes or by Category III CPT codes that directly crosswalk or are clinically similar to procedures in the CPT surgical range that we have determined do not pose a significant safety risk and that we would not expect to require an overnight stay when performed in ASCs. Having established what we consider to be a ''surgical procedure,'' we defined criteria that enable us to identify procedures that could pose a significant safety risk when performed in an ASC or that we expect would require an overnight stay within the bounds of prevailing medical practice.

b. Identification of Surgical Procedures Eligible for Payment Under the Revised ASC Payment System

ASC ''covered surgical procedures'' are those surgical procedures for which payment is made under the revised ASC payment system. Our final policy for identifying surgical procedures eligible for ASC payment excludes those surgical procedures that are on the OPPS inpatient list, procedures that are packaged under the OPPS, CPT unlisted surgical procedure codes, and surgical procedures that are not recognized for payment under the OPPS. Further, we exclude from ASC payment any procedure for which standard medical practice dictates that the beneficiary would typically be expected to require active medical monitoring and care at midnight following the procedure (overnight stay), and all surgical procedures that could pose a significant safety risk to Medicare beneficiaries. The criteria used under the revised ASC payment system to identify procedures that could pose a significant safety risk when performed in an ASC include those procedures that: generally result in extensive blood loss; require major or prolonged invasion of body cavities; directly involve major blood vessels; are emergent or life-threatening in nature; or commonly require systemic thrombolytic therapy. These criteria for evaluating surgical procedures are set forth in § 416.166(c).

c. Payment for Covered Surgical Procedures Under the Revised ASC Payment System

(1) General Policies

To make payment for most covered surgical procedures, we utilize the OPPS APCs as a ''grouper'' and the APC relative payment weights as the basis for ASC relative payment weights and for calculating ASC payment rates under the revised payment system, by applying a uniform ASC conversion factor to the ASC payment weights. For the first year of the revised ASC payment system, we adopted the OPPS relative payment weights as the ASC relative payment weights for most covered surgical procedures.

For future years, we will update the ASC relative payment weights annually using the OPPS relative payment weights for that calendar year, as well as the practice expense payment amounts under the MPFS schedule for that calendar year, because some covered office-based surgical procedures and covered ancillary services will be paid according to MPFS amounts if those amounts are less than the rates calculated under the standard methodology of the revised ASC payment system.

Just as we scale the OPPS relative payment weights each year to ensure that the OPPS is budget neutral from one year to the next, we will rescale relative weights each year for the revised ASC payment system. The purpose of scaling the relative weights is to ensure that the estimated aggregate payments under the ASC payment system for an upcoming year would be neither greater than nor less than the aggregate payments that would be made in the prior year, taking into consideration any changes or recalibrations for the upcoming year. Rescaling enables us to compensate for the effects of changes in the OPPS relative payment weights from year to year for services that are not performed in ASCs (for example, due to sudden increases or decreases in the costs of hospital outpatient emergency department visits) that could inappropriately cause the estimated ASC expenditures to increase or decrease as a function of those changes.

To establish the budget neutrality adjustment for the revised ASC payment system, we used a model that accounts for the migration of surgical procedures between ASCs, physicians' offices, and HOPDs as discussed in the July 2007 final rule for the revised ASC payment system. The budget neutrality adjustment for CY 2008 is based on updated proposed CY 2008 OPPS and MPFS rates, along with updated utilization data. The estimated ASC CY 2008 budget neutrality adjustment factor is multiplied by the proposed OPPS conversion factor to establish the proposed ASC conversion factor. The standard ASC payment for most of the covered surgical procedures displayed in Addendum AA of this proposed rule is calculated as the product of that proposed ASC conversion factor multiplied by the proposed OPPS relative payment weight for each separately payable procedure. A more detailed discussion of the methodology is provided in section XVI.L. of this proposed rule.

Beginning in CY 2010, we will update the ASC conversion factor for the revised ASC payment system by the percentage increase in the CPI–U (U.S. city average), as estimated for the 12-month period ending with the midpoint of the year involved. At the same time, we recognize that we continue to have flexibility under the statute to employ a different update mechanism under the revised ASC payment system. As one example, we do not intend for the revised ASC payment system to result in additional Medicare expenditures over

time. We will be monitoring this issue closely in the coming years. Consequently, we will reconsider the ASC update if expenditures increase inappropriately in future years.

(2) Office-Based Procedures

Among the procedures newly identified as covered surgical procedures for payment in ASCs beginning in CY 2008 are many procedures that are performed most of the time in physicians' offices. These procedures neither pose a significant safety risk nor are they expected to require an overnight stay when performed in ASCs, and they generally require a lower level of resource intensity than do most other ASC covered surgical procedures. For those reasons, in the July 2007 final rule for the revised ASC payment system, we adopted a policy to include them as covered surgical procedures but to ensure that payment for the facility resources associated with the procedures identified as ''office-based'' would not be greater when provided in ASCs than when furnished in physicians' offices.

Under the revised ASC payment system, we cap payment for office-based surgical procedures for which ASC payment would first be allowed beginning in CY 2008 or later years at the lesser of the MPFS nonfacility practice PE RVU amount or the ASC rate developed according to the standard methodology of the revised ASC payment system. For those office-based procedures for which there is no available MPFS nonfacility PE RVU amount, we will implement the cap, as appropriate, once a MPFS nonfacility PE RVU amount is available. Once procedures are finalized as being office-based procedures, they remain designated as office-based. We may propose that additional HCPCS codes be classified as office-based in a proposed rule for an annual ASC update after review of the most recent available utilization data. We consider for additional designation as office-based those procedures newly paid in ASCs in CY 2008 or later years that our review concludes are performed predominantly (more than 50 percent of the time) in physicians' offices, based on our consideration of volume and site of service utilization data for the procedures, as well as clinical information and comparable data for related procedures, if appropriate.

Procedures designated as office-based for CY 2008 are identified in Addendum AA to this proposed rule and assigned payment indicators ''P2'' (Office-based surgical procedures added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight); ''P3'' (Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs); and ''R2'' (Office-based surgical procedure added to ASC list in CY 2008 or later without MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight). Those procedures for which the designation as office-based is newly proposed for CY 2008 are identified in Addendum AA with comment indicator ''CH'' and those for which the payment indicator is a temporary designation are marked by an asterisk. The temporary designation means that the office-based payment indicator (''P2,'' '' P3,'' or ''R2'') assigned to the procedure is temporary because the code is a new HCPCS code for which we have insufficient data upon which to base a proposal for a final decision regarding the code's office-based status. The temporary designation will be reevaluated by CMS when there are data upon which to base a proposal for a final payment indicator. The remainder of the office-based procedure designations was finalized in the July 2007 final rule for the revised ASC payment system.

(3) Device-Intensive Procedures

Under the final policy of the revised ASC payment system, we use a modified payment methodology to establish the ASC payment rates for device-intensive procedures. We identify device-intensive procedures as covered surgical procedures that, under the OPPS, are assigned to those device-dependent APCs for which the ''device offset percentage'' is greater than 50 percent of the APC's median cost. The device offset percentage is our best estimate of the percentage of device cost that is included in an APC payment under the OPPS. The CY 2008 proposed device-dependent APCs and device offset percentages are discussed in section IV.A. of this proposed rule.

According to the final ASC policy, payment for implantable devices is packaged into payment for the covered surgical procedures, but we utilize a modified ASC methodology based on OPPS data to establish payment rates for the device-intensive procedures under the revised ASC payment system. According to that modified payment methodology, we apply the OPPS device offset percentage to the OPPS national unadjusted payment to determine the device cost included in the OPPS payment rate for a device-intensive ASC covered surgical procedure, which we then set as equal to the device portion of the national unadjusted ASC payment rate for the procedure. We then calculate the service portion of the ASC payment for device-intensive procedures by applying the uniform ASC conversion factor to the service (nondevice) portion of the OPPS relative payment weight for the device-intensive procedure. Finally, we sum the ASC device portion and ASC service portion to establish the full payment for the device-intensive procedure under the revised ASC payment system. For example, if the OPPS device offset percentage for the procedure is 80 percent and the OPPS national unadjusted payment is $100, the device cost included in that payment is $80. Under the ASC payment system, we also would pay $80 for the device portion of the procedure but the service portion of the OPPS payment, $20, would be adjusted by the budget neutrality adjustment factor (for example, using the proposed budget neutrality factor, the calculation would be: $20 x 0.65 = $13) and, if it is subject to the transition (as set forth in section XVI.C.1.c.(5) of this proposed rule), it would also be adjusted accordingly. If the procedure in the example is not subject to the transition, its CY 2008 payment would be equal to $93 ($80 + $13). This example illustrates the contributions of the device and service payment amounts to the national unadjusted ASC payment rate; payment to an ASC for the device-intensive service would be subject to the 50 percent geographic adjustment.

We also reduce the amount of payment made to ASCs for device-intensive procedures assigned to certain OPPS APCs in those cases in which the necessary device is furnished without cost to the ASC or the beneficiary, or with a full credit for the cost of the device being replaced. A full discussion of that policy may be found in section XVI.F. of this proposed rule.

(4) Multiple and Interrupted Procedure Discounting

Under the revised ASC payment system, we discount payment for certain multiple and interrupted procedures performed in ASCs. While most covered surgical procedures will be subject to a 50-percent reduction in ASC payment for the lower paying procedure when more than one procedure is performed in a single operative session, those covered surgical procedures that we are proposing to exempt from the multiple procedure reduction in ASCs because they are proposed to not be subject to this reduction under the OPPS are identified in Addendum AA to this

proposed rule. Procedures requiring anesthesia that are terminated after the patient has been prepared for surgery and taken to the operating room but before the administration of anesthesia will be reported with modifier 73, and the ASC payment for the covered surgical procedure will be reduced by 50 percent. Procedures requiring anesthesia that are terminated after administration of anesthesia or initiation of the procedure will be reported with modifier 74, and the ASC payment for the covered surgical procedure will be made at 100 percent of the established payment rate. Procedures and services not requiring anesthesia that are partially reduced or discontinued at the physician's discretion are reported with modifier 52, and the ASC payment for the covered surgical procedure or covered ancillary service is reduced by 50 percent.

(5) Transition to Revised ASC Payment Rates

Under the revised ASC payment system, we are providing a payment transition of 4 years for all services on the CY 2007 ASC list of covered surgical procedures. Beginning in CY 2008, the contribution of CY 2007 ASC payment rates to the blended transitional rates will decrease by 25 percentage point increments each year of transitional payment, until CY 2011, when we will fully implement the revised ASC payment rates calculated under the final methodology of the revised payment system. While we do not subject the device payment portion of the total ASC payment for a device-intensive procedure to the transition policy, we transition the service payment portion of the total ASC payment for the procedure over the 4 year phase-in period. Procedures new to ASC payment for CY 2008 or later calendar years receive payments determined according to the final methodology of the revised ASC payment system, without a transition.

ASC covered surgical procedures listed in Addendum AA to this proposed rule that are subject to the transition are assigned payment indicators ''A2'' (Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight) and ''H8'' (Device-intensive procedure on ASC list in CY 2007; paid at adjusted rate). ASC covered surgical procedures listed in Addendum AA to this proposed rule that are not subject to the transition are assigned payment indicators ''G2'' (Nonoffice-based surgical procedure added to ASC list in CY 2008 or later; payment based on OPPS relative payment weight); ''J8'' (Device-intensive procedure added to ASC list in CY 2008 or later; paid at adjusted rate); ''P2'' (Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight); ''P3'' (Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs); and ''R2'' (Office-based surgical procedure added to ASC list in CY 2008 or later without MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight).

2. Covered Ancillary Services Under the Revised ASC Payment System

a. General Policies

As described in § 416.163, payment is made under the revised ASC payment system for ASC services furnished in connection with covered surgical procedures. As set forth in § 416.2, ASC services include both facility services, which are defined as services that are furnished in connection with a covered surgical procedure performed in an ASC and for which payment is packaged into the ASC payment for the covered surgical procedure, and covered ancillary services, which are defined as those items and services that are integral to a covered surgical procedure and for which separate payment may be made under the revised ASC payment system.

Under the final policy of the revised ASC payment system, covered ancillary services are allowed separate payment. Covered ancillary services are defined at § 416.164(b) as follows: brachytherapy sources; certain implantable items that have pass-through status under the OPPS; certain items and services that we designate as contractor-priced (payment rate is determined by the Medicare contractor) including, but not limited to, the procurement of corneal tissue; certain drugs and biologicals for which separate payment is allowed under the OPPS; and certain radiology services for which separate payment is allowed under the OPPS.

We continue to consider to be outside the scope of ASC services, as set forth in § 416.164(c), the following items and services, including, but not limited to: physicians' services (including surgical procedures and all preoperative and postoperative services that are performed by a physician); anesthetists' services; radiology services (other than those integral to performance of a covered surgical procedure); diagnostic procedures (other than those directly related to performance of a covered surgical procedure); ambulance services; leg, arm, back, and neck braces other than those that serve the function of a cast or splint; artificial limbs; and nonimplantable prosthetic devices and DME.

b. Payment Policies for Specific Items and Services

(1) Radiology Services

Under the revised ASC payment system, we make separate payment to ASCs for ancillary radiology services designated as separately payable under the OPPS, when those radiology services are provided in the ASC integral to the performance of a covered surgical procedure provided on the same day. ASC payment for those ancillary services is at the lower of the rate developed according to the standard methodology of the revised ASC payment system or the MPFS nonfacility PE RVU amount (specifically for the technical component (TC) if the service is assigned a TC under the MPFS). No separate payment is made for those ancillary services that are designated as packaged under the OPPS. We specify that a radiology service is integral to the performance of a covered surgical procedure if it is required for the successful performance of the surgery and is performed in the ASC immediately preceding, during, or immediately following the covered surgical procedure. Payment under the revised ASC payment system for these ancillary radiology services is subject to geographic adjustment, like payment for ASC surgical procedures. Only the ASC can receive payment for the facility resources required to provide the ancillary radiology services, and ASCs are no longer able to bill as independent diagnostic testing facility (IDTF) suppliers to receive payment for ancillary radiology services that are integral to the performance of a covered surgical procedure for which the ASC is billing Medicare. Because the packaging status of radiology services under the revised ASC payment system parallels the OPPS, any changes to the packaging of radiology services under the OPPS would also occur under the revised ASC payment system.

Radiology services include all Category I CPT codes in the radiology range established by CPT, from 70000 to 79999, and Category III CPT codes and Level II HCPCS codes that describe radiology services that crosswalk or are clinically similar to procedures in the radiology range established by CPT. This revised ASC payment system policy for each calendar year applies to all radiology services that are separately

payable under the OPPS in that same calendar year. A listing that includes all radiology services that we are proposing for separate payment under the CY 2008 ASC payment system because they would be separately payable under the proposed CY 2008 OPPS may be found in Addendum BB to this proposed rule. Separately paid radiology services are assigned payment indicator ''Z2'' (Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS relative payment weight) or ''Z3'' (Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on MPFS nonfacility PE RVUs). Payment for ancillary radiology services that are packaged under the OPPS is packaged under the revised ASC payment system, and these services are identified in Addendum BB to this proposed rule with payment indicator ''N1'' (Packaged service/item; no separate payment made). ASC payment for these radiology services is not subject to the 4-year transition.

(2) Brachytherapy Sources

Under the revised ASC payment system, we provide separate payment to ASCs for brachytherapy sources as covered ancillary services when they are implanted in conjunction with covered surgical procedures billed by ASCs. The application of the brachytherapy sources is integrally related to the surgical procedures for insertion of brachytherapy needles and catheters. There is a statutory requirement that the OPPS establish separate payment groups for brachytherapy sources related to their number, radioisotope, and radioactive intensity, as well as for stranded and non-stranded sources as of July 1, 2007. OPPS procedure payments specifically do not include payment for brachytherapy sources. The ASC brachytherapy source payment rate for a given calendar year is the same as the OPPS payment rate for that year, without application of the ASC budget neutrality adjustment or, if specific OPPS prospective payment rates are unavailable, ASC payments for brachytherapy sources are contractor-priced. In addition, consistent with the payment of brachytherapy sources under the OPPS, the ASC payment rates for brachytherapy sources are not adjusted for geographic wage differences. Some Level II HCPCS codes and their proposed payment rates for brachytherapy sources for the CY 2008 revised ASC payment system, the same as those proposed for the CY 2008 OPPS, are included in Addendum BB to this proposed rule. Brachytherapy sources are assigned payment indicator ''H2'' (Brachytherapy source paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate). We note that the brachytherapy source payment indicator has changed for this proposed rule from the July 2007 final rule for the revised ASC payment system, in which sources were designated with payment indicator H4, defined as ''Brachytherapy source paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced.'' During CY 2007, brachytherapy source payment is made under the OPPS, according to the statute, at charges adjusted to cost. In order to be consistent with that OPPS policy under the revised ASC payment system, our policy is to pay for brachytherapy sources under the revised ASC payment system using contractor-based pricing because we have no CCR data for ASCs that would enable us to pay at charges adjusted to cost like we do under the OPPS. However, the CY 2008 proposal for OPPS payment of brachytherapy sources, as described in section VII. of this proposed rule, proposes payment at prospective rates calculated from historical claims data and, therefore, the proposed ASC payment for brachytherapy sources would be at those same rates. The HCPCS codes for all brachytherapy sources and their proposed ASC payment amounts and ASC payment indicators are listed in Table 57 below.

TABLE 57.—PROPOSED CY 2008 PAYMENTS FOR BRACHYTHERAPY SOURCES PROVIDED IN ASCS

HCPCS code	Short descriptor	ASC payment indicator	Proposed CY 2008 ASC payment rate
A9527	Iodine I–125 sodium iodide	H2	$28.62
C1716	Brachytx, non-str, Gold-198	H2	31.95
C1717	Brachytx, non-str, HDR Ir-192	H2	173.40
C1719	Brachytx, NS, Non-HDR Ir-192	H2	57.40
C2616	Brachytx, non-str,Yttrium-90	H2	11,943.79
C2634	Brachytx, non-str, HA, I–125	H2	29.93
C2635	Brachytx, non-str, HA, P–103	H2	47.06
C2636	Brachy linear, non-str, P–103	H2	37.09
C2638	Brachytx, stranded, I–125	H2	42.86
C2639	Brachytx, non-stranded, I–125	H2	31.91
C2640	Brachytx, stranded, P–103	H2	62.24
C2641	Brachytx, non-stranded, P–103	H2	45.29
C2642	Brachytx, stranded, C–131	H2	97.72
C2643	Brachytx, non-stranded, C–131	H2	51.35
C2698	Brachytx, stranded, NOS	H2	42.46
C2699	Brachytx, non-stranded, NOS	H2	29.93

The brachytherapy source HCPCS codes listed in Table 57 are not all included in Addendum BB to this proposed rule because they were new in July 2007, and Addendum BB reflects only those codes available for the April 2007 update to the OPPS. Although the proposed ASC payment rates for the new brachytherapy source HCPCS codes implemented under the OPPS in July 2007 are not displayed in Addendum BB to this proposed rule, they will be included in Addendum BB to the CY 2008 OPPS/ASC final rule with comment period and their final payment will be effective under the revised ASC payment system, beginning January 1, 2008.

(3) Drugs and Biologicals

Under the revised ASC payment system, we pay separately for all drugs and biologicals that are separately paid under the OPPS, when they are provided integral to a covered surgical procedure that is billed by the ASC to Medicare. We specify that a drug or biological is integral to a covered

surgical procedure if it is required for the successful performance of the surgery and is provided to the beneficiary in the ASC immediately preceding, during, or immediately following the covered surgical procedure. Payments for separately payable drugs and biologicals under the revised ASC payment system for a calendar year are equal to the OPPS payment rates for that same year, without application of the ASC budget neutrality adjustment. In addition, consistent with the payment of drugs and biologicals under the OPPS, the ASC payment rates for these items are not adjusted for geographic wage differences.

A list of the drugs and biologicals that we are proposing for separate payment under the CY 2008 revised ASC payment system and their proposed payment rates are included in Addendum BB to the proposed rule. Separately paid drugs and biologicals are assigned payment indicator ''K2'' (Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate). Drugs and biologicals for which we are proposing to package payment into the ASC payment for the covered surgical procedure in CY 2008 because we are proposing to package under the OPPS for CY 2008, are also listed in Addendum BB, where they are assigned payment indicator ''N1'' (Packaged service/item; no separate payment made).

(4) Implantable Devices with Pass-Through Status under the OPPS

Under the revised ASC payment system, we provide separate payment at contractor-priced rates for devices that are included in device categories with pass-through status under the OPPS when the devices are an integral part of a covered surgical procedure. As we have specified for drugs, biologicals, and ancillary radiology services, a pass-through device would be considered integral to the covered surgical procedure when it is required for the successful performance of the procedure; is provided in the ASC immediately before, during, or immediately following the covered surgical procedure; and is billed by the ASC on the same day as the covered surgical procedure.

In the future, new device categories may be established that will have OPPS pass through status during all or a portion of any calendar year. For CY 2008, there are two device categories with OPPS pass-through status that are proposed to continue in that status under the OPPS for CY 2008, specifically HCPCS code C1821 (Interspinous process distraction device (implantable)), and HCPCS code L8690 (Auditory osseointegrated device, includes all internal and external components). We note that only the surgical procedures associated with the implantation of HCPCS code L8690 are ASC covered surgical procedures for CY 2008. As under the OPPS, ASC payment for pass-through devices is not subject to the geographic wage adjustment.

The proposed pass-through device category HCPCS codes are included in Addendum BB to this proposed rule and are assigned payment indicator ''J7'' (OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced). Implantable devices that receive packaged payment because they do not have OPPS pass-through status are also listed in Addendum BB to this proposed rule, where they are assigned payment indicator ''N1'' (Packaged service/item; no separate payment made).

The associated non-device facility resources for the device implantation procedures are paid through the ASC surgical procedure service payment, based upon the payment weight for the non-device portion of the related OPPS APC payment weight.

(5) Corneal Tissue Acquisition

Under the revised ASC payment system, we pay separately for corneal tissue procurement provided integral to the performance of an ASC covered surgical procedure based on invoice costs. The HCPCS code for corneal tissue acquisition, V2785 (Processing, preserving and transporting corneal tissue), is listed in Addendum BB to this proposed rule, and it is assigned payment indicator ''F4'' (Corneal tissue processing; paid at reasonable cost).

3. General Payment Policies

a. Geographic Adjustment

Under the revised ASC payment system policy, we utilize 50 percent as the labor related share. Fifty percent is significantly higher than the labor-related share used for the ASC payment system through CY 2007 (34.45 percent) but is also lower than the OPPS labor-related share of 60 percent, a differential we believe is appropriate given the broader range of labor-intensive services provided in the HOPD setting.

Consistent with the OPPS, we apply to ASC payments the IPPS pre reclassification wage index values associated with the June 2003 OMB geographic localities, as recognized under the IPPS and OPPS, in order to adjust the labor-related portion of the national ASC payment rates for geographic wage differences. b. Beneficiary Coinsurance

Under the revised ASC payment system, beneficiary coinsurance remains at 20 percent for ASC services, except for screening flexible sigmoidoscopy and screening colonoscopy procedures. The coinsurance for screening colonoscopies and screening flexible sigmoidoscopies is 25 percent, as required by section 1834(d) of the Act, with no deductible for those services under the revised ASC payment system.

D. Proposed Treatment of New HCPCS Codes

1. Treatment of New CY 2008 Category I and III CPT Codes and Level II HCPCS Codes

We finalized a policy in the July 2007 final rule for the revised ASC payment system to evaluate each year all new HCPCS codes that describe surgical procedures to make preliminary determinations regarding whether or not they meet the criteria for payment in the ASC setting and, if so, whether they are office-based procedures. In the absence of claims data that indicate where procedures described by new codes are being performed and reflect the facility resources required to perform them, we decided to use other available information to make our interim decisions regarding assignment of payment indicators for the new codes. The other data available to us include our clinical advisors' judgment, data regarding predecessor and related HCPCS codes, information submitted by representatives of specialty societies and professional associations, and information submitted by commenters during the public comment period following publication of the final rule with comment period in the **Federal Register**. We will publish in the annual OPPS/ASC payment update final rule the interim ASC determinations for the new codes to be effective January 1 of the update year. The interim payment indicators assigned to new codes under the revised ASC payment system will be subject to comment in that final rule. We will respond to those comments in the OPPS/ASC update final rule for the following calendar year, just as we currently respond to OPPS comments about APC and status indicator assignments for new procedure codes in the OPPS update final rule for the year following publication of the code's interim OPPS treatment.

After our review of public comments and in the absence of physicians' claims data, our determination that a new code

is an office based procedure and is, thereby, subject to the payment limitation, would remain temporary and subject to review, until there are adequate data available to assess the procedure's predominant sites of service. Using those data, if we confirm our determination that the new code is office-based after taking into account the most recent available volume and utilization data for the procedure code and/or, if appropriate, the clinical characteristics, utilization, and volume of related codes, the code would be assigned permanently to the list of office-based procedures subject to the ASC payment limitation.

New HCPCS codes for ASC implementation on January 1, 2008, will be designated in Addenda AA and BB to the OPPS/ASC final rule with comment period with comment indicator ''NI.'' The ''NI'' comment indicator is used to identify those HCPCS codes for which the assigned ASC payment indicator is subject to public comment. (We refer readers to section XVI.J. of this proposed rule for discussion of ASC payment and comment indicators.)

2. Proposed Treatment of New Mid-Year Category III CPT Codes

Twice each year, the AMA issues Category III CPT codes, which the AMA defines as temporary codes for emerging technology, services, and procedures. The AMA established Category III CPT codes to allow collection of data specific to the service described by the code which otherwise could only be reported using a Category I CPT unlisted code. The AMA releases Category III CPT codes in January, for implementation beginning the following July, and in July, for implementation beginning the following January.

CMS provides a predictable quarterly update for the OPPS occurring throughout each calendar year (January, April, July, and October), and the final payment policies of the revised ASC payment system parallel, in many cases, the OPPS treatment of HCPCS codes. As discussed in the July 2007 final rule for the revised ASC payment system, we will provide a quarterly ASC update for each calendar quarter to recognize newly created HCPCS codes for ASC payment and to update the payment rates for separately paid drugs and biologicals based on the most recently submitted ASP data.

Under the OPPS and MPFS, CMS allows Category III CPT codes that are released by the AMA in January to be effective beginning July of the same calendar year in which they are issued, rather than deferring implementation of those codes to the following calendar year update of the payment systems, as is the case for the Category III codes that are released in July by the AMA for implementation in January of the upcoming calendar year. Therefore, in contrast to the Category I CPT codes that are issued only once annually and that CMS recognizes as effective under the MPFS and OPPS each January for the new calendar year, new Category III CPT codes are made effective under the MPFS and OPPS biannually. In order to be consistent in this regard across the three payment systems, we are proposing to adopt that same policy under the revised ASC payment system.

Some of the new Category III CPT codes may describe services that our medical advisors determine directly crosswalk or are clinically similar to HCPCS codes that describe ASC covered surgical procedures. In those instances, we may allow ASC payment for the new Category III CPT code as a covered surgical procedure. Similarly, the new code may represent an ancillary service that directly crosswalks or is clinically similar to those for which separate ASC payment is allowed when it is performed integral to a covered surgical procedure, and the new code also may be determined to be eligible for ASC payment as a covered ancillary service.

Therefore, beginning in CY 2008, we are proposing to include in the July update to the ASC payment system, the ASC payment indicators for new Category III CPT codes that the AMA releases in January, and that we determine are appropriate ASC covered surgical procedures or covered ancillary services for implementation, as payable in ASCs beginning in July of the same year. Likewise, as described above, we would implement annually for payment in the January update of the ASC payment system any of the Category III CPT codes that the AMA released the previous July, along with new Category I CPT codes that are determined to be appropriate for ASC payment. Interim ASC payment indicators will be assigned to those new mid-year Category III CPT codes that are released in January for implementation in July of a given calendar year, and the interim ASC indicators will be open to comment in the OPPS/ASC proposed rule for the following calendar year and their status will be made final in the update year's final rule.

Of the Category III CPT codes the AMA released January 1, 2007, we have determined that only one is appropriate for payment in ASCs as a covered ancillary radiology service. The new CPT code is 0182T (High dose rate electronic brachytherapy, per fraction), and we are proposing to assign it to the list of covered ancillary services with payment indicator ''Z2'' as noted in Table 58 below for payment in ASCs beginning January 1, 2008. This service has no MPFS nonfacility PE RVUs assigned to it. Therefore, we are proposing that its CY 2008 ASC payment be calculated according to the standard ASC payment system methodology, based on the code's OPPS relative payment weight.

We do not believe that any of the other Category III CPT codes released in January 2007 for implementation in July 2007 meet the criteria for inclusion on the ASC list of covered surgical procedures or covered ancillary services because they do not directly crosswalk and are not clinically similar to established covered ASC services.

TABLE 58.—CATEGORY III CPT CODE IMPLEMENTED IN JULY 2007AND PROPOSED FOR CY 2008 ASC PAYMENT

HCPCS code	Long descriptor	Proposed CY 2008 ASC Payment Indicator
0182T	High dose rate electronic brachytherapy, per fraction	Z2

3. Proposed Treatment of Level II HCPCS Codes Released on a Quarterly Basis

In addition to the Category III CPT codes that are released twice each year, new Level II HCPCS codes may be created more frequently and are implemented for the MPFS and OPPS on a quarterly basis. Level II HCPCS codes are most commonly created for the purpose of reporting new drugs and biologicals but also are created for reporting some surgical procedures and other services for which payment may be made under the revised ASC payment system, as it is under the OPPS.

We base the ASC payment policies for covered surgical procedures, drugs, biologicals, and certain other covered ancillary services integral to ASC covered surgical procedures on the OPPS and, therefore, we are proposing to update the coding and payment for the services in ASCs at the same time that the OPPS is updated. In order to maintain consistency across the OPPS and ASC payment systems, as discussed in the July 2007 final rule for the revised ASC payment system, we are proposing to recognize newly created Level II HCPCS codes under the revised ASC payment system for payment on a quarterly basis, consistent with the quarterly updates to the OPPS. CMS provides a predictable quarterly update for the OPPS occurring throughout each calendar year (January, April, July, and October). As discussed in the July 2007 final rule for the revised ASC payment system, we will provide a quarterly ASC update for each calendar quarter to recognize newly created Level II HCPCS codes for ASC payment and to update the payment rates for separately paid drugs and biologicals based on the most recently submitted ASP data.

We are proposing to update the lists of covered surgical procedures and ancillary services that qualify for separate payment in ASCs in CY 2008 by adding 8 new Level II HCPCS codes that were implemented in the OPPS in July 2007 and that were not addressed in the CY 2007 OPPS/ASC final rule with comment period. Because of the timing of this proposed rule, the new Level II HCPCS codes implemented through the July 2007 OPPS update are not included in Addendum BB to this proposed rule and there were no Level II HCPCS codes included in the April OPPS update that were eligible for payment under the OPPS. The new CY 2007 Level II HCPCS codes we are proposing for ASC payment beginning in January 2008 are listed in Table 59. Beginning in CY 2008, with implementation of the revised ASC payment system, the Level II HCPCS codes describing new procedures, drugs and biologicals would be made payable in ASCs in the same calendar quarter as they are initially paid under the OPPS.

We are proposing to assign payment indicator K2 to the 7 new codes for drugs to indicate that separate payment would be made for those drugs when they are provided to beneficiaries in ASCs integral to covered surgical procedures. We are proposing to include new Level II HCPCS code C9728 (Placement of interstitial device(s) for radiation/surgery guidance (e.g., fiducial markers, dosimeter), other than prostate (any approach), single or multiple) as a covered surgical procedure with payment indicator ''R2'' because it is clinically similar to CPT code 55876 (Placement of interstitial device(s) for radiation therapy guidance (e.g., fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple) that we have included on the list of covered surgical procedures with payment indicator of ''P3.'' While we believe both procedures are office-based, there are currently no nonfacility PE RVUs available for the Level II HCPCS code C9728, which was initially established in response to a New Technology APC application under the OPPS, and, therefore, its payment indicator is ''R2.''

TABLE 59.—LEVEL II HCPCS CODES IMPLEMENTED UNDER THE OPPS IN APRIL OR JULY 2007 AND PROPOSED FOR CY 2008 ASC PAYMENT

HCPCS code	Short descriptor	Proposed CY 2008 ASC payment indicator
C9728	Place device/marker, non prostate	R2
Q4087	Octagam injection	K2
Q4088	Gammagard liquid injection	K2
Q4089	Rhophylac injection	K2
Q4090	HepaGam B IM injection	K2
Q4091	Flebogamma injection	K2
Q4092	Gamunex injection	K2
Q4095	Reclast injection	K2

In summary, beginning in CY 2008 with implementation of the revised ASC payment system, we are proposing to implement new Level II HCPCS codes for ASC payment on a quarterly basis each year and new Category III CPT codes on a semi annual basis, to parallel the policies under the MPFS and OPPS for the recognition of those codes. Also, consistent with the MPFS and OPPS policies, our final policy with regard to Category I CPT codes is to publish the new codes and interim payment indicators annually in the OPPS/ASC final rule with comment period.

E. Proposed Updates to Covered Surgical Procedures and Covered Ancillary Services

1. Identification of Covered Surgical Procedures

a. General Policies

We published Addendum AA to the July 2007 final rule for the revised ASC payment system as an illustrative list of covered surgical procedures and payment rates for the revised ASC payment system to be implemented January 1, 2008. The final rule established our policies for determining which procedures are eligible to be considered ASC covered surgical procedures and, of those, which are excluded from ASC payment because they pose a significant risk to beneficiary safety or would be expected to require an overnight stay. We adopted a definition of surgical procedure for the revised ASC payment system as those procedures described by all Category I CPT codes in the surgical range from 10000 through 69999 except unlisted procedure codes, as well as those Category III CPT codes and Level II

HCPCS codes that crosswalk or are clinically similar to ASC covered surgical procedures.

Section 1833(i)(1) of the Act requires us to review and update the list of ASC procedures at least every 2 years. We finalized our policy to update the ASC list of covered surgical procedures annually, in conjunction with annual proposed and final rulemaking to update the OPPS and ASC payment systems. Each year we undertake a review of excluded procedures, new procedures, and procedures for which there is revised coding to identify any that we believe are appropriate for coverage in ASCs because they do not pose significant risks to beneficiary safety and would not be expected to require overnight stays.

In the July 2007 final rule for the revised ASC payment system, we finalized the addition of 793 new covered surgical procedures for payment under the revised ASC payment system beginning in CY 2008. We are proposing to remove 13 procedures from the OPPS inpatient list and, of those 13, we believe that 3 are safe for performance in ASCs. Therefore, at this time, we are proposing to add these three additional new surgical procedures to the ASC list of covered surgical procedures eligible for Medicare ASC payment in CY 2008. The proposed procedures and their ASC payment indicators are displayed in Table 60.

TABLE 60.—PROCEDURES PROPOSED AS NEW ASC COVERED SURGICAL PROCEDURES FOR CY 2008

HCPCS code	Short descriptor	Proposed ASC payment indicator
25931	Amputation follow-up surgery	G2
50580	Kidney endoscopy & treatment	G2
58805	Drainage of ovarian cyst(s)	G2

In this proposed rule, we are soliciting commenters' recommendations regarding additional surgical procedures that they believe should not be excluded from ASC payment beginning in CY 2008. We specifically encourage commenters to provide evidence, to the extent possible, to support their recommendations regarding procedures and services they believe should not be excluded from ASC payment.

b. Proposed Change in Designation of Covered Surgical Procedures as Office-Based

According to our final policy for the revised ASC payment system, we designate as office-based procedures that are added to the ASC list of covered surgical procedures in CY 2008 or later years and that we determine are predominantly performed in physicians' offices based on consideration of the most recent available volume and utilization data for each individual procedure code and/or, if appropriate, the clinical characteristics, utilization, and volume of related codes.

The list of codes that we identified as office-based in the July 2007 final rule for the revised ASC payment system took into account the most recent available CY 2005 volume and utilization data for each individual procedure code or related codes. In that rule, we finalized our policy to apply the office-based designation only to procedures that would no longer be excluded from ASC payment beginning in CY 2008 or later years and to exempt all procedures on the CY 2007 ASC list from application of the office based classification. We believe that the resulting list accurately reflected Medicare practice patterns and was clinically consistent. In Addendum AA to the July 2007 final rule for the revised ASC payment system, each of the office-based procedures is identified by payment indicator ''P2,'' ''P3,'' or ''R2,'' depending on whether we estimated it would be paid according to the standard ASC payment methodology based on its OPPS relative payment weight or at the MPFS nonfacility PE RVU amount.

Consistent with our final ASC policy to review and update annually the surgical procedures for which ASC payment is made and to identify new procedures that may be appropriate for ASC payment, in developing this proposed rule we reviewed the CY 2006 utilization data for all those surgical procedures newly added for ASC payment in CY 2008 that were assigned payment indicator ''G2'' as nonoffice-based additions in the July 2007 final rule for the revised ASC payment system. We based our evaluation of the potential designation of a procedure as office-based on the most recent available volume and utilization data for each individual procedure code and/or, as appropriate, the clinical characteristics, utilization, and volume of related codes. As a result of that review, we identified 19 procedures assigned payment indicator ''G2'' in the July 2007 final rule for the revised ASC payment system that we are proposing to assign to the office-based procedure list with payment indicator ''P2,'' ''P3,'' or ''R2,'' as appropriate. We refer readers to Addendum DD1 to this proposed rule for the definitions of the ASC payment indicators.

We will consider comments submitted timely on the proposed designation of these 19 new procedures as office-based for CY 2008. For example, in the July 2007 final rule for the revised ASC payment system, payment indicator ''G2'' was assigned to CPT code 64650 (Chemodenervation of eccrine glands; both axillae). After reviewing more recent CY 2006 data, we discovered that the procedure is performed predominantly in physicians' offices and we believe the procedure should be designated as an office-based procedure. Therefore, we are proposing to assign payment indicator ''P3'' to CPT code 64650, effective for CY 2008. In this proposed rule, we are proposing to assign an office-based payment indicator for CPT code 64650 and 18 other procedures, as displayed in Table 61.

TABLE 61.—PROPOSED CY 2008 NEW DESIGNATIONS OF ASC COVERED SURGICAL PROCEDURES AS OFFICE-BASED

HCPCS code	Short descriptor	ASC Payment Indicator in July 2007 ASC Final Rule	Proposed CY 2008 ASC payment indicator
24640	Treat elbow dislocation	G2	P3
26641	Treat thumb dislocation	G2	P2
26670	Treat hand dislocation	G2	P2
26700	Treat knuckle dislocation	G2	P2
26775	Treat finger dislocation	G2	P3
28630	Treat toe dislocation	G2	P3
28660	Treat toe dislocation	G2	P3
28890	High energy eswt, plantar fascia	G2	P3
29035	Application of body cast	G2	P2
29305	Application of hip cast	G2	P2
29325	Application of hip casts	G2	P2
29505	Application, long leg splint	G2	P3
29515	Application lower leg splint	G2	P3
36469	Injection(s), spider veins	G2	R2
46505	Chemodenervation anal misc	G2	P3
62292	Injection into disk lesion	G2	R2
64447	Nblock inj fem, single	G2	R2
64650	Chemodenerv, eccrine glands	G2	P3
64653	Chemodenerv, eccrine glands	G2	P3

We also reviewed the five procedures that were assigned temporary office-based payment indicators in the July 2007 final rule for the revised ASC payment system. Those codes are listed in Table 62 below. Using the most recent data available, we believe there are adequate claims data for two of the procedures upon which to base assignment of permanent office-based payment indicators. Table 62 shows that we are proposing to assign CPT code 36598 (Contrast injection(s) for radioisotope evaluation of existing central venous access device, including fluoroscopy, image documentation and report) permanently to the office-based list and assign it to payment indicator ''P3'' for CY 2008. In accordance with the CY 2008 OPPS proposal to package payment for CPT code 58110 (Endometrial sampling (biopsy) performed in conjunction with colposcopy), we are also proposing to package payment for this procedure under the ASC payment system and assign it payment indicator ''N1'' as indicated in Table 62.

We are proposing to maintain the temporary office-based payment indicator assignments for the other three procedures listed in Table 62. We have only a few claims for CPT code 0099T (Implantation of intrastromal corneal ring segments) and no claims for 0124T (Conjunctival incision with posterior juxtascleral placement of pharmacological agent (does not include supply of medication)) or CPT code 55876 (Placement of interstitial device(s) for radiation therapy guidance (e.g., fiduciary markers, dosimeter), prostate (via needle, any approach), single or multiple). We continue to believe these procedures are predominantly office-based. Therefore, we are not proposing to make any change to the temporary office-based designation of these procedures at this time.

TABLE 62.—PROPOSED PAYMENT INDICATORS FOR PROCEDURES ASSIGNED TEMPORARY OFFICE-BASED PAYMENT INDICATORS IN THE JULY 2007 ASC FINAL RULE

HCPCS Code	Short descriptor	Temporary Office Based Payment Indicator in July 2007 ASC Final Rule	Proposed Final CY 2008 ASC Payment Indicator (or * if HCPCS code will continue with temporary office-based assignment for CY 2008)
0099T	Implant corneal ring	R2	*
0124T	Conjunctival drug placement	R2	*
36598	Inj w/fluor, eval cv device	P2	P3
55876	Place rt device/marker, pros	P3	*
58110	Bx done w/colposcopy add-on	P3	N1

c. Proposed Changes to Designation of Covered Surgical Procedures as Device-Intensive

As explained in section XVI.C. of this proposed rule, we adopted a modified payment methodology for calculating the ASC payment rates for ASC covered surgical procedures that are assigned to the subset of device-dependent APCs under the OPPS with a device offset percentage greater than 50 percent under the OPPS to ensure that payment for the procedure is adequate to provide packaged payment for the high-cost implantable devices used in those procedures. In the July 2007 final rule for the revised ASC payment system, we identified 24 procedures that were on the CY 2007 ASC list of covered surgical procedures that would be subject to this policy, as well as 15 new ASC covered surgical procedures for CY 2008 to which we expected the final policy to apply.

As a result of the proposed CY 2008 reconfiguration of several device-dependent APCs under the OPPS and the proposed updated APC device offset percentages, we are proposing to designate as device-intensive for ASC payment in CY 2008 an additional 10 ASC covered surgical procedures. We are also proposing to remove 4 procedures from their estimated designation as device-intensive because we are proposing to recognize CPT codes instead of Level II HCPCS codes for ICD implantation.procedures as discussed in section III.D.7. of this proposed rule. In the July 2007 final rule for the revised ASC payment system, either payment indicator ''H8'' or ''J8'' was assigned to the procedures that we estimated would be designated as device-intensive procedures for CY 2008. As displayed in Table 63 below, we are proposing to assign payment indicators ''H8'' or ''J8,'' as appropriate, to the covered surgical procedures included in the table so that the payment for these surgical procedures would be made consistent with our final revised ASC payment system payment policy for device-intensive procedures that are identified according to their APC assignments under the OPPS.

TABLE 63.—PROPOSED ASC COVERED SURGICAL PROCEDURES PROPOSED FOR DESIGNATION AS DEVICE-INTENSIVE FOR CY 2008

HCPCS code	Short descriptor	Proposed CY 2008 OPPS APC	Proposed CY 2008 device-dependent APC offset percentage
33206	Insertion of heart pacemaker	0089	74.02
33207	Insertion of heart pacemaker	0089	74.02
33208	Insertion of heart pacemaker	0655	74.59
33210	Insertion of heart electrode	0106	57.20
33211	Insertion of heart electrode	0106	57.20
33212	Insertion of pulse generator	0090	75.54
33213	Insertion of pulse generator	0654	75.86
33214	Upgrade of pacemaker system	0655	74.59
33216	Insert lead pace-defib, one	0106	57.20
33217	Insert lead pace-defib, dual	0106	57.20
33224	Insert pacing lead & connect	0418	81.38
33225	Lventric pacing lead add-on	0418	81.38
33240	Insert pulse generator	0107	89.43
33249	Eltrd/insert pace-defib	0108	89.26
33282	Implant pat-active ht record	0680	72.14
36566	Insert tunneled cv cath	0625	62.63
53440	Male sling procedure	0385	51.67
53444	Insert tandem cuff	0385	51.67
53445	Insert uro/ves nck sphincter	0386	61.98
53447	Remove/replace ur sphincter	0386	61.98
54400	Insert semi-rigid prosthesis	0385	51.67
54401	Insert self-contd prosthesis	0386	61.98
54405	Insert multi-comp penis pros	0386	61.98
54410	Remove/replace penis prosth	0386	61.98
54416	Remv/repl penis contain pros	0386	61.98
55873	Cryoablate prostate	0674	59.34
61885	Insrt/redo neurostim 1 array	0039	82.15
61886	Implant neurostim arrays	0315	86.23
62361	Implant spine infusion pump	0227	79.69
62362	Implant spine infusion pump	0227	79.69
63650	Implant neuroelectrodes	0040	55.93
63655	Implant neuroelectrodes	0061	59.32
63685	Insrt/redo spine n generator	0222	83.29
64553	Implant neuroelectrodes	0225	80.84
64555	Implant neuroelectrodes	0040	55.93
64560	Implant neuroelectrodes	0040	55.93
64561	Implant neuroelectrodes	0040	55.93
64565	Implant neuroelectrodes	0040	55.93
64573	Implant neuroelectrodes	0225	80.84
64575	Implant neuroelectrodes	0061	59.32
64577	Implant neuroelectrodes	0061	59.32
64580	Implant neuroelectrodes	0061	59.32
64581	Implant neuroelectrodes	0061	59.32
64590	Insrt/redo pn/gastr stimul	0222	83.29
69930	Implant cochlear device	0259	83.03

2. Proposed Changes for Identification of Covered Ancillary Services

In the July 2007 final rule for the revised ASC payment system, we set forth our policy to make separate ASC payments for certain ancillary services, for which separate payment is made under the OPPS, when they are provided integral to ASC covered surgical procedures. Under the revised ASC payment system, we exclude from the scope of ASC facility services, for which payment is packaged into the ASC payment for the covered surgical procedure, the following ancillary services that are integral to a covered surgical procedure: brachytherapy sources; certain implantable items that have pass-through status under the OPPS; certain items and services that we designate as contractor-priced, including, but not limited to, procurement of corneal tissue; certain drugs and biologicals for which separate payment is allowed under the OPPS; and certain radiology services for which separate payment is allowed under the OPPS. These covered ancillary services are specified in § 416.164(b) and fall within the scope of ASC services, so they are eligible for separate ASC payment.

In this proposed rule, we are proposing to make changes to the list of covered ancillary services eligible for separate ASC payment, as proposed in Addendum BB to this proposed rule, to comport with their proposed treatment under the OPPS according to the final payment policies of the revised ASC payment system, and to add new Category III CPT code 0182T (High dose rate electronic brachytherapy, per fraction), as discussed in section XVI.D.2 of this proposed rule.

F. Proposed Payment for Covered Surgical Procedures and Covered Ancillary Services

1. Proposed Payment for Covered Surgical Procedures

a. Proposed Update to Payment Rates

Our final payment policy for covered surgical procedures under the revised ASC payment system is described in section XVI.C. of this proposed rule. For CY 2008, payment for procedures with payment indicator ''G2'' will be calculated by multiplying the ASC relative payment weight for the procedure by the final ASC conversion factor. For those procedures with payment indicator ''A2,'' a blended rate will be used that is comprised of 25 percent of the revised ASC payment rate added to 75 percent of the CY 2007 payment rate. Special payment policies apply to covered surgical procedures identified as office-based or device-intensive.

The payment amounts provided in Addendum AA to the July 2007 final rule for the revised ASC payment system were illustrative only, and we are proposing to update them in this proposed rule. We are not proposing to make any changes to the final policies established in the July 2007 final rule for the revised ASC payment system related to the methodology for developing the relative payment weights and rates. The differences in the payment rates for covered surgical procedures with ''G2'' and ''A2'' payment indicators, reflected in Addendum AA to this proposed rule, compared with the July 2007 final rule for the revised ASC payment system are due to our use of updated CY 2006 utilization data, proposed payment policy changes for the CY 2008 OPPS, including APC reassignments and changes to packaged services, and the proposed OPPS update factor.

We also are proposing to update the payment amounts for the office-based procedures in this rule. Using the most recent available MPFS and OPPS data, including the proposed CY 2008 rates, we compared the estimated CY 2008 rate for each of the office-based procedures calculated according to the standard methodology of the revised ASC payment system and to the MPFS nonfacility PE RVUs to determine which is the lower payment amount that, therefore, is the rate we are proposing for payment of the procedure according to the final policy of the revised ASC payment system. The proposed update to the rates results in changes to the payment indicators, as well as the rates, for several of the office-based procedures. For example, a procedure with payment indicator ''P2'' in the July 2007 final rule for the revised ASC payment system may be assigned payment indicator ''P3'' in this proposed rule, depending on the outcome of that rate comparison.

In addition, we are proposing to update the payment amounts for the device intensive procedures in this rule, based on the CY 2008 OPPS proposal and updated OPPS claims data.

b. Payment Policies When Devices Are Replaced at No Cost or With Credit

(1) Policy When Devices Are Replaced at No Cost or With Full Credit

Our final ASC policy with regard to payment for costly devices implanted in ASCs is fully consistent with the current OPPS policy. The ASC policy includes adoption of the OPPS policy for payment to providers when a device is replaced without cost or with full credit for the cost of the device being replaced, for those ASC covered surgical procedures that are assigned to APCs under the OPPS to which this policy applies. In the case of no cost or full credit cases under the OPPS, we reduce the APC payment to the hospital by the device offset amount that we estimate represents the cost of the device. Therefore, in accordance with the OPPS policy implemented in CY 2007, and the ASC policy as finalized in the July 2007 final rule for the revised ASC payment system, beginning in CY 2008, we reduce the amount of payment made to ASCs for certain covered surgical procedures when the necessary device is furnished without cost to the ASC or the beneficiary or with a full credit for the cost of the device being replaced. We provide the same amount of payment reduction based on the device offset amount in ASCs that would apply under the OPPS for performance of those procedures under the same circumstances. Specifically, when a procedure that is listed in Table 64 below is performed in an ASC and the case involves implantation of a no cost or full credit device listed in Table 65, the ASC must report the HCPCS ''FB'' modifier on the line with the covered surgical procedure code to indicate that an implantable device in Table 65 was furnished without cost. The devices listed in Table 65 are the same proposed devices to which the policy applies under the OPPS, and the procedures listed in Table 64 are those ASC covered surgical procedures assigned to proposed APCs under the OPPS to which the policy applies.

As finalized in the July 2007 final rule for the revised ASC payment system, when the ''FB'' modifier is reported with a procedure code that is listed in Table 64, the contractor reduces the ASC payment by the amount of payment that we attributed to the device when the ASC payment rate was calculated. The reduction of ASC payment in this circumstance is necessary to pay appropriately for the covered surgical procedure being furnished by the ASC.

(2) Proposed Policy When Implantable Devices Are Replaced With Partial Credit

Consistent with our CY 2008 OPPS proposal discussed in section IV.A.3. of this proposed rule, we are proposing to reduce the ASC payment by one half of the device offset amount for certain surgical procedures into which the device cost is packaged, when an ASC receives a partial credit toward replacement of an implantable device.

This partial payment reduction would apply to covered surgical procedures in which the amount of the device credit is greater than or equal to 20 percent of the cost of the new replacement device being implanted.

We also are proposing to base the beneficiary's coinsurance on the reduced ASC payment rate so that the beneficiary shares the benefit of the ASC's reduced costs. This proposed policy is set forth in proposed new § 416.179(b)(2).

We have no OPPS data to empirically determine by how much we should reduce the payment for ASC surgical procedures into which the costs of these devices are packaged. Device manufacturers and hospitals have told us that a common scenario is that, if a device fails 3 years after implantation, the hospital would receive a 50 percent credit towards a replacement device. We do not believe that hospitals reduce their device charges to reflect the credits that may have been received, so the lower facility costs associated with these partial credit scenarios would likely not be reflected in our proposed OPPS rates for these device-dependent procedures. Therefore, we are proposing under the OPPS to reduce the payment for the relevant device-dependent APCs and, under the revised ASC payment system, to reduce the payment for those ASC covered surgical procedures assigned to those APCs under the OPPS by half of the reduction that applies when the hospital or ASC receives a device without cost or receives a full credit for a device being replaced. That is, we are proposing to reduce the payments by half of the offset amount that represents the cost of the device packaged into the procedure payment. In the absence of OPPS claims data on which to base a reduction factor, but taking into consideration what we have been told is common industry practice, we believe that reducing the amount of payment for the device-dependent APC and the related ASC covered surgical procedure by half of the estimated cost of the device packaging represents a reasonable reduction in these cases.

Moreover, we are proposing to take this reduction only when the credit is for 20 percent or more of the cost of the new replacement device, so that the reduction is not taken in cases in which more than 80 percent of the cost of the replacement device has been incurred by the facility. If the partial credit is less than 20 percent of the cost of the new replacement device, we believe that reducing the payment for the device implantation procedure by 50 percent of the packaged device cost would provide too low a payment for necessary device replacement procedures. This proposed policy is discussed in section IV.A. of this proposed rule for the OPPS and is fully consistent with the proposed FY 2008 Medicare payment policy for hospital inpatient services and the proposed CY 2008 policy for hospital outpatient services.

Therefore, we are proposing that the new HCPCS partial credit modifier would be reported and the partial credit reduction would be taken only in cases in which the device credit is equal to or greater than 20 percent of the cost of the new replacement device. The partial credit reduction modifier would be reported in all cases in which the ASC receives a partial credit toward the replacement of a medical device listed in Table 65 when used in a surgical procedure listed in Table 64. The proposed policy related to partial device credits applies to the same devices and procedures to which our policy governing payment when the device is furnished to the ASC without cost or with full credit applies. We selected these devices because they have substantial costs and because each device is implanted in one beneficiary at least temporarily and, therefore, can be associated with an individual beneficiary. Moreover, we believe that this policy is a logical extension of our established policy regarding reduction of the ASC payment in cases in which the facility furnishes the device without cost or with a full credit to the ASC and ensures that beneficiary and Medicare payments are appropriate and consistent with costs incurred by ASCs.

This partial device credit policy that we are proposing would enhance our ability to track the replacement of these implantable medical devices and may enable us to identify patterns of device failure or limited longevity early in their natural history so that appropriate strategies to reduce future problems for our beneficiaries may be developed. We also are mindful of the opportunity to use our claims history data to promote high quality medical care with regard to the devices and the services in which they are used. Collecting data on a wider set of device replacements under full and partial credit situations in all sites of outpatient surgery, including ASCs, would assist in developing comprehensive summary data, not just a subset of data related to devices replaced without cost or with a full credit to facilities.

TABLE 64.—PROPOSED ADJUSTMENTS TO PAYMENTS FOR ASC COVERED SURGICAL PROCEDURES IN CY 2008 IN CASES OF DEVICES REPORTED WITHOUT COST OR FOR WHICH FULL OR PARTIAL CREDIT IS RECEIVED

HCPCS code	Short descriptor	Proposed CY 2008 OPPS APC	APC title	Proposed CY 2008 OPPS offset percentage	50 Percent of proposed CY 2008 OPPS offset percentage
61885	Insrt/redo neurostim 1 array	0039	Level I Implantation of Neurostimulator	82.15	41.07
63560	Implant neuroelectrodes	0040	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	55.93	27.97
64555	Implant neuroelectrodes				
64560	Implant neuroelectrodes				
64561	Implant neuroelectrodes				
63655	Implant neuroelectrodes	0061	Laminectomy or Incision for Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	59.32	29.66
64575	Implant neuroelectrodes				
64577	Implant neuroelectrodes				
64580	Implant neuroelectrodes				
64581	Implant neuroelectrodes				
33206	Insertion of heart pacemaker	089	Insertion/Replacement of Permanent Pacemaker and Electrodes.	74.02	37.01
33207	Insertion of heart pacemaker				
33212	Insertion of pulse generator	0090	Insertion/Replacement of Pacemaker Pulse Generator.	75.54	37.77

TABLE 64.—PROPOSED ADJUSTMENTS TO PAYMENTS FOR ASC COVERED SURGICAL PROCEDURES IN CY 2008 IN CASES OF DEVICES REPORTED WITHOUT COST OR FOR WHICH FULL OR PARTIAL CREDIT IS RECEIVED—Continued

HCPCS code	Short descriptor	Proposed CY 2008 OPPS APC	APC title	Proposed CY 2008 OPPS offset percentage	50 Percent of proposed CY 2008 OPPS offset percentage
33210	Insertion of heart electrode	0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes.	57.20	28.60
33211	Insertion of heart electrode				
33216	Insert lead pace-defib, one				
33217	Insert lead pace-defib, dual				
33240	Insert pulse generator	0107	Insertion of Cardioverter-Defibrillator	89.43	44.72
33249	Eltrd/insert pace-defib	0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads.	89.26	44.63
63685	Insrt/redo spine n generator	0222	Implantation of Neurological Device	83.29	41.64
64590	Insrt/redo perph n generator				
64553	Implant neuroelectrodes	0225	Implantation of Neurostimulator Electrodes, Cranial Nerve.	80.84	40.42
64573	Implant neuroelectrodes				
62361	Implant spine infusion pump	0227	Implantation of Drug Infusion Device	79.69	39.85
62362	Implant spine infusion pump				
69930	Implant cochlear device	0259	Level VI ENT Procedures	83.03	41.52
61886	Implant neurostim arrays	0315	Level II Implantation of Neurostimulator	86.23	43.12
53440	Male sling procedure	0385	Level I Prosthetic Urological Procedures	51.67	25.83
53444	Insert tandem cuff				
54400	Insert semi-rigid prosthesis				
53445	Insert uro/ves nck sphincter	0386	Level II Prosthetic Urological Procedures	61.98	30.99
53447	Remove/replace ur sphincter				
54401	Insert self-contd prosthesis				
54405	Insert multi-comp penis pros				
54410	Remove/replace penis prosth				
54416	Remv/repl penis contain pros				
33224	Insert pacing lead & connect	0418	Insertion of Left Ventricular Pacing Elect	81.38	40.69
33225	L ventric pacing lead add-on				
36566	Insert tunneled cv cath	0625	Level IV Vascular Access Procedures	62.63	32.32
33213	Insertion of pulse generator	0654	Insertion/Replacement of a permanent dual chamber pacemaker.	75.86	37.93
33214	Upgrade of pacemaker system	0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker.	74.59	37.30
33208	Insertion of heart pacemaker				
33282	Implant pat-active ht record	0680	Insertion of Patient Activated Event Recorders.	72.14	36.07

TABLE 65.—PROPOSED DEVICES FOR WHICH THE "FB" OR NEW HCPCS MODIFIER MUST BE REPORTED WITH THE PROCEDURE CODE WHEN FURNISHED WITHOUT COST OR FOR WHICH FULL OR PARTIAL CREDIT IS RECEIVED

Device HCPCS code	Short descriptor
C1721	AICD, dual chamber.
C1722	AICD, single chamber.
C1764	Event recorder, cardiac.
C1767	Generator, neurostim, imp.
C1771	Rep dev, urinary, w/sling.
C1772	Infusion pump, programmable.
C1776	Joint device (implantable).
C1777	Lead, AICD, endo single coil.
C1778	Lead, neurostimulators.
C1779	Lead, pmkr, transvenous VDD.
C1785	Pmkr, dual, rate-resp.
C1786	Pmkr, single, rate-resp.
C1813	Prosthesis, penile, inflatab.
C1815	Pros, urinary sph, imp.
C1820	Generator, neuro rechg bat sys.
C1881	Dialysis access system.
C1882	AICD, other than sing/dual.
C1891	Infusion pump, non-prog, perm.

TABLE 65.—PROPOSED DEVICES FOR WHICH THE "FB" OR NEW HCPCS MODIFIER MUST BE REPORTED WITH THE PROCEDURE CODE WHEN FURNISHED WITHOUT COST OR FOR WHICH FULL OR PARTIAL CREDIT IS RECEIVED—Continued

Device HCPCS code	Short descriptor
C1895	Lead, AICD, endo dual coil.
C1896	Lead, AICD, non sing/dual.
C1897	Lead, neurostim, test kit.
C1898	Lead, pmkr, other than trans.
C1899	Lead, pmkr/AICD combination.
C1900	Lead coronary venous.
C2619	Pmkr, dual, non rate-resp.
C2620	Pmkr, single, non rate-resp.
C2621	Pmkr, other than sing/dual.
C2622	Prosthesis, penile, non-inf.
C2626	Infusion pump, non-prog, temp.
C2631	Rep dev, urinary, w/o sling.
L8614	Cochlear device/system.

2. Proposed Payment for Covered Ancillary Services

Our final CY 2008 payment policies under the revised ASC payment system for covered ancillary services vary according to the particular type of service and its payment policy under the OPPS. Our overall policy provides for separate ASC payment for certain ancillary services integrally related to the provision of ASC covered surgical procedures if those services are paid separately under the OPPS. Thus, we established a policy to align ASC payment bundles with those under the OPPS. Specifically, our final ASC payment policies would provide separate ASC payment for brachytherapy sources and drugs and biologicals that are separately paid under the OPPS at the OPPS rates, while we would pay for radiology services at the lower of the MPFS nonfacility PE RVU (or technical component) amount or the rate calculated according to the standard methodology of the revised ASC payment system based on the

OPPS relative payment weight for the service.

As evidenced by our final policies for the CY 2008 revised ASC payment system, our intention is to maintain consistent payment and packaging policies across HOPD and ASC settings for covered ancillary services that are integral to covered surgical procedures performed in ASCs. Therefore, consistent with our policy to pay separately only for those ancillary services that are paid separately under the OPPS, we also are proposing to package into the ASC payment for covered surgical procedures the costs of those ancillary services that are proposed to be packaged under the OPPS for CY 2008. Certain covered ancillary services that we are proposing to package for the CY 2008 OPPS were assigned payment indicator ''Z2'' or ''Z3'' in the July 2007 final rule for the revised ASC payment system, but they are assigned payment indicator ''N1'' in Addendum BB to this proposed rule. We refer readers to section II.A.4 of this proposed rule for a description of the CY 2008 OPPS packaging approach that we also are proposing to adopt in ASCs and that would package ASC payment for certain covered ancillary services. In addition, proposed OPPS payments for brachytherapy sources and separately payable drugs and biologicals are discussed in sections VII.B. and V. of this proposed rule, respectively. Other separately paid covered ancillary services in ASCs, specifically corneal tissue acquisition and devices with OPPS pass-through status, do not have prospectively established ASC payment rates according to the final policies of the revised ASC payment system. Payments for devices with pass-through status under the OPPS, for which separate payment would be made to ASCs at contractor-priced rates, are discussed in detail in section VI. of this proposed rule.

G. Physician Payment for Procedures and Services Provided in ASCs

If you choose to comment on issues in this section, please include the caption ''Physician Payment for Procedures and Services Provided in ASCs'' at the beginning of your comment.)

Under current policy, when physicians perform surgical procedures in ASCs that are included on the ASC list of covered surgical procedures, they are paid under the MPFS for the PE component using the facility PE RVUs. This is appropriate because the surgical procedures are those for which Medicare allows facility payment to ASCs. However, when physicians perform surgical procedures in ASCs that are not included on the ASC list of covered surgical procedures and for which Medicare does not allow facility payments to ASCs, physicians are paid for the PE component at the higher nonfacility PE RVUs (unless a nonfacility rate does not exist, in which case Medicare pays the physician at the facility rate). These policies are set forth in § 414.22(b)(5)(i)(A) and (B), respectively. Furthermore, physician payment for nonsurgical services provided in ASCs, for which no facility payment is made to ASCs under the existing ASC payment system, varies based on local Medicare contractor policy. Some contractors pay physicians only for the professional component (PC) of the service and others make payment to the physician for the technical component (TC) as well. Under the current policy, as described in the CY 2002 Physician Fee Schedule final rule with comment period (66 FR 55264), Medicare payment to the physician for a noncovered surgical procedure performed in an ASC constitutes payment in full.This is so even if the physician is paid the facility rate (because there is no nonfacility rate). In this case, there is no beneficiary liability other than the deductible and copayment for the physician's services.

According to the policy adopted in the July 2007 final rule for the revised ASC payment system, Medicare will make facility payments to ASCs for all covered surgical procedures except those that could pose a significant risk to beneficiary safety or would be expected to require active medical monitoring and care at midnight following the procedure (that is, an overnight stay). The revised policy will result in a significant expansion in the number and type of surgical procedures for which Medicare will make an ASC facility payment. The final payment policy for the revised ASC payment system also allows separate payments to ASCs for certain covered ancillary services (for example, some drugs, brachytherapy sources, and certain radiology services) that are provided integral to an ASC covered surgical procedure. According to the final policy, when covered ancillary services are integral to the successful performance of a covered surgical procedure and are performed on the same day as the covered surgery, immediately before, during or following the procedure, Medicare will allow separate ASC payment for those services.

The revised ASC payment system is based on the APC groups and payment weights of the OPPS. We believe ASCs are facilities that are similar, insofar as the delivery of surgical and related nonsurgical services, to HOPDs. Specifically, when services are provided in ASCs, the ASC, not the physician, bears responsibility for the facility costs associated with the service. This situation parallels the hospital facility resource responsibility for hospital outpatient services. Therefore, we believe it would be more appropriate for physicians to be paid for all services furnished in ASCs just as they would be paid for all services furnished in the hospital outpatient setting. In addition, because we have adopted a final policy for the revised ASC payment system that identifies and excludes from ASC payment only those procedures that could pose a significant risk to beneficiary safety or would be expected to require an overnight stay, we believe that it would be incongruous with the revised ASC payment system methodology to continue to pay the higher nonfacility rate to physicians who furnish excluded ASC procedures. Because these excluded procedures have been specifically identified by CMS as procedures that could pose a significant risk to beneficiary safety or would be expected to require an overnight stay, we do not believe it would be appropriate to provide payment based on the higher nonfacility PE RVUs to physicians who furnish them. In fact, we do not expect that the excluded procedures will be performed in ASCs after the revised ASC payment system is implemented on January 1, 2008. Therefore, we are proposing to revise § 414.22(b)(5)(i)(A) and (B) to reflect this proposed policy.

We believe that the proposed revised policy would provide appropriate payment to physicians for services provided in the ASC facility setting and would encourage the most appropriate utilization of ASCs. For procedures that are not excluded from coverage under the revised ASC payment system, the ASC would be paid for the covered surgical procedure and associated covered ancillary services, and the physician would be paid for the professional work and facility PE associated with performing the procedure. In the case of noncovered surgical procedures or other noncovered services provided in ASCs, Medicare would make no payment to the ASC under the revised ASC payment system and no payment to the physician under the MPFS for the facility resources associated with providing those services. Although the current MPFS payment policy provides payment to the physician for some facility costs as if the service were being furnished in a

physician's office, according to the final policy of the revised payment system, these services would not be covered ASC services. These services have been excluded from ASC payment for safety reasons, because they are expected to require an overnight stay, or because they are not surgical procedures, and they would not be covered by Medicare either directly, under the ASC payment system, or indirectly, through PE payments to the physicians who perform them.

In summary, under the proposed policy, physicians would receive payment for all surgical and nonsurgical services furnished in ASCs based on the facility PE RVUs and excluding the TC payment, if applicable, consistent with physician payment for HOPD services. Medicare would make no payment for facility services to ASCs or physicians for procedures or services that are performed in ASCs but that are excluded from the list of covered ASC surgical procedures or that are not covered ancillary services. While physicians would be paid for these services based on the facility PE RVUs, physicians would no longer receive the additional payment for the associated facility resources.

Consistent with the current OPPS payment policy that prohibits facility payments to the hospital for noncovered services (such as those surgical procedures on the OPPS inpatient list) and makes the beneficiary liable for those charges, this proposed policy would make beneficiaries responsible for the ASC charges for noncovered services furnished to them in ASCs.

H. Proposed Changes to Definitions of ''Radiology and Certain Other Imaging Services'' and ''Outpatient Prescription Drugs

In section 1877(h)(6) of the Act, the Congress defined the ''designated health services'' (DHS) that are subject to the physician self-referral prohibition to include 11 broad categories of services. In our regulations at § 411.351, we define each of the 11 DHS categories, including ''radiology and certain other imaging services.'' In addition, we have clarified that the term ''designated health services'' excludes ''services that are reimbursed by Medicare as part of a composite rate (for example, ASC services or SNF Part A services)'' except to the extent that the DHS categories are themselves payable through a composite rate. In the definition of ''radiology and certain other imaging services'' at § 411.351, we exclude x-ray, fluoroscopy, or ultrasound procedures that require the insertion of a needle, catheter, tube, or probe through the skin or into a body orifice because we do not believe that a physician would inappropriately subject a Medicare patient to such a procedure. In addition, the definition of ''radiology and certain other imaging services'' excludes radiology services that are integral to the performance of a nonradiological medical procedure and performed during the nonradiological medical procedure or immediately following the nonradiological medical procedure when necessary to confirm placement of an item placed during the nonradiological medical procedure. Radiology and certain other imaging services performed *before* a nonradiological medical procedure are DHS subject to the physician self-referral prohibition.

Taken together, these provisions effectively exclude from the physician self-referral prohibition referrals for radiology services that are paid through the ASC composite payment rate, as well as any other radiology services that are integral to the performance of an ASC covered surgical procedure, that are paid separately, and that are performed in the ASC during the surgical procedure or immediately after the surgical procedure if required to confirm placement of an item placed during the nonradiological medical procedure. (For physician self-referral purposes, we have considered radiology services that are performed while the patient is still in the operating room to confirm that ASC surgery is effective to be performed during the surgical procedure.)

Through CY 2007, most radiology services performed as integral to ASC surgical procedures were either included in the ASC payment rate or were provided and billed by a separate entity. Effective beginning CY 2008, the revised ASC payment system will cover a greater variety of surgical procedures performed in an ASC and make separate payments (outside the ASC composite rate) for certain radiology services performed in an ASC that are integral to a covered surgical procedure and performed immediately before, during, or immediately after surgery. Consequently, under the revised ASC payment system, we expect that more radiology procedures would be performed in ASCs, and more of those services would be subject to the physician self-referral prohibition to the extent that those services are paid outside the ASC composite rate and are performed either immediately before an ASC procedure or during or immediately after an ASC procedure for a purpose other than to confirm placement of an item inserted during the ASC procedure.

We are proposing to revise the physician self-referral definition of ''radiology and certain other imaging services'' at § 411.351 to exclude those radiology and imaging services that are ''covered ancillary services'' (as defined at new § 416.164(b)) for which separate payment is made under the revised ASC payment system. That is, we propose that those radiology and imaging procedures that are integral to a covered ASC surgical procedure and that are performed immediately before, during, or immediately following the surgical procedure shall not constitute ''radiology and certain other imaging procedures'' for purposes of the physician self-referral law. If we do not revise the definition of radiology and certain other imaging services for physician self-referral purposes to exclude such radiological procedures, the physician self-referral law would prohibit an ASC from billing Medicare for such separately payable radiology services rendered to patients who had been referred by a physician with an ownership or investment interest in, or compensation relationship with, the ASC, unless an exception applies. Although there are a number of compensation exceptions that may be applicable, there are very few applicable ownership or investment exceptions. Thus, many physicians would not be able to refer Medicare patients to ASCs in which they have an ownership interest. We believe that this outcome would be burdensome to our beneficiaries and contrary to Medicare policies that support appropriate surgery in ASCs, and we further believe that our proposed revision to the definition of ''radiology and certain other imaging services'' would not pose a risk of program or patient abuse.

Under our proposal, the DHS category of ''radiology and certain other imaging services'' would continue to include those radiology and imaging services that are not paid for under the revised ASC payment system (that is, those radiology and imaging services that are ''excluded services'' as defined at new § 416.164(c)). For example, radiology and imaging services that are necessary for the performance of a covered surgical procedure, but are not integral to, a covered surgical procedure, such as preoperative studies not performed immediately before surgery, would be paid for under Part 414 of our regulations and would continue to be considered DHS.

For the reasons that we believe warrant our revising the definition of ''radiology and certain other imaging

services'' at § 411.351, we also propose to exclude from the definition of ''outpatient prescription drugs'' at § 411.351, drugs that are ''covered ancillary services'' as defined at new § 416.164(b) under the revised ASC payment system. These drugs are furnished, for example, during the immediate postoperative recovery period to a patient to reduce suffering from nausea or pain. Under the revised ASC payment system, an ASC would be permitted to furnish and bill separately for such outpatient prescription drugs, as appropriate. Under our proposal, such drugs would not constitute DHS. However, the physician self-referral provisions would continue to prohibit an ASC from furnishing outpatient prescription drugs for use in the patient's home.

For clarity, we would also make a technical correction to paragraph (2) of the definition of ''radiology and certain other imaging services'' at § 411.351. This paragraph currently excludes ''radiology procedures'' that are integral to the performance of a ''nonradiological procedure.'' We would revise paragraph (2) to exclude ''radiology and certain other imaging services'' that are integral to the performance of ''a medical procedure that is not identified on the List of CPT/HCPCS Codes as a 'radiology or certain other imaging service.' '' We would revise the language of paragraph (2) because we believe that, neither radiology services, nor certain other imaging services should constitute DHS if they are integral to the performance of a medical procedure that is neither a radiology service nor a certain other imaging service. We believe that this change would not result in any risk of program or patient abuse.

I. New Technology Intraocular Lenses

1. Background

At the inception of the ASC benefit on September 7, 1982, Medicare paid 80 percent of the reasonable charge for IOLs supplied for insertion concurrent with or following cataract surgery performed in an ASC (47 FR 34082, August 5, 1982). Section 4063(b) of OBRA 1987, Public Law 100–203, amended the Act to mandate that we include payment for an IOL furnished by an ASC for insertion during or following cataract surgery as part of the ASC facility fee for insertion of the IOL, and that the facility fee include payment that is reasonable and related to the cost of acquiring the class of lens involved in the procedure.

Section 4151(c)(3) of the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990), Public Law 101–508, froze the IOL payment amount at $200 for IOLs furnished by ASCs in conjunction with surgery performed during the period beginning November 5, 1990 and ending December 31, 1992. We continued paying an IOL allowance of $200 from January 1, 1993, through December 31, 1993.

Section 13533 of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993), Public Law 103–66, mandated that payment for an IOL furnished by an ASC be equal to $150 beginning January 1, 1994, through December 31, 1998. Section 141(b)(1) of the Social Security Act Amendments of 1994 (SSAA 1994), Public Law 103 432, required us to develop and implement a process under which interested parties may request a review of the appropriateness of the payment amount for insertion of an IOL, to ensure that the facility fee for the procedure includes payment that is reasonable and related to the cost of acquiring a lens that belongs to a class of NTIOLs.

In the February 8, 1990 **Federal Register** (55 FR 4526), we published a final notice entitled ''Revision of Ambulatory Surgery Center Payment Rate Methodology,'' which implemented Medicare payment for an IOL furnished at an ASC as part of the ASC facility fee for insertion of the IOL. In the June 16, 1999 **Federal Register** (64 FR 32198), we published a final rule entitled ''Adjustment in Payment Amounts for New Technology Intraocular Lenses Furnished by Ambulatory Surgical Centers,'' to add Subpart F (§§ 416.180 through 416.200) to 42 CFR Part 416, which established a process for adjusting payment amounts for insertion of a class of NTIOLs furnished by ASCs.

Since June 16, 1999, we have issued a series of **Federal Register** notices to list lenses for which we received requests for an NTIOL payment adjustment and to solicit comments on those requests, or to announce the lenses that we have determined meet the criteria and definition of NTIOLs. We last published a **Federal Register** notice pertaining specifically to NTIOLs on April 28, 2006 (71 FR 25176).

2. Changes to the NTIOL Determination Process Finalized for CY 2008

In the CY 2007 OPPS/ASC final rule with comment period, we finalized our proposal to update and streamline the process for recognizing IOLs inserted during or subsequent to cataract extraction as belonging to a new, active NTIOL class that is qualified for a payment adjustment. The following is a summary of the changes beginning for CY 2008 that were finalized in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68176 through 68181).

We modified the historical process of using separate **Federal Register** notices to notify the public of requests to review lenses for membership in new NTIOL classes, to solicit public comment on requests, and to notify the public of CMS' determinations concerning lenses assigned to classes of NTIOLs for which an ASC payment adjustment would be made. In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68176), we specified that these NTIOL–related notifications would be fully integrated into the annual notice and comment rulemaking cycle for updating the ASC payment rates, the specific payment system in which NTIOL payment adjustments are made. Our final policy for updating the revised ASC payment system to be implemented in January 2008 will utilize an annual update process in coordination with notice and comment rulemaking for the OPPS. Aligning the NTIOL process with this annual update will promote coordination and efficiency, thereby streamlining and expediting the NTIOL notification, comment, and review process.

Specifically, we established the following process:

- We will announce annually in the **Federal Register** document that proposes the update of ASC payment rates for the following calendar year, a list of all requests to establish new NTIOL classes accepted for review during the calendar year in which the proposal is published and the deadline for submission of public comments regarding those requests. The deadline for receipt of public comments will be 30 days following publication of the list of requests.
- In the **Federal Register** document that finalizes the update of ASC payment rates for the following calendar year, we will—

+ Provide a list of determinations made as a result of our review of all requests and public comments; and

+ Publish the deadline for submitting requests for review in the following calendar year.

In determining whether a lens belongs to a new class of NTIOLs and whether the ASC payment amount for insertion of that lens in conjunction with cataract surgery is appropriate, we expect that the insertion of the candidate IOL would result in significantly improved clinical outcomes compared to currently available IOLs. In addition, to establish a new NTIOL class, the candidate lens must be distinguishable from lenses

already approved as members of active or expired classes of NTIOLs that share a predominant characteristic associated with improved clinical outcomes that was identified for each class. In the CY 2007 final rule, we finalized our proposal to base our determinations on consideration of the following factors:

• The IOL must have been approved by the FDA and claims of specific clinical benefits and/or lens characteristics with established clinical relevance in comparison with currently available IOLs must have been approved by the FDA for use in labeling and advertising.

• The IOL is not described by an active or expired NTIOL class; that is, it does not share the predominant, class-defining characteristic associated with improved clinical outcomes with designated members of an active or expired NTIOL class.

• Evidence demonstrates that use of the IOL results in measurable, clinically meaningful, improved outcomes in comparison with use of currently available IOLs. According to the statute, and consistent with previous examples provided by CMS, superior outcomes that would be considered include the following:

+ Reduced risk of intraoperative or postoperative complication or trauma;

+ Accelerated postoperative recovery;

+ Reduced induced astigmatism;

+ Improved postoperative visual acuity;

+ More stable postoperative vision;

+ Other comparable clinical advantages, such as—

++ Reduced dependence on other eyewear (for example, spectacles, contact lenses, and reading glasses);

++ Decreased rate of subsequent diagnostic or therapeutic interventions, such as the need for YAG laser treatment;

++ Decreased incidence of subsequent IOL exchange;

++ Decreased blurred vision, glare, other quantifiable symptom or vision deficiency.

For a request to be considered complete, we require submission of the information that is found in the guidance document entitled ''Application Process and Information Requirements for Requests for a New Class of New Technology Intraocular Lens (NTIOL)'' posted on the CMS Web site at: *http://cms.hhs.gov/ASCPayment/05_NTIOLs.asp#TopOfPage.*

As stated in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68180), there are three possible outcomes from our review of a request for determination of a new NTIOL class. As appropriate, for each completed request for a candidate IOL that is received by the established deadline, one of the following determinations would be announced annually in the final rule updating the ASC payment rates for the next calendar year:

• The request for a payment adjustment is approved for the IOL for 5 full years as a member of a new NTIOL class described by a new HCPCS code.

• The request for a payment adjustment is approved for the IOL for the balance of time remaining as a member of an active NTIOL class.

• The request for a payment adjustment is not approved.

We also discussed our plan to summarize briefly in the final rule the evidence that was reviewed, the public comments, and the basis for our determinations. We established that when a new NTIOL class is created, we would identify the predominant characteristic of NTIOLs in that class that sets them apart from other IOLs (including those previously approved as members of other expired or active NTIOL classes) and is associated with improved clinical outcomes. The date of implementation of a payment adjustment in the case of approval of an IOL as a member of a new NTIOL class would be set prospectively as of 30 days after publication of the ASC payment update final rule, consistent with the statutory requirement. The date of implementation of a payment adjustment in the case of approval of a lens as a member of an active NTIOL class would be set prospectively as of the publication date of the ASC payment update final rule.

3. NTIOL Application Process for CY 2008 Payment Adjustment

To provide process and information requirements for applications requesting a review of the appropriateness of the payment amount for insertion of an IOL to ensure that the ASC payment for covered surgical procedures includes payment that is reasonable and related to the cost of acquiring a lens that is approved as belonging to a new class of NTIOLs, in the winter of CY 2007 we posted the guidance document to the CMS Web site regarding such requests as described above. We did not receive any review requests by the deadline of April 1, 2007 in response to the announcement made in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68181) soliciting CY 2008 requests for review of the appropriateness of the payment amount for new classes of NTIOLs furnished in ASCs.

We note that we have also issued a guidance document entitled ''Revised Process for Recognizing Intraocular Lenses Furnished by Ambulatory Surgery Centers (ASCs) as Belonging to an Active Subset of New Technology Intraocular Lenses (NTIOLs).'' This guidance document can be accessed on the CMS Web site at: *http://www.cms.hhs.gov/ASCPayment/05_NTIOLs.asp.*

This guidance document provides specific details regarding requests for recognition of IOLs as belonging to an existing, active NTIOL class, the review process, and information required for a request to review. Currently, there is one active NTIOL class whose defining characteristic is the reduction of spherical aberration. CMS accepts requests throughout the year to review the appropriateness of recognizing an IOL as a member of an active class of NTIOLs. That is, review of candidate lenses for membership in an existing, active NTIOL class is ongoing and not limited to the annual review process that applies to the establishment of new NTIOL classes. We ordinarily would complete the review of such a request within 90 days of receipt, and upon completion of our review, we would notify the requestor of our determination and post on the CMS Web site notification of a lens newly approved for a payment adjustment as an NTIOL belonging to an active NTIOL class when furnished in an ASC.

4. Classes of NTIOLs Approved for Payment Adjustment

Since implementation of the process for adjustment of payment amounts for NTIOLs that was established in the June 16, 1999 **Federal Register**, we have approved three classes of NTIOLs, as shown in the following table:

NTIOL category	HCPCS code	$50 approved for services furnished on or after	NTIOL characteristic	IOLs eligible for adjustment
1	Q1001	May 18, 2000, through May 18, 2005.	Multifocal	Allergan AMO Array Multifocal lens, model SA40N.

NTIOL category	HCPCS code	$50 approved for services furnished on or after	NTIOL characteristic	IOLs eligible for adjustment
2	Q1002	May 18, 2000, through May 18, 2005.	Reduction in Preexisting Astigmatism.	STAAR Surgical Elastic Ultraviolet-Absorbing Silicone Posterior Chamber IOL with Toric Optic, models AA4203T, AA4203TF, and AA4203TL.
3	Q1003	February 27, 2006, through February 26, 2011.	Reduced Spherical Aberration.	Advanced Medical Optics (AMO) Tecnis® IOL models Z9000, Z9001, Z9002, and ZA9003; Alcon Acrysof® IQ Model SN60WF; Bausch & Lomb Sofport AO models LI61AOV, and LI61AOV.

5. Payment Adjustment

The current payment adjustment for a 5-year period from the implementation date of a new NTIOL class is $50. In the CY 2007 OPPS/ASC final rule with comment period, we revised § 416.200(a) through (c) to clarify how the IOL payment adjustment will be made and how an NTIOL will be paid after expiration of the payment adjustment, as well as made minor editorial changes to § 416.200(d). For CY 2008, we are not proposing to revise the current payment adjustment amount, but we reiterate our intention, as stated in the CY 2007 final rule, to reevaluate whether or not the ASC payment rates established for cataract surgery with IOL insertion are appropriate when a lens determined to be an NTIOL is furnished after we have implemented the revised ASC payment system in CY 2008.

6. Proposed CY 2008 ASC Payment for Insertion of IOLs

In accordance with the final policies of the revised ASC payment system for CY 2008, payment for IOL insertion services will be established according to the standard payment methodology of the revised payment system, which applies the ASC budget neutrality adjustment to the OPPS conversion factor to calculate an ASC conversion factor that is then multiplied by the ASC payment weight for the surgical procedure to implant the IOL. CY 2008 ASC payment for the cost of a conventional lens will be packaged into the payment for the associated covered surgical procedure performed by the ASC. The proposed CY 2008 ASC payment rates for IOL insertion procedures are included in Table 66.

TABLE 66.—INSERTION OF IOL PROCEDURES AND THEIR PROPOSED CY 2008 ASC PAYMENT RATES

HCPCS code	Long descriptor	Proposed CY 2008 ASC payment
66983	Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)	$980.43
66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification).	980.43
66985	Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract removal	870.18
66986	Exchange of intraocular lens	870.18

J. Proposed ASC Payment and Comment Indicators

In addition to the payment indicators that we introduced in the July 2007 final rule for the revised ASC payment system, we also are introducing comment indicators for the ASC payment system in this proposed rule. We created Addendum DD1 to define ASC payment indicators that we will use in Addenda AA and BB to provide payment information regarding covered surgical procedures and covered ancillary services, respectively, under the revised ASC payment system. Analogous to the OPPS payment status indicators that we define in Addendum D1 to the annual OPPS proposed and final rules, the ASC payment indicators in Addendum DD1 are intended to capture policy-relevant characteristics of HCPCS codes that may receive packaged or separate payment in ASCs, including: their ASC payment status prior to CY 2008; their designations as device-intensive; their designations as office-based and the corresponding ASC payment methodology; and their classifications as separately payable radiology services, brachytherapy sources, OPPS pass-through devices, corneal tissue acquisition services, drugs or biologicals, or NTIOLs.

We have also created new Addendum DD2 to this proposed rule that lists the ASC comment indicators. Like the comment indicators used in the OPPS, the ASC comment indicators to be used in Addenda AA and BB to the OPPS/ASC final rule with comment period will serve to identify, for the revised ASC payment system, the status of a specific HCPCS code and its payment indicator with respect to the timeframe when comments would be accepted. The comment indicator ''NI'' will be used in the final rule to indicate new HCPCS codes for which the interim payment indicator assigned is subject to comment in the final rule.

The changes for CY 2008 that we are proposing to the payment indicators assigned to HCPCS codes for procedures and services in the July 2007 final rule for the revised ASC payment system are identified with a ''CH'' in Addenda AA and BB to this proposed rule and are subject to comment during the 60-day comment period provided for this proposed rule. ''CH'' will be used in Addenda AA and BB to the CY 2008 OPPS/ASC final rule with comment period to indicate that a new payment indicator (in comparison with that in the July 2007 final rule for the revised ASC payment system) has been assigned to an active HCPCS code in the current and next calendar year; that an active HCPCS code has been added to the list of procedures or services payable in ASCs; or that an active HCPCS code will be deleted at the end of the current calendar year. These ''CH'' comment indicators that will be published in the CY 2008 OPPS/ASC final rule with comment period will be provided to alert our readers that a change has been made since the July 2007 final rule for the revised ASC payment system, but do not indicate that the change is subject to comment. The full definitions for the comment indicators are provided in Addendum DD2 to this proposed rule.

K. ASC Policy and Payment Recommendations

The GAO published the statutorily mandated report entitled, ''Medicare: Payment for Ambulatory Surgical Centers Should Be Based on the Hospital Outpatient Payment System'' (GAO–07–86) on November 30, 2006. We considered the report's methodology, findings, and recommendations in the development of the July 2007 final rule for the revised ASC payment system. The GAO methodology, results, and recommendations are summarized below.

The GAO was directed to conduct a study comparing the relative costs of procedures furnished in ASCs to those furnished in HOPDs paid under the OPPS, including examining the accuracy of the APC with respect to surgical procedures furnished in ASCs. Section 626(d) of Pub. L. 108–173 indicated that the report should include recommendations on the following matters:

1. Appropriateness of using groups of covered services and relative weights established for the OPPS as the basis of payment for ASCs.

2. If the OPPS relative weights are appropriate for this purpose, whether the ASC payments should be based on a uniform percentage of the payment rates or weights under the OPPS, or should vary, or the weights should be revised based on specific procedures or types of services.

3. Whether a geographic adjustment should be used for ASC payment and, if so, the labor and nonlabor shares of such payment.

Based on its extensive analyses, the GAO determined that the APC groups in the OPPS accurately reflect the relative costs of the procedures performed in ASCs. The GAO's analysis of the cost ratios showed that the ASC-to-APC cost ratios were more tightly distributed around their median cost ratio than were the OPPS-to-APC cost ratios. The ASC-to-APC median cost ratio is a comparison of the median cost of each of the 20 surgical procedures with the highest ASC claims volume to the median cost of the APC group in which it would be placed under the OPPS, while the OPPS-to-APC cost ratio is a comparison of the median cost of each of those same procedures under the OPPS with the median cost of its assigned APC group. These patterns demonstrated that the APC groups reflect the relative costs of procedures performed by ASCs like they do for procedures performed in HOPDs and, therefore, that the APC groups could be used as the basis for an ASC payment system. The GAO determined, in fact, that there was less variation in the ASC setting between individual procedures' costs and the costs of their assigned APC groups than there is in the HOPD setting. It concluded that, as a group, the costs of procedures performed in ASCs have a relatively consistent relationship with the costs of the APC groups to which they are assigned under the OPPS. The GAO's analysis also found that procedures in the ASC setting had substantially lower costs than those same procedures in the HOPD. While ASC costs for individual procedures varied, in general, the median costs for procedures were lower in ASCs, relative to the median costs of their APC groups, than the median costs for the same procedures in the HOPD setting. The median cost ratio among all ASC procedures was 0.39 (0.84 when weighted by Medicare volume based on CY 2004 claims), whereas the median cost ratio among all OPPS procedures was 1.04.

The GAO found many similarities in the additional items and services provided by ASCs and HOPDs for the top 20 ASC procedures. However, of these additional items and services, few resulted in additional payment in one setting but not the other. HOPDs were paid for some of the related services separately, while in the ASC setting, other Part B suppliers billed Medicare and received payment for many of the related services.

Finally, in its analysis of labor-related costs, the GAO determined that the mean labor-related proportion of costs was 50 percent. The range of the labor-related costs for the middle 50 percent of responding ASCs was 43 percent to 57 percent of total costs.

Based on its findings from the study, the GAO recommended that CMS implement a payment system for procedures performed in ASCs based on the OPPS, taking into account the lower relative costs of procedures performed in ASCs compared to HOPDs in determining ASC payment rates.

L. Proposed Calculation of the ASC Conversion Factor and ASC Payment Rates

1. Overview

As discussed in section XVI.C. of this proposed rule, we finalized our policy to base ASC relative payment weights and payment rates under the revised ASC payment system on APC groups and relative payment weights established under the OPPS in the July 2007 final rule for the ASC revised payment system. In that rule, we made final our proposal to set the ASC relative payment weight for certain office-based surgical procedures so that the national unadjusted ASC payment rate does not exceed the MPFS unadjusted nonfacility PE RVU amount. Our final policy is to calculate ASC payment rates by multiplying the ASC relative payment weights by the ASC conversion factor. In the July 2007 final rule for the revised ASC payment system, our estimate of the CY 2008 budget neutral ASC conversion factor was $42.542. In this proposed rule, the proposed ASC conversion factor for CY 2008 is $41.400. This new estimate of the ASC conversion factor differs from the estimate in the July 2007 final rule for the revised ASC payment system for a number of reasons, including: (1) Use of the proposed OPPS relative payment weights for CY 2008; (2) use of the proposed MPFS nonfacility practice expense payment amounts for CY 2008; and (3) use of updated utilization data from CY 2006. Specific details regarding our final methodology for estimating the CY 2008 ASC conversion factor may be found in the July 2007 final rule for the revised ASC payment system.

We were not able to provide the final CY 2008 ASC conversion factor in the July 2007 final rule for the revised ASC payment system because the final CY 2008 conversion factor will be based on the final OPPS relative payment weights for CY 2008, the final MPFS nonfacility practice expense payment amounts for CY 2008, and updated and complete CY 2006 utilization data, all of which are unavailable at the time we are publishing the July 2007 final rule for the ASC revised payment system elsewhere in this issue of the **Federal Register**. In this proposed rule, we use the final methodology described in the July 2007 final rule for the revised ASC payment system to calculate the proposed CY 2008 ASC conversion factor and proposed ASC relative payment weights and rates that will be made final in the CY 2008 OPPS/ASC final rule with comment period.

2. Budget Neutrality Requirement

Section 626(b) of Pub. L. 108–173 amended section 1833(i)(2) of the Act by adding subparagraph (D) to require that in the year the revised ASC system is implemented:

'' * * * [S]uch system shall be designed to result in the same aggregate amount of expenditures for such services as would be made if this subparagraph did not apply, as estimated by the Secretary * * * ''

As discussed in the July 2007 final rule for the revised ASC payment system, the ASC conversion factor is

calculated so that estimated total Medicare payments under the revised ASC payment system would be budget neutral to estimated total Medicare payments under the current ASC payment system as required by the statute. That is, application of the ASC conversion factor is designed to result in aggregate expenditures under the revised ASC payment system in CY 2008 equal to aggregate expenditures that would have occurred in CY 2008 in the absence of the revised system, taking into consideration the cap on payments in CY 2007 as required under section 5103 of Pub. L. 109–171.

We note that we considered the term ''expenditures'' in the context of section 626(b) of the Pub. L. 108–173 budget neutrality requirement to mean expenditures from the Medicare Part B Trust Fund. We did not consider expenditures to include beneficiary coinsurance and copayments.

3. Calculation of the ASC Payment Rates for CY 2008

The following is a step-by-step illustration of the final budget neutrality adjustment calculation as finalized in the July 2007 final rule for the revised ASC payment system and as applied to updated data available for this proposed rule.

The final methodology for establishing budget neutrality under the revised ASC payment system takes into account a 4-year transition to full implementation of the revised payment rates and the effects of several assumptions regarding migration of services across ASCs, HOPDs, and physicians' offices. Payments during the 4-year transition to the fully implemented revised ASC payment rates will be based on a blend of the CY 2007 ASC payment rates and the revised ASC payment rates at 75/25 in CY 2008, 50/50 in CY 2009, and 25/75 in CY 2010, with payment at 100 percent of the revised ASC payment rates in 2011. The methodology assumes no net cost or savings to Medicare from the migration of existing ASC services among ASCs, HOPDs, and physicians' offices. It includes assumptions that 15 percent of physicians' office utilization for new ASC procedures, specifically those first added for ASC payment beginning in CY 2008, will migrate to ASCs over a 4-year period (3.75 percent each year) and that 25 percent of the new procedures' HOPD utilization will migrate over the first 2 years under the revised payment system (12.5 percent each year) and accounts for the Medicare costs and savings associated with that movement. A detailed explanation of the model may be found in section V.C. of the July 2007 final rule for the revised ASC payment system.

a. Estimated CY 2008 Medicare Program Payments (Excluding Beneficiary Coinsurance) Under the Existing ASC Payment System

Step 1: Migration from HOPDs to ASCs is valued using proposed CY 2008 OPPS payment rates.

(a) We multiply the estimated CY 2008 HOPD utilization for each new ASC procedure by 0.125, consistent with our assumption that 25 percent of the HOPD utilization for new ASC procedures will migrate to the ASC over the first 2 years of the revised ASC payment system, only half of which would occur in CY 2008. In estimating HOPD utilization for CY 2008, we take into account the impact of the multiple procedure discount (as discussed in more detail in section V.C.3. the July 2007 final rule for the revised ASC payment system).

(b) For each new ASC procedure, we multiply the results of Step 1(a) by the proposed CY 2008 OPPS payment rate for the procedure, and then subtract beneficiary coinsurance for the procedure.

(c) We sum the results of Step 1(b) across all new ASC procedures.

Step 2: Migration of procedures from physicians' offices to ASCs is valued using proposed CY 2008 physician in-office payment rates. ''Physician in-office payment rate'' is equal to the proposed MPFS nonfacility practice expense RVUs multiplied by the proposed CY 2008 MPFS conversion factor.

(a) We multiply the estimated physician office utilization for CY 2008 for each new ASC procedure by 0.0375, consistent with our assumption that 15 percent of the physician's office utilization for new ASC procedures will migrate to the ASC over the full 4-year transition period.

(b) For each new ASC procedure, we multiply the results of Step 2(a) by the proposed CY 2008 physician in-office payment rate for the procedure, and then subtract beneficiary coinsurance for the procedure.

(c) We sum the results of Step 2(b) across all new ASC procedures.

Step 3: CY 2007 ASC services are valued using the estimated CY 2008 ASC payment rates under the current ASC system.

To estimate the aggregate expenditures that would be made in CY 2008 under the existing ASC payment system:

(a) We multiply the estimated CY 2008 ASC utilization for each HCPCS code on the CY 2007 ASC list by the estimated CY 2008 ASC payment rate for the HCPCS code under the existing ASC payment system, and then subtract beneficiary coinsurance for the procedure. The estimated CY 2008 ASC payment rates are based on the CY 2007 ASC payment rates, which were listed in Addendum AA to the CY 2007 OPPS/ASC final rule with comment period (71 FR 68243 through 68283) and take into account the OPPS cap on payment for ASC services as required by section 5103 of Pub. L. 109–171 and reflect the zero percent CY 2008 update for ASC services mandated by section 1833(i)(2)(C) of the Act. In estimating ASC utilization for CY 2008, we take into account the impact of the multiple procedure discount (as discussed in section V.C.3. of the July 2007 final rule for the revised ASC payment system).

(b) We estimate the amount the Medicare program would pay in CY 2008 for implantable prosthetic devices and implantable DME for which ASCs currently receive separate payment under the DMEPOS fee schedule.

(c) We sum the results of Steps 3(a) and 3(b) to estimate the aggregate amount of expenditures that would be made in CY 2008 for current covered surgical procedures under the existing ASC payment system.

Step 4: Sum the results of Steps 1–3.

b. Estimated Medicare Program Payments (Excluding Beneficiary Coinsurance) Under the Revised ASC Payment System

Step 5: HOPD migration is valued using proposed CY 2008 OPPS payment rates.

This step is the same as Step 1, above.

Step 6: We identify new ASC procedures that are office-based (as discussed in section III.C. of the July 2007 final rule for the revised ASC payment system).

Step 7: Migration of new ASC office-based procedures from physicians' offices to ASCs is valued based on proposed CY 2008 OPPS payment rates capped at the proposed CY 2008 physician in-office payment rates, if appropriate.

(a) For each new ASC procedure determined to be office-based, we multiply the results of Step 2(a) above by the lesser of—

(1) The proposed CY 2008 OPPS rate for the procedure; or

(2) The proposed CY 2008 physician in-office payment rate for the procedure, and then subtract beneficiary coinsurance for the procedure

(b) The results of Step 7(a) are summed across all new ASC procedures considered to be office-based.

Step 8: Migration of new ASC procedures not determined to be office-based from physicians' offices to ASCs is valued using the proposed CY 2008 OPPS rates.

(a) For each new ASC procedure not considered to be office-based, we multiply the results of Step 2(a) above by the proposed CY 2008 OPPS rate for the procedure, and then subtract beneficiary coinsurance for the procedure.

(b) The results of Step 8(a) are summed across all new ASC procedures not considered to be office-based.

Step 9: Migration of new ASC procedures from physicians' offices to ASCs is valued using the proposed CY 2008 MPFS physician out-of-office payment rate. ''Physician out-of-office payment rate'' is equal to the proposed facility practice expense RVUs multiplied by the proposed CY 2008 MPFS conversion factor.

(a) For each new ASC procedure, we multiply the results of Step 2(a) from above by the proposed CY 2008 physician out-of-office payment rate for the procedure, and then subtract beneficiary coinsurance for the procedure.

(b) The results of Step 9(a) are summed across all new ASC procedures.

Step 10: Current ASC services are valued using the proposed CY 2008 OPPS payment rates.

To estimate the aggregate amount of expenditures that would be made in CY 2008, we use proposed CY 2008 OPPS payment amounts instead of estimated CY 2008 ASC payment amounts under the current system, and we multiply the estimated CY 2008 ASC volume for each HCPCS code on the CY 2007 ASC list of covered surgical procedures by the proposed CY 2008 OPPS payment rate for the HCPCS code, and then subtract beneficiary coinsurance for the procedure. We sum the results over all services on that ASC list.

Step 11: The results of Steps 5 and 7–10 are summed.

c. Calculation of the Proposed CY 2008 Budget Neutrality Adjustment

Step 12: The result of Step 4 is divided by the result of Step 11.

Step 13: The application of the cap at the proposed CY 2008 physician in-office payment rates that occurs in Step 7 is dependent on the ASC conversion factor. The ASC budget neutrality adjustment resulting from Step 12 is calibrated to take into account the interactive nature of the ASC conversion factor and the physician's office payment cap. The ASC budget neutrality calculation is also calibrated to take into account the fact that the additional physician out-of-office payment rates under the revised ASC payment system calculated in Step 9 must be fully offset by the budget neutrality adjustment to ASC services under the revised payment system. Furthermore, the budget neutrality calculation is calibrated to take into account the CY 2008 transitional payment rates for procedures on the CY 2007 ASC list of covered surgical procedures.

The application of the above methodology to the data available for this proposed rule results in an estimated budget neutrality adjustment of 0.65. This number differs from the estimated budget neutrality adjustment of 0.67 for the July 2007 final rule for the revised ASC payment system that was based on CY 2005 utilization and CY 2007 OPPS and MPFS payment rates. The proposed budget neutrality adjustment for CY 2008 reflects updated data, including CY 2006 utilization and proposed CY 2008 OPPS and MPFS payment rates. The CY 2008 budget neutrality adjustment for the revised ASC payment system, calculated based on the methodology outlined above, will be finalized in the CY 2008 OPPS/ASC final rule with comment period.

d. Calculation of the Proposed CY 2008 ASC Payment Rates

After developing the proposed CY 2008 budget neutrality adjustment of 0.65 according to the policies established in the July 2007 final rule for the revised ASC payment system, to determine the proposed CY 2008 ASC conversion factor, we multiplied the proposed CY 2008 OPPS conversion factor by the proposed ASC budget neutrality adjustment. The proposed CY 2008 OPPS conversion factor is $63.693 and multiplying that by the 0.65 budget neutrality adjustment yields our proposed CY 2008 ASC conversion factor of $41.400. To determine the proposed fully implemented ASC payment rates for this proposed rule, including beneficiary coinsurance, according to the final payment methodology that applies to covered surgical procedures and covered ancillary radiology services under the revised ASC payment system, we multiplied the proposed ASC conversion factor by the proposed ASC relative payment weight for each procedure or service. As further discussed in section XVI.C. of this proposed rule, the ASC relative payment weights for certain office-based surgical procedures and covered ancillary radiology services are set so that the national unadjusted ASC payment rate does not exceed the MPFS unadjusted nonfacility practice expense amount. In addition, the ASC relative payment weights for device-intensive covered surgical procedures are set according to a modified payment methodology to ensure the same device payment under the revised ASC payment system as under the OPPS. We then calculated the proposed CY 2008 payment rate for procedures on the CY 2007 ASC list of covered surgical procedures using a blend of 75 percent of the final CY 2007 ASC payment rate and 25 percent of the proposed CY 2008 ASC payment rate developed according to the methodology of the revised ASC payment system, applying the special transition treatment to device-intensive procedures as discussed in section XVI.C of this proposed rule. See Addenda AA and BB to this proposed rule for the proposed CY 2008 ASC payment weights and payment rates for covered surgical procedures and covered ancillary services that are expected to be paid separately under the CY 2008 revised ASC payment system.

4. Calculation of the ASC Payment Rates for CY 2009 and Future Years

a. Updating the ASC Relative Payment Weights

In the July 2007 final rule for the revised ASC payment system, we finalized our policy to update the ASC relative payment weights in the revised ASC payment system each year using the national OPPS relative payment weights (and MPFS nonfacility PE RVU amounts, as applicable) for that same calendar year and to uniformly scale the ASC relative payment weights for each update year to make them budget neutral. For example, holding ASC utilization and the mix of services constant, for CY 2009, we will compare the total weight using the CY 2008 ASC relative payment weights under the 75/25 blend (of the CY 2007 payment rate and the revised payment rate) with the total weight using CY 2009 relative payment weights under the 50/50 blend (of the CY 2007 payment rate and the revised payment rate), taking into account the changes in the OPPS relative payment weights between CY 2008 and CY 2009. We will use the ratio of CY 2008 to CY 2009 total weight to scale the ASC relative payment weights for CY 2009. Scaling of ASC relative payment weights would apply to covered surgical procedures and covered ancillary radiology services whose payment rates are related to OPPS relative payment weights. Scaling would not apply in the case of ASC payment for other separately payable

covered ancillary services that have a predetermined national payment amount (that is, their national payment amounts are not based on OPPS relative payment weights) such as drugs and biologicals that are separately paid under the OPPS. Any service with a predetermined national payment amount would be included in the budget neutrality comparison, but scaling of the relative payment weights would not apply to those services that have a predetermined payment amount. The ASC payment weights for those services without predetermined national payment amounts (that is, their national payment amounts would be based on OPPS relative payment weights if a payment limitation did not apply) would be scaled to eliminate any difference in the total payment weight between the current year and the update year. As we noted in the July 2007 final rule for the revised ASC payment system, while we do not currently have a provider-level dataset of ASC utilization that accurately identifies unique ASCs and their geographic information that would allow us to compare changes in geographic adjustment over time for budget neutrality purposes, we intend to take these changes into account in maintaining budget neutrality for the revised ASC payment system as soon as our provider-level ASC data permit.

b. Updating the ASC Conversion Factor

Section 1833(i)(2)(C) of the Act requires that, if the Secretary has not updated the ASC payment amounts in a calendar year after CY 2009, the payment amounts shall be increased by the percentage increase in the CPI-U as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved. Therefore, as discussed in the July 2007 final rule for the ASC revised payment system, we adopted a final policy to update the ASC conversion factor using the CPI-U in order to adjust ASC payment rates for inflation. We will implement the annual updates through an adjustment to the conversion factor under the revised ASC payment system, beginning in CY 2010 when the statutory requirement for a zero update no longer applies.

XVII. Reporting Quality Data for Annual Payment Rate Updates

(If you choose to comment on issues in this section, please include the caption ''Quality Data'' at the beginning of your comment.)

A. Background

1. Reporting Hospital Outpatient Quality Data for Annual Payment Update

Section 109(a) of the MIEA–TRHCA (Pub. L. 109–432) amended section 1833(t) of the Act by adding a new subsection (17) that affects the payment rate update applicable to OPPS payments for services furnished by hospitals in outpatient settings on or after January 1, 2009. New section 1833(t)(17)(A) of the Act, which applies to hospitals as defined under section 1886(d)(1)(B) of the Act, requires that hospitals that fail to report data required for the quality measures selected by the Secretary in the form and manner required by the Secretary under section 1833(t)(17)(B) of the Act will incur a reduction in their annual payment update factor by 2.0 percentage points. New section 1833(t)(17)(B) of the Act requires that hospitals submit quality data in a form and manner, and at a time that the Secretary specifies. New sections 1833(t)(17)(C)(i) and (ii) of the Act require the Secretary to develop measures appropriate for the measurement of the quality of care (including medication errors) furnished by hospitals in outpatient settings and that these measures reflect consensus among affected parties and, to the extent feasible and practicable, include measures set forth by one or more national consensus building entities. The Secretary is not prevented from selecting measures that are the same as (or a subset of) the measures for which data are required to be submitted under section 1886(b)(3)(B)(viii) of the Act for the IPPS Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program. New section 1833(t)(17)(D) of the Act, gives the Secretary the authority to replace measures or indicators as appropriate, such as when all hospitals are effectively in compliance or when the measures or indicators have been subsequently shown not to represent the best clinical practice. New section 1833(t)(17)(E) of the Act, requires the Secretary to establish procedures for making data submitted available to the public. Such procedures must give hospitals the opportunity to review data before these data are released.

In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68189), we indicated our intent to establish, in CY 2009, an OPPS RHQDAPU program modeled after the current IPPS RHQDAPU program in CY 2009. We stated our belief that the quality of hospital outpatient services would be most appropriately and fairly rewarded through the reporting of quality measures developed specifically for application in the hospital outpatient setting. We agreed with the commenters that assessment of hospital outpatient performance would ultimately be most appropriately based on reporting of hospital outpatient measures developed specifically for this purpose. We stated our intent to condition the full OPPS payment rate update beginning in CY 2009 based upon hospital reporting of quality data beginning in CY 2008, using effective measures of the quality of hospital outpatient care that have been carefully developed and evaluated, and endorsed as appropriate, with significant input from stakeholders.

The amendments to the Act made by section 109(a) of the MIEA–TRHCA are consistent with our intent and direction outlined in the CY 2007 OPPS/ASC final rule with comment period. Under these amendments, we are now statutorily required to establish a program under which hospitals will report data on the quality of hospital outpatient care using standardized measures of care to receive the full annual update to the OPPS payment rate, effective for payments beginning in CY 2009. We will refer to the program established under these amendments as the Hospital Outpatient Quality Data Reporting Program (HOP QDRP).

In reviewing the measures currently available for care in the hospital outpatient settings, we continue to believe that it would be most appropriate and desirable to use measures that have been specifically developed for application in the hospital outpatient setting. Although we still believe that hospitals generally function as integrated systems in inpatient and outpatient settings, we do not believe it is appropriate to use participation in the IPPS RHQDAPU program for the purpose of implementing section 1833(t)(17) of the Act in the hospital outpatient setting. Nonetheless, section 1833(t)(17)(C)(ii) of the Act indicates that the Secretary is not prevented ''from selecting measures that are the same as (or a subset of) the measures for which data are required to be submitted'' under the IPPS RHQDAPU program. In this proposed rule, we are proposing to establish a separate reporting program and proposing quality measures that are appropriate for measuring hospital outpatient quality of care, that reflect consensus among affected parties, and are set forth by one or more of the national consensus building entities.

2. Reporting ASC Quality Data for Annual Payment Increase

Section 109(b) of the MIEA–TRHCA, Pub. L. 109–432 amended section 1833(i) of the Act by adding new sections 1833(i)(2)(D)(iv) and 1833(i)(7) to the Act. These amendments may affect ASC payments for services furnished in ASC settings on or after January 1, 2009. New section 1833(i)(2)(D)(iv) of the Act authorizes the Secretary to implement the revised payment system for services furnished in ASCs (established under section 1833(i)(2)(D) of the Act), ''so as to provide for a reduction in any annual payment increase for failure to report on quality measures.''

New section 1833(i)(7)(A) of the Act authorizes the Secretary to provide that any ASC that fails to report data required for the quality measures selected by the Secretary in the form and manner required by the Secretary under new section 1833(i)(7) of the Act will incur a reduction in any annual payment increase of 2.0 percentage points. New section 1833(i)(7)(A) of the Act also specifies that a reduction for one year cannot be taken into account in computing the ASC update for a subsequent year.

New section 1833(i)(7)(B) of the Act provides that, ''except as the Secretary may otherwise provide,'' the hospital outpatient quality data provisions of section 1833(t)(17)(B) through (E) of the Act, summarized above, shall apply to ASCs.

We refer readers to section XVII.H. of this proposed rule for a discussion of our intent to introduce implementation of this provision in a later rulemaking.

B. Proposed Hospital Outpatient Measures

For the initial implementation of the HOP QDRP, we have identified 10 quality measures that we believe are both applicable to care provided in hospital outpatient settings and likely to be sufficiently developed to permit data collection consistent with the timeframes defined by statute. These measures address care provided to a large number of adult patients in hospital outpatient settings, across a diverse set of conditions, and were selected for the initial set of HOP QDRP measures based on their relevance as a set to all hospitals.

The first five of these measures capture the quality of outpatient care in hospital emergency departments (EDs), specifically for those adult patients with acute myocardial infarction (AMI) who are treated and then transferred to another facility for further care. These patients receive many of the same interventions as patients who are evaluated and admitted at the same facility, whose care is currently assessed in measures that are endorsed by the National Quality Forum (NQF). NQF is a voluntary consensus standard-setting organization established to standardize health care quality measurement and reporting through its consensus development process. Moreover, these are also inpatient AMI measures that have long been reported under the IPPS RHQDAPU program, and are published on the Hospital Compare Web site at: *http://www.HospitalCompare.hhs.gov.* Transferred AMI patients historically have not been included with the directly-admitted patients for purposes of the calculation of the inpatient AMI measures because of differences in data collection and reporting for the two groups. With the input of provider and practitioner experts in the field, we have developed specifications for related emergency department transfer measures that, while consistent with the measure specifications for the related hospital inpatient measures, reflect the unique operational and clinical aspects of care in hospital outpatient settings. The processes of care encompassed by these measures address care on arrival, the promptness of interventions, and discharge care for patients presenting to a hospital with an AMI.

In addition to the five ED–AMI measures, we have identified five quality measures that are directly related to conditions treated or interventions provided in hospital outpatient settings and that we believe are also appropriate and fully developed for use in the HOP QDRP. While currently specified in a form that assesses the care provided by physicians, these measures are also directly relevant to assessing care at the facility level. CMS is currently engaged in reviewing, and where appropriate, revising these measure specifications so that they explicitly assess care provided in hospital outpatient settings. The five measures include one measure related to treatment of heart failure, two measures related to surgical care improvement, one measure addressing treatment of community acquired pneumonia, and one measure related to diabetes care.

Specifically, in order for hospitals to receive the full OPPS payment update for services furnished in CY 2009, we are proposing to require that hospital outpatient settings submit data on the following 10 measures, effective with hospital outpatient services furnished on or after January 1, 2008:

- ED–AMI–1—Aspirin at Arrival
- ED–AMI–2—Median Time to Fibrinolysis
- ED–AMI–3—Fibrinolytic Therapy Received Within 30 Minutes of Arrival
- ED–AMI–4—Median Time to Electrocardiogram (ECG)
- ED–AMI–5—Median Time to Transfer for Primary PCI
- PQRI #5: Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or
- Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- PQRI #20 Perioperative Care: Timing of Antibiotic Prophylaxis
- PQRI #21 Perioperative Care: Selection of Prophylactic Antibiotic
- PQRI #59: Empiric Antibiotic for Community-Acquired Pneumonia
- PQRI #1: Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus

As required by statute, consensus was reached by affected parties, as the measures were identified as appropriate for reporting on hospital outpatient care in collaboration with professionals and providers with experience in hospital outpatient settings as well as with the Hospital Quality Alliance (HQA), a hospital-industry led, public-private collaboration established to promote public reporting on hospital quality of care. CMS is currently finalizing the specifications for these 10 measures and expects to release these specifications to the public by Fall 2007. In addition, CMS expects to submit these measures for endorsement by the NQF.

Nine of the ten measures are process measures, while one measure—Hemoglobin A1c >9.0 percent—is an intermediate outcome measure that has not been risk-adjusted. While poor quality of care can lead to poor diabetes control and elevated A1c levels, CMS recognizes the importance of compliance with prescribed treatment regimen in improving diabetes control and A1c levels. Patients with comorbidities or diabetes complications may experience challenges controlling their diabetes and may have higher A1c levels. Therefore, CMS specifically requests comments on this intermediate outcome measure and how to balance the desire for improved quality of care with individual patient challenges that may affect results.

CMS believes that an A1c level higher than 9.0 percent represents a level of control that is sufficiently poor enough that it should not result in any unintended consequences. The scientific literature would suggest that an A1c level of 8.0 percent or less might represent the best control that could be expected for some patients: therefore, CMS believes that an A1c level of > 9.0

percent represents a level of control that is poor enough that risk-adjustment is not warranted. Additionally, this A1c measure has been endorsed by the National Quality Forum (NQF) in 2006. One of the criteria for evaluation of measures within the NQF process is ''scientific acceptability,'' which includes appropriate risk-adjustment. Some measures are not endorsed by NQF if risk-adjustment is determined to be appropriate and is found to be inadequate. CMS believes that additional risk-adjustment is not necessary because the NQF endorsed this measure. We invite public comment on our rationale for choosing a diabetes outcome measures.

C. Other Proposed Hospital Outpatient Measures

In addition to the 10 measures identified above, we are considering a number of other possible quality measures for use in assessing the care of services provided by hospital outpatient settings, for the determination of CY 2010 or subsequent calendar year payments. These measures are, for the most part, either currently in use or were developed for use in settings other than hospital outpatient. However, we believe that these measures are applicable to the hospital outpatient settings.

These measures have not received formal review by either the HQA or the NQF as measures of HOP performance. As noted in the chart, however, the inpatient or ambulatory versions of these measures have all been either recommended by an NQF-subgroup for endorsement, are pending endorsement by the NQF, or are currently endorsed by the NQF. The measures present the diversity of services and clinical topics provided to adult patients in hospital outpatient settings. The measures address some aspects of care provided to cancer patients, patients presenting with diabetes, pneumonia, chest pains, syncope, or depression, and patients receiving services related to bones, eyes, and problems associated with aging. While some of the measures relate to acute care provided in a hospital outpatient setting, others assess care that a hospital outpatient clinic might provide on an ongoing basis. We are interested in receiving comments from the public concerning all dimensions of these measures.

We expect that once the HOP QDRP is established, we will expand the set of measures on which hospital outpatient settings must report data. We are interested in receiving comments concerning the relative priority that should be assigned to each of the measures or topics identified in the list below, as well as any additional measures, measure sets, or topics that should be developed for future reporting.

We would like to note that, while we are committed to identifying measures that are relevant to care in hospital outpatient settings, it is also our intent to develop, where feasible, hospital outpatient measures that are ''harmonized'' with measures for assessing comparable inpatient and ambulatory care—that is, measures that are similar in both the care that is assessed and the manner in which data are collected, regardless of the setting. The goal of harmonization is to assure that comparable care in different care settings can be evaluated in similar ways, which further assures that quality measurement and improvement can focus more on the needs of a patient with a particular condition than on the specific program or policy attributes of the setting at which the care is provided.

Therefore, we are seeking public comment on the following 30 additional measures, which have been identified as hospital outpatient-appropriate measures and are under consideration for inclusion in the HOP QDRP measure set, for CY 2010 or subsequent calendar years:

Measure	NQF endorsed for inpatient or ambulatory setting	Description
1 PQRI #2 Low Density Lipoprotein Control in Type 1 or 2 Diabetes Mellitus.	Endorsed 2006	Percentage of patients aged 18–75 years with diabetes (type 1 or type 2) who had most recent LDL–C level in control (less than 100 mg/dl).
2 PQRI #3 High Blood Pressure Control in Type 1 or 2 Diabetes Mellitus.	Endorsed 2006	Percentage of patients aged 18–75 years with diabetes (type 1 or type 2) who had most recent blood pressure in control (less than 140/80 mm Hg).
3 PQRI #4 Screening for Fall Risk.	2 year Endorsement until May 8, 2009.	Percentage of patients aged 65 years and older who were screened for fall risk (2 or more falls in the past year or any fall with injury in the past year) at least once within 12 months.
4 PQRI #9 Antidepressant Medication During Acute Phase for Patient with New Episode of Major Depression.	Endorsed 2006	Percentage of patients aged 18 years and older diagnosed with new episode of major depressive disorder (MDD) and documented as treated with antidepressant medication during the entire 84-day (12 week) acute treatment phase.
5 PQRI #10 Stroke and Stroke Rehabilitation: Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports.	2 year Endorsement until May 8, 2009.	Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or transient ischemic attack (TIA) or intracranial hemorrhage undergoing CT or MRI of the brain within 24 hours of arrival to the hospital whose final report of the CT or MRI includes documentation of the presence or absence of each of the following: hemorrhage and mass lesion and acute infarction.
6 PQRI #11 Stroke and Stroke Rehabilitation: Carotid Imaging Reports.	2 year Endorsement until May 8, 2009.	Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or transient ischemic attack (TIA) whose final reports of the carotid imaging studies performed, with characterization of internal carotid stenosis in the 30–99% range, include reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement.
7 PQRI #24 Osteoporosis: Communication with the Physician Managing Ongoing Care Post Fracture.	2 year Endorsement until May 8, 2009.	Percentage of patients aged 50 years and older treated for a hip, spine or distal radial fracture with documentation of communication with the physician managing the patient's ongoing care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis.

Measure	NQF endorsed for inpatient or ambulatory setting	Description
8 PQRI #46 Medication Reconciliation.	2 year Endorsement until May 8, 2009.	Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g., hospital skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.
9 PQRI #53 Asthma Pharmacological Therapy.	Endorsed 2006	Percentage of patients aged 5 to 40 with a diagnosis of mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment.
10 PQRI #58 Assessment of Mental Status for Community-acquired Pneumonia.	2 year Endorsement until May 8, 2009.	Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with mental status assessed.
11 Radiation therapy is administered within 1 year of diagnosis for women under age 70 receiving breast conserving surgery for breast cancer.	Endorsed May 9, 2007	Radiation therapy to the breast initiated within 1 year of date of diagnosis.
12 Adjuvant chemotherapy is considered or administered within 4 months of surgery to patients under the age of 80 with AJCC III (lymph node positive) colon cancer.	Endorsed May 9, 2007	Consideration or administration of chemotherapy initiated within 4 months of date of diagnosis.
13 Adjuvant hormonal therapy	Endorsed May 9, 2007	Cancer—Breast—consideration or administration of accompanying hormonal therapy for treatment of breast cancer.
14 Needle biopsy to establish diagnosis of cancer precedes surgical excision/resection.	Endorsed May 9, 2007	Patient whose date of needle biopsy precedes the date of surgery.
15 Osteo–02: Screening or Therapy for Women Aged 65 years and Older.	2 year Endorsement until May 8, 2009.	Bone and joint conditions (osteoporosis)—Screening or therapy for women aged 65 years and older.
16 Osteo–03: Management following fracture.	2 year Endorsement until May 8, 2009.	Bone and joint conditions (osteoporosis)—Management following fracture.
17 Osteo–04: Pharmacologic Therapy.	2 year Endorsement until May 8, 2009.	Bone and joint conditions (osteoporosis)—Pharmacologic therapy.
18 EC–01: Electrocardiogram (ECG) for Patients with Non-Traumatic Chest Pain.	2 year Endorsement until May 8, 2009.	Percentage of patients aged 40 years and older with an emergency department discharge diagnosis of nontraumatic chest pain who had an electrocardiogram (ECG).
19 EC–03: ECG Performed for Patients with Syncope.	2 year Endorsement until May 8, 2009.	Percentage of patients aged 18 to 60 years with an emergency department discharge diagnosis of syncope who had an ECG performed.
20 EC–04: Vital Signs Recorded and Reviewed for Patients with Community-Acquired Bacterial Pneumonia.	2 year Endorsement until May 8, 2009.	Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with vital signs recorded and reviewed.
21 Eye–01: Primary Open Angle Glaucoma—Optic Nerve Evaluation.	2 year Endorsement until May 8, 2009.	Primary open angle glaucoma—optic nerve evaluation.
22 Eye–02: Age-Related Macular Degeneration—Antioxidant Supplement Prescribed/Recommended.	Recommended for Endorsement ..	Age-related macular degeneration—antioxidant supplement prescribed/recommended.
23 Eye–03: Age-Related Macular Degeneration—Dilated Macular Examination.	2 year Endorsement until May 8, 2009.	Age-related macular degeneration—dilated macular examination.
24 Eye–07: Diabetic Retinopathy—Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy.	2 year Endorsement until May 8, 2009.	Documentation of presence or absence of macular edema and level of severity of retinopathy.
25 EYE–08: Diabetic Retinopathy—Communication with the Physician Managing Ongoing Diabetes Care.	2 year Endorsement until May 8, 2009.	Communication with the physician managing ongoing diabetes care.
26 GI–09: Colonoscopy for Polyp Surveillance—Description of Polyp Characteristics.	Recommended for Endorsement ..	Colonoscopy for polyp surveillance—description of polyp characteristics.
27 GER–02: Advance Care Plan	Recommended for Endorsement ..	Advance care plan.

Measure	NQF endorsed for inpatient or ambulatory setting	Description
28 GER–03: Urinary Incontinence—Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older.	2 year Endorsement until May 8, 2009.	Assessment of presence or absence of urinary incontinence in women aged 65 years and older.
29 GER–04: Urinary Incontinence—Characterization of Urinary Incontinence in Women Aged 65 Years and Older.	2 year Endorsement until May 8, 2009.	Characterization of urinary incontinence in women aged 65 years and older.
30 GER–05: Urinary Incontinence—Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older.	2 year Endorsement until May 8, 2009.	Plan of care for urinary incontinence in women aged 65 years and older.

While we are soliciting comments on these 30 additional measures for inclusion in the HOP QDRP for CY 2010 or subsequent calendar years, we also welcome comments on whether any of these additional measures should be included effective for services furnished on or after January 1, 2008 for the CY 2009 update.

D. Proposed Implementation of the HOP QDRP

For purposes of CY 2009 payments, we would require hospitals to begin to submit data on the 10 measures that we have identified under section XVII.B. of this proposed rule. While we would expect to focus on these 10 measures and will consider comments on them for the CY 2009 payment year, we will also consider the comments received from the public on the list of 30 additional measures cited above in developing the final lists of measures for future payment years.

As with the hemoglobin A1c diabetes intermediate outcome measure described in XVII.B of this preamble, we invite public comment on the two diabetes intermediate outcome measures proposed in this list of 30 additional measures—i.e., good control of blood pressure (less than 140/80 mm Hg) and LDL–C levels (less than 100 mg/dl). We invite comment on whether the use of these outcome measures will result in unintended consequences.

As described below, procedures for submission of hospital outpatient quality information will mirror as closely as possible all procedures for submission of inpatient quality information. The inpatient procedures are identified on the QualityNet Web site, at *http://www.qualitynet.org.* As required by new section 1833(t)(17)(E) of the Act, we will develop procedures to publicly report the measure results obtained under the HOP QDRP. Hospitals will have an opportunity to review the information that is to be made available to the public prior to its being made public.

We believe that assuring that Medicare beneficiaries receive the care they need and that such services are of appropriately high quality are the necessary initial steps to the incorporation of value-based purchasing into the OPPS. We seek to encourage care that is both efficient and of high quality in the hospital outpatient setting. We plan to work quickly and collaboratively with the hospital community to develop and implement quality measures for the OPPS that are fully and specifically reflective of the quality of hospital outpatient services.

We welcome the suggestion of other additional measures and topics relevant to the hospital outpatient setting for future development of the measure set, particularly measures from other settings (such as hospital inpatient, physician office, and emergency care settings) that would contribute to better coordination and harmonization of high quality patient care.

E. Proposed Requirements for HOP Quality Data Reporting for CY 2009 and Subsequent Calendar Years

To participate in the HOP QDRP for CY 2009 and subsequent calendar years, hospitals must meet administrative, data collection and submission, and data validation requirements. Hospitals not participating in the program or that withdraw from the program will not receive the full OPPS payment rate update. Instead, in accordance with the law, those hospitals would receive a reduction of 2.0 percentage points in their updates for the affected payment year.

Hospitals not meeting the requirements of the HOP QDRP also will not receive the full OPPS payment rate update. Instead, in accordance with the law, those hospitals also would receive a reduction of 2.0 percentage points in their payment update factor for the affected payment year.

Proposed requirements for participation in the HOP QDRP are:

1. Administrative Requirements

To participate in the HOP QDRP, the hospital must complete several administrative steps. These steps, as in the current IPPS RHQDAPU program, require the hospital to:

- Identify a QualityNet Exchange administrator who follows the registration process and submits the information through the CMS-designated contractor. The same person may be the QualityNet Exchange administrator for both the IPPS RHQDAPU program and the HOP QDRP. This designation must be kept current and must be done, regardless of whether the hospital submits data directly to the CMS designated contractor or uses a vendor for transmission of data.
- Register with the QualityNet Exchange, regardless of the method used for data submission.
- Complete the Notice of Participation form. All hospitals must send the form to a CMS-designated contractor no later than November 15, 2007 for the CY 2009 HOP QDRP. At this time, the participation form for the HOP QDRP is separate from the IPPS RHQDAPU program and completing a submission form for each program is required. Agreeing to participate includes acknowledging that the data submitted to the CMS designated contractor will be submitted to CMS and may be shared with a CMS contractor or contractors supporting the implementation of this program.

Hospitals not wishing to participate must submit a nonparticipation form. Hospitals that have completed a notice of participation form and subsequently wish to stop participating must submit a withdrawal form.

To reduce the burden on hospitals, once a hospital has indicated its intent to participate or not participate, we will consider the hospital to be in that status (either a participant or nonparticipant) until the hospital indicates a change in status by submitting a notice of participation or a withdrawal form.

2. Data Collection and Submission Requirements

We are proposing that, to be eligible for the full OPPS payment update in CY 2009 and subsequent years, hospitals must:

• Collect data required for the finalized set of measures, beginning with the specifications of the finalized set of measures that will be identified in the CY 2008 OPPS/ASC final rule (for payment updates for CY 2009 services) and that will be published and maintained in a specifications manual to be found on the Web site at: *http://www.qualitynet.org.*

• Submit the data according to a data submission schedule that will be available on the QualityNet Exchange Web site. We propose to have HOP data submitted through the QualityNet Exchange secure Web site (*https://www.qnetexchange.org*). This Web site meets or exceeds all current Health Insurance Portability and Accountability Act requirements. The submission deadline for January 2008 discharges will be May 31, 2008. Except for January 2008 discharges, submission deadlines will be 4 months after the last day of the calendar quarter. Data must be submitted to the CMS designated contractor using either the CMS Abstraction and Reporting Tool for Outpatient Department measures (CART–OPD) or another third-party vendor that has a tool which has met the measure specification requirements for data transmission to the QualityNet Exchange.

Hospitals must submit quality data through the CMS contractor's secure Web site. We will provide more detailed information about the Web site in the CY 2008 OPPS/ASC final rule, as we anticipate awarding the contract to design and manage the OPPS Clinical Warehouse before that final CY 2008 OPPS/ASC final rule is published. We expect the CMS contractor's Web site to meet or exceed all current Health Insurance Portability and Accountability Act requirements for security of personal health information.

The OPPS Clinical Warehouse will submit the data to CMS on behalf of the hospitals. While the CMS contract for managing the OPPS Clinical Warehouse was not awarded prior to publishing this proposed rule, it is possible that a QIO contractor (or subcontractor) would manage the OPPS Clinical Warehouse. Because the information in the OPPS Clinical Warehouse also may be considered QIO information, it may be subject to the stringent QIO confidentiality regulations in 42 CFR part 480.

For purposes of the CY 2009 annual payment update, we are proposing to require hospitals to submit data, for the finalized set of measures, beginning with services furnished on or after January 1, 2008. The deadline for submission of data for January 2008 discharges will be 4 months from the last day of the month, May 31, 2008. The deadline for submission for February–March 2008 discharges would be August 1, 2008. Thereafter, participating hospitals would be required to submit quarterly data on finalized measures 4 months from the last day of the calendar quarter for as long as the hospitals participated in the HOP QDRP. The deadline for April-June 2008 discharges, for example, would be November 1, 2009.

Hospitals will be expected to submit data under the HOP QDRP on outpatient episodes of care to which the required measures apply. For the purposes of the HOP QDRP, an outpatient episode of care is defined as care provided to a patient who has not been admitted as an inpatient but who is registered on the hospital's medical records as an outpatient and receives services (rather than supplies alone) directly from the hospital. Every effort will be made to assure that data elements common to both inpatient and outpatient settings are defined consistently (such as ''time of arrival''). However, HOP QDRP quality data, not quality data required to be submitted for a patient treated under the IPPS RHQDAPU program, would be submitted under the HOP QDRP.

To be accepted by the CMS designated contractor, submissions would, at a minimum, need to be accurate, timely, and complete. Data are considered to have been ''accepted'' by the CMS designated contractor, for purposes of determining eligibility for the full payment rate update, only when data are submitted prior to the reporting deadline and after they have passed all CMS designated contractor edits.

• Submit complete and accurate data. A ''complete'' submission is determined based on sampling criteria that will be published and maintained in a specifications manual to be found on the Web site at *http://www.qualitynet.org,* and must correspond to both the aggregate number of cases submitted by a hospital and the number of Medicare claims it submits for payment. To be considered ''accurate'', submissions must pass validation.

• Submit the aggregate numbers of outpatient episodes of care which were eligible for submission under the HOP QRDP. These numbers would indicate the number of outpatient episodes of care in the universe to which sampling criteria are applied.

New hospitals are expected to begin reporting data as soon as possible, but no later than beginning with services provided the first day of the calendar quarter immediately following a hospital's receipt of its Medicare provider number and the hospital's timely completion of the administrative requirements for participating in the HOP QDRP.

3. HOP QDRP Validation Requirements

We would require that data submitted under this program meet validation requirements. The proposed validation requirements are similar to FY 2006 IPPS RHQDAPU program validation requirement (the initial year validation requirement was added to the IPPS RHQDAPU program) and include independent reabstraction of medical record data elements by a clinical data abstraction center (CDAC). The CMS contractor will randomly select 5 medical records from all January 2008 discharge cases successfully submitted to the OPPS Clinical Warehouse. The CDAC will mail requests to the hospitals to send the selected medical records to the CDAC within 30 calendar days. The CDAC will independently reabstract the medical record data elements. We will provide abstraction feedback to all hospitals on abstracted data elements.

We are proposing the following chart audit validation requirements for full CY 2009 payment updates:

• Apply to January 2008 discharges only.

• Require submission of 5 charts sampled from each hospital.

• Establish a passing threshold of 80 percent reliability reflecting the accuracy of submitted data elements used to calculate quality measures.

• Use an upper bound of 95 percent confidence interval to measure accuracy.

• Incorporate clustering of variability at the chart level into the confidence interval.

Validation is intended to provide some assurance of the accuracy of the hospital abstracted data. We have specifically chosen these validation requirements and thresholds to allow this assurance, provide sufficient time to fully process validation data, and minimize the burden on hospitals.

To receive the full OPPS payment rate update in CY 2009, the hospital must pass our validation requirement of a minimum of 80 percent reliability, based upon our chart-audit validation process, for the January 2008 discharges. The 80-percent reliability threshold is consistent with the inpatient RHQDAPU validation reliability threshold. Based on our previous RHQDAPU experience, we believe that this threshold is reasonable and attainable by the vast majority of hospitals. Several of the measures used in the OPPS HOP QDRP are similar in construction to inpatient measures used in the current RHQDAPU program. Based on the similar nature of the inpatient and outpatient measure sets, we believe that the 80-percent reliability threshold is applicable in the OPPS HOP QDRP.

These data are due to the CMS designated contractor by May 31, 2008. We will use confidence intervals, as discussed below, to determine if a hospital has achieved an 80-percent reliability. The use of confidence intervals would allow us to establish an appropriate range below the 80 percent reliability threshold that would demonstrate a sufficient level of reliability to allow the data to still be considered validated. We note that, for both timing and burden reasons, we are proposing to apply the validation requirements only to January 2008 discharges for purposes of determining eligibility for the full CY 2009 OPPS payment rate update. However, hospitals would still be required to submit data for subsequent time periods.

We will use January 2008 discharges to estimate the hospitals' validation score for the CY 2009 validation proposed requirement. The timeframe for data collection, abstraction, and validation tasks total about nine to ten months between patient discharges to completion of validation appeals. We believe that using later discharges for the CY 2009 annual payment update would adversely impact CMS' ability to complete these tasks and apply the results to the CY 2009 annual payment update.

Based on our proposed methodology, the confidence interval will be slightly wider than is currently utilized for the IPPS RHQDAPU program due to the smaller sample size. However, given this is the first year of the HOP QDRP, we believe this is appropriate. We would estimate the percent reliability based upon a review of five charts and then calculate the upper 95 percent confidence limit for that estimate. If this upper limit is above the required 80 percent reliability threshold, the hospital data would be considered validated. We are proposing to use the design-specific estimate of the variance for the confidence interval calculation, which, in this case, is a single stage cluster sample, with unequal cluster sizes. (For reference, see Cochran, William G. (1977) Sampling Techniques, John Wiley & Sons, New York, chapter 3, section 3.12.) Each sampled medical record is considered as a cluster for variance estimation purposes, as documentation and abstraction errors are believed to be clustered within specific medical records.

F. Publication of HOP QDRP Data Collected

New section 1833(t)(17)(E) of the Act requires that the Secretary establish procedures to make data collected under this program available to the public and to report the quality measures on the CMS Web site. Our intent is to make this information public in CY 2009 by posting it on the CMS Web site. Participating hospitals will be granted the opportunity to preview this information prior to its public posting as we have recorded it.

G. Proposed Attestation Requirement for Future Payment Years

CMS also solicits comments on whether to implement an HOP QDRP attestation requirement in CY 2010 and subsequent payment years similar to the proposed attestation requirement in the IPPS RHQDAPU program set out in the FY 2008 IPPS proposed rule (72 FR 24808). Hospitals would be required to submit a written form to a CMS contractor indicating that they formally attest to the accuracy and completeness of their data, including the volume of data submitted to the OPPS Data Warehouse. We anticipate that the attestation form submission deadlines would parallel the HOP QDRP periodic data submission deadlines.

H. HOP QDRP Reconsiderations

When the IPPS RHQDAPU program was initially implemented, it did not include a reconsideration submission process for hospitals. Subsequently, we received many requests for reconsideration of those payment decisions, and as a result, identified a process by which participating hospitals would submit requests for reconsideration. We anticipate similar concerns with the HOP QDRP and, therefore, we are proposing to establish a reconsideration process for the HOP QDRP for those hospitals that fail to meet the CY 2009 HOP QDRP requirements. The procedural details of that process will be posted to the QualityNet Exchange Web site, *http://www.qnetexchange.org.* In this proposed rule, we are seeking public comment specifically on the need for a structured reconsideration process for CY 2009 and subsequent calendar years. We also request comment on what such a process should entail. For example, such a process, if established, could include—

- A limited time, such as 30 days from the public release of the decision, for requesting a reconsideration;
- Specific individuals or functions in a hospital organization that can request such a reconsideration and that would be notified of its outcome;
- The specific factors that CMS will consider in such a reconsideration, such as an inability to submit data timely due to CMS systems failures;
- Specific requirements for submitting a reconsideration request, such as a written request for reconsideration specifically stating all reasons and factors why the hospital believes it did meet the HOP QDRP program requirements;
- Suggestions regarding the type of entity that should conduct the reconsideration process; and
- The timeframe, such as 60 days, for CMS to provide its reconsideration decision to the hospital.

We also are requesting comments on the reasons for not establishing such a reconsideration process. We plan to establish procedures that are as similar as possible to those used by the IPPS RHQDAPU program should we finalize our proposal to implement a reconsideration process for HOP QDRP.

I. Reporting of ASC Quality Data

As discussed above, section 109(b) of the MIEA–TRHCA (Pub. L. 109– 432) amended section 1833(i) of the Act by redesignating clause (iv) as clause (v), adding new section 1833(i)(2)(D)(iv), and adding new section 1833(i)(7) to the Act. These amendments authorize the Secretary to require ASCs to submit data on quality measures and to reduce the annual increase in a year by 2.0 percentage points for ASCs that fail to do so. These provisions permit, but do not require, the Secretary to require ASCs to submit such data and to reduce any annual increase for non-compliant ASCs.

We are not proposing to introduce quality measures for reporting in ASCs for CY 2008 as we are for the OPPS as described in sections XVII.B. through H. of this proposed rule. While we believe that promoting high quality care in the ASC setting through quality reporting is highly desirable and fully in line with

our efforts under other payment systems, we also believe that the transition to the revised payment system in CY 2008 poses such a significant challenge to ASCs that it would be most appropriate to allow some experience with the revised payment system before introducing other new requirements. Implementation of quality reporting at this time would require systems changes and other accommodations by ASCs, facilities which do not have prior experience with quality reporting as hospitals already have for inpatient quality measures, at a time when they are implementing a significantly revised payment system. We believe that our CY 2008 proposal to implement quality reporting for HOPs prior to establishing quality reporting for ASCs would allow time for ASCs to adjust to the changes in payment and case-mix that are anticipated under the revised payment system. We would also gain experience with quality measurement in the ambulatory setting in order to identify the most appropriate measures for quality reporting in ASCs prior to the introduction of the requirement in ASCs. We intend to implement the provisions of section 109(b) of the MIEA–TRHCA, Pub. L. 109–432, in a future rulemaking.

XVIII. Proposed Changes Affecting Critical Access Hospitals (CAHs) and Hospital Conditions of Participation (CoPs)

A. Proposed Changes Affecting CAHs

(If you choose to comment on the issues in this section, please include the caption ''Necessary Provider CAHs'' at the beginning of your comment.)

1. Background

CAHs are subject to different participation requirements than are hospitals. Among other requirements, a CAH must be located in a rural area (or an area treated as rural), and, under § 485.610(c), must meet an additional distance-related location requirement. Under this requirement, a CAH must be located at least 35-miles (or, in the case of mountainous terrain or in areas with only secondary roads, 15-miles) from the nearest hospital or other CAH. In addition, CAHs receive payment for services furnished to Medicare beneficiaries differently. CAHs receive cost-based payment for 101 percent of their reasonable costs.

Prior to January 1, 2006, States were permitted to waive the CAH minimum distance eligibility requirement by certifying that a CAH was a necessary provider. Approximately 850 current CAHs entered the program on the basis of a necessary provider designation. The criteria used to qualify a CAH as a necessary provider were established by each State in its Medicare Rural Hospital Flexibility Program (MRHFP). The State's MRHFP rural health care plan contains the necessary assurances that the plan was developed to further the goals of the statute and regulations to ensure access to essential health care services for rural residents. The statute and regulations give some discretion and flexibility within a Federal framework for a State to designate CAHs. States, in consultation with their hospital associations and Offices of Rural Health, have defined those CAHs that provide necessary services to a particular patient community in the event that the facility did not meet the required 35-mile (or, in the case of mountainous terrain or in areas with only secondary roads, 15-mile) distance requirement from the nearest hospital or CAH. Each State's criteria are different, but the criteria share certain similarities and all define a necessary provider related to the facility location.

However, section 405(h)(1) of Pub. L. 108–173 amended section 1820(c)(2)(B)(i)(II) of the Act by adding language that ended States' authority to waive the location requirement for a CAH by certifying the CAH as a necessary provider, effective January 1, 2006. In addition, section 405(h)(2) of Pub. L. 108–173 amended section 1820(h) of the Act to include a grandfathering provision for CAHs that were certified as necessary providers prior to January 1, 2006. We incorporated these amendments in § 485.610(c) of our regulations in the FY 2005 IPPS final rule (69 FR 49220). Because those regulations did not address the situation where the grandfathered CAH is no longer the same facility due to relocation, in the FY 2006 IPPS final rule (70 FR 47490), we amended § 485.610 of our regulations to add a new § 485.610(d) that addressed the relocation criteria a necessary provider CAH has to meet to retain its necessary provider designation.

Additional circumstances concerning CAHs with existing necessary provider designations have come to our attention that we believe also need to be addressed. Specifically, we have learned that some CAHs with grandfathered necessary provider designations are co-located with other hospitals, which typically are PPS-excluded inpatient psychiatric facilities or inpatient rehabilitation facilities. We are also aware that there is interest in the creation or acquisition by CAHs with necessary provider designation of off-campus facilities that they do not believe would be subject to CAH location requirements.

For the reasons noted below, we are taking a proactive approach by proposing a change in the regulation to be consistent with our belief that the intent of the CAH program is to maintain hospital-level services in rural communities while ensuring access to care. We believe that this proposed change to the regulations will help to maintain the integrity of the MRHFP within the statutory requirements.

2. Co-Location of Necessary Provider CAHs

Some necessary provider CAHs are co-located with other hospitals, particularly specialty psychiatric and or rehabilitation hospitals. Prior to the enactment of section 405(g) of Pub. L. 108–173, it is understandable that a State MRHFP might have allowed co-location of a CAH with a necessary provider designation with the specialized services of a psychiatric and/or an inpatient rehabilitation hospital. The State may have believed that beneficiary access to care would be enhanced through the provision of both CAH and these specialized services at the same location, and the CAH itself might have had difficulty in providing such services within its permitted bed limits. However, section 405 of Pub. L. 108 173 included several provisions that permit CAHs themselves to address such access to care issues.

Specifically, section 405(e) of Pub. L. 108–173 amended sections 1820(c)(2)(B)(iii) and 1820(f) of the Act to increase the permitted number of CAH inpatient beds from 15 to 25. In addition, section 405(g) of Pub. L. 108–173 added section 1820(c)(2)(E) to the Act, which permits a CAH to operate distinct part inpatient psychiatric and/or rehabilitation units, each subject to a 10-bed limit that is not included as part of the CAH's 25-bed limit. Therefore, a CAH can operate a 45-bed facility addressing a wide range of needs in the rural community it serves. We believe that CAHs seeking to provide access to specialized services should avail themselves of the statutory provisions governing distinct part units in CAHs rather than making arrangements with other hospital providers to share space at the CAH location.

In light of these changes to the statute, we are proposing to no longer allow a necessary provider CAH to enter into co-location arrangements between CAHs and hospitals unless such arrangements were in effect on or before January 1, 2008 and the type and scope of services offered by the facility co-located with

the necessary provider CAH do not change. We believe that this restriction will help to ensure that the current necessary services will remain in the community. Further, we are proposing to clarify that a change of ownership of the CAH, when the new owners assume the original provider agreement, does not constitute a new co-location arrangement and, thereby, under our proposal, a necessary provider CAH would be permitted to continue under an existing co-location arrangement.

We are concerned that, without this change, there may be situations where more necessary provider CAHs will co-locate with PPS hospitals. Currently, co-location arrangements seem to involve psychiatric or rehabilitation hospitals. We are concerned about co-location by a necessary provider CAHs with a short-term acute care hospital, including a physician-owned specialty hospital. We also cannot rule out a scenario where two necessary provider CAHs could co-locate after relocation. We believe the co-location of a necessary provider CAH with another hospital or necessary provider CAH is not consistent with the CAH statutory framework that establishes requirements for a CAH to be a certain minimum distance from other hospitals or CAHs. We believe that the elimination of States' authority to designate necessary provider CAHs and the ability for CAHs to operate psychiatric and rehabilitation units should provide sufficient flexibility for necessary provider CAHs to operate within the statutory framework without engaging in additional arrangements.

We also are clarifying in this proposed rule that under certain circumstances, a change of ownership of any of the facilities (either the CAH or the existing co-located facility) with a co-location arrangement that was in effect before January 1, 2008, will not be considered to be a new co-location arrangement. If a change of ownership should occur in a CAH with a grandfathered co-location arrangement on or after January 1, 2008, we note the provider agreement is generally automatically assigned to the new owner, unless the new owner rejects assignment of the provider agreement or assignment of the provider agreement is otherwise not made. If the new owner does not get assignment of the provider agreement, the new owner would have to go through the same enrollment process as any other new provider; that is, enrolling with the fiscal intermediary (or if applicable, the MAC), applying for participation, undergoing the Office of Civil Rights clearance and an initial certification survey that meets all the current Medicare conditions (see State Operations Manual 3210) to obtain CAH status. Thus, grandfathered necessary provider CAH status, including grandfathered co-location arrangements, would not transfer to a new CAH owner who does not assume the provider agreement from the previous owner. To obtain CAH designation, the new provider would have to comply with all the CAH designation requirements, including the location requirements relative to other providers, that is, more than a 35-mile drive (or 15 miles in areas of mountainous terrain or secondary roads).

3. Provider-Based Facilities of CAHs

We have consistently taken the position that the intent of the CAH program is to keep hospital-level services in rural communities, thereby ensuring access to care (FY 2006 IPPS final rule (70 FR 47469)). A CAH is permitted to create or acquire an off-campus location, including a distinct part unit that satisfies the location criteria for a CAH and operates under the CAH's provider agreement under the provider-based rules at 42 CFR 413.65. We note that, under section 1820(c)(2)(B)(i)(II) of the Act, a CAH does not have to meet the distance requirements relative to other hospitals or CAHs if it was certified prior to January 1, 2006, as a necessary provider by the State. We stated in the FY 2006 IPPS final rule (70 FR 47472), when addressing the relocation criteria for a necessary provider CAH, that the ''necessary provider'' designation is specific to the physical location(s) of the CAH in existence at the time of the designation. We believe the necessary provider CAH designation cannot be considered to extend to any new facilities not in existence when the CAH received its original necessary provider designation. Accordingly, we believe the creation of any new location that would cause any part of the CAH to be situated at a location not in compliance with the distance requirements at 42 CFR 485.610 would cause the entire CAH to violate the distance requirements.

Of the approximately 1,300 CAHs, 453 CAHs have health clinics, 81 have psychiatric units, and 20 have rehabilitation units. We do not know how many of the existing clinics and distinct part units are at off-site locations. However, we are concerned with CAHs creating or acquiring off-campus locations, including distinct part psychiatric and rehabilitation units, that do not comply with the CAH location requirement relative to other facilities. Therefore, when such off-campus facilities are created by a CAH with a necessary provider designation, there is no reason to assume that the distance exemption given to the CAH should be extended without qualification to any location for that CAH's off-campus facilities. Accordingly, any CAH off-campus locations must satisfy the current statutory CAH distance requirements, without exception and regardless of whether the main provider CAH is a necessary provider CAH.

Therefore, we are proposing to clarify that if a necessary provider CAH, or a CAH that does not have a necessary provider designation, operates a provider-based facility as defined in § 413.65(a)(2), or a psychiatric or rehabilitation distinct part unit as defined in § 485.647 that was created or acquired on or after January 1, 2008, it must comply with the distance requirement of a 35-mile drive to the nearest hospital or CAH (or 15 miles in the case of mountainous terrain or in areas with only secondary roads).

4. Termination of Provider Agreement

In the event that a CAH with a necessary provider designation enters into a co-location arrangement after January 1, 2008, or acquires or creates an off-campus facility after January 1, 2008, that does not satisfy the CAH distance requirements in § 485.610(c), we are proposing to terminate that CAH's provider agreement, in accordance with the provisions of § 489.53(a)(3). The necessary provider CAH could avoid termination by converting to a hospital that is paid under the IPPS, assuming that the facility satisfies all requirements for participation as a hospital in the Medicare program under the provisions in 42 CFR Part 482. We also note that if the necessary provider CAH corrects the situation that led to the noncompliance, a termination action will not be triggered. A CAH that is not a necessary provider CAH could not have a co-location situation due to the distance requirements it is required to meet at 485.610 (c).

5. Proposed Regulation Changes

We are proposing to amend § 485.610 by adding a new paragraph (e) to address situations under our proposal relating to off-campus and co-location requirements for CAHs with a necessary provider designation.

B. Proposed Revisions to Hospital CoPs

(If you choose to comment on the issues in this section, please include the caption ''Hospital CoPs'' at the beginning of your comment.)

1. Background

On November 27, 2006, we published a final rule in the **Federal Register** entitled ''Medicare and Medicaid Programs; Hospital Conditions of Participation: Requirements for History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Postanesthesia Evaluations'' (71 FR 68672). In that final rule (also frequently referred to as the ''Carve-out rule''), we finalized changes, which were based on timely public comments submitted on the proposed rule published in the March 25, 2005 **Federal Register** (70 FR 15266), to four of the current requirements (or conditions of participation (CoPs)) that hospitals must meet to participate in the Medicare and Medicaid programs. Specifically, that final rule revised and updated our CoP requirements for: completion of the history and physical examination in the Medical staff and the Medical record services CoPs; authentication of verbal orders in the Nursing services and the Medical record services CoPs; securing medications in the Pharmaceutical services CoP; and, completion of the postanesthesia evaluation in the Anesthesia services CoP. This action was initiated in response to broad criticism from the medical community that the then-current requirements governing these areas were burdensome and did not reflect current practice.

Since this final rule became effective on January 26, 2007, we have received a great number of comments and questions from providers about the timeframe requirements (for both the initial medical history and physical examination and its update) as well as about the postanesthesia evaluation requirements. In both areas, commenters have sought clarification on the application of these requirements for patients undergoing outpatient surgeries and procedures. While the new requirements contained in the Carve-out rule provide hospitals greater flexibility in ensuring the quality of inpatient care, the issues surrounding outpatient care in the hospital setting, particularly with regard to outpatient surgeries and procedures, are not clear. After conducting a thorough review of the hospital CoPs and the interpretive guidelines, we have isolated the relevant issues regarding outpatient care and are proposing revisions to the current regulations to address these concerns.

According to the most recent data, 30 million surgical procedures are performed each year in the United States with over 60 percent done as outpatient procedures and another 10 to 15 percent performed on a same-day admission basis. These figures combined translate to approximately 21 million surgical procedures performed each year in the U.S. on patients who are admitted to the hospital on the day of their procedure. A majority of these patients are also discharged from the hospital the same day that they are admitted. It is unclear whether these numbers also include other procedures, such as diagnostic ones, which also require anesthesia services, and which include all of the risks to patient safety inherent in such procedures. In either case, significant numbers of patients undergo surgeries and other procedures each year as either outpatients or same-day admission patients.

The current requirements for the completion of the medical history and physical examination are found in the regulations at § 482.22 (Medical staff CoP), § 482.24 (Medical record services CoP), and § 482.51 (Surgical services CoP). We believe that these requirements do not adequately address the patient who is admitted for outpatient or same-day surgery or a procedure requiring anesthesia services. The standards at § 482.22(c), Medical staff bylaws, and § 482.24(c), Content of record, both contain requirements for a medical history and physical examination, and an update of the medical history and physical examination documenting any changes in a patient's condition if the medical history and physical examination was completed within 30 days before admission, to be completed and documented within 24 hours after admission. Under the Surgical services CoP at § 482.51(b)(1), there is a provision that requires a complete history and physical workup to be in the chart of every patient prior to surgery. However, there is currently no requirement for an updated examination of the patient, including any changes to the patient's condition, to be completed and documented after admission or registration, and prior to any surgery or procedure being performed. For patients who are admitted as inpatients for surgery to be performed in the next day or so, this does not pose a problem. These inpatients will be followed while in the hospital with both daily progress and nursing notes made in their medical record. In addition, as required under the current regulations, these patients will also have an updated examination for any changes in their condition within 24 hours after their admission.

As evidenced by the numbers of outpatient and same day admission inpatient procedures discussed above, procedures that were once done only on an inpatient basis are now routinely performed in outpatient settings. Therefore, the patient is not admitted or registered as an outpatient until the day of the procedure. Often this admission or registration is just hours before the procedure is performed. In addition, there are many patients who are admitted as inpatients on the same day that they are scheduled for more complex procedures, which will then require postoperative hospital stays. However, for patients admitted or registered for outpatient procedures as well as for those patients admitted on the same day as their surgery, there is currently no mechanism to ensure that these patients are examined for any changes in their condition prior to undergoing a procedure. Paragraph (b)(1) of § 482.51 currently requires that every patient have a complete medical history and physical examination documented in the chart prior to surgery, except in emergencies. However, the timeframe requirements for this medical history and physical examination contained under both § 482.22(c)(5) and § 482.24(c) (2)(i)(A) allow for a medical history and physical examination that may be as much as 30 days old. Without a requirement that an updated examination be completed after admission and prior to surgery or other procedure, any changes in a patient's condition would most likely be missed by hospital staff. Failing to identify changes in a patient's condition prior to surgery may adversely impact not only the procedure but also consequently, and perhaps more significantly, the outcome of the procedure for the patient.

We are proposing revisions to §§ 482.22, 482.24, and 482.51 that would require an updated examination, including any changes in a patient's condition, to be completed and documented for each patient after admission or registration and prior to surgery or to a procedure requiring anesthesia services. These revisions would ensure that any changes in the patient's condition are discovered before a procedure is performed. With the most up-to-date information regarding a patient's condition readily available to hospital staff prior to a procedure, the risks to patient safety should be minimized and a poor outcome for the patient would be avoided. However, under these proposed requirements, it is not our intent to include those minor procedures that only require the administration of local anesthetics, as might be the case for procedures such as

biopsies of skin lesions or suturing of noncomplex lacerations.

Conversely, the current requirements at § 482.52, Anesthesia services, still distinguish between inpatients and outpatients with regard to postanesthesia evaluation, with the requirements for outpatient evaluation actually being less stringent than those for inpatients. When the current hospital regulations were originally written in 1986, these differences in regulatory oversight may have been entirely appropriate. At that time there were still very clear differences between inpatient and outpatient procedures, with inpatient procedures (and the anesthesia services required) considered much more serious and complex in nature. Since that time, there has been a gradual blurring of the distinctions between what were previously termed ''inpatient'' procedures and those that were classified as ''outpatient'' procedures. Procedures that were once done only on an inpatient basis are now routinely performed in outpatient settings. While advances in medical technology and surgical technique have allowed for this shift, the complexity and seriousness of these procedures still remain as do the risks to patient health and safety. Along with the increased complexity and types of outpatient procedures being performed today, come the higher levels of sedation and anesthesia required for these procedures. Thus, distinctions between inpatients and outpatients in the requirements for postanesthesia evaluations are less relevant than ever.

In addition, the current language regarding the completion and documentation of an evaluation ''within 48 hours after surgery'' assumes that all patients receiving anesthesia services have undergone surgery. It also assumes that they have not been discharged from the hospital prior to the end of this 48-hour timeframe and that they are still available for evaluation. Many patients who have received anesthesia services (either general anesthesia or monitored anesthesia care) have undergone diagnostic or therapeutic procedures as opposed to surgical ones and are discharged within hours after such procedures. Diagnostic and therapeutic procedures that require anesthesia services (either general anesthesia or monitored anesthesia care) include esophagogastroduodenoscopy (EGD), colonoscopy, endoscopic retrograde cholangiopancreatography (ERCP), and electroconvulsive therapy (ECT). Furthermore, and as noted above, even those patients who have undergone inpatient surgical procedures are often discharged well before 48 hours after surgery.

Therefore, we are proposing revisions to § 482.52(b) that would ensure that all patients who have received anesthesia services, regardless of inpatient or outpatient status, have a postanesthesia evaluation completed and documented by an individual qualified to administer anesthesia before they are discharged or transferred from the postanesthesia recovery area.

Finally, in our review of the CoPs, we discovered a cross-reference under § 482.23, Nursing services, that is no longer valid. We are taking the opportunity in this proposed rule to correct this error through a technical amendment.

2. Provisions of the Proposed Regulations

a. Proposed Timeframes for Completion of the Medical History and Physical Examination

The proposed revisions to § 482.22(c)(5) would retain the requirement that the medical staff bylaws include a requirement that a medical history and physical examination be completed no more than 30 days before or 24 hours after admission for each patient. We are proposing to revise this provision to include the requirement that the completion and documentation of the medical history and physical examination (and the updated examination) would also be required prior to surgery or a procedure requiring anesthesia services.

We also are proposing to retain the current provision that the medical staff bylaws contain a requirement for the completion and documentation of an updated examination within 24 hours after admission (when the medical history and physical examination has been completed within 30 days before admission). However, we are proposing to delete the language regarding the placement of the medical history and physical examination and the updated examination in the medical record within 24 hours after admission because we believe that the proposed language requiring not only the completion, but also the documentation, of both the medical history and physical examination and the updated examination, achieves this purpose. In addition, requirements for the physical placement of the medical history and physical examination and the updated examination in the patient's medical record are currently, and more appropriately, contained under the ''Medical record services'' CoP at § 482.24(c)(2), which we are proposing to retain under this rule.

Further, we are proposing to separate the requirements for the medical history and physical examination and for the updated examination under two provisions at § 482.22(c)(5)(i) and § 482.22(c)(5)(ii), respectively. At § 482.22(c)(5)(i), we are proposing to retain the current requirement that the medical history and physical examination be completed by a physician (as defined in section 1861(r) of the Act), an oromaxillofacial surgeon, or other qualified individual in accordance with State law and hospital policy. However, we are proposing to add the words ''and documented'' after ''be completed'' as well as ''licensed'' after ''qualified'' to further clarify this requirement. In addition, we are proposing to revise § 482.22(c)(5)(ii) to require that the updated examination of the patient must be completed and documented by the same individuals as proposed above. We also are proposing to add the words ''or registration'' to follow ''after admission'' to reflect differences in terminology that may exist with the admission of patients for outpatient procedures. We are proposing this revision here as well as in § 482.24 and § 482.51, where appropriate.

We are proposing to revise the words ''for any changes in the patient's condition'' to ''including any changes in the patient's condition'' at both § 482.22(c)(5) and § 482.24(c)(2)(i)(B).

Under § 482.24(c), Content of record, we are proposing to revise both § 482.24(c)(2)(i)(A) and § 482.24(c)(2)(i)(B) by adding the language ''but prior to surgery or a procedure requiring anesthesia services'' with regard to both the completion and the documentation of the medical history and physical examination and the updated examination.

We are proposing to revise the Surgical services CoP at § 482.51(b)(1) by deleting the language regarding medical histories and physical examinations that have been dictated but which are not yet recorded in the patient's chart. Our overall intent in this proposed rule is to require that the most current information regarding a patient's condition be available to the hospital staff prior to surgery or a procedure requiring anesthesia services so that risks to patient safety can be minimized and potential adverse outcomes can be avoided.

We are proposing to retain the language regarding the requirement for a medical history and physical examination prior to surgery, except in

the case of emergencies, and are proposing to extend this to a requirement for an updated examination. We are proposing to divide the requirements for the medical history physical examination and the updated examination under two separate provisions at § 482.51(b)(1)(i) and § 482.51(b)(1)(ii) in the Surgical services CoP.

b. Proposed Requirements for Preanesthesia and Postanesthesia Evaluations

At § 482.52(b)(1), under the ''Delivery of services'' standard of the ''Anesthesia services'' CoP, we are proposing to revise the requirement for a preanesthesia evaluation to include the language ''or a procedure requiring anesthesia services'' to include the range of procedures that require anesthesia services, but that are not necessarily surgical in nature. We also are proposing to add this language under § 482.52(b)(3) for the postanesthesia evaluation requirement.

Further, we are proposing to revise this standard by deleting both the words ''with respect to inpatients'' at § 482.52(b)(3) and the entire provision at § 482.52(b)(4), which are the current requirements for postanesthesia evaluations for patients. We are proposing to revise § 482.52(b)(3) by requiring that the postanesthesia evaluation be completed and documented before discharge or transfer from the postanesthesia recovery area. As discussed above, the intent of this section of the proposed rule is to eliminate the distinctions currently found in the regulations between inpatients and outpatients with regard to anesthesia services.

c. Proposed Technical Amendment to Nursing Services CoP

We are proposing to revise the cross-reference to § 405.1910(c) currently found under the nursing services CoP at § 482.23(b)(1) as this citation has been changed and is no longer valid. We are proposing a technical amendment to this provision to correct the cross-reference to § 488.54(c).

XIX. Files Available to the Public Via the Internet

A. Information in Addenda Related to the Revised CY 2008 Hospital OPPS

Addenda A and B to this proposed rule provide various data pertaining to the CY 2008 payment for items and services under the OPPS. Addendum A, a complete list of all APCs payable under the OPPS, and Addendum B, a complete list of all active HCPCS codes regardless of their assigned payment status or comment indicators under the OPPS, will be available to the public by clicking ''Addendum A and Addendum B Updates'' on the CMS Web site at: *http://www.cms.hhs.gov/HospitalOutpatientPPS/.*

For the convenience of the public, we are also including on the CMS Web site a table that displays the HCPCS data in Addendum B sorted by APC assignment, identified as Addendum C.

Addendum D1 defines payment status indicators that are used in Addenda A and B. Addendum D2 defines comment indicators that are used in Addendum B. Addendum E lists HCPCS codes that are only payable as inpatient procedures and are not payable under the OPPS. Addendum L contains the out-migration wage adjustment for CY 2008. Addendum M lists the HCPCS codes that are members of a composite APC and identifies the composite APC to which they are assigned. This addendum also identifies the status indicator for the code and a change indicator if there has been a change in the code's status with regard to its membership in the composite APC. Each of the HCPCS codes included in Addendum M has a single procedure payment APC, listed in Addendum B, to which it is assigned when the criteria for assignment to the composite APC are not met. When the criteria for payment of the code through the composite APC are met, one unit of the composite APC payment is paid, thereby providing packaged payment for all services that are assigned to the composite APC according to the specific OCE logic that applies to the APC. We refer readers to the discussion of composite APCs in section II.A.4.d. of this proposed rule for a complete description of the proposed composite APCs.

Those addenda and other supporting OPPS data files are available on the CMS Web site at: *http://www.cms.hhs.gov/HospitalOutpatientPPS.*

B. Information in Addenda Related to the Revised CY 2008 ASC Payment System

Addenda AA, BB, DD1, and DD2 to this proposed rule provide various data pertaining to the ASC covered surgical procedures and the covered ancillary services for which ASCs may receive separate payment beginning in CY 2008 when the ancillary service provided in the ASC is integral to a covered surgical procedure and provided immediately before, during, or immediately following the covered surgical procedure. All relative payment weights and payment rates are proposed and exemplify the results of applying the revised ASC payment system methodology established in the final rule for the revised ASC payment system published elsewhere in this issue of the **Federal Register**, to the proposed CY 2008 OPPS and MPFS ratesetting information.

Addendum DD1 defines the payment indicators that are used in Addenda AA and BB to this proposed rule. Addenda AA and BB provide payment information regarding covered surgical procedures and covered ancillary services under the revised ASC payment system. Addendum DD2 defines the comment indicators that we are proposing to use to provide additional information about the status of ASC covered surgical procedures and covered ancillary services. Those addenda and other supporting ASC data files are included on the CMS Web site at: *http://www.cms.hhs.gov/ASCPayment/* in a format that can be easily downloaded and manipulated. The final ASC relative weights and payment rates for CY 2008 will be published in the CY 2008 OPPS/ASC final rule with comment period, and related data files will be included on the CMS Web site as noted above. MPSF data files are located at *http://www.cms.hhs.gov/PhysicianFeeSched/.*

The links to all of the FY 2008 IPPS wage index related tables (that would be used for the CY 2008 OPPS) from the FY 2008 IPPS proposed rule (72 FR 24851 through 24960) and to the correction notice for the FY 2008 IPPS proposed rule that was published in the **Federal Register** on June 7, 2007 (72 FR 31507) are accessible on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage*

For additional assistance, contact Chuck Braver, (410) 786–6719.

XX. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 (PRA) requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.

• The quality, utility, and clarity of the information to be collected.

• Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections included in this proposed rule that contain information collection requirements.

Section 419.43(h) Adjustment to national program payment and beneficiary co-payment amounts: Applicable adjustments to conversion factor for CY 2009 and for subsequent calendar years

Section 419.43(h) requires hospitals, in order to qualify for the full annual update, to submit quality data to CMS, as specified by CMS. In this proposed rule, we are proposing the specific requirements related to the data that must be submitted for the update for CY 2009. The burden associated with this section is the time and effort associated with collecting and submitting the data, completing participating forms and submitting charts for chart audit validation. We estimate that there will be approximately 3,500 respondents per year.

For hospitals to collect and submit the information on the required measures, we estimate it will take 30 minutes per sampled case. Further, based on an estimated ten percent sample size and estimated populations of 2.5–5 million outpatient visits per measure, we estimate a total of 1,800,000 cases per year. In addition, we estimate that completing participation forms with require approximately 4 hours per hospital per year. We expect the burden for all of these hospitals to total 914,000 hours per year.

For CY 2009. our validation process requires participating hospitals to submit 5 charts. The burden associated with this requirement is the time and effort associated with collecting, copying, and submitting these charts. It will take approximately 2 hours per hospital to submit the 5 charts. There will be a total of approximately 17,500 charts (3,500 hospitals x 5 charts per hospital) submitted by the hospitals to CMS for a total burden of 7,000 hours. Therefore, the total burden for all hospitals would be 921,000 hours per year.

Section 482.22 Condition of participation: Medical staff

Proposed § 482.22(c)(5)(i) would require that a medical history and physical examination be completed and documented no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, for each patient by a physician (as defined in section 1861(r) of the Act), an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

The burden associated with this proposed requirement is the time and effort it would take for medical staff to document the patient's medical history and the results of a physical examination. While the burden associated with this proposed requirement is subject to the PRA, we believe the burden is exempt as defined in 5 CFR 1320.3(b) (2) because the time, effort, and financial resources necessary to comply with the requirement would be incurred by persons in the normal course of their activities.

Proposed § 482.22(c)(5)(ii) would require that an updated examination of the patient, including any changes in the patient's condition, be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 days before admission or registration. The updated examination must also be completed and documented by the same individuals as required under proposed § 482.22(c)(5)(i).

The burden associated with this proposed requirement is the time and effort it would take for medical staff to document any changes in the patient's condition. While the burden associated with this proposed requirement is subject to the PRA, we believe the burden is exempt as defined in 5 CFR 1320.3(b)(2) because the time, effort, and financial resources necessary to comply with the requirement would be incurred by persons in the normal course of their activities.

Section 482.24 Condition of participation: Medical record services

Proposed § 482.24(c)(2)(i) would require evidence of:

(1) A medical history and physical examination completed and documented no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia.

(2) An updated examination of the patient, including any changes in the patient's condition, when the medical history and physical examination are completed within 30 days before admission or registration. Documentation of the updated examination must be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

While the burden associated with these two proposed requirements is subject to the PRA, we believe the burden is exempt as defined in 5 CFR 1320.3(b)(2) because the time, effort, and financial resources necessary to comply with the requirement would be incurred by persons in the normal course of their activities.

Section 482.51 Condition of participation: Surgical services

Proposed § 482.51(b)(1) would require medical staff, prior to surgery or a procedure requiring anesthesia services, and except in the case of emergencies, to document no more than 30 days before or 24 hours after admission or registration a patient's medical history, the results of the patient's physical examination, and any changes in the patient's condition.

While the burden associated with these proposed requirements is subject to the PRA, we believe the burden is exempt as defined in 5 CFR 1320.3(b)(2) because the time, effort, and financial resources necessary to comply with the requirement would be incurred by persons in the normal course of their activities.

Section 482.52 Condition of participation: Anesthesia services

Proposed § 482.52(b)(1) would require a preanesthesia evaluation to be completed and documented by an individual qualified to administer anesthesia, performed within 48 hours prior to surgery or a procedure requiring anesthesia services. Proposed § 482.52(b)(3) would require a postanesthesia evaluation to be completed and documented by an individual qualified to administer anesthesia, after surgery or a procedure requiring anesthesia services, but before discharge or transfer from the postanesthesia recovery area.

While the burden associated with these requirements is subject to the PRA, we believe the burden is exempt as defined in 5 CFR 1320.3(b)(2) because the time, effort, and financial resources necessary to comply with the requirement would be incurred by

persons in the normal course of their activities.

We have submitted a copy of this proposed rule to OMB for its review of the information collection requirements described above. These requirements are not effective until they have been approved by OMB.

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following:

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development, Attn: Melissa Musotto, (CMS–1392–P), Room C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850; and

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Carolyn Lovett, CMS Desk Officer, CMS–1392–P, *carolyn_lovett@omb.eop.gov.* Fax (202) 395–6974.

XXI. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this proposed rule, and, when we proceed with a subsequent document(s), we will respond to those comments in the preamble to that document(s).

XXII. Regulatory Impact Analysis

A. Overall Impact

(If you choose to comment on issues in this section, please include the caption ''Impact'' at the beginning of your comment.)

We have examined the impacts of this proposed rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

1. Executive Order 12866

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

We estimate that the effects of the OPPS provisions that would be implemented by this proposed rule would result in expenditures exceeding $100 million in any 1 year. We estimate the total increase (from changes in this proposed rule as well as enrollment, utilization, and case-mix changes) in expenditures under the OPPS for CY 2008 compared to CY 2007 to be approximately $3.3 billion.

We estimate that implementing the revised ASC payment system in CY 2008 based on the July 2007 final rule for the revised ASC payment system and the proposals in this CY 2008 OPPS/ASC proposed rule (such as adding 4 procedures to the ASC list of covered surgical procedures and designating 19 additional procedures as office-based) will have no net effect on Medicare expenditures in CY 2008 compared to the level of expenditures that would have occurred in CY 2008 in the absence of the revised payment system. A more detailed discussion of the effects of the changes to the ASC list of covered surgical procedures and the effects of the revisions to the ASC payment system in CY 2008 is provided in section XXII.C. of this proposed rule.

While we estimate that there will be no net change in Medicare expenditures in CY 2008 as a result of implementing the revised ASC payment system and the proposed ASC provisions of this proposed rule, we estimate that the revised system will result in savings of $200 million over 5 years due to migration of new ASC covered surgical procedures from HOPDs and physicians' offices to ASCs over time. In addition, we note that there will be a total increase in Medicare payments to ASCs of approximately $240 million for CY 2008 compared to Medicare expenditures that would have occurred in the absence of the revised payment system. These additional payments to ASCs of approximately $240 million in CY 2008 will be fully offset by savings from reduced Medicare spending in HOPDs and physicians' offices on services that migrate from these settings to ASCs, as described in detail in section XVI.L. of this proposed rule.

Our estimate in this proposed rule of 5-year savings as a result of the revised ASC payment system and our estimate of additional payments to ASCs in CY 2008 differ slightly from the estimates presented in the July 2007 final rule for the revised ASC payment system. The ASC budget neutrality adjustment and the resulting savings estimates in the July 2007 final rule are calculated using CY 2005 utilization data, the current CY 2007 OPPS relative weights with an estimated update factor for CY 2008, and the CY 2007 MPFS PE RVUs trended forwarded to CY 2008. The ASC budget neutrality adjustment and the resulting savings estimates in this proposed rule are calculated using the newly available CY 2006 utilization data, the CY 2008 OPPS relative payment weights proposed in this proposed rule, and and the CY 2008 MPFS PE RVUs proposed in the CY 2008 MPFS proposed rule (72 FR 38234 through 38361). As we indicated in the July 2007 final rule, the estimates in that rule are meant to be illustrative of the final policies only, in large part because they use the existing CY 2007 OPPS relative payment weights and the existing CY 2007 MPFS PE RVUs to estimate the CY 2008 values. Since the savings estimates in this proposed rule are based on the actual proposed CY 2008 OPPS relative payment weights that have just become available in this proposed rule and the actual proposed CY 2008 MPFS PE RVUs that recently became available in the CY 2008 MPFS proposed rule, the estimates in this proposed rule based on that newly available information represent our best estimates at this time. Our final budget neutrality adjustment and savings estimates will be provided in the CY 2008 OPPS/ASC final rule.

This proposed rule is an economically significant rule under Executive Order 12866, and a major rule under 5 U.S.C. 804(2).

2. Regulatory Flexibility Act (RFA)

The RFA requires agencies to determine whether a rule would have a significant economic impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having average annual revenues of $31 million or less.

For purposes of the RFA, we have determined that approximately 37 percent of hospitals and 73 percent of ASCs would be considered small entities according to the Small Business Administration (SBA) size standards. We do not have data available to calculate the percentages of entities in the pharmaceutical preparation, manufacturing, biological products, or medical instrument industries that

would be considered to be small entities according to the SBA size standards. For the pharmaceutical preparation manufacturing industry (NAICS 325412), the size standard is 750 or fewer employees. For biological products (except diagnostic) (NAICS 325414), the standard size is 500 or fewer employees, and for surgical and medical instrument manufacturing (NAICS 339112), the standard is 500 or fewer employees (see the standards Web site at: *http//www.sba.gov/idc/groups/public/documents/serv_sstd_tablepdf.pdf*). Individuals and States are not included in the definition of a small entity.

Not-for-profit organizations are also considered to be small entities under the RFA. There are 2,146 voluntary hospitals that we consider to be not for-profit organizations to which this proposed rule applies.

3. Small Rural Hospitals

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we previously defined a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) (or New England County Metropolitan Area (NECMA)). However, under the new labor market definitions that we adopted in the CY 2005 final rule with comment period (consistent with the FY 2005 IPPS final rule), we no longer employ NECMAs to define urban areas in New England. Therefore, we now define a small rural hospital as a hospital with fewer than 100 beds that is located outside of an MSA. Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the OPPS, we classify these hospitals as urban hospitals. We believe that the changes to the OPPS in this proposed rule would affect both a substantial number of rural hospitals as well as other classes of hospitals and that the effects on some may be significant. The changes to the ASC payment system for CY 2008 will have no effect on small rural hospitals. Therefore, we conclude that this proposed rule would have a significant impact on a substantial number of small rural hospitals.

4. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $120 million. This proposed rule would not mandate any requirements for State, local, or tribal government, nor would it affect private sector costs.

5. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it publishes any rule (proposed or final) that imposes substantial direct costs on State and local governments, preempts State law, or otherwise has Federalism implications.

We have examined this proposed rule in accordance with Executive Order 13132, Federalism, and have determined that it would not have an impact on the rights, roles, and responsibilities of State, local or tribal governments. As reflected in Table 67, we estimate that OPPS payments to governmental hospitals (including State and local governmental hospitals) would increase by 3.6 percent under this proposed rule. The provisions related to payments to ASCs in CY 2008 would not affect payments to government hospitals.

B. Effects of OPPS Changes in This Proposed Rule

(If you choose to comment on issues in this section, please include the comment ''OPPS Impact'' at the beginning of your comment.)

We are proposing to make several changes to the OPPS that are required by the statute. We are required under section 1833(t)(3)(C)(ii) of the Act to update annually the conversion factor used to determine the APC payment rates. We are also required under section 1833(t)(9)(A) of the Act to revise, not less often than annually, the wage index and other adjustments. In addition, we must review the clinical integrity of payment groups and weights at least annually. Accordingly, in this proposed rule, we are proposing to update the conversion factor and the wage index adjustment for hospital outpatient services furnished beginning January 1, 2008, as we discuss in sections II.C. and II.D., respectively, of this proposed rule. We also are proposing to revise the relative APC payment weights using claims data from January 1, 2006, through December 31, 2006, and updated cost report information. In response to a provision in Pub. L. 108–173 that we analyze the cost of outpatient services in rural hospitals relative to urban hospitals, we are proposing to continue increased payments to rural SCHs, including EACHs. Section II.F. of this proposed rule provides greater detail on this rural adjustment. Finally, we are proposing to remove one device category, HCPCS code C1820 (Generator, neurostimulator, (implantable), with rechargeable battery and charging system), from pass-through payment status in CY 2008.

Under this proposed rule, the update change to the conversion factor as provided by statute would increase total OPPS payments by 3.3 percent in CY 2008. The one-time wage reclassification under section 508 expires September 30, 2007, and therefore is not contemplated in this proposed rule. The proposed changes to the APC weights including the changes that would result from the proposal to expand packaging, changes to the wage indices, the continuation of a payment adjustment for rural SCHs and EACHs would not increase OPPS payments because these changes to the OPPS are budget neutral. However, these proposed updates do change the distribution of payments within the budget neutral system as shown in Table 67 and described in more detail in this section.

1. Alternatives Considered

Alternatives to the changes we are proposing to make and the reasons that we have chosen the options are discussed throughout this proposed rule. Some of the major issues discussed in this proposed rule and the options considered are discussed below.

a. Alternatives Considered for the Packaging Proposals for CY 2008 OPPS

In section II.A.4.c. of this proposed rule, we are proposing to package payment for the following seven categories of ancillary supportive services into payment for the independent service with which they are billed. We are also proposing to pay for low dose rate prostate brachytherapy and cardiac electrophysiology evaluation and ablation services under composite APCs in which a single payment is made for multiple major services that are commonly performed on the same date. We discuss each category of services that we propose to package and each set of services for which we propose a composite APC below:

(1) Guidance Services

We are proposing to package payment for supportive guidance services into the payment for the independent procedure to which the guidance service is ancillary and supportive. In the case of one particular guidance procedure, which would usually be provided in conjunction with another independent procedure but may occasionally be provided without another independent service on the same date of service, we propose to permit separate payment if the service is billed without an independent procedure on the same date of service. We refer readers to section II.A.4.c.(1) of this proposed rule for the complete discussion of this proposal. We considered several policy options for the payment of guidance services in CY 2008.

The first alternative we considered was to propose no changes to packaging for the CY 2008 OPPS. Under this alternative, codes that were packaged for CY 2007 would remain packaged for CY 2008 and codes that were separately paid for CY 2007 would remain separately paid for CY 2008. There are a number of CPT codes that describe independent surgical procedures for which the code descriptors indicate that guidance is included in the code reported for the surgical procedure if it is used and, therefore, for which the OPPS already makes packaged payment for the associated guidance service. With a number of guidance services already packaged, we did not select this option in part because we did not want to create financial incentives for hospitals to use one form of guidance instead of another or to use guidance all the time, even if a procedure could be safely provided without guidance. Furthermore, we believe this alternative would not provide additional incentives for hospitals to utilize the most cost-effective and clinically advantageous method of guidance that is appropriate in each situation.

The second alternative we considered was to package the costs of guidance services in all cases, without regard to the possibility of the service being furnished without an independent service on the same date of service. We did not select this alternative because we believe that in the case of one particular guidance procedure, the procedure may sometimes be appropriately furnished without other independent services on the same date and in these cases, we believe that there should be separate payment for the guidance service.

The third alternative we considered, and the alternative we selected, was to always package payment for most supportive guidance services, while allowing separate payment for one particular guidance service when that guidance service is furnished without an independent service. When guidance services are furnished as an ancillary and supportive adjunct to an independent procedure, we are proposing to package payment for all guidance procedures. When one specific guidance service (which is occasionally not provided in conjunction with an independent procedure on the same date of service) is not provided on the same date as an independent procedure, we would pay separately for that service. We believe that this alternative would provide the most appropriate incentives to control volume and spending for these services, without discouraging the performance of the service in those infrequent cases when one particular guidance service is provided without an independent procedure.

(2) Image Processing

We are proposing to package payment for image processing services into the payment for the major independent service to which the image processing service is ancillary and supportive. We refer readers to section II.A.4.(c)(2) of this proposed rule for the complete discussion of this proposal. We considered several policy options for the payment of image processing services in CY 2008.

The first alternative we considered was to propose no changes to packaging for CY 2008 OPPS. Under this alternative, codes that were packaged for CY 2007 would remain packaged for CY 2008 and codes that were separately paid for CY 2007 would remain separately paid for CY 2008. We did not select this alternative because we believe it would not provide additional incentives for hospitals to utilize the most cost-effective and clinically advantageous image processing services that are appropriate in each situation.

The second alternative we considered was to package the costs of image processing services in cases in which the image processing service is furnished on the same date as an independent service to which the image processing service is ancillary and supportive but to pay separately for the image processing service when it is furnished without an independent service on the same date of service. We did not select this alternative because it would not have provided substantial additional incentives for hospitals to utilize image processing in the most cost-effective and clinically advantageous manner.

The third alternative we considered, and ultimately selected, was to package payment for the costs of image processing services in all cases, without regard to the possibility of the service being furnished without an independent service on the same date of service. While an image processing service is not necessarily provided on the same date of service as the independent procedure to which it is ancillary and supportive, providing separate payment for each imaging processing service whenever it is performed is not consistent with encouraging value-based purchasing under the OPPS. We believe it is important to package payment for supportive dependent services that accompany independent procedures but that may not need to be provided face-to-face with the patient in the same encounter as the independent service. Packaging encourages hospitals to establish protocols that ensure that services are furnished only when they are medically necessary and to carefully scrutinize the services ordered by practitioners to minimize unnecessary use of hospital resources. We also note that our standard methodology to calculate median costs packages the costs of dependent services with the costs of independent services on ''natural'' single claims across different dates of service, so we are confident that we would capture the costs of the supportive image processing services for ratesetting, even if they were provided on a different date than the independent procedure. Therefore, we believe that this alternative would provide additional appropriate incentives to control volume and spending for these services, without discouraging the use of the service in those infrequent cases when it is provided with an independent procedure but on a different date of service.

(3) Intraoperative Services

We are proposing to package payment for intraoperative services into the payment for the independent procedure to which the intraoperative service is ancillary and supportive. In the case of one intraoperative service, which would usually be provided in conjunction with another independent procedure but may occasionally be provided without another independent service on the same date of service, we propose to permit separate payment if the service is billed without an independent procedure on the same date of service. We refer readers to section II.A.4.c.(3) of this proposed rule for the complete discussion of this proposal. We

considered several policy options for the payment of intraoperative services in CY 2008.

The first alternative we considered was to propose no changes to packaging for CY 2008 OPPS. Under this alternative, codes that were packaged for CY 2007 would remain packaged for CY 2008 and codes that were separately paid for CY 2007 would remain separately paid for CY 2008. We did not select this alternative because we believe it would not provide additional incentives for hospitals to utilize the most cost-effective and clinically advantageous intraoperative services that are appropriate in each situation.

The second alternative we considered was to package payment for the costs of intraoperative services in all cases, without regard to the possibility of the service being furnished without an independent service on the same date of service. We did not select this alternative because we believe that in the case of one particular intraoperative procedure, the procedure may sometimes be appropriately furnished without other independent services on the same date and in these cases, we believe that there should be separate payment for the intraoperative service.

The third alternative we considered, and ultimately selected, was to unconditionally package the costs of intraoperative services in all cases except one, to allow for the possibility of this one commonly intraoperative service being furnished without an independent service on the same date of service. We believe that there is some possibility that this procedure could be appropriately performed without another independent procedure on the same date of service. We do not believe this to be true of the other intraoperative services that we propose to unconditionally package. We selected this alternative because we thought it unlikely that intraoperative services other than the one particular service would ever be provided without an independent service. Packaging encourages hospitals to establish protocols that ensure that services are furnished only when they are medically necessary and to carefully scrutinize the services ordered by practitioners to minimize unnecessary use of hospital resources. We believe that this is the most appropriate alternative because, in general, it creates additional incentives for hospitals to provide intraoperative services only when both medically necessary and cost efficient for the individual patient. Therefore, we believe that this alternative would provide the most appropriate incentives to control volume and spending for these services.

(4) Imaging Supervision and Interpretation Services

We are proposing to package payment for imaging supervision and interpretation services into the payment for the independent service to which the imaging supervision and interpretation service is ancillary and supportive. For some imaging supervision and interpretation services, we are proposing to permit separate payment if the service is the only separately paid service billed for the date of service. We refer readers to section II.A.4.c.(4) of this proposed rule for the complete discussion of this proposal. We considered several policy options for the payment of imaging supervision and interpretation services in CY 2008.

The first alternative we considered was to propose no changes to packaging for CY 2008 OPPS. Under this alternative, codes that were packaged for CY 2007 would remain packaged and codes that were separately paid for CY 2007 would remain separately paid for CY 2008. We did not select this alternative because we believe it would not provide additional incentives for hospitals to utilize the most cost-effective and clinically advantageous radiological supervision and interpretation services that are appropriate in each situation.

The second alternative we considered was to package the costs of imaging supervision and interpretation services in all cases, without regard to the possibility of the service being furnished without an independent separately payable service on the same date of service. This alternative might substantially reduce the financial incentive to furnish the service because separate payment would never be made in any case for the service, even when it was furnished without a separately payable service on the same date of service. We did not select this alternative because we believe that some of the imaging supervision and interpretation services may occasionally be furnished in conjunction with other services that are currently packaged under the OPPS. In these circumstances, if we were to unconditionally package payment for these imaging supervision and interpretation services, hospitals would receive no payment at all for providing the imaging supervision and interpretation service and the other minor procedure(s).

The third alternative we considered, and the alternative we selected, was to unconditionally package imaging supervision and interpretation procedures that we believe are always integral to and dependent upon an independent separately payable procedure, but to conditionally package payment for those imaging supervision and interpretation services that we believe are sometimes furnished without another separately payable service on the same date. We believe that this alternative is the most appropriate choice because it creates additional incentives for hospitals to provide services only when medically necessary to the individual patient when the supervision and interpretation services is furnished as an ancillary and supportive adjunct to the independent procedure. We would pay separately for some imaging supervision and interpretation services in those cases, which our data show are limited, where they are not furnished on the same date as another separately paid procedure. Therefore, we believe that this alternative would provide the most appropriate incentives to control volume and spending for these services, without discouraging the performance of the services in those relatively infrequent cases when they are the only services furnished.

(5) Diagnostic Radiopharmaceuticals

We are proposing to package payment for diagnostic radiopharmaceuticals into the payment for their associated nuclear medicine procedures. We refer readers to section II.A.4.c.(5) of this proposed rule for the complete discussion of this proposal. We considered several policy options for the payment of diagnostic radiopharmaceuticals in CY 2008.

The first alternative we considered was to propose no changes to our packaging methodology for diagnostic radiopharmaceuticals in the CY 2008 OPPS. Under this alternative, diagnostic radiopharmaceuticals with a mean per-day cost of $60 or under would be packaged into the payment for associated procedures present on the claim. Diagnostic radiopharmaceuticals with a per-day cost over $60 would receive separate payment. We did not select this alternative because we believe it would not provide additional incentives for hospitals to utilize the most cost-effective and clinically advantageous diagnostic radiopharmaceuticals that are appropriate in each situation.

The second alternative we considered was to package the costs of diagnostic radiopharmaceuticals in cases in which the diagnostic radiopharmaceutical is furnished on the same date as an independent service to which the diagnostic radiopharmaceutical is ancillary and supportive but to pay

separately for the diagnostic radiopharmaceutical when it is furnished without an independent service on the same date of service. We did not select this alternative because diagnostic radiopharmaceuticals are always intended to be used with a diagnostic nuclear medicine procedure. Our claims data indicate that diagnostic radiopharmaceuticals are infrequently provided on a different date of service from a nuclear medicine procedure. Since our standard OPPS ratesetting methodology packages costs across dates of service on ''natural'' single claims, we believe that our standard methodology adequately captures the costs of diagnostic radiopharmaceuticals associated with diagnostic nuclear medicine procedures that are not provided on the same date of service.

The third alternative we considered, and the alternative we selected, was to package the costs of diagnostic radiopharmaceuticals with their associated nuclear medicine procedures. Packaging the costs of supportive items and services into the payment for the independent procedure or service with which they are associated encourages additional hospital efficiencies and enables hospitals to better manage their resources with maximum flexibility. Diagnostic radiopharmaceuticals are always intended to be used with a diagnostic nuclear medicine procedure, and are, therefore, particularly well suited for packaging under the OPPS for the reasons identified in section II.A.4.c.(5) of this proposed rule.

(6) Contrast Media

We are proposing to package payment for contrast media into their associated independent diagnostic and therapeutic procedures. We refer readers to section II.A.4.c.(6) of this proposed rule for the complete discussion of this proposal. We considered several policy options for the payment of contrast media in CY 2008.

The first alternative we considered was to propose no changes to our packaging methodology for contrast media in the CY 2008 OPPS. Under this alternative, contrast media with a mean per-day cost of $60 or under would be packaged into the payment for associated procedures present on the claim. Contrast media with a per-day cost over $60 would receive separate payment. We did not select this alternative because we believe it would not provide additional incentives for hospitals to utilize contrast media in the most cost-effective and clinically advantageous manner. With most contrast media already packaged based on our proposed $60 packaging threshold, this alternative would potentially maintain inconsistent payment incentives across similar products.

The second alternative we considered was to package the costs of contrast media in cases in which the contrast medium is furnished on the same date as an independent service but to pay separately for the contrast medium when it is furnished without an independent service on the same date of service. We did not select this alternative because we thought it unlikely that contrast media would ever be provided without an independent service on the same date of service.

The third alternative we considered, and the alternative we selected, was to unconditionally package the costs of contrast media with their associated independent diagnostic and therapeutic procedures. The vast majority of contrast media would currently be packaged under the proposed $60 packaging threshold. Given that most contrast agents would already be packaged under the OPPS in CY 2008, we believe it would be desirable to package payment for the remaining contrast agents as this approach promotes additional efficiency and results in a more consistent payment policy across products that may be used in many of the same independent procedures.

(7) Observation Services

We are proposing to package payment for all observation care, reported under HCPCS code G0378 (Hospital observation services, per hour) for CY 2008. Payment for observation would be packaged as part of the payment for the separately payable services with which it is billed. We refer readers to section II.A.4.c.(7) of this proposed rule for the complete discussion of this proposal. We considered several policy options for the payment of observation services in CY 2008.

The first alternative we considered was to propose no changes to payment of observation services for the CY 2008 OPPS. Since January 1, 2006, hospitals have reported observation services based on an hourly unit of care using HCPCS code G0378. This code has a status indicator of ''Q'' under the CY 2007 OPPS, meaning that the OPPS claims processing logic determines whether the observation is packaged or separately payable. The OCE's current logic determines whether observation care billed under G0378 is separately payable through APC 0339 (Observation), or whether payment for observation services would be packaged into the payment for other separately payable services provided by the hospital in the same encounter based on criteria discussed in more detail in section II.A.4.c.(7) of this proposed rule. For CY 2007, we continued to apply the criteria for separate payment for observation care and the coding and payment methodology for observation care that were implemented in CY 2006. We did not select this alternative because the current criteria for separate payment for observation services treat payment for observation care for various clinical conditions differently and may provide disincentives for efficiency. In addition, there has been substantial growth in program expenditures for hospital outpatient services under the OPPS in recent years, a trend that is reflected in the rapidly increasing volume of claims for separately payable observation services. This alternative would not provide additional incentives for hospitals to utilize observation services in the most cost-effective and clinically advantageous manner.

The second alternative we considered was to accept the APC Panel's recommendations to add syncope and dehydration to the list of diagnoses eligible for separate payment or to consider other clinical conditions for separate payment for observation care. We believe that in certain circumstances observation could be appropriate for patients with a range of diagnoses. Both the APC Panel and numerous commenters to prior OPPS proposed rules have confirmed their agreement with this perspective. However, as packaging payment provides additional desirable incentives for more efficient delivery of health care and provides hospitals with significant flexibility to manage their resources, we believe it is most appropriate to treat observation care for all diagnoses similarly by packaging its costs into payment for the separately payable procedures with which the observation is associated. Consequently, we did not select this alternative to expand separate observation payment to additional diagnoses.

The third alternative we considered, and the alternative we selected, was to package payment for all observation services reported with CPT code G0378 under the CY 2008 OPPS. We believe this is the most appropriate alternative within the context of our proposed packaging approach because observation is always provided as a supportive service in conjunction with other independent separately payable hospital outpatient services such as an emergency department visit, surgical procedure, or another separately payable service, and thus its costs can

be packaged into the OPPS payment for such services. We believe that packaging payment into larger payment bundles creates incentives for providers to furnish services in the most efficient way that meets the needs of the patient, encouraging long-term cost containment. With approximately 70 percent of the occurrences of observation care billed under the OPPS currently packaged, this alternative would extend the incentives for efficiency already present for the vast majority of observation care that is already packaged under the OPPS to the remaining 30 percent of observation care for which we currently make separate payment. (8) Composite APCs

We are proposing to establish two composite APCs for CY 2008 OPPS. A composite APC is an APC that provides a single payment for several independent services when they are furnished on the same date of service. Composite APCs are intended to establish APC payment rates for combinations of services that are frequently furnished together so that the multiple procedure claims on which they are submitted may be used to set the payment rates for them and so that the payment for the services provides greater incentives for efficient use of hospital resources. Specifically, we are proposing to establish composite APCs for low dose rate prostate brachytherapy (which would be paid when CPT codes 55875 (Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy) and 77778 (Interstitial radiation source application; complex) are billed with the same date of service) and for cardiac electrophysiology evaluation and ablation services (which would be paid when at least one designated electrophysiology evaluation service is billed on the same date as at least one designated cardiac ablation service). We refer readers to sections II.A.4.d.(2) and II.A.4.d.(3) of this proposed rule for a detailed discussion of the proposals for these APCs. We note that we will continue to pay individual services under their single procedure APCs as we have in the past, in recognition that there are clinical circumstances in which the combinations of services proposed for payment through the composite APCs are not furnished on the same date. We considered two alternatives with regard to the proposal to create composite APCs.

The first alternative we considered was to make no change to how we pay for these services. If we were to make no change, we could continue to pay separately for each service. The payment rates would continue to be based on single procedure claims, which we have been told by stakeholders do not represent the typical treatment scenario. Interested parties have repeatedly told us, and our examination of claims data supports, that these services are typically furnished in combination with one another and, therefore, this may suggest that the use of single procedure claims to establish the median costs that form the basis for payment for these services may result in our using clinically unusual or incorrectly coded claims as the basis for payment.

The second alternative we considered, and the alternative we selected, is to propose to create composite APCs for these services which are commonly furnished in combination with one another and to make a single payment for the multiple services specified in the composite APC at a prospectively established rate based on the total cost of the combination of services furnished. This alternative responds to public comments that multiple procedure claims for these services that we have heretofore been unable to use for ratesetting reflect the most common treatment scenarios. It also provides additional incentives for efficient provision of services by bundling payment for multiple services into a single payment. Composite APCs enable us to use more of our claims data and to use single procedure claims only to set payment rates for the uncommon circumstances in which a particular service is not furnished in combination with other related independent services. Therefore, we are proposing to establish two composite APCs for the CY 2008 OPPS.

b. Partial Device Credits

We are proposing to reduce payment by 50 percent of the device offset amount for specified APCs when hospitals report that they have received a credit for a replacement device of greater than or equal to 20 percent of the cost of the new replacement device being implanted, if the device is on a list of specified devices. We refer readers to section IV.A.3. of this proposed rule for a complete discussion of this proposal. This is an extension of the current policy that reduces the APC payment by the full device offset amount when the hospital receives a replacement device without cost or receives a credit for the full cost of the device being replaced. We considered several alternatives in developing this partial device credit proposal for CY 2008.

The first alternative we considered was to make no change to the current policy. Under this alternative, Medicare and the beneficiary would continue to pay the full APC rate, which is calculated using only claims for which the full cost of a device is billed by the hospital, even if the hospital received a substantial credit towards the cost of the replacement device. We did not select this alternative because we believe that, as long as the APC payment amount is initially established to reflect the full cost of the device when there is no credit, there should be a reduction in the Medicare payment amount when the hospital receives a substantial credit toward cost of the replacement device. Similarly, we believe that the beneficiary cost sharing should be based on an amount that also reflects the credit.

The second alternative we considered was to extend the current policy to cases of partial credit without change. This would reduce the payment in all cases in which the hospital received a credit by the full offset amount for the APC, that is, by 100 percent of the estimated device cost contained in the APC. We considered this alternative because, in our discussions with hospitals about partial credits for devices, they advised us that hospitals generally charge the same amount for a device regardless of whether they receive a significant amount in credit towards the cost of that device. Hence, in such a case the costs that are packaged into the APC payment for the applicable procedure contain the same amount of device cost as if the hospital incurred the full cost of the device. We did not select this alternative because we did not believe it was appropriate to reduce the payment to the hospital by the full cost of a device if the hospital only received a partial credit, and not a full credit, towards the cost of the device.

The third alternative, which we are proposing, is to reduce the APC payment by 50 percent of the offset amount (that would be applied if the hospital received full credit) in cases in which the hospital receives a partial credit of 20 percent or more of the cost of the new replacement device being implanted. Moreover, we are proposing to require hospitals to report a new modifier when the hospital receives a partial credit that is 20 percent or more of the cost of the device being replaced. We are proposing this alternative because we believe that this approach provides an appropriate and equitable payment to the hospital from Medicare and, depending on the service, may reduce the beneficiary's cost sharing for the service.

c. Brachytherapy Sources

Pursuant to sections 1833(t)(2)(H) and 1833(t)(16)(C) of the Act, we paid for brachytherapy sources furnished from January 1, 2004 through December 31, 2006 on a per source basis at an amount equal to the hospital's charge adjusted to cost by application of the hospital-specific overall CCR. Moreover, pursuant to section 107(a) of the MIEA–TRHCA, which amended section 1833(t)(16)(C) of the Act by extending the payment period for brachytherapy sources based on a hospital's charges adjusted to cost, we are paying for brachytherapy sources using the charges adjusted to cost methodology through December 31, 2007. Section 107(b)(1) of the MIEA–TRHCA amended section 1833(t)(2)(H) of the Act, by adding a requirement for the establishment of separate payment groups for ''stranded and non stranded'' brachytherapy devices beginning July 1, 2007. In section VII. B. of this proposed rule, we are proposing prospective payment for all brachytherapy sources, including separate payment for stranded and non-stranded versions of sources currently known to us, that is, iodine–125, palladium–103 and cesium–131. For each of the sources for which we have information that only non-stranded source versions are marketed, we are proposing to pay based on the median cost per source based on our CY 2006 claims data. For sources for which we have information that both stranded and non-stranded versions are marketed and for which our CY 2006 billing codes do not differentiate stranded and non-stranded sources, we are proposing to base payment for stranded and non-stranded brachytherapy sources on the 60th percentile and 40th percentile of our claims data, respectively, for CY 2008. We discuss each option we considered below.

The first alternative we considered was to pay for each source of brachytherapy based on our CY 2006 median costs, with the exception of the 3 sources for which we do not have separately reported cost data for their stranded and non-stranded versions, i.e., iodine–125, palladium–103, and cesium–131. Under this option, for these six stranded and non-stranded sources, we considered payment based on hospital charges reduced to cost for CY 2008. This approach would be a step toward prospective payment for brachytherapy sources, as the sources that only have non-stranded versions would receive prospective payment consistent with the overall OPPS methodology. However, payment for stranded and non-stranded iodine–125, palladium–103 and cesium–131 would deviate from the overall OPPS framework for prospective payment and from the proposed prospective payment of the non-stranded only sources specifically. This approach would subject similar items that are essential to brachytherapy treatments to different payment methodologies and could potentially create financial incentives for the use of some products over others.

The second alternative we considered was to continue making payments for all sources based on hospital charges reduced to cost. Although hospitals are familiar with this payment methodology and this methodology would be consistent with the requirement that brachytherapy sources be paid separately, we believe that to continue to pay on this basis would be inconsistent with the general methodology of a prospective payment system and would provide no incentive for hospitals to provide brachytherapy treatments in the most cost-effective and clinically advantageous manner.

The third alternative we considered, and the alternative we selected, is to propose prospective payment for each brachytherapy source based on its median costs. For the sources which only have non-stranded versions, we are proposing to use our standard median cost methodology. For the three sources which have stranded and non-stranded versions and for which we do not yet have separately reported stranded and non-stranded claims data, we are proposing to calculate the median costs based on the assumption that the reportedly lower cost non-stranded sources would be unlikely to be in the top 20 percent of the cost distribution of our aggregate CY 2006 claims data for each respective source, and on the assumption that the reportedly higher cost stranded sources would be unlikely to be in the bottom 20 percent of the CY 2006 cost distribution for each source. This approach to calculating median costs for stranded and non-stranded iodine–125, palladium–103, and cesium–131 sources results in proposed Medicare payment rates based on the 60th percentile of our aggregate data for stranded sources and the 40th percentile of our aggregate data for non-stranded sources. This methodology provides for separate payment of all sources, including stranded and non-stranded sources, recognizes a cost differential between stranded and non-stranded sources, is consistent with our prospective payment methodology for setting payment rates for other services, and is consistent with the expiration of the requirement of the MIEA–TRHCA that payment for brachytherapy sources be made at charges reduced to cost through December 31, 2007.

2. Limitations of Our Analysis

The distributional impacts presented here are the projected effects of the policy changes on various hospital groups. We estimate the effects of individual policy changes by estimating payments per service, while holding all other payment policies constant. We use the best data available but do not attempt to predict behavioral responses to our policy changes. In addition, we do not make adjustments for future changes in variables such as service volume, service-mix, or number of encounters. As we have done in previous rules, we are soliciting comments and information about the anticipated effect of the proposed changes on hospitals and our methodology for estimating them. We discuss below several specific limitations of our analysis.

One limitation of our analysis is our inability to estimate behavioral responses to our proposal to increase packaging and our proposal to pay for multiple procedures based on one composite payment rate. Specifically, it is possible that there could be a behavioral response to our proposals to package guidance services, image processing services, intraoperative services, imaging supervision and interpretation services, diagnostic radiopharmaceuticals, contrast agents, and observation services, and to pay some services using composite APCs when the services are furnished in specified combinations. However, we are unable to estimate what the effect of the behavioral response may be on payment to hospitals. We refer readers to section II.A.4. of this proposed rule for further discussion of the proposed packaging approach. The purpose of packaging these services and creating composite APCs is to remove financial incentives to furnish additional services and, instead, to provide greater incentives for hospitals to assess the most cost-effective and appropriate means to furnish necessary services. In addition, we expect that hospitals will negotiate for lower prices from suppliers to maximize the margin between their cost of providing services and the Medicare payment for the services. We recognize that it is also possible that hospitals could change behavior in a manner that seeks to overcome any reductions in total payments by ceasing to provide certain packaged services on the same date of service and instead requiring patients to receive those services on different dates of service or at different locations, so as to either

receive separate additional payment for services that would otherwise be packaged or to not incur the additional costs of those services. We believe that this will be uncommon for several reasons. We anticipate that hospitals would continue to provide care that is aligned with the best interests of the patient. In the vast majority of cases for the services that are newly proposed for unconditional packaging in CY 2008, the services would need to be provided in the same facility and during the same encounter as the independent procedure they support. Furthermore, in the case of conditionally packaged services, we note that the supportive services that we have included in our packaging proposals are typically services that are provided during or shortly preceding the independent procedure to which they are ancillary and supportive, and thus it is unlikely that the supportive service that is packaged and the independent procedure would be performed in different locations. However, we are unable to quantify the extent to which such behavioral change may impact Medicare payments to hospitals.

Secondly, we are not able to estimate the impact on hospitals of our proposal to reduce payment when a hospital receives a partial credit for a medical device that fails while under warranty or otherwise. We do not currently require hospitals to notify us when they received a partial credit for a device for which they are billing. In addition, hospitals have informed us that hospitals generally do not currently reduce the charge for a device when they receive a partial credit toward the device for which they are billing Medicare. Therefore, we have no means of knowing the frequency with which this happens or the extent to which hospitals' costs for the devices being replaced are reduced as a result of the partial credits and cannot estimate the impact of the proposed policy on hospital payments under OPPS in CY 2008.

Third, we are unable to estimate the extent to which hospitals will incur no cost for devices or will receive full credits for devices being replaced as a result of the failure of the device. In CY 2006, hospitals reported the ''FB'' modifier on codes for devices that they received without cost or for which they received a full credit. However, we are unable to forecast the extent to which the frequency or the type of device for which this occurred in CY 2006 will recur for CY 2008. We believe that most of these occurrences were the result of specific activity that we have no reason to believe will occur in CY 2008 at the same frequency at which it occurred in CY 2006, and hence we have made no estimates of how such activity may impact payments to hospitals.

Fourth, for purposes of this impact analysis, for those brachytherapy sources with proposed new codes to distinguish between stranded and non-stranded version, we assumed that half of the brachytherapy sources that hospitals will use in CY 2008 will be stranded sources and that half of them will be non-stranded sources. The statute requires us to pay for stranded and non stranded sources through different APC groups, but given the lack of separately reported claims data for stranded and non-stranded sources, for the purposes of this impact analysis, we made this assumption. We welcome data that would provide the expected CY 2008 ratio of stranded sources to non-stranded sources for purposes of the CY 2008 final rule impact analysis.

The final limitation of our analysis is that we cannot predict the utilization of new CY 2007 CPT codes that replace existing CY 2006 CPT codes for which we have cost data on which we base the proposed CY 2008 OPPS payment rates. In years past, we have estimated the impact of these code changes as if the deleted codes would continue to exist for the applicable year for which we were estimating impacts. For this proposed rule, we applied the AMA's estimates of new code utilization which are used for the MPFS proposed rule. However, we do not know whether these estimates of physician utilization are equally applicable to outpatient hospital services. We request comments regarding whether it is appropriate for us to use the AMA estimates of utilization for new codes in the estimation of the impact of proposed CY 2008 payments on hospitals.

3. Estimated Impacts of This Proposed Rule on Hospitals and CMHCs

Table 67 below shows the estimated impacts of this proposed rule on hospitals. Historically, the first line of the impact table, which estimates the change in payments to all hospitals, has always included cancer and children's hospitals, which are held harmless to their pre–BBA payment to cost ratio. This year, for the first time, we are also including CMHCs in the first line that includes all providers because we included CMHCs in our weight scaler estimate. We are not showing the estimated impact of the proposed changes on CMHCs alone because CMHCs bill only one service under the OPPS, partial hospitalization, and each CMHC can, therefore easily estimate the impact of the proposed changes by referencing payment for APC 0033 in Addendum A to this proposed rule.

The estimated increase in the total payments made under the OPPS is limited by the increase to the conversion factor set under the methodology in the statute. The distributional impacts presented do not include assumptions about changes in volume and service-mix. The enactment of Pub. L. 108–173 on December 8, 2003, provided for the additional payment outside of the budget neutrality requirement for wage indices for specific hospitals reclassified under section 508. The amounts attributable to this reclassification are incorporated into the CY 2007 estimates but because section 508 expires for CY 2008 rates, no additional payments under section 508 are considered for CY 2008 in this impact analysis.

Table 67 shows the estimated redistribution of hospital and CMHC payments among providers as a result of APC reconfiguration and recalibration without the proposal to expand packaging; APC reconfiguration and recalibration including the proposal to expand packaging; wage indices and continuation of the adjustment for rural SCHs and EACHs with extension to brachytherapy sources in CY 2008; the estimated distribution of increased payments in CY 2008 resulting from the combined impact of the APC recalibration with the proposal to expand packaging, wage effects, the rural SCH and EACH adjustment, and the market basket update to the conversion factor; and, finally, estimated payments considering all payments for CY 2008 relative to all payments for CY 2007, including the impact of expiring wage provisions of section 508, changes in the outlier threshold, and changes to the pass-through estimate. Because updates to the conversion factor, including the update of the market basket and the addition of money not dedicated to pass-through payments, are applied uniformly, observed redistributions of payments in the impact table for hospitals largely depend on the mix of services furnished by a hospital (for example, how the APCs for the hospital's most frequently furnished services would change), the impact of the wage index changes on the hospital, and the impact of the payment adjustment for rural SCHs, including EACHs. However, total payments made under this system and the extent to which this proposed rule would redistribute money during implementation also would depend on changes in volume, practice patterns, and the mix of services billed between

CY 2007 and CY 2008, which CMS cannot forecast.

Overall, the proposed OPPS rates for CY 2008 would have a positive effect for providers paid under the OPPS, resulting in a 3.3 percent increase in Medicare payments. Removing cancer and children's hospitals because their payments are held harmless to the pre–BBA ratio between payment and cost, and CMHCs, suggests that changes would result in a 3.5 percent increase in Medicare payments to all other hospitals, exclusive of transitional pass-through payments.

To illustrate the impact of the proposed CY 2008 changes, our analysis begins with a baseline simulation model that uses the final CY 2007 weights, the FY 2007 final post-reclassification IPPS wage indices, and the final CY 2007 conversion factor. Column 2A in Table 67 shows the independent effect of changes resulting from the proposed reclassification of services among APC groups and the proposed recalibration of APC weights without the proposed changes to packaging, based on 12 months of CY 2006 hospital OPPS claims data and more recent cost report data. We modeled the independent effect of APC recalibration by varying only the weights, the final CY 2007 weights versus the estimated CY 2008 weights without expanded packaging in our baseline model, and calculating the percent difference in payments. Column 2B in Table 67 shows the independent effect of changes resulting from the proposed packaging approach, including the proposed creation of composite APCs 8000 and 8001, based on 12 months of CY 2006 hospital OPPS claims data and more recent cost report data. We modeled the independent effect of APC recalibration by varying only the weights in the baseline model, the proposed CY 2008 weights without packaging and CY 2008 weights with expanded packaging, and calculating the percent difference in payments relative to the CY 2007 base used in Column 2A in order to show the packaging proposal's additive effect. Column 2B also reflects the independent effect of changes resulting from APC reclassification and recalibration changes and changes in multiple procedure discount patterns that occur as a result of the proposed changes to packaging. When services were packaged as proposed, the resulting median costs at the HCPCS code level often changed, requiring migration of HCPCS codes to different APCs to address violations of the two times rule (that is, to ensure that the HCPCS codes within the APC remained homogeneous with regard to clinical and resource characteristics). The placement of the HCPCS code in a new APC as a result of the effect of the proposed packaging approach often changed the APC median cost. Furthermore, changing the cost of a service subject to the multiple procedure discount policy, as well as packaging some services previously subject to the multiple procedure discount policy, changed the relative weight ranking of services on a claim subject to the multiple procedure discount policy, significantly changing discounting patterns in some cases.

Column 2 reflects the combined effects of APC reclassification and recalibration changes attributable to changes resulting from the proposed reclassification of services codes among APC groups and the proposed recalibration of APC weights without the proposed packaging approach in addition to all APC reclassification and recalibration changes attributable to the proposed packaging approach. We modeled the independent effect of all APC recalibration by varying only the weights in the baseline model, the final CY 2007 weights versus the proposed CY 2008 weights, and calculating the percent difference in payments.

Column 3 reflects the independent effects of updated wage indices, including the new occupational mix data described in the FY 2008 IPPS final rule, and the proposed 7.1 percent rural adjustment for SCHs and EACHs with extension to brachytherapy sources. The OPPS wage index for CY 2008 includes the budget neutrality adjustment for the rural floor, as discussed in section II.D. of this proposed rule. We modeled the independent effect of updating the wage index and the rural adjustment by varying only the wage index, using the proposed CY 2008 scaled weights, and a CY 2007 conversion factor that included a budget neutrality adjustment for changes in wage effects and the rural adjustment between CY 2007 and CY 2008.

Column 4 demonstrates the combined ''budget neutral'' impact of proposed APC recalibration with the packaging proposal (that is, Column 2), the wage index update and the proposed adjustment for rural SCHs and EACHs on various classes of hospitals (that is, Column 3), as well as the impact of updating the conversion factor with the market basket update. We modeled the independent effect of the proposed budget neutrality adjustments and the proposed market basket update by using the weights and wage indices for each year, and using a CY 2007 conversion factor that included the proposed market basket update and budget neutrality adjustments for differences in wages and the adjustment for rural SCHs and EACHs.

Finally, Column 5 depicts the full impact of the proposed CY 2008 policy on each hospital group by including the effect of all the proposed changes for CY 2008 (including the APC reconfiguration and recalibration with the packaging changes shown in Column 2) and comparing them to all estimated payments in CY 2007, including changes to the wage index under section 508 of Pub. L. 108–173 and expiring in September 2007. Column 5 shows the combined budget neutral effects of Columns 2 through 4, plus the impact of the proposed change to the fixed outlier threshold from $1,825 to $2,000, expiring section 508 reclassification wage index increases, and the impact of changing the percentage of total payments dedicated to transitional pass through payments. We estimate that these cumulative changes increase payments by 3.3 percent.

We modeled the independent effect of all changes in Column 5 using the final weights for CY 2007 and the proposed weights for CY 2008. We used the final conversion factor for CY 2007 of $61.468 and the proposed CY 2008 conversion factor of $63.693. Column 5 also contains simulated outlier payments for each year. We used the charge inflation factor used in the FY 2008 IPPS proposed rule of 7.26 percent (1.0726) to increase individual costs on the CY 2006 claims to reflect CY 2007 dollars, and we used the most recent overall CCR in the April Outpatient Provider-Specific File. Using the CY 2006 claims and a 7.26 percent charge inflation factor, we currently estimate that actual outlier payments for CY 2007, using a multiple threshold of 1.75 and a fixed-dollar threshold of $1,825 would be approximately 1.0 (0.96) percent of total payments. Outlier payments of 0.96 percent appear in the CY 2007 comparison in Column 5. We used the same set of claims and a charge inflation factor of 15.04 percent (1.1504) and the CCRs on the April Outpatient Provider-Specific File with an adjustment of 0.9912 to reflect relative changes in cost and charge inflation between CY 2007 and CY 2008 to model the CY 2008 outliers at 1.0 percent of total payments using a multiple threshold of 1.75 and a fixed dollar threshold of $2,000.

Column 1: Total Number of Hospitals

The first line in Column 1 in Table 67 shows the total number of providers (4,171), including cancer and children's hospitals and CMHCs for which we were able to use CY 2006 hospital

outpatient claims to model CY 2007 and CY 2008 payments by classes of hospitals. We excluded all hospitals for which we could not accurately estimate CY 2007 or CY 2008 payment and entities that are not paid under the OPPS. The latter entities include CAHs, all-inclusive hospitals, and hospitals located in Guam, the U.S. Virgin Islands, Northern Mariana Islands, American Samoa, and the State of Maryland. This process is discussed in greater detail in section II.A. of this proposed rule. At this time, we are unable to calculate a disproportionate share (DSH) variable for hospitals not participating in the IPPS. Hospitals for which we do not have a DSH variable are grouped separately and generally include psychiatric hospitals, rehabilitation hospitals, and LTCHs. We show the total number (3,911) of OPPS hospitals, excluding the hold-harmless cancer and children's hospitals, and CMHCs, on the second line of the table. We excluded cancer and children's hospitals because section 1833(t)(7)(D) of the Act permanently holds harmless cancer hospitals and children's hospitals to a proportion of their pre-BBA payment relative to their pre-BBA costs and, therefore, we removed them from our impact analyses. We excluded CMHCs, because they only bill one service under the OPPS, and thus they can easily determine the impact of the proposed changes.

Column 2A: APC Recalibration Prior to the Packaging Proposal

This column estimates what the effects of APC reconfiguration and recalibration would be if we were not to finalize the proposed packaging changes. The effects described in this column reflect updated cost report and claims data, as well as policy changes not related to proposed additional packaging, including APC Panel recommendations and proposed payment for brachytherapy sources. We assumed that radiopharmaceuticals would be paid prospectively based on their mean unit cost. In general, the combined effects of the APC reclassification and recalibration without the packaging proposal for hospitals in Column 2A are similar to the effects of APC recalibration in recent years. The 0.3 percent increase for all hospitals reflects the redistribution of lost partial hospitalization per diem payment from CMHCs to other hospitals. For example, overall, these changes would increase payments to urban hospitals by 0.3 percent. We estimate that large urban hospitals would see a 0.2 percent increase, while ''other'' urban hospitals experience an increase of 0.5 percent.

Overall, rural hospitals would show a modest 0.2 percent increase as a result of proposed changes to the APC structure that would occur without the proposed changes in packaging. In general, rural hospitals with 101 or more beds would experience increases greater than rural hospitals with 100 beds or fewer. Similarly, rural hospitals that bill greater than 10,999 lines (that is, total payable claim lines in CY 2006) would experience increases greater than rural hospitals that bill 10,999 lines and fewer. Urban and rural hospitals that bill Medicare fewer than 5,000 lines would see reductions of 10.7 percent and 8.1 percent respectively, due to the proposed reduction in payment for partial hospitalization (APC 0033) for CY 2008 and due to the limitation on the aggregate total OPPS payment per day for mental health services to the per diem payment for partial hospitalization (APC 0034).

Among teaching hospitals, the largest observed impacts resulting from proposed APC recalibration include an increase of 0.5 percent for minor teaching hospitals and an increase of 0.1 percent for major teaching hospitals.

Classifying hospitals by type of ownership suggests that proprietary hospitals would not experience any change in payment, governmental hospitals would experience an increase of 0.2 percent, and voluntary hospitals would experience an increase of 0.4 percent.

Column 2B: APC Recalibration and Addition of the Packaging Proposal

This column estimates what the additional, independent effects of APC reconfiguration and recalibration, and resulting changes in discounting patterns, would be with the expanded packaging and all other changes that we propose for CY 2008. Significant changes not related to packaging were addressed in column 2A. In general, the packaging proposal redistributes payments from larger and urban hospitals to smaller and rural hospitals that provide fewer packaged services and fewer of the independent services into which the supportive services were packaged. Overall, these additional changes would decrease payments to urban hospitals by 0.1 percent. We estimate that urban hospitals that bill less than 11,000 lines would see an increase of slightly over 1 percent, while urban hospitals that bill at least 11,000 lines or more would experience less of an increase or a small decrease.

Overall, rural hospitals would show a modest 0.4 percent increase as a result of proposed changes to packaging. Rural hospitals with 150 or more beds would experience decreases while smaller rural hospitals would experience increases in payment.

Among teaching hospitals, the largest observed impacts resulting from the proposed packaging include a decrease of 0.4 percent for minor teaching hospitals and an increase of 0.3 percent for major teaching hospitals.

Classifying hospitals by type of ownership suggests that proprietary hospitals would decrease 0.2 percent, and governmental and voluntary hospitals would experience no change.

Column 2: Combination of Columns 2A and 2B

This column shows the combined effects of proposed policies other than the proposed changes to packaging (for example, changes to payment for brachytherapy sources and therapeutic radiopharmaceuticals), which are reflected in part in column 2A with the additional changes to reconfiguration and recalibration that would be made if we were to finalize the packaging proposal (Column 2B). In many cases, the redistribution created by the reduction in the partial hospitalization payment offsets other recalibration losses. Overall, these changes would increase payments to urban hospitals by 0.2 percent. We estimate that both large urban hospitals and other urban hospitals would see a 0.2 percent increase in payments attributable to all recalibration.

Overall, rural hospitals would show a modest 0.6 percent increase as a result of proposed changes to the APC structure and the packaging proposal. Rural hospitals with 200 or more beds would experience decreases while smaller rural hospitals would experience increases in payment.

Among teaching hospitals, the largest observed impacts resulting from proposed APC recalibration and the packaging proposal include an increase of 0.5 percent for major teaching hospitals and an increase of 0.1 percent for minor teaching hospitals.

Classifying hospitals by type of ownership suggests that proprietary hospitals would decrease 0.2 percent, governmental hospitals would increase by 0.2 percent, and voluntary hospitals would increase by 0.4 percent.

Column 3: New Wage Indices and the Effect of the Rural Adjustment

This column estimates impact of applying the proposed IPPS FY 2008 wage indices for CY 2008, continuing the rural adjustment for CY 2008, and extending the rural adjustment to

include brachytherapy sources. Overall, these changes would not change the payments to urban hospitals. Overall, rural hospitals would show no change as a result of proposed changes to the wage indices and the continuation of the rural adjustment.

Among teaching hospitals, the largest observed impacts resulting from proposed changes to the wage indices and the continuation of the rural adjustment include a decrease of 0.2 percent for major teaching hospitals and no change for minor teaching hospitals.

Classifying hospitals by type of ownership suggests that proprietary hospitals would gain 0.2 percent, government hospitals would experience an increase of 0.1 percent, and voluntary hospitals would experience no change.

Column 4: All Budget Neutrality Changes and Market Basket Update

The addition of the proposed market update alleviates any negative impacts on payments for CY 2008 created by the proposed budget neutrality adjustments made in Columns 2 and 3, with the exception of urban and rural hospitals with the lowest volume of services and hospitals not paid under the IPPS, including psychiatric hospitals, rehabilitation hospitals, and LTCHs (DSH not available). In many instances, the redistribution of payments created by APC recalibration offsets those introduced by updating the wage indices.

Overall, these changes would increase payments to urban hospitals by 3.5 percent. We estimate that both large urban hospitals and other urban hospitals would see a 3.5 percent increase. In contrast, small urban hospitals that bill fewer than 5000 lines per year would experience a decrease in payment of 6 percent, largely as a result of the proposed decreases in payment for partial hospitalization and mental health services appearing in Column 2A.

Overall, rural hospitals would show a 3.9 percent increase as a result of proposed market basket update. Rural hospitals that bill less than 5,000 lines would see a 4.2 percent decrease, also as a result of proposed decreases in payment for partial hospitalization appearing in Column 2A. Rural hospitals that bill more than 5,000 lines would experience increases.

Among teaching hospitals, the largest observed impacts resulting from the proposed market basket update include an increase of 3.6 percent for major teaching hospitals and an increase of 3.4 percent for minor teaching hospitals.

Classifying hospitals by type of ownership suggests that proprietary hospitals would gain 3.3 percent, government hospitals would experience an increase of 3.6 percent, and voluntary hospitals would experience an increase of 3.6 percent.

Column 5: All Proposed Changes for CY 2008

Column 5 compares all proposed changes for CY 2008 to final payment for CY 2007 and includes the expiring section 508 reclassification wage indices, the proposed change in the outlier threshold, and the difference in pass through estimates which are not included in the combined percentages shown in Column 4. Overall, we estimate that providers would gain 3.3 percent under this proposed rule in CY 2008 relative to total spending in CY 2007. The 3.3 percent for all providers in Column 5 is rounded from 3.26 percent, which reflects the 3.3 percent market basket increase, plus 0.06 percent for the change in the pass-through estimate between CY 2007 and CY 2008, plus 0.04 percent for the difference in estimated outlier payments between CY 2007 and CY 2008, less 0.14 percent for expiring 508 wage payments. When we exclude cancer and children's hospitals (which are held harmless to their pre-OPPS costs), and CMHCs, the gain becomes 3.5 percent.

The combined effect of all proposed changes for CY 2008 would increase payments to urban hospitals by 3.5 percent. We estimate that large urban hospitals would see a 3.5 percent increase, while ''other'' urban hospitals experience an increase of 3.4 percent. Urban hospitals that bill less than 5,000 lines experience a decrease of 5.4 percent, up from 6.0 percent in column 4 due to increases in outlier payments for partial hospitalization.

Overall, rural hospitals would show a 3.8 percent increase as a result of the combined effects of all proposed changes for CY 2008. Rural hospitals that bill less than 5,000 lines experience a decrease of 3.0 percent, which is less than the 4.2 percent in column 4 due to an increase in outlier payments for partial hospitalization. All rural hospitals that bill greater than 5,000 lines experience increases ranging from 3.3 percent to 4.9 percent.

Among teaching hospitals, the largest observed impacts resulting from the combined effects of all proposed changes include an increase of 3.5 percent for major teaching hospitals and an increase of 3.3 percent for minor teaching hospitals.

Classifying hospitals by type of ownership suggests that proprietary hospitals would gain 3.4 percent, government hospitals would experience an increase of 3.6 percent, and voluntary hospitals would experience an increase of 3.5 percent.

TABLE 67.—PROPOSED IMPACT OF CHANGES FOR CY 2008 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

	Number of hospitals	APC changes			New wage index and rural adjustment	Comb (cols 2,3) with update	All changes
		Prior to packaging proposal	Packaging proposal	Comb (cols 2A,2B)			
	(1)	(2A)	(2B)	(2)	(3)	(4)	(5)
Proposed Impact of CY 2008 Hospital Outpatient Prospective Payment System Changes							
ALL PROVIDERS*	4171	0.0	0.0	0.0	0.0	3.3	3.3
ALL HOSPITALS (excludes hospitals held harmless and CMHCs)	3911	0.3	0.0	0.3	0.0	3.6	3.5
URBAN HOSPITALS	2916	0.3	−0.1	0.2	0.0	3.5	3.5
LARGE URBAN (GT 1 MILL.)	1591	0.2	0.1	0.2	0.0	3.5	3.5
OTHER URBAN (LE 1 MILL.)	1325	0.5	−0.3	0.2	0.0	3.5	3.4
RURAL HOSPITALS	995	0.2	0.4	0.6	0.0	3.9	3.8
SOLE COMMUNITY	410	0.3	0.4	0.7	0.2	4.2	3.9

TABLE 67.—PROPOSED IMPACT OF CHANGES FOR CY 2008 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM—Continued

	Number of hospitals	APC changes			New wage index and rural adjustment	Comb (cols 2,3) with update	All changes
		Prior to packaging proposal	Packaging proposal	Comb (cols 2A,2B)			
	(1)	(2A)	(2B)	(2)	(3)	(4)	(5)
OTHER RURAL	585	0.2	0.4	0.5	−0.2	3.7	3.8
BEDS (URBAN):							
0–99 BEDS	947	−0.2	0.5	0.3	0.1	3.7	3.7
100–199 BEDS	917	0.1	0.1	0.2	0.0	3.5	3.4
200–299 BEDS	469	0.5	−0.2	0.3	−0.1	3.6	3.5
300–499 BEDS	409	0.4	−0.2	0.2	0.1	3.6	3.6
500 + BEDS	174	0.4	−0.3	0.1	0.0	3.4	3.3
BEDS (RURAL):							
0–49 BEDS***	345	0.1	1.2	1.4	−0.1	4.6	4.5
50–100 BEDS***	383	0.1	0.9	1.0	0.2	4.5	4.5
101–149 BEDS	159	0.3	0.4	0.7	0.0	4.0	4.0
150–199 BEDS	64	0.4	−0.3	0.1	−0.6	2.7	2.7
200 + BEDS	44	0.3	−0.7	−0.5	0.1	2.9	2.6
VOLUME (URBAN):							
LT 5,000 Lines	591	−10.7	1.4	−9.3	0.0	−6.0	−5.4
5,000–10,999 Lines	165	−1.6	1.2	−0.3	0.1	3.1	3.0
11,000–20,999 Lines	269	−0.5	0.6	0.1	0.1	3.6	3.7
21,000–42,999 Lines	545	0.3	0.3	0.6	0.2	4.0	4.0
GT 42,999 Lines	1346	0.4	−0.2	0.2	0.0	3.5	3.5
VOLUME (RURAL):							
LT 5,000 Lines	82	−8.1	1.3	−6.8	−0.6	−4.2	−3.0
5,000–10,999 Lines	104	0.0	1.2	1.2	0.3	4.9	4.8
11,000–20,999 Lines	208	0.3	1.3	1.6	0.1	5.0	4.8
21,000–42,999 Lines	310	0.3	1.1	1.4	0.2	4.9	4.9
GT 42,999 Lines	291	0.2	0.0	0.2	−0.1	3.4	3.3
REGION (URBAN):							
NEW ENGLAND	157	0.0	0.8	0.8	−0.1	4.0	3.8
MIDDLE ATLANTIC	378	0.4	0.6	1.0	−0.4	3.9	3.5
SOUTH ATLANTIC	454	0.4	−0.4	0.0	0.1	3.5	3.5
EAST NORTH CENT	461	0.5	−0.2	0.3	−0.2	3.4	3.2
EAST SOUTH CENT	195	0.7	−0.6	0.1	0.1	3.4	3.5
WEST NORTH CENT	187	0.4	−0.2	0.2	0.3	3.8	3.8
WEST SOUTH CENT	464	0.5	−0.8	−0.3	−0.2	2.8	2.9
MOUNTAIN	181	0.6	−0.1	0.5	0.0	3.8	3.9
PACIFIC	388	−0.4	0.2	−0.3	0.6	3.6	3.7
PUERTO RICO	51	1.0	0.3	1.2	−0.2	4.4	4.4
REGION (RURAL):							
NEW ENGLAND	21	0.0	0.9	0.8	−0.5	3.6	3.7
MIDDLE ATLANTIC	70	0.1	0.8	0.8	0.0	4.2	4.2
SOUTH ATLANTIC	171	0.2	0.4	0.6	−0.2	3.7	3.8
EAST NORTH CENT	126	0.2	0.3	0.5	0.0	3.8	3.4
EAST SOUTH CENT	177	0.2	−0.1	0.1	−0.1	3.3	3.4
WEST NORTH CENT	116	0.3	0.2	0.5	0.1	3.9	3.6
WEST SOUTH CENT	198	0.2	0.1	0.4	−0.6	3.0	3.2
MOUNTAIN	78	0.4	1.3	1.7	0.7	5.7	5.5
PACIFIC	38	0.4	0.9	1.3	1.8	6.4	6.0
TEACHING STATUS:							
NON-TEACHING	2889	0.3	0.0	0.3	0.1	3.7	3.7
MINOR	739	0.5	−0.4	0.1	0.0	3.4	3.3
MAJOR	283	0.1	0.3	0.5	−0.2	3.6	3.5
DSH PATIENT PERCENT:							
.0	10	2.8	2.2	5.0	0.0	8.4	8.3
GT 0–0.10	394	0.6	0.1	0.6	−0.1	3.8	3.8
0.10–0.16	467	0.5	−0.1	0.4	−0.1	3.6	3.4
0.16–0.23	764	0.4	−0.1	0.3	0.1	3.7	3.6
0.23–0.35	955	0.4	−0.1	0.3	0.0	3.6	3.6
GE 0.35	757	0.0	0.1	0.1	0.1	3.5	3.6
DSH NOT AVAILABLE**	564	−10.7	0.8	−9.9	0.2	−6.4	−6.0
URBAN TEACHING/DSH:							
TEACHING & DSH	916	0.4	−0.1	0.3	−0.1	3.5	3.4
NO TEACHING/DSH	1455	0.4	−0.1	0.3	0.1	3.7	3.7
NO TEACHING/NO DSH	9	2.8	2.2	5.0	0.0	8.4	8.3
DSH NOT AVAILABLE[2]	536	−10.7	0.8	−9.9	0.3	−6.4	−5.9
TYPE OF OWNERSHIP:							
VOLUNTARY	2146	0.4	0.0	0.4	0.0	3.6	3.5

TABLE 67.—PROPOSED IMPACT OF CHANGES FOR CY 2008 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM—Continued

	Number of hospitals	APC changes			New wage index and rural adjustment	Comb (cols 2,3) with update	All changes
		Prior to packaging proposal	Packaging proposal	Comb (cols 2A,2B)			
	(1)	(2A)	(2B)	(2)	(3)	(4)	(5)
PROPRIETARY	1179	0.0	−0.2	−0.2	0.2	3.3	3.4
GOVERNMENT	586	0.2	0.0	0.2	0.1	3.6	3.6

Column (1) shows total providers.
Column (2A) shows the impact of changes resulting from the reclassification of HCPCS codes among APC groups resulting from updated 2006 claims data and implementation of policies not related to packaging, such as proposed payment for brachytherapy sources.
Column (2B) shows the impact of changes resulting from the packaging proposal and any resulting changes to APC recalibration and discounting patterns.
Column (2) shows the combined impact of all APC reconfiguration and recalibration changes in columns 2A and 2B.
Column (3) shows the budget neutral impact of updating the wage index and rural adjustment by applying the FY 2008 hospital inpatient wage index and extending the rural adjustment to brachytherapy sources.
Column (4) shows the impact of all budget neutrality adjustments and the addition of the market basket update.
Column (5) shows the additional adjustments to the conversion factor resulting from the change in the pass-through estimate and outlier payments. This column also shows the impact of the expiring 508 wage reclassification, which ends in September 2007
* These 4,171 providers include children and cancer hospitals, which are held harmless to pre-BBA payment to cost ratios, and Community Mental Health Centers.
** Complete DSH numbers are not available for providers that are not paid under IPPS, including rehabilitation, psychiatric, and long-term care hospitals.
*** Section 1833(t)(7)(D) of the Act specifies that rural hospitals with 100 or fewer beds (that are not also sole community hospitals) receive additional payment for covered hospital outpatient services furnished during CY 2008 for which the prospective payment system amount is less than the pre-BBA amount. The amount of payment is increased by 85 percent of that difference for CY 2008.

4. Estimated Effect of This Proposed Rule on Beneficiaries

For services for which the beneficiary pays a copayment of 20 percent of the payment rate, the beneficiary share of payment would increase for services for which the OPPS payments would rise and would decrease for services for which the OPPS payments would fall. For example, for an electrocardiogram (APC 0099), the minimum unadjusted copayment in CY 2007 was $4.66. In this proposed rule, the minimum unadjusted copayment for APC 0099 is $4.98 because the OPPS payment for the service would increase under this proposed rule. In another example, for a Level IV Needle Biopsy (APC 0037), in the CY 2007 OPPS, the national unadjusted copayment was $228.76, and the minimum unadjusted copayment was $126.20. In this proposed rule, the national unadjusted copayment for APC 0037 is $228.70. The minimum unadjusted copayment for APC 0037 is $177.83, or 20 percent of the payment for APC 0037. The minimum unadjusted copayment would rise because the payment rate for APC 0037 would rise. In all cases, the statute limits beneficiary liability for copayment for a service to the inpatient hospital deductible for the applicable year. For CY 2007, the inpatient deductible is $992.

In order to better understand the impact of changes in copayment on beneficiaries, we modeled the percent change in total copayment liability using CY 2006 claims. We estimate, using the claims of the 4,171 hospitals and CMHCs on which our modeling is based, that total beneficiary liability for copayments would decline as an overall percentage of total payments from 26.6 percent in CY 2007 to 25.6 percent in CY 2008. This estimated decline in beneficiary liability is a consequence of the APC recalibration and reconfiguration we are proposing to make for CY 2008.

With respect to partial hospitalization, the copayment in CY 2007 of $46.95 would decline to $35.98 under this proposed rule as a result of the proposed decline in the per diem payment for partial hospitalization from $234.73 in CY 2007 to $179.88 for CY 2008.

5. Conclusion

The changes in this proposed rule would affect all classes of hospitals. Some classes of hospitals experience significant gains and others less significant gains, but almost all classes of hospitals would experience positive updates in OPPS payments in CY 2008. Table 67 demonstrates the estimated distributional impact of the OPPS budget neutrality requirements and an additional 3.3 percent increase in payments for CY 2008, after considering all proposed changes to APC reconfiguration and recalibration, including those resulting from the proposal to expand packaging and the proposal to pay for brachytherapy sources on a prospective payment basis, as well as the proposed market basket increase, and the estimated cost of outliers and proposed changes to the pass through estimate. The accompanying discussion, in combination with the rest of this proposed rule constitutes a regulatory impact analysis.

6. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in Table 68, we have prepared an accounting statement showing the CY 2008 estimated hospital OPPS incurred benefit impact associated with the estimated CY 2008 outpatient hospital market basket update shown in this proposed rule, based on the 2007 Trustees' Report baseline. This estimate only reflects the effect of the statutorily required market basket update and does not take into account potential enrollment, utilization, or case-mix changes. All estimated impacts are classified as transfers.

TABLE 68.—ACCOUNTING STATEMENT: CY 2008 ESTIMATED HOSPITAL OPPS INCURRED BENEFIT IMPACT ASSOCIATED WITH THE ESTIMATED CY 2008 OUTPATIENT HOSPITAL MARKET BASKET UPDATE

[in billions]

Category	Transfers
Annualized Monetized Transfers	$0.8
From Whom To Whom?	Federal Government to outpatient hospitals and other providers who receive payment under the hospital OPPS.

C. Effects of ASC Payment System Changes in This Proposed Rule

(If you choose to comment on issues in this section, please include the caption ''ASC Impact'' at the beginning of your comment.)

We are publishing elsewhere in this issue of the **Federal Register** the final rule for the revised ASC payment system, effective January 1, 2008. In the July 2007 final rule for the revised ASC payment system, we adopted the method we will use to set payment rates for ASC services furnished in association with covered surgical procedures and covered ancillary procedures beginning January 1, 2008. In that final rule, we established that the OPPS relative payment weights and payment rates will be used as the basis for the payment of most covered surgical procedures and covered ancillary services under the revised ASC payment system.

In the July 2007 final rule for the revised ASC payment system, we also established that we would update the ASC payment system annually as part of the OPPS rulemaking cycle. As part of the annual OPPS rulemaking cycle, we indicated we would update the ASC covered surgical procedures and covered ancillary services, as well as their payment rates. Such an update is very important because the OPPS relative payment weights and rates will be used as the basis for the payment of most covered surgical procedures and covered ancillary services under the revised ASC payment system. This joint update process will ensure that the ASC updates occur in a regular, predictable, and timely manner, and that the ASC payment rates immediately reflect the updated OPPS relative payment weights.

In this CY 2008 OPPS/ASC proposed rule, we are proposing to update the revised ASC payment system for CY 2008 to reflect the proposed CY 2008 OPPS relative payment weights and rates, as well as update the list of covered surgical and covered ancillary services. We are also proposing to revise the regulations to make practice expense payment to physicians who perform noncovered ASC procedures in ASCs based on the MPFS facility PE RVUs and to exclude covered ancillary radiology services and covered ancillary drugs and biologicals from the categories of DHS that are subject to the physician self-referral prohibition.

The revised Medicare ASC payment system that we are implementing beginning January 1, 2008 could have a far-reaching effect on the provision of outpatient surgical services for a number of years to come for several reasons. First, the list of procedures that will be eligible for payment under the revised ASC payment system is greatly expanded from the list of surgical procedures eligible for payment under the ASC payment system in CY 2007 and earlier years. In addition, we are moving from a limited fee schedule based on nine disparate payment groups to a payment system incorporating relative payment weights for groups of procedures with similar clinical and resource characteristics, that is, the APC groups that are the unit of payment in the OPPS.

Implementation by January 1, 2008 of a revised ASC payment system designed to result in budget neutrality is mandated by section 626 of Pub. L. 108–173. To set ASC payment rates for CY 2008 under the revised payment system, we are multiplying ASC relative payment weights for surgical procedures by an ASC conversion factor that we calculated to result in the same amount of aggregate Medicare expenditures in CY 2008 as we estimate would have been made if the revised payment system were not implemented.

The effects of the expanded number and types of procedures for which an ASC payment may be made and other policy changes that affect the revised payment system, combined with significant changes in payment rates for covered surgical procedures, will vary across ASCs, depending on whether or not the ASC limits its services to those in a particular surgical specialty area, the volume of specific services provided by the ASC, the extent to which ASCs will offer different services, and the percentage of its patients that are Medicare beneficiaries.

In the July 2007 final rule for the revised ASC payment system, we estimated the CY 2008 ASC payment rates, budget neutrality factor, and impacts using the CY 2007 OPPS relative payment weights with an estimated update factor for CY 2008, the CY 2007 MPFS PE RVUs trended forward to CY 2008, and CY 2005 utilization data projected forward to CY 2008. In that final rule, we indicated that these estimates were illustrative and that the CY 2008 ASC payment rates and budget neutrality factor would be proposed in the CY 2008 OPPS/ASC proposed rule based on the methodology for calculating budget neutrality established in the July 2007 final rule and incorporating the proposed CY 2008 OPPS relative payment weights, the proposed CY 2008 MPFS PE RVUs, and CY 2006 utilization information projected forward to CY 2008. The final CY 2008 ASC payment rates and budget neutrality factor will be established in the CY 2008 OPPS/ASC final rule with comment period, in accord with the methodology for calculating budget neutrality established in the July 2007 final rule and based on the final CY 2008 OPPS payment weights, the final CY 2008 MPFS RVUs, and updated CY 2006 utilization data projected forward to CY 2008.

Our final methodology for calculating the budget neutrality adjustment factor established in the July 2007 final rule considered not only the effects of the new payment rates to be implemented under the revised payment system, but also the estimated net effect of migration of new ASC procedures across ambulatory care settings. Both the estimated budget neutrality adjustment factor presented in the July 2007 final rule and the budget neutrality adjustment factor proposed in this rule are based on that methodology, which takes into account projected migration. In the final model, we assume that over the first 2 years of the revised payment system, approximately 25 percent of the HOPD volume of new ASC procedures would migrate from the HOPD service setting to ASCs, and that over the 4-year transition period, approximately 15 percent of the physicians' office volume

of new ASC procedures would migrate to ASCs.

We estimate that the revised ASC payment system will result in neither savings nor costs to the Medicare program in CY 2008. That is, because it is designed to be budget neutral, in CY 2008, the revised ASC payment system will neither increase nor decrease expenditures under Part B of Medicare. We further estimate that beneficiaries will save approximately $20 million under the revised ASC payment system in CY 2008, because ASC payment rates will, in most cases, be lower than OPPS payment rates for the same services and because, except for screening flexible sigmoidoscopy and screening colonoscopy procedures, beneficiary coinsurance for ASC services is 20 percent rather than 20 to 40 percent as is the case under the OPPS. (The only possible instance in which an ASC coinsurance amount could exceed the OPPS copayment amount would be when the coinsurance amount for a procedure under the revised ASC payment system exceeds the hospital inpatient deductible. Section 1833(t)(8)(C)(i) of the Act provides that the copayment amount for a procedure paid under the OPPS cannot exceed the inpatient deductible established for the year in which the procedure is performed, but there is no such requirement related to the ASC coinsurance amount.) Beneficiary coinsurance for services migrating from physicians' offices to ASCs may decrease or increase under the revised ASC payment system, depending on the particular service and whether the Medicare payment to the physician for providing that service in his or her office is higher or lower than the sum of the Medicare payment to the ASC for providing the facility portion of that service and the Medicare payment to the physician for providing that service in a facility (non-office) setting. As noted previously, the net effect of the revised ASC payment system on beneficiary coinsurance, taking into account the migration of services from HOPDs and physicians' offices, is estimated to be $20 million in beneficiary savings in CY 2008.

1. Alternatives Considered

Alternatives to the changes we are making and the reasons that we have chosen the options are discussed throughout this proposed rule. Some of the major issues discussed in this proposed rule and the options considered are discussed below.

a. Office-Based Procedures

According to our final policy for the revised ASC payment system, we designate as office-based those procedures that are added to the ASC list of covered surgical procedures in CY 2008 or later years and that we determine are predominantly performed in physicians' offices based on consideration of the most recent available volume and utilization data for each individual procedure code and/or, if appropriate, the clinical characteristics, utilization, and volume of related codes. We establish payment for procedures designated as office-based at the lesser of the MPFS nonfacility PE RVU amount or the ASC rate developed according to the standard methodology of the revised ASC payment system. In the July 2007 final rule for the revised ASC payment system, we designated a number of procedures as office-based, based on our evaluation of the most recent available CY 2005 volume and utilization data for each individual procedure code and/or related codes. In developing this proposed rule, we reviewed the newly available CY 2006 utilization data for all those surgical procedures newly added for ASC payment in CY 2008 that were assigned payment indicator ''G2'' as non-office-based additions in the July 2007 final rule for the revised ASC payment system. Based on this analysis, we are proposing to designate 19 additional procedures as office-based for CY 2008. We considered two alternatives in developing this proposal.

The first alternative we considered was to make no change to the current policy for these 19 procedures. This would mean that we would continue to pay these procedures at the standard ASC payment rate developed according to the standard methodology of the revised ASC payment system. We did not select this alternative because our analysis of the most recently available utilization data for these services and related procedures indicates that these 19 procedures could be considered to be predominantly performed in physicians' offices. We were concerned that if these services were not designated as office-based, it could create financial incentives for these procedures to shift from physicians' offices to ASCs for reasons unrelated to the most appropriate setting for surgical care.

The second alternative we considered, and the alternative we selected, is to propose to designate 19 additional procedures as office-based for CY 2008. We selected this alternative because our claims data indicate that these procedures could be considered to be predominantly performed in physicians' offices. We believe that designating these procedures as office-based, which results in the ASC payment rate for these procedures being capped at the physician office rate (that is, the MPFS nonfacility practice PE RVU amount), if applicable, is an appropriate step to ensure that Medicare payment policy does not create financial incentives for such procedures to shift unnecessarily from physicians' offices to ASCs.

b. Partial Device Credits

We are proposing to reduce the ASC payment by one half of the device offset amount for certain surgical procedures into which the device cost is packaged, when an ASC receives a partial credit toward replacement of specific implantable devices. This partial payment reduction would apply when the amount of the device credit is greater than or equal to 20 percent of the cost of the new replacement device being implanted. Under this proposed policy, both the Medicare payment to the ASC and the beneficiary coinsurance liability would be reduced when an ASC receives a partial device credit. This proposal is an extension of the policy established in the final rule for the revised ASC payment system, which reduces the ASC payment by the full device offset amount for certain devices when the ASC receives a replacement device without cost or receives a credit for the full cost of the device being replaced. This partial device credit proposal for ASCs mirrors the partial device credit proposal for the OPPS in this proposed rule. We considered several alternatives in developing this partial device credit proposal for CY 2008.

The first alternative we considered was to make no change to the current policy. Under this alternative, Medicare and the beneficiary would continue to pay the ASC the full payment rate for the device implantation procedure even if the ASC received a substantial credit towards the cost of the replacement device. The ASC payment for the device implantation procedure is based on the OPPS relative weight for the procedure, which is calculated using only OPPS claims for which the full cost of a device is billed. We did not select this alternative because we believe that, as long as the ASC payment amount is established based on an OPPS relative weight that is calculated using only claims that reflect the full cost of the device when there is no credit, there should be a reduction in the Medicare payment amount when the ASC receives a substantial credit toward cost of the replacement device. Similarly, we

believe that the beneficiary cost sharing should be based on an amount that also reflects the credit.

The second alternative we considered was to extend the current no cost/full credit reduction policy to cases of partial credit without change. This would reduce the payment in all cases in which the ASC received a credit by the full offset amount for the device implantation procedure, that is, by 100 percent of the estimated device cost included in the procedure payment rate. We did not select this alternative because we did not believe it was appropriate to reduce the payment to the ASC by the full cost of a device if the ASC only received a partial credit, and not a full credit, towards the cost of the device.

The third alternative, which we are proposing, is to reduce the ASC procedure payment by 50 percent of the offset amount (that would be applied if the ASC received full credit) in cases in which the ASC receives a partial credit greater than or equal to 20 percent of the cost of the new replacement device being implanted. Moreover, we are proposing to require the ASC to report a new modifier when the ASC receives a partial credit that is equal to or greater than 20 percent of the cost of the device being replaced. We are proposing this alternative because we believe that this approach provides an appropriate and equitable payment to the ASC from Medicare and will reduce the beneficiary's cost sharing for the service.

c. Payment to Physicians for Services Not on the ASC List of Covered Surgical Procedures

Under current policy, when physicians perform surgical procedures in ASCs that are included on the ASC list of covered surgical procedures, they are paid under the MPFS for the PE component using the facility PE RVUs. When physicians perform surgical procedures in ASCs that are not included on the ASC list of covered surgical procedures and for which Medicare does not allow facility payments to ASCs, physicians currently are paid for the PE component at the higher nonfacility rate (unless a nonfacility rate does not exist in which case Medicare pays the facility rate). In this proposed rule, we are proposing that regardless of whether a procedure is on the ASC list of covered surgical procedures, a physician performing that procedure in an ASC would receive payment based on the facility PE RVUs and excluding the technical component (TC) payment, if applicable. We considered two alternatives in developing this proposal.

The first alternative we considered was to make no change to the current policy concerning physician payment for services performed in ASCs that are not on the ASC list of covered surgical procedures. Under current policy, the physician is paid the higher nonfacility PE amount when the physician performs a service in an ASC that is not on the ASC list of covered surgical procedures (unless a nonfacility rate does not exist in which case Medicare pays the facility rate). In the final rule for the revised ASC payment system, we adopted a final policy that identifies and excludes from ASC payment only those procedures that could pose a significant risk to beneficiary safety or would be expected to require an overnight stay. Because these excluded procedures have been specifically identified by CMS as procedures that could pose a significant risk to beneficiary safety or would be expected to require an overnight stay, we do not believe it would be appropriate to provide payment based on the higher nonfacility PE RVUs to physicians who furnish them as we do not believe these procedures are safe for performance in an ASC. Consequently, we did not select this alternative.

The second alternative that we considered, and that we selected, was to propose that a physician performing a procedure in an ASC would receive payment based on the facility PE RVUs and excluding the TC payment, if applicable, regardless of whether a procedure is on the ASC list of covered surgical procedures. We selected this alternative for several reasons. We believe ASCs are facilities that are similar, insofar as the delivery of surgical and related nonsurgical services, to HOPDs. Specifically, when services are provided in ASCs, the ASC, not the physician, bears responsibility for the facility costs associated with the service. This situation parallels the hospital facility resource responsibility for hospital outpatient services. Therefore, we believe it would be more appropriate for physicians to be paid for all services furnished in ASCs just as they would be paid for all services furnished in the hospital outpatient setting. In addition, because we have adopted a final policy for the revised ASC payment system that identifies and excludes from ASC payment only those procedures that could pose a significant risk to beneficiary safety or would be expected to require an overnight stay, we believe that it would be incongruous with the revised ASC payment system methodology to continue to pay the higher nonfacility rate to physicians who furnish excluded ASC procedures.

2. Limitations of Our Analysis

Presented here are the projected effects of the policy and statutory changes that will be effective for CY 2008 on aggregate ASC utilization and Medicare payments. One limitation of this analysis is that we could only infer the effects of the revised payment system on different types of ASCs, for example, single or multispecialty, high or low volume, and urban or nonurban ASCs, based on an overall comparison of procedure volumes and facility payments between the current and the revised payment system. At this time, we do not have a provider-level dataset of CY 2006 ASC utilization that accurately identifies unique ASCs and their geographic information that would allow us to compare estimated payments and geographic adjustment among classes of ASCs based on a provider-level analysis.

A second limitation is our lack of information on ASC resource use. ASCs are not required to file Medicare cost reports and, therefore, we do not have cost information to evaluate whether or not the proposed payments for ASC services coincide with the resources required by ASCs to provide those services.

A third limitation of our analysis is our inability to predict changes in service mix between CY 2006 and CY 2008 with precision. The aggregated impact tables below are based upon a methodology that assumes no changes in service mix with respect to the CY 2006 ASC data used for this proposed rule. We believe that the net effect on Medicare expenditures of changes in service mix for current ASC covered surgical procedures will be negligible in the aggregate. Such changes may have differential effects across surgical specialties as ASCs adjust to proposed payment rates. However, we are unable to accurately project such changes at a disaggregated level. Clearly, individual ASCs will experience changes in payment that differ from the aggregated estimated changes presented below.

Because we do not have experience with ASC payment under the revised payment system, we have relied on comments and information from stakeholders in response to our August 2006 proposed rule for the revised ASC payment system to mitigate the limitations in the data available to us for analysis of the impact of the changes on classes of specialty ASCs, on physicians, and on beneficiaries. We anticipate improving the accuracy of estimated impacts over time.

3. Estimated Effects of This Proposed Rule on ASCs

a. Payment to ASCs

Some ASCs are multispecialty facilities that perform the gamut of surgical procedures, from excision of lesions to hernia repair to cataract extraction; others focus on a single specialty and perform only a limited range of surgical procedures, such as eye procedures, gastrointestinal procedures, or orthopedic surgery. The combined effect on an individual ASC of the CY 2008 revised payment system and the expanded ASC list of covered surgical procedures will depend on a number of factors, including, but not limited to, the mix of services the ASC provides, the volume of specific services provided by the ASC, the percentage of its patients who are Medicare beneficiaries, and the extent to which an ASC will choose to provide different services. The following discussion presents two tables that provide estimates of the impact of the revised ASC payment system on Medicare payments to ASC for current ASC services, assuming the same mix of services as offered by ASCs in our CY 2006 claims data. The first table depicts aggregate percent change in payment by surgical specialty group and the other compares payment for procedures estimated to receive the most payment in CY 2008 under the current payment system. A third table highlights changes in payment rates between this CY 2008 proposed rule and those in the July 2007 final rule for the revised ASC payment system for procedures estimated to receive the most payment in CY 2008 under the existing payment system.

In section XVI.C. of this proposed rule, we reiterate the transition of 4 years, where payments will generally be made using a blend of the rates based on the CY 2007 ASC payment rate and the revised ASC payment rate. In CY 2008, we will pay ASCs using a 75/25 blend, in which payment will be calculated by adding 75 percent of the CY 2007 ASC rate for a surgical procedure on the CY 2007 ASC list of covered surgical procedures and 25 percent of the revised CY 2008 ASC rate for the same procedure. For CYs 2009 and 2010, we will transition the blend first to 50/50 and then to a 25/75 blend of the CY 2007 ASC rate and the revised ASC payment rate. Beginning in CY 2011, we will pay ASCs for covered surgical procedures on the CY 2007 ASC list at the fully implemented revised ASC payment rates. We will not transition payment for procedures that were not included on the ASC list of covered surgical procedures in CY 2007; we will pay these procedures as at the fully implemented ASC rate, beginning in CY 2008.

Table 69 shows the impact of the revised payment system by surgical specialty group. We have aggregated the surgical HCPCS codes by specialty group and estimated the effect on aggregated payment for surgical specialty groups, considering separately the proposed CY 2008 transitional rate and the proposed fully implemented revised payment rate discussed above. The groups are sorted for display in descending order by estimated Medicare program payment to ASCs for CY 2008 in the absence of the revised ASC payment system. The following is an explanation of the information presented in Table 69.

- Column 1—*Surgical Specialty Group* indicates the surgical specialties into which ASC procedures are grouped. We used the CPT code range definitions and Level II HCPCS codes and Category III CPT codes, as appropriate, to account for all surgical procedures to which the proposed Medicare program payments are attributed.
- Column 2—*Estimated CY 2008 ASC Payments* in the absence of the revised ASC payment system were calculated by multiplying the CY 2007 ASC payment rate by CY 2008 ASC utilization (which is based on CY 2006 ASC utilization multiplied by a factor of 1.176 to take into account expected volume growth with volume adjustment, as appropriate, for the multiple procedure discount). The resulting amount was then multiplied by 0.8 to estimate the Medicare program's share of the total payments to the ASC. The estimated CY 2008 payment amounts are expressed in millions of dollars.
- Column 3—*Estimated CY 2008 Percent Change with Transition (75/25 Blend)* is the aggregate percentage increase or decrease in Medicare program payment to ASCs for each surgical specialty group that is attributable to proposed changes in the ASC payment rates for CY 2008 under the 75/25 blend of the CY 2007 ASC payment rate and the CY 2008 revised ASC payment rate.
- Column 4—*Estimated CY 2008 Percent Change without Transition (Fully Implemented)* is the aggregate percentage increase or decrease in Medicare program payment to ASCs for each surgical specialty group that is attributable to proposed changes in the ASC payment rates for CY 2008 if there were no transition period to the revised payment rates. The percentages appearing in column 4 are presented as a comparison for the transition policy in column 3 and do not depict the impact of the fully implemented proposal in 2011.

Table 69 depicts estimated proposed changes to ASCs' payments at the surgical specialty group level. For all but gastrointestinal procedures, if an ASC offers the same mix of services in CY 2008 that is reflected in our national CY 2006 claims data, proposed Medicare payments to the ASC for services in that surgical specialty group are expected to increase under the revised payment system. If the revised payment system was fully implemented in CY 2008, we would expect all but gastrointestinal procedures and nervous system procedures to receive greater Medicare payment. In addition to the impacts on Medicare payments for current ASC procedures shown in Table 69, it is important to note that estimated CY 2008 payments to ASCs are estimated to increase by more than $240 million in CY 2008 due to projected migration of new ASC services from HOPDs and physician offices to ASC. This increased spending in ASCs is projected to be fully offset by savings from reduced spending in HOPDs and physicians' offices due to service migration.

TABLE 69.—ESTIMATED CY 2008 IMPACT OF THE REVISED ASC PAYMENT SYSTEM ON ESTIMATED AGGREGATE PROPOSED CY 2008 MEDICARE PROGRAM PAYMENTS UNDER THE 75/25 TRANSITION BLEND AND WITHOUT A TRANSITION, BY SURGICAL SPECIALTY GROUP

Surgical specialty group	Estimated CY 2008 ASC payments (in millions)	Estimated CY 2008 percent change with transition (75/25 blend)	Estimated CY 2008 percent change without transition (fully implemented)
(1)	(2)	(3)	(4)
Eye and ocular adnexa	$1,205	1	5
Digestive system	661	−4	−14
Nervous system	251	3	−2
Musculoskeletal system	148	25	100
Integumentary system	81	8	34
Genitourinary system	68	12	46
Respiratory system	19	18	72
Cardiovascular system	7	25	98
Auditory system	4	24	83
Hemic and lymphatic systems	2	32	129
Other systems	0.1	29	116

Table 70 below shows the estimated impact of the revised payment system on proposed aggregate ASC payments for selected procedures during the first year of implementation (CY 2008) with and without the transitional blended rate. The table displays 30 of the procedures receiving the highest estimated CY 2008 ASC payments under the existing Medicare payment system. The HCPCS codes are sorted in descending order by estimated program payment.

- Column 1—*HCPCS code*
- Column 2—*Short Descriptor* of the HCPCS code
- Column 3—*Estimated CY 2008 ASC Payments* in the absence of the revised payment system were calculated by multiplying the CY 2007 ASC payment rate by CY 2008 ASC utilization (which is based on CY 2006 ASC utilization multiplied by a factor of 1.176 to take into account expected volume growth with volume adjustment, as appropriate, for the multiple procedure discount). The resulting amount was then multiplied by 0.8 to estimate the Medicare program's share of the total payments to the ASC. The estimated CY 2008 payment amounts are expressed in millions of dollars.
- Column 4—*CY 2008 Proposed Percent Change with Transition (75/25 Blend)* reflects the percent differences between the estimated ASC payment rates for CY 2008 under the current system and the proposed payment rates for CY 2008 under the revised system, incorporating a 75/25 blend of the estimated ASC payment using the CY 2007 ASC payment rate and the CY 2008 revised ASC payment rate.
- Column 5—*CY 2008 Proposed Percent Change without Transition (Fully Implemented)* reflects the percent differences between the estimated ASC payment rates for CY 2008 under the current system and the proposed estimated payment rates for CY 2008 under the revised payment system if there were no transition period to the revised payment rates. The percentages appearing in column 5 are presented as a comparison for the transition policy in column 4 and do not depict the impact of the fully implemented proposal in 2011.

TABLE 70.—ESTIMATED CY 2008 IMPACT OF PROPOSED REVISED ASC PAYMENT SYSTEM ON AGGREGATE PAYMENTS FOR PROCEDURES WITH THE HIGHEST ESTIMATED CY 2008 PAYMENTS UNDER THE CURRENT SYSTEM

HCPCS code	Short Descriptor	Estimated CY 2008 ASC payments (in millions)	Estimated CY 2008 percent change (75/25 blend)	Estimated CY 2008 percent changes without transition (fully implemented)
(1)	(2)	(3)	(4)	(5)
66984	Cataract surg w/iol, 1 stage	$981	1	3
43239	Upper GI endoscopy, biopsy	143	−5	−19
45378	Diagnostic colonoscopy	133	−4	−16
45380	Colonoscopy and biopsy	110	−4	−16
66821	After cataract laser surgery	87	−8	−31
45385	Lesion removal colonoscopy	87	−4	−16
62311	Inject spine l/s (cd)	70	−3	−11
64483	Inj foramen epidural l/s	42	−3	−11
66982	Cataract surgery, complex	37	1	3
45384	Lesion remove colonoscopy	36	−4	−16
15823	Revision of upper eyelid	35	5	21
G0121	Colon ca scrn not hi rsk ind	34	−6	−26
G0105	Colorectal scrn; hi risk ind	27	−6	−26
64476	Inj paravertebral l/s ADD-on	24	−12	−48
64475	Inj paravertebral l/s	24	−3	−11

TABLE 70.—ESTIMATED CY 2008 IMPACT OF PROPOSED REVISED ASC PAYMENT SYSTEM ON AGGREGATE PAYMENTS FOR PROCEDURES WITH THE HIGHEST ESTIMATED CY 2008 PAYMENTS UNDER THE CURRENT SYSTEM—Continued

HCPCS code	Short Descriptor	Estimated CY 2008 ASC payments (in millions)	Estimated CY 2008 percent change (75/25 blend)	Estimated CY 2008 percent changes without transition (fully implemented)
(1)	(2)	(3)	(4)	(5)
43235	Uppr gi endoscopy, diagnosis	23	2	8
52000	Cystoscopy	21	−6	−24
67904	Repair eyelid defect	16	7	26
64721	Carpal tunnel surgery	15	18	72
29881	Knee arthroscopy/surgery	15	23	94
43248	Uppr gi endoscopy/guide wire	14	−5	−19
62310	Inject spine c/t	12	−3	−11
64484	Inj foramen epidural ADD-on	11	−3	−11
29880	Knee arthroscopy/surgery	11	23	94
G0260	Inj for sacroiliac jt anesth	9	−3	−11
28285	Repair of hammertoe	9	18	72
67038	Strip retinal membrane	9	30	120
29848	Wrist endoscopy/surgery	9	−2	−9
64623	Destr paravertebral n ADD-on	9	−3	−11
45383	Lesion removal colonoscopy	8	−4	−16

Over time, we believe that the current ASC payment system has served as an incentive to ASCs to focus on providing procedures for which they determine Medicare payments would support the ASC's continued operation. We would expect that, under the existing payment system, the ASC payment rates for many of the most frequently performed procedures in ASCs are similar to the OPPS payment rates for the same procedures. Conversely, we would expect that procedures with existing ASC payment rates that are substantially lower than the OPPS rates would be performed least often in ASCs. We believe the revised ASC payment system represents a major stride towards encouraging greater efficiency in ASCs and promoting a significant increase in the breadth of surgical procedures performed in ASCs, because it distributes payments across the entire spectrum of covered surgical procedures, based on a coherent system of relative payment weights that are related to the clinical and facility resource characteristics of those procedures.

Table 70 identifies a number of ASC procedures receiving the highest estimated CY 2008 payment under the current system and shows that most of them will experience payment decreases in CY 2008 under the revised ASC payment system. This contrasts with the estimated aggregate payment increases at the surgical specialty group level displayed in Table 69. In fact, Table 69 shows only one surgical specialty group of procedures for which the proposed payments are expected to decrease in the first year under the revised ASC payment system, and only two groups for which a decrease would be expected if there were no transition period to the revised CY 2008 payment rates. The estimated increased payments at the full group level are due to the moderating effect of the proposed payment increases for the less frequently performed procedures within the surgical specialty group. The exception to this is the surgical specialty group of eye and ocular adnexa where the projected aggregate increase in CY 2008 under the revised system is driven by a small proposed increase, 1 percent, in payment for the highest volume procedure (CPT code 66984, Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedures), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification)).

As a result of the redistribution of payments across the expanded breadth of surgical procedures for which Medicare will provide an ASC payment, we believe that ASCs may change the mix of services they provide over the next several years. The revised ASC payment system should encourage ASCs to expand their service mix beyond the handful of the highest paying procedures which comprise the majority of ASC utilization under the existing ASC payment system. For example, although the proposed payment rate for cystoscopy (CPT code 52000), the highest volume ASC genitourinary procedure, is 6 percent less for CY 2008 than under the existing payment system, overall proposed payment to ASCs for the group of genitourinary procedures currently performed in ASCs is expected to increase by 12 percent. Although a urology specialty ASC may currently perform more cystoscopy procedures than any other genitourinary procedure, we believe that under the revised ASC payment system, each ASC has the opportunity to adapt to the payment decrease for its most frequently performed procedures by offering an increased breadth of procedures, still within the clinical specialty area, and receive payments that are adequate to support continued operations. Similarly, proposed payment for all of the highest volume pain management injection procedures are expected to decrease in CY 2008, although payment for nervous system procedures overall are expected to increase. However, without a transition for CY 2008, we estimate that payments also would decrease slightly for the nervous system surgical specialty group.

For those procedures that will be paid a significantly lower amount under the revised payment system than they are currently paid, we believe that their current payment rates, which are closer to the OPPS payment rates than other ASC procedures, are likely to be generous relative to ASC costs, so ASCs would, in all likelihood, continue performing those procedures under the revised payment system. We also note that the majority of the most frequently performed ASC procedures specifically studied by the GAO, as described in the July 2007 final rule for the revised ASC payment system, appear in Table 70 with proposed payment decreases under

the revised ASC payment system. The GAO concluded that for these procedures the OPPS APC groups accurately reflect the relative costs of procedures performed at ASCs and that ASCs have substantially lower costs.

For some procedures the proposed payment amounts in CY 2008 are much higher than the CY 2007 rates currently paid to ASCs. For example, payment for CPT code 67038 (Vitrectomy, mechanical, pars plana approach; with epiretinal membrane stripping) increases by 30 percent compared to estimated CY 2008 payments under the current system. Similarly, the proposed CY 2008 ASC payment for CPT code 29880 (Arthroscopy, knee, surgical; with meniscetomy (medial AND lateral, including any meniscal shaving)) increases by 23 percent. For these two procedures and the other procedures with estimated payment increases greater than 10 percent, the increases are due to the comparatively higher OPPS rates which, when adjusted by the ASC budget neutrality factor and blended with the CY 2007 ASC payment amounts, generate CY 2008 ASC payment rates that are substantially above the current CY 2007 ASC payment amounts.

As proposed in this rule, payments for most of the highest volume colonoscopy and upper gastrointestinal endoscopy procedures will decrease under the revised payment system. Table 69 estimates that payment decreases also are expected for the gastrointestinal surgical specialty group overall. We believe that decreased payments for so many of the gastrointestinal procedures are because current ASC payment rates are close to the OPPS rates. Procedures with current payment rates that are nearly as high as their OPPS rates are negatively affected under the revised payment system while procedures for which ASC rates have historically been much lower than the comparable OPPS rates are positively affected. The payment decreases expected in the first year under the revised ASC payment system for some of the high volume gastrointestinal procedures are not large (all less than 7 percent). We believe that ASCs can generally continue to cover their costs for these procedures, and that ASCs specializing in providing those services will be able to adapt their business practices and case mix to manage declines for individual procedures.

In addition to the procedures currently on the ASC list of covered surgical procedures discussed above, in CY 2008 we also are adding hundreds of surgical procedures to the already extensive list of procedures for which Medicare allows payment to ASCs, creating new opportunities for ASCs to expand their range of covered surgical procedures. For the first time, ASCs will be paid separately for covered ancillary services that are integral to covered surgical procedures, including certain radiology procedures, costly drugs and biologicals, devices with pass-through status under the OPPS, and brachytherapy sources. While separately paid radiology services will be paid based on their ASC relative payment weight calculated according to the standard rate-setting methodology of the revised ASC payment system or to the MPFS nonfacility practice expense amount, whichever is lower, the other items newly eligible for separate payment in ASCs will be paid comparably to their OPPS rates because we would not expect ASCs to experience efficiencies in providing them. Lastly, the July 2007 final rule for the revised ASC payment system established a specific payment methodology for device-intensive procedures that provides the same packaged payment for the device as under the OPPS, while providing a reduced service payment that is subject to the 4-year transition if the device-intensive procedure is on the CY 2007 ASC list of covered surgical procedures. We expect that this final methodology will allow ASCs to continue to expand their provision of device-intensive services and to begin performing new device intensive ASC procedures.

Table 71 displays a comparison of the Medicare payment rates for ASC procedures receiving the highest estimated CY 2008 payment under the current ASC payment system, based on the estimates provided in the July 2007 ASC final rule for illustrative purposes, and the proposed payment rates presented in this CY 2008 OPPS/ASC proposed rule.

- Column 1—*HCPCS code.*
- Column 2—*Short Descriptor* of the HCPCS code.
- Column 3—*Estimated CY 2008 ASC Payments* in the absence of the revised payment system were calculated by multiplying the CY 2007 ASC payment rate by CY 2008 ASC utilization (which is based on CY 2006 ASC utilization multiplied by a factor of 1.176 to take into account expected volume growth with volume adjustment, as appropriate, for the multiple procedure discount). The resulting amount was then multiplied by 0.8 to estimate the Medicare program's share of the total payments to the ASC. The estimated CY 2008 payment amounts are expressed in millions of dollars.
- Column 4—*Final Rule Estimated CY 2008 Payment Rate with Transition* (75/25 Blend) presents the estimated CY 2008 payment rate from the July 2007 final rule for the revised ASC payment system.
- Column 5—*Proposed Rule Estimated CY 2008 Payment Rate* presents the proposed CY 2008 payment rate in this proposed rule.
- Column 6—*Estimated Percent Change from Final Rule to Proposed Rule* presents the percent change in the payment rate from the final rule to this proposed rule.

Table 71 shows that although the estimated ASC budget neutrality percentage has changed from the July 2007 final rule for the revised ASC payment system (67 percent) to this CY 2008 OPPS/ASC proposed rule (65 percent), payment rates for individual procedures generally change very little from the final rule to this proposed rule. Due to the proposed OPPS APC recalibration for CY 2008, including the OPPS packaging proposal, the CY 2008 OPPS payment rates are typically increasing slightly for many surgical procedures compared to the CY 2007 OPPS payment rates. Because the proposed CY 2008 ASC payment rates in this proposed rule are a product of typically higher OPPS payment rates and a slightly lower budget neutrality factor (as compared to the final rule on the revised ASC payment system), these two forces in many cases balance each other, and the resulting ASC payment rates estimated in this proposed rule for many procedures change little compared with the final rule for the revised ASC payment system. Because we have not revised our budget neutrality methodology nor other ASC ratesetting policies from the July 2007 final rule, to the extent that there are significant observed changes for particular surgical procedures in estimated payment rates between the final rule and this proposed rule, these reflect more specific changes in the OPPS payment rates stemming from the proposed APC recalibration, including the effects of the OPPS packaging proposal, under the proposed CY 2008 OPPS.

TABLE 71.—COMPARISON OF ESTIMATED CY 2008 MEDICARE PAYMENT RATES IN THE JULY 2007 FINAL RULE FOR THE REVISED ASC PAYMENT SYSTEM AND CY 2008 OPPS/ASC PROPOSED RULE FOR PROCEDURES WITH THE HIGHEST ESTIMATED CY 2008 PAYMENTS UNDER THE CURRENT SYSTEM

HCPCS code	Short Descriptor	Estimated CY 2008 ASC payments (in millions)	July 2007 ASC final rule estimated CY 2008 payment rate (75/25 blend)	Proposed rule estimated CY 2008 payment rate (75/25 blend)	Estimated percent change from July 2007 ASC final rule to proposed rule
66984	Cataract surg w/iol, 1 stage	$981	$981.09	$980.43	0
43239	Upper GI endoscopy, biopsy	143	422.96	424.27	0
45378	Diagnostic colonoscopy	133	427.76	428.0	2
45380	Colonoscopy and biopsy	110	427.76	428.02	0
66821	After cataract laser surgery	87	288.45	288.60	0
45385	Lesion removal colonoscopy	87	427.76	428.02	0
62311	Inject spine l/s (cd)	70	317.40	323.62	2
64483	Inj foramen epidural l/s	42	317.40	323.62	2
66982	Cataract surgery, complex	37	981.09	980.43	0
45384	Lesion remove colonoscopy	36	427.76	428.02	0
15823	Revision of upper eyelid	35	687.02	754.42	10
G0121	Colon ca scrn not hi rsk ind	34	417.98	417.44	0
G0105	Colorectal scrn; hi risk ind	27	417.98	417.44	0
64476	Inj paravertebral l/s ADD-on	24	310.64	292.80	−6
64475	Inj paravertebral l/s	24	317.40	323.62	2
43235	Uppr gi endoscopy, diagnosis	23	338.21	339.52	0
52000	Cystoscopy	21	318.83	312.97	−2
67904	Repair eyelid defect	16	654.63	671.51	3
64721	Carpal tunnel surgery	15	524.35	526.05	0
29881	Knee arthroscopy/surgery	15	776.94	777.27	0
43248	Uppr gi endoscopy/guide wire	14	422.96	424.27	0
62310	Inject spine c/t	12	317.40	323.62	2
64484	Inj foramen epidural ADD-on	11	317.40	323.62	2
29880	Knee arthroscopy/surgery	11	776.94	777.27	0
G0260	Inj for sacroiliac jt anesth	9	310.64	323.62	4
28285	Repair of hammertoe	9	599.75	601.67	0
67038	Strip retinal membrane	9	935.83	932.21	0
29848	Wrist endoscopy/surgery	9	1,308.69	1,309.02	0
64623	Destr paravertebral n ADD-on	9	317.40	323.62	2
45383	Lesion removal colonoscopy	8	427.76	428.02	0

b. Payment to Physicians for Performing Excluded ASC Procedures in an ASC

As discussed in section XVI.G. of this proposed rule, we are proposing to pay physicians at the facility rate for furnishing procedures in ASCs that are excluded from the ASC list of covered procedures. This policy reduces site of service (facility versus nonfacility) differentials that currently exist and aligns physician payment policies for services furnished in ASCs and hospital outpatient departments.

We believe that the effect of the proposed change will be small. Currently, physicians are paid for procedures performed in ASCs that are not on the list of ASC covered surgical procedures based on the nonfacility PE RVUs, unless a nonfacility rate does not exist in which case they are paid based on the facility rate. For CY 2008, we excluded procedures from the ASC list of covered surgical procedures because they could pose a significant risk to beneficiary safety or would be expected to require an overnight stay and, as such, these procedures are generally more complex than procedures furnished in physicians' offices. Consequently, most surgical procedures that will be excluded from the list of ASC covered surgical procedures in CY 2008 do not have nonfacility PE RVUs. Specifically, only 25 of approximately 280 excluded ASC procedures for CY 2008 have nonfacility PE RVUs. As a result, even under our current policy, physicians performing an excluded ASC procedure in an ASC would be paid for most excluded procedures based on the facility PE RVUs. Thus, our proposed policy to pay physicians for excluded ASC procedures performed in ASCs based on the facility PE RVUs would only impact Medicare payment rates for the small proportion of excluded procedures that have nonfacility PE RVUs.

4. Estimated Effects of This Proposed Rule on Beneficiaries

a. Payment to ASCs

We estimate that the changes for CY 2008 will be positive for beneficiaries in at least two respects. Except for screening colonoscopy and flexible sigmoidoscopy procedures, the ASC coinsurance rate for all procedures is 20 percent. This contrasts with procedures performed in HOPDs where the beneficiary is responsible for copayments that range from 20 percent to 40 percent. In addition, ASC payment rates under the revised payment system are lower than payment rates for the same procedures under the OPPS, so the beneficiary coinsurance amount under the ASC payment system almost always will be less than the OPPS copayment amount for the same services. (The only exceptions will be when the ASC coinsurance amount exceeds the inpatient deductible. The statute requires that copayment amounts under the OPPS not exceed the inpatient deductible.) Beneficiary coinsurance for services migrating from physicians' offices to ASCs may decrease or increase under the revised ASC payment system, depending on the particular service and the relative payment amounts for that service in the physician's office compared with the ASC. As noted previously, the net effect of the revised

ASC payment system on beneficiary coinsurance, taking into account the migration of services from HOPDs and physicians' offices, is estimated to be $20 million in beneficiary savings in CY 2008.

In addition to the lower out-of-pocket expenses, we believe that beneficiaries also will have access to more services in ASCs as a result of the addition of approximately 790 surgical procedures to the ASC list of covered surgical services eligible for Medicare payment. We expect that ASCs will provide a broader range of surgical services under the revised payment system and that beneficiaries will benefit from having access to a greater variety of surgical procedures in ASCs.

b. Payment to ASCs for Excluded Procedures Performed in an ASC

In addition, the proposed revision to § 414.22(b)(5)(i) (A) and (B) would impose beneficiary liability for facility costs associated with surgical procedures that are not Medicare covered surgical procedures in ASCs. In the July 2007 final rule for the revised ASC payment system, CMS determined that the only surgical procedures that will be excluded from ASC payment in CY 2008 are those that could pose a significant safety risk to beneficiaries when furnished in an ASC or are expected to require an overnight stay when furnished in ASCs and, therefore, Medicare provides no payment to ASCs for these procedures. The proposed revision to § 414.22(b)(5)(i)(A) and (B) would also provide for no payment to physicians for the facility resources required to furnish these services, leaving the beneficiary liable for the facility payment if a surgical procedure excluded by Medicare from ASC payment is, in fact, performed in the ASC setting. In reality, however, we do not expect that the proposed change would result in a meaningful increase in beneficiary liability because we do not expect that these excluded services, which we have determined could pose a significant risk to beneficiary safety or would be expected to require an overnight stay, will be furnished to Medicare beneficiaries in ASCs. We expect further that physicians and ASCs would advise beneficiaries of all of the possible consequences (including denial of Medicare payment with concomitant beneficiary liability and significant surgical risk) if surgical procedures excluded from ASC payment were provided in ASCs.

5. Conclusion

The changes to the ASC payment system for CY 2008 will affect each of the approximately 4,600 ASCs currently approved for participation in the Medicare program. The effect on an individual ASC will depend on the ASC's mix of patients, the proportion of the ASC's patients that are Medicare beneficiaries, the degree to which the payments for the procedures offered by the ASC are changed under the revised payment system, and the degree to which the ASC chooses to provide a different set of procedures.

The revised ASC payment system is designed to result in the same aggregate amount of Medicare expenditures in CY 2008 that would be made in the absence of the revised ASC payment system. As mentioned previously, we estimate that the revised ASC payment system and the expanded ASC list of covered surgical procedures that we are implementing in CY 2008 will have no net effect on Medicare expenditures compared to the level of Medicare expenditures that would have occurred in CY 2008 in the absence of the revised payment system. However, there will be a total increase in Medicare payments to ASCs for CY 2008 of approximately $240 million as a result of the revised ASC payment system, which will be fully offset by savings from reduced Medicare spending in HOPDs and physicians' offices on services that migrate from these settings to ASCs (as discussed in detail in section XVI.L. of this proposed rule). Furthermore, we estimate that the revised ASC payment system will result in Medicare savings of $200 million over 5 years due to migration of new ASC services from HOPDs and physicians' offices to ASCs over time. We anticipate that this proposed rule will have a significant economic impact on a substantial number of small entities.

6. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehousegov/omb/circulars/a004/a-4.pdf)*, in Table 72 below, we have prepared an accounting statement showing the classification of the expenditures associated with the implementation of the CY 2008 revised ASC payment system, based on the provisions of this final rule. As explained above, we estimate that Medicare payments to ASCs for CY 2008 will be about $240 million higher than they otherwise would be in the absence of the revised ASC payment system. This $240 million in additional payments to ASCs will be fully offset by savings from reduced Medicare spending in HOPDs and physicians' offices on services that migrate from these settings to ASCs. This table provides our best estimate of Medicare payments to providers and suppliers as a result of the CY 2008 revised ASC payment system, as presented in this proposed rule. All expenditures are classified as transfers.

TABLE 72.—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES FROM CY 2007 TO CY 2008 AS A RESULT OF THE CY 2008 REVISED ASC PAYMENT SYSTEM

Category	Transfers
Annualized Monetized Transfers	$0 Million.
From Whom to Whom	Federal Government to Medicare Providers and Suppliers.
Annualized Monetized Transfer	0 Million.
From Whom to Whom	Premium Payments from Beneficiaries to Federal Government.
Total	0 Million.

D. Effects of the Proposed Requirements for Reporting of Quality Data for Hospital Outpatient Settings

In section XVII. of this proposed rule, we discuss our proposed measures and requirements for reporting of quality data to CMS for services furnished in hospital outpatient settings under the HOP QDRP. We also note that, for the CY 2009 payment update, hospitals must pass our validation requirement of a minimum of 80 percent reliability, based upon our chart-audit validation process, for January 2008. These data are due to the OPPS Clinical Warehouse by May 31, 2008. CMS and its contractors will provide assistance to all hospitals that wish to submit data. As noted in section XVIII of this proposed rule, we are also providing additional validation criteria to ensure that the quality data being sent to CMS are accurate. The requirement of 5 charts

per hospital will result in the submission of approximately 21,500 charts for services furnished in January 2008 to the agency. We reimburse hospitals for the cost of sending charts to the Clinical Data Abstraction Center (CDAC) at the rate of 12 cents per page for copying and approximately $4.00 per chart for postage. Our experience shows that the average inpatient chart received at the CDAC is approximately 150 pages, and we estimate outpatient charts will contain a similar number of pages. Thus, the agency estimates that it will have expenditures of approximately $473,200 to collect the January 2008 charts. Given that we reimburse for the copying and mailing related to this data collection effort, we believe that a requirement for five charts per hospital for services furnished in January 2008 represents a minimal burden to the participating hospital.

E. Effects of the Proposed Policy on CAH Off-Campus and Co-Location Requirements

In section XVIII.A. of this proposed rule, we discuss our proposed changes regarding a CAH's ability to co-locate with another acute care hospital or establish an off-campus location that does not comply with the location requirements (more than a 35-mile drive, or in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) for CAHs. We are proposing to clarify in this proposed rule that if a CAH with a necessary provider designation has a co-location arrangement with another hospital or CAH that was in effect before January 1, 2008, and the type and scope of services offered by the facilities co-located with the necessary provider CAH do not change, the CAH can continue those arrangements. In addition, if a CAH (including one with a necessary provider designation) operates a provider-based location or an off-campus distinct part psychiatric or rehabilitation unit after January 1, 2008, the CAH must comply with the location requirements. We have proposed that CAHs can continue current co-location and off-campus arrangements that are in place as of January 1, 2008. We believe there is no burden associated with this proposed clarifying regulation.

F. Effects of Proposed Policy Revisions to the Hospital CoPs

In section XVIII.B. of this proposed rule, we discuss proposed changes to the hospital CoPs relating to timeframes for completion of medical history and physical examination and proposed requirements for preanesthesia and postanesthesia evaluations of Medicare beneficiaries. We believe that these proposed revisions would impose minimal additional costs on hospitals. In fact, hospitals may realize some minimal cost savings. The cost of implementing these proposed changes would largely be limited to the one-time cost related to the revision of a hospital's medical staff bylaws and its policies and procedures as they relate to the proposed requirements for medical history and physical examinations and for preanesthesia and postanesthesia evaluations. There also may be some minimal cost associated with communicating these changes to affected hospital staff. However, we believe that these costs would be offset by the benefits derived from the overall intent of these proposed revisions to require that the most current information regarding a patient's condition be available to hospital staff so that risks to patient safety can be minimized and potential adverse outcomes can be avoided. Furthermore, the proposed changes would clarify existing hospital CoPs to make them more consistent with current practice, while still retaining the flexibility and reduction in burden that hospitals are currently provided in meeting those CoPs. Therefore, no burden is being assessed on the revision of medical staff bylaws and hospital policies and procedures or on the communication of these revisions to staff that would be required by these proposed revisions as these practices are usual and customary business practices.

G. Executive Order 12866

In accordance with the provisions of Executive Order 12866, this proposed rule was reviewed by the OMB.

List of Subjects

42 CFR Part 410

Health facilities, Health professions, Laboratories, Medicare, Rural areas, X rays.

42 CFR Part 411

Kidney diseases, Medicare, Physician referral, Reporting and recordkeeping requirements.

42 CFR Part 414

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

42 CFR Part 416

Health facilities, Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 419

Hospitals, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 482

Grant program-health, Hospitals, Medicaid, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 485

Grant program-health, Health facilities, Medicaid, Medicare, Reporting and recordkeeping requirements.

For reasons stated in the preamble of this proposed rule, the Centers for Medicare & Medicaid Services is proposing to amend 42 CFR Chapter IV as set forth below:

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

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

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

2. Section 410.27 is amended by—
a. Revising paragraph (a)(1)(iii).
b. Revising paragraph (f).
The revisions read as follows:

§ 410.27 Outpatient hospital services and supplies incident to a physician service: Conditions.

(a) * * *
(1) * * *
(iii) In the hospital or at a department of a provider, as defined in § 413.65(a)(2) of this subchapter, that has provider-based status in relation to a hospital under § 413.65 of this subchapter; and
* * * * * *

(f) Services furnished at a department of a provider, as defined in § 413.65(a)(2) of this subchapter, that has provider-based status in relation to a hospital under § 413.65 of this subchapter, must be under the direct supervision of a physician. ''Direct supervision'' means the physician must be present and on the premises of the location and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

3. The authority citation for Part 411 continues to read as follows:

Authority: Secs. 1102, 1860D–1 through 1860D–42, 1871, and 1877 of the Social

Security Act (42 U.S.C. 1302, 1395w-101 through 1395w-152, and 1395nn.

4. Section 411.351 is amended by revising the definitions of ''outpatient prescription drugs'' and ''radiology and certain other imaging services'' to read as follows:

§ 411.351 Definitions.

* * * * *

Outpatient prescription drugs means all drugs covered by Medicare Part B or D, except for those drugs that are ''covered ancillary services,'' as defined at § 416.164(b) of this chapter, for which separate payment is made to an ambulatory surgical center.

* * * * *

Radiology and certain other imaging services means those particular services so identified on the List of CPT/HCPCS Codes. All services identified on the List of CPT/HCPCS Codes are radiology and certain other imaging services for purposes of this subpart. Any service not specifically identified as radiology and certain other imaging services on the List of CPT/HCPCS Codes is not a radiology or certain other imaging service for purposes of this subpart. The list of codes identifying radiology and certain other imaging services includes the professional and technical components of any diagnostic test or procedure using x-rays, ultrasound, computerized axial tomography, magnetic resonance imaging, nuclear medicine (effective January 1, 2007), or other imaging services. All codes identified as radiology and certain other imaging services are covered under section 1861(s)(3) of the Act and § 410.32 and § 410.34 of this chapter, but do not include—

(1) X ray, fluoroscopy, or ultrasound procedures that require the insertion of a needle, catheter, tube, or probe through the skin or into a body orifice;

(2) Radiology or certain other imaging services that are integral to the performance of a medical procedure that is not identified on the list of CPT/HCPCS codes as a radiology or certain other imaging service and is performed—

(i) Immediately prior to or during the medical procedure; or

(ii) Immediately following the medical procedure when necessary to confirm placement of an item placed during the medical procedure.

(3) Radiology and certain other imaging services that are ''covered ancillary services,'' as defined at § 416.164(b), for which separate payment is made to an ASC.

* * * * *

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

5. The authority citation for Part 414 continues to read as follows:

Authority: Secs. 1102, 1871, and 1881(b)(1) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr(b)(1)).

6. Section 414.22 is amended by revising paragraphs (b)(5)(i)(A) and (B) to read as follows:

§ 414.22 Relative value units (RVUs).

* * * * *

(b) * * *

(5) * * *

(i) * * *

(A) *Facility practice expense RVUs.* The lower facility practice expense RVUs apply to services furnished to patients in the hospital, skilled nursing facility, community mental health center, or in an ambulatory surgical center. (The facility practice expense RVUs for a particular code may not be greater than the nonfacility RVUs for the code.)

(B) *Nonfacility practice expense RVUs.* The higher nonfacility practice expense RVUs apply to services performed in a physician's office, a patient's home, a nursing facility, or a facility or institution other than a hospital or skilled nursing facility, community mental health center, or ASC.

* * * * *

PART 416—AMBULATORY SURGICAL SERVICES

7. The authority citation for Part 416 continues to read as follows:

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

8. Added in a separate final rule published elsewhere in this issue of the **Federal Register**, § 416.179 is amended by—

a. Revising the section heading.

b. Revising paragraphs (a)(1) and (a)(2)

c. Adding new paragraph (a)(3).

d. Redesignating the text of paragraph (b) as paragraph (b)(1).

e. Revising newly redesignated paragraph (b)(1).

f. Adding new paragraph (b)(2).

The revisions and additions read as follows:

§ 416.179 Payment and coinsurance reduction for devices replaced without cost or when full or partial credit is received.

(a) * * *

(1) The device is replaced without cost to the ASC or the beneficiary;

(2) The ASC receives full credit for the cost of a replaced device; or

(3) The ASC receives partial credit for the cost of a replaced device but only where the amount of the device credit is greater than or equal to 20 percent of the cost of the new replacement device being implanted.

(b) *Amount of reduction to the ASC payment for the covered surgical procedure.* (1) The amount of the reduction to the ASC payment made under paragraphs (a)(1) and (a)(2) of this section is calculated in the same manner as the device payment reduction that would be applied to the ASC payment for the covered surgical procedure in order to remove predecessor device costs so that the ASC payment amount for a device with pass-through status under § 419.66 of this subchapter represents the full cost of the device, and no packaged device payment is provided through the ASC payment for the covered surgical procedure.

(2) The amount of the reduction to the ASC payment made under paragraph (a)(3) of this section is 50 percent of the payment reduction that would be calculated under paragraph (b)(1) of this section.

* * * * *

PART 419—PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

9. The authority citation for Part 419 continues to read as follows:

Authority: Secs. 1102, 1833(t), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395l(t), and 1395hh).

10. Section 419.43 is amended by revising paragraph (g)(4) to read as follows:

§ 419.43 Adjustments to national program payment and beneficiary copayment amounts.

* * * * *

(g) * * *

(4) *Excluded services and groups.* Drugs and biologicals that are paid under a separate APC and devices paid under § 419.66 are excluded from qualification for the payment adjustment in paragraph (g)(2) of this section.

* * * * *

11. Section 419.44 is amended by—

a. Revising the section heading.

b. Revising paragraph (b).

The revisions and addition read as follows:

§ 419.44 Payment reductions for procedures.

* * * * *

(b) *Interrupted procedures.* When a procedure is terminated prior to

completion due to extenuating circumstances or circumstances that threaten the well-being of the patient, the Medicare program payment amount and the beneficiary copayment amount are based on—

(1) The full program and beneficiary copayment amounts if the procedure for which anesthesia is planned is discontinued after the induction of anesthesia or after the procedure is started;

(2) One-half the full program and the beneficiary copayment amounts if the procedure for which anesthesia is planned is discontinued after the patient is prepared and taken to the room where the procedure is to be performed but before anesthesia is induced; or

(3) One-half of the full program and beneficiary copayment amounts if a procedure for which anesthesia is not planned is discontinued after the patient is prepared and taken to the room where the procedure is to be performed.

12. Section 419.45 is amended by—

a. Revising the section heading.

b. Revising paragraph (a)(1).

c. Revising paragraph (a)(2).

d. Adding new paragraph (a)(3).

e. Revising paragraph (b).

The revisions and additions read as follows:

§ 419.45 Payment and copayment reduction for devices replaced without cost or when full or partial credit is received.

(a) * * *

(1) The device is replaced without cost to the provider or the beneficiary;

(2) The provider receives full credit for the cost of a replaced device; or

(3) The provider receives partial credit for the cost of a replaced device but only where the amount of the device credit is greater than or equal to 20 percent of the cost of the new replacement device being implanted.

(b) *Amount of reduction to the APC payment.*

(1) The amount of the reduction to the APC payment made under paragraphs (a)(1) and (a)(2) of this section is calculated in the same manner as the offset amount that would be applied if the device implanted during a procedure assigned to the APC had transitional pass-through status under § 419.66.

(2) The amount of the reduction to the APC payment made under paragraph (a)(3) of this section is 50 percent of the offset amount that would be applied if the device implanted during a procedure assigned to the APC had transitional pass-through status under § 419.66.

* * * * *

§ 419.70 [Amended]

13. Section 419.70 is amended by—

a. In paragraph (d)(1)(i), removing the cross-reference ''§ 412.63(b)'' and adding the cross-reference ''§ 412.64(b)'' in its place.

b. In paragraph (d)(2)(i), removing the cross-reference ''§ 412.63(b)'' and adding the cross-reference ''§ 412.64(b)'' in its place.

c. In paragraph (d)(4)(ii), removing the cross-reference ''§ 412.63(b)'' and adding the phrase ''§ 412.63(b) or § 412.64(b), as applicable,'' in its place.

PART 482—CONDITIONS OF PARTICIPATION FOR HOSPITALS

14. The authority citation for Part 482 continues to read as follows:

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

15. Section 482.22 is amended by revising paragraph (c)(5) to read as follows:

§ 482.22 Condition of participation: Medical staff.

* * * * *

(c) * * *

(5) Include a requirement that—

(i) A medical history and physical examination be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician (as defined in section 1861(r) of the Act), an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

(ii) An updated examination of the patient, including any changes in the patient's condition, be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician (as defined in section 1861(r) of the Act), an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

* * * * *

§ 482.23 [Amended]

16. In § 482.23(b)(1), the cross-reference ''§ 405.1910(c)'' is removed and the cross-reference ''§ 488.54(c)'' is added in its place.

17. Section 482.24 is amended by revising paragraph (c)(2)(i) to read as follows:

§ 482.24 Condition of participation: Medical record services.

* * * * *

(c) * * *

(2) * * *

(i) Evidence of—

(A) A medical history and physical examination completed and documented no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

(B) An updated examination of the patient, including any changes in the patient's condition, when the medical history and physical examination are completed within 30 days before admission or registration. Documentation of the updated examination must be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

* * * * *

18. Section 482.51 is amended by revising paragraph (b)(1) to read as follows:

§ 482.51 Condition of participation: Surgical services.

* * * * *

(b) * * *

(1) Prior to surgery or a procedure requiring anesthesia services and except in the case of emergencies:

(i) A medical history and physical examination must be completed and documented no more than 30 days before or 24 hours after admission or registration.

(ii) An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration when the medical history and physical examination are completed within 30 days before admission or registration.

* * * * *

19. Section 482.52 is amended by—

a. Revising paragraph (b)(1).

b. Revising paragraph (b)(3).

c. Removing paragraph (b)(4).

The revisions read as follows:

§ 482.52 Condition of participation: Anesthesia services.

* * * * *

(b) * * *

(1) A preanesthesia evaluation completed and documented by an individual qualified to administer anesthesia, as specified in paragraph (a) of this section, performed within 48 hours prior to surgery or a procedure requiring anesthesia services.

* * * * *

(3) A postanesthesia evaluation completed and documented by an individual qualified to administer anesthesia, as specified in paragraph (a) of this section, after surgery or a procedure requiring anesthesia services, but before discharge or transfer from the postanesthesia recovery area.

* * * * *

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

20, The authority citation for Part 485 continues to read as follows:

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

21. Section 485.610 is amended by adding new paragraph (e) to read as follows:

§ 485.610 Condition of participation: Status and location.

* * * * *

(e) *Standard: Off-campus and co-location requirements for CAHs.* A CAH may continue to meet the location requirement of paragraph (c) of this section based only if the CAH meets the following:

(1) If a CAH with a necessary provider designation is co-located (that is, it shares a campus, as defined in § 413.65(a)(2) of this chapter, with another hospital or CAH), the necessary provider CAH can continue to meet the location requirement of paragraph (c) of this section only if the co-location arrangement was in effect before January 1, 2008, and the type and scope of services offered by the facility co-located with the necessary provider CAH do not change. A change of ownership of any of the facilities with a co-location arrangement that was in effect before January 1, 2008 will not be considered to be a new co-location arrangement.

(2) If a CAH or a necessary provider CAH operates a provider-based location, including a department or remote location, as defined in § 413.65(a)(2) of this chapter, or an off-campus distinct part psychiatric or rehabilitation unit, as defined in § 485.647, that was created or acquired by the CAH after January 1, 2008, the CAH can continue to meet the location requirement of paragraph (c) of this section only if the provider-based location or off-campus distinct part unit is located more than a 35-mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from a hospital or another CAH.

(3) If either a CAH or a CAH that has been designated as a necessary provider by the State does not meet the requirements in paragraph (e)(1) of this section, by co locating with another hospital or CAH after January 1, 2008, or creates or acquires a provider-based location or off-campus distinct part unit after January 1, 2008, that does not meet the requirements in paragraph (e)(2) of this section, the CAH's provider agreement will be subject to termination in accordance with the provisions of § 489.53(a)(3), unless the CAH terminates the off-campus arrangement or the co-location arrangement, or both.

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

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: July 5, 2007.

Leslie V. Norwalk,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: July 10, 2007.

Michael O. Leavitt,

Secretary.

ADDENDUM A.—PROPOSED OPPS APCS FOR CY 2008

APC	Group Title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0001	Level I Photochemotherapy	S	0.5204	$33.15	$7.00	$6.63
0002	Level I Fine Needle Biopsy/Aspiration	T	1.1915	$75.89	.....	$15.18
0003	Bone Marrow Biopsy/Aspiration	T	3.2390	$206.30	.....	$41.26
0004	Level I Needle Biopsy/Aspiration Except Bone Marrow	T	4.5062	$287.01	.....	$57.40
0005	Level II Needle Biopsy/Aspiration Except Bone Marrow	T	7.3012	$465.04	.....	$93.01
0006	Level I Incision & Drainage	T	1.4630	$93.18	.....	$18.64
0007	Level II Incision & Drainage	T	12.5792	$801.21	.....	$160.24
0008	Level III Incision and Drainage	T	19.0457	$1,213.08	.....	$242.62
0012	Level I Debridement & Destruction	T	0.2682	$17.08	.....	$3.42
0013	Level II Debridement & Destruction	T	0.8046	$51.25	.....	$10.25
0015	Level III Debridement & Destruction	T	1.5119	$96.30	.....	$19.26
0016	Level IV Debridement & Destruction	T	2.7493	$175.11	.....	$35.02
0017	Level VI Debridement & Destruction	T	20.0977	$1,280.08	.....	$256.02
0019	Level I Excision/Biopsy	T	4.4463	$283.20	$71.80	$56.64
0020	Level II Excision/Biopsy	T	8.7155	$555.12	.....	$111.02
0021	Level III Excision/Biopsy	T	16.5832	$1,056.23	$219.40	$211.25
0022	Level IV Excision/Biopsy	T	21.4534	$1,366.43	$354.40	$273.29
0023	Exploration Penetrating Wound	T	9.5721	$609.68	.....	$121.94
0028	Level I Breast Surgery	T	20.9980	$1,337.43	$303.70	$267.49
0029	Level II Breast Surgery	T	32.4940	$2,069.64	$581.50	$413.93
0030	Level III Breast Surgery	T	40.4634	$2,577.24	$747.00	$515.45
0031	Smoking Cessation Services	X	0.1660	$10.57	.....	$2.11
0033	Partial Hospitalization	P	2.8241	$179.88	.....	$35.98
0034	Mental Health Services Composite	P	2.8241	$179.88	.....	$35.98
0035	Arterial/Venous Puncture	T	0.2091	$13.32	.....	$2.66
0037	Level IV Needle Biopsy/Aspiration Except Bone Marrow	T	13.9599	$889.15	$228.70	$177.83
0039	Level I Implantation of Neurostimulator	S	197.4688	$12,577.38	.....	$2,515.48
0040	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	S	63.7536	$4,060.66	.....	$812.13
0041	Level I Arthroscopy	T	29.4467	$1,875.55	.....	$375.11
0042	Level II Arthroscopy	T	47.7765	$3,043.03	$804.70	$608.61
0043	Closed Treatment Fracture Finger/Toe/Trunk	T	1.8742	$119.37	.....	$23.87
0045	Bone/Joint Manipulation Under Anesthesia	T	15.0176	$956.52	$268.40	$191.30

ADDENDUM A.—PROPOSED OPPS APCS FOR CY 2008—Continued

APC	Group Title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0047	Arthroplasty without Prosthesis	T	35.9249	$2,288.16	$537.00	$457.63
0048	Level I Arthroplasty with Prosthesis	T	51.0431	$3,251.09		$650.22
0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	21.5761	$1,374.25		$274.85
0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	29.3263	$1,867.88		$373.58
0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	43.5953	$2,776.72		$555.34
0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	78.6518	$5,009.57		$1,001.91
0053	Level I Hand Musculoskeletal Procedures	T	16.8220	$1,071.44	$253.40	$214.29
0054	Level II Hand Musculoskeletal Procedures	T	26.7322	$1,702.65		$340.53
0055	Level I Foot Musculoskeletal Procedures	T	21.1762	$1,348.78	$355.30	$269.76
0056	Level II Foot Musculoskeletal Procedures	T	44.4710	$2,832.49		$566.50
0057	Bunion Procedures	T	29.8356	$1,900.32	$475.90	$380.06
0058	Level I Strapping and Cast Application	S	1.1272	$71.79		$14.36
0060	Manipulation Therapy	S	0.4877	$31.06		$6.21
0061	Laminectomy or Incision for Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	S	81.3252	$5,179.85		$1,035.97
0062	Level I Treatment Fracture/Dislocation	T	26.3092	$1,675.71	$372.80	$335.14
0063	Level II Treatment Fracture/Dislocation	T	40.3466	$2,569.80	$548.30	$513.96
0064	Level III Treatment Fracture/Dislocation	T	60.0595	$3,825.37	$835.70	$765.07
0065	Level I Stereotactic Radiosurgery, MRgFUS, and MEG	S	17.1992	$1,095.47		$219.09
0066	Level II Stereotactic Radiosurgery, MRgFUS, and MEG	S	47.3767	$3,017.56		$603.51
0067	Level III Stereotactic Radiosurgery, MRgFUS, and MEG	S	61.5205	$3,918.43		$783.69
0069	Thoracoscopy	T	33.1688	$2,112.62	$591.60	$422.52
0070	Thoracentesis/Lavage Procedures	T	5.3095	$338.18		$67.64
0071	Level I Endoscopy Upper Airway	T	0.8256	$52.58	$11.20	$10.52
0072	Level II Endoscopy Upper Airway	T	1.5730	$100.19	$21.20	$20.04
0073	Level III Endoscopy Upper Airway	T	4.2060	$267.89	$69.10	$53.58
0074	Level IV Endoscopy Upper Airway	T	17.4546	$1,111.74	$292.20	$222.35
0075	Level V Endoscopy Upper Airway	T	23.2819	$1,482.89	$445.90	$296.58
0076	Level I Endoscopy Lower Airway	T	10.1732	$647.96	$189.80	$129.59
0077	Level I Pulmonary Treatment	S	0.3904	$24.87	$7.70	$4.97
0078	Level II Pulmonary Treatment	S	1.3636	$86.85		$17.37
0079	Ventilation Initiation and Management	S	2.6745	$170.35		$34.07
0080	Diagnostic Cardiac Catheterization	T	39.8631	$2,539.00	$838.90	$507.80
0082	Coronary or Non-Coronary Atherectomy	T	88.7717	$5,654.14		$1,130.83
0083	Coronary or Non-Coronary Angioplasty and Percutaneous Valvuloplasty	T	46.0685	$2,934.24		$586.85
0084	Level I Electrophysiologic Procedures	S	10.2918	$655.52		$131.10
0085	Level II Electrophysiologic Procedures	T	48.6296	$3,097.37		$619.47
0086	Level III Electrophysiologic Procedures	T	90.7639	$5,781.03		$1,156.21
0088	Thrombectomy	T	39.8001	$2,534.99	$655.20	$507.00
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	T	122.5662	$7,806.61	$1,682.20	$1,561.32
0090	Insertion/Replacement of Pacemaker Pulse Generator	T	99.8268	$6,358.27	$1,612.80	$1,271.65
0091	Level II Vascular Ligation	T	43.6609	$2,780.89		$556.18
0092	Level I Vascular Ligation	T	26.4396	$1,684.02		$336.80
0093	Vascular Reconstruction/Fistula Repair without Device	T	30.8639	$1,965.81		$393.16
0094	Level I Resuscitation and Cardioversion	S	2.5547	$162.72	$46.20	$32.54
0095	Cardiac Rehabilitation	S	0.5868	$37.38	$13.80	$7.48
0096	Non-Invasive Vascular Studies	S	1.5254	$97.16	$37.60	$19.43
0097	Prolonged Physiologic and Ambulatory Monitoring	X	1.0396	$66.22	$23.70	$13.24
0099	Electrocardiograms	S	0.3912	$24.92		$4.98
0100	Cardiac Stress Tests	X	2.8631	$182.36	$41.40	$36.47
0101	Tilt Table Evaluation	S	4.4249	$281.84	$100.20	$56.37
0103	Miscellaneous Vascular Procedures	T	15.2572	$971.78		$194.36
0104	Transcatheter Placement of Intracoronary Stents	T	89.0212	$5,670.03		$1,134.01
0105	Repair/Revision/Removal of Pacemakers, AICDs, or Vascular Devices	T	24.7274	$1,574.96	$370.40	$314.99
0106	Insertion/Replacement of Pacemaker Leads and/or Electrodes	T	75.0068	$4,777.41		$955.48
0107	Insertion of Cardioverter-Defibrillator	T	353.1242	$22,491.54		$4,498.31
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	T	403.0232	$25,669.76		$5,133.95
0109	Removal/Repair of Implanted Devices	T	6.1077	$389.02		$77.80
0110	Transfusion	S	3.4924	$222.44		$44.49
0111	Blood Product Exchange	S	12.1982	$776.94	$198.40	$155.39
0112	Apheresis and Stem Cell Procedures	S	31.9648	$2,035.93	$433.20	$407.19
0113	Excision Lymphatic System	T	23.5105	$1,497.45		$299.49
0114	Thyroid/Lymphadenectomy Procedures	T	45.1729	$2,877.20		$575.44
0115	Cannula/Access Device Procedures	T	30.5379	$1,945.05		$389.01
0121	Level I Tube changes and Repositioning	T	3.2914	$209.64	$43.80	$41.93
0125	Refilling of Infusion Pump	T	2.3262	$148.16		$29.63
0126	Level I Urinary and Anal Procedures	T	1.0850	$69.11	$16.40	$13.82
0127	Level IV Stereotactic Radiosurgery, MRgFUS, and MEG	S	123.4696	$7,864.15		$1,572.83
0130	Level I Laparoscopy	T	34.8153	$2,217.49	$659.50	$443.50
0131	Level II Laparoscopy	T	46.1201	$2,937.53	$1,001.80	$587.51
0132	Level III Laparoscopy	T	71.0022	$4,522.34	$1,239.20	$904.47
0133	Level I Skin Repair	T	1.3340	$84.97	$26.76	$16.99
0134	Level II Skin Repair	T	2.1114	$134.48	$42.36	$26.90
0135	Level III Skin Repair	T	4.6816	$298.19		$59.64
0136	Level IV Skin Repair	T	15.4399	$983.41		$196.68
0137	Level V Skin Repair	T	20.9338	$1,333.34		$266.67
0140	Esophageal Dilation without Endoscopy	T	6.0867	$387.68	$91.40	$77.54
0141	Level I Upper GI Procedures	T	8.6730	$552.41	$143.30	$110.48
0142	Small Intestine Endoscopy	T	9.6264	$613.13	$152.70	$122.63
0143	Lower GI Endoscopy	T	9.0360	$575.53	$186.00	$115.11

ADDENDUM A.—PROPOSED OPPS APCS FOR CY 2008—Continued

APC	Group Title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0146	Level I Sigmoidoscopy and Anoscopy	T	5.1441	$327.64		$65.53
0147	Level II Sigmoidoscopy and Anoscopy	T	8.8611	$564.39		$112.88
0148	Level I Anal/Rectal Procedures	T	4.5189	$287.82		$57.56
0149	Level III Anal/Rectal Procedures	T	23.2282	$1,479.47		$295.89
0150	Level IV Anal/Rectal Procedures	T	30.5544	$1,946.10	$437.10	$389.22
0151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP)	T	21.2820	$1,355.51		$271.10
0152	Level I Percutaneous Abdominal and Biliary Procedures	T	28.7304	$1,829.93		$365.99
0153	Peritoneal and Abdominal Procedures	T	25.4636	$1,621.85	$397.90	$324.37
0154	Hernia/Hydrocele Procedures	T	31.1722	$1,985.45	$464.80	$397.09
0155	Level II Anal/Rectal Procedures	T	11.6524	$742.18		$148.44
0156	Level III Urinary and Anal Procedures	T	3.0601	$194.91		$38.98
0157	Colorectal Cancer Screening: Barium Enema	S	2.2613	$144.03		$28.81
0158	Colorectal Cancer Screening: Colonoscopy	T	8.0134	$510.40		$127.60
0159	Colorectal Cancer Screening: Flexible Sigmoidoscopy	S	4.7799	$304.45		$76.11
0160	Level I Cystourethroscopy and other Genitourinary Procedures	T	6.1077	$389.02		$77.80
0161	Level II Cystourethroscopy and other Genitourinary Procedures	T	18.1376	$1,155.24	$243.72	$231.05
0162	Level III Cystourethroscopy and other Genitourinary Procedures	T	25.2775	$1,610.00		$322.00
0163	Level IV Cystourethroscopy and other Genitourinary Procedures	T	36.9175	$2,351.39		$470.28
0164	Level II Urinary and Anal Procedures	T	2.1659	$137.95		$27.59
0165	Level IV Urinary and Anal Procedures	T	19.6126	$1,249.19		$249.84
0166	Level I Urethral Procedures	T	19.6570	$1,252.01		$250.40
0168	Level II Urethral Procedures	T	30.1994	$1,923.49	$388.10	$384.70
0169	Lithotripsy	T	43.0352	$2,741.04	$1,009.40	$548.21
0170	Dialysis	S	6.7915	$432.57		$86.51
0181	Level II Male Genital Procedures	T	35.1574	$2,239.28	$621.80	$447.86
0183	Level I Male Genital Procedures	T	22.7802	$1,450.94		$290.19
0184	Prostate Biopsy	T	11.3168	$720.80		$144.16
0188	Level II Female Reproductive Proc	T	1.4138	$90.05		$18.01
0189	Level III Female Reproductive Proc	T	3.0466	$194.05		$38.81
0190	Level I Hysteroscopy	T	22.1171	$1,408.70	$424.20	$281.74
0191	Level I Female Reproductive Proc	T	0.1414	$9.01	$2.50	$1.80
0192	Level IV Female Reproductive Proc	T	7.4497	$474.49		$94.90
0193	Level V Female Reproductive Proc	T	19.2052	$1,223.24		$244.65
0195	Level VI Female Reproductive Procedures	T	32.9713	$2,100.04	$483.80	$420.01
0202	Level VII Female Reproductive Procedures	T	43.2255	$2,753.16	$981.50	$550.63
0203	Level IV Nerve Injections	T	15.5687	$991.62	$240.30	$198.32
0204	Level I Nerve Injections	T	2.3254	$148.11	$40.10	$29.62
0206	Level II Nerve Injections	T	4.1589	$264.89	$56.83	$52.98
0207	Level III Nerve Injections	T	7.1370	$454.58		$90.92
0208	Laminotomies and Laminectomies	T	47.6714	$3,036.33		$607.27
0209	Level II Extended EEG and Sleep Studies	S	11.5647	$736.59	$268.70	$147.32
0212	Nervous System Injections	T	8.6797	$552.84		$110.57
0213	Level I Extended EEG and Sleep Studies	S	2.3476	$149.53	$53.50	$29.91
0215	Level I Nerve and Muscle Tests	S	0.5746	$36.60		$7.32
0216	Level III Nerve and Muscle Tests	S	2.7680	$176.30		$35.26
0218	Level II Nerve and Muscle Tests	S	1.1861	$75.55		$15.11
0220	Level I Nerve Procedures	T	18.5069	$1,178.76		$235.75
0221	Level II Nerve Procedures	T	32.0518	$2,041.48	$463.60	$408.30
0222	Implantation of Neurological Device	T	193.3327	$12,313.94		$2,462.79
0224	Implantation of Catheter/Reservoir/Shunt	T	37.1117	$2,363.76		$472.75
0225	Implantation of Neurostimulator Electrodes, Cranial Nerve	S	221.4181	$14,102.78		$2,820.56
0227	Implantation of Drug Infusion Device	T	178.7228	$11,383.39		$2,276.68
0229	Transcatherter Placement of Intravascular Shunts	T	89.7027	$5,713.43		$1,142.69
0230	Level I Eye Tests & Treatments	S	0.7379	$47.00		$9.40
0231	Level III Eye Tests & Treatments	S	2.3117	$147.24		$29.45
0232	Level I Anterior Segment Eye Procedures	T	5.1145	$325.76	$81.59	$65.15
0233	Level II Anterior Segment Eye Procedures	T	16.5252	$1,052.54	$266.30	$210.51
0234	Level III Anterior Segment Eye Procedures	T	24.0821	$1,533.86	$511.30	$306.77
0235	Level I Posterior Segment Eye Procedures	T	4.0100	$255.41	$58.90	$51.08
0236	Level II Posterior Segment Eye Procedures	T	18.8779	$1,202.39		$240.48
0237	Level III Posterior Segment Eye Procedures	T	29.0019	$1,847.22		$369.44
0238	Level I Repair and Plastic Eye Procedures	T	2.8636	$182.39		$36.48
0239	Level II Repair and Plastic Eye Procedures	T	7.1099	$452.85		$90.57
0240	Level III Repair and Plastic Eye Procedures	T	19.2280	$1,224.69	$309.50	$244.94
0241	Level IV Repair and Plastic Eye Procedures	T	24.8916	$1,585.42	$384.40	$317.08
0242	Level V Repair and Plastic Eye Procedures	T	37.3504	$2,378.96	$597.30	$475.79
0243	Strabismus/Muscle Procedures	T	24.3920	$1,553.60	$430.30	$310.72
0244	Corneal Transplant	T	38.2919	$2,438.93	$803.20	$487.79
0245	Level I Cataract Procedures without IOL Insert	T	14.9022	$949.17	$217.00	$189.83
0246	Cataract Procedures with IOL Insert	T	24.2197	$1,542.63	$495.90	$308.53
0247	Laser Eye Procedures	T	5.2389	$333.68	$104.30	$66.74
0249	Level II Cataract Procedures without IOL Insert	T	29.7487	$1,894.78	$524.60	$378.96
0250	Nasal Cauterization/Packing	T	1.1708	$74.57	$25.30	$14.91
0251	Level I ENT Procedures	T	2.5765	$164.11		$32.82
0252	Level II ENT Procedures	T	7.6539	$487.50	$109.10	$97.50
0253	Level III ENT Procedures	T	16.6341	$1,059.48	$282.20	$211.90
0254	Level IV ENT Procedures	T	24.3535	$1,551.15	$321.30	$310.23
0256	Level V ENT Procedures	T	40.5598	$2,583.38		$516.68
0258	Tonsil and Adenoid Procedures	T	22.9075	$1,459.05	$437.20	$291.81
0259	Level VI ENT Procedures	T	404.3379	$25,753.49	$8,698.40	$5,150.70

ADDENDUM A.—PROPOSED OPPS APCS FOR CY 2008—Continued

APC	Group Title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0260	Level I Plain Film Except Teeth	X	0.7259	$46.23	.....	$9.25
0261	Level II Plain Film Except Teeth Including Bone Density Measurement	X	1.2024	$76.58	.....	$15.32
0262	Plain Film of Teeth	X	0.5739	$36.55	.....	$7.31
0263	Miscellaneous Radiology Procedures	X	1.4802	$94.28	$21.44	$18.86
0265	Level I Diagnostic and Screening Ultrasound	S	0.9925	$63.22	$23.60	$12.64
0266	Level II Diagnostic and Screening Ultrasound	S	1.5657	$99.72	$37.80	$19.94
0267	Level III Diagnostic and Screening Ultrasound	S	2.4859	$158.33	$60.50	$31.67
0269	Level II Echocardiogram Except Transesophageal	S	6.5908	$419.79	.....	$83.96
0270	Transesophageal Echocardiogram	S	8.4200	$536.30	$141.30	$107.26
0272	Fluoroscopy	X	1.3270	$84.52	$31.60	$16.90
0274	Myelography	S	3.9008	$248.45	$62.80	$49.69
0275	Arthrography	S	2.2785	$145.12	$44.13	$29.02
0276	Level I Digestive Radiology	S	1.4387	$91.64	$34.90	$18.33
0277	Level II Digestive Radiology	S	2.2875	$145.70	$54.50	$29.14
0278	Diagnostic Urography	S	2.6114	$166.33	$59.40	$33.27
0279	Level II Angiography and Venography	S	5.9365	$378.11	$97.07	$75.62
0280	Level III Angiography and Venography	S	11.3221	$721.14	$199.34	$144.23
0282	Miscellaneous Computed Axial Tomography	S	1.6768	$106.80	$37.80	$21.36
0283	Level I Computed Tomography with Contrast	S	4.5485	$289.71	$100.30	$57.94
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast.	S	6.7963	$432.88	$148.40	$86.58
0288	Bone Density:Axial Skeleton	S	1.1920	$75.92	$28.90	$15.18
0293	Level V Anterior Segment Eye Procedures	T	83.0605	$5,290.37	$1,128.20	$1,058.07
0299	Hyperthermia and Radiation Treatment Procedures	S	6.0275	$383.91	.....	$76.78
0300	Level I Radiation Therapy	S	1.5000	$95.54	.....	$19.11
0301	Level II Radiation Therapy	S	2.2933	$146.07	.....	$29.21
0303	Treatment Device Construction	X	3.0657	$195.26	$66.90	$39.05
0304	Level I Therapeutic Radiation Treatment Preparation	X	1.6409	$104.51	$38.60	$20.90
0305	Level II Therapeutic Radiation Treatment Preparation	X	4.1775	$266.08	$91.30	$53.22
0307	Myocardial Positron Emission Tomography (PET) imaging	S	42.5674	$2,711.25	.....	$542.25
0308	Non-Myocardial Positron Emission Tomography (PET) imaging	S	17.3837	$1,107.22	.....	$221.44
0310	Level III Therapeutic Radiation Treatment Preparation	X	14.0797	$896.78	$325.20	$179.36
0312	Radioelement Applications	S	8.3915	$534.48	.....	$106.90
0313	Brachytherapy	S	11.6098	$739.46	.....	$147.89
0315	Level II Implantation of Neurostimulator	T	262.8116	$16,739.26	.....	$3,347.85
0316	Level II Computed Tomography with Contrast	S	11.7923	$751.09	$300.26	$150.22
0320	Electroconvulsive Therapy	S	5.9448	$378.64	$80.00	$75.73
0322	Brief Individual Psychotherapy	S	1.2454	$79.32	.....	$15.86
0323	Extended Individual Psychotherapy	S	1.6720	$106.49	.....	$21.30
0324	Family Psychotherapy	S	2.2233	$141.61	.....	$28.32
0325	Group Psychotherapy	S	1.0119	$64.45	$14.04	$12.89
0330	Dental Procedures	S	9.2780	$590.94	.....	$118.19
0332	Computed Tomography without Contrast	S	3.1487	$200.55	$75.20	$40.11
0333	Computed Tomography without Contrast followed by Contrast)	S	5.3374	$339.96	$119.00	$67.99
0335	Magnetic Resonance Imaging, Miscellaneous	S	5.0067	$318.89	$111.90	$63.78
0336	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast.	S	5.7101	$363.69	$139.50	$72.74
0337	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast followed by Contrast.	S	8.6689	$552.15	$199.50	$110.43
0340	Minor Ancillary Procedures	X	0.6416	$40.87	.....	$8.17
0341	Skin Tests	X	0.0879	$5.60	$2.20	$1.12
0342	Level I Pathology	X	0.0928	$5.91	$2.00	$1.18
0343	Level III Pathology	X	0.5372	$34.22	$10.80	$6.84
0344	Level IV Pathology	X	0.8586	$54.69	$15.60	$10.94
0345	Level I Transfusion Laboratory Procedures	X	0.2211	$14.08	.....	$2.82
0346	Level II Transfusion Laboratory Procedures	X	0.3464	$22.06	.....	$4.41
0347	Level III Transfusion Laboratory Procedures	X	0.8166	$52.01	$11.20	$10.40
0350	Administration of flu and PPV vaccine	S	0.4037	$25.71	.....	$0.00
0360	Level I Alimentary Tests	X	1.6383	$104.35	$33.80	$20.87
0361	Level II Alimentary Tests	X	4.0867	$260.29	$83.20	$52.06
0363	Level I Otorhinolaryngologic Function Tests	X	0.8542	$54.41	$17.40	$10.88
0364	Level I Audiometry	X	0.4448	$28.33	$6.98	$5.67
0365	Level II Audiometry	X	1.2810	$81.59	$18.50	$16.32
0366	Level III Audiometry	X	1.8646	$118.76	$26.10	$23.75
0367	Level I Pulmonary Test	X	0.5955	$37.93	$14.38	$7.59
0368	Level II Pulmonary Tests	X	0.9541	$60.77	$22.70	$12.15
0369	Level III Pulmonary Tests	X	2.7874	$177.54	$44.10	$35.51
0370	Allergy Tests	X	1.1024	$70.22	.....	$14.04
0373	Level I Neuropsychological Testing	X	1.8183	$115.81	.....	$23.16
0375	Ancillary Outpatient Services When Patient Expires	S	73.4077	$4,675.56	.....	$935.11
0377	Level II Cardiac Imaging	S	12.0147	$765.25	$158.80	$153.05
0378	Level II Pulmonary Imaging	S	5.1617	$328.76	$125.30	$65.75
0379	Injection adenosine 6 MG	K	.....	$22.65	.....	$4.53
0381	Single Allergy Tests	X	0.3014	$19.20	.....	$3.84
0382	Level II Neuropsychological Testing	X	2.6763	$170.46	.....	$34.09
0383	Cardiac Computed Tomographic Imaging	S	4.9887	$317.75	$124.17	$63.55
0384	GI Procedures with Stents	T	25.2289	$1,606.90	.....	$321.38
0385	Level I Prosthetic Urological Procedures	S	85.3372	$5,435.38	.....	$1,087.08
0386	Level II Prosthetic Urological Procedures	S	143.8001	$9,159.06	.....	$1,831.81
0387	Level II Hysteroscopy	T	34.8162	$2,217.55	$655.50	$443.51

ADDENDUM A.—PROPOSED OPPS APCS FOR CY 2008—Continued

APC	Group Title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0388	Discography	S	9.0300	$575.15	$169.68	$115.03
0389	Level I Non-imaging Nuclear Medicine	S	1.5806	$100.67	$33.80	$20.13
0390	Level I Endocrine Imaging	S	2.8272	$180.07	$57.60	$36.01
0391	Level II Endocrine Imaging	S	3.6540	$232.73	$66.10	$46.55
0392	Level II Non-imaging Nuclear Medicine	S	3.2810	$208.98	$49.30	$41.80
0393	Red Cell/Plasma Studies	S	5.5260	$351.97	$82.00	$70.39
0394	Hepatobiliary Imaging	S	4.5297	$288.51	$102.60	$57.70
0395	GI Tract Imaging	S	3.8546	$245.51	$89.70	$49.10
0396	Bone Imaging	S	3.9566	$252.01	$95.00	$50.40
0397	Vascular Imaging	S	3.0424	$193.78	$49.50	$38.76
0398	Level I Cardiac Imaging	S	5.4404	$346.52	$100.00	$69.30
0400	Hematopoietic Imaging	S	4.1916	$266.98	$93.20	$53.40
0401	Level I Pulmonary Imaging	S	3.2976	$210.03	$78.10	$42.01
0402	Level II Nervous System Imaging	S	8.8414	$563.14	$114.10	$112.63
0403	Level I Nervous System Imaging	S	3.3325	$212.26	$82.39	$42.45
0404	Renal and Genitourinary Studies	S	5.0935	$324.42	$84.10	$64.88
0406	Level I Tumor/Infection Imaging	S	4.4988	$286.54	$98.10	$57.31
0407	Level I Radionuclide Therapy	S	3.4563	$220.14	$78.10	$44.03
0408	Level III Tumor/Infection Imaging	S	16.0595	$1,022.88	.....	$204.58
0409	Red Blood Cell Tests	X	0.1246	$7.94	$2.20	$1.59
0412	IMRT Treatment Delivery	S	5.7275	$364.80	.....	$72.96
0413	Level II Radionuclide Therapy	S	5.4891	$349.62	.....	$69.92
0414	Level II Tumor/Infection Imaging	S	7.4985	$477.60	$190.92	$95.52
0415	Level II Endoscopy Lower Airway	T	24.2882	$1,546.99	$459.90	$309.40
0417	Computerized Reconstruction	S	2.3401	$149.05	.....	$29.81
0418	Insertion of Left Ventricular Pacing Elect.	T	250.5383	$15,957.54	.....	$3,191.51
0422	Level II Upper GI Procedures	T	24.6480	$1,569.91	$445.06	$313.98
0423	Level II Percutaneous Abdominal and Biliary Procedures	T	44.1192	$2,810.08	.....	$562.02
0425	Level II Arthroplasty with Prosthesis	T	113.6713	$7,240.07	.....	$1,448.01
0426	Level II Strapping and Cast Application	S	2.2383	$142.56	.....	$28.51
0427	Level II Tube Changes and Repositioning	T	14.8912	$948.47	.....	$189.69
0428	Level III Sigmoidoscopy and Anoscopy	T	21.8923	$1,394.39	.....	$278.88
0429	Level V Cystourethroscopy and other Genitourinary Procedures	T	45.9021	$2,923.64	.....	$584.73
0430	Drug Preadministration-Related Services	S	0.6123	$39.00	.....	$7.80
0432	Health and Behavior Services	S	0.3020	$19.24	.....	$3.85
0433	Level II Pathology	X	0.2482	$15.81	$5.90	$3.16
0434	Cardiac Defect Repair	T	141.9601	$9,041.86	.....	$1,808.37
0436	Level I Drug Administration	S	0.2201	$14.02	.....	$2.80
0437	Level II Drug Administration	S	0.4037	$25.71	.....	$5.14
0438	Level III Drug Administration	S	0.8310	$52.93	.....	$10.59
0439	Level IV Drug Administration	S	1.7152	$109.25	.....	$21.85
0440	Level V Drug Administration	S	1.8310	$116.62	.....	$23.32
0441	Level VI Drug Administration	S	2.4378	$155.27	.....	$31.05
0442	Dosimetric Drug Administration	S	30.2249	$1,925.11	.....	$385.02
0604	Level 1 Hospital Clinic Visits	V	0.8381	$53.38	.....	$10.68
0605	Level 2 Hospital Clinic Visits	V	1.0016	$63.79	.....	$12.76
0606	Level 3 Hospital Clinic Visits	V	1.3665	$87.04	.....	$17.41
0607	Level 4 Hospital Clinic Visits	V	1.7181	$109.43	.....	$21.89
0608	Level 5 Hospital Clinic Visits	V	2.2077	$140.62	.....	$28.12
0609	Level 1 Emergency Visits	V	0.8271	$52.68	$12.70	$10.54
0613	Level 2 Emergency Visits	V	1.3789	$87.83	$21.00	$17.57
0614	Level 3 Emergency Visits	V	2.1716	$138.32	$34.50	$27.66
0615	Level 4 Emergency Visits	V	3.5191	$224.14	$48.40	$44.83
0616	Level 5 Emergency Visits	V	5.4765	$348.81	$75.10	$69.76
0617	Critical Care	S	6.8478	$436.16	$111.50	$87.23
0618	Trauma Response with Critical Care	S	5.6539	$360.11	$144.04	$72.02
0621	Level I Vascular Access Procedures	T	11.0043	$700.90	.....	$140.18
0622	Level II Vascular Access Procedures	T	24.5273	$1,562.22	.....	$312.44
0623	Level III Vascular Access Procedures	T	29.3210	$1,867.54	.....	$373.51
0624	Phlebotomy and Minor Vascular Access Device Procedures	X	0.5763	$36.71	$12.60	$7.34
0625	Level IV Vascular Access Procedures	T	87.3200	$5,561.67	.....	$1,112.33
0648	Level IV Breast Surgery	T	52.9438	$3,372.15	.....	$674.43
0651	Complex Interstitial Radiation Source Application	S	15.4158	$981.88	.....	$196.38
0652	Insertion of Intraperitoneal and Pleural Catheters	T	31.7598	$2,022.88	.....	$404.58
0653	Vascular Reconstruction/Fistula Repair with Device	T	41.0875	$2,616.99	.....	$523.40
0654	Insertion/Replacement of a permanent dual chamber pacemaker	T	106.9053	$6,809.12	.....	$1,361.82
0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker.	T	144.2764	$9,189.40	.....	$1,837.88
0656	Transcatheter Placement of Intracoronary Drug-Eluting Stents	T	118.8818	$7,571.94	.....	$1,514.39
0659	Hyperbaric Oxygen	S	1.5679	$99.86	.....	$19.97
0660	Level II Otorhinolaryngologic Function Tests	X	1.4408	$91.77	$28.00	$18.35
0661	Level V Pathology	X	2.8336	$180.48	$62.00	$36.10
0662	CT Angiography	S	5.2818	$336.41	$118.80	$67.28
0663	Level I Electronic Analysis of Neurostimulator Pulse Generators	S	1.6671	$106.18	.....	$21.24
0664	Level I Proton Beam Radiation Therapy	S	13.2746	$845.50	.....	$169.10
0665	Bone Density:AppendicularSkeleton	S	0.5225	$33.28	$13.31	$6.66
0667	Level II Proton Beam Radiation Therapy	S	15.8841	$1,011.71	.....	$202.34
0668	Level I Angiography and Venography	S	3.3354	$212.44	$48.81	$42.49
0672	Level IV Posterior Segment Eye Procedures	T	38.1121	$2,427.47	.....	$485.49
0673	Level IV Anterior Segment Eye Procedures	T	40.8481	$2,601.74	$649.50	$520.35

ADDENDUM A.—PROPOSED OPPS APCS FOR CY 2008—Continued

APC	Group Title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0674	Prostate Cryoablation	T	123.7218	$7,880.21		$1,576.04
0676	Thrombolysis and Thrombectomy	T	2.5179	$160.37		$32.07
0678	External Counterpulsation	T	1.7081	$108.79		$21.76
0679	Level II Resuscitation and Cardioversion	S	5.5905	$356.08	$95.30	$71.22
0680	Insertion of Patient Activated Event Recorders	S	71.6463	$4,563.37		$912.67
0681	Knee Arthroplasty	T	191.2387	$12,180.57		$2,436.11
0682	Level V Debridement & Destruction	T	7.1126	$453.02	$158.60	$90.60
0683	Level II Photochemotherapy	S	2.9292	$186.57		$37.31
0685	Level III Needle Biopsy/Aspiration Except Bone Marrow	T	9.5741	$609.80		$121.96
0687	Revision/Removal of Neurostimulator Electrodes	T	24.1752	$1,539.79	$438.40	$307.96
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver	T	35.7248	$2,275.42	$874.50	$455.08
0689	Electronic Analysis of Cardioverter-defibrillators	S	0.5936	$37.81		$7.56
0690	Electronic Analysis of Pacemakers and other Cardiac Devices	S	0.3590	$22.87	$8.60	$4.57
0691	Electronic Analysis of Programmable Shunts/Pumps	S	2.5849	$164.64	$56.08	$32.93
0692	Level II Electronic Analysis of Neurostimulator Pulse Generators	S	1.9206	$122.33	$30.10	$24.47
0694	Mohs Surgery	T	3.9713	$252.94	$91.60	$50.59
0697	Level I Echocardiogram Except Transesophageal	S	4.8072	$306.18		$61.24
0698	Level II Eye Tests & Treatments	S	1.1576	$73.73		$14.75
0699	Level IV Eye Tests & Treatments	T	14.2784	$909.43		$181.89
0701	Sr89 strontium	K		$610.07		$122.01
0702	Sm 153 lexidronm	K		$1,446.05		$289.21
0726	Dexrazoxane HCl injection	K		$172.43		$34.49
0728	Filgrastim 300 mcg injection	K		$187.68		$37.54
0730	Pamidronate disodium/30 MG	K		$30.49		$6.10
0731	Sargramostim injection	K		$25.08		$5.02
0732	Mesna injection	K		$8.89		$1.78
0735	Ampho b cholesteryl sulfate	K		$11.89		$2.38
0736	Amphotericin b liposome inj	K		$17.07		$3.41
0738	Rasburicase	K		$131.28		$26.26
0747	Chlorothiazide sodium inj	K		$122.67		$24.53
0748	Bleomycin sulfate injection	K		$35.52		$7.10
0750	Dolasetron mesylate	K		$6.05		$1.21
0751	Mechlorethamine hcl inj	K		$140.27		$28.05
0752	Dactinomycin actinomycin d	K		$488.78		$97.76
0759	Naltrexone, depot form	K		$1.88		$0.38
0760	Anadulafungin injection	G		$1.91		$0.38
0763	Dolasetron mesylate oral	K		$47.07		$9.41
0764	Granisetron HCl injection	K		$7.43		$1.49
0765	Granisetron HCl 1 mg oral	K		$44.44		$8.89
0767	Enfuvirtide injection	K		$22.69		$4.54
0768	Ondansetron hcl injection	K		$3.37		$0.67
0769	Ondansetron HCl 8mg oral	K		$36.21		$7.24
0800	Leuprolide acetate/3.75 MG	K		$429.83		$85.97
0802	Etoposide oral 50 MG	K		$29.32		$5.86
0804	Immune globulin subcutaneous	K		$12.60		$2.52
0805	Mecasermin injection	K		$11.81		$2.36
0806	Hyaluronidase recombinant	G		$0.40		$0.08
0807	Aldesleukin/single use vial	K		$755.78		$151.16
0808	Nabilone oral	K		$16.80		$3.36
0809	Bcg live intravesical vac	K		$109.63		$21.93
0810	Goserelin acetate implant	K		$196.81		$39.36
0811	Carboplatin injection	K		$8.38		$1.68
0812	Carmus bischl nitro inj	K		$138.52		$27.70
0814	Asparaginase injection	K		$54.20		$10.84
0820	Daunorubicin	K		$20.28		$4.06
0821	Daunorubicin citrate liposom	K		$55.40		$11.08
0823	Docetaxel	K		$303.92		$60.78
0825	Nelarabine injection	K		$82.54		$16.51
0827	Floxuridine injection	K		$50.82		$10.16
0828	Gemcitabine HCl	K		$123.98		$24.80
0830	Irinotecan injection	K		$124.81		$24.96
0831	Ifosfomide injection	K		$46.15		$9.23
0832	Idarubicin hcl injection	K		$301.74		$60.35
0834	Interferon alfa-2a inj	K		$37.53		$7.51
0835	Inj cosyntropin per 0.25 MG	K		$63.25		$12.65
0836	Interferon alfa-2b inj	K		$13.75		$2.75
0837	Non-human, non-metab tissue	K		$35.76		$7.15
0838	Interferon gamma 1-b inj	K		$287.13		$57.43
0840	Inj melphalan hydrochl 50 MG	K		$1,272.00		$254.40
0842	Fludarabine phosphate inj	K		$234.21		$46.84
0843	Pegaspargase/singl dose vial	K		$1,667.61		$333.52
0844	Pentostatin injection	K		$1,916.66		$383.33
0849	Rituximab cancer treatment	K		$491.54		$98.31
0850	Streptozocin injection	K		$152.28		$30.46
0851	Thiotepa injection	K		$40.32		$8.06
0852	Topotecan	K		$822.90		$164.58
0855	Vinorelbine tartrate/10 mg	K		$19.88		$3.98
0856	Porfimer sodium	K		$2,539.13		$507.83
0858	Inj cladribine per 1 MG	K		$35.78		$7.16
0861	Leuprolide acetate injeciton	K		$8.79		$1.76

ADDENDUM A.—PROPOSED OPPS APCS FOR CY 2008—Continued

APC	Group Title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0862	Mitomycin 5 MG inj	K		$15.98		$3.20
0863	Paclitaxel injection	K		$12.47		$2.49
0864	Mitoxantrone hydrochl/5 MG	K		$166.64		$33.33
0865	Interferon alfa-n3 inj	K		$9.03		$1.81
0868	Oral aprepitant	K		$5.02		$1.00
0873	Hyalgan/supartz inj per dose	K		$103.86		$20.77
0874	Synvisc inj per dose	K		$184.89		$36.98
0875	Euflexxa inj per dose	K		$115.19		$23.04
0877	Orthovisc inj per dose	K		$196.47		$39.29
0878	Gallium nitrate injection	K		$1.47		$0.29
0879	Bethanechol chloride inject	K	0.5128	$32.66		$6.53
0880	Pentastarch 10% solution	K	0.3707	$23.61		$4.72
0881	Urokinase 5000 IU injection	K		$9.07		$1.81
0882	Melphalan oral 2 MG	K	0.0681	$4.34		$0.87
0883	Fondaparinux sodium	K		$5.82		$1.16
0884	Rho d immune globulin inj	K		$80.71		$16.14
0887	Azathioprine parenteral	K		$47.99		$9.60
0888	Cyclosporine oral 100 mg	K		$3.57		$0.71
0890	Lymphocyte immune globulin	K		$314.19		$62.84
0891	Tacrolimus oral per 1 MG	K		$3.63		$0.73
0898	Gamma globulin 2 CC inj	K		$22.63		$4.53
0899	Gamma globulin 3 CC inj	K		$33.93		$6.79
0900	Alglucerase injection	K		$38.85		$7.77
0901	Alpha 1 proteinase inhibitor	K		$3.24		$0.65
0902	Botulinum toxin a per unit	K		$5.05		$1.01
0903	Cytomegalovirus imm IV/vial	K		$859.86		$171.97
0904	Gamma globulin 4 CC inj	K		$45.25		$9.05
0906	RSV-ivig	K		$16.02		$3.20
0910	Interferon beta-1b/.25 MG	K		$84.12		$16.82
0911	Inj streptokinase/250000 IU	K	1.1851	$75.48		$15.10
0912	Interferon alfacon-1	K		$4.60		$0.92
0913	Ganciclovir long act implant	K		$4,707.42		$941.48
0916	Injection imiglucerase/unit	K		$3.89		$0.78
0917	Adenosine injection	K		$68.50		$13.70
0919	Gamma globulin 5 CC inj	K		$56.56		$11.31
0920	Gamma globulin 6 CC inj	K		$67.91		$13.58
0921	Gamma globulin 7 CC inj	K		$79.14		$15.83
0922	Gamma globulin 8 CC inj	K		$90.50		$18.10
0923	Gamma globulin 9 CC inj	K		$101.88		$20.38
0924	Gamma globulin 10 CC inj	K		$113.13		$22.63
0925	Factor viii	K		$0.70		$0.14
0927	Factor viii recombinant	K		$1.07		$0.21
0928	Factor ix complex	K		$0.75		$0.15
0929	Anti-inhibitor	K		$1.35		$0.27
0930	Antithrombin iii injection	K		$1.62		$0.32
0931	Factor IX non-recombinant	K		$0.89		$0.18
0932	Factor IX recombinant	K		$0.99		$0.20
0933	Gamma globulin ≤ 10 CC inj	K		$113.13		$22.63
0934	Capecitabine, oral, 500 mg	K		$13.12		$2.62
0935	Clonidine hydrochloride	K		$62.86		$12.57
0941	Mitomycin 20 MG inj	K		$63.93		$12.79
0942	Mitomycin 40 MG inj	K		$127.85		$25.57
0949	Frozen plasma, pooled, sd	K	1.1981	$76.31		$15.26
0950	Whole blood for transfusion	K	4.4374	$282.63		$56.53
0952	Cryoprecipitate each unit	K	0.6843	$43.59		$8.72
0954	RBC leukocytes reduced	K	2.9590	$188.47		$37.69
0955	Plasma, frz between 8-24hour	K	1.2456	$79.34		$15.87
0956	Plasma protein fract,5%,50ml	K	1.4392	$91.67		$18.33
0957	Platelets, each unit	K	1.0834	$69.00		$13.80
0958	Plaelet rich plasma unit	K	5.3744	$342.31		$68.46
0959	Red blood cells unit	K	2.0343	$129.57		$25.91
0960	Washed red blood cells unit	K	4.2092	$268.10		$53.62
0961	Albumin (human),5%, 50ml	K	0.3757	$23.93		$4.79
0963	Albumin (human), 5%, 250 ml	K	1.1351	$72.30		$14.46
0964	Albumin (human), 25%, 20 ml	K	0.4448	$28.33		$5.67
0965	Albumin (human), 25%, 50ml	K	1.1679	$74.39		$14.88
0966	Plasmaprotein fract,5%,250ml	K	3.9009	$248.46		$49.69
0967	Blood split unit	K	2.1237	$135.26		$27.05
0968	Platelets leukoreduced irrad	K	2.0280	$129.17		$25.83
0969	RBC leukoreduced irradiated	K	3.8191	$243.25		$48.65
1009	Cryoprecipitatereducedplasma	K	1.3131	$83.64		$16.73
1010	Blood, l/r, cmv-neg	K	2.3865	$152.00		$30.40
1011	Platelets, hla-m, l/r, unit	K	9.6766	$616.33		$123.27
1013	Platelets leukocytes reduced	K	1.7207	$109.60		$21.92
1016	Blood, l/r, froz/degly/wash	K	3.3520	$213.50		$42.70
1017	Plt, aph/pher, l/r, cmv-neg	K	7.7915	$496.26		$99.25
1018	Blood, l/r, irradiated	K	2.4372	$155.23		$31.05
1019	Plate pheres leukoredu irrad	K	10.0408	$639.53		$127.91
1020	Plt, pher, l/r cmv-neg, irr	K	10.7802	$686.62		$137.32
1021	RBC, frz/deg/wsh, l/r, irrad	K	6.4694	$412.06		$82.41

ADDENDUM A.—PROPOSED OPPS APCS FOR CY 2008—Continued

APC	Group Title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
1022	RBC, l/r, cmv-neg, irrad	K	4.6286	$294.81		$58.96
1032	Aud osseo dev, int/ext comp	H				.
1052	Injection, voriconazole	K		$4.94		$0.99
1064	I131 iodide cap, rx	K		$16.22		$3.24
1083	Adalimumab injection	K		$316.02		$63.20
1084	Denileukin diftitox, 300 mcg	K		$1,393.32		$278.66
1086	Temozolomide	K		$7.34		$1.47
1150	I131 iodide sol, rx	K		$11.74		$2.35
1166	Cytarabine liposome	K		$391.31		$78.26
1167	Inj, epirubicin hcl, 2 mg	K		$21.01		$4.20
1178	Busulfan injection	K		$8.80		$1.76
1203	Verteporfin injection	K		$8.84		$1.77
1207	Octreotide injection, depot	K		$95.86		$19.17
1280	Corticotropin injection	K		$126.52		$25.30
1436	Etidronate disodium inj	K		$70.73		$14.15
1491	New Technology—Level IA ($0–$10)	S		$5.00		$1.00
1492	New Technology—Level IB ($10–$20)	S		$15.00		$3.00
1493	New Technology—Level IC ($20–$30)	S		$25.00		$5.00
1494	New Technology—Level ID ($30–$40)	S		$35.00		$7.00
1495	New Technology—Level IE ($40–$50)	S		$45.00		$9.00
1496	New Technology—Level IA ($0–$10)	T		$5.00		$1.00
1497	New Technology—Level IB ($10–$20)	T		$15.00		$3.00
1498	New Technology—Level IC ($20–$30)	T		$25.00		$5.00
1499	New Technology—Level ID ($30–$40)	T		$35.00		$7.00
1500	New Technology—Level IE ($40–$50)	T		$45.00		$9.00
1502	New Technology—Level II ($50–$100)	S		$75.00		$15.00
1503	New Technology—Level III ($100–$200)	S		$150.00		$30.00
1504	New Technology—Level IV ($200–$300)	S		$250.00		$50.00
1505	New Technology—Level V ($300–$400)	S		$350.00		$70.00
1506	New Technology—Level VI ($400–$500)	S		$450.00		$90.00
1507	New Technology—Level VII ($500–$600)	S		$550.00		$110.00
1508	New Technology—Level VIII ($600–$700)	S		$650.00		$130.00
1509	New Technology—Level IX ($700–$800)	S		$750.00		$150.00
1510	New Technology—Level X ($800–$900)	S		$850.00		$170.00
1511	New Technology—Level XI ($900–$1000)	S		$950.00		$190.00
1512	New Technology—Level XII ($1000–$1100)	S		$1,050.00		$210.00
1513	New Technology—Level XIII ($1100–$1200)	S		$1,150.00		$230.00
1514	New Technology—Level XIV ($1200- $1300)	S		$1,250.00		$250.00
1515	New Technology—Level XV ($1300–$1400)	S		$1,350.00		$270.00
1516	New Technology—Level XVI ($1400–$1500)	S		$1,450.00		$290.00
1517	New Technology—Level XVII ($1500–$1600)	S		$1,550.00		$310.00
1518	New Technology—Level XVIII ($1600–$1700)	S		$1,650.00		$330.00
1519	New Technology—Level IXX ($1700–$1800)	S		$1,750.00		$350.00
1520	New Technology—Level XX ($1800–$1900)	S		$1,850.00		$370.00
1521	New Technology—Level XXI ($1900–$2000)	S		$1,950.00		$390.00
1522	New Technology—Level XXII ($2000–$2500)	S		$2,250.00		$450.00
1523	New Technology—Level XXIII ($2500–$3000)	S		$2,750.00		$550.00
1524	New Technology—Level XXIV ($3000–$3500)	S		$3,250.00		$650.00
1525	New Technology—Level XXV ($3500–$4000)	S		$3,750.00		$750.00
1526	New Technology—Level XXVI ($4000–$4500)	S		$4,250.00		$850.00
1527	New Technology—Level XXVII ($4500–$5000)	S		$4,750.00		$950.00
1528	New Technology—Level XXVIII ($5000–$5500)	S		$5,250.00		$1,050.00
1529	New Technology—Level XXIX ($5500–$6000)	S		$5,750.00		$1,150.00
1530	New Technology—Level XXX ($6000–$6500)	S		$6,250.00		$1,250.00
1531	New Technology—Level XXXI ($6500–$7000)	S		$6,750.00		$1,350.00
1532	New Technology—Level XXXII ($7000–$7500)	S		$7,250.00		$1,450.00
1533	New Technology—Level XXXIII ($7500–$8000)	S		$7,750.00		$1,550.00
1534	New Technology—Level XXXIV ($8000–$8500)	S		$8,250.00		$1,650.00
1535	New Technology—Level XXXV ($8500–$9000)	S		$8,750.00		$1,750.00
1536	New Technology—Level XXXVI ($9000–$9500)	S		$9,250.00		$1,850.00
1537	New Technology—Level XXXVII ($9500–$10000)	S		$9,750.00		$1,950.00
1539	New Technology—Level II ($50–$100)	T		$75.00		$15.00
1540	New Technology—Level III ($100–$200)	T		$150.00		$30.00
1541	New Technology—Level IV ($200–$300)	T		$250.00		$50.00
1542	New Technology—Level V ($300–$400)	T		$350.00		$70.00
1543	New Technology—Level VI ($400–$500)	T		$450.00		$90.00
1544	New Technology—Level VII ($500–$600)	T		$550.00		$110.00
1545	New Technology—Level VIII ($600–$700)	T		$650.00		$130.00
1546	New Technology—Level IX ($700–$800)	T		$750.00		$150.00
1547	New Technology—Level X ($800–$900)	T		$850.00		$170.00
1548	New Technology—Level XI ($900–$1000)	T		$950.00		$190.00
1549	New Technology—Level XII ($1000–$1100)	T		$1,050.00		$210.00
1550	New Technology—Level XIII ($1100–$1200)	T		$1,150.00		$230.00
1551	New Technology—Level XIV ($1200–$1300)	T		$1,250.00		$250.00
1552	New Technology—Level XV ($1300–$1400)	T		$1,350.00		$270.00
1553	New Technology—Level XVI ($1400–$1500)	T		$1,450.00		$290.00
1554	New Technology—Level XVII ($1500-$1600)	T		$1,550.00		$310.00
1555	New Technology—Level XVIII ($1600–$1700)	T		$1,650.00		$330.00
1556	New Technology—Level XIX ($1700–$1800)	T		$1,750.00		$350.00
1557	New Technology—Level XX ($1800–$1900)	T		$1,850.00		$370.00

ADDENDUM A.—PROPOSED OPPS APCS FOR CY 2008—Continued

APC	Group Title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
1558	New Technology—Level XXI ($1900–$2000)	T		$1,950.00		$390.00
1559	New Technology—Level XXII ($2000–$2500)	T		$2,250.00		$450.00
1560	New Technology—Level XXIII ($2500–$3000)	T		$2,750.00		$550.00
1561	New Technology—Level XXIV ($3000–$3500)	T		$3,250.00		$650.00
1562	New Technology—Level XXV ($3500–$4000)	T		$3,750.00		$750.00
1563	New Technology—Level XXVI ($4000–$4500)	T		$4,250.00		$850.00
1564	New Technology—Level XXVII ($4500–$5000)	T		$4,750.00		$950.00
1565	New Technology—Level XXVIII ($5000–$5500)	T		$5,250.00		$1,050.00
1566	New Technology—Level XXIX ($5500–$6000)	T		$5,750.00		$1,150.00
1567	New Technology—Level XXX ($6000–$6500)	T		$6,250.00		$1,250.00
1568	New Technology—Level XXXI ($6500–$7000)	T		$6,750.00		$1,350.00
1569	New Technology—Level XXXII ($7000–$7500)	T		$7,250.00		$1,450.00
1570	New Technology—Level XXXIII ($7500–$8000)	T		$7,750.00		$1,550.00
1571	New Technology—Level XXXIV ($8000–$8500)	T		$8,250.00		$1,650.00
1572	New Technology—Level XXXV ($8500–$9000)	T		$8,750.00		$1,750.00
1573	New Technology—Level XXXVI ($9000–$9500)	T		$9,250.00		$1,850.00
1574	New Technology—Level XXXVII ($9500–$10000)	T		$9,750.00		$1,950.00
1605	Abciximab injection	K		$409.26		$81.85
1606	Injection anistreplase 30 u	K	42.2935	$2,693.80		$538.76
1607	Eptifibatide injection	K		$15.90		$3.18
1608	Etanercept injection	K		$160.03		$32.01
1609	Rho(D) immune globulin h, sd	K		$15.76		$3.15
1612	Daclizumab, parenteral	K		$297.03		$59.41
1613	Trastuzumab	K		$57.33		$11.47
1629	Nonmetabolic act d/e tissue	K		$18.13		$3.63
1630	Hep b ig, im	K		$132.42		$26.48
1631	Baclofen intrathecal trial	K		$70.92		$14.18
1632	Metabolic active D/E tissue	K		$28.51		$5.70
1633	Alefacept	K		$25.82		$5.16
1643	Y90 ibritumomab, rx	K		$12,030.02		$2,406.00
1645	I131 tositumomab, rx	K		$8,283.41		$1,656.68
1670	Tetanus immune globulin inj	K		$96.35		$19.27
1675	P32 Na phosphate	K		$118.02		$23.60
1676	P32 chromic phosphate	K		$122.17		$24.43
1682	Aprotonin, 10,000 kiu	K		$2.50		$0.50
1683	Basiliximab	K		$1,347.14		$269.43
1684	Corticorelin ovine triflutal	K		$4.26		$0.85
1685	Darbepoetin alfa, non-esrd	K		$3.11		$0.62
1686	Epoetin alfa, non-esrd	K		$9.36		$1.87
1687	Digoxin immune fab (ovine)	K		$511.48		$102.30
1688	Ethanolamine oleate 100 mg	K		$78.26		$15.65
1689	Fomepizole, 15 mg	K		$12.28		$2.46
1690	Hemin, 1 mg	K		$6.74		$1.35
1691	Iron dextran 165 injection	K		$11.61		$2.32
1692	Iron dextran 267 injection	K		$10.32		$2.06
1693	Lepirudin	K		$153.42		$30.68
1694	Ziconotide injection	K		$6.46		$1.29
1695	Nesiritide injection	K		$31.36		$6.27
1696	Palifermin injection	K		$11.32		$2.26
1697	Pegaptanib sodium injection	K		$1,054.70		$210.94
1700	Inj secretin synthetic human	K		$20.12		$4.02
1701	Treprostinil injection	K		$55.36		$11.07
1703	Ovine, 1000 USP units	K		$133.77		$26.75
1704	Inj Vonwillebrand factor IU	K		$0.88		$0.18
1705	Factor viia	K		$1.11		$0.22
1709	Azacitidine injection	K		$4.26		$0.85
1710	Clofarabine injection	K		$115.64		$23.13
1711	Histrelin implant	K		$1,446.98		$289.40
1712	Paclitaxel protein bound	K		$7.03		$1.41
1716	Brachytx source, Gold 198	K	0.5016	$31.95		$6.39
1717	Brachytx source, HDR Ir–192	K	2.7225	$173.40		$34.68
1719	Brachytx sour,Non-HDR Ir–192	K	0.9012	$57.40		$11.48
1738	Oxaliplatin	K		$8.89		$1.78
1739	Pegademase bovine, 25 iu	K		$176.16		$35.23
1740	Diazoxide injection	K		$113.24		$22.65
1741	Urofollitropin, 75 iu	K		$50.22		$10.04
1821	Interspinous implant	H				.
2210	Methyldopate hcl injection	K		$10.01		$2.00
2616	Brachytx source, Yttrium-90	K	187.5212	$11,943.79		$2,388.76
2632	Iodine I-125 sodium iodide	K	0.4494	$28.62		$5.72
2634	Brachytx source, HA, I–125	K	0.4699	$29.93		$5.99
2635	Brachytx source, HA, P–103	K	0.7389	$47.06		$9.41
2636	Brachytx linear source, P–103	K	0.5824	$37.09		$7.42
2731	Immune globulin, powder	K		$25.48		$5.10
2732	Immune globulin, liquid	K		$30.28		$6.06
2770	Quinupristin/dalfopristin	K		$116.70		$23.34
2940	Somatrem injection	K	1.0916	$69.53		$13.91
3030	Sumatriptan succinate/6 MG	K		$58.82		$11.76
3041	Bivalirudin	K		$1.72		$0.34
3043	Gamma globulin 1 CC inj	K		$11.31		$2.26

ADDENDUM A.—PROPOSED OPPS APCS FOR CY 2008—Continued

APC	Group Title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
3050	Sermorelin acetate injection	K		$1.74		$0.35
7000	Amifostine	K		$476.10		$95.22
7005	Gonadorelin hydroch/100 mcg	K		$178.59		$35.72
7011	Oprelvekin injection	K		$244.98		$49.00
7015	Oral busulfan	K		$2.12		$0.42
7028	Fosphenytoin, 50 mg	K		$5.50		$1.10
7034	Somatropin injection	K		$46.75		$9.35
7035	Teniposide, 50 mg	K		$261.93		$52.39
7036	Urokinase 250,000 IU inj	K		$453.41		$90.68
7038	Monoclonal antibodies	K		$886.70		$177.34
7041	Tirofiban HCl	K		$7.66		$1.53
7042	Capecitabine, oral, 150 mg	K		$3.94		$0.79
7043	Infliximab injection	K		$53.25		$10.65
7045	Inj trimetrexate glucoronate	K		$143.89		$28.78
7046	Doxorubicin hcl liposome inj	K		$385.81		$77.16
7048	Alteplase recombinant	K		$32.48		$6.50
7049	Filgrastim 480 mcg injection	K		$297.75		$59.55
7051	Leuprolide acetate implant	K		$1,696.96		$339.39
7308	Aminolevulinic acid hcl top	K		$104.43		$20.89
8000	Cardiac Electrophysiologic Evaluation and Ablation Composite	T	135.5822	$8,635.64		$1,727.13
8001	LDR Prostate Brachytherapy Composite	T	49.7153	$3,166.52		$633.30
9001	Linezolid injection	K		$24.93		$4.99
9002	Tenecteplase injection	K		$2,024.13		$404.83
9003	Palivizumab, per 50 mg	K		$677.97		$135.59
9004	Gemtuzumab ozogamicin	K		$2,334.75		$466.95
9005	Reteplase injection	K		$891.03		$178.21
9006	Tacrolimus injection	K		$139.11		$27.82
9012	Arsenic trioxide	K		$33.84		$6.77
9015	Mycophenolate mofetil oral	K		$2.60		$0.52
9018	Botulinum toxin type B	K		$8.30		$1.66
9019	Caspofungin acetate	K		$30.07		$6.01
9020	Sirolimus, oral	K		$7.15		$1.43
9022	IM inj interferon beta 1–a	K		$113.49		$22.70
9023	Rho d immune globulin 50 mcg	K		$26.41		$5.28
9024	Amphotericin b lipid complex	K		$10.28		$2.06
9032	Baclofen 10 MG injection	K		$195.18		$39.04
9033	Cidofovir injection	K		$754.62		$150.92
9038	Inj estrogen conjugate 25 MG	K		$60.32		$12.06
9042	Glucagon hydrochloride/1 MG	K		$65.64		$13.13
9044	Ibutilide fumarate injection	K		$264.40		$52.88
9046	Iron sucrose injection	K		$0.37		$0.08
9047	Itraconazole injection	K		$38.05		$7.61
9051	Urea injection	K		$73.46		$14.69
9054	Metabolically active tissue	K		$31.36		$6.27
9104	Antithymocyte globuln rabbit	K		$324.66		$64.93
9108	Thyrotropin injection	K		$758.16		$151.63
9110	Alemtuzumab injection	K		$536.10		$107.22
9115	Zoledronic acid	K		$204.09		$40.82
9119	Injection, pegfilgrastim 6mg	K		$2,142.92		$428.58
9120	Injection, Fulvestrant	K		$79.80		$15.96
9121	Injection, argatroban	K		$17.87		$3.57
9122	Triptorelin pamoate	K		$153.97		$30.79
9124	Daptomycin injection	K		$0.33		$0.07
9125	Risperidone, long acting	K		$4.80		$0.96
9126	Natalizumab injection	K		$7.45		$1.49
9133	Rabies ig, im/sc	K		$64.82		$12.96
9134	Rabies ig, heat treated	K		$69.40		$13.88
9135	Varicella-zoster ig, im	K		$121.58		$24.32
9137	Bcg vaccine, percut	K		$112.56		$22.51
9139	Rabies vaccine, im	K		$145.53		$29.11
9140	Rabies vaccine, id	K	1.9483	$124.09		$24.82
9141	Measles-rubella vaccine, sc	K	0.9593	$61.10		$12.22
9143	Meningococcal vaccine, sc	K		$88.59		$17.72
9144	Encephalitis vaccine, sc	K		$98.17		$19.63
9145	Meningococcal vaccine, im	K	1.1309	$72.03		$14.41
9156	Nonmetabolic active tissue	K		$88.37		$17.67
9167	Valrubicin, 200 mg	K	3.4445	$219.39		$43.88
9207	Bortezomib injection	K		$32.37		$6.47
9208	Agalsidase beta injection	K		$126.00		$25.20
9209	Laronidase injection	K		$23.64		$4.73
9210	Palonosetron HCl	K		$15.85		$3.17
9213	Pemetrexed injection	K		$43.38		$8.68
9214	Bevacizumab injection	K		$56.98		$11.40
9215	Cetuximab injection	K		$49.34		$9.87
9216	Abarelix injection	K		$67.97		$13.59
9217	Leuprolide acetate suspnsion	K		$227.34		$45.47
9219	Mycophenolic acid	K		$2.25		$0.45
9222	Injectable human tissue	K		$728.44		$145.69
9224	Galsulfase injection	K		$297.09		$59.42
9225	Fluocinolone acetonide implt	K		$19,162.50		$3,832.50

ADDENDUM A.—PROPOSED OPPS APCS FOR CY 2008—Continued

APC	Group Title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
9227	Micafungin sodium injection	G		$1.71		$0.34
9228	Tigecycline injection	G		$0.91		$0.18
9229	Ibandronate sodium injection	G		$138.71		$27.74
9230	Abatacept injection	G		$18.69		$3.74
9231	Decitabine injection	G	0.4157	$26.48		$5.30
9232	Injection, idursulfase	G		$455.03		$91.01
9233	Injection, ranibizumab	G		$2,030.92		$406.18
9234	Inj, alglucosidase alfa	K		$126.00		$25.20
9235	Injection, panitumumab	G		$84.80		$16.96
9300	Omalizumab injection	K		$16.79		$3.36
9350	Porous collagen tube per cm	G		$485.91		$97.18
9351	Acellular derm tissue percm2	G		$41.59		$8.32
9500	Platelets, irradiated	K	2.0742	$132.11		$26.42
9501	Platelet pheres leukoreduced	K	7.9954	$509.25		$101.85
9502	Platelet pheresis irradiated	K	7.0075	$446.33		$89.27
9503	Fr frz plasma donor retested	K	1.1632	$74.09		$14.82
9504	RBC deglycerolized	K	5.7938	$369.02		$73.80
9505	RBC irradiated	K	3.3259	$211.84		$42.37
9506	Granulocytes, pheresis unit	K	15.5519	$990.55		$198.11
9507	Platelets, pheresis	K	7.0406	$448.44		$89.69
9508	Plasma 1 donor frz w/in 8 hr	K	1.0902	$69.44		$13.89

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
0016T	Thermotx choroid vasc lesion	Y		R2		4.0100	$166.01	$166.01
0017T	Photocoagulat macular drusen	Y		R2		4.0100	$166.01	$166.01
0027T	Endoscopic epidural lysis	Y		G2		18.5069	$766.19	$766.19
0031T	Speculoscopy	N		N1				
0032T	Speculoscopy w/direct sample	N		N1				
0046T	Cath lavage, mammary duct(s)	Y		R2		16.5832	$686.54	$686.54
0047T	Cath lavage, mammary duct(s)	Y		R2		16.5832	$686.54	$686.54
0062T	Rep intradisc annulus; 1 lev	Y		G2		29.3263	$1,214.11	$1,214.11
0063T	Rep intradisc annulus; >1 lev	Y		G2		29.3263	$1,214.11	$1,214.11
0084T	Temp prostate urethral stent	Y		G2		2.1659	$89.67	$89.67
0099T*	Implant corneal ring	Y		R2		16.5252	$684.14	$684.14
0100T	Prosth retina receive&gen	Y		G2		38.1121	$1,577.84	$1,577.84
0101T	Extracorp shockwv tx,hi enrg	Y		G2		29.3263	$1,214.11	$1,214.11
0102T	Extracorp shockwv tx,anesth	Y		G2		29.3263	$1,214.11	$1,214.11
0123T	Scleral fistulization	Y		G2		24.0821	$997.00	$997.00
0124T*	Conjunctival drug placement	Y		R2		5.1145	$211.74	$211.74
0133T	Esophageal implant injexn	Y		G2		24.6480	$1,020.43	$1,020.43
0176T	Aqu canal dilat w/o retent	Y		A2	$1,339.00	40.8481	$1,691.11	$1,427.03
0177T	Aqu canal dilat w retent	Y		A2	$1,339.00	40.8481	$1,691.11	$1,427.03
10021	Fna w/o image	Y		P2		1.1915	$49.33	$49.33
10022	Fna w/image	Y		G2		4.5062	$186.56	$186.56
10040	Acne surgery	Y		P2		0.8046	$33.31	$33.31
10060	Drainage of skin abscess	Y		P3		1.1130	$46.08	$46.08
10061	Drainage of skin abscess	Y		P2		1.4630	$60.57	$60.57
10080	Drainage of pilonidal cyst	Y		P2		1.4630	$60.57	$60.57
10081	Drainage of pilonidal cyst	Y		P3		3.1002	$128.35	$128.35
10120	Remove foreign body	Y		P2		1.4630	$60.57	$60.57
10121	Remove foreign body	Y		A2	$446.00	16.5832	$686.54	$506.14
10140	Drainage of hematoma/fluid	Y		P3		1.6490	$68.27	$68.27
10160	Puncture drainage of lesion	Y	CH	P3		1.4099	$58.37	$58.37
10180	Complex drainage, wound	Y		A2	$446.00	19.0457	$788.49	$531.62
11000	Debride infected skin	Y		P3		0.5360	$22.19	$22.19
11001	Debride infected skin add-on	Y		P3		0.1896	$7.85	$7.85
11010	Debride skin, fx	Y		A2	$251.52	4.4463	$184.08	$234.66
11011	Debride skin/muscle, fx	Y		A2	$251.52	4.4463	$184.08	$234.66
11012	Debride skin/muscle/bone, fx	Y		A2	$251.52	4.4463	$184.08	$234.66
11040	Debride skin, partial	Y		P3		0.4865	$20.14	$20.14
11041	Debride skin, full	Y		P3		0.5688	$23.55	$23.55
11042	Debride skin/tissue	Y		A2	$164.42	2.7493	$113.82	$151.77
11043	Debride tissue/muscle	Y		A2	$164.42	2.7493	$113.82	$151.77
11044	Debride tissue/muscle/bone	Y		A2	$423.10	7.1126	$294.46	$390.94
11055	Trim skin lesion	Y		P3		0.5606	$23.21	$23.21
11056	Trim skin lesions, 2 to 4	Y		P3		0.6184	$25.60	$25.60
11057	Trim skin lesions, over 4	Y		P3		0.7092	$29.36	$29.36
11100	Biopsy, skin lesion	Y		P2		0.8046	$33.31	$33.31
11101	Biopsy, skin add-on	Y		P3		0.3051	$12.63	$12.63
11200	Removal of skin tags	Y	CH	P2		0.8046	$33.31	$33.31
11201	Remove skin tags add-on	Y		P3		0.1319	$5.46	$5.46
11300	Shave skin lesion	Y		P2		0.8046	$33.31	$33.31
11301	Shave skin lesion	Y		P2		0.8046	$33.31	$33.31
11302	Shave skin lesion	Y		P2		0.8046	$33.31	$33.31
11303	Shave skin lesion	Y		P3		1.4841	$61.44	$61.44
11305	Shave skin lesion	Y		P3		0.7833	$32.43	$32.43
11306	Shave skin lesion	Y	CH	P2		0.8046	$33.31	$33.31
11307	Shave skin lesion	Y		P2		0.8046	$33.31	$33.31
11308	Shave skin lesion	Y		P2		0.8046	$33.31	$33.31
11310	Shave skin lesion	Y	CH	P2		0.8046	$33.31	$33.31
11311	Shave skin lesion	Y		P2		0.8046	$33.31	$33.31
11312	Shave skin lesion	Y		P2		0.8046	$33.31	$33.31
11313	Shave skin lesion	Y	CH	P2		0.8046	$33.31	$33.31
11400	Exc tr-ext b9+marg 0.5 < cm	Y		P3		1.5913	$65.88	$65.88
11401	Exc tr-ext b9+marg 0.6–1 cm	Y		P3		1.7396	$72.02	$72.02
11402	Exc tr-ext b9+marg 1.1–2 cm	Y		P3		1.8964	$78.51	$78.51
11403	Exc tr-ext b9+marg 2.1–3 cm	Y		P3		2.0365	$84.31	$84.31
11404	Exc tr-ext b9+marg 3.1–4 cm	Y		A2	$333.00	16.5832	$686.54	$421.39
11406	Exc tr-ext b9+marg > 4.0 cm	Y		A2	$446.00	16.5832	$686.54	$506.14
11420	Exc h-f-nk-sp b9+marg 0.5 <	Y		P3		1.4758	$61.10	$61.10
11421	Exc h-f-nk-sp b9+marg 0.6–1	Y		P3		1.7563	$72.71	$72.71
11422	Exc h-f-nk-sp b9+marg 1.1–2	Y		P3		1.9210	$79.53	$79.53
11423	Exc h-f-nk-sp b9+marg 2.1–3	Y		P3		2.1601	$89.43	$89.43
11424	Exc h-f-nk-sp b9+marg 3.1–4	Y		A2	$446.00	16.5832	$686.54	$506.14
11426	Exc h-f-nk-sp b9+marg > 4 cm	Y		A2	$446.00	21.4534	$888.17	$556.54
11440	Exc face-mm b9+marg 0.5 < cm	Y		P3		1.7314	$71.68	$71.68
11441	Exc face-mm b9+marg 0.6–1 cm	Y		P3		1.9459	$80.56	$80.56
11442	Exc face-mm b9+marg 1.1–2 cm	Y		P3		2.1273	$88.07	$88.07
11443	Exc face-mm b9+marg 2.1–3 cm	Y		P3		2.3829	$98.65	$98.65

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
11444	Exc face-mm b9+marg 3.1–4 cm	Y		A2	$333.00	8.7155	$360.82	$339.96
11446	Exc face-mm b9+marg > 4 cm	Y		A2	$446.00	21.4534	$888.17	$556.54
11450	Removal, sweat gland lesion	Y		A2	$446.00	21.4534	$888.17	$556.54
11451	Removal, sweat gland lesion	Y		A2	$446.00	21.4534	$888.17	$556.54
11462	Removal, sweat gland lesion	Y		A2	$446.00	21.4534	$888.17	$556.54
11463	Removal, sweat gland lesion	Y		A2	$446.00	21.4534	$888.17	$556.54
11470	Removal, sweat gland lesion	Y		A2	$446.00	21.4534	$888.17	$556.54
11471	Removal, sweat gland lesion	Y		A2	$446.00	21.4534	$888.17	$556.54
11600	Exc tr-ext mlg+marg 0.5 < cm	Y		P3		2.2097	$91.48	$91.48
11601	Exc tr-ext mlg+marg 0.6–1 cm	Y		P3		2.5312	$104.79	$104.79
11602	Exc tr-ext mlg+marg 1.1–2 cm	Y		P3		2.7457	$113.67	$113.67
11603	Exc tr-ext mlg+marg 2.1–3 cm	Y		P3		2.9353	$121.52	$121.52
11604	Exc tr-ext mlg+marg 3.1–4 cm	Y		A2	$418.49	8.7155	$360.82	$404.07
11606	Exc tr-ext mlg+marg > 4 cm	Y		A2	$446.00	16.5832	$686.54	$506.14
11620	Exc h-f-nk-sp mlg+marg 0.5 <	Y		P3		2.2428	$92.85	$92.85
11621	Exc h-f-nk-sp mlg+marg 0.6–1	Y		P3		2.5560	$105.82	$105.82
11622	Exc h-f-nk-sp mlg+marg 1.1–2	Y		P3		2.8280	$117.08	$117.08
11623	Exc h-f-nk-sp mlg+marg 2.1–3	Y		P3		3.0671	$126.98	$126.98
11624	Exc h-f-nk-sp mlg+marg 3.1–4	Y		A2	$446.00	16.5832	$686.54	$506.14
11626	Exc h-f-nk-sp mlg+mar > 4 cm	Y		A2	$446.00	21.4534	$888.17	$556.54
11640	Exc face-mm malig+marg 0.5 <	Y		P3		2.3498	$97.28	$97.28
11641	Exc face-mm malig+marg 0.6–1	Y		P3		2.7457	$113.67	$113.67
11642	Exc face-mm malig+marg 1.1–2	Y		P3		3.0671	$126.98	$126.98
11643	Exc face-mm malig+marg 2.1–3	Y		P3		3.3312	$137.91	$137.91
11644	Exc face-mm malig+marg 3.1–4	Y		A2	$446.00	16.5832	$686.54	$506.14
11646	Exc face-mm mlg+marg > 4 cm	Y		A2	$446.00	21.4534	$888.17	$556.54
11719	Trim nail(s)	Y		P3		0.2556	$10.58	$10.58
11720	Debride nail, 1–5	Y		P3		0.3297	$13.65	$13.65
11721	Debride nail, 6 or more	Y		P3		0.4041	$16.73	$16.73
11730	Removal of nail plate	Y	CH	P2		0.8046	$33.31	$33.31
11732	Remove nail plate, add-on	Y		P3		0.4041	$16.73	$16.73
11740	Drain blood from under nail	Y	CH	P2		0.2682	$11.10	$11.10
11750	Removal of nail bed	Y		P3		2.0942	$86.70	$86.70
11752	Remove nail bed/finger tip	Y		P3		2.8940	$119.81	$119.81
11755	Biopsy, nail unit	Y		P3		1.4758	$61.10	$61.10
11760	Repair of nail bed	Y		G2		2.1114	$87.41	$87.41
11762	Reconstruction of nail bed	Y	CH	P3		2.6961	$111.62	$111.62
11765	Excision of nail fold, toe	Y		P2		1.5119	$62.59	$62.59
11770	Removal of pilonidal lesion	Y		A2	$510.00	21.4534	$888.17	$604.54
11771	Removal of pilonidal lesion	Y		A2	$510.00	21.4534	$888.17	$604.54
11772	Removal of pilonidal lesion	Y		A2	$510.00	21.4534	$888.17	$604.54
11900	Injection into skin lesions	Y		P3		0.6514	$26.97	$26.97
11901	Added skin lesions injection	Y		P3		0.6925	$28.67	$28.67
11920	Correct skin color defects	Y		P2		2.1114	$87.41	$87.41
11921	Correct skin color defects	Y		P2		2.1114	$87.41	$87.41
11922	Correct skin color defects	Y		P3		0.8493	$35.16	$35.16
11950	Therapy for contour defects	Y		P3		0.8329	$34.48	$34.48
11951	Therapy for contour defects	Y		P3		1.0225	$42.33	$42.33
11952	Therapy for contour defects	Y	CH	P2		1.3340	$55.23	$55.23
11954	Therapy for contour defects	Y		P2		1.3340	$55.23	$55.23
11960	Insert tissue expander(s)	Y		A2	$446.00	20.9338	$866.66	$551.17
11970	Replace tissue expander	Y		A2	$510.00	43.5953	$1,804.85	$833.71
11971	Remove tissue expander(s)	Y		A2	$333.00	21.4534	$888.17	$471.79
11976	Removal of contraceptive cap	Y		P3		1.4181	$58.71	$58.71
11980	Implant hormone pellet(s)	N		P2		0.6416	$26.56	$26.56
11981	Insert drug implant device	N		P2		0.6416	$26.56	$26.56
11982	Remove drug implant device	N		P2		0.6416	$26.56	$26.56
11983	Remove/insert drug implant	N		P2		0.6416	$26.56	$26.56
12001	Repair superficial wound(s)	Y		P2		1.3340	$55.23	$55.23
12002	Repair superficial wound(s)	Y		P2		1.3340	$55.23	$55.23
12004	Repair superficial wound(s)	Y		P2		1.3340	$55.23	$55.23
12005	Repair superficial wound(s)	Y		A2	$91.24	1.3340	$55.23	$82.24
12006	Repair superficial wound(s)	Y		A2	$91.24	1.3340	$55.23	$82.24
12007	Repair superficial wound(s)	Y		A2	$91.24	1.3340	$55.23	$82.24
12011	Repair superficial wound(s)	Y		P2		1.3340	$55.23	$55.23
12013	Repair superficial wound(s)	Y		P2		1.3340	$55.23	$55.23
12014	Repair superficial wound(s)	Y		P2		1.3340	$55.23	$55.23
12015	Repair superficial wound(s)	Y		G2		1.3340	$55.23	$55.23
12016	Repair superficial wound(s)	Y		A2	$91.24	1.3340	$55.23	$82.24
12017	Repair superficial wound(s)	Y		A2	$91.24	1.3340	$55.23	$82.24
12018	Repair superficial wound(s)	Y		A2	$91.24	1.3340	$55.23	$82.24
12020	Closure of split wound	Y		A2	$91.24	4.6816	$193.82	$116.89
12021	Closure of split wound	Y		A2	$91.24	4.6816	$193.82	$116.89
12031	Layer closure of wound(s)	Y		P2		2.1114	$87.41	$87.41
12032	Layer closure of wound(s)	Y		P2		2.1114	$87.41	$87.41
12034	Layer closure of wound(s)	Y		A2	$91.24	2.1114	$87.41	$90.28

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
12035	Layer closure of wound(s)	Y		A2	$91.24	2.1114	$87.41	$90.28
12036	Layer closure of wound(s)	Y		A2	$91.24	2.1114	$87.41	$90.28
12037	Layer closure of wound(s)	Y		A2	$323.28	2.1114	$87.41	$264.31
12041	Layer closure of wound(s)	Y		P2		2.1114	$87.41	$87.41
12042	Layer closure of wound(s)	Y		P2		2.1114	$87.41	$87.41
12044	Layer closure of wound(s)	Y		A2	$91.24	2.1114	$87.41	$90.28
12045	Layer closure of wound(s)	Y		A2	$91.24	2.1114	$87.41	$90.28
12046	Layer closure of wound(s)	Y		A2	$91.24	2.1114	$87.41	$90.28
12047	Layer closure of wound(s)	Y		A2	$323.28	2.1114	$87.41	$264.31
12051	Layer closure of wound(s)	Y		P2		2.1114	$87.41	$87.41
12052	Layer closure of wound(s)	Y		P2		2.1114	$87.41	$87.41
12053	Layer closure of wound(s)	Y		P2		2.1114	$87.41	$87.41
12054	Layer closure of wound(s)	Y		A2	$91.24	2.1114	$87.41	$90.28
12055	Layer closure of wound(s)	Y		A2	$91.24	2.1114	$87.41	$90.28
12056	Layer closure of wound(s)	Y		A2	$91.24	2.1114	$87.41	$90.28
12057	Layer closure of wound(s)	Y		A2	$323.28	2.1114	$87.41	$264.31
13100	Repair of wound or lesion	Y		A2	$323.28	4.6816	$193.82	$290.92
13101	Repair of wound or lesion	Y		A2	$323.28	4.6816	$193.82	$290.92
13102	Repair wound/lesion add-on	Y		A2	$91.24	4.6816	$193.82	$116.89
13120	Repair of wound or lesion	Y		A2	$91.24	2.1114	$87.41	$90.28
13121	Repair of wound or lesion	Y		A2	$91.24	4.6816	$193.82	$116.89
13122	Repair wound/lesion add-on	Y		A2	$91.24	2.1114	$87.41	$90.28
13131	Repair of wound or lesion	Y		A2	$91.24	4.6816	$193.82	$116.89
13132	Repair of wound or lesion	Y		A2	$91.24	4.6816	$193.82	$116.89
13133	Repair wound/lesion add-on	Y		A2	$91.24	4.6816	$193.82	$116.89
13150	Repair of wound or lesion	Y		A2	$323.28	4.6816	$193.82	$290.92
13151	Repair of wound or lesion	Y		A2	$323.28	4.6816	$193.82	$290.92
13152	Repair of wound or lesion	Y		A2	$323.28	4.6816	$193.82	$290.92
13153	Repair wound/lesion add-on	Y		A2	$91.24	2.1114	$87.41	$90.28
13160	Late closure of wound	Y		A2	$446.00	20.9338	$866.66	$551.17
14000	Skin tissue rearrangement	Y		A2	$446.00	15.4399	$639.21	$494.30
14001	Skin tissue rearrangement	Y		A2	$510.00	15.4399	$639.21	$542.30
14020	Skin tissue rearrangement	Y		A2	$510.00	15.4399	$639.21	$542.30
14021	Skin tissue rearrangement	Y		A2	$510.00	15.4399	$639.21	$542.30
14040	Skin tissue rearrangement	Y		A2	$446.00	15.4399	$639.21	$494.30
14041	Skin tissue rearrangement	Y		A2	$510.00	15.4399	$639.21	$542.30
14060	Skin tissue rearrangement	Y		A2	$510.00	15.4399	$639.21	$542.30
14061	Skin tissue rearrangement	Y		A2	$510.00	15.4399	$639.21	$542.30
14300	Skin tissue rearrangement	Y		A2	$630.00	20.9338	$866.66	$689.17
14350	Skin tissue rearrangement	Y		A2	$510.00	20.9338	$866.66	$599.17
15002	Wnd prep, ch/inf, trk/arm/lg	Y		A2	$323.28	4.6816	$193.82	$290.92
15003	Wnd prep, ch/inf addl 100 cm	Y		A2	$323.28	4.6816	$193.82	$290.92
15004	Wnd prep ch/inf, f/n/hf/g	Y		A2	$323.28	4.6816	$193.82	$290.92
15005	Wnd prep, f/n/hf/g, addl cm	Y		A2	$323.28	4.6816	$193.82	$290.92
15040	Harvest cultured skin graft	Y		A2	$91.24	2.1114	$87.41	$90.28
15050	Skin pinch graft	Y		A2	$323.28	4.6816	$193.82	$290.92
15100	Skin splt grft, trnk/arm/leg	Y		A2	$446.00	20.9338	$866.66	$551.17
15101	Skin splt grft t/a/l, add-on	Y		A2	$510.00	20.9338	$866.66	$599.17
15110	Epidrm autogrft trnk/arm/leg	Y		A2	$446.00	4.6816	$193.82	$382.96
15111	Epidrm autogrft t/a/l add-on	Y		A2	$333.00	4.6816	$193.82	$298.21
15115	Epidrm a-grft face/nck/hf/g	Y		A2	$446.00	4.6816	$193.82	$382.96
15116	Epidrm a-grft f/n/hf/g addl	Y		A2	$333.00	4.6816	$193.82	$298.21
15120	Skn splt a-grft fac/nck/hf/g	Y		A2	$446.00	20.9338	$866.66	$551.17
15121	Skn splt a-grft f/n/hf/g add	Y		A2	$510.00	20.9338	$866.66	$599.17
15130	Derm autograft, trnk/arm/leg	Y		A2	$446.00	15.4399	$639.21	$494.30
15131	Derm autograft t/a/l add-on	Y		A2	$333.00	15.4399	$639.21	$409.55
15135	Derm autograft face/nck/hf/g	Y		A2	$446.00	15.4399	$639.21	$494.30
15136	Derm autograft, f/n/hf/g add	Y		A2	$333.00	15.4399	$639.21	$409.55
15150	Cult epiderm grft t/arm/leg	Y		A2	$446.00	4.6816	$193.82	$382.96
15151	Cult epiderm grft t/a/l addl	Y		A2	$333.00	4.6816	$193.82	$298.21
15152	Cult epiderm graft t/a/l +%	Y		A2	$333.00	4.6816	$193.82	$298.21
15155	Cult epiderm graft, f/n/hf/g	Y		A2	$446.00	4.6816	$193.82	$382.96
15156	Cult epidrm grft f/n/hfg add	Y		A2	$333.00	4.6816	$193.82	$298.21
15157	Cult epiderm grft f/n/hfg +%	Y		A2	$333.00	4.6816	$193.82	$298.21
15200	Skin full graft, trunk	Y		A2	$510.00	15.4399	$639.21	$542.30
15201	Skin full graft trunk add-on	Y		A2	$323.28	15.4399	$639.21	$402.26
15220	Skin full graft sclp/arm/leg	Y		A2	$446.00	15.4399	$639.21	$494.30
15221	Skin full graft add-on	Y		A2	$323.28	4.6816	$193.82	$290.92
15240	Skin full grft face/genit/hf	Y		A2	$510.00	15.4399	$639.21	$542.30
15241	Skin full graft add-on	Y		A2	$323.28	4.6816	$193.82	$290.92
15260	Skin full graft een & lips	Y		A2	$446.00	15.4399	$639.21	$494.30
15261	Skin full graft add-on	Y		A2	$323.28	15.4399	$639.21	$402.26
15300	Apply skinallogrft, t/arm/lg	Y		A2	$323.28	4.6816	$193.82	$290.92
15301	Apply sknallogrft t/a/l addl	Y		A2	$323.28	4.6816	$193.82	$290.92
15320	Apply skin allogrft f/n/hf/g	Y		A2	$323.28	4.6816	$193.82	$290.92
15321	Aply sknallogrft f/n/hfg add	Y		A2	$323.28	4.6816	$193.82	$290.92

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
15330	Aply acell alogrft t/arm/leg	Y		A2	$323.28	4.6816	$193.82	$290.92
15331	Aply acell grft t/a/l add-on	Y		A2	$323.28	4.6816	$193.82	$290.92
15335	Apply acell graft, f/n/hf/g	Y		A2	$323.28	4.6816	$193.82	$290.92
15336	Aply acell grft f/n/hf/g add	Y		A2	$323.28	4.6816	$193.82	$290.92
15340	Apply cult skin substitute	Y		G2		2.1114	$87.41	$87.41
15341	Apply cult skin sub add-on	Y		G2		2.1114	$87.41	$87.41
15360	Apply cult derm sub, t/a/l	Y		G2		2.1114	$87.41	$87.41
15361	Aply cult derm sub t/a/l add	Y		G2		2.1114	$87.41	$87.41
15365	Apply cult derm sub f/n/hf/g	Y		G2		2.1114	$87.41	$87.41
15366	Apply cult derm f/hf/g add	Y		G2		2.1114	$87.41	$87.41
15400	Apply skin xenograft, t/a/l	Y		A2	$323.28	4.6816	$193.82	$290.92
15401	Apply skn xenogrft t/a/l add	Y		A2	$323.28	4.6816	$193.82	$290.92
15420	Apply skin xgraft, f/n/hf/g	Y		A2	$323.28	4.6816	$193.82	$290.92
15421	Apply skn xgrft f/n/hf/g add	Y		A2	$323.28	4.6816	$193.82	$290.92
15430	Apply acellular xenograft	Y		A2	$323.28	4.6816	$193.82	$290.92
15431	Apply acellular xgraft add	Y		A2	$323.28	4.6816	$193.82	$290.92
15570	Form skin pedicle flap	Y		A2	$510.00	20.9338	$866.66	$599.17
15572	Form skin pedicle flap	Y		A2	$510.00	20.9338	$866.66	$599.17
15574	Form skin pedicle flap	Y		A2	$510.00	20.9338	$866.66	$599.17
15576	Form skin pedicle flap	Y		A2	$510.00	20.9338	$866.66	$599.17
15600	Skin graft	Y		A2	$510.00	20.9338	$866.66	$599.17
15610	Skin graft	Y		A2	$510.00	20.9338	$866.66	$599.17
15620	Skin graft	Y		A2	$630.00	20.9338	$866.66	$689.17
15630	Skin graft	Y		A2	$510.00	20.9338	$866.66	$599.17
15650	Transfer skin pedicle flap	Y		A2	$717.00	20.9338	$866.66	$754.42
15731	Forehead flap w/vasc pedicle	Y		A2	$510.00	20.9338	$866.66	$599.17
15732	Muscle-skin graft, head/neck	Y		A2	$510.00	20.9338	$866.66	$599.17
15734	Muscle-skin graft, trunk	Y		A2	$510.00	20.9338	$866.66	$599.17
15736	Muscle-skin graft, arm	Y		A2	$510.00	20.9338	$866.66	$599.17
15738	Muscle-skin graft, leg	Y		A2	$510.00	20.9338	$866.66	$599.17
15740	Island pedicle flap graft	Y		A2	$446.00	15.4399	$639.21	$494.30
15750	Neurovascular pedicle graft	Y		A2	$446.00	20.9338	$866.66	$551.17
15760	Composite skin graft	Y		A2	$446.00	20.9338	$866.66	$551.17
15770	Derma-fat-fascia graft	Y		A2	$510.00	20.9338	$866.66	$599.17
15775	Hair transplant punch grafts	Y		A2	$323.28	1.3340	$55.23	$256.27
15776	Hair transplant punch grafts	Y		A2	$323.28	1.3340	$55.23	$256.27
15780	Abrasion treatment of skin	Y		P3		9.5232	$394.26	$394.26
15781	Abrasion treatment of skin	Y		P2		4.4463	$184.08	$184.08
15782	Abrasion treatment of skin	Y		P2		4.4463	$184.08	$184.08
15783	Abrasion treatment of skin	Y		P2		2.7493	$113.82	$113.82
15786	Abrasion, lesion, single	Y		P2		0.8046	$33.31	$33.31
15787	Abrasion, lesions, add-on	Y		P3		0.7915	$32.77	$32.77
15788	Chemical peel, face, epiderm	Y		P2		0.8046	$33.31	$33.31
15789	Chemical peel, face, dermal	Y		P2		1.5119	$62.59	$62.59
15792	Chemical peel, nonfacial	Y		P2		1.5119	$62.59	$62.59
15793	Chemical peel, nonfacial	Y		P2		0.8046	$33.31	$33.31
15819	Plastic surgery, neck	Y		G2		2.1114	$87.41	$87.41
15820	Revision of lower eyelid	Y		A2	$510.00	20.9338	$866.66	$599.17
15821	Revision of lower eyelid	Y		A2	$510.00	20.9338	$866.66	$599.17
15822	Revision of upper eyelid	Y		A2	$510.00	20.9338	$866.66	$599.17
15823	Revision of upper eyelid	Y		A2	$717.00	20.9338	$866.66	$754.42
15824	Removal of forehead wrinkles	Y		A2	$510.00	20.9338	$866.66	$599.17
15825	Removal of neck wrinkles	Y		A2	$510.00	20.9338	$866.66	$599.17
15826	Removal of brow wrinkles	Y		A2	$510.00	20.9338	$866.66	$599.17
15828	Removal of face wrinkles	Y		A2	$510.00	20.9338	$866.66	$599.17
15829	Removal of skin wrinkles	Y		A2	$717.00	20.9338	$866.66	$754.42
15830	Exc skin abd	Y		A2	$510.00	21.4534	$888.17	$604.54
15832	Excise excessive skin tissue	Y		A2	$510.00	21.4534	$888.17	$604.54
15833	Excise excessive skin tissue	Y		A2	$510.00	21.4534	$888.17	$604.54
15834	Excise excessive skin tissue	Y		A2	$510.00	21.4534	$888.17	$604.54
15835	Excise excessive skin tissue	Y		A2	$323.28	21.4534	$888.17	$464.50
15836	Excise excessive skin tissue	Y		A2	$510.00	16.5832	$686.54	$554.14
15837	Excise excessive skin tissue	Y		G2		16.5832	$686.54	$686.54
15838	Excise excessive skin tissue	Y		G2		16.5832	$686.54	$686.54
15839	Excise excessive skin tissue	Y		A2	$510.00	16.5832	$686.54	$554.14
15840	Graft for face nerve palsy	Y		A2	$630.00	20.9338	$866.66	$689.17
15841	Graft for face nerve palsy	Y		A2	$630.00	20.9338	$866.66	$689.17
15842	Flap for face nerve palsy	Y		G2		20.9338	$866.66	$866.66
15845	Skin and muscle repair, face	Y		A2	$630.00	20.9338	$866.66	$689.17
15847	Exc skin abd add-on	Y		A2	$510.00	21.4534	$888.17	$604.54
15850	Removal of sutures	Y		G2		2.7493	$113.82	$113.82
15851	Removal of sutures	Y		P3		1.2367	$51.20	$51.20
15852	Dressing change not for burn	N		G2		0.6416	$26.56	$26.56
15860	Test for blood flow in graft	N		G2		0.6416	$26.56	$26.56
15876	Suction assisted lipectomy	Y		A2	$510.00	20.9338	$866.66	$599.17
15877	Suction assisted lipectomy	Y		A2	$510.00	20.9338	$866.66	$599.17

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
15878	Suction assisted lipectomy	Y		A2	$510.00	20.9338	$866.66	$599.17
15879	Suction assisted lipectomy	Y		A2	$510.00	20.9338	$866.66	$599.17
15920	Removal of tail bone ulcer	Y		A2	$251.52	4.4463	$184.08	$234.66
15922	Removal of tail bone ulcer	Y		A2	$630.00	20.9338	$866.66	$689.17
15931	Remove sacrum pressure sore	Y		A2	$510.00	21.4534	$888.17	$604.54
15933	Remove sacrum pressure sore	Y		A2	$510.00	21.4534	$888.17	$604.54
15934	Remove sacrum pressure sore	Y		A2	$510.00	20.9338	$866.66	$599.17
15935	Remove sacrum pressure sore	Y		A2	$630.00	20.9338	$866.66	$689.17
15936	Remove sacrum pressure sore	Y		A2	$630.00	15.4399	$639.21	$632.30
15937	Remove sacrum pressure sore	Y		A2	$630.00	20.9338	$866.66	$689.17
15940	Remove hip pressure sore	Y		A2	$510.00	21.4534	$888.17	$604.54
15941	Remove hip pressure sore	Y		A2	$510.00	21.4534	$888.17	$604.54
15944	Remove hip pressure sore	Y		A2	$510.00	20.9338	$866.66	$599.17
15945	Remove hip pressure sore	Y		A2	$630.00	20.9338	$866.66	$689.17
15946	Remove hip pressure sore	Y		A2	$630.00	20.9338	$866.66	$689.17
15950	Remove thigh pressure sore	Y		A2	$510.00	21.4534	$888.17	$604.54
15951	Remove thigh pressure sore	Y		A2	$630.00	21.4534	$888.17	$694.54
15952	Remove thigh pressure sore	Y		A2	$510.00	15.4399	$639.21	$542.30
15953	Remove thigh pressure sore	Y		A2	$630.00	15.4399	$639.21	$632.30
15956	Remove thigh pressure sore	Y		A2	$510.00	15.4399	$639.21	$542.30
15958	Remove thigh pressure sore	Y		A2	$630.00	15.4399	$639.21	$632.30
16000	Initial treatment of burn(s)	Y		P3		0.6514	$26.97	$26.97
16020	Dress/debrid p-thick burn, s	Y		P3		0.9894	$40.96	$40.96
16025	Dress/debrid p-thick burn, m	Y		A2	$67.11	2.7493	$113.82	$78.79
16030	Dress/debrid p-thick burn, l	Y		A2	$99.83	2.7493	$113.82	$103.33
16035	Incision of burn scab, initi	Y		G2		2.7493	$113.82	$113.82
17000	Destruct premalg lesion	Y		P2		0.8046	$33.31	$33.31
17003	Destruct premalg les, 2–14	Y		P3		0.0906	$3.75	$3.75
17004	Destroy premlg lesions 15+	Y		P3		1.9541	$80.90	$80.90
17106	Destruction of skin lesions	Y		P2		2.7493	$113.82	$113.82
17107	Destruction of skin lesions	Y		P2		2.7493	$113.82	$113.82
17108	Destruction of skin lesions	Y		P2		2.7493	$113.82	$113.82
17110	Destruct b9 lesion, 1–14	Y		P2		0.8046	$33.31	$33.31
17111	Destruct lesion, 15 or more	Y		P2		1.5119	$62.59	$62.59
17250	Chemical cautery, tissue	Y		P3		1.0471	$43.35	$43.35
17260	Destruction of skin lesions	Y		P3		1.1130	$46.08	$46.08
17261	Destruction of skin lesions	Y		P2		1.5119	$62.59	$62.59
17262	Destruction of skin lesions	Y		P2		1.5119	$62.59	$62.59
17263	Destruction of skin lesions	Y		P2		1.5119	$62.59	$62.59
17264	Destruction of skin lesions	Y		P2		1.5119	$62.59	$62.59
17266	Destruction of skin lesions	Y		P3		2.4819	$102.75	$102.75
17270	Destruction of skin lesions	Y		P2		1.5119	$62.59	$62.59
17271	Destruction of skin lesions	Y		P2		1.5119	$62.59	$62.59
17272	Destruction of skin lesions	Y		P2		1.5119	$62.59	$62.59
17273	Destruction of skin lesions	Y	CH	P3		2.2345	$92.51	$92.51
17274	Destruction of skin lesions	Y		P3		2.5560	$105.82	$105.82
17276	Destruction of skin lesions	Y		P2		2.7493	$113.82	$113.82
17280	Destruction of skin lesions	Y	CH	P2		1.5119	$62.59	$62.59
17281	Destruction of skin lesions	Y	CH	P3		1.9210	$79.53	$79.53
17282	Destruction of skin lesions	Y	CH	P3		2.1932	$90.80	$90.80
17283	Destruction of skin lesions	Y	CH	P3		2.5229	$104.45	$104.45
17284	Destruction of skin lesions	Y		P2		2.7493	$113.82	$113.82
17286	Destruction of skin lesions	Y		P2		2.7493	$113.82	$113.82
17311	Mohs, 1 stage, h/n/hf/g	Y		P2		3.9713	$164.41	$164.41
17312	Mohs addl stage	Y		P2		3.9713	$164.41	$164.41
17313	Mohs, 1 stage, t/a/l	Y		P2		3.9713	$164.41	$164.41
17314	Mohs, addl stage, t/a/l	Y		P2		3.9713	$164.41	$164.41
17315	Mohs surg, addl block	Y		P3		0.9483	$39.26	$39.26
17340	Cryotherapy of skin	Y		P3		0.2969	$12.29	$12.29
17360	Skin peel therapy	Y		P2		0.8046	$33.31	$33.31
17380	Hair removal by electrolysis	Y		R2		0.8046	$33.31	$33.31
19000	Drainage of breast lesion	Y		P3		1.5831	$65.54	$65.54
19001	Drain breast lesion add-on	Y		P3		0.2060	$8.53	$8.53
19020	Incision of breast lesion	Y		A2	$446.00	19.0457	$788.49	$531.62
19030	Injection for breast x-ray	N		N1				
19100	Bx breast percut w/o image	Y		A2	$240.00	4.5062	$186.56	$226.64
19101	Biopsy of breast, open	Y		A2	$446.00	20.9980	$869.32	$551.83
19102	Bx breast percut w/image	Y		A2	$240.00	7.3012	$302.27	$255.57
19103	Bx breast percut w/device	Y		A2	$395.77	13.9599	$577.94	$441.31
19105	Cryosurg ablate fa, each	Y		G2		32.4940	$1,345.25	$1,345.25
19110	Nipple exploration	Y		A2	$446.00	20.9980	$869.32	$551.83
19112	Excise breast duct fistula	Y		A2	$510.00	20.9980	$869.32	$599.83
19120	Removal of breast lesion	Y		A2	$510.00	20.9980	$869.32	$599.83
19125	Excision, breast lesion	Y		A2	$510.00	20.9980	$869.32	$599.83
19126	Excision, addl breast lesion	Y		A2	$510.00	20.9980	$869.32	$599.83
19290	Place needle wire, breast	N		N1	$333.00			

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
19291	Place needle wire, breast	N		N1	$333.00			
19295	Place breast clip, percut	N	CH	N1	$106.76			
19296	Place po breast cath for rad	Y		A2	$1,339.00	52.9438	$2,191.87	$1,552.22
19297	Place breast cath for rad	Y		A2	$1,339.00	52.9438	$2,191.87	$1,552.22
19298	Place breast rad tube/caths	Y	CH	A2	$1,339.00	52.9438	$2,191.87	$1,552.22
19300	Removal of breast tissue	Y		A2	$630.00	20.9980	$869.32	$689.83
19301	Partical mastectomy	Y		A2	$510.00	20.9980	$869.32	$599.83
19302	P-mastectomy w/ln removal	Y		A2	$995.00	40.4634	$1,675.18	$1,165.05
19303	Mast, simple, complete	Y		A2	$630.00	32.4940	$1,345.25	$808.81
19304	Mast, subq	Y		A2	$630.00	32.4940	$1,345.25	$808.81
19316	Suspension of breast	Y		A2	$630.00	32.4940	$1,345.25	$808.81
19318	Reduction of large breast	Y		A2	$630.00	40.4634	$1,675.18	$891.30
19324	Enlarge breast	Y		A2	$630.00	40.4634	$1,675.18	$891.30
19325	Enlarge breast with implant	Y		A2	$1,339.00	52.9438	$2,191.87	$1,552.22
19328	Removal of breast implant	Y		A2	$333.00	32.4940	$1,345.25	$586.06
19330	Removal of implant material	Y		A2	$333.00	32.4940	$1,345.25	$586.06
19340	Immediate breast prosthesis	Y		A2	$446.00	40.4634	$1,675.18	$753.30
19342	Delayed breast prosthesis	Y		A2	$510.00	52.9438	$2,191.87	$930.47
19350	Breast reconstruction	Y		A2	$630.00	20.9980	$869.32	$689.83
19355	Correct inverted nipple(s)	Y		A2	$630.00	32.4940	$1,345.25	$808.81
19357	Breast reconstruction	Y		A2	$717.00	52.9438	$2,191.87	$1,085.72
19366	Breast reconstruction	Y		A2	$717.00	32.4940	$1,345.25	$874.06
19370	Surgery of breast capsule	Y		A2	$630.00	32.4940	$1,345.25	$808.81
19371	Removal of breast capsule	Y		A2	$630.00	32.4940	$1,345.25	$808.81
19380	Revise breast reconstruction	Y		A2	$717.00	40.4634	$1,675.18	$956.55
19396	Design custom breast implant	Y		G2		32.4940	$1,345.25	$1,345.25
20000	Incision of abscess	Y		P2		1.4630	$60.57	$60.57
20005	Incision of deep abscess	Y		A2	$446.00	21.5761	$893.25	$557.81
20103	Explore wound, extremity	Y		G2		9.5721	$396.28	$396.28
20150	Excise epiphyseal bar	Y		G2		43.5953	$1,804.85	$1,804.85
20200	Muscle biopsy	Y		A2	$446.00	16.5832	$686.54	$506.14
20205	Deep muscle biopsy	Y		A2	$510.00	16.5832	$686.54	$554.14
20206	Needle biopsy, muscle	Y		A2	$240.00	7.3012	$302.27	$255.57
20220	Bone biopsy, trocar/needle	Y		A2	$251.52	8.7155	$360.82	$278.85
20225	Bone biopsy, trocar/needle	Y		A2	$418.49	8.7155	$360.82	$404.07
20240	Bone biopsy, excisional	Y		A2	$446.00	21.4534	$888.17	$556.54
20245	Bone biopsy, excisional	Y		A2	$510.00	21.4534	$888.17	$604.54
20250	Open bone biopsy	Y		A2	$510.00	21.5761	$893.25	$605.81
20251	Open bone biopsy	Y		A2	$510.00	21.5761	$893.25	$605.81
20500	Injection of sinus tract	Y		P3		1.4676	$60.76	$60.76
20501	Inject sinus tract for x-ray	N		N1				
20520	Removal of foreign body	Y		P3		2.2674	$93.87	$93.87
20525	Removal of foreign body	Y		A2	$510.00	21.4534	$888.17	$604.54
20526	Ther injection, carp tunnel	Y		P3		0.7338	$30.38	$30.38
20550	Inj tendon sheath/ligament	Y		P3		0.5524	$22.87	$22.87
20551	Inj tendon origin/insertion	Y		P3		0.5442	$22.53	$22.53
20552	Inj trigger point, 1/2 muscl	Y		P3		0.5360	$22.19	$22.19
20553	Inject trigger points, =/> 3	Y		P3		0.6019	$24.92	$24.92
20600	Drain/inject, joint/bursa	Y		P3		0.5442	$22.53	$22.53
20605	Drain/inject, joint/bursa	Y		P3		0.6184	$25.60	$25.60
20610	Drain/inject, joint/bursa	Y		P3		0.8329	$34.48	$34.48
20612	Aspirate/inj ganglion cyst	Y		P3		0.5771	$23.89	$23.89
20615	Treatment of bone cyst	Y	CH	P3		2.5560	$105.82	$105.82
20650	Insert and remove bone pin	Y		A2	$510.00	21.5761	$893.25	$605.81
20662	Application of pelvis brace	Y		R2		21.5761	$893.25	$893.25
20663	Application of thigh brace	Y		R2		21.5761	$893.25	$893.25
20665	Removal of fixation device	N		G2		0.6416	$26.56	$26.56
20670	Removal of support implant	Y		A2	$333.00	16.5832	$686.54	$421.39
20680	Removal of support implant	Y		A2	$510.00	21.4534	$888.17	$604.54
20690	Apply bone fixation device	Y		A2	$446.00	29.3263	$1,214.11	$638.03
20692	Apply bone fixation device	Y		A2	$510.00	29.3263	$1,214.11	$686.03
20693	Adjust bone fixation device	Y		A2	$510.00	21.5761	$893.25	$605.81
20694	Remove bone fixation device	Y		A2	$333.00	21.5761	$893.25	$473.06
20822	Replantation digit, complete	Y		G2		26.7322	$1,106.71	$1,106.71
20900	Removal of bone for graft	Y		A2	$510.00	29.3263	$1,214.11	$686.03
20902	Removal of bone for graft	Y		A2	$630.00	29.3263	$1,214.11	$776.03
20910	Remove cartilage for graft	Y		A2	$510.00	20.9338	$866.66	$599.17
20912	Remove cartilage for graft	Y		A2	$510.00	20.9338	$866.66	$599.17
20920	Removal of fascia for graft	Y		A2	$630.00	15.4399	$639.21	$632.30
20922	Removal of fascia for graft	Y		A2	$510.00	15.4399	$639.21	$542.30
20924	Removal of tendon for graft	Y		A2	$630.00	29.3263	$1,214.11	$776.03
20926	Removal of tissue for graft	Y		A2	$630.00	4.6816	$193.82	$520.96
20950	Fluid pressure, muscle	Y		G2		1.4630	$60.57	$60.57
20972	Bone/skin graft, metatarsal	Y		G2		44.4710	$1,841.10	$1,841.10
20973	Bone/skin graft, great toe	Y		R2		44.4710	$1,841.10	$1,841.10
20975	Electrical bone stimulation	N	CH	N1	$37.51			

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
20979	Us bone stimulation	N		P3		0.5771	$23.89	$23.89
20982	Ablate, bone tumor(s) perq	Y		G2		43.5953	$1,804.85	$1,804.85
21010	Incision of jaw joint	Y		A2	$446.00	24.3535	$1,008.23	$586.56
21015	Resection of facial tumor	Y		A2	$510.00	16.6341	$688.65	$554.66
21025	Excision of bone, lower jaw	Y		A2	$446.00	40.5598	$1,679.18	$754.30
21026	Excision of facial bone(s)	Y		A2	$446.00	40.5598	$1,679.18	$754.30
21029	Contour of face bone lesion	Y		A2	$446.00	40.5598	$1,679.18	$754.30
21030	Excise max/zygoma b9 tumor	Y		P3		5.5737	$230.75	$230.75
21031	Remove exostosis, mandible	Y		P3		4.5761	$189.45	$189.45
21032	Remove exostosis, maxilla	Y		P3		4.6915	$194.23	$194.23
21034	Excise max/zygoma mlg tumor	Y		A2	$510.00	40.5598	$1,679.18	$802.30
21040	Excise mandible lesion	Y		A2	$446.00	24.3535	$1,008.23	$586.56
21044	Removal of jaw bone lesion	Y		A2	$446.00	40.5598	$1,679.18	$754.30
21046	Remove mandible cyst complex	Y		A2	$446.00	40.5598	$1,679.18	$754.30
21047	Excise lwr jaw cyst w/repair	Y		A2	$446.00	40.5598	$1,679.18	$754.30
21048	Remove maxilla cyst complex	Y		R2		40.5598	$1,679.18	$1,679.18
21050	Removal of jaw joint	Y		A2	$510.00	40.5598	$1,679.18	$802.30
21060	Remove jaw joint cartilage	Y		A2	$446.00	40.5598	$1,679.18	$754.30
21070	Remove coronoid process	Y		A2	$510.00	40.5598	$1,679.18	$802.30
21076	Prepare face/oral prosthesis	Y		P3		8.3442	$345.45	$345.45
21077	Prepare face/oral prosthesis	Y		P3		20.4563	$846.89	$846.89
21079	Prepare face/oral prosthesis	Y		P3		14.5198	$601.12	$601.12
21080	Prepare face/oral prosthesis	Y		P3		16.6471	$689.19	$689.19
21081	Prepare face/oral prosthesis	Y		P3		15.2783	$632.52	$632.52
21082	Prepare face/oral prosthesis	Y		P3		14.0993	$583.71	$583.71
21083	Prepare face/oral prosthesis	Y		P3		13.7860	$570.74	$570.74
21084	Prepare face/oral prosthesis	Y		P3		16.0370	$663.93	$663.93
21085	Prepare face/oral prosthesis	Y		P3		6.2333	$258.06	$258.06
21086	Prepare face/oral prosthesis	Y		P3		15.0391	$622.62	$622.62
21087	Prepare face/oral prosthesis	Y		P3		14.9237	$617.84	$617.84
21088	Prepare face/oral prosthesis	Y		R2		40.5598	$1,679.18	$1,679.18
21100	Maxillofacial fixation	Y		A2	$446.00	40.5598	$1,679.18	$754.30
21110	Interdental fixation	Y		P2		7.6539	$316.87	$316.87
21116	Injection, jaw joint x-ray	N		N1				
21120	Reconstruction of chin	Y		A2	$995.00	24.3535	$1,008.23	$998.31
21121	Reconstruction of chin	Y		A2	$995.00	24.3535	$1,008.23	$998.31
21122	Reconstruction of chin	Y		A2	$995.00	24.3535	$1,008.23	$998.31
21123	Reconstruction of chin	Y		A2	$995.00	24.3535	$1,008.23	$998.31
21125	Augmentation, lower jaw bone	Y		A2	$995.00	24.3535	$1,008.23	$998.31
21127	Augmentation, lower jaw bone	Y		A2	$1,339.00	40.5598	$1,679.18	$1,424.05
21137	Reduction of forehead	Y		G2		24.3535	$1,008.23	$1,008.23
21138	Reduction of forehead	Y		G2		40.5598	$1,679.18	$1,679.18
21139	Reduction of forehead	Y		G2		40.5598	$1,679.18	$1,679.18
21150	Reconstruct midface, lefort	Y		G2		40.5598	$1,679.18	$1,679.18
21181	Contour cranial bone lesion	Y		A2	$995.00	24.3535	$1,008.23	$998.31
21198	Reconstr lwr jaw segment	Y		G2		40.5598	$1,679.18	$1,679.18
21199	Reconstr lwr jaw w/advance	Y		G2		40.5598	$1,679.18	$1,679.18
21206	Reconstruct upper jaw bone	Y		A2	$717.00	40.5598	$1,679.18	$957.55
21208	Augmentation of facial bones	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
21209	Reduction of facial bones	Y		A2	$717.00	40.5598	$1,679.18	$957.55
21210	Face bone graft	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
21215	Lower jaw bone graft	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
21230	Rib cartilage graft	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
21235	Ear cartilage graft	Y		A2	$995.00	24.3535	$1,008.23	$998.31
21240	Reconstruction of jaw joint	Y		A2	$630.00	40.5598	$1,679.18	$892.30
21242	Reconstruction of jaw joint	Y		A2	$717.00	40.5598	$1,679.18	$957.55
21243	Reconstruction of jaw joint	Y		A2	$717.00	40.5598	$1,679.18	$957.55
21244	Reconstruction of lower jaw	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
21245	Reconstruction of jaw	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
21246	Reconstruction of jaw	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
21248	Reconstruction of jaw	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
21249	Reconstruction of jaw	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
21260	Revise eye sockets	Y		G2		40.5598	$1,679.18	$1,679.18
21267	Revise eye sockets	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
21270	Augmentation, cheek bone	Y		A2	$717.00	40.5598	$1,679.18	$957.55
21275	Revision, orbitofacial bones	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
21280	Revision of eyelid	Y		A2	$717.00	40.5598	$1,679.18	$957.55
21282	Revision of eyelid	Y		A2	$717.00	16.6341	$688.65	$709.91
21295	Revision of jaw muscle/bone	Y		A2	$333.00	7.6539	$316.87	$328.97
21296	Revision of jaw muscle/bone	Y		A2	$333.00	24.3535	$1,008.23	$501.81
21310	Treatment of nose fracture	Y		A2	$150.72	2.5765	$106.67	$139.71
21315	Treatment of nose fracture	Y		A2	$150.72	2.5765	$106.67	$139.71
21320	Treatment of nose fracture	Y		A2	$446.00	16.6341	$688.65	$506.66
21325	Treatment of nose fracture	Y		A2	$630.00	24.3535	$1,008.23	$724.56
21330	Treatment of nose fracture	Y		A2	$717.00	24.3535	$1,008.23	$789.81
21335	Treatment of nose fracture	Y		A2	$995.00	24.3535	$1,008.23	$998.31

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
21336	Treat nasal septal fracture	Y		A2	$630.00	40.3466	$1,670.35	$890.09
21337	Treat nasal septal fracture	Y		A2	$446.00	16.6341	$688.65	$506.66
21338	Treat nasoethmoid fracture	Y		A2	$630.00	24.3535	$1,008.23	$724.56
21339	Treat nasoethmoid fracture	Y		A2	$717.00	24.3535	$1,008.23	$789.81
21340	Treatment of nose fracture	Y		A2	$630.00	40.5598	$1,679.18	$892.30
21345	Treat nose/jaw fracture	Y		A2	$995.00	24.3535	$1,008.23	$998.31
21355	Treat cheek bone fracture	Y		A2	$510.00	40.5598	$1,679.18	$802.30
21356	Treat cheek bone fracture	Y		A2	$510.00	24.3535	$1,008.23	$634.56
21390	Treat eye socket fracture	Y		G2		40.5598	$1,679.18	$1,679.18
21400	Treat eye socket fracture	Y		A2	$446.00	7.6539	$316.87	$413.72
21401	Treat eye socket fracture	Y		A2	$510.00	16.6341	$688.65	$554.66
21406	Treat eye socket fracture	Y		G2		40.5598	$1,679.18	$1,679.18
21407	Treat eye socket fracture	Y		G2		40.5598	$1,679.18	$1,679.18
21421	Treat mouth roof fracture	Y		A2	$630.00	24.3535	$1,008.23	$724.56
21440	Treat dental ridge fracture	Y		P3		7.0990	$293.90	$293.90
21445	Treat dental ridge fracture	Y		A2	$630.00	24.3535	$1,008.23	$724.56
21450	Treat lower jaw fracture	Y		A2	$150.72	2.5765	$106.67	$139.71
21451	Treat lower jaw fracture	Y		A2	$464.15	7.6539	$316.87	$427.33
21452	Treat lower jaw fracture	Y		A2	$446.00	16.6341	$688.65	$506.66
21453	Treat lower jaw fracture	Y		A2	$510.00	40.5598	$1,679.18	$802.30
21454	Treat lower jaw fracture	Y		A2	$717.00	24.3535	$1,008.23	$789.81
21461	Treat lower jaw fracture	Y		A2	$630.00	40.5598	$1,679.18	$892.30
21462	Treat lower jaw fracture	Y		A2	$717.00	40.5598	$1,679.18	$957.55
21465	Treat lower jaw fracture	Y		A2	$630.00	40.5598	$1,679.18	$892.30
21480	Reset dislocated jaw	Y		A2	$150.72	2.5765	$106.67	$139.71
21485	Reset dislocated jaw	Y		A2	$446.00	16.6341	$688.65	$506.66
21490	Repair dislocated jaw	Y		A2	$510.00	40.5598	$1,679.18	$802.30
21495	Treat hyoid bone fracture	Y		G2		16.6341	$688.65	$688.65
21497	Interdental wiring	Y		A2	$446.00	16.6341	$688.65	$506.66
21501	Drain neck/chest lesion	Y		A2	$446.00	19.0457	$788.49	$531.62
21502	Drain chest lesion	Y		A2	$446.00	21.5761	$893.25	$557.81
21550	Biopsy of neck/chest	Y		G2		8.7155	$360.82	$360.82
21555	Remove lesion, neck/chest	Y		A2	$446.00	21.4534	$888.17	$556.54
21556	Remove lesion, neck/chest	Y		A2	$446.00	21.4534	$888.17	$556.54
21557	Remove tumor, neck/chest	Y		G2		21.4534	$888.17	$888.17
21600	Partial removal of rib	Y		A2	$446.00	29.3263	$1,214.11	$638.03
21610	Partial removal of rib	Y		A2	$446.00	29.3263	$1,214.11	$638.03
21685	Hyoid myotomy & suspension	Y		G2		7.6539	$316.87	$316.87
21700	Revision of neck muscle	Y		A2	$446.00	21.5761	$893.25	$557.81
21720	Revision of neck muscle	Y		A2	$510.00	21.5761	$893.25	$605.81
21725	Revision of neck muscle	Y		A2	$88.46	1.4630	$60.57	$81.49
21800	Treatment of rib fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
21805	Treatment of rib fracture	Y		A2	$446.00	26.3092	$1,089.20	$606.80
21820	Treat sternum fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
21920	Biopsy soft tissue of back	Y		P3		3.1744	$131.42	$131.42
21925	Biopsy soft tissue of back	Y		A2	$446.00	21.4534	$888.17	$556.54
21930	Remove lesion, back or flank	Y		A2	$446.00	21.4534	$888.17	$556.54
21935	Remove tumor, back	Y		A2	$510.00	21.4534	$888.17	$604.54
22102	Remove part, lumbar vertebra	Y		G2		47.6714	$1,973.60	$1,973.60
22103	Remove extra spine segment	Y		G2		47.6714	$1,973.60	$1,973.60
22305	Treat spine process fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
22310	Treat spine fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
22315	Treat spine fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
22505	Manipulation of spine	Y		A2	$446.00	15.0176	$621.73	$489.93
22520	Percut vertebroplasty thor	Y		A2	$1,339.00	29.3263	$1,214.11	$1,307.78
22521	Percut vertebroplasty lumb	Y		A2	$1,339.00	29.3263	$1,214.11	$1,307.78
22522	Percut vertebroplasty add'l	Y		A2	$1,339.00	29.3263	$1,214.11	$1,307.78
22523	Percut kyphoplasty, thor	Y		G2		78.6518	$3,256.18	$3,256.18
22524	Percut kyphoplasty, lumbar	Y		G2		78.6518	$3,256.18	$3,256.18
22525	Percut kyphoplasty, add-on	Y		G2		78.6518	$3,256.18	$3,256.18
22900	Remove abdominal wall lesion	Y		A2	$630.00	21.4534	$888.17	$694.54
23000	Removal of calcium deposits	Y		A2	$446.00	16.5832	$686.54	$506.14
23020	Release shoulder joint	Y		A2	$446.00	43.5953	$1,804.85	$785.71
23030	Drain shoulder lesion	Y		A2	$333.00	19.0457	$788.49	$446.87
23031	Drain shoulder bursa	Y		A2	$510.00	19.0457	$788.49	$579.62
23035	Drain shoulder bone lesion	Y		A2	$510.00	21.5761	$893.25	$605.81
23040	Exploratory shoulder surgery	Y		A2	$510.00	29.3263	$1,214.11	$686.03
23044	Exploratory shoulder surgery	Y		A2	$630.00	29.3263	$1,214.11	$776.03
23065	Biopsy shoulder tissues	Y		P3		2.2428	$92.85	$92.85
23066	Biopsy shoulder tissues	Y		A2	$446.00	21.4534	$888.17	$556.54
23075	Removal of shoulder lesion	Y		A2	$446.00	16.5832	$686.54	$506.14
23076	Removal of shoulder lesion	Y		A2	$446.00	21.4534	$888.17	$556.54
23077	Remove tumor of shoulder	Y		A2	$510.00	21.4534	$888.17	$604.54
23100	Biopsy of shoulder joint	Y		A2	$446.00	21.5761	$893.25	$557.81
23101	Shoulder joint surgery	Y		A2	$995.00	29.3263	$1,214.11	$1,049.78
23105	Remove shoulder joint lining	Y		A2	$630.00	29.3263	$1,214.11	$776.03

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
23106	Incision of collarbone joint	Y		A2	$630.00	29.3263	$1,214.11	$776.03
23107	Explore treat shoulder joint	Y		A2	$630.00	29.3263	$1,214.11	$776.03
23120	Partial removal, collar bone	Y		A2	$717.00	29.3263	$1,214.11	$841.28
23125	Removal of collar bone	Y		A2	$717.00	29.3263	$1,214.11	$841.28
23130	Remove shoulder bone, part	Y		A2	$717.00	43.5953	$1,804.85	$988.96
23140	Removal of bone lesion	Y		A2	$630.00	21.5761	$893.25	$695.81
23145	Removal of bone lesion	Y		A2	$717.00	29.3263	$1,214.11	$841.28
23146	Removal of bone lesion	Y		A2	$717.00	29.3263	$1,214.11	$841.28
23150	Removal of humerus lesion	Y		A2	$630.00	29.3263	$1,214.11	$776.03
23155	Removal of humerus lesion	Y		A2	$717.00	29.3263	$1,214.11	$841.28
23156	Removal of humerus lesion	Y		A2	$717.00	29.3263	$1,214.11	$841.28
23170	Remove collar bone lesion	Y		A2	$446.00	29.3263	$1,214.11	$638.03
23172	Remove shoulder blade lesion	Y		A2	$446.00	29.3263	$1,214.11	$638.03
23174	Remove humerus lesion	Y		A2	$446.00	29.3263	$1,214.11	$638.03
23180	Remove collar bone lesion	Y		A2	$630.00	29.3263	$1,214.11	$776.03
23182	Remove shoulder blade lesion	Y		A2	$630.00	29.3263	$1,214.11	$776.03
23184	Remove humerus lesion	Y		A2	$630.00	29.3263	$1,214.11	$776.03
23190	Partial removal of scapula	Y		A2	$630.00	29.3263	$1,214.11	$776.03
23195	Removal of head of humerus	Y		A2	$717.00	29.3263	$1,214.11	$841.28
23330	Remove shoulder foreign body	Y		A2	$333.00	8.7155	$360.82	$339.96
23331	Remove shoulder foreign body	Y		A2	$333.00	21.4534	$888.17	$471.79
23350	Injection for shoulder x-ray	N		N1				
23395	Muscle transfer,shoulder/arm	Y		A2	$717.00	43.5953	$1,804.85	$988.96
23397	Muscle transfers	Y		A2	$995.00	78.6518	$3,256.18	$1,560.30
23400	Fixation of shoulder blade	Y		A2	$995.00	29.3263	$1,214.11	$1,049.78
23405	Incision of tendon & muscle	Y		A2	$446.00	29.3263	$1,214.11	$638.03
23406	Incise tendon(s) & muscle(s)	Y		A2	$446.00	29.3263	$1,214.11	$638.03
23410	Repair rotator cuff, acute	Y		A2	$717.00	43.5953	$1,804.85	$988.96
23412	Repair rotator cuff, chronic	Y		A2	$995.00	43.5953	$1,804.85	$1,197.46
23415	Release of shoulder ligament	Y		A2	$717.00	43.5953	$1,804.85	$988.96
23420	Repair of shoulder	Y		A2	$995.00	43.5953	$1,804.85	$1,197.46
23430	Repair biceps tendon	Y		A2	$630.00	43.5953	$1,804.85	$923.71
23440	Remove/transplant tendon	Y		A2	$630.00	43.5953	$1,804.85	$923.71
23450	Repair shoulder capsule	Y		A2	$717.00	78.6518	$3,256.18	$1,351.80
23455	Repair shoulder capsule	Y		A2	$995.00	78.6518	$3,256.18	$1,560.30
23460	Repair shoulder capsule	Y		A2	$717.00	78.6518	$3,256.18	$1,351.80
23462	Repair shoulder capsule	Y		A2	$995.00	43.5953	$1,804.85	$1,197.46
23465	Repair shoulder capsule	Y		A2	$717.00	78.6518	$3,256.18	$1,351.80
23466	Repair shoulder capsule	Y		A2	$995.00	43.5953	$1,804.85	$1,197.46
23480	Revision of collar bone	Y		A2	$630.00	43.5953	$1,804.85	$923.71
23485	Revision of collar bone	Y		A2	$995.00	78.6518	$3,256.18	$1,560.30
23490	Reinforce clavicle	Y		A2	$510.00	43.5953	$1,804.85	$833.71
23491	Reinforce shoulder bones	Y		A2	$510.00	78.6518	$3,256.18	$1,196.55
23500	Treat clavicle fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
23505	Treat clavicle fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
23515	Treat clavicle fracture	Y		A2	$510.00	60.0595	$2,486.46	$1,004.12
23520	Treat clavicle dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
23525	Treat clavicle dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
23530	Treat clavicle dislocation	Y		A2	$510.00	40.3466	$1,670.35	$800.09
23532	Treat clavicle dislocation	Y		A2	$630.00	26.3092	$1,089.20	$744.80
23540	Treat clavicle dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
23545	Treat clavicle dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
23550	Treat clavicle dislocation	Y		A2	$510.00	40.3466	$1,670.35	$800.09
23552	Treat clavicle dislocation	Y		A2	$630.00	40.3466	$1,670.35	$890.09
23570	Treat shoulder blade fx	Y		A2	$103.62	1.8742	$77.59	$97.11
23575	Treat shoulder blade fx	Y		A2	$103.62	1.8742	$77.59	$97.11
23585	Treat scapula fracture	Y		A2	$510.00	60.0595	$2,486.46	$1,004.12
23600	Treat humerus fracture	Y		P2		1.8742	$77.59	$77.59
23605	Treat humerus fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
23615	Treat humerus fracture	Y		A2	$630.00	60.0595	$2,486.46	$1,094.12
23616	Treat humerus fracture	Y		A2	$630.00	60.0595	$2,486.46	$1,094.12
23620	Treat humerus fracture	Y		P2		1.8742	$77.59	$77.59
23625	Treat humerus fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
23630	Treat humerus fracture	Y		A2	$717.00	60.0595	$2,486.46	$1,159.37
23650	Treat shoulder dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
23655	Treat shoulder dislocation	Y		A2	$333.00	15.0176	$621.73	$405.18
23660	Treat shoulder dislocation	Y		A2	$510.00	40.3466	$1,670.35	$800.09
23665	Treat dislocation/fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
23670	Treat dislocation/fracture	Y		A2	$510.00	60.0595	$2,486.46	$1,004.12
23675	Treat dislocation/fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
23680	Treat dislocation/fracture	Y		A2	$510.00	40.3466	$1,670.35	$800.09
23700	Fixation of shoulder	Y		A2	$333.00	15.0176	$621.73	$405.18
23800	Fusion of shoulder joint	Y		A2	$630.00	78.6518	$3,256.18	$1,286.55
23802	Fusion of shoulder joint	Y		A2	$995.00	43.5953	$1,804.85	$1,197.46
23921	Amputation follow-up surgery	Y		A2	$323.28	15.4399	$639.21	$402.26
23930	Drainage of arm lesion	Y		A2	$333.00	19.0457	$788.49	$446.87

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
23931	Drainage of arm bursa	Y		A2	$446.00	19.0457	$788.49	$531.62
23935	Drain arm/elbow bone lesion	Y		A2	$446.00	21.5761	$893.25	$557.81
24000	Exploratory elbow surgery	Y		A2	$630.00	29.3263	$1,214.11	$776.03
24006	Release elbow joint	Y		A2	$630.00	29.3263	$1,214.11	$776.03
24065	Biopsy arm/elbow soft tissue	Y		P3		3.0343	$125.62	$125.62
24066	Biopsy arm/elbow soft tissue	Y		A2	$446.00	16.5832	$686.54	$506.14
24075	Remove arm/elbow lesion	Y		A2	$446.00	16.5832	$686.54	$506.14
24076	Remove arm/elbow lesion	Y		A2	$446.00	21.4534	$888.17	$556.54
24077	Remove tumor of arm/elbow	Y		A2	$510.00	21.4534	$888.17	$604.54
24100	Biopsy elbow joint lining	Y		A2	$333.00	21.5761	$893.25	$473.06
24101	Explore/treat elbow joint	Y		A2	$630.00	29.3263	$1,214.11	$776.03
24102	Remove elbow joint lining	Y		A2	$630.00	29.3263	$1,214.11	$776.03
24105	Removal of elbow bursa	Y		A2	$510.00	21.5761	$893.25	$605.81
24110	Remove humerus lesion	Y		A2	$446.00	21.5761	$893.25	$557.81
24115	Remove/graft bone lesion	Y		A2	$510.00	29.3263	$1,214.11	$686.03
24116	Remove/graft bone lesion	Y		A2	$510.00	29.3263	$1,214.11	$686.03
24120	Remove elbow lesion	Y		A2	$510.00	21.5761	$893.25	$605.81
24125	Remove/graft bone lesion	Y		A2	$510.00	29.3263	$1,214.11	$686.03
24126	Remove/graft bone lesion	Y		A2	$510.00	29.3263	$1,214.11	$686.03
24130	Removal of head of radius	Y		A2	$510.00	29.3263	$1,214.11	$686.03
24134	Removal of arm bone lesion	Y		A2	$446.00	29.3263	$1,214.11	$638.03
24136	Remove radius bone lesion	Y		A2	$446.00	29.3263	$1,214.11	$638.03
24138	Remove elbow bone lesion	Y		A2	$446.00	29.3263	$1,214.11	$638.03
24140	Partial removal of arm bone	Y		A2	$510.00	29.3263	$1,214.11	$686.03
24145	Partial removal of radius	Y		A2	$510.00	29.3263	$1,214.11	$686.03
24147	Partial removal of elbow	Y		A2	$446.00	29.3263	$1,214.11	$638.03
24149	Radical resection of elbow	Y		G2		29.3263	$1,214.11	$1,214.11
24152	Extensive radius surgery	Y		G2		43.5953	$1,804.85	$1,804.85
24153	Extensive radius surgery	Y		G2		78.6518	$3,256.18	$3,256.18
24155	Removal of elbow joint	Y		A2	$510.00	43.5953	$1,804.85	$833.71
24160	Remove elbow joint implant	Y		A2	$446.00	29.3263	$1,214.11	$638.03
24164	Remove radius head implant	Y		A2	$510.00	29.3263	$1,214.11	$686.03
24200	Removal of arm foreign body	Y		P3		2.5312	$104.79	$104.79
24201	Removal of arm foreign body	Y		A2	$446.00	16.5832	$686.54	$506.14
24220	Injection for elbow x-ray	N		N1				
24300	Manipulate elbow w/anesth	Y		G2		15.0176	$621.73	$621.73
24301	Muscle/tendon transfer	Y		A2	$630.00	29.3263	$1,214.11	$776.03
24305	Arm tendon lengthening	Y		A2	$630.00	29.3263	$1,214.11	$776.03
24310	Revision of arm tendon	Y		A2	$510.00	21.5761	$893.25	$605.81
24320	Repair of arm tendon	Y		A2	$510.00	43.5953	$1,804.85	$833.71
24330	Revision of arm muscles	Y		A2	$510.00	78.6518	$3,256.18	$1,196.55
24331	Revision of arm muscles	Y		A2	$510.00	43.5953	$1,804.85	$833.71
24332	Tenolysis, triceps	Y		G2		21.5761	$893.25	$893.25
24340	Repair of biceps tendon	Y		A2	$510.00	43.5953	$1,804.85	$833.71
24341	Repair arm tendon/muscle	Y		A2	$510.00	43.5953	$1,804.85	$833.71
24342	Repair of ruptured tendon	Y		A2	$510.00	43.5953	$1,804.85	$833.71
24343	Repr elbow lat ligmnt w/tiss	Y		G2		29.3263	$1,214.11	$1,214.11
24344	Reconstruct elbow lat ligmnt	Y		G2		78.6518	$3,256.18	$3,256.18
24345	Repr elbw med ligmnt w/tissu	Y		A2	$446.00	29.3263	$1,214.11	$638.03
24346	Reconstruct elbow med ligmnt	Y		G2		43.5953	$1,804.85	$1,804.85
24350	Repair of tennis elbow	Y		A2	$510.00	29.3263	$1,214.11	$686.03
24351	Repair of tennis elbow	Y		A2	$510.00	29.3263	$1,214.11	$686.03
24352	Repair of tennis elbow	Y		A2	$510.00	29.3263	$1,214.11	$686.03
24354	Repair of tennis elbow	Y		A2	$510.00	29.3263	$1,214.11	$686.03
24356	Revision of tennis elbow	Y		A2	$510.00	29.3263	$1,214.11	$686.03
24360	Reconstruct elbow joint	Y		A2	$717.00	35.9249	$1,487.29	$909.57
24361	Reconstruct elbow joint	Y		A2	$717.00	113.6713	$4,705.99	$1,714.25
24362	Reconstruct elbow joint	Y		A2	$717.00	51.0431	$2,113.18	$1,066.05
24363	Replace elbow joint	Y		A2	$995.00	113.6713	$4,705.99	$1,922.75
24365	Reconstruct head of radius	Y		A2	$717.00	35.9249	$1,487.29	$909.57
24366	Reconstruct head of radius	Y		A2	$717.00	113.6713	$4,705.99	$1,714.25
24400	Revision of humerus	Y		A2	$630.00	29.3263	$1,214.11	$776.03
24410	Revision of humerus	Y		A2	$630.00	29.3263	$1,214.11	$776.03
24420	Revision of humerus	Y		A2	$510.00	43.5953	$1,804.85	$833.71
24430	Repair of humerus	Y		A2	$510.00	78.6518	$3,256.18	$1,196.55
24435	Repair humerus with graft	Y		A2	$630.00	78.6518	$3,256.18	$1,286.55
24470	Revision of elbow joint	Y		A2	$510.00	43.5953	$1,804.85	$833.71
24495	Decompression of forearm	Y		A2	$446.00	29.3263	$1,214.11	$638.03
24498	Reinforce humerus	Y		A2	$510.00	78.6518	$3,256.18	$1,196.55
24500	Treat humerus fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
24505	Treat humerus fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
24515	Treat humerus fracture	Y		A2	$630.00	60.0595	$2,486.46	$1,094.12
24516	Treat humerus fracture	Y		A2	$630.00	60.0595	$2,486.46	$1,094.12
24530	Treat humerus fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
24535	Treat humerus fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
24538	Treat humerus fracture	Y		A2	$446.00	26.3092	$1,089.20	$606.80

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
24545	Treat humerus fracture	Y		A2	$630.00	60.0595	$2,486.46	$1,094.12
24546	Treat humerus fracture	Y		A2	$717.00	60.0595	$2,486.46	$1,159.37
24560	Treat humerus fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
24565	Treat humerus fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
24566	Treat humerus fracture	Y		A2	$446.00	26.3092	$1,089.20	$606.80
24575	Treat humerus fracture	Y		A2	$510.00	60.0595	$2,486.46	$1,004.12
24576	Treat humerus fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
24577	Treat humerus fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
24579	Treat humerus fracture	Y		A2	$510.00	60.0595	$2,486.46	$1,004.12
24582	Treat humerus fracture	Y		A2	$446.00	26.3092	$1,089.20	$606.80
24586	Treat elbow fracture	Y		A2	$630.00	60.0595	$2,486.46	$1,094.12
24587	Treat elbow fracture	Y		A2	$717.00	60.0595	$2,486.46	$1,159.37
24600	Treat elbow dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
24605	Treat elbow dislocation	Y		A2	$446.00	15.0176	$621.73	$489.93
24615	Treat elbow dislocation	Y		A2	$510.00	60.0595	$2,486.46	$1,004.12
24620	Treat elbow fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
24635	Treat elbow fracture	Y		A2	$510.00	60.0595	$2,486.46	$1,004.12
24640	Treat elbow dislocation	Y	CH	P3		1.3771	$57.01	$57.01
24650	Treat radius fracture	Y		P2		1.8742	$77.59	$77.59
24655	Treat radius fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
24665	Treat radius fracture	Y		A2	$630.00	40.3466	$1,670.35	$890.09
24666	Treat radius fracture	Y		A2	$630.00	60.0595	$2,486.46	$1,094.12
24670	Treat ulnar fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
24675	Treat ulnar fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
24685	Treat ulnar fracture	Y		A2	$510.00	40.3466	$1,670.35	$800.09
24800	Fusion of elbow joint	Y		A2	$630.00	43.5953	$1,804.85	$923.71
24802	Fusion/graft of elbow joint	Y		A2	$717.00	43.5953	$1,804.85	$988.96
24925	Amputation follow-up surgery	Y		A2	$510.00	21.5761	$893.25	$605.81
25000	Incision of tendon sheath	Y		A2	$510.00	21.5761	$893.25	$605.81
25001	Incise flexor carpi radialis	Y		G2		21.5761	$893.25	$893.25
25020	Decompress forearm 1 space	Y		A2	$510.00	21.5761	$893.25	$605.81
25023	Decompress forearm 1 space	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25024	Decompress forearm 2 spaces	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25025	Decompress forearm 2 spaces	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25028	Drainage of forearm lesion	Y		A2	$333.00	21.5761	$893.25	$473.06
25031	Drainage of forearm bursa	Y		A2	$446.00	21.5761	$893.25	$557.81
25035	Treat forearm bone lesion	Y		A2	$446.00	21.5761	$893.25	$557.81
25040	Explore/treat wrist joint	Y		A2	$717.00	29.3263	$1,214.11	$841.28
25065	Biopsy forearm soft tissues	Y		P3		3.1085	$128.69	$128.69
25066	Biopsy forearm soft tissues	Y		A2	$446.00	21.4534	$888.17	$556.54
25075	Removal forearm lesion subcu	Y		A2	$446.00	16.5832	$686.54	$506.14
25076	Removal forearm lesion deep	Y		A2	$510.00	21.4534	$888.17	$604.54
25077	Remove tumor, forearm/wrist	Y		A2	$510.00	21.4534	$888.17	$604.54
25085	Incision of wrist capsule	Y		A2	$510.00	21.5761	$893.25	$605.81
25100	Biopsy of wrist joint	Y		A2	$446.00	21.5761	$893.25	$557.81
25101	Explore/treat wrist joint	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25105	Remove wrist joint lining	Y		A2	$630.00	29.3263	$1,214.11	$776.03
25107	Remove wrist joint cartilage	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25109	Excise tendon forearm/wrist	Y		G2		21.5761	$893.25	$893.25
25110	Remove wrist tendon lesion	Y		A2	$510.00	21.5761	$893.25	$605.81
25111	Remove wrist tendon lesion	Y		A2	$510.00	16.8220	$696.43	$556.61
25112	Reremove wrist tendon lesion	Y		A2	$630.00	16.8220	$696.43	$646.61
25115	Remove wrist/forearm lesion	Y		A2	$630.00	21.5761	$893.25	$695.81
25116	Remove wrist/forearm lesion	Y		A2	$630.00	21.5761	$893.25	$695.81
25118	Excise wrist tendon sheath	Y		A2	$446.00	29.3263	$1,214.11	$638.03
25119	Partial removal of ulna	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25120	Removal of forearm lesion	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25125	Remove/graft forearm lesion	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25126	Remove/graft forearm lesion	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25130	Removal of wrist lesion	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25135	Remove & graft wrist lesion	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25136	Remove & graft wrist lesion	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25145	Remove forearm bone lesion	Y		A2	$446.00	29.3263	$1,214.11	$638.03
25150	Partial removal of ulna	Y		A2	$446.00	29.3263	$1,214.11	$638.03
25151	Partial removal of radius	Y		A2	$446.00	29.3263	$1,214.11	$638.03
25210	Removal of wrist bone	Y		A2	$510.00	26.7322	$1,106.71	$659.18
25215	Removal of wrist bones	Y		A2	$630.00	26.7322	$1,106.71	$749.18
25230	Partial removal of radius	Y		A2	$630.00	29.3263	$1,214.11	$776.03
25240	Partial removal of ulna	Y		A2	$630.00	29.3263	$1,214.11	$776.03
25246	Injection for wrist x-ray	N		N1				
25248	Remove forearm foreign body	Y		A2	$446.00	21.5761	$893.25	$557.81
25250	Removal of wrist prosthesis	Y		A2	$333.00	29.3263	$1,214.11	$553.28
25251	Removal of wrist prosthesis	Y		A2	$333.00	29.3263	$1,214.11	$553.28
25259	Manipulate wrist w/anesthes	Y		G2		1.8742	$77.59	$77.59
25260	Repair forearm tendon/muscle	Y		A2	$630.00	29.3263	$1,214.11	$776.03
25263	Repair forearm tendon/muscle	Y		A2	$446.00	29.3263	$1,214.11	$638.03

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
25265	Repair forearm tendon/muscle	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25270	Repair forearm tendon/muscle	Y		A2	$630.00	29.3263	$1,214.11	$776.03
25272	Repair forearm tendon/muscle	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25274	Repair forearm tendon/muscle	Y		A2	$630.00	29.3263	$1,214.11	$776.03
25275	Repair forearm tendon sheath	Y		A2	$630.00	29.3263	$1,214.11	$776.03
25280	Revise wrist/forearm tendon	Y		A2	$630.00	29.3263	$1,214.11	$776.03
25290	Incise wrist/forearm tendon	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25295	Release wrist/forearm tendon	Y		A2	$510.00	21.5761	$893.25	$605.81
25300	Fusion of tendons at wrist	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25301	Fusion of tendons at wrist	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25310	Transplant forearm tendon	Y		A2	$510.00	43.5953	$1,804.85	$833.71
25312	Transplant forearm tendon	Y		A2	$630.00	43.5953	$1,804.85	$923.71
25315	Revise palsy hand tendon(s)	Y		A2	$510.00	43.5953	$1,804.85	$833.71
25316	Revise palsy hand tendon(s)	Y		A2	$510.00	78.6518	$3,256.18	$1,196.55
25320	Repair/revise wrist joint	Y		A2	$510.00	43.5953	$1,804.85	$833.71
25332	Revise wrist joint	Y		A2	$717.00	35.9249	$1,487.29	$909.57
25335	Realignment of hand	Y		A2	$510.00	43.5953	$1,804.85	$833.71
25337	Reconstruct ulna/radioulnar	Y		A2	$717.00	43.5953	$1,804.85	$988.96
25350	Revision of radius	Y		A2	$510.00	78.6518	$3,256.18	$1,196.55
25355	Revision of radius	Y		A2	$510.00	43.5953	$1,804.85	$833.71
25360	Revision of ulna	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25365	Revise radius & ulna	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25370	Revise radius or ulna	Y		A2	$510.00	43.5953	$1,804.85	$833.71
25375	Revise radius & ulna	Y		A2	$630.00	43.5953	$1,804.85	$923.71
25390	Shorten radius or ulna	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25391	Lengthen radius or ulna	Y		A2	$630.00	43.5953	$1,804.85	$923.71
25392	Shorten radius & ulna	Y		A2	$510.00	29.3263	$1,214.11	$686.03
25393	Lengthen radius & ulna	Y		A2	$630.00	43.5953	$1,804.85	$923.71
25394	Repair carpal bone, shorten	Y		G2		16.8220	$696.43	$696.43
25400	Repair radius or ulna	Y		A2	$510.00	78.6518	$3,256.18	$1,196.55
25405	Repair/graft radius or ulna	Y		A2	$630.00	78.6518	$3,256.18	$1,286.55
25415	Repair radius & ulna	Y		A2	$510.00	78.6518	$3,256.18	$1,196.55
25420	Repair/graft radius & ulna	Y		A2	$630.00	78.6518	$3,256.18	$1,286.55
25425	Repair/graft radius or ulna	Y		A2	$510.00	43.5953	$1,804.85	$833.71
25426	Repair/graft radius & ulna	Y		A2	$630.00	43.5953	$1,804.85	$923.71
25430	Vasc graft into carpal bone	Y		G2		26.7322	$1,106.71	$1,106.71
25431	Repair nonunion carpal bone	Y		G2		26.7322	$1,106.71	$1,106.71
25440	Repair/graft wrist bone	Y		A2	$630.00	78.6518	$3,256.18	$1,286.55
25441	Reconstruct wrist joint	Y		A2	$717.00	113.6713	$4,705.99	$1,714.25
25442	Reconstruct wrist joint	Y		A2	$717.00	113.6713	$4,705.99	$1,714.25
25443	Reconstruct wrist joint	Y		A2	$717.00	51.0431	$2,113.18	$1,066.05
25444	Reconstruct wrist joint	Y		A2	$717.00	51.0431	$2,113.18	$1,066.05
25445	Reconstruct wrist joint	Y		A2	$717.00	51.0431	$2,113.18	$1,066.05
25446	Wrist replacement	Y		A2	$995.00	113.6713	$4,705.99	$1,922.75
25447	Repair wrist joint(s)	Y		A2	$717.00	35.9249	$1,487.29	$909.57
25449	Remove wrist joint implant	Y		A2	$717.00	35.9249	$1,487.29	$909.57
25450	Revision of wrist joint	Y		A2	$510.00	43.5953	$1,804.85	$833.71
25455	Revision of wrist joint	Y		A2	$510.00	43.5953	$1,804.85	$833.71
25490	Reinforce radius	Y		A2	$510.00	43.5953	$1,804.85	$833.71
25491	Reinforce ulna	Y		A2	$510.00	43.5953	$1,804.85	$833.71
25492	Reinforce radius and ulna	Y		A2	$510.00	43.5953	$1,804.85	$833.71
25500	Treat fracture of radius	Y		P2		1.8742	$77.59	$77.59
25505	Treat fracture of radius	Y		A2	$103.62	1.8742	$77.59	$97.11
25515	Treat fracture of radius	Y		A2	$510.00	40.3466	$1,670.35	$800.09
25520	Treat fracture of radius	Y		A2	$103.62	1.8742	$77.59	$97.11
25525	Treat fracture of radius	Y		A2	$630.00	40.3466	$1,670.35	$890.09
25526	Treat fracture of radius	Y		A2	$717.00	40.3466	$1,670.35	$955.34
25530	Treat fracture of ulna	Y		P2		1.8742	$77.59	$77.59
25535	Treat fracture of ulna	Y		A2	$103.62	1.8742	$77.59	$97.11
25545	Treat fracture of ulna	Y		A2	$510.00	40.3466	$1,670.35	$800.09
25560	Treat fracture radius & ulna	Y		P2		1.8742	$77.59	$77.59
25565	Treat fracture radius & ulna	Y		A2	$103.62	1.8742	$77.59	$97.11
25574	Treat fracture radius & ulna	Y		A2	$510.00	60.0595	$2,486.46	$1,004.12
25575	Treat fracture radius/ulna	Y		A2	$510.00	60.0595	$2,486.46	$1,004.12
25600	Treat fracture radius/ulna	Y		P2		1.8742	$77.59	$77.59
25605	Treat fracture radius/ulna	Y		A2	$103.62	1.8742	$77.59	$97.11
25606	Treat fx distal radial	Y		A2	$510.00	26.3092	$1,089.20	$654.80
25607	Treat fx rad extra-articul	Y		A2	$717.00	60.0595	$2,486.46	$1,159.37
25608	Treat fx rad intra-articul	Y		A2	$717.00	60.0595	$2,486.46	$1,159.37
25609	Treat fx radial 3+ frag	Y		A2	$717.00	60.0595	$2,486.46	$1,159.37
25622	Treat wrist bone fracture	Y		P2		1.8742	$77.59	$77.59
25624	Treat wrist bone fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
25628	Treat wrist bone fracture	Y		A2	$510.00	40.3466	$1,670.35	$800.09
25630	Treat wrist bone fracture	Y		P2		1.8742	$77.59	$77.59
25635	Treat wrist bone fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
25645	Treat wrist bone fracture	Y		A2	$510.00	40.3466	$1,670.35	$800.09

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
25650	Treat wrist bone fracture	Y		P2		1.8742	$77.59	$77.59
25651	Pin ulnar styloid fracture	Y		G2		26.3092	$1,089.20	$1,089.20
25652	Treat fracture ulnar styloid	Y		G2		40.3466	$1,670.35	$1,670.35
25660	Treat wrist dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
25670	Treat wrist dislocation	Y		A2	$510.00	26.3092	$1,089.20	$654.80
25671	Pin radioulnar dislocation	Y		A2	$333.00	26.3092	$1,089.20	$522.05
25675	Treat wrist dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
25676	Treat wrist dislocation	Y		A2	$446.00	26.3092	$1,089.20	$606.80
25680	Treat wrist fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
25685	Treat wrist fracture	Y		A2	$510.00	26.3092	$1,089.20	$654.80
25690	Treat wrist dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
25695	Treat wrist dislocation	Y		A2	$446.00	26.3092	$1,089.20	$606.80
25800	Fusion of wrist joint	Y		A2	$630.00	78.6518	$3,256.18	$1,286.55
25805	Fusion/graft of wrist joint	Y		A2	$717.00	43.5953	$1,804.85	$988.96
25810	Fusion/graft of wrist joint	Y		A2	$717.00	78.6518	$3,256.18	$1,351.80
25820	Fusion of hand bones	Y		A2	$630.00	16.8220	$696.43	$646.61
25825	Fuse hand bones with graft	Y		A2	$717.00	78.6518	$3,256.18	$1,351.80
25830	Fusion, radioulnar jnt/ulna	Y		A2	$717.00	78.6518	$3,256.18	$1,351.80
25907	Amputation follow-up surgery	Y		A2	$510.00	21.5761	$893.25	$605.81
25922	Amputate hand at wrist	Y		A2	$510.00	21.5761	$893.25	$605.81
25929	Amputation follow-up surgery	Y		A2	$510.00	15.4399	$639.21	$542.30
25931	Amputation follow-up surgery	Y	CH	G2		21.5761	$893.25	$893.25
26010	Drainage of finger abscess	Y		P2		1.4630	$60.57	$60.57
26011	Drainage of finger abscess	Y		A2	$333.00	12.5792	$520.78	$379.95
26020	Drain hand tendon sheath	Y		A2	$446.00	16.8220	$696.43	$508.61
26025	Drainage of palm bursa	Y		A2	$333.00	16.8220	$696.43	$423.86
26030	Drainage of palm bursa(s)	Y		A2	$446.00	16.8220	$696.43	$508.61
26034	Treat hand bone lesion	Y		A2	$446.00	16.8220	$696.43	$508.61
26035	Decompress fingers/hand	Y		G2		16.8220	$696.43	$696.43
26040	Release palm contracture	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26045	Release palm contracture	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26055	Incise finger tendon sheath	Y		A2	$446.00	16.8220	$696.43	$508.61
26060	Incision of finger tendon	Y		A2	$446.00	16.8220	$696.43	$508.61
26070	Explore/treat hand joint	Y		A2	$446.00	16.8220	$696.43	$508.61
26075	Explore/treat finger joint	Y		A2	$630.00	16.8220	$696.43	$646.61
26080	Explore/treat finger joint	Y		A2	$630.00	16.8220	$696.43	$646.61
26100	Biopsy hand joint lining	Y		A2	$446.00	16.8220	$696.43	$508.61
26105	Biopsy finger joint lining	Y		A2	$333.00	16.8220	$696.43	$423.86
26110	Biopsy finger joint lining	Y		A2	$333.00	16.8220	$696.43	$423.86
26115	Removal hand lesion subcut	Y		A2	$446.00	21.4534	$888.17	$556.54
26116	Removal hand lesion, deep	Y		A2	$446.00	21.4534	$888.17	$556.54
26117	Remove tumor, hand/finger	Y		A2	$510.00	21.4534	$888.17	$604.54
26121	Release palm contracture	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26123	Release palm contracture	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26125	Release palm contracture	Y		A2	$630.00	16.8220	$696.43	$646.61
26130	Remove wrist joint lining	Y		A2	$510.00	16.8220	$696.43	$556.61
26135	Revise finger joint, each	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26140	Revise finger joint, each	Y		A2	$446.00	16.8220	$696.43	$508.61
26145	Tendon excision, palm/finger	Y		A2	$510.00	16.8220	$696.43	$556.61
26160	Remove tendon sheath lesion	Y		A2	$510.00	16.8220	$696.43	$556.61
26170	Removal of palm tendon, each	Y		A2	$510.00	16.8220	$696.43	$556.61
26180	Removal of finger tendon	Y		A2	$510.00	16.8220	$696.43	$556.61
26185	Remove finger bone	Y		A2	$630.00	16.8220	$696.43	$646.61
26200	Remove hand bone lesion	Y		A2	$446.00	16.8220	$696.43	$508.61
26205	Remove/graft bone lesion	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26210	Removal of finger lesion	Y		A2	$446.00	16.8220	$696.43	$508.61
26215	Remove/graft finger lesion	Y		A2	$510.00	16.8220	$696.43	$556.61
26230	Partial removal of hand bone	Y		A2	$992.95	16.8220	$696.43	$918.82
26235	Partial removal, finger bone	Y		A2	$510.00	16.8220	$696.43	$556.61
26236	Partial removal, finger bone	Y		A2	$510.00	16.8220	$696.43	$556.61
26250	Extensive hand surgery	Y		A2	$510.00	16.8220	$696.43	$556.61
26255	Extensive hand surgery	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26260	Extensive finger surgery	Y		A2	$510.00	16.8220	$696.43	$556.61
26261	Extensive finger surgery	Y		A2	$510.00	16.8220	$696.43	$556.61
26262	Partial removal of finger	Y		A2	$446.00	16.8220	$696.43	$508.61
26320	Removal of implant from hand	Y		A2	$446.00	16.5832	$686.54	$506.14
26340	Manipulate finger w/anesth	Y		G2		1.8742	$77.59	$77.59
26350	Repair finger/hand tendon	Y		A2	$333.00	26.7322	$1,106.71	$526.43
26352	Repair/graft hand tendon	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26356	Repair finger/hand tendon	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26357	Repair finger/hand tendon	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26358	Repair/graft hand tendon	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26370	Repair finger/hand tendon	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26372	Repair/graft hand tendon	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26373	Repair finger/hand tendon	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26390	Revise hand/finger tendon	Y		A2	$630.00	26.7322	$1,106.71	$749.18

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
26392	Repair/graft hand tendon	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26410	Repair hand tendon	Y		A2	$510.00	16.8220	$696.43	$556.61
26412	Repair/graft hand tendon	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26415	Excision, hand/finger tendon	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26416	Graft hand or finger tendon	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26418	Repair finger tendon	Y		A2	$630.00	16.8220	$696.43	$646.61
26420	Repair/graft finger tendon	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26426	Repair finger/hand tendon	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26428	Repair/graft finger tendon	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26432	Repair finger tendon	Y		A2	$510.00	16.8220	$696.43	$556.61
26433	Repair finger tendon	Y		A2	$510.00	16.8220	$696.43	$556.61
26434	Repair/graft finger tendon	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26437	Realignment of tendons	Y		A2	$510.00	16.8220	$696.43	$556.61
26440	Release palm/finger tendon	Y		A2	$510.00	16.8220	$696.43	$556.61
26442	Release palm & finger tendon	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26445	Release hand/finger tendon	Y		A2	$510.00	16.8220	$696.43	$556.61
26449	Release forearm/hand tendon	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26450	Incision of palm tendon	Y		A2	$510.00	16.8220	$696.43	$556.61
26455	Incision of finger tendon	Y		A2	$510.00	16.8220	$696.43	$556.61
26460	Incise hand/finger tendon	Y		A2	$510.00	16.8220	$696.43	$556.61
26471	Fusion of finger tendons	Y		A2	$446.00	16.8220	$696.43	$508.61
26474	Fusion of finger tendons	Y		A2	$446.00	16.8220	$696.43	$508.61
26476	Tendon lengthening	Y		A2	$333.00	16.8220	$696.43	$423.86
26477	Tendon shortening	Y		A2	$333.00	16.8220	$696.43	$423.86
26478	Lengthening of hand tendon	Y		A2	$333.00	16.8220	$696.43	$423.86
26479	Shortening of hand tendon	Y		A2	$333.00	16.8220	$696.43	$423.86
26480	Transplant hand tendon	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26483	Transplant/graft hand tendon	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26485	Transplant palm tendon	Y		A2	$446.00	26.7322	$1,106.71	$611.18
26489	Transplant/graft palm tendon	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26490	Revise thumb tendon	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26492	Tendon transfer with graft	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26494	Hand tendon/muscle transfer	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26496	Revise thumb tendon	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26497	Finger tendon transfer	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26498	Finger tendon transfer	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26499	Revision of finger	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26500	Hand tendon reconstruction	Y		A2	$630.00	16.8220	$696.43	$646.61
26502	Hand tendon reconstruction	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26508	Release thumb contracture	Y		A2	$510.00	16.8220	$696.43	$556.61
26510	Thumb tendon transfer	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26516	Fusion of knuckle joint	Y		A2	$333.00	26.7322	$1,106.71	$526.43
26517	Fusion of knuckle joints	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26518	Fusion of knuckle joints	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26520	Release knuckle contracture	Y		A2	$510.00	16.8220	$696.43	$556.61
26525	Release finger contracture	Y		A2	$510.00	16.8220	$696.43	$556.61
26530	Revise knuckle joint	Y		A2	$510.00	35.9249	$1,487.29	$754.32
26531	Revise knuckle with implant	Y		A2	$995.00	51.0431	$2,113.18	$1,274.55
26535	Revise finger joint	Y		A2	$717.00	35.9249	$1,487.29	$909.57
26536	Revise/implant finger joint	Y		A2	$717.00	51.0431	$2,113.18	$1,066.05
26540	Repair hand joint	Y		A2	$630.00	16.8220	$696.43	$646.61
26541	Repair hand joint with graft	Y		A2	$995.00	26.7322	$1,106.71	$1,022.93
26542	Repair hand joint with graft	Y		A2	$630.00	16.8220	$696.43	$646.61
26545	Reconstruct finger joint	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26546	Repair nonunion hand	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26548	Reconstruct finger joint	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26550	Construct thumb replacement	Y		A2	$446.00	26.7322	$1,106.71	$611.18
26555	Positional change of finger	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26560	Repair of web finger	Y		A2	$446.00	16.8220	$696.43	$508.61
26561	Repair of web finger	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26562	Repair of web finger	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26565	Correct metacarpal flaw	Y		A2	$717.00	26.7322	$1,106.71	$814.43
26567	Correct finger deformity	Y		A2	$717.00	26.7322	$1,106.71	$814.43
26568	Lengthen metacarpal/finger	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26580	Repair hand deformity	Y		A2	$717.00	16.8220	$696.43	$711.86
26587	Reconstruct extra finger	Y		A2	$717.00	16.8220	$696.43	$711.86
26590	Repair finger deformity	Y		A2	$717.00	16.8220	$696.43	$711.86
26591	Repair muscles of hand	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26593	Release muscles of hand	Y		A2	$510.00	16.8220	$696.43	$556.61
26596	Excision constricting tissue	Y		A2	$446.00	16.8220	$696.43	$508.61
26600	Treat metacarpal fracture	Y		P2		1.8742	$77.59	$77.59
26605	Treat metacarpal fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
26607	Treat metacarpal fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
26608	Treat metacarpal fracture	Y		A2	$630.00	26.3092	$1,089.20	$744.80
26615	Treat metacarpal fracture	Y		A2	$630.00	40.3466	$1,670.35	$890.09
26641	Treat thumb dislocation	Y	CH	P2		1.8742	$77.59	$77.59

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
26645	Treat thumb fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
26650	Treat thumb fracture	Y		A2	$446.00	26.3092	$1,089.20	$606.80
26665	Treat thumb fracture	Y		A2	$630.00	40.3466	$1,670.35	$890.09
26670	Treat hand dislocation	Y	CH	P2		1.8742	$77.59	$77.59
26675	Treat hand dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
26676	Pin hand dislocation	Y		A2	$446.00	26.3092	$1,089.20	$606.80
26685	Treat hand dislocation	Y		A2	$510.00	40.3466	$1,670.35	$800.09
26686	Treat hand dislocation	Y		A2	$510.00	60.0595	$2,486.46	$1,004.12
26700	Treat knuckle dislocation	Y	CH	P2		1.8742	$77.59	$77.59
26705	Treat knuckle dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
26706	Pin knuckle dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
26715	Treat knuckle dislocation	Y		A2	$630.00	40.3466	$1,670.35	$890.09
26720	Treat finger fracture, each	Y		P2		1.8742	$77.59	$77.59
26725	Treat finger fracture, each	Y		P2		1.8742	$77.59	$77.59
26727	Treat finger fracture, each	Y		A2	$995.00	26.3092	$1,089.20	$1,018.55
26735	Treat finger fracture, each	Y		A2	$630.00	40.3466	$1,670.35	$890.09
26740	Treat finger fracture, each	Y		P2		1.8742	$77.59	$77.59
26742	Treat finger fracture, each	Y		A2	$103.62	1.8742	$77.59	$97.11
26746	Treat finger fracture, each	Y		A2	$717.00	40.3466	$1,670.35	$955.34
26750	Treat finger fracture, each	Y		P2		1.8742	$77.59	$77.59
26755	Treat finger fracture, each	Y		G2		1.8742	$77.59	$77.59
26756	Pin finger fracture, each	Y		A2	$446.00	26.3092	$1,089.20	$606.80
26765	Treat finger fracture, each	Y		A2	$630.00	40.3466	$1,670.35	$890.09
26770	Treat finger dislocation	Y		G2		1.8742	$77.59	$77.59
26775	Treat finger dislocation	Y	CH	P3		4.0319	$166.92	$166.92
26776	Pin finger dislocation	Y		A2	$446.00	26.3092	$1,089.20	$606.80
26785	Treat finger dislocation	Y		A2	$446.00	26.3092	$1,089.20	$606.80
26820	Thumb fusion with graft	Y		A2	$717.00	26.7322	$1,106.71	$814.43
26841	Fusion of thumb	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26842	Thumb fusion with graft	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26843	Fusion of hand joint	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26844	Fusion/graft of hand joint	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26850	Fusion of knuckle	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26852	Fusion of knuckle with graft	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26860	Fusion of finger joint	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26861	Fusion of finger jnt, add-on	Y		A2	$446.00	26.7322	$1,106.71	$611.18
26862	Fusion/graft of finger joint	Y		A2	$630.00	26.7322	$1,106.71	$749.18
26863	Fuse/graft added joint	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26910	Amputate metacarpal bone	Y		A2	$510.00	26.7322	$1,106.71	$659.18
26951	Amputation of finger/thumb	Y		A2	$446.00	16.8220	$696.43	$508.61
26952	Amputation of finger/thumb	Y		A2	$630.00	16.8220	$696.43	$646.61
26990	Drainage of pelvis lesion	Y		A2	$333.00	21.5761	$893.25	$473.06
26991	Drainage of pelvis bursa	Y		A2	$333.00	21.5761	$893.25	$473.06
27000	Incision of hip tendon	Y		A2	$446.00	21.5761	$893.25	$557.81
27001	Incision of hip tendon	Y		A2	$510.00	29.3263	$1,214.11	$686.03
27003	Incision of hip tendon	Y		A2	$510.00	29.3263	$1,214.11	$686.03
27033	Exploration of hip joint	Y		A2	$510.00	43.5953	$1,804.85	$833.71
27035	Denervation of hip joint	Y		A2	$630.00	43.5953	$1,804.85	$923.71
27040	Biopsy of soft tissues	Y		A2	$333.00	8.7155	$360.82	$339.96
27041	Biopsy of soft tissues	Y		A2	$418.49	8.7155	$360.82	$404.07
27047	Remove hip/pelvis lesion	Y		A2	$446.00	21.4534	$888.17	$556.54
27048	Remove hip/pelvis lesion	Y		A2	$510.00	21.4534	$888.17	$604.54
27049	Remove tumor, hip/pelvis	Y		A2	$510.00	21.4534	$888.17	$604.54
27050	Biopsy of sacroiliac joint	Y		A2	$510.00	21.5761	$893.25	$605.81
27052	Biopsy of hip joint	Y		A2	$510.00	21.5761	$893.25	$605.81
27060	Removal of ischial bursa	Y		A2	$717.00	21.5761	$893.25	$761.06
27062	Remove femur lesion/bursa	Y		A2	$717.00	21.5761	$893.25	$761.06
27065	Removal of hip bone lesion	Y		A2	$717.00	21.5761	$893.25	$761.06
27066	Removal of hip bone lesion	Y		A2	$717.00	29.3263	$1,214.11	$841.28
27067	Remove/graft hip bone lesion	Y		A2	$717.00	29.3263	$1,214.11	$841.28
27080	Removal of tail bone	Y		A2	$446.00	29.3263	$1,214.11	$638.03
27086	Remove hip foreign body	Y		A2	$333.00	8.7155	$360.82	$339.96
27087	Remove hip foreign body	Y		A2	$510.00	21.5761	$893.25	$605.81
27093	Injection for hip x-ray	N		N1				
27095	Injection for hip x-ray	N		N1				
27097	Revision of hip tendon	Y		A2	$510.00	29.3263	$1,214.11	$686.03
27098	Transfer tendon to pelvis	Y		A2	$510.00	29.3263	$1,214.11	$686.03
27100	Transfer of abdominal muscle	Y		A2	$630.00	43.5953	$1,804.85	$923.71
27105	Transfer of spinal muscle	Y		A2	$630.00	43.5953	$1,804.85	$923.71
27110	Transfer of iliopsoas muscle	Y		A2	$630.00	43.5953	$1,804.85	$923.71
27111	Transfer of iliopsoas muscle	Y		A2	$630.00	43.5953	$1,804.85	$923.71
27193	Treat pelvic ring fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27194	Treat pelvic ring fracture	Y		A2	$446.00	15.0176	$621.73	$489.93
27200	Treat tail bone fracture	Y		P3		1.7727	$73.39	$73.39
27202	Treat tail bone fracture	Y		A2	$446.00	40.3466	$1,670.35	$752.09
27220	Treat hip socket fracture	Y		G2		1.8742	$77.59	$77.59

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
27230	Treat thigh fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27238	Treat thigh fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27246	Treat thigh fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27250	Treat hip dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
27252	Treat hip dislocation	Y		A2	$446.00	15.0176	$621.73	$489.93
27256	Treat hip dislocation	Y		G2		1.8742	$77.59	$77.59
27257	Treat hip dislocation	Y		A2	$510.00	15.0176	$621.73	$537.93
27265	Treat hip dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
27266	Treat hip dislocation	Y		A2	$446.00	15.0176	$621.73	$489.93
27275	Manipulation of hip joint	Y		A2	$446.00	15.0176	$621.73	$489.93
27301	Drain thigh/knee lesion	Y		A2	$510.00	19.0457	$788.49	$579.62
27305	Incise thigh tendon & fascia	Y		A2	$446.00	21.5761	$893.25	$557.81
27306	Incision of thigh tendon	Y		A2	$510.00	21.5761	$893.25	$605.81
27307	Incision of thigh tendons	Y		A2	$510.00	21.5761	$893.25	$605.81
27310	Exploration of knee joint	Y		A2	$630.00	29.3263	$1,214.11	$776.03
27323	Biopsy, thigh soft tissues	Y		A2	$333.00	8.7155	$360.82	$339.96
27324	Biopsy, thigh soft tissues	Y		A2	$333.00	21.4534	$888.17	$471.79
27325	Neurectomy, hamstring	Y		A2	$446.00	18.5069	$766.19	$526.05
27326	Neurectomy, popliteal	Y		A2	$446.00	18.5069	$766.19	$526.05
27327	Removal of thigh lesion	Y		A2	$446.00	21.4534	$888.17	$556.54
27328	Removal of thigh lesion	Y		A2	$510.00	21.4534	$888.17	$604.54
27329	Remove tumor, thigh/knee	Y		A2	$630.00	21.4534	$888.17	$694.54
27330	Biopsy, knee joint lining	Y		A2	$630.00	29.3263	$1,214.11	$776.03
27331	Explore/treat knee joint	Y		A2	$630.00	29.3263	$1,214.11	$776.03
27332	Removal of knee cartilage	Y		A2	$630.00	29.3263	$1,214.11	$776.03
27333	Removal of knee cartilage	Y		A2	$630.00	29.3263	$1,214.11	$776.03
27334	Remove knee joint lining	Y		A2	$630.00	29.3263	$1,214.11	$776.03
27335	Remove knee joint lining	Y		A2	$630.00	29.3263	$1,214.11	$776.03
27340	Removal of kneecap bursa	Y		A2	$510.00	21.5761	$893.25	$605.81
27345	Removal of knee cyst	Y		A2	$630.00	21.5761	$893.25	$695.81
27347	Remove knee cyst	Y		A2	$630.00	21.5761	$893.25	$695.81
27350	Removal of kneecap	Y		A2	$630.00	29.3263	$1,214.11	$776.03
27355	Remove femur lesion	Y		A2	$510.00	29.3263	$1,214.11	$686.03
27356	Remove femur lesion/graft	Y		A2	$630.00	29.3263	$1,214.11	$776.03
27357	Remove femur lesion/graft	Y		A2	$717.00	29.3263	$1,214.11	$841.28
27358	Remove femur lesion/fixation	Y		A2	$717.00	29.3263	$1,214.11	$841.28
27360	Partial removal, leg bone(s)	Y		A2	$717.00	29.3263	$1,214.11	$841.28
27370	Injection for knee x-ray	N		N1				
27372	Removal of foreign body	Y		A2	$995.00	21.4534	$888.17	$968.29
27380	Repair of kneecap tendon	Y		A2	$333.00	21.5761	$893.25	$473.06
27381	Repair/graft kneecap tendon	Y		A2	$510.00	21.5761	$893.25	$605.81
27385	Repair of thigh muscle	Y		A2	$510.00	21.5761	$893.25	$605.81
27386	Repair/graft of thigh muscle	Y		A2	$510.00	21.5761	$893.25	$605.81
27390	Incision of thigh tendon	Y		A2	$333.00	21.5761	$893.25	$473.06
27391	Incision of thigh tendons	Y		A2	$446.00	21.5761	$893.25	$557.81
27392	Incision of thigh tendons	Y		A2	$510.00	21.5761	$893.25	$605.81
27393	Lengthening of thigh tendon	Y		A2	$446.00	29.3263	$1,214.11	$638.03
27394	Lengthening of thigh tendons	Y		A2	$510.00	29.3263	$1,214.11	$686.03
27395	Lengthening of thigh tendons	Y		A2	$510.00	43.5953	$1,804.85	$833.71
27396	Transplant of thigh tendon	Y		A2	$510.00	29.3263	$1,214.11	$686.03
27397	Transplants of thigh tendons	Y		A2	$510.00	43.5953	$1,804.85	$833.71
27400	Revise thigh muscles/tendons	Y		A2	$510.00	43.5953	$1,804.85	$833.71
27403	Repair of knee cartilage	Y		A2	$630.00	29.3263	$1,214.11	$776.03
27405	Repair of knee ligament	Y		A2	$630.00	43.5953	$1,804.85	$923.71
27407	Repair of knee ligament	Y		A2	$630.00	78.6518	$3,256.18	$1,286.55
27409	Repair of knee ligaments	Y		A2	$630.00	43.5953	$1,804.85	$923.71
27418	Repair degenerated kneecap	Y		A2	$510.00	43.5953	$1,804.85	$833.71
27420	Revision of unstable kneecap	Y		A2	$510.00	43.5953	$1,804.85	$833.71
27422	Revision of unstable kneecap	Y		A2	$995.00	43.5953	$1,804.85	$1,197.46
27424	Revision/removal of kneecap	Y		A2	$510.00	43.5953	$1,804.85	$833.71
27425	Lat retinacular release open	Y		A2	$995.00	29.3263	$1,214.11	$1,049.78
27427	Reconstruction, knee	Y		A2	$510.00	43.5953	$1,804.85	$833.71
27428	Reconstruction, knee	Y		A2	$630.00	78.6518	$3,256.18	$1,286.55
27429	Reconstruction, knee	Y		A2	$630.00	78.6518	$3,256.18	$1,286.55
27430	Revision of thigh muscles	Y		A2	$630.00	43.5953	$1,804.85	$923.71
27435	Incision of knee joint	Y		A2	$630.00	43.5953	$1,804.85	$923.71
27437	Revise kneecap	Y		A2	$630.00	35.9249	$1,487.29	$844.32
27438	Revise kneecap with implant	Y		A2	$717.00	51.0431	$2,113.18	$1,066.05
27440	Revision of knee joint	Y		G2		35.9249	$1,487.29	$1,487.29
27441	Revision of knee joint	Y		A2	$717.00	35.9249	$1,487.29	$909.57
27442	Revision of knee joint	Y		A2	$717.00	35.9249	$1,487.29	$909.57
27443	Revision of knee joint	Y		A2	$717.00	35.9249	$1,487.29	$909.57
27446	Revision of knee joint	Y		G2		191.2387	$7,917.28	$7,917.28
27496	Decompression of thigh/knee	Y		A2	$717.00	21.5761	$893.25	$761.06
27497	Decompression of thigh/knee	Y		A2	$510.00	21.5761	$893.25	$605.81
27498	Decompression of thigh/knee	Y		A2	$510.00	21.5761	$893.25	$605.81

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
27499	Decompression of thigh/knee	Y		A2	$510.00	21.5761	$893.25	$605.81
27500	Treatment of thigh fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27501	Treatment of thigh fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27502	Treatment of thigh fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27503	Treatment of thigh fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27508	Treatment of thigh fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27509	Treatment of thigh fracture	Y		A2	$510.00	26.3092	$1,089.20	$654.80
27510	Treatment of thigh fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27516	Treat thigh fx growth plate	Y		A2	$103.62	1.8742	$77.59	$97.11
27517	Treat thigh fx growth plate	Y		A2	$103.62	1.8742	$77.59	$97.11
27520	Treat kneecap fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27530	Treat knee fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27532	Treat knee fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27538	Treat knee fracture(s)	Y		A2	$103.62	1.8742	$77.59	$97.11
27550	Treat knee dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
27552	Treat knee dislocation	Y		A2	$333.00	15.0176	$621.73	$405.18
27560	Treat kneecap dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
27562	Treat kneecap dislocation	Y		A2	$333.00	15.0176	$621.73	$405.18
27566	Treat kneecap dislocation	Y		A2	$446.00	40.3466	$1,670.35	$752.09
27570	Fixation of knee joint	Y		A2	$333.00	15.0176	$621.73	$405.18
27594	Amputation follow-up surgery	Y		A2	$510.00	21.5761	$893.25	$605.81
27600	Decompression of lower leg	Y		A2	$510.00	21.5761	$893.25	$605.81
27601	Decompression of lower leg	Y		A2	$510.00	21.5761	$893.25	$605.81
27602	Decompression of lower leg	Y		A2	$510.00	21.5761	$893.25	$605.81
27603	Drain lower leg lesion	Y		A2	$446.00	19.0457	$788.49	$531.62
27604	Drain lower leg bursa	Y		A2	$446.00	21.5761	$893.25	$557.81
27605	Incision of achilles tendon	Y		A2	$333.00	21.1762	$876.69	$468.92
27606	Incision of achilles tendon	Y		A2	$333.00	21.5761	$893.25	$473.06
27607	Treat lower leg bone lesion	Y		A2	$446.00	21.5761	$893.25	$557.81
27610	Explore/treat ankle joint	Y		A2	$446.00	29.3263	$1,214.11	$638.03
27612	Exploration of ankle joint	Y		A2	$510.00	29.3263	$1,214.11	$686.03
27613	Biopsy lower leg soft tissue	Y		P3		2.9271	$121.18	$121.18
27614	Biopsy lower leg soft tissue	Y		A2	$446.00	21.4534	$888.17	$556.54
27615	Remove tumor, lower leg	Y		A2	$510.00	29.3263	$1,214.11	$686.03
27618	Remove lower leg lesion	Y		A2	$446.00	16.5832	$686.54	$506.14
27619	Remove lower leg lesion	Y		A2	$510.00	21.4534	$888.17	$604.54
27620	Explore/treat ankle joint	Y		A2	$630.00	29.3263	$1,214.11	$776.03
27625	Remove ankle joint lining	Y		A2	$630.00	29.3263	$1,214.11	$776.03
27626	Remove ankle joint lining	Y		A2	$630.00	29.3263	$1,214.11	$776.03
27630	Removal of tendon lesion	Y		A2	$510.00	21.5761	$893.25	$605.81
27635	Remove lower leg bone lesion	Y		A2	$510.00	29.3263	$1,214.11	$686.03
27637	Remove/graft leg bone lesion	Y		A2	$510.00	29.3263	$1,214.11	$686.03
27638	Remove/graft leg bone lesion	Y		A2	$510.00	29.3263	$1,214.11	$686.03
27640	Partial removal of tibia	Y		A2	$446.00	43.5953	$1,804.85	$785.71
27641	Partial removal of fibula	Y		A2	$446.00	29.3263	$1,214.11	$638.03
27647	Extensive ankle/heel surgery	Y		A2	$510.00	43.5953	$1,804.85	$833.71
27648	Injection for ankle x-ray	N		N1				
27650	Repair achilles tendon	Y		A2	$510.00	43.5953	$1,804.85	$833.71
27652	Repair/graft achilles tendon	Y		A2	$510.00	78.6518	$3,256.18	$1,196.55
27654	Repair of achilles tendon	Y		A2	$510.00	43.5953	$1,804.85	$833.71
27656	Repair leg fascia defect	Y		A2	$446.00	21.5761	$893.25	$557.81
27658	Repair of leg tendon, each	Y		A2	$333.00	21.5761	$893.25	$473.06
27659	Repair of leg tendon, each	Y		A2	$446.00	21.5761	$893.25	$557.81
27664	Repair of leg tendon, each	Y		A2	$446.00	21.5761	$893.25	$557.81
27665	Repair of leg tendon, each	Y		A2	$446.00	29.3263	$1,214.11	$638.03
27675	Repair lower leg tendons	Y		A2	$446.00	21.5761	$893.25	$557.81
27676	Repair lower leg tendons	Y		A2	$510.00	29.3263	$1,214.11	$686.03
27680	Release of lower leg tendon	Y		A2	$510.00	29.3263	$1,214.11	$686.03
27681	Release of lower leg tendons	Y		A2	$446.00	29.3263	$1,214.11	$638.03
27685	Revision of lower leg tendon	Y		A2	$510.00	29.3263	$1,214.11	$686.03
27686	Revise lower leg tendons	Y		A2	$510.00	29.3263	$1,214.11	$686.03
27687	Revision of calf tendon	Y		A2	$510.00	29.3263	$1,214.11	$686.03
27690	Revise lower leg tendon	Y		A2	$630.00	43.5953	$1,804.85	$923.71
27691	Revise lower leg tendon	Y		A2	$630.00	43.5953	$1,804.85	$923.71
27692	Revise additional leg tendon	Y		A2	$510.00	43.5953	$1,804.85	$833.71
27695	Repair of ankle ligament	Y		A2	$446.00	29.3263	$1,214.11	$638.03
27696	Repair of ankle ligaments	Y		A2	$446.00	29.3263	$1,214.11	$638.03
27698	Repair of ankle ligament	Y		A2	$446.00	29.3263	$1,214.11	$638.03
27700	Revision of ankle joint	Y		A2	$717.00	35.9249	$1,487.29	$909.57
27704	Removal of ankle implant	Y		A2	$446.00	21.5761	$893.25	$557.81
27705	Incision of tibia	Y		A2	$446.00	43.5953	$1,804.85	$785.71
27707	Incision of fibula	Y		A2	$446.00	21.5761	$893.25	$557.81
27709	Incision of tibia & fibula	Y		A2	$446.00	29.3263	$1,214.11	$638.03
27730	Repair of tibia epiphysis	Y		A2	$446.00	29.3263	$1,214.11	$638.03
27732	Repair of fibula epiphysis	Y		A2	$446.00	29.3263	$1,214.11	$638.03
27734	Repair lower leg epiphyses	Y		A2	$446.00	29.3263	$1,214.11	$638.03

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
27740	Repair of leg epiphyses	Y		A2	$446.00	29.3263	$1,214.11	$638.03
27742	Repair of leg epiphyses	Y		A2	$446.00	43.5953	$1,804.85	$785.71
27745	Reinforce tibia	Y		A2	$510.00	78.6518	$3,256.18	$1,196.55
27750	Treatment of tibia fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27752	Treatment of tibia fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27756	Treatment of tibia fracture	Y		A2	$510.00	26.3092	$1,089.20	$654.80
27758	Treatment of tibia fracture	Y		A2	$630.00	40.3466	$1,670.35	$890.09
27759	Treatment of tibia fracture	Y		A2	$630.00	60.0595	$2,486.46	$1,094.12
27760	Treatment of ankle fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27762	Treatment of ankle fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27766	Treatment of ankle fracture	Y		A2	$510.00	40.3466	$1,670.35	$800.09
27780	Treatment of fibula fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27781	Treatment of fibula fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27784	Treatment of fibula fracture	Y		A2	$510.00	40.3466	$1,670.35	$800.09
27786	Treatment of ankle fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27788	Treatment of ankle fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27792	Treatment of ankle fracture	Y		A2	$510.00	40.3466	$1,670.35	$800.09
27808	Treatment of ankle fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27810	Treatment of ankle fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27814	Treatment of ankle fracture	Y		A2	$510.00	40.3466	$1,670.35	$800.09
27816	Treatment of ankle fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27818	Treatment of ankle fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27822	Treatment of ankle fracture	Y		A2	$510.00	40.3466	$1,670.35	$800.09
27823	Treatment of ankle fracture	Y		A2	$510.00	60.0595	$2,486.46	$1,004.12
27824	Treat lower leg fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27825	Treat lower leg fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
27826	Treat lower leg fracture	Y		A2	$510.00	40.3466	$1,670.35	$800.09
27827	Treat lower leg fracture	Y		A2	$510.00	60.0595	$2,486.46	$1,004.12
27828	Treat lower leg fracture	Y		A2	$630.00	60.0595	$2,486.46	$1,094.12
27829	Treat lower leg joint	Y		A2	$446.00	40.3466	$1,670.35	$752.09
27830	Treat lower leg dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
27831	Treat lower leg dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
27832	Treat lower leg dislocation	Y		A2	$446.00	40.3466	$1,670.35	$752.09
27840	Treat ankle dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
27842	Treat ankle dislocation	Y		A2	$333.00	15.0176	$621.73	$405.18
27846	Treat ankle dislocation	Y		A2	$510.00	40.3466	$1,670.35	$800.09
27848	Treat ankle dislocation	Y		A2	$510.00	40.3466	$1,670.35	$800.09
27860	Fixation of ankle joint	Y		A2	$333.00	15.0176	$621.73	$405.18
27870	Fusion of ankle joint, open	Y		A2	$630.00	78.6518	$3,256.18	$1,286.55
27871	Fusion of tibiofibular joint	Y		A2	$630.00	78.6518	$3,256.18	$1,286.55
27884	Amputation follow-up surgery	Y		A2	$510.00	21.5761	$893.25	$605.81
27889	Amputation of foot at ankle	Y		A2	$510.00	29.3263	$1,214.11	$686.03
27892	Decompression of leg	Y		A2	$510.00	21.5761	$893.25	$605.81
27893	Decompression of leg	Y		A2	$510.00	21.5761	$893.25	$605.81
27894	Decompression of leg	Y		A2	$510.00	21.5761	$893.25	$605.81
28001	Drainage of bursa of foot	Y		P3		2.8529	$118.11	$118.11
28002	Treatment of foot infection	Y		A2	$510.00	21.5761	$893.25	$605.81
28003	Treatment of foot infection	Y		A2	$510.00	21.5761	$893.25	$605.81
28005	Treat foot bone lesion	Y		A2	$510.00	21.1762	$876.69	$601.67
28008	Incision of foot fascia	Y		A2	$510.00	21.1762	$876.69	$601.67
28010	Incision of toe tendon	Y		P3		2.1437	$88.75	$88.75
28011	Incision of toe tendons	Y		A2	$510.00	21.1762	$876.69	$601.67
28020	Exploration of foot joint	Y		A2	$446.00	21.1762	$876.69	$553.67
28022	Exploration of foot joint	Y		A2	$446.00	21.1762	$876.69	$553.67
28024	Exploration of toe joint	Y		A2	$446.00	21.1762	$876.69	$553.67
28035	Decompression of tibia nerve	Y		A2	$630.00	18.5069	$766.19	$664.05
28043	Excision of foot lesion	Y		A2	$446.00	21.4534	$888.17	$556.54
28045	Excision of foot lesion	Y		A2	$510.00	21.1762	$876.69	$601.67
28046	Resection of tumor, foot	Y		A2	$510.00	21.1762	$876.69	$601.67
28050	Biopsy of foot joint lining	Y		A2	$446.00	21.1762	$876.69	$553.67
28052	Biopsy of foot joint lining	Y		A2	$446.00	21.1762	$876.69	$553.67
28054	Biopsy of toe joint lining	Y		A2	$446.00	21.1762	$876.69	$553.67
28055	Neurectomy, foot	Y		A2	$630.00	18.5069	$766.19	$664.05
28060	Partial removal, foot fascia	Y		A2	$446.00	21.1762	$876.69	$553.67
28062	Removal of foot fascia	Y		A2	$510.00	21.1762	$876.69	$601.67
28070	Removal of foot joint lining	Y		A2	$510.00	21.1762	$876.69	$601.67
28072	Removal of foot joint lining	Y		A2	$510.00	21.1762	$876.69	$601.67
28080	Removal of foot lesion	Y		A2	$510.00	21.1762	$876.69	$601.67
28086	Excise foot tendon sheath	Y		A2	$446.00	21.1762	$876.69	$553.67
28088	Excise foot tendon sheath	Y		A2	$446.00	21.1762	$876.69	$553.67
28090	Removal of foot lesion	Y		A2	$510.00	21.1762	$876.69	$601.67
28092	Removal of toe lesions	Y		A2	$510.00	21.1762	$876.69	$601.67
28100	Removal of ankle/heel lesion	Y		A2	$446.00	21.1762	$876.69	$553.67
28102	Remove/graft foot lesion	Y		A2	$510.00	44.4710	$1,841.10	$842.78
28103	Remove/graft foot lesion	Y		A2	$510.00	44.4710	$1,841.10	$842.78
28104	Removal of foot lesion	Y		A2	$446.00	21.1762	$876.69	$553.67

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
28106	Remove/graft foot lesion	Y		A2	$510.00	44.4710	$1,841.10	$842.78
28107	Remove/graft foot lesion	Y		A2	$510.00	44.4710	$1,841.10	$842.78
28108	Removal of toe lesions	Y		A2	$446.00	21.1762	$876.69	$553.67
28110	Part removal of metatarsal	Y		A2	$510.00	21.1762	$876.69	$601.67
28111	Part removal of metatarsal	Y		A2	$510.00	21.1762	$876.69	$601.67
28112	Part removal of metatarsal	Y		A2	$510.00	21.1762	$876.69	$601.67
28113	Part removal of metatarsal	Y		A2	$510.00	21.1762	$876.69	$601.67
28114	Removal of metatarsal heads	Y		A2	$510.00	21.1762	$876.69	$601.67
28116	Revision of foot	Y		A2	$510.00	21.1762	$876.69	$601.67
28118	Removal of heel bone	Y		A2	$630.00	21.1762	$876.69	$691.67
28119	Removal of heel spur	Y		A2	$630.00	21.1762	$876.69	$691.67
28120	Part removal of ankle/heel	Y		A2	$995.00	21.1762	$876.69	$965.42
28122	Partial removal of foot bone	Y		A2	$510.00	21.1762	$876.69	$601.67
28124	Partial removal of toe	Y		P3		4.8152	$199.35	$199.35
28126	Partial removal of toe	Y		A2	$510.00	21.1762	$876.69	$601.67
28130	Removal of ankle bone	Y		A2	$510.00	21.1762	$876.69	$601.67
28140	Removal of metatarsal	Y		A2	$510.00	21.1762	$876.69	$601.67
28150	Removal of toe	Y		A2	$510.00	21.1762	$876.69	$601.67
28153	Partial removal of toe	Y		A2	$510.00	21.1762	$876.69	$601.67
28160	Partial removal of toe	Y		A2	$510.00	21.1762	$876.69	$601.67
28171	Extensive foot surgery	Y		A2	$510.00	21.1762	$876.69	$601.67
28173	Extensive foot surgery	Y		A2	$510.00	21.1762	$876.69	$601.67
28175	Extensive foot surgery	Y		A2	$510.00	21.1762	$876.69	$601.67
28190	Removal of foot foreign body	Y		P3		3.0261	$125.28	$125.28
28192	Removal of foot foreign body	Y		A2	$446.00	16.5832	$686.54	$506.14
28193	Removal of foot foreign body	Y		A2	$418.49	8.7155	$360.82	$404.07
28200	Repair of foot tendon	Y		A2	$510.00	21.1762	$876.69	$601.67
28202	Repair/graft of foot tendon	Y		A2	$510.00	21.1762	$876.69	$601.67
28208	Repair of foot tendon	Y		A2	$510.00	21.1762	$876.69	$601.67
28210	Repair/graft of foot tendon	Y		A2	$510.00	44.4710	$1,841.10	$842.78
28220	Release of foot tendon	Y		P3		4.5266	$187.40	$187.40
28222	Release of foot tendons	Y		A2	$333.00	21.1762	$876.69	$468.92
28225	Release of foot tendon	Y		A2	$333.00	21.1762	$876.69	$468.92
28226	Release of foot tendons	Y		A2	$333.00	21.1762	$876.69	$468.92
28230	Incision of foot tendon(s)	Y		P3		4.4771	$185.35	$185.35
28232	Incision of toe tendon	Y		P3		4.2710	$176.82	$176.82
28234	Incision of foot tendon	Y		A2	$446.00	21.1762	$876.69	$553.67
28238	Revision of foot tendon	Y		A2	$510.00	44.4710	$1,841.10	$842.78
28240	Release of big toe	Y		A2	$446.00	21.1762	$876.69	$553.67
28250	Revision of foot fascia	Y		A2	$510.00	21.1762	$876.69	$601.67
28260	Release of midfoot joint	Y		A2	$510.00	21.1762	$876.69	$601.67
28261	Revision of foot tendon	Y		A2	$510.00	21.1762	$876.69	$601.67
28262	Revision of foot and ankle	Y		A2	$630.00	21.1762	$876.69	$691.67
28264	Release of midfoot joint	Y		A2	$333.00	44.4710	$1,841.10	$710.03
28270	Release of foot contracture	Y		A2	$510.00	21.1762	$876.69	$601.67
28272	Release of toe joint, each	Y		P3		4.0896	$169.31	$169.31
28280	Fusion of toes	Y		A2	$446.00	21.1762	$876.69	$553.67
28285	Repair of hammertoe	Y		A2	$510.00	21.1762	$876.69	$601.67
28286	Repair of hammertoe	Y		A2	$630.00	21.1762	$876.69	$691.67
28288	Partial removal of foot bone	Y		A2	$510.00	21.1762	$876.69	$601.67
28289	Repair hallux rigidus	Y		A2	$510.00	21.1762	$876.69	$601.67
28290	Correction of bunion	Y		A2	$446.00	29.8356	$1,235.19	$643.30
28292	Correction of bunion	Y		A2	$446.00	29.8356	$1,235.19	$643.30
28293	Correction of bunion	Y		A2	$510.00	29.8356	$1,235.19	$691.30
28294	Correction of bunion	Y		A2	$510.00	29.8356	$1,235.19	$691.30
28296	Correction of bunion	Y		A2	$510.00	29.8356	$1,235.19	$691.30
28297	Correction of bunion	Y		A2	$510.00	29.8356	$1,235.19	$691.30
28298	Correction of bunion	Y		A2	$510.00	29.8356	$1,235.19	$691.30
28299	Correction of bunion	Y		A2	$717.00	29.8356	$1,235.19	$846.55
28300	Incision of heel bone	Y		A2	$446.00	44.4710	$1,841.10	$794.78
28302	Incision of ankle bone	Y		A2	$446.00	21.1762	$876.69	$553.67
28304	Incision of midfoot bones	Y		A2	$446.00	44.4710	$1,841.10	$794.78
28305	Incise/graft midfoot bones	Y		A2	$510.00	44.4710	$1,841.10	$842.78
28306	Incision of metatarsal	Y		A2	$630.00	21.1762	$876.69	$691.67
28307	Incision of metatarsal	Y		A2	$630.00	21.1762	$876.69	$691.67
28308	Incision of metatarsal	Y		A2	$446.00	21.1762	$876.69	$553.67
28309	Incision of metatarsals	Y		A2	$630.00	44.4710	$1,841.10	$932.78
28310	Revision of big toe	Y		A2	$510.00	21.1762	$876.69	$601.67
28312	Revision of toe	Y		A2	$510.00	21.1762	$876.69	$601.67
28313	Repair deformity of toe	Y		A2	$446.00	21.1762	$876.69	$553.67
28315	Removal of sesamoid bone	Y		A2	$630.00	21.1762	$876.69	$691.67
28320	Repair of foot bones	Y		A2	$630.00	44.4710	$1,841.10	$932.78
28322	Repair of metatarsals	Y		A2	$630.00	44.4710	$1,841.10	$932.78
28340	Resect enlarged toe tissue	Y		A2	$630.00	21.1762	$876.69	$691.67
28341	Resect enlarged toe	Y		A2	$630.00	21.1762	$876.69	$691.67
28344	Repair extra toe(s)	Y		A2	$630.00	21.1762	$876.69	$691.67

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
28345	Repair webbed toe(s)	Y		A2	$630.00	21.1762	$876.69	$691.67
28400	Treatment of heel fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
28405	Treatment of heel fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
28406	Treatment of heel fracture	Y		A2	$446.00	26.3092	$1,089.20	$606.80
28415	Treat heel fracture	Y		A2	$510.00	40.3466	$1,670.35	$800.09
28420	Treat/graft heel fracture	Y		A2	$630.00	40.3466	$1,670.35	$890.09
28430	Treatment of ankle fracture	Y		P2		1.8742	$77.59	$77.59
28435	Treatment of ankle fracture	Y		A2	$103.62	1.8742	$77.59	$97.11
28436	Treatment of ankle fracture	Y		A2	$446.00	26.3092	$1,089.20	$606.80
28445	Treat ankle fracture	Y		A2	$510.00	40.3466	$1,670.35	$800.09
28450	Treat midfoot fracture, each	Y		P2		1.8742	$77.59	$77.59
28455	Treat midfoot fracture, each	Y		P2		1.8742	$77.59	$77.59
28456	Treat midfoot fracture	Y		A2	$446.00	26.3092	$1,089.20	$606.80
28465	Treat midfoot fracture, each	Y		A2	$510.00	40.3466	$1,670.35	$800.09
28470	Treat metatarsal fracture	Y		P2		1.8742	$77.59	$77.59
28475	Treat metatarsal fracture	Y		P2		1.8742	$77.59	$77.59
28476	Treat metatarsal fracture	Y		A2	$446.00	26.3092	$1,089.20	$606.80
28485	Treat metatarsal fracture	Y		A2	$630.00	40.3466	$1,670.35	$890.09
28490	Treat big toe fracture	Y		P3		1.6821	$69.64	$69.64
28495	Treat big toe fracture	Y		P2		1.8742	$77.59	$77.59
28496	Treat big toe fracture	Y		A2	$446.00	26.3092	$1,089.20	$606.80
28505	Treat big toe fracture	Y		A2	$510.00	40.3466	$1,670.35	$800.09
28510	Treatment of toe fracture	Y		P3		1.3193	$54.62	$54.62
28515	Treatment of toe fracture	Y		P3		1.6821	$69.64	$69.64
28525	Treat toe fracture	Y		A2	$510.00	40.3466	$1,670.35	$800.09
28530	Treat sesamoid bone fracture	Y		P3		1.2534	$51.89	$51.89
28531	Treat sesamoid bone fracture	Y		A2	$510.00	40.3466	$1,670.35	$800.09
28540	Treat foot dislocation	Y		P2		1.8742	$77.59	$77.59
28545	Treat foot dislocation	Y		A2	$333.00	26.3092	$1,089.20	$522.05
28546	Treat foot dislocation	Y		A2	$446.00	26.3092	$1,089.20	$606.80
28555	Repair foot dislocation	Y		A2	$446.00	40.3466	$1,670.35	$752.09
28570	Treat foot dislocation	Y		P2		1.8742	$77.59	$77.59
28575	Treat foot dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
28576	Treat foot dislocation	Y		A2	$510.00	26.3092	$1,089.20	$654.80
28585	Repair foot dislocation	Y		A2	$510.00	40.3466	$1,670.35	$800.09
28600	Treat foot dislocation	Y		P2		1.8742	$77.59	$77.59
28605	Treat foot dislocation	Y		A2	$103.62	1.8742	$77.59	$97.11
28606	Treat foot dislocation	Y		A2	$446.00	26.3092	$1,089.20	$606.80
28615	Repair foot dislocation	Y		A2	$510.00	40.3466	$1,670.35	$800.09
28630	Treat toe dislocation	Y	CH	P3		1.4181	$58.71	$58.71
28635	Treat toe dislocation	Y		A2	$333.00	15.0176	$621.73	$405.18
28636	Treat toe dislocation	Y		A2	$510.00	26.3092	$1,089.20	$654.80
28645	Repair toe dislocation	Y		A2	$510.00	40.3466	$1,670.35	$800.09
28660	Treat toe dislocation	Y	CH	P3		1.0471	$43.35	$43.35
28665	Treat toe dislocation	Y		A2	$333.00	15.0176	$621.73	$405.18
28666	Treat toe dislocation	Y		A2	$510.00	26.3092	$1,089.20	$654.80
28675	Repair of toe dislocation	Y		A2	$510.00	40.3466	$1,670.35	$800.09
28705	Fusion of foot bones	Y		A2	$630.00	44.4710	$1,841.10	$932.78
28715	Fusion of foot bones	Y		A2	$630.00	78.6518	$3,256.18	$1,286.55
28725	Fusion of foot bones	Y		A2	$630.00	44.4710	$1,841.10	$932.78
28730	Fusion of foot bones	Y		A2	$630.00	44.4710	$1,841.10	$932.78
28735	Fusion of foot bones	Y		A2	$630.00	44.4710	$1,841.10	$932.78
28737	Revision of foot bones	Y		A2	$717.00	44.4710	$1,841.10	$998.03
28740	Fusion of foot bones	Y		A2	$630.00	44.4710	$1,841.10	$932.78
28750	Fusion of big toe joint	Y		A2	$630.00	44.4710	$1,841.10	$932.78
28755	Fusion of big toe joint	Y		A2	$630.00	21.1762	$876.69	$691.67
28760	Fusion of big toe joint	Y		A2	$630.00	44.4710	$1,841.10	$932.78
28810	Amputation toe & metatarsal	Y		A2	$446.00	21.1762	$876.69	$553.67
28820	Amputation of toe	Y		A2	$446.00	21.1762	$876.69	$553.67
28825	Partial amputation of toe	Y		A2	$446.00	21.1762	$876.69	$553.67
28890	High energy eswt, plantar f	Y	CH	P3		4.2297	$175.11	$175.11
29000	Application of body cast	N		G2		1.1272	$46.67	$46.67
29010	Application of body cast	N		P2		2.2383	$92.67	$92.67
29015	Application of body cast	N		P2		2.2383	$92.67	$92.67
29020	Application of body cast	N		G2		1.1272	$46.67	$46.67
29025	Application of body cast	N		P2		1.1272	$46.67	$46.67
29035	Application of body cast	N	CH	P2		2.2383	$92.67	$92.67
29040	Application of body cast	N		G2		1.1272	$46.67	$46.67
29044	Application of body cast	N		P2		2.2383	$92.67	$92.67
29046	Application of body cast	N		G2		2.2383	$92.67	$92.67
29049	Application of figure eight	N		P3		0.9976	$41.30	$41.30
29055	Application of shoulder cast	N		P2		2.2383	$92.67	$92.67
29058	Application of shoulder cast	N		P2		1.1272	$46.67	$46.67
29065	Application of long arm cast	N		P3		1.0720	$44.38	$44.38
29075	Application of forearm cast	N		P3		1.0225	$42.33	$42.33
29085	Apply hand/wrist cast	N		P3		1.0471	$43.35	$43.35

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
29086	Apply finger cast	N		P3		0.8329	$34.48	$34.48
29105	Apply long arm splint	N		P3		0.9565	$39.60	$39.60
29125	Apply forearm splint	N		P3		0.8162	$33.79	$33.79
29126	Apply forearm splint	N		P3		0.9152	$37.89	$37.89
29130	Application of finger splint	N		P3		0.3710	$15.36	$15.36
29131	Application of finger splint	N		P3		0.5524	$22.87	$22.87
29200	Strapping of chest	N		P3		0.5442	$22.53	$22.53
29220	Strapping of low back	N		P3		0.5524	$22.87	$22.87
29240	Strapping of shoulder	N		P3		0.6348	$26.28	$26.28
29260	Strapping of elbow or wrist	N		P3		0.5771	$23.89	$23.89
29280	Strapping of hand or finger	N		P3		0.6019	$24.92	$24.92
29305	Application of hip cast	N	CH	P2		2.2383	$92.67	$92.67
29325	Application of hip casts	N	CH	P2		2.2383	$92.67	$92.67
29345	Application of long leg cast	N		P3		1.4099	$58.37	$58.37
29355	Application of long leg cast	N		P3		1.3686	$56.66	$56.66
29358	Apply long leg cast brace	N		P3		1.6821	$69.64	$69.64
29365	Application of long leg cast	N		P3		1.3357	$55.30	$55.30
29405	Apply short leg cast	N		P3		0.9976	$41.30	$41.30
29425	Apply short leg cast	N		P3		1.0058	$41.64	$41.64
29435	Apply short leg cast	N		P3		1.2698	$52.57	$52.57
29440	Addition of walker to cast	N		P3		0.5442	$22.53	$22.53
29445	Apply rigid leg cast	N		P3		1.3935	$57.69	$57.69
29450	Application of leg cast	N		P2		1.1272	$46.67	$46.67
29505	Application, long leg splint	N	CH	P3		0.9234	$38.23	$38.23
29515	Application lower leg splint	N	CH	P3		0.7502	$31.06	$31.06
29520	Strapping of hip	N		P3		0.6266	$25.94	$25.94
29530	Strapping of knee	N		P3		0.5937	$24.58	$24.58
29540	Strapping of ankle and/or ft	N		P3		0.3957	$16.38	$16.38
29550	Strapping of toes	N		P3		0.4041	$16.73	$16.73
29580	Application of paste boot	N		P3		0.5606	$23.21	$23.21
29590	Application of foot splint	N		P3		0.4534	$18.77	$18.77
29700	Removal/revision of cast	N		P3		0.7585	$31.40	$31.40
29705	Removal/revision of cast	N		P3		0.6514	$26.97	$26.97
29710	Removal/revision of cast	N		P3		1.1872	$49.15	$49.15
29715	Removal/revision of cast	N		P3		0.9729	$40.28	$40.28
29720	Repair of body cast	N		P3		0.9565	$39.60	$39.60
29730	Windowing of cast	N		P3		0.6432	$26.63	$26.63
29740	Wedging of cast	N		P3		0.9070	$37.55	$37.55
29750	Wedging of clubfoot cast	N		P3		0.8575	$35.50	$35.50
29800	Jaw arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29804	Jaw arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29805	Shoulder arthroscopy, dx	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29806	Shoulder arthroscopy/surgery	Y		A2	$510.00	47.7765	$1,977.95	$876.99
29807	Shoulder arthroscopy/surgery	Y		A2	$510.00	47.7765	$1,977.95	$876.99
29819	Shoulder arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29820	Shoulder arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29821	Shoulder arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29822	Shoulder arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29823	Shoulder arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29824	Shoulder arthroscopy/surgery	Y		A2	$717.00	29.4467	$1,219.09	$842.52
29825	Shoulder arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29826	Shoulder arthroscopy/surgery	Y		A2	$510.00	47.7765	$1,977.95	$876.99
29827	Arthroscop rotator cuff repr	Y		A2	$717.00	47.7765	$1,977.95	$1,032.24
29830	Elbow arthroscopy	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29834	Elbow arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29835	Elbow arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29836	Elbow arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29837	Elbow arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29838	Elbow arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29840	Wrist arthroscopy	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29843	Wrist arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29844	Wrist arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29845	Wrist arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29846	Wrist arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29847	Wrist arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29848	Wrist endoscopy/surgery	Y		A2	$1,339.00	29.4467	$1,219.09	$1,309.02
29850	Knee arthroscopy/surgery	Y		A2	$630.00	29.4467	$1,219.09	$777.27
29851	Knee arthroscopy/surgery	Y		A2	$630.00	47.7765	$1,977.95	$966.99
29855	Tibial arthroscopy/surgery	Y		A2	$630.00	47.7765	$1,977.95	$966.99
29856	Tibial arthroscopy/surgery	Y		A2	$630.00	29.4467	$1,219.09	$777.27
29860	Hip arthroscopy, dx	Y		A2	$630.00	29.4467	$1,219.09	$777.27
29861	Hip arthroscopy/surgery	Y		A2	$630.00	29.4467	$1,219.09	$777.27
29862	Hip arthroscopy/surgery	Y		A2	$1,339.00	47.7765	$1,977.95	$1,498.74
29863	Hip arthroscopy/surgery	Y		A2	$630.00	47.7765	$1,977.95	$966.99
29870	Knee arthroscopy, dx	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29871	Knee arthroscopy/drainage	Y		A2	$510.00	29.4467	$1,219.09	$687.27

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
29873	Knee arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29874	Knee arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29875	Knee arthroscopy/surgery	Y		A2	$630.00	29.4467	$1,219.09	$777.27
29876	Knee arthroscopy/surgery	Y		A2	$630.00	29.4467	$1,219.09	$777.27
29877	Knee arthroscopy/surgery	Y		A2	$630.00	29.4467	$1,219.09	$777.27
29879	Knee arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29880	Knee arthroscopy/surgery	Y		A2	$630.00	29.4467	$1,219.09	$777.27
29881	Knee arthroscopy/surgery	Y		A2	$630.00	29.4467	$1,219.09	$777.27
29882	Knee arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29883	Knee arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29884	Knee arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29885	Knee arthroscopy/surgery	Y		A2	$510.00	47.7765	$1,977.95	$876.99
29886	Knee arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29887	Knee arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29888	Knee arthroscopy/surgery	Y		A2	$510.00	47.7765	$1,977.95	$876.99
29889	Knee arthroscopy/surgery	Y		A2	$510.00	47.7765	$1,977.95	$876.99
29891	Ankle arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29892	Ankle arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29893	Scope, plantar fasciotomy	Y		A2	$1,255.56	21.1762	$876.69	$1,160.84
29894	Ankle arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29895	Ankle arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29897	Ankle arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29898	Ankle arthroscopy/surgery	Y		A2	$510.00	29.4467	$1,219.09	$687.27
29899	Ankle arthroscopy/surgery	Y		A2	$510.00	47.7765	$1,977.95	$876.99
29900	Mcp joint arthroscopy, dx	Y		A2	$510.00	16.8220	$696.43	$556.61
29901	Mcp joint arthroscopy, surg	Y		A2	$510.00	16.8220	$696.43	$556.61
29902	Mcp joint arthroscopy, surg	Y		A2	$510.00	16.8220	$696.43	$556.61
30000	Drainage of nose lesion	Y		P2		2.5765	$106.67	$106.67
30020	Drainage of nose lesion	Y		P2		2.5765	$106.67	$106.67
30100	Intranasal biopsy	Y		P3		1.8469	$76.46	$76.46
30110	Removal of nose polyp(s)	Y		P3		2.9024	$120.16	$120.16
30115	Removal of nose polyp(s)	Y		A2	$446.00	16.6341	$688.65	$506.66
30117	Removal of intranasal lesion	Y		A2	$510.00	16.6341	$688.65	$554.66
30118	Removal of intranasal lesion	Y		A2	$510.00	24.3535	$1,008.23	$634.56
30120	Revision of nose	Y		A2	$333.00	16.6341	$688.65	$421.91
30124	Removal of nose lesion	Y		R2		7.6539	$316.87	$316.87
30125	Removal of nose lesion	Y		A2	$446.00	40.5598	$1,679.18	$754.30
30130	Excise inferior turbinate	Y		A2	$510.00	16.6341	$688.65	$554.66
30140	Resect inferior turbinate	Y		A2	$446.00	24.3535	$1,008.23	$586.56
30150	Partial removal of nose	Y		A2	$510.00	40.5598	$1,679.18	$802.30
30160	Removal of nose	Y		A2	$630.00	40.5598	$1,679.18	$892.30
30200	Injection treatment of nose	Y		P3		1.4841	$61.44	$61.44
30210	Nasal sinus therapy	Y		P3		1.8717	$77.49	$77.49
30220	Insert nasal septal button	Y		A2	$464.15	7.6539	$316.87	$427.33
30300	Remove nasal foreign body	N		P2		0.6416	$26.56	$26.56
30310	Remove nasal foreign body	Y		A2	$333.00	16.6341	$688.65	$421.91
30320	Remove nasal foreign body	Y		A2	$446.00	16.6341	$688.65	$506.66
30400	Reconstruction of nose	Y		A2	$630.00	40.5598	$1,679.18	$892.30
30410	Reconstruction of nose	Y		A2	$717.00	40.5598	$1,679.18	$957.55
30420	Reconstruction of nose	Y		A2	$717.00	40.5598	$1,679.18	$957.55
30430	Revision of nose	Y		A2	$510.00	24.3535	$1,008.23	$634.56
30435	Revision of nose	Y		A2	$717.00	40.5598	$1,679.18	$957.55
30450	Revision of nose	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
30460	Revision of nose	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
30462	Revision of nose	Y		A2	$1,339.00	40.5598	$1,679.18	$1,424.05
30465	Repair nasal stenosis	Y		A2	$1,339.00	40.5598	$1,679.18	$1,424.05
30520	Repair of nasal septum	Y		A2	$630.00	24.3535	$1,008.23	$724.56
30540	Repair nasal defect	Y		A2	$717.00	40.5598	$1,679.18	$957.55
30545	Repair nasal defect	Y		A2	$717.00	40.5598	$1,679.18	$957.55
30560	Release of nasal adhesions	Y		A2	$150.72	2.5765	$106.67	$139.71
30580	Repair upper jaw fistula	Y		A2	$630.00	40.5598	$1,679.18	$892.30
30600	Repair mouth/nose fistula	Y		A2	$630.00	40.5598	$1,679.18	$892.30
30620	Intranasal reconstruction	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
30630	Repair nasal septum defect	Y		A2	$995.00	24.3535	$1,008.23	$998.31
30801	Ablate inf turbinate, superf	Y		A2	$333.00	7.6539	$316.87	$328.97
30802	Cauterization, inner nose	Y		A2	$333.00	7.6539	$316.87	$328.97
30901	Control of nosebleed	Y		P3		1.0720	$44.38	$44.38
30903	Control of nosebleed	Y		A2	$72.48	1.1708	$48.47	$66.48
30905	Control of nosebleed	Y		A2	$72.48	1.1708	$48.47	$66.48
30906	Repeat control of nosebleed	Y		A2	$72.48	1.1708	$48.47	$66.48
30915	Ligation, nasal sinus artery	Y		A2	$446.00	26.4396	$1,094.60	$608.15
30920	Ligation, upper jaw artery	Y		A2	$510.00	26.4396	$1,094.60	$656.15
30930	Ther fx, nasal inf turbinate	Y		A2	$630.00	16.6341	$688.65	$644.66
31000	Irrigation, maxillary sinus	Y		P3		2.4570	$101.72	$101.72
31002	Irrigation, sphenoid sinus	Y		R2		7.6539	$316.87	$316.87
31020	Exploration, maxillary sinus	Y		A2	$446.00	24.3535	$1,008.23	$586.56

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
31030	Exploration, maxillary sinus	Y		A2	$510.00	40.5598	$1,679.18	$802.30
31032	Explore sinus, remove polyps	Y		A2	$630.00	40.5598	$1,679.18	$892.30
31040	Exploration behind upper jaw	Y		R2		24.3535	$1,008.23	$1,008.23
31050	Exploration, sphenoid sinus	Y		A2	$446.00	40.5598	$1,679.18	$754.30
31051	Sphenoid sinus surgery	Y		A2	$630.00	40.5598	$1,679.18	$892.30
31070	Exploration of frontal sinus	Y		A2	$446.00	24.3535	$1,008.23	$586.56
31075	Exploration of frontal sinus	Y		A2	$630.00	40.5598	$1,679.18	$892.30
31080	Removal of frontal sinus	Y		A2	$630.00	40.5598	$1,679.18	$892.30
31081	Removal of frontal sinus	Y		A2	$630.00	40.5598	$1,679.18	$892.30
31084	Removal of frontal sinus	Y		A2	$630.00	40.5598	$1,679.18	$892.30
31085	Removal of frontal sinus	Y		A2	$630.00	40.5598	$1,679.18	$892.30
31086	Removal of frontal sinus	Y		A2	$630.00	40.5598	$1,679.18	$892.30
31087	Removal of frontal sinus	Y		A2	$630.00	40.5598	$1,679.18	$892.30
31090	Exploration of sinuses	Y		A2	$717.00	40.5598	$1,679.18	$957.55
31200	Removal of ethmoid sinus	Y		A2	$446.00	40.5598	$1,679.18	$754.30
31201	Removal of ethmoid sinus	Y		A2	$717.00	40.5598	$1,679.18	$957.55
31205	Removal of ethmoid sinus	Y		A2	$510.00	40.5598	$1,679.18	$802.30
31231	Nasal endoscopy, dx	Y		P2		1.5730	$65.12	$65.12
31233	Nasal/sinus endoscopy, dx	Y		A2	$86.39	1.5730	$65.12	$81.07
31235	Nasal/sinus endoscopy, dx	Y		A2	$333.00	17.4546	$722.62	$430.41
31237	Nasal/sinus endoscopy, surg	Y		A2	$446.00	17.4546	$722.62	$515.16
31238	Nasal/sinus endoscopy, surg	Y		A2	$333.00	17.4546	$722.62	$430.41
31239	Nasal/sinus endoscopy, surg	Y		A2	$630.00	23.2819	$963.87	$713.47
31240	Nasal/sinus endoscopy, surg	Y		A2	$446.00	17.4546	$722.62	$515.16
31254	Revision of ethmoid sinus	Y		A2	$510.00	23.2819	$963.87	$623.47
31255	Removal of ethmoid sinus	Y		A2	$717.00	23.2819	$963.87	$778.72
31256	Exploration maxillary sinus	Y		A2	$510.00	23.2819	$963.87	$623.47
31267	Endoscopy, maxillary sinus	Y		A2	$510.00	23.2819	$963.87	$623.47
31276	Sinus endoscopy, surgical	Y		A2	$510.00	23.2819	$963.87	$623.47
31287	Nasal/sinus endoscopy, surg	Y		A2	$510.00	23.2819	$963.87	$623.47
31288	Nasal/sinus endoscopy, surg	Y		A2	$510.00	23.2819	$963.87	$623.47
31300	Removal of larynx lesion	Y		A2	$717.00	24.3535	$1,008.23	$789.81
31320	Diagnostic incision, larynx	Y		A2	$446.00	40.5598	$1,679.18	$754.30
31400	Revision of larynx	Y		A2	$446.00	40.5598	$1,679.18	$754.30
31420	Removal of epiglottis	Y		A2	$446.00	40.5598	$1,679.18	$754.30
31500	Insert emergency airway	N		G2		2.5547	$105.76	$105.76
31502	Change of windpipe airway	N	CH	G2		1.3636	$56.45	$56.45
31505	Diagnostic laryngoscopy	Y		P2		0.8256	$34.18	$34.18
31510	Laryngoscopy with biopsy	Y		A2	$446.00	17.4546	$722.62	$515.16
31511	Remove foreign body, larynx	Y		A2	$86.39	1.5730	$65.12	$81.07
31512	Removal of larynx lesion	Y		A2	$446.00	17.4546	$722.62	$515.16
31513	Injection into vocal cord	Y		A2	$86.39	1.5730	$65.12	$81.07
31515	Laryngoscopy for aspiration	Y		A2	$333.00	17.4546	$722.62	$430.41
31520	Dx laryngoscopy, newborn	Y		G2		1.5730	$65.12	$65.12
31525	Dx laryngoscopy excl nb	Y		A2	$333.00	17.4546	$722.62	$430.41
31526	Dx laryngoscopy w/oper scope	Y		A2	$446.00	23.2819	$963.87	$575.47
31527	Laryngoscopy for treatment	Y		A2	$333.00	23.2819	$963.87	$490.72
31528	Laryngoscopy and dilation	Y		A2	$446.00	17.4546	$722.62	$515.16
31529	Laryngoscopy and dilation	Y		A2	$446.00	17.4546	$722.62	$515.16
31530	Laryngoscopy w/fb removal	Y		A2	$446.00	23.2819	$963.87	$575.47
31531	Laryngoscopy w/fb & op scope	Y		A2	$510.00	23.2819	$963.87	$623.47
31535	Laryngoscopy w/biopsy	Y		A2	$446.00	23.2819	$963.87	$575.47
31536	Laryngoscopy w/bx & op scope	Y		A2	$510.00	23.2819	$963.87	$623.47
31540	Laryngoscopy w/exc of tumor	Y		A2	$510.00	23.2819	$963.87	$623.47
31541	Larynscop w/tumr exc + scope	Y		A2	$630.00	23.2819	$963.87	$713.47
31545	Remove vc lesion w/scope	Y		A2	$630.00	23.2819	$963.87	$713.47
31546	Remove vc lesion scope/graft	Y		A2	$630.00	23.2819	$963.87	$713.47
31560	Laryngoscop w/arytenoidectom	Y		A2	$717.00	23.2819	$963.87	$778.72
31561	Larynscop, remve cart + scop	Y		A2	$717.00	23.2819	$963.87	$778.72
31570	Laryngoscope w/vc inj	Y		A2	$446.00	17.4546	$722.62	$515.16
31571	Laryngoscop w/vc inj + scope	Y		A2	$446.00	23.2819	$963.87	$575.47
31575	Diagnostic laryngoscopy	Y		P3		1.4676	$60.76	$60.76
31576	Laryngoscopy with biopsy	Y		A2	$446.00	23.2819	$963.87	$575.47
31577	Remove foreign body, larynx	Y		A2	$236.42	4.2060	$174.13	$220.85
31578	Removal of larynx lesion	Y		A2	$446.00	23.2819	$963.87	$575.47
31579	Diagnostic laryngoscopy	Y		P3		2.7126	$112.30	$112.30
31580	Revision of larynx	Y		A2	$717.00	40.5598	$1,679.18	$957.55
31582	Revision of larynx	Y		A2	$717.00	40.5598	$1,679.18	$957.55
31588	Revision of larynx	Y		A2	$717.00	40.5598	$1,679.18	$957.55
31590	Reinnervate larynx	Y		A2	$717.00	40.5598	$1,679.18	$957.55
31595	Larynx nerve surgery	Y		A2	$446.00	40.5598	$1,679.18	$754.30
31603	Incision of windpipe	Y		A2	$333.00	7.6539	$316.87	$328.97
31605	Incision of windpipe	Y		G2		7.6539	$316.87	$316.87
31611	Surgery/speech prosthesis	Y		A2	$510.00	24.3535	$1,008.23	$634.56
31612	Puncture/clear windpipe	Y		A2	$333.00	24.3535	$1,008.23	$501.81
31613	Repair windpipe opening	Y		A2	$446.00	24.3535	$1,008.23	$586.56

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
31614	Repair windpipe opening	Y		A2	$446.00	40.5598	$1,679.18	$754.30
31615	Visualization of windpipe	Y		A2	$333.00	10.1732	$421.17	$355.04
31620	Endobronchial us add-on	N	CH	N1	$333.00			
31622	Dx bronchoscope/wash	Y		A2	$333.00	10.1732	$421.17	$355.04
31623	Dx bronchoscope/brush	Y		A2	$446.00	10.1732	$421.17	$439.79
31624	Dx bronchoscope/lavage	Y		A2	$446.00	10.1732	$421.17	$439.79
31625	Bronchoscopy w/biopsy(s)	Y		A2	$446.00	10.1732	$421.17	$439.79
31628	Bronchoscopy/lung bx, each	Y		A2	$446.00	10.1732	$421.17	$439.79
31629	Bronchoscopy/needle bx, each	Y		A2	$446.00	10.1732	$421.17	$439.79
31630	Bronchoscopy dilate/fx repr	Y		A2	$446.00	24.2882	$1,005.53	$585.88
31631	Bronchoscopy, dilate w/stent	Y		A2	$446.00	24.2882	$1,005.53	$585.88
31632	Bronchoscopy/lung bx, add'l	Y		G2		10.1732	$421.17	$421.17
31633	Bronchoscopy/needle bx add'l	Y		G2		10.1732	$421.17	$421.17
31635	Bronchoscopy w/fb removal	Y		A2	$446.00	10.1732	$421.17	$439.79
31636	Bronchoscopy, bronch stents	Y		A2	$446.00	24.2882	$1,005.53	$585.88
31637	Bronchoscopy, stent add-on	Y		A2	$333.00	10.1732	$421.17	$355.04
31638	Bronchoscopy, revise stent	Y		A2	$446.00	24.2882	$1,005.53	$585.88
31640	Bronchoscopy w/tumor excise	Y		A2	$446.00	24.2882	$1,005.53	$585.88
31641	Bronchoscopy, treat blockage	Y		A2	$446.00	24.2882	$1,005.53	$585.88
31643	Diag bronchoscope/catheter	Y		A2	$446.00	10.1732	$421.17	$439.79
31645	Bronchoscopy, clear airways	Y		A2	$333.00	10.1732	$421.17	$355.04
31646	Bronchoscopy, reclear airway	Y		A2	$333.00	10.1732	$421.17	$355.04
31656	Bronchoscopy, inj for x-ray	Y		A2	$333.00	10.1732	$421.17	$355.04
31715	Injection for bronchus x-ray	N		N1				
31717	Bronchial brush biopsy	Y		A2	$236.42	4.2060	$174.13	$220.85
31720	Clearance of airways	N	CH	A2	$47.32	0.3904	$16.16	$39.53
31730	Intro, windpipe wire/tube	Y		A2	$236.42	4.2060	$174.13	$220.85
31750	Repair of windpipe	Y		A2	$717.00	40.5598	$1,679.18	$957.55
31755	Repair of windpipe	Y		A2	$446.00	40.5598	$1,679.18	$754.30
31820	Closure of windpipe lesion	Y		A2	$333.00	16.6341	$688.65	$421.91
31825	Repair of windpipe defect	Y		A2	$446.00	24.3535	$1,008.23	$586.56
31830	Revise windpipe scar	Y		A2	$446.00	24.3535	$1,008.23	$586.56
32000	Drainage of chest	Y		A2	$222.78	5.3095	$219.81	$222.04
32002	Treatment of collapsed lung	Y		G2		5.3095	$219.81	$219.81
32019	Insert pleural catheter	Y		G2		31.7598	$1,314.86	$1,314.86
32400	Needle biopsy chest lining	Y		A2	$333.00	9.5741	$396.37	$348.84
32405	Biopsy, lung or mediastinum	Y		A2	$333.00	9.5741	$396.37	$348.84
32420	Puncture/clear lung	Y		A2	$222.78	5.3095	$219.81	$222.04
32960	Therapeutic pneumothorax	Y		G2		5.3095	$219.81	$219.81
33010	Drainage of heart sac	Y		A2	$222.78	5.3095	$219.81	$222.04
33011	Repeat drainage of heart sac	Y		A2	$222.78	5.3095	$219.81	$222.04
33206	Insertion of heart pacemaker	Y		J8		171.4188	$7,096.74	$7,096.74
33207	Insertion of heart pacemaker	Y		J8		171.4188	$7,096.74	$7,096.74
33208	Insertion of heart pacemaker	Y		J8		202.2251	$8,372.12	$8,372.12
33210	Insertion of heart electrode	Y	CH	J8		98.1097	$4,061.74	$4,061.74
33211	Insertion of heart electrode	Y	CH	J8		98.1097	$4,061.74	$4,061.74
33212	Insertion of pulse generator	Y		H8	$510.00	140.4331	$5,813.93	$5,438.26
33213	Insertion of pulse generator	Y		H8	$510.00	150.5751	$6,233.81	$5,815.00
33214	Upgrade of pacemaker system	Y		J8		202.2251	$8,372.12	$8,372.12
33215	Reposition pacing-defib lead	Y		G2		24.7274	$1,023.71	$1,023.71
33216	Insert lead pace-defib, one	Y	CH	J8		98.1097	$4,061.74	$4,061.74
33217	Insert lead pace-defib, dual	Y	CH	J8		98.1097	$4,061.74	$4,061.74
33218	Repair lead pace-defib, one	Y		G2		24.7274	$1,023.71	$1,023.71
33220	Repair lead pace-defib, dual	Y		G2		24.7274	$1,023.71	$1,023.71
33222	Revise pocket, pacemaker	Y		A2	$446.00	15.4399	$639.21	$494.30
33223	Revise pocket, pacing-defib	Y		A2	$446.00	15.4399	$639.21	$494.30
33224	Insert pacing lead & connect	Y		J8		360.3278	$14,917.57	$14,917.57
33225	Lventric pacing lead add-on	Y		J8		360.3278	$14,917.57	$14,917.57
33226	Reposition l ventric lead	Y		G2		24.7274	$1,023.71	$1,023.71
33233	Removal of pacemaker system	Y		A2	$446.00	24.7274	$1,023.71	$590.43
33234	Removal of pacemaker system	Y		G2		24.7274	$1,023.71	$1,023.71
33235	Removal pacemaker electrode	Y		G2		24.7274	$1,023.71	$1,023.71
33240	Insert pulse generator	Y	CH	J8		523.1751	$21,659.45	$21,659.45
33241	Remove pulse generator	Y		G2		24.7274	$1,023.71	$1,023.71
33249	Eltrd/insert pace-defib	Y	CH	J8		596.7345	$24,704.81	$24,704.81
33282	Implant pat-active ht record	N		J8		99.4780	$4,118.39	$4,118.39
33284	Remove pat-active ht record	Y		G2		6.1077	$252.86	$252.86
33508	Endoscopic vein harvest	N		N1				
35188	Repair blood vessel lesion	Y		A2	$630.00	39.8001	$1,647.72	$884.43
35207	Repair blood vessel lesion	Y		A2	$630.00	39.8001	$1,647.72	$884.43
35473	Repair arterial blockage	Y		G2		46.0685	$1,907.24	$1,907.24
35474	Repair arterial blockage	Y		G2		46.0685	$1,907.24	$1,907.24
35476	Repair venous blockage	Y		G2		46.0685	$1,907.24	$1,907.24
35492	Atherectomy, percutaneous	Y		G2		88.7717	$3,675.15	$3,675.15
35572	Harvest femoropopliteal vein	N		N1				
35761	Exploration of artery/vein	Y		G2		30.5379	$1,264.27	$1,264.27

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
35875	Removal of clot in graft	Y		A2	$1,339.00	39.8001	$1,647.72	$1,416.18
35876	Removal of clot in graft	Y		A2	$1,339.00	39.8001	$1,647.72	$1,416.18
36000	Place needle in vein	N		N1				
36002	Pseudoaneurysm injection trt	N		G2		2.4859	$102.92	$102.92
36005	Injection ext venography	N		N1				
36010	Place catheter in vein	N		N1				
36011	Place catheter in vein	N		N1				
36012	Place catheter in vein	N		N1				
36013	Place catheter in artery	N		N1				
36014	Place catheter in artery	N		N1				
36015	Place catheter in artery	N		N1				
36100	Establish access to artery	N		N1				
36120	Establish access to artery	N		N1				
36140	Establish access to artery	N		N1				
36145	Artery to vein shunt	N		N1				
36160	Establish access to aorta	N		N1				
36200	Place catheter in aorta	N		N1				
36215	Place catheter in artery	N		N1				
36216	Place catheter in artery	N		N1				
36217	Place catheter in artery	N		N1				
36218	Place catheter in artery	N		N1				
36245	Place catheter in artery	N		N1				
36246	Place catheter in artery	N		N1				
36247	Place catheter in artery	N		N1				
36248	Place catheter in artery	N		N1				
36260	Insertion of infusion pump	Y		A2	$510.00	29.3210	$1,213.89	$685.97
36261	Revision of infusion pump	Y		A2	$446.00	29.3210	$1,213.89	$637.97
36262	Removal of infusion pump	Y		A2	$333.00	24.5273	$1,015.43	$503.61
36400	Bl draw < 3 yrs fem/jugular	N		N1				
36405	Bl draw < 3 yrs scalp vein	N		N1				
36406	Bl draw < 3 yrs other vein	N		N1				
36410	Non-routine bl draw > 3 yrs	N		N1				
36416	Capillary blood draw	N		N1				
36420	Vein access cutdown < 1 yr	Y		G2		0.2091	$8.66	$8.66
36425	Vein access cutdown > 1 yr	Y		R2		0.2091	$8.66	$8.66
36430	Blood transfusion service	N		P3		0.7998	$33.11	$33.11
36440	Bl push transfuse, 2 yr or <	N		R2		3.4924	$144.59	$144.59
36450	Bl exchange/transfuse, nb	N		R2		3.4924	$144.59	$144.59
36468	Injection(s), spider veins	Y		R2		0.8046	$33.31	$33.31
36469	Injection(s), spider veins	Y	CH	R2		0.8046	$33.31	$33.31
36470	Injection therapy of vein	Y		P2		0.8046	$33.31	$33.31
36471	Injection therapy of veins	Y		P2		0.8046	$33.31	$33.31
36475	Endovenous rf, 1st vein	Y		A2	$1,339.00	43.6609	$1,807.56	$1,456.14
36476	Endovenous rf, vein add-on	Y		A2	$1,339.00	26.4396	$1,094.60	$1,277.90
36478	Endovenous laser, 1st vein	Y		A2	$1,339.00	26.4396	$1,094.60	$1,277.90
36479	Endovenous laser vein addon	Y		A2	$1,339.00	26.4396	$1,094.60	$1,277.90
36481	Insertion of catheter, vein	N		N1				
36500	Insertion of catheter, vein	N		N1				
36510	Insertion of catheter, vein	N		N1				
36511	Apheresis wbc	N		G2		12.1982	$505.01	$505.01
36512	Apheresis rbc	N		G2		12.1982	$505.01	$505.01
36513	Apheresis platelets	N		G2		12.1982	$505.01	$505.01
36514	Apheresis plasma	N		G2		12.1982	$505.01	$505.01
36515	Apheresis, adsorp/reinfuse	N		G2		31.9648	$1,323.34	$1,323.34
36516	Apheresis, selective	N		G2		31.9648	$1,323.34	$1,323.34
36522	Photopheresis	N		G2		31.9648	$1,323.34	$1,323.34
36540	Collect blood venous device	N		N1				
36550	Declot vascular device	Y		P3		0.2886	$11.95	$11.95
36555	Insert non-tunnel cv cath	Y		A2	$333.00	11.0043	$455.58	$363.65
36556	Insert non-tunnel cv cath	Y		A2	$333.00	11.0043	$455.58	$363.65
36557	Insert tunneled cv cath	Y		A2	$446.00	24.5273	$1,015.43	$588.36
36558	Insert tunneled cv cath	Y		A2	$446.00	24.5273	$1,015.43	$588.36
36560	Insert tunneled cv cath	Y		A2	$510.00	29.3210	$1,213.89	$685.97
36561	Insert tunneled cv cath	Y		A2	$510.00	29.3210	$1,213.89	$685.97
36563	Insert tunneled cv cath	Y		A2	$510.00	29.3210	$1,213.89	$685.97
36565	Insert tunneled cv cath	Y		A2	$510.00	29.3210	$1,213.89	$685.97
36566	Insert tunneled cv cath	Y		H8	$510.00	116.7686	$4,834.22	$4,203.51
36568	Insert picc cath	Y		A2	$333.00	11.0043	$455.58	$363.65
36569	Insert picc cath	Y		A2	$333.00	11.0043	$455.58	$363.65
36570	Insert picvad cath	Y		A2	$510.00	24.5273	$1,015.43	$636.36
36571	Insert picvad cath	Y		A2	$510.00	24.5273	$1,015.43	$636.36
36575	Repair tunneled cv cath	Y		A2	$446.00	6.1077	$252.86	$397.72
36576	Repair tunneled cv cath	Y		A2	$446.00	11.0043	$455.58	$448.40
36578	Replace tunneled cv cath	Y		A2	$446.00	24.5273	$1,015.43	$588.36
36580	Replace cvad cath	Y		A2	$333.00	11.0043	$455.58	$363.65
36581	Replace tunneled cv cath	Y		A2	$446.00	24.5273	$1,015.43	$588.36

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
36582	Replace tunneled cv cath	Y		A2	$510.00	29.3210	$1,213.89	$685.97
36583	Replace tunneled cv cath	Y		A2	$510.00	29.3210	$1,213.89	$685.97
36584	Replace picc cath	Y		A2	$333.00	11.0043	$455.58	$363.65
36585	Replace picvad cath	Y		A2	$510.00	24.5273	$1,015.43	$636.36
36589	Removal tunneled cv cath	Y		A2	$333.00	6.1077	$252.86	$312.97
36590	Removal tunneled cv cath	Y		A2	$333.00	11.0043	$455.58	$363.65
36595	Mech remov tunneled cv cath	Y		G2		24.5273	$1,015.43	$1,015.43
36596	Mech remov tunneled cv cath	Y		G2		11.0043	$455.58	$455.58
36597	Reposition venous catheter	Y		G2		11.0043	$455.58	$455.58
36598	Inj w/fluor, eval cv device	Y	CH	P3		1.9872	$82.27	$82.27
36600	Withdrawal of arterial blood	N		N1				
36620	Insertion catheter, artery	N		N1				
36625	Insertion catheter, artery	N		N1				
36640	Insertion catheter, artery	Y		A2	$333.00	29.3210	$1,213.89	$553.22
36680	Insert needle, bone cavity	Y		G2		1.1915	$49.33	$49.33
36800	Insertion of cannula	Y		A2	$510.00	30.5379	$1,264.27	$698.57
36810	Insertion of cannula	Y		A2	$510.00	30.5379	$1,264.27	$698.57
36815	Insertion of cannula	Y		A2	$510.00	30.5379	$1,264.27	$698.57
36818	Av fuse, uppr arm, cephalic	Y		A2	$510.00	39.8001	$1,647.72	$794.43
36819	Av fuse, uppr arm, basilic	Y		A2	$510.00	39.8001	$1,647.72	$794.43
36820	Av fusion/forearm vein	Y		A2	$510.00	39.8001	$1,647.72	$794.43
36821	Av fusion direct any site	Y		A2	$510.00	39.8001	$1,647.72	$794.43
36825	Artery-vein autograft	Y		A2	$630.00	39.8001	$1,647.72	$884.43
36830	Artery-vein nonautograft	Y		A2	$630.00	39.8001	$1,647.72	$884.43
36831	Open thrombect av fistula	Y		A2	$1,339.00	39.8001	$1,647.72	$1,416.18
36832	Av fistula revision, open	Y		A2	$630.00	39.8001	$1,647.72	$884.43
36833	Av fistula revision	Y		A2	$630.00	39.8001	$1,647.72	$884.43
36834	Repair A-V aneurysm	Y		A2	$510.00	39.8001	$1,647.72	$794.43
36835	Artery to vein shunt	Y		A2	$630.00	30.5379	$1,264.27	$788.57
36860	External cannula declotting	Y		A2	$127.40	2.5179	$104.24	$121.61
36861	Cannula declotting	Y		A2	$510.00	30.5379	$1,264.27	$698.57
36870	Percut thrombect av fistula	Y		A2	$1,339.00	41.0875	$1,701.02	$1,429.51
37184	Prim art mech thrombectomy	Y		G2		39.8001	$1,647.72	$1,647.72
37185	Prim art m-thrombect add-on	Y		G2		39.8001	$1,647.72	$1,647.72
37186	Sec art m-thrombect add-on	Y		G2		39.8001	$1,647.72	$1,647.72
37187	Venous mech thrombectomy	Y		G2		39.8001	$1,647.72	$1,647.72
37188	Venous m-thrombectomy add-on	Y		G2		39.8001	$1,647.72	$1,647.72
37200	Transcatheter biopsy	Y		G2		29.3210	$1,213.89	$1,213.89
37203	Transcatheter retrieval	Y		G2		29.3210	$1,213.89	$1,213.89
37250	Iv us first vessel add-on	N	CH	N1				
37251	Iv us each add vessel add-on	N	CH	N1				
37500	Endoscopy ligate perf veins	Y		A2	$510.00	43.6609	$1,807.56	$834.39
37607	Ligation of a-v fistula	Y		A2	$510.00	26.4396	$1,094.60	$656.15
37609	Temporal artery procedure	Y		A2	$446.00	16.5832	$686.54	$506.14
37650	Revision of major vein	Y		A2	$446.00	26.4396	$1,094.60	$608.15
37700	Revise leg vein	Y		A2	$446.00	26.4396	$1,094.60	$608.15
37718	Ligate/strip short leg vein	Y		A2	$510.00	26.4396	$1,094.60	$656.15
37722	Ligate/strip long leg vein	Y		A2	$510.00	43.6609	$1,807.56	$834.39
37735	Removal of leg veins/lesion	Y		A2	$510.00	43.6609	$1,807.56	$834.39
37760	Ligation, leg veins, open	Y		A2	$510.00	26.4396	$1,094.60	$656.15
37765	Phleb veins—extrem—to 20	Y		R2		26.4396	$1,094.60	$1,094.60
37766	Phleb veins—extrem 20+	Y		R2		26.4396	$1,094.60	$1,094.60
37780	Revision of leg vein	Y		A2	$510.00	26.4396	$1,094.60	$656.15
37785	Ligate/divide/excise vein	Y		A2	$510.00	26.4396	$1,094.60	$656.15
37790	Penile venous occlusion	Y		A2	$510.00	35.1574	$1,455.52	$746.38
38200	Injection for spleen x-ray	N		N1				
38204	Bl donor search management	N		N1				
38205	Harvest allogenic stem cells	N		G2		12.1982	$505.01	$505.01
38206	Harvest auto stem cells	N		G2		12.1982	$505.01	$505.01
38220	Bone marrow aspiration	Y	CH	P3		2.6302	$108.89	$108.89
38221	Bone marrow biopsy	Y	CH	P3		2.7621	$114.35	$114.35
38230	Bone marrow collection	N		G2		31.9648	$1,323.34	$1,323.34
38241	Bone marrow/stem transplant	N		G2		31.9648	$1,323.34	$1,323.34
38242	Lymphocyte infuse transplant	N		R2		12.1982	$505.01	$505.01
38300	Drainage, lymph node lesion	Y		A2	$333.00	12.5792	$520.78	$379.95
38305	Drainage, lymph node lesion	Y		A2	$446.00	19.0457	$788.49	$531.62
38308	Incision of lymph channels	Y		A2	$446.00	23.5105	$973.33	$577.83
38500	Biopsy/removal, lymph nodes	Y		A2	$446.00	23.5105	$973.33	$577.83
38505	Needle biopsy, lymph nodes	Y		A2	$240.00	7.3012	$302.27	$255.57
38510	Biopsy/removal, lymph nodes	Y		A2	$446.00	23.5105	$973.33	$577.83
38520	Biopsy/removal, lymph nodes	Y		A2	$446.00	23.5105	$973.33	$577.83
38525	Biopsy/removal, lymph nodes	Y		A2	$446.00	23.5105	$973.33	$577.83
38530	Biopsy/removal, lymph nodes	Y		A2	$446.00	23.5105	$973.33	$577.83
38542	Explore deep node(s), neck	Y		A2	$446.00	45.1729	$1,870.16	$802.04
38550	Removal, neck/armpit lesion	Y		A2	$510.00	23.5105	$973.33	$625.83
38555	Removal, neck/armpit lesion	Y		A2	$630.00	23.5105	$973.33	$715.83

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
38570	Laparoscopy, lymph node biop	Y		A2	$1,339.00	46.1201	$1,909.37	$1,481.59
38571	Laparoscopy, lymphadenectomy	Y		A2	$1,339.00	71.0022	$2,939.49	$1,739.12
38572	Laparoscopy, lymphadenectomy	Y		A2	$1,339.00	46.1201	$1,909.37	$1,481.59
38700	Removal of lymph nodes, neck	Y		G2		23.5105	$973.33	$973.33
38740	Remove armpit lymph nodes	Y		A2	$446.00	45.1729	$1,870.16	$802.04
38745	Remove armpit lymph nodes	Y		A2	$630.00	45.1729	$1,870.16	$940.04
38760	Remove groin lymph nodes	Y		A2	$446.00	23.5105	$973.33	$577.83
38790	Inject for lymphatic x-ray	N		N1				
38792	Identify sentinel node	N		N1				
38794	Access thoracic lymph duct	N		N1				
40490	Biopsy of lip	Y		P3		1.5336	$63.49	$63.49
40500	Partial excision of lip	Y		A2	$446.00	16.6341	$688.65	$506.66
40510	Partial excision of lip	Y		A2	$446.00	24.3535	$1,008.23	$586.56
40520	Partial excision of lip	Y		A2	$446.00	16.6341	$688.65	$506.66
40525	Reconstruct lip with flap	Y		A2	$446.00	24.3535	$1,008.23	$586.56
40527	Reconstruct lip with flap	Y		A2	$446.00	24.3535	$1,008.23	$586.56
40530	Partial removal of lip	Y		A2	$446.00	24.3535	$1,008.23	$586.56
40650	Repair lip	Y		A2	$464.15	7.6539	$316.87	$427.33
40652	Repair lip	Y		A2	$464.15	7.6539	$316.87	$427.33
40654	Repair lip	Y		A2	$464.15	7.6539	$316.87	$427.33
40700	Repair cleft lip/nasal	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
40701	Repair cleft lip/nasal	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
40702	Repair cleft lip/nasal	Y		R2		40.5598	$1,679.18	$1,679.18
40720	Repair cleft lip/nasal	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
40761	Repair cleft lip/nasal	Y		A2	$510.00	40.5598	$1,679.18	$802.30
40800	Drainage of mouth lesion	Y		P2		1.4630	$60.57	$60.57
40801	Drainage of mouth lesion	Y		A2	$446.00	7.6539	$316.87	$413.72
40804	Removal, foreign body, mouth	N		P2		0.6416	$26.56	$26.56
40805	Removal, foreign body, mouth	Y		P3		3.9495	$163.51	$163.51
40806	Incision of lip fold	Y		P3		1.7481	$72.37	$72.37
40808	Biopsy of mouth lesion	Y		P3		2.5643	$106.16	$106.16
40810	Excision of mouth lesion	Y		P3		2.6879	$111.28	$111.28
40812	Excise/repair mouth lesion	Y		P3		3.4053	$140.98	$140.98
40814	Excise/repair mouth lesion	Y		A2	$446.00	16.6341	$688.65	$506.66
40816	Excision of mouth lesion	Y		A2	$446.00	24.3535	$1,008.23	$586.56
40818	Excise oral mucosa for graft	Y		A2	$150.72	2.5765	$106.67	$139.71
40819	Excise lip or cheek fold	Y		A2	$333.00	7.6539	$316.87	$328.97
40820	Treatment of mouth lesion	Y		P3		3.7763	$156.34	$156.34
40830	Repair mouth laceration	Y		G2		2.5765	$106.67	$106.67
40831	Repair mouth laceration	Y		A2	$333.00	7.6539	$316.87	$328.97
40840	Reconstruction of mouth	Y		A2	$446.00	24.3535	$1,008.23	$586.56
40842	Reconstruction of mouth	Y		A2	$510.00	24.3535	$1,008.23	$634.56
40843	Reconstruction of mouth	Y		A2	$510.00	24.3535	$1,008.23	$634.56
40844	Reconstruction of mouth	Y		A2	$717.00	40.5598	$1,679.18	$957.55
40845	Reconstruction of mouth	Y		A2	$717.00	40.5598	$1,679.18	$957.55
41000	Drainage of mouth lesion	Y		P3		1.9954	$82.61	$82.61
41005	Drainage of mouth lesion	Y		A2	$150.72	2.5765	$106.67	$139.71
41006	Drainage of mouth lesion	Y		A2	$333.00	24.3535	$1,008.23	$501.81
41007	Drainage of mouth lesion	Y		A2	$333.00	16.6341	$688.65	$421.91
41008	Drainage of mouth lesion	Y		A2	$333.00	16.6341	$688.65	$421.91
41009	Drainage of mouth lesion	Y		A2	$150.72	2.5765	$106.67	$139.71
41010	Incision of tongue fold	Y		A2	$333.00	7.6539	$316.87	$328.97
41015	Drainage of mouth lesion	Y		A2	$150.72	2.5765	$106.67	$139.71
41016	Drainage of mouth lesion	Y		A2	$333.00	7.6539	$316.87	$328.97
41017	Drainage of mouth lesion	Y		A2	$333.00	7.6539	$316.87	$328.97
41018	Drainage of mouth lesion	Y		A2	$333.00	7.6539	$316.87	$328.97
41100	Biopsy of tongue	Y		P3		2.0860	$86.36	$86.36
41105	Biopsy of tongue	Y		P3		2.0365	$84.31	$84.31
41108	Biopsy of floor of mouth	Y		P3		1.8717	$77.49	$77.49
41110	Excision of tongue lesion	Y		P3		2.7043	$111.96	$111.96
41112	Excision of tongue lesion	Y		A2	$446.00	16.6341	$688.65	$506.66
41113	Excision of tongue lesion	Y		A2	$446.00	16.6341	$688.65	$506.66
41114	Excision of tongue lesion	Y		A2	$446.00	24.3535	$1,008.23	$586.56
41115	Excision of tongue fold	Y		P3		3.0920	$128.01	$128.01
41116	Excision of mouth lesion	Y		A2	$333.00	16.6341	$688.65	$421.91
41120	Partial removal of tongue	Y		A2	$717.00	24.3535	$1,008.23	$789.81
41250	Repair tongue laceration	Y		A2	$150.72	2.5765	$106.67	$139.71
41251	Repair tongue laceration	Y		A2	$150.72	2.5765	$106.67	$139.71
41252	Repair tongue laceration	Y		A2	$446.00	7.6539	$316.87	$413.72
41500	Fixation of tongue	Y		A2	$333.00	24.3535	$1,008.23	$501.81
41510	Tongue to lip surgery	Y		A2	$333.00	16.6341	$688.65	$421.91
41520	Reconstruction, tongue fold	Y		A2	$446.00	7.6539	$316.87	$413.72
41800	Drainage of gum lesion	Y		A2	$88.46	1.4630	$60.57	$81.49
41805	Removal foreign body, gum	Y		P3		3.0176	$124.93	$124.93
41806	Removal foreign body, jawbone	Y		P3		3.8836	$160.78	$160.78
41820	Excision, gum, each quadrant	Y		R2		7.6539	$316.87	$316.87

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
41821	Excision of gum flap	Y		G2		7.6539	$316.87	$316.87
41822	Excision of gum lesion	Y		P3		3.5618	$147.46	$147.46
41823	Excision of gum lesion	Y		P3		4.9471	$204.81	$204.81
41825	Excision of gum lesion	Y		P3		2.7703	$114.69	$114.69
41826	Excision of gum lesion	Y		P3		3.1002	$128.35	$128.35
41827	Excision of gum lesion	Y		A2	$446.00	24.3535	$1,008.23	$586.56
41828	Excision of gum lesion	Y		P3		3.2568	$134.83	$134.83
41830	Removal of gum tissue	Y		P3		4.5184	$187.06	$187.06
41850	Treatment of gum lesion	Y		R2		16.6341	$688.65	$688.65
41870	Gum graft	Y		G2		24.3535	$1,008.23	$1,008.23
41872	Repair gum	Y		P3		4.5348	$187.74	$187.74
41874	Repair tooth socket	Y		P3		4.3452	$179.89	$179.89
42000	Drainage mouth roof lesion	Y		A2	$150.72	2.5765	$106.67	$139.71
42100	Biopsy roof of mouth	Y		P3		1.7809	$73.73	$73.73
42104	Excision lesion, mouth roof	Y		P3		2.4983	$103.43	$103.43
42106	Excision lesion, mouth roof	Y		P3		3.1580	$130.74	$130.74
42107	Excision lesion, mouth roof	Y		A2	$446.00	24.3535	$1,008.23	$586.56
42120	Remove palate/lesion	Y		A2	$630.00	40.5598	$1,679.18	$892.30
42140	Excision of uvula	Y		A2	$446.00	7.6539	$316.87	$413.72
42145	Repair palate, pharynx/uvula	Y		A2	$717.00	24.3535	$1,008.23	$789.81
42160	Treatment mouth roof lesion	Y		P3		3.2899	$136.20	$136.20
42180	Repair palate	Y		A2	$150.72	2.5765	$106.67	$139.71
42182	Repair palate	Y		A2	$446.00	40.5598	$1,679.18	$754.30
42200	Reconstruct cleft palate	Y		A2	$717.00	40.5598	$1,679.18	$957.55
42205	Reconstruct cleft palate	Y		A2	$717.00	40.5598	$1,679.18	$957.55
42210	Reconstruct cleft palate	Y		A2	$717.00	40.5598	$1,679.18	$957.55
42215	Reconstruct cleft palate	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
42220	Reconstruct cleft palate	Y		A2	$717.00	40.5598	$1,679.18	$957.55
42226	Lengthening of palate	Y		A2	$717.00	40.5598	$1,679.18	$957.55
42235	Repair palate	Y		A2	$717.00	16.6341	$688.65	$709.91
42260	Repair nose to lip fistula	Y		A2	$630.00	24.3535	$1,008.23	$724.56
42280	Preparation, palate mold	Y		P3		1.7314	$71.68	$71.68
42281	Insertion, palate prosthesis	Y		G2		16.6341	$688.65	$688.65
42300	Drainage of salivary gland	Y		A2	$333.00	16.6341	$688.65	$421.91
42305	Drainage of salivary gland	Y		A2	$446.00	16.6341	$688.65	$506.66
42310	Drainage of salivary gland	Y		A2	$150.72	2.5765	$106.67	$139.71
42320	Drainage of salivary gland	Y		A2	$150.72	2.5765	$106.67	$139.71
42330	Removal of salivary stone	Y		P3		2.6715	$110.60	$110.60
42335	Removal of salivary stone	Y		P3		4.3534	$180.23	$180.23
42340	Removal of salivary stone	Y		A2	$446.00	16.6341	$688.65	$506.66
42400	Biopsy of salivary gland	Y		P3		1.4841	$61.44	$61.44
42405	Biopsy of salivary gland	Y		A2	$446.00	16.6341	$688.65	$506.66
42408	Excision of salivary cyst	Y		A2	$510.00	16.6341	$688.65	$554.66
42409	Drainage of salivary cyst	Y		A2	$510.00	16.6341	$688.65	$554.66
42410	Excise parotid gland/lesion	Y		A2	$510.00	40.5598	$1,679.18	$802.30
42415	Excise parotid gland/lesion	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
42420	Excise parotid gland/lesion	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
42425	Excise parotid gland/lesion	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
42440	Excise submaxillary gland	Y		A2	$510.00	40.5598	$1,679.18	$802.30
42450	Excise sublingual gland	Y		A2	$446.00	24.3535	$1,008.23	$586.56
42500	Repair salivary duct	Y		A2	$510.00	24.3535	$1,008.23	$634.56
42505	Repair salivary duct	Y		A2	$630.00	40.5598	$1,679.18	$892.30
42507	Parotid duct diversion	Y		A2	$510.00	40.5598	$1,679.18	$802.30
42508	Parotid duct diversion	Y		A2	$630.00	40.5598	$1,679.18	$892.30
42509	Parotid duct diversion	Y		A2	$630.00	40.5598	$1,679.18	$892.30
42510	Parotid duct diversion	Y		A2	$630.00	40.5598	$1,679.18	$892.30
42550	Injection for salivary x-ray	N		N1				
42600	Closure of salivary fistula	Y		A2	$333.00	16.6341	$688.65	$421.91
42650	Dilation of salivary duct	Y		P3		0.9729	$40.28	$40.28
42660	Dilation of salivary duct	Y		P3		1.1543	$47.79	$47.79
42665	Ligation of salivary duct	Y		A2	$995.00	24.3535	$1,008.23	$998.31
42700	Drainage of tonsil abscess	Y		A2	$150.72	2.5765	$106.67	$139.71
42720	Drainage of throat abscess	Y		A2	$333.00	16.6341	$688.65	$421.91
42725	Drainage of throat abscess	Y		A2	$446.00	40.5598	$1,679.18	$754.30
42800	Biopsy of throat	Y		P3		1.8882	$78.17	$78.17
42802	Biopsy of throat	Y		A2	$333.00	16.6341	$688.65	$421.91
42804	Biopsy of upper nose/throat	Y		A2	$333.00	16.6341	$688.65	$421.91
42806	Biopsy of upper nose/throat	Y		A2	$446.00	24.3535	$1,008.23	$586.56
42808	Excise pharynx lesion	Y		A2	$446.00	16.6341	$688.65	$506.66
42809	Remove pharynx foreign body	N		G2		0.6416	$26.56	$26.56
42810	Excision of neck cyst	Y		A2	$510.00	24.3535	$1,008.23	$634.56
42815	Excision of neck cyst	Y		A2	$717.00	40.5598	$1,679.18	$957.55
42820	Remove tonsils and adenoids	Y		A2	$510.00	22.9075	$948.37	$619.59
42821	Remove tonsils and adenoids	Y		A2	$717.00	22.9075	$948.37	$774.84
42825	Removal of tonsils	Y		A2	$630.00	22.9075	$948.37	$709.59
42826	Removal of tonsils	Y		A2	$630.00	22.9075	$948.37	$709.59

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
42830	Removal of adenoids	Y		A2	$630.00	22.9075	$948.37	$709.59
42831	Removal of adenoids	Y		A2	$630.00	22.9075	$948.37	$709.59
42835	Removal of adenoids	Y		A2	$630.00	22.9075	$948.37	$709.59
42836	Removal of adenoids	Y		A2	$630.00	22.9075	$948.37	$709.59
42860	Excision of tonsil tags	Y		A2	$510.00	22.9075	$948.37	$619.59
42870	Excision of lingual tonsil	Y		A2	$510.00	22.9075	$948.37	$619.59
42890	Partial removal of pharynx	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
42892	Revision of pharyngeal walls	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
42900	Repair throat wound	Y		A2	$333.00	7.6539	$316.87	$328.97
42950	Reconstruction of throat	Y		A2	$446.00	24.3535	$1,008.23	$586.56
42955	Surgical opening of throat	Y		A2	$446.00	24.3535	$1,008.23	$586.56
42960	Control throat bleeding	Y		A2	$72.48	1.1708	$48.47	$66.48
42962	Control throat bleeding	Y		A2	$446.00	40.5598	$1,679.18	$754.30
42970	Control nose/throat bleeding	Y		R2	.....	1.1708	$48.47	$48.47
42972	Control nose/throat bleeding	Y		A2	$510.00	16.6341	$688.65	$554.66
43030	Throat muscle surgery	Y		G2	.....	16.6341	$688.65	$688.65
43200	Esophagus endoscopy	Y		A2	$333.00	8.6730	$359.06	$339.52
43201	Esoph scope w/submucous inj	Y		A2	$333.00	8.6730	$359.06	$339.52
43202	Esophagus endoscopy, biopsy	Y		A2	$333.00	8.6730	$359.06	$339.52
43204	Esoph scope w/sclerosis inj	Y		A2	$333.00	8.6730	$359.06	$339.52
43205	Esophagus endoscopy/ligation	Y		A2	$333.00	8.6730	$359.06	$339.52
43215	Esophagus endoscopy	Y		A2	$333.00	8.6730	$359.06	$339.52
43216	Esophagus endoscopy/lesion	Y		A2	$333.00	8.6730	$359.06	$339.52
43217	Esophagus endoscopy	Y		A2	$333.00	8.6730	$359.06	$339.52
43219	Esophagus endoscopy	Y		A2	$333.00	25.2289	$1,044.48	$510.87
43220	Esoph endoscopy, dilation	Y		A2	$333.00	8.6730	$359.06	$339.52
43226	Esoph endoscopy, dilation	Y		A2	$333.00	8.6730	$359.06	$339.52
43227	Esoph endoscopy, repair	Y		A2	$446.00	8.6730	$359.06	$424.27
43228	Esoph endoscopy, ablation	Y		A2	$446.00	24.6480	$1,020.43	$589.61
43231	Esoph endoscopy w/us exam	Y		A2	$446.00	8.6730	$359.06	$424.27
43232	Esoph endoscopy w/us fn bx	Y		A2	$446.00	8.6730	$359.06	$424.27
43234	Upper GI endoscopy, exam	Y		A2	$333.00	8.6730	$359.06	$339.52
43235	Uppr gi endoscopy, diagnosis	Y		A2	$333.00	8.6730	$359.06	$339.52
43236	Uppr gi scope w/submuc inj	Y		A2	$446.00	8.6730	$359.06	$424.27
43237	Endoscopic us exam, esoph	Y		A2	$446.00	8.6730	$359.06	$424.27
43238	Uppr gi endoscopy w/us fn bx	Y		A2	$446.00	8.6730	$359.06	$424.27
43239	Upper GI endoscopy, biopsy	Y		A2	$446.00	8.6730	$359.06	$424.27
43240	Esoph endoscope w/drain cyst	Y		A2	$446.00	8.6730	$359.06	$424.27
43241	Upper GI endoscopy with tube	Y		A2	$446.00	8.6730	$359.06	$424.27
43242	Uppr gi endoscopy w/us fn bx	Y		A2	$446.00	8.6730	$359.06	$424.27
43243	Upper gi endoscopy & inject	Y		A2	$446.00	8.6730	$359.06	$424.27
43244	Upper GI endoscopy/ligation	Y		A2	$446.00	8.6730	$359.06	$424.27
43245	Uppr gi scope dilate strictr	Y		A2	$446.00	8.6730	$359.06	$424.27
43246	Place gastrostomy tube	Y		A2	$446.00	8.6730	$359.06	$424.27
43247	Operative upper GI endoscopy	Y		A2	$446.00	8.6730	$359.06	$424.27
43248	Uppr gi endoscopy/guide wire	Y		A2	$446.00	8.6730	$359.06	$424.27
43249	Esoph endoscopy, dilation	Y		A2	$446.00	8.6730	$359.06	$424.27
43250	Upper GI endoscopy/tumor	Y		A2	$446.00	8.6730	$359.06	$424.27
43251	Operative upper GI endoscopy	Y		A2	$446.00	8.6730	$359.06	$424.27
43255	Operative upper GI endoscopy	Y		A2	$446.00	8.6730	$359.06	$424.27
43256	Uppr gi endoscopy w/stent	Y		A2	$510.00	25.2289	$1,044.48	$643.62
43257	Uppr gi scope w/thrml txmnt	Y		A2	$510.00	24.6480	$1,020.43	$637.61
43258	Operative upper GI endoscopy	Y		A2	$510.00	8.6730	$359.06	$472.27
43259	Endoscopic ultrasound exam	Y		A2	$510.00	8.6730	$359.06	$472.27
43260	Endo cholangiopancreatograph	Y		A2	$446.00	21.2820	$881.07	$554.77
43261	Endo cholangiopancreatograph	Y		A2	$446.00	21.2820	$881.07	$554.77
43262	Endo cholangiopancreatograph	Y		A2	$446.00	21.2820	$881.07	$554.77
43263	Endo cholangiopancreatograph	Y		A2	$446.00	21.2820	$881.07	$554.77
43264	Endo cholangiopancreatograph	Y		A2	$446.00	21.2820	$881.07	$554.77
43265	Endo cholangiopancreatograph	Y		A2	$446.00	21.2820	$881.07	$554.77
43267	Endo cholangiopancreatograph	Y		A2	$446.00	21.2820	$881.07	$554.77
43268	Endo cholangiopancreatograph	Y		A2	$446.00	25.2289	$1,044.48	$595.62
43269	Endo cholangiopancreatograph	Y		A2	$446.00	25.2289	$1,044.48	$595.62
43271	Endo cholangiopancreatograph	Y		A2	$446.00	21.2820	$881.07	$554.77
43272	Endo cholangiopancreatograph	Y		A2	$446.00	21.2820	$881.07	$554.77
43450	Dilate esophagus	Y		A2	$333.00	6.0867	$251.99	$312.75
43453	Dilate esophagus	Y		A2	$333.00	6.0867	$251.99	$312.75
43456	Dilate esophagus	Y		A2	$335.41	6.0867	$251.99	$314.56
43458	Dilate esophagus	Y		A2	$335.41	8.6730	$359.06	$341.32
43600	Biopsy of stomach	Y		A2	$333.00	8.6730	$359.06	$339.52
43653	Laparoscopy, gastrostomy	Y		A2	$1,339.00	46.1201	$1,909.37	$1,481.59
43750	Place gastrostomy tube	Y		A2	$446.00	8.6730	$359.06	$424.27
43760	Change gastrostomy tube	Y		A2	$144.98	3.2914	$136.26	$142.80
43761	Reposition gastrostomy tube	Y		A2	$333.00	8.6730	$359.06	$339.52
43870	Repair stomach opening	Y		A2	$333.00	8.6730	$359.06	$339.52
43886	Revise gastric port, open	Y		G2	.....	20.9338	$866.66	$866.66

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
43887	Remove gastric port, open	Y		G2		4.6816	$193.82	$193.82
43888	Change gastric port, open	Y		G2		20.9338	$866.66	$866.66
44100	Biopsy of bowel	Y		A2	$333.00	8.6730	$359.06	$339.52
44312	Revision of ileostomy	Y		A2	$333.00	20.9338	$866.66	$466.42
44340	Revision of colostomy	Y		A2	$510.00	20.9338	$866.66	$599.17
44360	Small bowel endoscopy	Y		A2	$446.00	9.6264	$398.53	$434.13
44361	Small bowel endoscopy/biopsy	Y		A2	$446.00	9.6264	$398.53	$434.13
44363	Small bowel endoscopy	Y		A2	$446.00	9.6264	$398.53	$434.13
44364	Small bowel endoscopy	Y		A2	$446.00	9.6264	$398.53	$434.13
44365	Small bowel endoscopy	Y		A2	$446.00	9.6264	$398.53	$434.13
44366	Small bowel endoscopy	Y		A2	$446.00	9.6264	$398.53	$434.13
44369	Small bowel endoscopy	Y		A2	$446.00	9.6264	$398.53	$434.13
44370	Small bowel endoscopy/stent	Y		A2	$1,339.00	25.2289	$1,044.48	$1,265.37
44372	Small bowel endoscopy	Y		A2	$446.00	9.6264	$398.53	$434.13
44373	Small bowel endoscopy	Y		A2	$446.00	9.6264	$398.53	$434.13
44376	Small bowel endoscopy	Y		A2	$446.00	9.6264	$398.53	$434.13
44377	Small bowel endoscopy/biopsy	Y		A2	$446.00	9.6264	$398.53	$434.13
44378	Small bowel endoscopy	Y		A2	$446.00	9.6264	$398.53	$434.13
44379	Sbowel endoscope w/stent	Y		A2	$1,339.00	25.2289	$1,044.48	$1,265.37
44380	Small bowel endoscopy	Y		A2	$333.00	9.6264	$398.53	$349.38
44382	Small bowel endoscopy	Y		A2	$333.00	9.6264	$398.53	$349.38
44383	Ileoscopy w/stent	Y		A2	$1,339.00	25.2289	$1,044.48	$1,265.37
44385	Endoscopy of bowel pouch	Y		A2	$333.00	9.0360	$374.09	$343.27
44386	Endoscopy, bowel pouch/biop	Y		A2	$333.00	9.0360	$374.09	$343.27
44388	Colonoscopy	Y		A2	$333.00	9.0360	$374.09	$343.27
44389	Colonoscopy with biopsy	Y		A2	$333.00	9.0360	$374.09	$343.27
44390	Colonoscopy for foreign body	Y		A2	$333.00	9.0360	$374.09	$343.27
44391	Colonoscopy for bleeding	Y		A2	$333.00	9.0360	$374.09	$343.27
44392	Colonoscopy & polypectomy	Y		A2	$333.00	9.0360	$374.09	$343.27
44393	Colonoscopy, lesion removal	Y		A2	$333.00	9.0360	$374.09	$343.27
44394	Colonoscopy w/snare	Y		A2	$333.00	9.0360	$374.09	$343.27
44397	Colonoscopy w/stent	Y		A2	$333.00	25.2289	$1,044.48	$510.87
44701	Intraop colon lavage add-on	N		N1				
45000	Drainage of pelvic abscess	Y		A2	$312.07	11.6524	$482.41	$354.66
45005	Drainage of rectal abscess	Y		A2	$446.00	11.6524	$482.41	$455.10
45020	Drainage of rectal abscess	Y		A2	$446.00	11.6524	$482.41	$455.10
45100	Biopsy of rectum	Y		A2	$333.00	23.2282	$961.65	$490.16
45108	Removal of anorectal lesion	Y		A2	$446.00	23.2282	$961.65	$574.91
45150	Excision of rectal stricture	Y		A2	$446.00	23.2282	$961.65	$574.91
45160	Excision of rectal lesion	Y		A2	$446.00	23.2282	$961.65	$574.91
45170	Excision of rectal lesion	Y		A2	$446.00	23.2282	$961.65	$574.91
45190	Destruction, rectal tumor	Y		A2	$1,339.00	23.2282	$961.65	$1,244.66
45300	Proctosigmoidoscopy dx	Y		P3		1.4345	$59.39	$59.39
45303	Proctosigmoidoscopy dilate	Y		P2		8.8611	$366.85	$366.85
45305	Proctosigmoidoscopy w/bx	Y		A2	$333.00	8.8611	$366.85	$341.46
45307	Proctosigmoidoscopy fb	Y		A2	$333.00	21.8923	$906.34	$476.34
45308	Proctosigmoidoscopy removal	Y		A2	$333.00	8.8611	$366.85	$341.46
45309	Proctosigmoidoscopy removal	Y		A2	$333.00	8.8611	$366.85	$341.46
45315	Proctosigmoidoscopy removal	Y		A2	$333.00	8.8611	$366.85	$341.46
45317	Proctosigmoidoscopy bleed	Y		A2	$333.00	8.8611	$366.85	$341.46
45320	Proctosigmoidoscopy ablate	Y		A2	$333.00	21.8923	$906.34	$476.34
45321	Proctosigmoidoscopy volvul	Y		A2	$333.00	21.8923	$906.34	$476.34
45327	Proctosigmoidoscopy w/stent	Y		A2	$333.00	25.2289	$1,044.48	$510.87
45330	Diagnostic sigmoidoscopy	Y		P3		1.9705	$81.58	$81.58
45331	Sigmoidoscopy and biopsy	Y		A2	$299.24	5.1441	$212.97	$277.67
45332	Sigmoidoscopy w/fb removal	Y		A2	$299.24	5.1441	$212.97	$277.67
45333	Sigmoidoscopy & polypectomy	Y		A2	$333.00	8.8611	$366.85	$341.46
45334	Sigmoidoscopy for bleeding	Y		A2	$333.00	8.8611	$366.85	$341.46
45335	Sigmoidoscopy w/submuc inj	Y		A2	$299.24	5.1441	$212.97	$277.67
45337	Sigmoidoscopy & decompress	Y		A2	$299.24	5.1441	$212.97	$277.67
45338	Sigmoidoscopy w/tumr remove	Y		A2	$333.00	8.8611	$366.85	$341.46
45339	Sigmoidoscopy w/ablate tumr	Y		A2	$333.00	8.8611	$366.85	$341.46
45340	Sig w/balloon dilation	Y		A2	$333.00	8.8611	$366.85	$341.46
45341	Sigmoidoscopy w/ultrasound	Y		A2	$333.00	8.8611	$366.85	$341.46
45342	Sigmoidoscopy w/us guide bx	Y		A2	$333.00	8.8611	$366.85	$341.46
45345	Sigmoidoscopy w/stent	Y		A2	$333.00	25.2289	$1,044.48	$510.87
45355	Surgical colonoscopy	Y		A2	$333.00	9.0360	$374.09	$343.27
45378	Diagnostic colonoscopy	Y		A2	$446.00	9.0360	$374.09	$428.02
45379	Colonoscopy w/fb removal	Y		A2	$446.00	9.0360	$374.09	$428.02
45380	Colonoscopy and biopsy	Y		A2	$446.00	9.0360	$374.09	$428.02
45381	Colonoscopy, submucous inj	Y		A2	$446.00	9.0360	$374.09	$428.02
45382	Colonoscopy/control bleeding	Y		A2	$446.00	9.0360	$374.09	$428.02
45383	Lesion removal colonoscopy	Y		A2	$446.00	9.0360	$374.09	$428.02
45384	Lesion remove colonoscopy	Y		A2	$446.00	9.0360	$374.09	$428.02
45385	Lesion removal colonoscopy	Y		A2	$446.00	9.0360	$374.09	$428.02
45386	Colonoscopy dilate stricture	Y		A2	$446.00	9.0360	$374.09	$428.02

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
45387	Colonoscopy w/stent	Y		A2	$333.00	25.2289	$1,044.48	$510.87
45391	Colonoscopy w/endoscope us	Y		A2	$446.00	9.0360	$374.09	$428.02
45392	Colonoscopy w/endoscopic fnb	Y		A2	$446.00	9.0360	$374.09	$428.02
45500	Repair of rectum	Y		A2	$446.00	23.2282	$961.65	$574.91
45505	Repair of rectum	Y		A2	$446.00	30.5544	$1,264.95	$650.74
45520	Treatment of rectal prolapse	Y		P2		0.8046	$33.31	$33.31
45560	Repair of rectocele	Y		A2	$446.00	30.5544	$1,264.95	$650.74
45900	Reduction of rectal prolapse	Y		A2	$312.07	4.5189	$187.08	$280.82
45905	Dilation of anal sphincter	Y		A2	$333.00	23.2282	$961.65	$490.16
45910	Dilation of rectal narrowing	Y		A2	$333.00	23.2282	$961.65	$490.16
45915	Remove rectal obstruction	Y		A2	$312.07	11.6524	$482.41	$354.66
45990	Surg dx exam, anorectal	Y		A2	$312.07	23.2282	$961.65	$474.47
46020	Placement of seton	Y		A2	$510.00	23.2282	$961.65	$622.91
46030	Removal of rectal marker	Y		A2	$312.07	4.5189	$187.08	$280.82
46040	Incision of rectal abscess	Y		A2	$510.00	23.2282	$961.65	$622.91
46045	Incision of rectal abscess	Y		A2	$446.00	23.2282	$961.65	$574.91
46050	Incision of anal abscess	Y		A2	$312.07	11.6524	$482.41	$354.66
46060	Incision of rectal abscess	Y		A2	$446.00	23.2282	$961.65	$574.91
46070	Incision of anal septum	Y		G2		11.6524	$482.41	$482.41
46080	Incision of anal sphincter	Y		A2	$510.00	23.2282	$961.65	$622.91
46083	Incise external hemorrhoid	Y		P3		2.0036	$82.95	$82.95
46200	Removal of anal fissure	Y		A2	$446.00	23.2282	$961.65	$574.91
46210	Removal of anal crypt	Y		A2	$446.00	23.2282	$961.65	$574.91
46211	Removal of anal crypts	Y		A2	$446.00	23.2282	$961.65	$574.91
46220	Removal of anal tag	Y		A2	$333.00	23.2282	$961.65	$490.16
46221	Ligation of hemorrhoid(s)	Y		P3		2.6138	$108.21	$108.21
46230	Removal of anal tags	Y		A2	$333.00	23.2282	$961.65	$490.16
46250	Hemorrhoidectomy	Y		A2	$510.00	23.2282	$961.65	$622.91
46255	Hemorrhoidectomy	Y		A2	$510.00	23.2282	$961.65	$622.91
46257	Remove hemorrhoids & fissure	Y		A2	$510.00	23.2282	$961.65	$622.91
46258	Remove hemorrhoids & fistula	Y		A2	$510.00	23.2282	$961.65	$622.91
46260	Hemorrhoidectomy	Y		A2	$510.00	23.2282	$961.65	$622.91
46261	Remove hemorrhoids & fissure	Y		A2	$630.00	23.2282	$961.65	$712.91
46262	Remove hemorrhoids & fistula	Y		A2	$630.00	23.2282	$961.65	$712.91
46270	Removal of anal fistula	Y		A2	$510.00	23.2282	$961.65	$622.91
46275	Removal of anal fistula	Y		A2	$510.00	23.2282	$961.65	$622.91
46280	Removal of anal fistula	Y		A2	$630.00	23.2282	$961.65	$712.91
46285	Removal of anal fistula	Y		A2	$333.00	23.2282	$961.65	$490.16
46288	Repair anal fistula	Y		A2	$630.00	23.2282	$961.65	$712.91
46320	Removal of hemorrhoid clot	Y		P3		1.8635	$77.15	$77.15
46500	Injection into hemorrhoid(s)	Y		P3		2.3498	$97.28	$97.28
46505	Chemodenervation anal musc	Y	CH	P3		2.5973	$107.53	$107.53
46600	Diagnostic anoscopy	N		P2		0.6416	$26.56	$26.56
46604	Anoscopy and dilation	Y		P2		8.8611	$366.85	$366.85
46606	Anoscopy and biopsy	Y		P3		3.1498	$130.40	$130.40
46608	Anoscopy, remove for body	Y		A2	$333.00	8.8611	$366.85	$341.46
46610	Anoscopy, remove lesion	Y		A2	$333.00	21.8923	$906.34	$476.34
46611	Anoscopy	Y		A2	$333.00	8.8611	$366.85	$341.46
46612	Anoscopy, remove lesions	Y		A2	$333.00	21.8923	$906.34	$476.34
46614	Anoscopy, control bleeding	Y		P3		1.8386	$76.12	$76.12
46615	Anoscopy	Y		A2	$446.00	21.8923	$906.34	$561.09
46700	Repair of anal stricture	Y		A2	$510.00	23.2282	$961.65	$622.91
46706	Repr of anal fistula w/glue	Y		A2	$333.00	30.5544	$1,264.95	$565.99
46750	Repair of anal sphincter	Y		A2	$510.00	30.5544	$1,264.95	$698.74
46753	Reconstruction of anus	Y		A2	$510.00	23.2282	$961.65	$622.91
46754	Removal of suture from anus	Y		A2	$446.00	23.2282	$961.65	$574.91
46760	Repair of anal sphincter	Y		A2	$446.00	30.5544	$1,264.95	$650.74
46761	Repair of anal sphincter	Y		A2	$510.00	30.5544	$1,264.95	$698.74
46762	Implant artificial sphincter	Y		A2	$995.00	30.5544	$1,264.95	$1,062.49
46900	Destruction, anal lesion(s)	Y		P3		2.5560	$105.82	$105.82
46910	Destruction, anal lesion(s)	Y		P3		2.7870	$115.38	$115.38
46916	Cryosurgery, anal lesion(s)	Y		P2		1.5119	$62.59	$62.59
46917	Laser surgery, anal lesions	Y		A2	$333.00	20.0977	$832.04	$457.76
46922	Excision of anal lesion(s)	Y		A2	$333.00	20.0977	$832.04	$457.76
46924	Destruction, anal lesion(s)	Y		A2	$333.00	20.0977	$832.04	$457.76
46934	Destruction of hemorrhoids	Y		P3		4.3534	$180.23	$180.23
46935	Destruction of hemorrhoids	Y		P3		2.9930	$123.91	$123.91
46936	Destruction of hemorrhoids	Y		P3		4.5597	$188.77	$188.77
46937	Cryotherapy of rectal lesion	Y		A2	$446.00	23.2282	$961.65	$574.91
46938	Cryotherapy of rectal lesion	Y		A2	$446.00	30.5544	$1,264.95	$650.74
46940	Treatment of anal fissure	Y		P3		1.9872	$82.27	$82.27
46942	Treatment of anal fissure	Y		P3		1.9046	$78.85	$78.85
46945	Ligation of hemorrhoids	Y		P3		3.3145	$137.22	$137.22
46946	Ligation of hemorrhoids	Y		A2	$333.00	11.6524	$482.41	$370.35
46947	Hemorrhoidopexy by stapling	Y		A2	$995.00	30.5544	$1,264.95	$1,062.49
47000	Needle biopsy of liver	Y		A2	$333.00	9.5741	$396.37	$348.84

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
47001	Needle biopsy, liver add-on	N		N1				
47382	Percut ablate liver rf	Y		G2		44.1192	$1,826.53	$1,826.53
47500	Injection for liver x-rays	N		N1				
47505	Injection for liver x-rays	N		N1				
47510	Insert catheter, bile duct	Y		A2	$446.00	28.7304	$1,189.44	$631.86
47511	Insert bile duct drain	Y		A2	$1,245.85	28.7304	$1,189.44	$1,231.75
47525	Change bile duct catheter	Y		A2	$333.00	14.8912	$616.50	$403.88
47530	Revise/reinsert bile tube	Y		A2	$333.00	14.8912	$616.50	$403.88
47552	Biliary endoscopy thru skin	Y		A2	$446.00	28.7304	$1,189.44	$631.86
47553	Biliary endoscopy thru skin	Y		A2	$510.00	28.7304	$1,189.44	$679.86
47554	Biliary endoscopy thru skin	Y		A2	$510.00	28.7304	$1,189.44	$679.86
47555	Biliary endoscopy thru skin	Y		A2	$510.00	28.7304	$1,189.44	$679.86
47556	Biliary endoscopy thru skin	Y		A2	$1,245.85	28.7304	$1,189.44	$1,231.75
47560	Laparoscopy w/cholangio	Y		A2	$510.00	34.8153	$1,441.35	$742.84
47561	Laparo w/cholangio/biopsy	Y		A2	$510.00	34.8153	$1,441.35	$742.84
47562	Laparoscopic cholecystectomy	Y		G2		46.1201	$1,909.37	$1,909.37
47563	Laparo cholecystectomy/graph	Y		G2		46.1201	$1,909.37	$1,909.37
47564	Laparo cholecystectomy/explr	Y		G2		46.1201	$1,909.37	$1,909.37
47630	Remove bile duct stone	Y		A2	$510.00	28.7304	$1,189.44	$679.86
48102	Needle biopsy, pancreas	Y		A2	$333.00	9.5741	$396.37	$348.84
49080	Puncture, peritoneal cavity	Y		A2	$222.78	5.3095	$219.81	$222.04
49081	Removal of abdominal fluid	Y		A2	$222.78	5.3095	$219.81	$222.04
49180	Biopsy, abdominal mass	Y		A2	$333.00	9.5741	$396.37	$348.84
49250	Excision of umbilicus	Y		A2	$630.00	25.4636	$1,054.19	$736.05
49320	Diag laparo separate proc	Y		A2	$510.00	34.8153	$1,441.35	$742.84
49321	Laparoscopy, biopsy	Y		A2	$630.00	34.8153	$1,441.35	$832.84
49322	Laparoscopy, aspiration	Y		A2	$630.00	34.8153	$1,441.35	$832.84
49400	Air injection into abdomen	N		N1				
49402	Remove foreign body, adbomen	Y		A2	$446.00	25.4636	$1,054.19	$598.05
49419	Insrt abdom cath for chemotx	Y		A2	$333.00	30.5379	$1,264.27	$565.82
49420	Insert abdom drain, temp	Y		A2	$333.00	31.7598	$1,314.86	$578.47
49421	Insert abdom drain, perm	Y		A2	$333.00	31.7598	$1,314.86	$578.47
49422	Remove perm cannula/catheter	Y		A2	$333.00	24.7274	$1,023.71	$505.68
49423	Exchange drainage catheter	Y		G2		14.8912	$616.50	$616.50
49424	Assess cyst, contrast inject	N		N1				
49426	Revise abdomen-venous shunt	Y		A2	$446.00	25.4636	$1,054.19	$598.05
49427	Injection, abdominal shunt	N		N1				
49429	Removal of shunt	Y		G2		24.7274	$1,023.71	$1,023.71
49495	Rpr ing hernia baby, reduc	Y		A2	$630.00	31.1722	$1,290.53	$795.13
49496	Rpr ing hernia baby, blocked	Y		A2	$630.00	31.1722	$1,290.53	$795.13
49500	Rpr ing hernia, init, reduce	Y		A2	$630.00	31.1722	$1,290.53	$795.13
49501	Rpr ing hernia, init blocked	Y		A2	$1,339.00	31.1722	$1,290.53	$1,326.88
49505	Prp i/hern init reduc >5 yr	Y		A2	$630.00	31.1722	$1,290.53	$795.13
49507	Prp i/hern init block >5 yr	Y		A2	$1,339.00	31.1722	$1,290.53	$1,326.88
49520	Rerepair ing hernia, reduce	Y		A2	$995.00	31.1722	$1,290.53	$1,068.88
49521	Rerepair ing hernia, blocked	Y		A2	$1,339.00	31.1722	$1,290.53	$1,326.88
49525	Repair ing hernia, sliding	Y		A2	$630.00	31.1722	$1,290.53	$795.13
49540	Repair lumbar hernia	Y		A2	$446.00	31.1722	$1,290.53	$657.13
49550	Rpr rem hernia, init, reduce	Y		A2	$717.00	31.1722	$1,290.53	$860.38
49553	Rpr fem hernia, init blocked	Y		A2	$1,339.00	31.1722	$1,290.53	$1,326.88
49555	Rerepair fem hernia, reduce	Y		A2	$717.00	31.1722	$1,290.53	$860.38
49557	Rerepair fem hernia, blocked	Y		A2	$1,339.00	31.1722	$1,290.53	$1,326.88
49560	Rpr ventral hern init, reduc	Y		A2	$630.00	31.1722	$1,290.53	$795.13
49561	Rpr ventral hern init, block	Y		A2	$1,339.00	31.1722	$1,290.53	$1,326.88
49565	Rerepair ventrl hern, reduce	Y		A2	$630.00	31.1722	$1,290.53	$795.13
49566	Rerepair ventrl hern, block	Y		A2	$1,339.00	31.1722	$1,290.53	$1,326.88
49568	Hernia repair w/mesh	Y		A2	$995.00	31.1722	$1,290.53	$1,068.88
49570	Rpr epigastric hern, reduce	Y		A2	$630.00	31.1722	$1,290.53	$795.13
49572	Rpr epigastric hern, blocked	Y		A2	$1,339.00	31.1722	$1,290.53	$1,326.88
49580	Rpr umbil hern, reduc < 5 yr	Y		A2	$630.00	31.1722	$1,290.53	$795.13
49582	Rpr umbil hern, block < 5 yr	Y		A2	$1,339.00	31.1722	$1,290.53	$1,326.88
49585	Rpr umbil hern, reduc > 5 yr	Y		A2	$630.00	31.1722	$1,290.53	$795.13
49587	Rpr umbil hern, block > 5 yr	Y		A2	$1,339.00	31.1722	$1,290.53	$1,326.88
49590	Repair spigelian hernia	Y		A2	$510.00	31.1722	$1,290.53	$705.13
49600	Repair umbilical lesion	Y		A2	$630.00	31.1722	$1,290.53	$795.13
49650	Laparo hernia repair initial	Y		A2	$630.00	46.1201	$1,909.37	$949.84
49651	Laparo hernia repair recur	Y		A2	$995.00	46.1201	$1,909.37	$1,223.59
50200	Biopsy of kidney	Y		A2	$333.00	9.5741	$396.37	$348.84
50382	Change ureter stent, percut	Y		G2		25.2775	$1,046.49	$1,046.49
50384	Remove ureter stent, percut	Y		G2		18.1376	$750.90	$750.90
50387	Change ext/int ureter stent	Y		G2		14.8912	$616.50	$616.50
50389	Remove renal tube w/fluoro	Y		G2		6.1077	$252.86	$252.86
50390	Drainage of kidney lesion	Y		A2	$333.00	9.5741	$396.37	$348.84
50391	Instll rx agnt into rnal tub	Y		P2		1.0850	$44.92	$44.92
50392	Insert kidney drain	Y		A2	$333.00	18.1376	$750.90	$437.48
50393	Insert ureteral tube	Y		A2	$333.00	25.2775	$1,046.49	$511.37

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
50394	Injection for kidney x-ray	N		N1				
50395	Create passage to kidney	Y		A2	$333.00	18.1376	$750.90	$437.48
50396	Measure kidney pressure	Y		A2	$131.50	2.1659	$89.67	$121.04
50398	Change kidney tube	Y		A2	$333.00	14.8912	$616.50	$403.88
50551	Kidney endoscopy	Y		A2	$333.00	6.1077	$252.86	$312.97
50553	Kidney endoscopy	Y		A2	$333.00	25.2775	$1,046.49	$511.37
50555	Kidney endoscopy & biopsy	Y		A2	$333.00	6.1077	$252.86	$312.97
50557	Kidney endoscopy & treatment	Y		A2	$333.00	25.2775	$1,046.49	$511.37
50561	Kidney endoscopy & treatment	Y		A2	$333.00	25.2775	$1,046.49	$511.37
50562	Renal scope w/tumor resect	Y		G2		6.1077	$252.86	$252.86
50570	Kidney endoscopy	Y		G2		6.1077	$252.86	$252.86
50572	Kidney endoscopy	Y		G2		6.1077	$252.86	$252.86
50574	Kidney endoscopy & biopsy	Y		G2		6.1077	$252.86	$252.86
50575	Kidney endoscopy	Y		G2		36.9175	$1,528.38	$1,528.38
50576	Kidney endoscopy & treatment	Y		G2		18.1376	$750.90	$750.90
50580	Kidney endoscopy & treatment	Y	CH	G2		18.1376	$750.90	$750.90
50590	Fragmenting of kidney stone	Y		G2		43.0352	$1,781.66	$1,781.66
50592	Perc rf ablate renal tumor	Y		G2		44.1192	$1,826.53	$1,826.53
50684	Injection for ureter x-ray	N		N1				
50686	Measure ureter pressure	Y		P2		1.0850	$44.92	$44.92
50688	Change of ureter tube/stent	Y		A2	$333.00	14.8912	$616.50	$403.88
50690	Injection for ureter x-ray	N		N1				
50947	Laparo new ureter/bladder	Y		A2	$1,339.00	46.1201	$1,909.37	$1,481.59
50948	Laparo new ureter/bladder	Y		A2	$1,339.00	46.1201	$1,909.37	$1,481.59
50951	Endoscopy of ureter	Y		A2	$333.00	6.1077	$252.86	$312.97
50953	Endoscopy of ureter	Y		A2	$333.00	6.1077	$252.86	$312.97
50955	Ureter endoscopy & biopsy	Y		A2	$333.00	25.2775	$1,046.49	$511.37
50957	Ureter endoscopy & treatment	Y		A2	$333.00	25.2775	$1,046.49	$511.37
50961	Ureter endoscopy & treatment	Y		A2	$333.00	25.2775	$1,046.49	$511.37
50970	Ureter endoscopy	Y		A2	$333.00	6.1077	$252.86	$312.97
50972	Ureter endoscopy & catheter	Y		A2	$333.00	6.1077	$252.86	$312.97
50974	Ureter endoscopy & biopsy	Y		A2	$333.00	18.1376	$750.90	$437.48
50976	Ureter endoscopy & treatment	Y		A2	$333.00	18.1376	$750.90	$437.48
50980	Ureter endoscopy & treatment	Y		A2	$333.00	25.2775	$1,046.49	$511.37
51000	Drainage of bladder	Y		P3		1.1790	$48.81	$48.81
51005	Drainage of bladder	Y		P2		1.0850	$44.92	$44.92
51010	Drainage of bladder	Y		A2	$333.00	19.6126	$811.96	$452.74
51020	Incise & treat bladder	Y		A2	$630.00	25.2775	$1,046.49	$734.12
51030	Incise & treat bladder	Y		A2	$630.00	25.2775	$1,046.49	$734.12
51040	Incise & drain bladder	Y		A2	$630.00	25.2775	$1,046.49	$734.12
51045	Incise bladder/drain ureter	Y		A2	$399.24	6.1077	$252.86	$362.65
51050	Removal of bladder stone	Y		A2	$630.00	25.2775	$1,046.49	$734.12
51065	Remove ureter calculus	Y		A2	$630.00	25.2775	$1,046.49	$734.12
51080	Drainage of bladder abscess	Y		A2	$333.00	19.0457	$788.49	$446.87
51500	Removal of bladder cyst	Y		A2	$630.00	31.1722	$1,290.53	$795.13
51520	Removal of bladder lesion	Y		A2	$630.00	25.2775	$1,046.49	$734.12
51600	Injection for bladder x-ray	N		N1				
51605	Preparation for bladder xray	N		N1				
51610	Injection for bladder x-ray	N		N1				
51700	Irrigation of bladder	Y		P3		1.2780	$52.91	$52.91
51701	Insert bladder catheter	N		P2		0.6416	$26.56	$26.56
51702	Insert temp bladder cath	N		P2		0.6416	$26.56	$26.56
51703	Insert bladder cath, complex	Y		P2		1.0850	$44.92	$44.92
51705	Change of bladder tube	Y		P3		1.7727	$73.39	$73.39
51710	Change of bladder tube	Y		A2	$333.00	14.8912	$616.50	$403.88
51715	Endoscopic injection/implant	Y		A2	$510.00	30.1994	$1,250.26	$695.07
51720	Treatment of bladder lesion	Y		P3		1.3935	$57.69	$57.69
51725	Simple cystometrogram	Y		P2		3.0601	$126.69	$126.69
51726	Complex cystometrogram	Y		A2	$209.48	3.0601	$126.69	$188.78
51736	Urine flow measurement	Y		P3		0.4452	$18.43	$18.43
51741	Electro-uroflowmetry, first	Y		P3		0.5111	$21.16	$21.16
51772	Urethra pressure profile	Y		A2	$131.50	2.1659	$89.67	$121.04
51784	Anal/urinary muscle study	Y		P2		1.0850	$44.92	$44.92
51785	Anal/urinary muscle study	Y		A2	$66.92	1.0850	$44.92	$61.42
51792	Urinary reflex study	Y		P2		1.0850	$44.92	$44.92
51795	Urine voiding pressure study	Y		P2		2.1659	$89.67	$89.67
51797	Intraabdominal pressure test	Y		P2		2.1659	$89.67	$89.67
51798	Us urine capacity measure	N		P3		0.3792	$15.70	$15.70
51880	Repair of bladder opening	Y		A2	$333.00	25.2775	$1,046.49	$511.37
51992	Laparo sling operation	Y		A2	$717.00	46.1201	$1,909.37	$1,015.09
52000	Cystoscopy	Y		A2	$333.00	6.1077	$252.86	$312.97
52001	Cystoscopy, removal of clots	Y		A2	$399.24	18.1376	$750.90	$487.16
52005	Cystoscopy & ureter catheter	Y		A2	$446.00	18.1376	$750.90	$522.23
52007	Cystoscopy and biopsy	Y		A2	$446.00	25.2775	$1,046.49	$596.12
52010	Cystoscopy & duct catheter	Y		A2	$399.24	6.1077	$252.86	$362.65
52204	Cystoscopy w/biopsy(s)	Y		A2	$446.00	18.1376	$750.90	$522.23

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
52214	Cystoscopy and treatment	Y		A2	$446.00	25.2775	$1,046.49	$596.12
52224	Cystoscopy and treatment	Y		A2	$446.00	25.2775	$1,046.49	$596.12
52234	Cystoscopy and treatment	Y		A2	$446.00	25.2775	$1,046.49	$596.12
52235	Cystoscopy and treatment	Y		A2	$510.00	25.2775	$1,046.49	$644.12
52240	Cystoscopy and treatment	Y		A2	$510.00	25.2775	$1,046.49	$644.12
52250	Cystoscopy and radiotracer	Y		A2	$630.00	25.2775	$1,046.49	$734.12
52260	Cystoscopy and treatment	Y		A2	$446.00	18.1376	$750.90	$522.23
52265	Cystoscopy and treatment	Y		P2		6.1077	$252.86	$252.86
52270	Cystoscopy & revise urethra	Y		A2	$446.00	18.1376	$750.90	$522.23
52275	Cystoscopy & revise urethra	Y		A2	$446.00	25.2775	$1,046.49	$596.12
52276	Cystoscopy and treatment	Y		A2	$510.00	25.2775	$1,046.49	$644.12
52277	Cystoscopy and treatment	Y		A2	$446.00	25.2775	$1,046.49	$596.12
52281	Cystoscopy and treatment	Y		A2	$446.00	18.1376	$750.90	$522.23
52282	Cystoscopy, implant stent	Y		A2	$1,339.00	36.9175	$1,528.38	$1,386.35
52283	Cystoscopy and treatment	Y		A2	$446.00	25.2775	$1,046.49	$596.12
52285	Cystoscopy and treatment	Y		A2	$446.00	18.1376	$750.90	$522.23
52290	Cystoscopy and treatment	Y		A2	$446.00	18.1376	$750.90	$522.23
52300	Cystoscopy and treatment	Y		A2	$446.00	25.2775	$1,046.49	$596.12
52301	Cystoscopy and treatment	Y		A2	$510.00	25.2775	$1,046.49	$644.12
52305	Cystoscopy and treatment	Y		A2	$446.00	25.2775	$1,046.49	$596.12
52310	Cystoscopy and treatment	Y		A2	$399.24	18.1376	$750.90	$487.16
52315	Cystoscopy and treatment	Y		A2	$446.00	25.2775	$1,046.49	$596.12
52317	Remove bladder stone	Y		A2	$333.00	25.2775	$1,046.49	$511.37
52318	Remove bladder stone	Y		A2	$446.00	25.2775	$1,046.49	$596.12
52320	Cystoscopy and treatment	Y		A2	$717.00	25.2775	$1,046.49	$799.37
52325	Cystoscopy, stone removal	Y		A2	$630.00	25.2775	$1,046.49	$734.12
52327	Cystoscopy, inject material	Y		A2	$446.00	25.2775	$1,046.49	$596.12
52330	Cystoscopy and treatment	Y		A2	$446.00	25.2775	$1,046.49	$596.12
52332	Cystoscopy and treatment	Y		A2	$446.00	25.2775	$1,046.49	$596.12
52334	Create passage to kidney	Y		A2	$510.00	25.2775	$1,046.49	$644.12
52341	Cysto w/ureter stricture tx	Y		A2	$510.00	25.2775	$1,046.49	$644.12
52342	Cysto w/up stricture tx	Y		A2	$510.00	25.2775	$1,046.49	$644.12
52343	Cysto w/renal stricture tx	Y		A2	$510.00	25.2775	$1,046.49	$644.12
52344	Cysto/uretero, stricture tx	Y		A2	$510.00	25.2775	$1,046.49	$644.12
52345	Cysto/uretero w/up stricture	Y		A2	$510.00	25.2775	$1,046.49	$644.12
52346	Cystouretero w/renal strict	Y		A2	$510.00	25.2775	$1,046.49	$644.12
52351	Cystouretero & or pyeloscope	Y		A2	$510.00	25.2775	$1,046.49	$644.12
52352	Cystouretero w/stone remove	Y		A2	$630.00	25.2775	$1,046.49	$734.12
52353	Cystouretero w/lithotripsy	Y		A2	$630.00	36.9175	$1,528.38	$854.60
52354	Cystouretero w/biopsy	Y		A2	$630.00	25.2775	$1,046.49	$734.12
52355	Cystouretero w/excise tumor	Y		A2	$630.00	25.2775	$1,046.49	$734.12
52400	Cystouretero w/congen repr	Y		A2	$510.00	25.2775	$1,046.49	$644.12
52402	Cystourethro cut ejacul duct	Y		A2	$510.00	25.2775	$1,046.49	$644.12
52450	Incision of prostate	Y		A2	$510.00	25.2775	$1,046.49	$644.12
52500	Revision of bladder neck	Y		A2	$510.00	25.2775	$1,046.49	$644.12
52510	Dilation prostatic urethra	Y		A2	$510.00	25.2775	$1,046.49	$644.12
52601	Prostatectomy (TURP)	Y		A2	$630.00	36.9175	$1,528.38	$854.60
52606	Control postop bleeding	Y		A2	$333.00	25.2775	$1,046.49	$511.37
52612	Prostatectomy, first stage	Y		A2	$446.00	36.9175	$1,528.38	$716.60
52614	Prostatectomy, second stage	Y		A2	$333.00	36.9175	$1,528.38	$631.85
52620	Remove residual prostate	Y		A2	$333.00	36.9175	$1,528.38	$631.85
52630	Remove prostate regrowth	Y		A2	$446.00	36.9175	$1,528.38	$716.60
52640	Relieve bladder contracture	Y		A2	$446.00	25.2775	$1,046.49	$596.12
52647	Laser surgery of prostate	Y		A2	$1,339.00	45.9021	$1,900.35	$1,479.34
52648	Laser surgery of prostate	Y		A2	$1,339.00	45.9021	$1,900.35	$1,479.34
52700	Drainage of prostate abscess	Y		A2	$446.00	25.2775	$1,046.49	$596.12
53000	Incision of urethra	Y		A2	$333.00	19.6570	$813.80	$453.20
53010	Incision of urethra	Y		A2	$333.00	19.6570	$813.80	$453.20
53020	Incision of urethra	Y		A2	$333.00	19.6570	$813.80	$453.20
53025	Incision of urethra	Y		R2		19.6570	$813.80	$813.80
53040	Drainage of urethra abscess	Y		A2	$446.00	19.6570	$813.80	$537.95
53060	Drainage of urethra abscess	Y		P3		1.7068	$70.66	$70.66
53080	Drainage of urinary leakage	Y		A2	$510.00	19.6570	$813.80	$585.95
53085	Drainage of urinary leakage	Y		G2		19.6570	$813.80	$813.80
53200	Biopsy of urethra	Y		A2	$333.00	19.6570	$813.80	$453.20
53210	Removal of urethra	Y		A2	$717.00	30.1994	$1,250.26	$850.32
53215	Removal of urethra	Y		A2	$717.00	19.6570	$813.80	$741.20
53220	Treatment of urethra lesion	Y		A2	$446.00	30.1994	$1,250.26	$647.07
53230	Removal of urethra lesion	Y		A2	$446.00	30.1994	$1,250.26	$647.07
53235	Removal of urethra lesion	Y		A2	$510.00	19.6570	$813.80	$585.95
53240	Surgery for urethra pouch	Y		A2	$446.00	30.1994	$1,250.26	$647.07
53250	Removal of urethra gland	Y		A2	$446.00	19.6570	$813.80	$537.95
53260	Treatment of urethra lesion	Y		A2	$446.00	19.6570	$813.80	$537.95
53265	Treatment of urethra lesion	Y		A2	$446.00	19.6570	$813.80	$537.95
53270	Removal of urethra gland	Y		A2	$446.00	19.6570	$813.80	$537.95
53275	Repair of urethra defect	Y		A2	$446.00	19.6570	$813.80	$537.95

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
53400	Revise urethra, stage 1	Y		A2	$510.00	30.1994	$1,250.26	$695.07
53405	Revise urethra, stage 2	Y		A2	$446.00	30.1994	$1,250.26	$647.07
53410	Reconstruction of urethra	Y		A2	$446.00	30.1994	$1,250.26	$647.07
53420	Reconstruct urethra, stage 1	Y		A2	$510.00	30.1994	$1,250.26	$695.07
53425	Reconstruct urethra, stage 2	Y		A2	$446.00	30.1994	$1,250.26	$647.07
53430	Reconstruction of urethra	Y		A2	$446.00	30.1994	$1,250.26	$647.07
53431	Reconstruct urethra/bladder	Y		A2	$446.00	30.1994	$1,250.26	$647.07
53440	Male sling procedure	N	CH	H8	$446.00	109.0807	$4,515.94	$3,569.83
53442	Remove/revise male sling	Y		A2	$333.00	30.1994	$1,250.26	$562.32
53444	Insert tandem cuff	N	CH	H8	$446.00	109.0807	$4,515.94	$3,569.83
53445	Insert uro/ves nck sphincter	N		H8	$333.00	191.7932	$7,940.24	$6,492.40
53446	Remove uro sphincter	Y		A2	$333.00	30.1994	$1,250.26	$562.32
53447	Remove/replace ur sphincter	N		H8	$333.00	191.7932	$7,940.24	$6,492.40
53449	Repair uro sphincter	Y		A2	$333.00	30.1994	$1,250.26	$562.32
53450	Revision of urethra	Y		A2	$333.00	30.1994	$1,250.26	$562.32
53460	Revision of urethra	Y		A2	$333.00	19.6570	$813.80	$453.20
53502	Repair of urethra injury	Y		A2	$446.00	19.6570	$813.80	$537.95
53505	Repair of urethra injury	Y		A2	$446.00	30.1994	$1,250.26	$647.07
53510	Repair of urethra injury	Y		A2	$446.00	19.6570	$813.80	$537.95
53515	Repair of urethra injury	Y		A2	$446.00	30.1994	$1,250.26	$647.07
53520	Repair of urethra defect	Y		A2	$446.00	30.1994	$1,250.26	$647.07
53600	Dilate urethra stricture	Y		P3		0.9483	$39.26	$39.26
53601	Dilate urethra stricture	Y	CH	P2		1.0850	$44.92	$44.92
53605	Dilate urethra stricture	Y		A2	$446.00	18.1376	$750.90	$522.23
53620	Dilate urethra stricture	Y		P3		1.5254	$63.15	$63.15
53621	Dilate urethra stricture	Y		P3		1.5995	$66.22	$66.22
53660	Dilation of urethra	Y		P3		1.0802	$44.72	$44.72
53661	Dilation of urethra	Y		P3		1.0720	$44.38	$44.38
53665	Dilation of urethra	Y		A2	$333.00	19.6570	$813.80	$453.20
53850	Prostatic microwave thermotx	Y		P2		36.9175	$1,528.38	$1,528.38
53852	Prostatic rf thermotx	Y		P2		36.9175	$1,528.38	$1,528.38
53853	Prostatic water thermother	Y		P2		25.2775	$1,046.49	$1,046.49
54000	Slitting of prepuce	Y		A2	$446.00	19.6570	$813.80	$537.95
54001	Slitting of prepuce	Y		A2	$446.00	19.6570	$813.80	$537.95
54015	Drain penis lesion	Y		A2	$630.00	19.0457	$788.49	$669.62
54050	Destruction, penis lesion(s)	Y		P2		1.5119	$62.59	$62.59
54055	Destruction, penis lesion(s)	Y		P3		1.4676	$60.76	$60.76
54056	Cryosurgery, penis lesion(s)	Y		P2		0.8046	$33.31	$33.31
54057	Laser surg, penis lesion(s)	Y		A2	$333.00	20.0977	$832.04	$457.76
54060	Excision of penis lesion(s)	Y		A2	$333.00	20.0977	$832.04	$457.76
54065	Destruction, penis lesion(s)	Y		A2	$333.00	20.0977	$832.04	$457.76
54100	Biopsy of penis	Y		A2	$333.00	16.5832	$686.54	$421.39
54105	Biopsy of penis	Y		A2	$333.00	21.4534	$888.17	$471.79
54110	Treatment of penis lesion	Y		A2	$446.00	35.1574	$1,455.52	$698.38
54111	Treat penis lesion, graft	Y		A2	$446.00	35.1574	$1,455.52	$698.38
54112	Treat penis lesion, graft	Y		A2	$446.00	35.1574	$1,455.52	$698.38
54115	Treatment of penis lesion	Y		A2	$333.00	19.0457	$788.49	$446.87
54120	Partial removal of penis	Y		A2	$446.00	35.1574	$1,455.52	$698.38
54150	Circumcision w/regionl block	Y		A2	$333.00	22.7802	$943.10	$485.53
54160	Circumcision, neonate	Y		A2	$446.00	22.7802	$943.10	$570.28
54161	Circum 28 days or older	Y		A2	$446.00	22.7802	$943.10	$570.28
54162	Lysis penil circumic lesion	Y		A2	$446.00	22.7802	$943.10	$570.28
54163	Repair of circumcision	Y		A2	$446.00	22.7802	$943.10	$570.28
54164	Frenulotomy of penis	Y		A2	$446.00	22.7802	$943.10	$570.28
54200	Treatment of penis lesion	Y		P3		1.5667	$64.86	$64.86
54205	Treatment of penis lesion	Y		A2	$630.00	35.1574	$1,455.52	$836.38
54220	Treatment of penis lesion	Y		A2	$131.50	2.1659	$89.67	$121.04
54230	Prepare penis study	N		N1				
54231	Dynamic cavernosometry	Y		P3		1.3686	$56.66	$56.66
54235	Penile injection	Y		P3		0.9729	$40.28	$40.28
54240	Penis study	Y		P3		0.6679	$27.65	$27.65
54250	Penis study	Y		P3		0.2309	$9.56	$9.56
54300	Revision of penis	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54304	Revision of penis	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54308	Reconstruction of urethra	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54312	Reconstruction of urethra	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54316	Reconstruction of urethra	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54318	Reconstruction of urethra	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54322	Reconstruction of urethra	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54324	Reconstruction of urethra	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54326	Reconstruction of urethra	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54328	Revise penis/urethra	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54340	Secondary urethral surgery	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54344	Secondary urethral surgery	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54348	Secondary urethral surgery	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54352	Reconstruct urethra/penis	Y		A2	$510.00	35.1574	$1,455.52	$746.38

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
54360	Penis plastic surgery	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54380	Repair penis	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54385	Repair penis	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54400	Insert semi-rigid prosthesis	N	CH	H8	$510.00	109.0807	$4,515.94	$3,617.83
54401	Insert self-contd prosthesis	N		H8	$510.00	191.7932	$7,940.24	$6,625.15
54405	Insert multi-comp penis pros	N		H8	$510.00	191.7932	$7,940.24	$6,625.15
54406	Remove muti-comp penis pros	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54408	Repair multi-comp penis pros	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54410	Remove/replace penis prosth	N		H8	$510.00	191.7932	$7,940.24	$6,625.15
54415	Remove self-contd penis pros	Y		A2	$510.00	35.1574	$1,455.52	$746.38
54416	Remv/repl penis contain pros	N		H8	$510.00	191.7932	$7,940.24	$6,625.15
54420	Revision of penis	Y		A2	$630.00	35.1574	$1,455.52	$836.38
54435	Revision of penis	Y		A2	$630.00	35.1574	$1,455.52	$836.38
54440	Repair of penis	Y		A2	$630.00	35.1574	$1,455.52	$836.38
54450	Preputial stretching	Y		A2	$209.48	3.0601	$126.69	$188.78
54500	Biopsy of testis	Y		A2	$333.00	13.9599	$577.94	$394.24
54505	Biopsy of testis	Y		A2	$333.00	22.7802	$943.10	$485.53
54512	Excise lesion testis	Y		A2	$446.00	22.7802	$943.10	$570.28
54520	Removal of testis	Y		A2	$510.00	22.7802	$943.10	$618.28
54522	Orchiectomy, partial	Y		A2	$510.00	22.7802	$943.10	$618.28
54530	Removal of testis	Y		A2	$630.00	31.1722	$1,290.53	$795.13
54550	Exploration for testis	Y		A2	$630.00	31.1722	$1,290.53	$795.13
54560	Exploration for testis	Y		G2		22.7802	$943.10	$943.10
54600	Reduce testis torsion	Y		A2	$630.00	22.7802	$943.10	$708.28
54620	Suspension of testis	Y		A2	$510.00	22.7802	$943.10	$618.28
54640	Suspension of testis	Y		A2	$630.00	31.1722	$1,290.53	$795.13
54660	Revision of testis	Y		A2	$446.00	22.7802	$943.10	$570.28
54670	Repair testis injury	Y		A2	$510.00	22.7802	$943.10	$618.28
54680	Relocation of testis(es)	Y		A2	$510.00	22.7802	$943.10	$618.28
54690	Laparoscopy, orchiectomy	Y		A2	$1,339.00	46.1201	$1,909.37	$1,481.59
54692	Laparoscopy, orchiopexy	Y		G2		71.0022	$2,939.49	$2,939.49
54700	Drainage of scrotum	Y		A2	$446.00	22.7802	$943.10	$570.28
54800	Biopsy of epididymis	Y		A2	$127.16	4.5062	$186.56	$142.01
54830	Remove epididymis lesion	Y		A2	$510.00	22.7802	$943.10	$618.28
54840	Remove epididymis lesion	Y		A2	$630.00	22.7802	$943.10	$708.28
54860	Removal of epididymis	Y		A2	$510.00	22.7802	$943.10	$618.28
54861	Removal of epididymis	Y		A2	$630.00	22.7802	$943.10	$708.28
54865	Explore epididymis	Y		A2	$333.00	22.7802	$943.10	$485.53
54900	Fusion of spermatic ducts	Y		A2	$630.00	22.7802	$943.10	$708.28
54901	Fusion of spermatic ducts	Y		A2	$630.00	22.7802	$943.10	$708.28
55000	Drainage of hydrocele	Y		P3		1.6159	$66.90	$66.90
55040	Removal of hydrocele	Y		A2	$510.00	31.1722	$1,290.53	$705.13
55041	Removal of hydroceles	Y		A2	$717.00	31.1722	$1,290.53	$860.38
55060	Repair of hydrocele	Y		A2	$630.00	22.7802	$943.10	$708.28
55100	Drainage of scrotum abscess	Y		A2	$333.00	12.5792	$520.78	$379.95
55110	Explore scrotum	Y		A2	$446.00	22.7802	$943.10	$570.28
55120	Removal of scrotum lesion	Y		A2	$446.00	22.7802	$943.10	$570.28
55150	Removal of scrotum	Y		A2	$333.00	22.7802	$943.10	$485.53
55175	Revision of scrotum	Y		A2	$333.00	22.7802	$943.10	$485.53
55180	Revision of scrotum	Y		A2	$446.00	22.7802	$943.10	$570.28
55200	Incision of sperm duct	Y		A2	$446.00	22.7802	$943.10	$570.28
55250	Removal of sperm duct(s)	Y		A2	$446.00	22.7802	$943.10	$570.28
55300	Prepare, sperm duct x-ray	N		N1				
55400	Repair of sperm duct	Y		A2	$333.00	22.7802	$943.10	$485.53
55450	Ligation of sperm duct	Y		P3		5.2027	$215.39	$215.39
55500	Removal of hydrocele	Y		A2	$510.00	22.7802	$943.10	$618.28
55520	Removal of sperm cord lesion	Y		A2	$630.00	22.7802	$943.10	$708.28
55530	Revise spermatic cord veins	Y		A2	$630.00	22.7802	$943.10	$708.28
55535	Revise spermatic cord veins	Y		A2	$630.00	31.1722	$1,290.53	$795.13
55540	Revise hernia & sperm veins	Y		A2	$717.00	31.1722	$1,290.53	$860.38
55550	Laparo ligate spermatic vein	Y		A2	$1,339.00	46.1201	$1,909.37	$1,481.59
55600	Incise sperm duct pouch	Y		R2		22.7802	$943.10	$943.10
55680	Remove sperm pouch lesion	Y		A2	$333.00	22.7802	$943.10	$485.53
55700	Biopsy of prostate	Y		A2	$345.83	11.3168	$468.52	$376.50
55705	Biopsy of prostate	Y		A2	$345.83	11.3168	$468.52	$376.50
55720	Drainage of prostate abscess	Y		A2	$333.00	25.2775	$1,046.49	$511.37
55725	Drainage of prostate abscess	Y		A2	$446.00	25.2775	$1,046.49	$596.12
55860	Surgical exposure, prostate	Y		G2		19.6126	$811.96	$811.96
55870	Electroejaculation	Y		P3		1.6572	$68.61	$68.61
55873	Cryoablate prostate	Y	CH	H8	$1,339.00	163.2548	$6,758.75	$6,201.03
55875	Transperi needle place, pros	N	CH	A2	$1,339.00	36.9175	$1,528.38	$1,386.35
55876*	Place rt device/marker, pros	Y		P3		1.6903	$69.98	$69.98
56405	I & D of vulva/perineum	Y		P3		1.0307	$42.67	$42.67
56420	Drainage of gland abscess	Y		P2		1.4138	$58.53	$58.53
56440	Surgery for vulva lesion	Y		A2	$446.00	19.2052	$795.10	$533.28
56441	Lysis of labial lesion(s)	Y		A2	$333.00	19.2052	$795.10	$448.53

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
56442	Hymenotomy	Y		A2	$333.00	19.2052	$795.10	$448.53
56501	Destroy, vulva lesions, sim	Y		P3		1.4017	$58.03	$58.03
56515	Destroy vulva lesion/s compl	Y		A2	$510.00	20.0977	$832.04	$590.51
56605	Biopsy of vulva/perineum	Y		P3		0.8162	$33.79	$33.79
56606	Biopsy of vulva/perineum	Y		P3		0.3546	$14.68	$14.68
56620	Partial removal of vulva	Y		A2	$717.00	19.2052	$795.10	$736.53
56625	Complete removal of vulva	Y		A2	$995.00	19.2052	$795.10	$945.03
56700	Partial removal of hymen	Y		A2	$333.00	19.2052	$795.10	$448.53
56740	Remove vagina gland lesion	Y		A2	$510.00	19.2052	$795.10	$581.28
56800	Repair of vagina	Y		A2	$510.00	19.2052	$795.10	$581.28
56805	Repair clitoris	Y		G2		19.2052	$795.10	$795.10
56810	Repair of perineum	Y		A2	$717.00	19.2052	$795.10	$736.53
56820	Exam of vulva w/scope	Y		P3		1.0307	$42.67	$42.67
56821	Exam/biopsy of vulva w/scope	Y		P3		1.3522	$55.98	$55.98
57000	Exploration of vagina	Y		A2	$333.00	19.2052	$795.10	$448.53
57010	Drainage of pelvic abscess	Y		A2	$446.00	19.2052	$795.10	$533.28
57020	Drainage of pelvic fluid	Y		A2	$409.33	7.4497	$308.42	$384.10
57022	I & d vaginal hematoma, pp	Y		G2		12.5792	$520.78	$520.78
57023	I & d vag hematoma, non-ob	Y		A2	$333.00	19.0457	$788.49	$446.87
57061	Destroy vag lesions, simple	Y		P3		1.3027	$53.93	$53.93
57065	Destroy vag lesions, complex	Y		A2	$333.00	19.2052	$795.10	$448.53
57100	Biopsy of vagina	Y		P3		0.8329	$34.48	$34.48
57105	Biopsy of vagina	Y		A2	$446.00	19.2052	$795.10	$533.28
57130	Remove vagina lesion	Y		A2	$446.00	19.2052	$795.10	$533.28
57135	Remove vagina lesion	Y		A2	$446.00	19.2052	$795.10	$533.28
57150	Treat vagina infection	Y		P3		0.6925	$28.67	$28.67
57155	Insert uteri tandems/ovoids	Y		A2	$409.33	7.4497	$308.42	$384.10
57160	Insert pessary/other device	Y		P3		0.8493	$35.16	$35.16
57170	Fitting of diaphragm/cap	Y		P2		0.1414	$5.85	$5.85
57180	Treat vaginal bleeding	Y		A2	$178.05	1.4138	$58.53	$148.17
57200	Repair of vagina	Y		A2	$333.00	19.2052	$795.10	$448.53
57210	Repair vagina/perineum	Y		A2	$446.00	19.2052	$795.10	$533.28
57220	Revision of urethra	Y		A2	$510.00	43.2255	$1,789.54	$829.89
57230	Repair of urethral lesion	Y		A2	$510.00	32.9713	$1,365.01	$723.75
57240	Repair bladder & vagina	Y		A2	$717.00	32.9713	$1,365.01	$879.00
57250	Repair rectum & vagina	Y		A2	$717.00	32.9713	$1,365.01	$879.00
57260	Repair of vagina	Y		A2	$717.00	32.9713	$1,365.01	$879.00
57265	Extensive repair of vagina	Y		A2	$995.00	43.2255	$1,789.54	$1,193.64
57267	Insert mesh/pelvic flr addon	Y		A2	$995.00	32.9713	$1,365.01	$1,087.50
57268	Repair of bowel bulge	Y		A2	$510.00	32.9713	$1,365.01	$723.75
57287	Revise/remove sling repair	Y		G2		32.9713	$1,365.01	$1,365.01
57288	Repair bladder defect	Y		A2	$717.00	43.2255	$1,789.54	$985.14
57289	Repair bladder & vagina	Y		A2	$717.00	32.9713	$1,365.01	$879.00
57291	Construction of vagina	Y		A2	$717.00	32.9713	$1,365.01	$879.00
57300	Repair rectum-vagina fistula	Y		A2	$510.00	32.9713	$1,365.01	$723.75
57320	Repair bladder-vagina lesion	Y		G2		32.9713	$1,365.01	$1,365.01
57400	Dilation of vagina	Y		A2	$446.00	19.2052	$795.10	$533.28
57410	Pelvic examination	Y		A2	$446.00	19.2052	$795.10	$533.28
57415	Remove vaginal foreign body	Y		A2	$446.00	19.2052	$795.10	$533.28
57420	Exam of vagina w/scope	Y		P3		1.0635	$44.03	$44.03
57421	Exam/biopsy of vag w/scope	Y		P3		1.4181	$58.71	$58.71
57452	Exam of cervix w/scope	Y		P3		1.0143	$41.99	$41.99
57454	Bx/curett of cervix w/scope	Y		P3		1.2534	$51.89	$51.89
57455	Biopsy of cervix w/scope	Y		P3		1.3275	$54.96	$54.96
57456	Endocerv curettage w/scope	Y		P3		1.2780	$52.91	$52.91
57460	Bx of cervix w/scope, leep	Y		P3		4.1638	$172.38	$172.38
57461	Conz of cervix w/scope, leep	Y		P3		4.3865	$181.60	$181.60
57500	Biopsy of cervix	Y		P3		1.8717	$77.49	$77.49
57505	Endocervical curettage	Y		P3		1.1461	$47.45	$47.45
57510	Cauterization of cervix	Y		P3		1.1872	$49.15	$49.15
57511	Cryocautery of cervix	Y	CH	P3		1.4099	$58.37	$58.37
57513	Laser surgery of cervix	Y		A2	$446.00	19.2052	$795.10	$533.28
57520	Conization of cervix	Y		A2	$446.00	19.2052	$795.10	$533.28
57522	Conization of cervix	Y		A2	$446.00	19.2052	$795.10	$533.28
57530	Removal of cervix	Y		A2	$510.00	32.9713	$1,365.01	$723.75
57550	Removal of residual cervix	Y		A2	$510.00	32.9713	$1,365.01	$723.75
57556	Remove cervix, repair bowel	Y		A2	$717.00	43.2255	$1,789.54	$985.14
57558	D&c of cervical stump	Y		A2	$510.00	19.2052	$795.10	$581.28
57700	Revision of cervix	Y		A2	$333.00	19.2052	$795.10	$448.53
57720	Revision of cervix	Y		A2	$510.00	19.2052	$795.10	$581.28
57800	Dilation of cervical canal	Y		P3		0.6101	$25.26	$25.26
58100	Biopsy of uterus lining	Y		P3		1.0143	$41.99	$41.99
58110	Bx done w/colposcopy add-on	N	CH	N1				
58120	Dilation and curettage	Y		A2	$446.00	19.2052	$795.10	$533.28
58145	Myomectomy vag method	Y		A2	$717.00	32.9713	$1,365.01	$879.00
58301	Remove intrauterine device	Y		P3		0.9729	$40.28	$40.28

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
58321	Artificial insemination	Y		P3		0.8575	$35.50	$35.50
58322	Artificial insemination	Y		P3		0.9234	$38.23	$38.23
58323	Sperm washing	Y		P3		0.2886	$11.95	$11.95
58340	Catheter for hysterography	N		N1				
58345	Reopen fallopian tube	Y		R2		19.2052	$795.10	$795.10
58346	Insert heyman uteri capsule	Y		A2	$446.00	19.2052	$795.10	$533.28
58350	Reopen fallopian tube	Y		A2	$510.00	32.9713	$1,365.01	$723.75
58353	Endometr ablate, thermal	Y		A2	$995.00	32.9713	$1,365.01	$1,087.50
58356	Endometrial cryoablation	Y		P3		43.0481	$1,782.19	$1,782.19
58545	Laparoscopic myomectomy	Y		A2	$1,339.00	34.8153	$1,441.35	$1,364.59
58546	Laparo-myomectomy, complex	Y		A2	$1,339.00	46.1201	$1,909.37	$1,481.59
58550	Laparo-asst vag hysterectomy	Y		A2	$1,339.00	71.0022	$2,939.49	$1,739.12
58552	Laparo-vag hyst incl t/o	Y		G2		46.1201	$1,909.37	$1,909.37
58555	Hysteroscopy, dx, sep proc	Y		A2	$333.00	22.1171	$915.65	$478.66
58558	Hysteroscopy, biopsy	Y		A2	$510.00	22.1171	$915.65	$611.41
58559	Hysteroscopy, lysis	Y		A2	$446.00	22.1171	$915.65	$563.41
58560	Hysteroscopy, resect septum	Y		A2	$510.00	34.8162	$1,441.39	$742.85
58561	Hysteroscopy, remove myoma	Y		A2	$510.00	34.8162	$1,441.39	$742.85
58562	Hysteroscopy, remove fb	Y		A2	$510.00	22.1171	$915.65	$611.41
58563	Hysteroscopy, ablation	Y		A2	$1,339.00	34.8162	$1,441.39	$1,364.60
58565	Hysteroscopy, sterilization	Y		A2	$1,339.00	43.2255	$1,789.54	$1,451.64
58600	Division of fallopian tube	Y		G2		32.9713	$1,365.01	$1,365.01
58615	Occlude fallopian tube(s)	Y		G2		19.2052	$795.10	$795.10
58660	Laparoscopy, lysis	Y		A2	$717.00	46.1201	$1,909.37	$1,015.09
58661	Laparoscopy, remove adnexa	Y		A2	$717.00	46.1201	$1,909.37	$1,015.09
58662	Laparoscopy, excise lesions	Y		A2	$717.00	46.1201	$1,909.37	$1,015.09
58670	Laparoscopy, tubal cautery	Y		A2	$510.00	46.1201	$1,909.37	$859.84
58671	Laparoscopy, tubal block	Y		A2	$510.00	46.1201	$1,909.37	$859.84
58672	Laparoscopy, fimbrioplasty	Y		A2	$717.00	46.1201	$1,909.37	$1,015.09
58673	Laparoscopy, salpingostomy	Y		A2	$717.00	46.1201	$1,909.37	$1,015.09
58800	Drainage of ovarian cyst(s)	Y		A2	$510.00	19.2052	$795.10	$581.28
58805	Drainage of ovarian cyst(s)	Y	CH	G2		32.9713	$1,365.01	$1,365.01
58820	Drain ovary abscess, open	Y		A2	$510.00	32.9713	$1,365.01	$723.75
58900	Biopsy of ovary(s)	Y		A2	$510.00	19.2052	$795.10	$581.28
58970	Retrieval of oocyte	Y		A2	$245.92	3.0466	$126.13	$215.97
58974	Transfer of embryo	Y		A2	$245.92	3.0466	$126.13	$215.97
58976	Transfer of embryo	Y		A2	$245.92	3.0466	$126.13	$215.97
59000	Amniocentesis, diagnostic	Y	CH	P3		1.5667	$64.86	$64.86
59001	Amniocentesis, therapeutic	Y		R2		7.4497	$308.42	$308.42
59012	Fetal cord puncture,prenatal	Y		G2		3.0466	$126.13	$126.13
59015	Chorion biopsy	Y		P3		1.2285	$50.86	$50.86
59020	Fetal contract stress test	Y		P3		0.5771	$23.89	$23.89
59025	Fetal non-stress test	Y		P3		0.2886	$11.95	$11.95
59070	Transabdom amnioinfus w/us	Y		G2		3.0466	$126.13	$126.13
59072	Umbilical cord occlud w/us	Y		G2		3.0466	$126.13	$126.13
59076	Fetal shunt placement, w/us	Y		G2		3.0466	$126.13	$126.13
59100	Remove uterus lesion	Y		R2		32.9713	$1,365.01	$1,365.01
59150	Treat ectopic pregnancy	Y		G2		46.1201	$1,909.37	$1,909.37
59151	Treat ectopic pregnancy	Y		G2		46.1201	$1,909.37	$1,909.37
59160	D& c after delivery	Y		A2	$510.00	19.2052	$795.10	$581.28
59200	Insert cervical dilator	Y		P3		0.8821	$36.52	$36.52
59300	Episiotomy or vaginal repair	Y		P3		1.7973	$74.41	$74.41
59320	Revision of cervix	Y		A2	$333.00	19.2052	$795.10	$448.53
59412	Antepartum manipulation	Y		G2		19.2052	$795.10	$795.10
59414	Deliver placenta	Y		G2		19.2052	$795.10	$795.10
59812	Treatment of miscarriage	Y		A2	$717.00	19.2052	$795.10	$736.53
59820	Care of miscarriage	Y		A2	$717.00	19.2052	$795.10	$736.53
59821	Treatment of miscarriage	Y		A2	$717.00	19.2052	$795.10	$736.53
59840	Abortion	Y		A2	$717.00	19.2052	$795.10	$736.53
59841	Abortion	Y		A2	$717.00	19.2052	$795.10	$736.53
59866	Abortion (mpr)	Y		G2		3.0466	$126.13	$126.13
59870	Evacuate mole of uterus	Y		A2	$717.00	19.2052	$795.10	$736.53
59871	Remove cerclage suture	Y		A2	$717.00	19.2052	$795.10	$736.53
60000	Drain thyroid/tongue cyst	Y		A2	$333.00	7.6539	$316.87	$328.97
60001	Aspirate/inject thyriod cyst	Y		P3		1.3686	$56.66	$56.66
60100	Biopsy of thyroid	Y		P3		1.1048	$45.74	$45.74
60200	Remove thyroid lesion	Y		A2	$446.00	45.1729	$1,870.16	$802.04
60280	Remove thyroid duct lesion	Y		A2	$630.00	45.1729	$1,870.16	$940.04
60281	Remove thyroid duct lesion	Y		A2	$630.00	45.1729	$1,870.16	$940.04
61000	Remove cranial cavity fluid	Y		R2		8.6797	$359.34	$359.34
61001	Remove cranial cavity fluid	Y		R2		8.6797	$359.34	$359.34
61020	Remove brain cavity fluid	Y		A2	$183.83	8.6797	$359.34	$227.71
61026	Injection into brain canal	Y		A2	$183.83	8.6797	$359.34	$227.71
61050	Remove brain canal fluid	Y		A2	$183.83	8.6797	$359.34	$227.71
61055	Injection into brain canal	Y		A2	$183.83	8.6797	$359.34	$227.71
61070	Brain canal shunt procedure	Y		A2	$183.83	3.2914	$136.26	$171.94

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
61215	Insert brain-fluid device	Y		A2	$510.00	37.1117	$1,536.42	$766.61
61330	Decompress eye socket	Y		G2		40.5598	$1,679.18	$1,679.18
61334	Explore orbit/remove object	Y		G2		40.5598	$1,679.18	$1,679.18
61790	Treat trigeminal nerve	Y		A2	$510.00	18.5069	$766.19	$574.05
61791	Treat trigeminal tract	Y		A2	$351.92	15.5687	$644.54	$425.08
61795	Brain surgery using computer	N	CH	N1	$302.04			
61880	Revise/remove neuroelectrode	Y		G2		24.1752	$1,000.85	$1,000.85
61885	Insrt/redo neurostim 1 array	N		H8	$446.00	284.8210	$11,791.59	$11,031.64
61886	Implant neurostim arrays	Y		H8	$510.00	384.8428	$15,932.49	$15,191.32
61888	Revise/remove neuroreceiver	Y		A2	$333.00	35.7248	$1,479.01	$619.50
62194	Replace/irrigate catheter	Y		A2	$333.00	8.6797	$359.34	$339.59
62225	Replace/irrigate catheter	Y		A2	$333.00	14.8912	$616.50	$403.88
62230	Replace/revise brain shunt	Y		A2	$446.00	37.1117	$1,536.42	$718.61
62252	Csf shunt reprogram	N		P3		1.0720	$44.38	$44.38
62263	Epidural lysis mult sessions	Y		A2	$333.00	15.5687	$644.54	$410.89
62264	Epidural lysis on single day	Y		A2	$333.00	15.5687	$644.54	$410.89
62268	Drain spinal cord cyst	Y		A2	$183.83	8.6797	$359.34	$227.71
62269	Needle biopsy, spinal cord	Y		A2	$333.00	9.5741	$396.37	$348.84
62270	Spinal fluid tap, diagnostic	Y		A2	$139.00	4.1589	$172.18	$147.30
62272	Drain cerebro spinal fluid	Y		A2	$139.00	4.1589	$172.18	$147.30
62273	Inject epidural patch	Y		A2	$333.00	4.1589	$172.18	$292.80
62280	Treat spinal cord lesion	Y		A2	$333.00	7.1370	$295.47	$323.62
62281	Treat spinal cord lesion	Y		A2	$333.00	7.1370	$295.47	$323.62
62282	Treat spinal canal lesion	Y		A2	$333.00	7.1370	$295.47	$323.62
62284	Injection for myelogram	N		N1				
62287	Percutaneous diskectomy	Y		A2	$1,339.00	32.0518	$1,326.94	$1,335.99
62290	Inject for spine disk x-ray	N		N1				
62291	Inject for spine disk x-ray	N		N1				
62292	Injection into disk lesion	Y	CH	R2		8.6797	$359.34	$359.34
62294	Injection into spinal artery	Y		A2	$183.83	8.6797	$359.34	$227.71
62310	Inject spine c/t	Y		A2	$333.00	7.1370	$295.47	$323.62
62311	Inject spine l/s (cd)	Y		A2	$333.00	7.1370	$295.47	$323.62
62318	Inject spine w/cath, c/t	Y		A2	$333.00	7.1370	$295.47	$323.62
62319	Inject spine w/cath l/s (cd)	Y		A2	$333.00	7.1370	$295.47	$323.62
62350	Implant spinal canal cath	Y		A2	$446.00	37.1117	$1,536.42	$718.61
62355	Remove spinal canal catheter	Y		A2	$446.00	15.5687	$644.54	$495.64
62360	Insert spine infusion device	Y		A2	$446.00	37.1117	$1,536.42	$718.61
62361	Implant spine infusion pump	Y		H8	$446.00	255.4150	$10,574.18	$9,781.61
62362	Implant spine infusion pump	Y		H8	$446.00	255.4150	$10,574.18	$9,781.61
62365	Remove spine infusion device	Y		A2	$446.00	32.0518	$1,326.94	$666.24
62367	Analyze spine infusion pump	N		P3		0.4205	$17.41	$17.41
62368	Analyze spine infusion pump	N		P3		0.5278	$21.85	$21.85
63600	Remove spinal cord lesion	Y		A2	$446.00	18.5069	$766.19	$526.05
63610	Stimulation of spinal cord	Y		A2	$333.00	18.5069	$766.19	$441.30
63615	Remove lesion of spinal cord	Y		R2		18.5069	$766.19	$766.19
63650	Implant neuroelectrodes	N		H8	$446.00	82.9543	$3,434.31	$2,896.42
63655	Implant neuroelectrodes	N		J8		107.3027	$4,442.33	$4,442.33
63660	Revise/remove neuroelectrode	Y		A2	$333.00	24.1752	$1,000.85	$499.96
63685	Insrt/redo spine n generator	Y		H8	$446.00	280.0420	$11,593.74	$10,925.15
63688	Revise/remove neuroreceiver	Y		A2	$333.00	35.7248	$1,479.01	$619.50
63744	Revision of spinal shunt	Y		A2	$510.00	37.1117	$1,536.42	$766.61
63746	Removal of spinal shunt	Y		A2	$446.00	6.1077	$252.86	$397.72
64400	Nblock inj, trigeminal	Y		P3		1.3604	$56.32	$56.32
64402	Nblock inj, facial	Y		P3		1.2449	$51.54	$51.54
64405	Nblock inj, occipital	Y		P3		1.0802	$44.72	$44.72
64408	Nblock inj, vagus	Y		P3		1.2449	$51.54	$51.54
64410	Nblock inj, phrenic	Y		A2	$333.00	7.1370	$295.47	$323.62
64412	Nblock inj, spinal accessor	Y		P3		1.9541	$80.90	$80.90
64413	Nblock inj, cervical plexus	Y		P3		1.2944	$53.59	$53.59
64415	Nblock inj, brachial plexus	Y		A2	$139.00	4.1589	$172.18	$147.30
64416	Nblock cont infuse, b plex	Y		G2		7.1370	$295.47	$295.47
64417	Nblock inj, axillary	Y		A2	$139.00	4.1589	$172.18	$147.30
64418	Nblock inj, suprascapular	Y		P3		1.8551	$76.80	$76.80
64420	Nblock inj, intercost, sng	Y		A2	$139.00	4.1589	$172.18	$147.30
64421	Nblock inj, intercost, mlt	Y		A2	$333.00	4.1589	$172.18	$292.80
64425	Nblock inj, ilio-ing/hypogi	Y		P3		1.2203	$50.52	$50.52
64430	Nblock inj, pudendal	Y		A2	$139.00	7.1370	$295.47	$178.12
64435	Nblock inj, paracervical	Y		P3		1.8551	$76.80	$76.80
64445	Nblock inj, sciatic, sng	Y		P3		1.7727	$73.39	$73.39
64446	Nblk inj, sciatic, cont inf	Y		G2		15.5687	$644.54	$644.54
64447	Nblock inj fem, single	Y	CH	R2		4.1589	$172.18	$172.18
64450	Nblock, other peripheral	Y		P3		1.0307	$42.67	$42.67
64470	Inj paravertebral c/t	Y		A2	$333.00	7.1370	$295.47	$323.62
64472	Inj paravertebral c/t add-on	Y		A2	$333.00	4.1589	$172.18	$292.80
64475	Inj paravertebral l/s	Y		A2	$333.00	7.1370	$295.47	$323.62
64476	Inj paravertebral l/s add-on	Y		A2	$333.00	4.1589	$172.18	$292.80

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
64479	Inj foramen epidural c/t	Y		A2	$333.00	7.1370	$295.47	$323.62
64480	Inj foramen epidural add-on	Y		A2	$333.00	4.1589	$172.18	$292.80
64483	Inj foramen epidural l/s	Y		A2	$333.00	7.1370	$295.47	$323.62
64484	Inj foramen epidural add-on	Y		A2	$333.00	7.1370	$295.47	$323.62
64505	Nblock, spenopalatine gangl	Y		P3		0.9729	$40.28	$40.28
64508	Nblock, carotid sinus s/p	Y		P3		2.1768	$90.12	$90.12
64510	Nblock, stellate ganglion	Y		A2	$333.00	7.1370	$295.47	$323.62
64517	Nblock inj, hypogas plxs	Y		A2	$139.00	7.1370	$295.47	$178.12
64520	Nblock, lumbar/thoracic	Y		A2	$333.00	7.1370	$295.47	$323.62
64530	Nblock inj, celiac pelus	Y		A2	$333.00	7.1370	$295.47	$323.62
64553	Implant neuroelectrodes	N		H8	$333.00	317.8027	$13,157.03	$12,089.52
64555	Implant neuroelectrodes	N		J8		82.9543	$3,434.31	$3,434.31
64560	Implant neuroelectrodes	N		J8		82.9543	$3,434.31	$3,434.31
64561	Implant neuroelectrodes	N		H8	$510.00	82.9543	$3,434.31	$2,944.42
64565	Implant neuroelectrodes	N		J8		82.9543	$3,434.31	$3,434.31
64573	Implant neuroelectrodes	N		H8	$333.00	317.8027	$13,157.03	$12,089.52
64575	Implant neuroelectrodes	N		H8	$333.00	107.3027	$4,442.33	$3,664.85
64577	Implant neuroelectrodes	N		H8	$333.00	107.3027	$4,442.33	$3,664.85
64580	Implant neuroelectrodes	N		H8	$333.00	107.3027	$4,442.33	$3,664.85
64581	Implant neuroelectrodes	N		H8	$510.00	107.3027	$4,442.33	$3,797.60
64585	Revise/remove neuroelectrode	Y		A2	$333.00	24.1752	$1,000.85	$499.96
64590	Insrt/redo pn/gastr stimul	Y		H8	$446.00	280.0420	$11,593.74	$10,925.15
64595	Revise/rmv pn/gastr stimul	Y		A2	$333.00	35.7248	$1,479.01	$619.50
64600	Injection treatment of nerve	Y		A2	$333.00	15.5687	$644.54	$410.89
64605	Injection treatment of nerve	Y		A2	$333.00	15.5687	$644.54	$410.89
64610	Injection treatment of nerve	Y		A2	$333.00	15.5687	$644.54	$410.89
64612	Destroy nerve, face muscle	Y		P3		1.6821	$69.64	$69.64
64613	Destroy nerve, neck muscle	Y		P3		1.7727	$73.39	$73.39
64614	Destroy nerve, extrem musc	Y		P3		1.9954	$82.61	$82.61
64620	Injection treatment of nerve	Y		A2	$333.00	7.1370	$295.47	$323.62
64622	Destr paravertebrl nerve l/s	Y		A2	$333.00	7.1370	$295.47	$323.62
64623	Destr paravertebral n add-on	Y		A2	$333.00	7.1370	$295.47	$323.62
64626	Destr paravertebrl nerve c/t	Y		A2	$333.00	7.1370	$295.47	$323.62
64627	Destr paravertebral n add-on	Y		A2	$333.00	2.3254	$96.27	$273.82
64630	Injection treatment of nerve	Y		A2	$351.92	7.1370	$295.47	$337.81
64640	Injection treatment of nerve	Y		P3		2.7126	$112.30	$112.30
64650	Chemodenerv eccrine glands	Y	CH	P3		0.6597	$27.31	$27.31
64653	Chemodenerv eccrine glands	Y	CH	P3		0.7007	$29.01	$29.01
64680	Injection treatment of nerve	Y		A2	$390.95	7.1370	$295.47	$367.08
64681	Injection treatment of nerve	Y		A2	$446.00	15.5687	$644.54	$495.64
64702	Revise finger/toe nerve	Y		A2	$333.00	18.5069	$766.19	$441.30
64704	Revise hand/foot nerve	Y		A2	$333.00	18.5069	$766.19	$441.30
64708	Revise arm/leg nerve	Y		A2	$446.00	18.5069	$766.19	$526.05
64712	Revision of sciatic nerve	Y		A2	$446.00	18.5069	$766.19	$526.05
64713	Revision of arm nerve(s)	Y		A2	$446.00	18.5069	$766.19	$526.05
64714	Revise low back nerve(s)	Y		A2	$446.00	18.5069	$766.19	$526.05
64716	Revision of cranial nerve	Y		A2	$510.00	18.5069	$766.19	$574.05
64718	Revise ulnar nerve at elbow	Y		A2	$446.00	18.5069	$766.19	$526.05
64719	Revise ulnar nerve at wrist	Y		A2	$446.00	18.5069	$766.19	$526.05
64721	Carpal tunnel surgery	Y		A2	$446.00	18.5069	$766.19	$526.05
64722	Relieve pressure on nerve(s)	Y		A2	$333.00	18.5069	$766.19	$441.30
64726	Release foot/toe nerve	Y		A2	$333.00	18.5069	$766.19	$441.30
64727	Internal nerve revision	Y		A2	$333.00	18.5069	$766.19	$441.30
64732	Incision of brow nerve	Y		A2	$446.00	18.5069	$766.19	$526.05
64734	Incision of cheek nerve	Y		A2	$446.00	18.5069	$766.19	$526.05
64736	Incision of chin nerve	Y		A2	$446.00	18.5069	$766.19	$526.05
64738	Incision of jaw nerve	Y		A2	$446.00	18.5069	$766.19	$526.05
64740	Incision of tongue nerve	Y		A2	$446.00	18.5069	$766.19	$526.05
64742	Incision of facial nerve	Y		A2	$446.00	18.5069	$766.19	$526.05
64744	Incise nerve, back of head	Y		A2	$446.00	18.5069	$766.19	$526.05
64746	Incise diaphragm nerve	Y		A2	$446.00	18.5069	$766.19	$526.05
64761	Incision of pelvis nerve	Y		G2		18.5069	$766.19	$766.19
64763	Incise hip/thigh nerve	Y		G2		18.5069	$766.19	$766.19
64766	Incise hip/thigh nerve	Y		G2		32.0518	$1,326.94	$1,326.94
64771	Sever cranial nerve	Y		A2	$446.00	18.5069	$766.19	$526.05
64772	Incision of spinal nerve	Y		A2	$446.00	18.5069	$766.19	$526.05
64774	Remove skin nerve lesion	Y		A2	$446.00	18.5069	$766.19	$526.05
64776	Remove digit nerve lesion	Y		A2	$510.00	18.5069	$766.19	$574.05
64778	Digit nerve surgery add-on	Y		A2	$446.00	18.5069	$766.19	$526.05
64782	Remove limb nerve lesion	Y		A2	$510.00	18.5069	$766.19	$574.05
64783	Limb nerve surgery add-on	Y		A2	$446.00	18.5069	$766.19	$526.05
64784	Remove nerve lesion	Y		A2	$510.00	18.5069	$766.19	$574.05
64786	Remove sciatic nerve lesion	Y		A2	$510.00	32.0518	$1,326.94	$714.24
64787	Implant nerve end	Y		A2	$446.00	18.5069	$766.19	$526.05
64788	Remove skin nerve lesion	Y		A2	$510.00	18.5069	$766.19	$574.05
64790	Removal of nerve lesion	Y		A2	$510.00	18.5069	$766.19	$574.05

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
64792	Removal of nerve lesion	Y		A2	$510.00	32.0518	$1,326.94	$714.24
64795	Biopsy of nerve	Y		A2	$446.00	18.5069	$766.19	$526.05
64802	Remove sympathetic nerves	Y		A2	$446.00	18.5069	$766.19	$526.05
64820	Remove sympathetic nerves	Y		G2		18.5069	$766.19	$766.19
64821	Remove sympathetic nerves	Y		A2	$630.00	26.7322	$1,106.71	$749.18
64822	Remove sympathetic nerves	Y		G2		26.7322	$1,106.71	$1,106.71
64823	Remove sympathetic nerves	Y		G2		26.7322	$1,106.71	$1,106.71
64831	Repair of digit nerve	Y		A2	$630.00	32.0518	$1,326.94	$804.24
64832	Repair nerve add-on	Y		A2	$333.00	32.0518	$1,326.94	$581.49
64834	Repair of hand or foot nerve	Y		A2	$446.00	32.0518	$1,326.94	$666.24
64835	Repair of hand or foot nerve	Y		A2	$510.00	32.0518	$1,326.94	$714.24
64836	Repair of hand or foot nerve	Y		A2	$510.00	32.0518	$1,326.94	$714.24
64837	Repair nerve add-on	Y		A2	$333.00	32.0518	$1,326.94	$581.49
64840	Repair of leg nerve	Y		A2	$446.00	32.0518	$1,326.94	$666.24
64856	Repair/transpose nerve	Y		A2	$446.00	32.0518	$1,326.94	$666.24
64857	Repair arm/leg nerve	Y		A2	$446.00	32.0518	$1,326.94	$666.24
64858	Repair sciatic nerve	Y		A2	$446.00	32.0518	$1,326.94	$666.24
64859	Nerve surgery	Y		A2	$333.00	32.0518	$1,326.94	$581.49
64861	Repair of arm nerves	Y		A2	$510.00	32.0518	$1,326.94	$714.24
64862	Repair of low back nerves	Y		A2	$510.00	32.0518	$1,326.94	$714.24
64864	Repair of facial nerve	Y		A2	$510.00	32.0518	$1,326.94	$714.24
64865	Repair of facial nerve	Y		A2	$630.00	32.0518	$1,326.94	$804.24
64870	Fusion of facial/other nerve	Y		A2	$630.00	32.0518	$1,326.94	$804.24
64872	Subsequent repair of nerve	Y		A2	$446.00	32.0518	$1,326.94	$666.24
64874	Repair & revise nerve add-on	Y		A2	$510.00	32.0518	$1,326.94	$714.24
64876	Repair nerve/shorten bone	Y		A2	$510.00	32.0518	$1,326.94	$714.24
64885	Nerve graft, head or neck	Y		A2	$446.00	32.0518	$1,326.94	$666.24
64886	Nerve graft, head or neck	Y		A2	$446.00	32.0518	$1,326.94	$666.24
64890	Nerve graft, hand or foot	Y		A2	$446.00	32.0518	$1,326.94	$666.24
64891	Nerve graft, hand or foot	Y		A2	$446.00	32.0518	$1,326.94	$666.24
64892	Nerve graft, arm or leg	Y		A2	$446.00	32.0518	$1,326.94	$666.24
64893	Nerve graft, arm or leg	Y		A2	$446.00	32.0518	$1,326.94	$666.24
64895	Nerve graft, hand or foot	Y		A2	$510.00	32.0518	$1,326.94	$714.24
64896	Nerve graft, hand or foot	Y		A2	$510.00	32.0518	$1,326.94	$714.24
64897	Nerve graft, arm or leg	Y		A2	$510.00	32.0518	$1,326.94	$714.24
64898	Nerve graft, arm or leg	Y		A2	$510.00	32.0518	$1,326.94	$714.24
64901	Nerve graft add-on	Y		A2	$446.00	32.0518	$1,326.94	$666.24
64902	Nerve graft add-on	Y		A2	$446.00	32.0518	$1,326.94	$666.24
64905	Nerve pedicle transfer	Y		A2	$446.00	32.0518	$1,326.94	$666.24
64907	Nerve pedicle transfer	Y		A2	$333.00	32.0518	$1,326.94	$581.49
65091	Revise eye	Y		A2	$510.00	37.3504	$1,546.31	$769.08
65093	Revise eye with implant	Y		A2	$510.00	37.3504	$1,546.31	$769.08
65101	Removal of eye	Y		A2	$510.00	37.3504	$1,546.31	$769.08
65103	Remove eye/insert implant	Y		A2	$510.00	37.3504	$1,546.31	$769.08
65105	Remove eye/attach implant	Y		A2	$630.00	37.3504	$1,546.31	$859.08
65110	Removal of eye	Y		A2	$717.00	37.3504	$1,546.31	$924.33
65112	Remove eye/revise socket	Y		A2	$995.00	37.3504	$1,546.31	$1,132.83
65114	Remove eye/revise socket	Y		A2	$995.00	37.3504	$1,546.31	$1,132.83
65125	Revise ocular implant	Y		G2		19.2280	$796.04	$796.04
65130	Insert ocular implant	Y		A2	$510.00	24.8916	$1,030.51	$640.13
65135	Insert ocular implant	Y		A2	$446.00	24.8916	$1,030.51	$592.13
65140	Attach ocular implant	Y		A2	$510.00	37.3504	$1,546.31	$769.08
65150	Revise ocular implant	Y		A2	$446.00	24.8916	$1,030.51	$592.13
65155	Reinsert ocular implant	Y		A2	$510.00	37.3504	$1,546.31	$769.08
65175	Removal of ocular implant	Y		A2	$333.00	19.2280	$796.04	$448.76
65205	Remove foreign body from eye	N		P3		0.5029	$20.82	$20.82
65210	Remove foreign body from eye	N		P3		0.6266	$25.94	$25.94
65220	Remove foreign body from eye	N		G2		1.1576	$47.92	$47.92
65222	Remove foreign body from eye	N		P3		0.6925	$28.67	$28.67
65235	Remove foreign body from eye	Y		A2	$446.00	16.5252	$684.14	$505.54
65260	Remove foreign body from eye	Y		A2	$510.00	18.8779	$781.55	$577.89
65265	Remove foreign body from eye	Y		A2	$630.00	29.0019	$1,200.68	$772.67
65270	Repair of eye wound	Y		A2	$446.00	19.2280	$796.04	$533.51
65272	Repair of eye wound	Y		A2	$446.00	24.0821	$997.00	$583.75
65275	Repair of eye wound	Y		A2	$630.00	24.0821	$997.00	$721.75
65280	Repair of eye wound	Y		A2	$630.00	18.8779	$781.55	$667.89
65285	Repair of eye wound	Y		A2	$630.00	38.1121	$1,577.84	$866.96
65286	Repair of eye wound	Y		P2		5.1145	$211.74	$211.74
65290	Repair of eye socket wound	Y		A2	$510.00	24.3920	$1,009.83	$634.96
65400	Removal of eye lesion	Y		A2	$333.00	16.5252	$684.14	$420.79
65410	Biopsy of cornea	Y		A2	$446.00	16.5252	$684.14	$505.54
65420	Removal of eye lesion	Y		A2	$446.00	16.5252	$684.14	$505.54
65426	Removal of eye lesion	Y		A2	$717.00	24.0821	$997.00	$787.00
65430	Corneal smear	N		P3		0.9894	$40.96	$40.96
65435	Curette/treat cornea	Y		P3		0.7669	$31.75	$31.75
65436	Curette/treat cornea	Y		G2		16.5252	$684.14	$684.14

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
65450	Treatment of corneal lesion	N		G2		2.3117	$95.70	$95.70
65600	Revision of cornea	Y		P3		3.9164	$162.14	$162.14
65710	Corneal transplant	Y		A2	$995.00	38.2919	$1,585.28	$1,142.57
65730	Corneal transplant	Y		A2	$995.00	38.2919	$1,585.28	$1,142.57
65750	Corneal transplant	Y		A2	$995.00	38.2919	$1,585.28	$1,142.57
65755	Corneal transplant	Y		A2	$995.00	38.2919	$1,585.28	$1,142.57
65770	Revise cornea with implant	Y		A2	$995.00	83.0605	$3,438.70	$1,605.93
65772	Correction of astigmatism	Y		A2	$630.00	16.5252	$684.14	$643.54
65775	Correction of astigmatism	Y		A2	$630.00	16.5252	$684.14	$643.54
65780	Ocular reconst, transplant	Y		A2	$717.00	38.2919	$1,585.28	$934.07
65781	Ocular reconst, transplant	Y		A2	$717.00	38.2919	$1,585.28	$934.07
65782	Ocular reconst, transplant	Y		A2	$717.00	38.2919	$1,585.28	$934.07
65800	Drainage of eye	Y		A2	$333.00	16.5252	$684.14	$420.79
65805	Drainage of eye	Y		A2	$333.00	16.5252	$684.14	$420.79
65810	Drainage of eye	Y		A2	$510.00	24.0821	$997.00	$631.75
65815	Drainage of eye	Y		A2	$446.00	24.0821	$997.00	$583.75
65820	Relieve inner eye pressure	Y		A2	$333.00	5.1145	$211.74	$302.69
65850	Incision of eye	Y		A2	$630.00	24.0821	$997.00	$721.75
65855	Laser surgery of eye	Y		P3		3.2403	$134.15	$134.15
65860	Incise inner eye adhesions	Y		P3		3.0343	$125.62	$125.62
65865	Incise inner eye adhesions	Y		A2	$333.00	16.5252	$684.14	$420.79
65870	Incise inner eye adhesions	Y		A2	$630.00	24.0821	$997.00	$721.75
65875	Incise inner eye adhesions	Y		A2	$630.00	24.0821	$997.00	$721.75
65880	Incise inner eye adhesions	Y		A2	$630.00	16.5252	$684.14	$643.54
65900	Remove eye lesion	Y		A2	$717.00	16.5252	$684.14	$708.79
65920	Remove implant of eye	Y		A2	$995.00	24.0821	$997.00	$995.50
65930	Remove blood clot from eye	Y		A2	$717.00	24.0821	$997.00	$787.00
66020	Injection treatment of eye	Y		A2	$333.00	16.5252	$684.14	$420.79
66030	Injection treatment of eye	Y		A2	$333.00	5.1145	$211.74	$302.69
66130	Remove eye lesion	Y		A2	$995.00	24.0821	$997.00	$995.50
66150	Glaucoma surgery	Y		A2	$630.00	24.0821	$997.00	$721.75
66155	Glaucoma surgery	Y		A2	$630.00	24.0821	$997.00	$721.75
66160	Glaucoma surgery	Y		A2	$446.00	24.0821	$997.00	$583.75
66165	Glaucoma surgery	Y		A2	$630.00	24.0821	$997.00	$721.75
66170	Glaucoma surgery	Y		A2	$630.00	24.0821	$997.00	$721.75
66172	Incision of eye	Y		A2	$630.00	24.0821	$997.00	$721.75
66180	Implant eye shunt	Y		A2	$717.00	40.8481	$1,691.11	$960.53
66185	Revise eye shunt	Y		A2	$446.00	40.8481	$1,691.11	$757.28
66220	Repair eye lesion	Y		A2	$510.00	38.1121	$1,577.84	$776.96
66225	Repair/graft eye lesion	Y		A2	$630.00	40.8481	$1,691.11	$895.28
66250	Follow-up surgery of eye	Y		A2	$446.00	16.5252	$684.14	$505.54
66500	Incision of iris	Y		A2	$333.00	5.1145	$211.74	$302.69
66505	Incision of iris	Y		A2	$333.00	5.1145	$211.74	$302.69
66600	Remove iris and lesion	Y		A2	$510.00	24.0821	$997.00	$631.75
66605	Removal of iris	Y		A2	$510.00	24.0821	$997.00	$631.75
66625	Removal of iris	Y		A2	$372.94	5.1145	$211.74	$332.64
66630	Removal of iris	Y		A2	$510.00	24.0821	$997.00	$631.75
66635	Removal of iris	Y		A2	$510.00	24.0821	$997.00	$631.75
66680	Repair iris & ciliary body	Y		A2	$510.00	24.0821	$997.00	$631.75
66682	Repair iris & ciliary body	Y		A2	$446.00	24.0821	$997.00	$583.75
66700	Destruction, ciliary body	Y		A2	$446.00	16.5252	$684.14	$505.54
66710	Ciliary transsleral therapy	Y		A2	$446.00	16.5252	$684.14	$505.54
66711	Ciliary endoscopic ablation	Y		A2	$446.00	16.5252	$684.14	$505.54
66720	Destruction, ciliary body	Y		A2	$446.00	16.5252	$684.14	$505.54
66740	Destruction, ciliary body	Y		A2	$446.00	24.0821	$997.00	$583.75
66761	Revision of iris	Y		P3		4.4029	$182.28	$182.28
66762	Revision of iris	Y		P3		4.4606	$184.67	$184.67
66770	Removal of inner eye lesion	Y		P3		4.8234	$199.69	$199.69
66820	Incision, secondary cataract	Y		G2		5.1145	$211.74	$211.74
66821	After cataract laser surgery	Y		A2	$312.50	5.2389	$216.89	$288.60
66825	Reposition intraocular lens	Y		A2	$630.00	24.0821	$997.00	$721.75
66830	Removal of lens lesion	Y		A2	$372.94	5.1145	$211.74	$332.64
66840	Removal of lens material	Y		A2	$630.00	14.9022	$616.95	$626.74
66850	Removal of lens material	Y		A2	$995.00	29.7487	$1,231.60	$1,054.15
66852	Removal of lens material	Y		A2	$630.00	29.7487	$1,231.60	$780.40
66920	Extraction of lens	Y		A2	$630.00	29.7487	$1,231.60	$780.40
66930	Extraction of lens	Y		A2	$717.00	29.7487	$1,231.60	$845.65
66940	Extraction of lens	Y		A2	$717.00	14.9022	$616.95	$691.99
66982	Cataract surgery, complex	Y		A2	$973.00	24.2197	$1,002.70	$980.43
66983	Cataract surg w/iol, 1 stage	Y		A2	$973.00	24.2197	$1,002.70	$980.43
66984	Cataract surg w/iol, 1 stage	Y		A2	$973.00	24.2197	$1,002.70	$980.43
66985	Insert lens prosthesis	Y		A2	$826.00	24.2197	$1,002.70	$870.18
66986	Exchange lens prosthesis	Y		A2	$826.00	24.2197	$1,002.70	$870.18
66990	Ophthalmic endoscope add-on	N		N1				
67005	Partial removal of eye fluid	Y		A2	$630.00	29.0019	$1,200.68	$772.67
67010	Partial removal of eye fluid	Y		A2	$630.00	29.0019	$1,200.68	$772.67

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
67015	Release of eye fluid	Y		A2	$333.00	29.0019	$1,200.68	$549.92
67025	Replace eye fluid	Y		A2	$333.00	29.0019	$1,200.68	$549.92
67027	Implant eye drug system	Y		A2	$630.00	38.1121	$1,577.84	$866.96
67028	Injection eye drug	N		P3		2.0200	$83.63	$83.63
67030	Incise inner eye strands	Y		A2	$333.00	18.8779	$781.55	$445.14
67031	Laser surgery, eye strands	Y		A2	$312.50	5.2389	$216.89	$288.60
67036	Removal of inner eye fluid	Y		A2	$630.00	38.1121	$1,577.84	$866.96
67038	Strip retinal membrane	Y		A2	$717.00	38.1121	$1,577.84	$932.21
67039	Laser treatment of retina	Y		A2	$995.00	38.1121	$1,577.84	$1,140.71
67040	Laser treatment of retina	Y		A2	$995.00	38.1121	$1,577.84	$1,140.71
67101	Repair detached retina	Y		P3		7.3135	$302.78	$302.78
67105	Repair detached retina	Y		P2		5.2389	$216.89	$216.89
67107	Repair detached retina	Y		A2	$717.00	38.1121	$1,577.84	$932.21
67108	Repair detached retina	Y		A2	$995.00	38.1121	$1,577.84	$1,140.71
67110	Repair detached retina	Y		P3		7.9565	$329.40	$329.40
67112	Rerepair detached retina	Y		A2	$995.00	38.1121	$1,577.84	$1,140.71
67115	Release encircling material	Y		A2	$446.00	18.8779	$781.55	$529.89
67120	Remove eye implant material	Y		A2	$446.00	18.8779	$781.55	$529.89
67121	Remove eye implant material	Y		A2	$446.00	29.0019	$1,200.68	$634.67
67141	Treatment of retina	Y		A2	$241.77	4.0100	$166.01	$222.83
67145	Treatment of retina	Y		P3		4.6007	$190.47	$190.47
67208	Treatment of retinal lesion	Y		P3		4.8976	$202.76	$202.76
67210	Treatment of retinal lesion	Y		P3		5.2027	$215.39	$215.39
67218	Treatment of retinal lesion	Y		A2	$717.00	18.8779	$781.55	$733.14
67220	Treatment of choroid lesion	Y		P2		4.0100	$166.01	$166.01
67221	Ocular photodynamic ther	Y		P3		3.0094	$124.59	$124.59
67225	Eye photodynamic ther add-on	Y		P3		0.1978	$8.19	$8.19
67227	Treatment of retinal lesion	Y		A2	$333.00	29.0019	$1,200.68	$549.92
67228	Treatment of retinal lesion	Y		P2		5.2389	$216.89	$216.89
67250	Reinforce eye wall	Y		A2	$510.00	19.2280	$796.04	$581.51
67255	Reinforce/graft eye wall	Y		A2	$510.00	29.0019	$1,200.68	$682.67
67311	Revise eye muscle	Y		A2	$510.00	24.3920	$1,009.83	$634.96
67312	Revise two eye muscles	Y		A2	$630.00	24.3920	$1,009.83	$724.96
67314	Revise eye muscle	Y		A2	$630.00	24.3920	$1,009.83	$724.96
67316	Revise two eye muscles	Y		A2	$630.00	24.3920	$1,009.83	$724.96
67318	Revise eye muscle(s)	Y		A2	$630.00	24.3920	$1,009.83	$724.96
67320	Revise eye muscle(s) add-on	Y		A2	$630.00	24.3920	$1,009.83	$724.96
67331	Eye surgery follow-up add-on	Y		A2	$630.00	24.3920	$1,009.83	$724.96
67332	Rerevise eye muscles add-on	Y		A2	$630.00	24.3920	$1,009.83	$724.96
67334	Revise eye muscle w/suture	Y		A2	$630.00	24.3920	$1,009.83	$724.96
67335	Eye suture during surgery	Y		A2	$630.00	24.3920	$1,009.83	$724.96
67340	Revise eye muscle add-on	Y		A2	$630.00	24.3920	$1,009.83	$724.96
67343	Release eye tissue	Y		A2	$995.00	24.3920	$1,009.83	$998.71
67345	Destroy nerve of eye muscle	Y		P3		1.9787	$81.92	$81.92
67346	Biopsy, eye muscle	Y		A2	$333.00	14.2784	$591.13	$397.53
67400	Explore/biopsy eye socket	Y		A2	$510.00	24.8916	$1,030.51	$640.13
67405	Explore/drain eye socket	Y		A2	$630.00	24.8916	$1,030.51	$730.13
67412	Explore/treat eye socket	Y		A2	$717.00	24.8916	$1,030.51	$795.38
67413	Explore/treat eye socket	Y		A2	$717.00	24.8916	$1,030.51	$795.38
67414	Explr/decompress eye socket	Y		G2		37.3504	$1,546.31	$1,546.31
67415	Aspiration, orbital contents	Y		A2	$333.00	19.2280	$796.04	$448.76
67420	Explore/treat eye socket	Y		A2	$717.00	37.3504	$1,546.31	$924.33
67430	Explore/treat eye socket	Y		A2	$717.00	37.3504	$1,546.31	$924.33
67440	Explore/drain eye socket	Y		A2	$717.00	37.3504	$1,546.31	$924.33
67445	Explr/decompress eye socket	Y		A2	$717.00	37.3504	$1,546.31	$924.33
67450	Explore/biopsy eye socket	Y		A2	$717.00	37.3504	$1,546.31	$924.33
67500	Inject/treat eye socket	N		G2		2.3117	$95.70	$95.70
67505	Inject/treat eye socket	Y		G2		2.8636	$118.55	$118.55
67515	Inject/treat eye socket	Y		P3		0.5688	$23.55	$23.55
67550	Insert eye socket implant	Y		A2	$630.00	37.3504	$1,546.31	$859.08
67560	Revise eye socket implant	Y		A2	$446.00	24.8916	$1,030.51	$592.13
67570	Decompress optic nerve	Y		A2	$630.00	37.3504	$1,546.31	$859.08
67700	Drainage of eyelid abscess	Y		P2		2.8636	$118.55	$118.55
67710	Incision of eyelid	Y		P3		3.7432	$154.97	$154.97
67715	Incision of eyelid fold	Y		A2	$333.00	19.2280	$796.04	$448.76
67800	Remove eyelid lesion	Y		P3		1.2534	$51.89	$51.89
67801	Remove eyelid lesions	Y		P3		1.5089	$62.47	$62.47
67805	Remove eyelid lesions	Y		P3		1.9541	$80.90	$80.90
67808	Remove eyelid lesion(s)	Y		A2	$446.00	19.2280	$796.04	$533.51
67810	Biopsy of eyelid	Y		P2		2.8636	$118.55	$118.55
67820	Revise eyelashes	N		P3		0.4370	$18.09	$18.09
67825	Revise eyelashes	Y		P3		1.2944	$53.59	$53.59
67830	Revise eyelashes	Y		A2	$446.00	7.1099	$294.35	$408.09
67835	Revise eyelashes	Y		A2	$446.00	19.2280	$796.04	$533.51
67840	Remove eyelid lesion	Y		P3		3.8751	$160.43	$160.43
67850	Treat eyelid lesion	Y		P3		2.7457	$113.67	$113.67

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
67875	Closure of eyelid by suture	Y		G2		7.1099	$294.35	$294.35
67880	Revision of eyelid	Y		A2	$510.00	16.5252	$684.14	$553.54
67882	Revision of eyelid	Y		A2	$510.00	19.2280	$796.04	$581.51
67900	Repair brow defect	Y		A2	$630.00	19.2280	$796.04	$671.51
67901	Repair eyelid defect	Y		A2	$717.00	19.2280	$796.04	$736.76
67902	Repair eyelid defect	Y		A2	$717.00	19.2280	$796.04	$736.76
67903	Repair eyelid defect	Y		A2	$630.00	19.2280	$796.04	$671.51
67904	Repair eyelid defect	Y		A2	$630.00	19.2280	$796.04	$671.51
67906	Repair eyelid defect	Y		A2	$717.00	19.2280	$796.04	$736.76
67908	Repair eyelid defect	Y		A2	$630.00	19.2280	$796.04	$671.51
67909	Revise eyelid defect	Y		A2	$630.00	19.2280	$796.04	$671.51
67911	Revise eyelid defect	Y		A2	$510.00	19.2280	$796.04	$581.51
67912	Correction eyelid w/implant	Y		A2	$510.00	19.2280	$796.04	$581.51
67914	Repair eyelid defect	Y		A2	$510.00	19.2280	$796.04	$581.51
67915	Repair eyelid defect	Y		P3		4.2792	$177.16	$177.16
67916	Repair eyelid defect	Y		A2	$630.00	19.2280	$796.04	$671.51
67917	Repair eyelid defect	Y		A2	$630.00	19.2280	$796.04	$671.51
67921	Repair eyelid defect	Y		A2	$510.00	19.2280	$796.04	$581.51
67922	Repair eyelid defect	Y		P3		4.1969	$173.75	$173.75
67923	Repair eyelid defect	Y		A2	$630.00	19.2280	$796.04	$671.51
67924	Repair eyelid defect	Y		A2	$630.00	19.2280	$796.04	$671.51
67930	Repair eyelid wound	Y		P3		4.1720	$172.72	$172.72
67935	Repair eyelid wound	Y		A2	$446.00	19.2280	$796.04	$533.51
67938	Remove eyelid foreign body	N		P2		1.1576	$47.92	$47.92
67950	Revision of eyelid	Y		A2	$446.00	19.2280	$796.04	$533.51
67961	Revision of eyelid	Y		A2	$510.00	19.2280	$796.04	$581.51
67966	Revision of eyelid	Y		A2	$510.00	19.2280	$796.04	$581.51
67971	Reconstruction of eyelid	Y		A2	$510.00	24.8916	$1,030.51	$640.13
67973	Reconstruction of eyelid	Y		A2	$510.00	24.8916	$1,030.51	$640.13
67974	Reconstruction of eyelid	Y		A2	$510.00	24.8916	$1,030.51	$640.13
67975	Reconstruction of eyelid	Y		A2	$510.00	19.2280	$796.04	$581.51
68020	Incise/drain eyelid lining	Y		P3		1.0966	$45.40	$45.40
68040	Treatment of eyelid lesions	N		P3		0.5442	$22.53	$22.53
68100	Biopsy of eyelid lining	Y		P3		2.3169	$95.92	$95.92
68110	Remove eyelid lining lesion	Y		P3		2.9684	$122.89	$122.89
68115	Remove eyelid lining lesion	Y		A2	$446.00	19.2280	$796.04	$533.51
68130	Remove eyelid lining lesion	Y		A2	$446.00	16.5252	$684.14	$505.54
68135	Remove eyelid lining lesion	Y		P3		1.4099	$58.37	$58.37
68200	Treat eyelid by injection	N		P3		0.4123	$17.07	$17.07
68320	Revise/graft eyelid lining	Y		A2	$630.00	19.2280	$796.04	$671.51
68325	Revise/graft eyelid lining	Y		A2	$630.00	24.8916	$1,030.51	$730.13
68326	Revise/graft eyelid lining	Y		A2	$630.00	24.8916	$1,030.51	$730.13
68328	Revise/graft eyelid lining	Y		A2	$630.00	24.8916	$1,030.51	$730.13
68330	Revise eyelid lining	Y		A2	$630.00	24.0821	$997.00	$721.75
68335	Revise/graft eyelid lining	Y		A2	$630.00	24.8916	$1,030.51	$730.13
68340	Separate eyelid adhesions	Y		A2	$630.00	19.2280	$796.04	$671.51
68360	Revise eyelid lining	Y		A2	$446.00	24.0821	$997.00	$583.75
68362	Revise eyelid lining	Y		A2	$446.00	24.0821	$997.00	$583.75
68371	Harvest eye tissue, alograft	Y		A2	$446.00	16.5252	$684.14	$505.54
68400	Incise/drain tear gland	Y		P2		2.8636	$118.55	$118.55
68420	Incise/drain tear sac	Y		P3		4.4606	$184.67	$184.67
68440	Incise tear duct opening	Y		P3		1.3771	$57.01	$57.01
68500	Removal of tear gland	Y		A2	$510.00	24.8916	$1,030.51	$640.13
68505	Partial removal, tear gland	Y		A2	$510.00	24.8916	$1,030.51	$640.13
68510	Biopsy of tear gland	Y		A2	$333.00	19.2280	$796.04	$448.76
68520	Removal of tear sac	Y		A2	$510.00	24.8916	$1,030.51	$640.13
68525	Biopsy of tear sac	Y		A2	$333.00	19.2280	$796.04	$448.76
68530	Clearance of tear duct	Y		P3		5.6973	$235.87	$235.87
68540	Remove tear gland lesion	Y		A2	$510.00	24.8916	$1,030.51	$640.13
68550	Remove tear gland lesion	Y		A2	$510.00	24.8916	$1,030.51	$640.13
68700	Repair tear ducts	Y		A2	$446.00	24.8916	$1,030.51	$592.13
68705	Revise tear duct opening	Y		P2		2.8636	$118.55	$118.55
68720	Create tear sac drain	Y		A2	$630.00	24.8916	$1,030.51	$730.13
68745	Create tear duct drain	Y		A2	$630.00	24.8916	$1,030.51	$730.13
68750	Create tear duct drain	Y		A2	$630.00	24.8916	$1,030.51	$730.13
68760	Close tear duct opening	N		P2		2.3117	$95.70	$95.70
68761	Close tear duct opening	N		P3		1.6986	$70.32	$70.32
68770	Close tear system fistula	Y		A2	$630.00	19.2280	$796.04	$671.51
68801	Dilate tear duct opening	N		P2		1.1576	$47.92	$47.92
68810	Probe nasolacrimal duct	N		A2	$131.86	2.3117	$95.70	$122.82
68811	Probe nasolacrimal duct	Y		A2	$446.00	19.2280	$796.04	$533.51
68815	Probe nasolacrimal duct	Y		A2	$446.00	19.2280	$796.04	$533.51
68840	Explore/irrigate tear ducts	N		P2		1.1576	$47.92	$47.92
68850	Injection for tear sac x-ray	N		N1				
69000	Drain external ear lesion	Y		P2		1.4630	$60.57	$60.57
69005	Drain external ear lesion	Y		P3		2.4075	$99.67	$99.67

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
69020	Drain outer ear canal lesion	Y		P2		1.4630	$60.57	$60.57
69100	Biopsy of external ear	Y		P3		1.4676	$60.76	$60.76
69105	Biopsy of external ear canal	Y		P3		2.0283	$83.97	$83.97
69110	Remove external ear, partial	Y		A2	$333.00	16.5832	$686.54	$421.39
69120	Removal of external ear	Y		A2	$446.00	24.3535	$1,008.23	$586.56
69140	Remove ear canal lesion(s)	Y		A2	$446.00	24.3535	$1,008.23	$586.56
69145	Remove ear canal lesion(s)	Y		A2	$446.00	16.5832	$686.54	$506.14
69150	Extensive ear canal surgery	Y		A2	$464.15	7.6539	$316.87	$427.33
69200	Clear outer ear canal	N		P2		0.6416	$26.56	$26.56
69205	Clear outer ear canal	Y		A2	$333.00	21.4534	$888.17	$471.79
69210	Remove impacted ear wax	N		P3		0.4947	$20.48	$20.48
69220	Clean out mastoid cavity	Y		P2		0.8046	$33.31	$33.31
69222	Clean out mastoid cavity	Y		P3		3.1826	$131.76	$131.76
69300	Revise external ear	Y		A2	$510.00	24.3535	$1,008.23	$634.56
69310	Rebuild outer ear canal	Y		A2	$510.00	40.5598	$1,679.18	$802.30
69320	Rebuild outer ear canal	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69400	Inflate middle ear canal	Y		P3		2.0200	$83.63	$83.63
69401	Inflate middle ear canal	Y		P3		1.1295	$46.76	$46.76
69405	Catheterize middle ear canal	Y		P3		2.9188	$120.84	$120.84
69420	Incision of eardrum	Y		P2		2.5765	$106.67	$106.67
69421	Incision of eardrum	Y		A2	$510.00	16.6341	$688.65	$554.66
69424	Remove ventilating tube	Y		P3		1.8386	$76.12	$76.12
69433	Create eardrum opening	Y		P3		2.6056	$107.87	$107.87
69436	Create eardrum opening	Y		A2	$510.00	16.6341	$688.65	$554.66
69440	Exploration of middle ear	Y		A2	$510.00	24.3535	$1,008.23	$634.56
69450	Eardrum revision	Y		A2	$333.00	40.5598	$1,679.18	$669.55
69501	Mastoidectomy	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69502	Mastoidectomy	Y		A2	$995.00	24.3535	$1,008.23	$998.31
69505	Remove mastoid structures	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69511	Extensive mastoid surgery	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69530	Extensive mastoid surgery	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69540	Remove ear lesion	Y		P3		3.1085	$128.69	$128.69
69550	Remove ear lesion	Y		A2	$717.00	40.5598	$1,679.18	$957.55
69552	Remove ear lesion	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69601	Mastoid surgery revision	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69602	Mastoid surgery revision	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69603	Mastoid surgery revision	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69604	Mastoid surgery revision	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69605	Mastoid surgery revision	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69610	Repair of eardrum	Y		P3		4.2546	$176.14	$176.14
69620	Repair of eardrum	Y		A2	$446.00	24.3535	$1,008.23	$586.56
69631	Repair eardrum structures	Y		A2	$717.00	40.5598	$1,679.18	$957.55
69632	Rebuild eardrum structures	Y		A2	$717.00	40.5598	$1,679.18	$957.55
69633	Rebuild eardrum structures	Y		A2	$717.00	40.5598	$1,679.18	$957.55
69635	Repair eardrum structures	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69636	Rebuild eardrum structures	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69637	Rebuild eardrum structures	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69641	Revise middle ear & mastoid	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69642	Revise middle ear & mastoid	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69643	Revise middle ear & mastoid	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69644	Revise middle ear & mastoid	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69645	Revise middle ear & mastoid	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69646	Revise middle ear & mastoid	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69650	Release middle ear bone	Y		A2	$995.00	24.3535	$1,008.23	$998.31
69660	Revise middle ear bone	Y		A2	$717.00	40.5598	$1,679.18	$957.55
69661	Revise middle ear bone	Y		A2	$717.00	40.5598	$1,679.18	$957.55
69662	Revise middle ear bone	Y		A2	$717.00	40.5598	$1,679.18	$957.55
69666	Repair middle ear structures	Y		A2	$630.00	40.5598	$1,679.18	$892.30
69667	Repair middle ear structures	Y		A2	$630.00	40.5598	$1,679.18	$892.30
69670	Remove mastoid air cells	Y		A2	$510.00	40.5598	$1,679.18	$802.30
69676	Remove middle ear nerve	Y		A2	$510.00	40.5598	$1,679.18	$802.30
69700	Close mastoid fistula	Y		A2	$510.00	40.5598	$1,679.18	$802.30
69711	Remove/repair hearing aid	Y		A2	$333.00	40.5598	$1,679.18	$669.55
69714	Implant temple bone w/stimul	Y		A2	$1,339.00	40.5598	$1,679.18	$1,424.05
69715	Temple bne implnt w/stimulat	Y		A2	$1,339.00	40.5598	$1,679.18	$1,424.05
69717	Temple bone implant revision	Y		A2	$1,339.00	40.5598	$1,679.18	$1,424.05
69718	Revise temple bone implant	Y		A2	$1,339.00	40.5598	$1,679.18	$1,424.05
69720	Release facial nerve	Y		A2	$717.00	40.5598	$1,679.18	$957.55
69740	Repair facial nerve	Y		A2	$717.00	40.5598	$1,679.18	$957.55
69745	Repair facial nerve	Y		A2	$717.00	40.5598	$1,679.18	$957.55
69801	Incise inner ear	Y		A2	$717.00	40.5598	$1,679.18	$957.55
69802	Incise inner ear	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69805	Explore inner ear	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69806	Explore inner ear	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69820	Establish inner ear window	Y		A2	$717.00	40.5598	$1,679.18	$957.55
69840	Revise inner ear window	Y		A2	$717.00	40.5598	$1,679.18	$957.55

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS Code	Short Descriptor	Subject to multiple procedure discounting	Comment indicator	Payment indicator	CY 2007 ASC payment rate	Proposed fully implemented payment weight	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment
69905	Remove inner ear	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69910	Remove inner ear & mastoid	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69915	Incise inner ear nerve	Y		A2	$995.00	40.5598	$1,679.18	$1,166.05
69930	Implant cochlear device	Y		H8	$995.00	585.1167	$24,223.83	$22,839.55
69990	Microsurgery add-on	N		N1				
C9716	Radiofrequency energy to anu	Y		G2		30.5544	$1,264.95	$1,264.95
C9724	EPS gast cardia plic	Y		G2		24.6480	$1,020.43	$1,020.43
C9725	Place endorectal app	N		G2		8.6353	$357.50	$357.50
C9726	Rxt breast appl place/remov	N		G2		10.2053	$422.50	$422.50
C9727	Insert palate implants	N		G2		13.3454	$552.50	$552.50
G0104	CA screen;flexi sigmoidscope	N		P3		1.9705	$81.58	$81.58
G0105	Colorectal scrn; hi risk ind	Y		A2	$446.00	8.0134	$331.75	$417.44
G0121	Colon ca scrn not hi rsk ind	Y		A2	$446.00	8.0134	$331.75	$417.44
G0127	Trim nail(s)	Y		P3		0.2556	$10.58	$10.58
G0186	Dstry eye lesn,fdr vssl tech	Y		R2		4.0100	$166.01	$166.01
G0247	Routine footcare pt w lops	Y		P3		0.4865	$20.14	$20.14
G0260	Inj for sacroiliac jt anesth	Y		A2	$333.00	7.1370	$295.47	$323.62
G0268	Removal of impacted wax md	N	CH	N1				
G0364	Bone marrow aspirate &biopsy	Y		P3		0.1237	$5.12	$5.12
G0392	AV fistula or graft arterial	Y		A2	$1,339.00	46.0685	$1,907.24	$1,481.06
G0393	AV fistula or graft venous	Y		A2	$1,339.00	46.0685	$1,907.24	$1,481.06

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
00100	Anesth, salivary gland		N					
00102	Anesth, repair of cleft lip		N					
00103	Anesth, blepharoplasty		N					
00104	Anesth, electroshock		N					
00120	Anesth, ear surgery		N					
00124	Anesth, ear exam		N					
00126	Anesth, tympanotomy		N					
0012F	Cap bacterial assess		M					
00140	Anesth, procedures on eye		N					
00142	Anesth, lens surgery		N					
00144	Anesth, corneal transplant		N					
00145	Anesth, vitreoretinal surg		N					
00147	Anesth, iridectomy		N					
00148	Anesth, eye exam		N					
00160	Anesth, nose/sinus surgery		N					
00162	Anesth, nose/sinus surgery		N					
00164	Anesth, biopsy of nose		N					
0016T	Thermotx choroid vasc lesion		T	0235	4.01	$255.41	$58.90	$51.08
00170	Anesth, procedure on mouth		N					
00172	Anesth, cleft palate repair		N					
00174	Anesth, pharyngeal surgery		N					
00176	Anesth, pharyngeal surgery		C					
0017T	Photocoagulat macular drusen		T	0235	4.01	$255.41	$58.90	$51.08
00190	Anesth, face/skull bone surg		N					
00192	Anesth, facial bone surgery		C					
0019T	Extracorp shock wv tx,ms nos		A					
00210	Anesth, open head surgery		N					
00212	Anesth, skull drainage		N					
00214	Anesth, skull drainage		C					
00215	Anesth, skull repair/fract		C					
00216	Anesth, head vessel surgery		N					
00218	Anesth, special head surgery		N					
00220	Anesth, intrcrn nerve		N					
00222	Anesth, head nerve surgery		N					
0024T	Transcath cardiac reduction		C					
0026T	Measure remnant lipoproteins		A					
0027T	Endoscopic epidural lysis		T	0220	18.5069	$1,178.76		$235.75
0028T	Dexa body composition study		N					
0029T	Magnetic tx for incontinence		A					
00300	Anesth, head/neck/ptrunk		N					
0030T	Antiprothrombin antibody		A					
0031T	Speculoscopy		N					
00320	Anesth, neck organ, 1 & over		N					
00322	Anesth, biopsy of thyroid		N					
00326	Anesth, larynx/trach, < 1 yr		N					
0032T	Speculoscopy w/direct sample		N					
00350	Anesth, neck vessel surgery		N					
00352	Anesth, neck vessel surgery		N					
00400	Anesth, skin, ext/per/atrunk		N					
00402	Anesth, surgery of breast		N					
00404	Anesth, surgery of breast		N					
00406	Anesth, surgery of breast		N					
00410	Anesth, correct heart rhythm		N					
0041T	Detect ur infect agnt w/cpas		A					
0042T	Ct perfusion w/contrast, cbf		N					
0043T	Co expired gas analysis		A					
00450	Anesth, surgery of shoulder		N					
00452	Anesth, surgery of shoulder		C					
00454	Anesth, collar bone biopsy		N					
0046T	Cath lavage, mammary duct(s)		T	0021	16.5832	$1,056.23	$219.40	$211.25
00470	Anesth, removal of rib		N					
00472	Anesth, chest wall repair		N					
00474	Anesth, surgery of rib(s)		C					
0047T	Cath lavage, mammary duct(s)		T	0021	16.5832	$1,056.23	$219.40	$211.25
0048T	Implant ventricular device		C					
0049T	External circulation assist		C					
00500	Anesth, esophageal surgery		N					
0050T	Removal circulation assist		C					
0051T	Implant total heart system		C					
00520	Anesth, chest procedure		N					
00522	Anesth, chest lining biopsy		N					
00524	Anesth, chest drainage		C					
00528	Anesth, chest partition view		N					
00529	Anesth, chest partition view		N					
0052T	Replace component heart syst		C					
00530	Anesth, pacemaker insertion		N					
00532	Anesth, vascular access		N					
00534	Anesth, cardioverter/defib		N					
00537	Anesth, cardiac electrophys		N					
00539	Anesth, trach-bronch reconst		N					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0053T	Replace component heart syst		C					
00540	Anesth, chest surgery		C					
00541	Anesth, one lung ventilation		N					
00542	Anesth, release of lung		C					
00546	Anesth, lung,chest wall surg		C					
00548	Anesth, trachea,bronchi surg		N					
0054T	Bone surgery using computer	CH	N					
00550	Anesth, sternal debridement		N					
0055T	Bone surgery using computer	CH	N					
00560	Anesth, heart surg w/o pump		C					
00561	Anesth, heart surg < age 1		C					
00562	Anesth, heart surg w/pump		C					
00563	Anesth, heart surg w/arrest		N					
00566	Anesth, cabg w/o pump		N					
0056T	Bone surgery using computer	CH	N					
00580	Anesth, heart/lung transplnt		C					
0058T	Cryopreservation, ovary tiss	CH	X	0344	0.8586	$54.69	$15.60	$10.94
0059T	Cryopreservation, oocyte	CH	X	0344	0.8586	$54.69	$15.60	$10.94
00600	Anesth, spine, cord surgery		N					
00604	Anesth, sitting procedure		C					
0060T	Electrical impedance scan		B					
0061T	Destruction of tumor, breast		B					
00620	Anesth, spine, cord surgery		N					
00622	Anesth, removal of nerves		C					
00625	Anes spine tranthor w/o vent		N					
00626	Anes, spine transthor w/vent		N					
0062T	Rep intradisc annulus;1 lev		T	0050	29.3263	$1,867.88		$373.58
00630	Anesth, spine, cord surgery		N					
00632	Anesth, removal of nerves		C					
00634	Anesth for chemonucleolysis		N					
00635	Anesth, lumbar puncture		N					
0063T	Rep intradisc annulus;>1lev		T	0050	29.3263	$1,867.88		$373.58
00640	Anesth, spine manipulation		N					
0064T	Spectroscop eval expired gas		X	0367	0.5955	$37.93	$14.38	$7.59
0065T	Ocular photoscreen bilat		E					
0066T	Ct colonography;screen		E					
00670	Anesth, spine, cord surgery		C					
0067T	Ct colonography;dx	CH	S	0332	3.1487	$200.55	$75.20	$40.11
0068T	Interp/rept heart sound		B					
0069T	Analysis only heart sound		N					
00700	Anesth, abdominal wall surg		N					
00702	Anesth, for liver biopsy		N					
0070T	Interp only heart sound		B					
0071T	U/s leiomyomata ablate <200	CH	S	0067	61.5205	$3,918.43		$783.69
0072T	U/s leiomyomata ablate >200	CH	S	0067	61.5205	$3,918.43		$783.69
00730	Anesth, abdominal wall surg		N					
0073T	Delivery, comp imrt		S	0412	5.7275	$364.80		$72.96
00740	Anesth, upper gi visualize		N					
0074T	Online physician e/m		E					
00750	Anesth, repair of hernia		N					
00752	Anesth, repair of hernia		N					
00754	Anesth, repair of hernia		N					
00756	Anesth, repair of hernia		N					
0075T	Perq stent/chest vert art		C					
0076T	S&i stent/chest vert art		C					
00770	Anesth, blood vessel repair		N					
0077T	Cereb therm perfusion probe		C					
0078T	Endovasc aort repr w/device		C					
00790	Anesth, surg upper abdomen		N					
00792	Anesth, hemorr/excise liver		C					
00794	Anesth, pancreas removal		C					
00796	Anesth, for liver transplant		C					
00797	Anesth, surgery for obesity		N					
0079T	Endovasc visc extnsn repr		C					
00800	Anesth, abdominal wall surg		N					
00802	Anesth, fat layer removal		C					
0080T	Endovasc aort repr rad s&i		C					
00810	Anesth, low intestine scope		N					
0081T	Endovasc visc extnsn s&i		C					
00820	Anesth, abdominal wall surg		N					
00830	Anesth, repair of hernia		N					
00832	Anesth, repair of hernia		N					
00834	Anesth, hernia repair< 1 yr		N					
00836	Anesth hernia repair preemie		N					
00840	Anesth, surg lower abdomen		N					
00842	Anesth, amniocentesis		N					
00844	Anesth, pelvis surgery		C					
00846	Anesth, hysterectomy		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
00848	Anesth, pelvic organ surg		C					
0084T	Temp prostate urethral stent		T	0164	2.1659	$137.95		$27.59
00851	Anesth, tubal ligation		N					
0085T	Breath test heart reject		X	0340	0.6416	$40.87		$8.17
00860	Anesth, surgery of abdomen		N					
00862	Anesth, kidney/ureter surg		N					
00864	Anesth, removal of bladder		C					
00865	Anesth, removal of prostate		C					
00866	Anesth, removal of adrenal		C					
00868	Anesth, kidney transplant		C					
0086T	L ventricle fill pressure		N					
00870	Anesth, bladder stone surg		N					
00872	Anesth kidney stone destruct		N					
00873	Anesth kidney stone destruct		N					
0087T	Sperm eval hyaluronan	CH	X	0344	0.8586	$54.69	$15.60	$10.94
00880	Anesth, abdomen vessel surg		N					
00882	Anesth, major vein ligation		C					
0088T	Rf tongue base vol reduxn		T	0253	16.6341	$1,059.48	$282.20	$211.90
0089T	Actigraphy testing, 3-day		S	0218	1.1861	$75.55		$15.11
00902	Anesth, anorectal surgery		N					
00904	Anesth, perineal surgery		C					
00906	Anesth, removal of vulva		N					
00908	Anesth, removal of prostate		C					
0090T	Cervical artific disc		C					
00910	Anesth, bladder surgery		N					
00912	Anesth, bladder tumor surg		N					
00914	Anesth, removal of prostate		N					
00916	Anesth, bleeding control		N					
00918	Anesth, stone removal		N					
00920	Anesth, genitalia surgery		N					
00921	Anesth, vasectomy		N					
00922	Anesth, sperm duct surgery		N					
00924	Anesth, testis exploration		N					
00926	Anesth, removal of testis		N					
00928	Anesth, removal of testis		N					
0092T	Artific disc addl		C					
00930	Anesth, testis suspension		N					
00932	Anesth, amputation of penis		C					
00934	Anesth, penis, nodes removal		C					
00936	Anesth, penis, nodes removal		C					
00938	Anesth, insert penis device		N					
0093T	Cervical artific diskectomy		C					
00940	Anesth, vaginal procedures		N					
00942	Anesth, surg on vag/urethral		N					
00944	Anesth, vaginal hysterectomy		C					
00948	Anesth, repair of cervix		N					
00950	Anesth, vaginal endoscopy		N					
00952	Anesth, hysteroscope/graph		N					
0095T	Artific diskectomy addl		C					
0096T	Rev cervical artific disc		C					
0098T	Rev artific disc addl		C					
0099T	Implant corneal ring		T	0233	16.5252	$1,052.54	$266.30	$210.51
0100T	Prosth retina receive&gen		T	0672	38.1121	$2,427.47		$485.49
0101T	Extracorp shockwv tx,hi enrg		T	0050	29.3263	$1,867.88		$373.58
0102T	Extracorp shockwv tx,anesth		T	0050	29.3263	$1,867.88		$373.58
0103T	Holotranscobalamin		A					
0104T	At rest cardio gas rebreathe		A					
0105T	Exerc cardio gas rebreathe		A					
0106T	Touch quant sensory test		X	0341	0.0879	$5.60	$2.20	$1.12
0107T	Vibrate quant sensory test		X	0341	0.0879	$5.60	$2.20	$1.12
0108T	Cool quant sensory test		X	0341	0.0879	$5.60	$2.20	$1.12
0109T	Heat quant sensory test		X	0341	0.0879	$5.60	$2.20	$1.12
0110T	Nos quant sensory test		X	0341	0.0879	$5.60	$2.20	$1.12
01112	Anesth, bone aspirate/bx		N					
0111T	Rbc membranes fatty acids		A					
01120	Anesth, pelvis surgery		N					
01130	Anesth, body cast procedure		N					
01140	Anesth, amputation at pelvis		C					
01150	Anesth, pelvic tumor surgery		C					
0115T	Med tx mngmt 15 min		B					
01160	Anesth, pelvis procedure		N					
0116T	Med tx mngmt subsqt		B					
01170	Anesth, pelvis surgery		N					
01173	Anesth, fx repair, pelvis		N					
0117T	Med tx mngmt addl 15 min		B					
01180	Anesth, pelvis nerve removal		N					
01190	Anesth, pelvis nerve removal		N					
01200	Anesth, hip joint procedure		N					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
01202	Anesth, arthroscopy of hip		N					
01210	Anesth, hip joint surgery		N					
01212	Anesth, hip disarticulation		C					
01214	Anesth, hip arthroplasty		C					
01215	Anesth, revise hip repair		N					
01220	Anesth, procedure on femur		N					
01230	Anesth, surgery of femur		N					
01232	Anesth, amputation of femur		C					
01234	Anesth, radical femur surg		C					
0123T	Scleral fistulization		T	0234	24.0821	$1,533.86	$511.30	$306.77
0124T	Conjunctival drug placement		T	0232	5.1145	$325.76	$81.59	$65.15
01250	Anesth, upper leg surgery		N					
01260	Anesth, upper leg veins surg		N					
0126T	Chd risk imt study	CH	Q	0340	0.6416	$40.87		$8.17
01270	Anesth, thigh arteries surg		N					
01272	Anesth, femoral artery surg		C					
01274	Anesth, femoral embolectomy		C					
0130T	Chron care drug investigatn		B					
01320	Anesth, knee area surgery		N					
0133T	Esophageal implant injexn		T	0422	24.648	$1,569.91	$445.06	$313.98
01340	Anesth, knee area procedure		N					
0135T	Perq cryoablate renal tumor		T	0423	44.1192	$2,810.08		$562.02
01360	Anesth, knee area surgery		N					
0137T	Prostate saturation sampling		T	0184	11.3168	$720.80		$144.16
01380	Anesth, knee joint procedure		N					
01382	Anesth, dx knee arthroscopy		N					
01390	Anesth, knee area procedure		N					
01392	Anesth, knee area surgery		N					
01400	Anesth, knee joint surgery		N					
01402	Anesth, knee arthroplasty		C					
01404	Anesth, amputation at knee		C					
0140T	Exhaled breath condensate ph		A					
0141T	Perq islet transplant		E					
01420	Anesth, knee joint casting		N					
0142T	Open islet transplant		E					
01430	Anesth, knee veins surgery		N					
01432	Anesth, knee vessel surg		N					
0143T	Laparoscopic islet transplnt		E					
01440	Anesth, knee arteries surg		N					
01442	Anesth, knee artery surg		C					
01444	Anesth, knee artery repair		C					
0144T	CT heart wo dye; qual calc	CH	S	0282	1.6768	$106.80	$37.80	$21.36
0145T	CT heart w/wo dye funct	CH	S	0383	4.9887	$317.75	$124.17	$63.55
01462	Anesth, lower leg procedure		N					
01464	Anesth, ankle/ft arthroscopy		N					
0146T	CCTA w/wo dye	CH	S	0383	4.9887	$317.75	$124.17	$63.55
01470	Anesth, lower leg surgery		N					
01472	Anesth, achilles tendon surg		N					
01474	Anesth, lower leg surgery		N					
0147T	CCTA w/wo, quan calcium	CH	S	0383	4.9887	$317.75	$124.17	$63.55
01480	Anesth, lower leg bone surg		N					
01482	Anesth, radical leg surgery		N					
01484	Anesth, lower leg revision		N					
01486	Anesth, ankle replacement		C					
0148T	CCTA w/wo, strxr	CH	S	0383	4.9887	$317.75	$124.17	$63.55
01490	Anesth, lower leg casting		N					
0149T	CCTA w/wo, strxr quan calc	CH	S	0383	4.9887	$317.75	$124.17	$63.55
01500	Anesth, leg arteries surg		N					
01502	Anesth, lwr leg embolectomy		C					
0150T	CCTA w/wo, disease strxr	CH	S	0383	4.9887	$317.75	$124.17	$63.55
0151T	CT heart funct add-on		S	0282	1.6768	$106.80	$37.80	$21.36
01520	Anesth, lower leg vein surg		N					
01522	Anesth, lower leg vein surg		N					
0153T	Tcath sensor aneurysm sac		C					
0154T	Study sensor aneurysm sac		X	0097	1.0396	$66.22	$23.70	$13.24
0155T	Lap impl gast curve electrd		T	0130	34.8153	$2,217.49	$659.50	$443.50
0156T	Lap remv gast curve electrd		T	0130	34.8153	$2,217.49	$659.50	$443.50
0157T	Open impl gast curve electrd		C					
0158T	Open remv gast curve electrd		C					
0159T	Cad breast mri		N					
0160T	Tcranial magn stim tx plan		S	0216	2.768	$176.30		$35.26
01610	Anesth, surgery of shoulder		N					
0161T	Tcranial magn stim tx deliv		S	0216	2.768	$176.30		$35.26
01620	Anesth, shoulder procedure		N					
01622	Anes dx shoulder arthroscopy		N					
0162T	Anal program gast neurostim		S	0692	1.9206	$122.33	$30.10	$24.47
01630	Anesth, surgery of shoulder		N					
01632	Anesth, surgery of shoulder		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
01634	Anesth, shoulder joint amput		C					
01636	Anesth, forequarter amput		C					
01638	Anesth, shoulder replacement		C					
0163T	Lumb artif diskectomy addl		C					
0164T	Remove lumb artif disc addl		C					
01650	Anesth, shoulder artery surg		N					
01652	Anesth, shoulder vessel surg		C					
01654	Anesth, shoulder vessel surg		C					
01656	Anesth, arm-leg vessel surg		C					
0165T	Revise lumb artif disc addl		C					
0166T	Tcath vsd close w/o bypass		C					
01670	Anesth, shoulder vein surg		N					
0167T	Tcath vsd close w bypass		C					
01680	Anesth, shoulder casting		N					
01682	Anesth, airplane cast		N					
0168T	Rhinophototx light app bilat		T	0251	2.5765	$164.11		$32.82
0169T	Place stereo cath brain		C					
0170T	Anorectal fistula plug rpr		T	0150	30.5544	$1,946.10	$437.10	$389.22
01710	Anesth, elbow area surgery		N					
01712	Anesth, uppr arm tendon surg		N					
01714	Anesth, uppr arm tendon surg		N					
01716	Anesth, biceps tendon repair		N					
0171T	Lumbar spine proces distract		T	0050	29.3263	$1,867.88		$373.58
0172T	Lumbar spine proces addl		T	0050	29.3263	$1,867.88		$373.58
01730	Anesth, uppr arm procedure		N					
01732	Anesth, dx elbow arthroscopy		N					
0173T	Iop monit io pressure		N					
01740	Anesth, upper arm surgery		N					
01742	Anesth, humerus surgery		N					
01744	Anesth, humerus repair		N					
0174T	Cad cxr with interp		N					
01756	Anesth, radical humerus surg		C					
01758	Anesth, humeral lesion surg		N					
0175T	Cad cxr remote		N					
01760	Anesth, elbow replacement		N					
0176T	Aqu canal dilat w/o retent		T	0673	40.8481	$2,601.74	$649.50	$520.35
01770	Anesth, uppr arm artery surg		N					
01772	Anesth, uppr arm embolectomy		N					
0177T	Aqu canal dilat w retent		T	0673	40.8481	$2,601.74	$649.50	$520.35
01780	Anesth, upper arm vein surg		N					
01782	Anesth, uppr arm vein repair		N					
01810	Anesth, lower arm surgery		N					
01820	Anesth, lower arm procedure		N					
01829	Anesth, dx wrist arthroscopy		N					
01830	Anesth, lower arm surgery		N					
01832	Anesth, wrist replacement		N					
01840	Anesth, lwr arm artery surg		N					
01842	Anesth, lwr arm embolectomy		N					
01844	Anesth, vascular shunt surg		N					
01850	Anesth, lower arm vein surg		N					
01852	Anesth, lwr arm vein repair		N					
01860	Anesth, lower arm casting		N					
01905	Anes, spine inject, x-ray/re		N					
01916	Anesth, dx arteriography		N					
01920	Anesth, catheterize heart		N					
01922	Anesth, cat or MRI scan		N					
01924	Anes, ther interven rad, art		N					
01925	Anes, ther interven rad, car		N					
01926	Anes, tx interv rad hrt/cran		N					
01930	Anes, ther interven rad, vei		N					
01931	Anes, ther interven rad, tip		N					
01932	Anes, tx interv rad, th vein		N					
01933	Anes, tx interv rad, cran v		N					
01951	Anesth, burn, less 4 percent		N					
01952	Anesth, burn, 4-9 percent		N					
01953	Anesth, burn, each 9 percent		N					
01958	Anesth, antepartum manipul		N					
01960	Anesth, vaginal delivery		N					
01961	Anesth, cs delivery		N					
01962	Anesth, emer hysterectomy		N					
01963	Anesth, cs hysterectomy		N					
01965	Anesth, inc/missed ab proc		N					
01966	Anesth, induced ab procedure		N					
01967	Anesth/analg, vag delivery		N					
01968	Anes/analg cs deliver add-on		N					
01969	Anesth/analg cs hyst add-on		N					
01990	Support for organ donor		C					
01991	Anesth, nerve block/inj		N					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
01992	Anesth, n block/inj, prone		N					
01996	Hosp manage cont drug admin		N					
01999	Unlisted anesth procedure		N					
0500F	Initial prenatal care visit		M					
0501F	Prenatal flow sheet		M					
0502F	Subsequent prenatal care		M					
0503F	Postpartum care visit		M					
0505F	Hemodialysis plan doc'd		M					
0507F	Periton dialysis plan doc'd		M					
0509F	Urine incon plan doc		M					
1000F	Tobacco use assessed		M					
10021	Fna w/o image		T	0002	1.1915	$75.89		$15.18
10022	Fna w/image	CH	T	0004	4.5062	$287.01		$57.40
1002F	Assess anginal symptom/level		M					
1003F	Level of activity assess		M					
10040	Acne surgery	CH	T	0013	0.8046	$51.25		$10.25
1004F	Clin symp vol ovrld assess		M					
1005F	Asthma symptoms evaluate		M					
10060	Drainage of skin abscess		T	0006	1.463	$93.18		$18.64
10061	Drainage of skin abscess		T	0006	1.463	$93.18		$18.64
1006F	Osteoarthritis assess		M					
1007F	Anti-inflm/anlgsc otc assess		M					
10080	Drainage of pilonidal cyst		T	0006	1.463	$93.18		$18.64
10081	Drainage of pilonidal cyst		T	0007	12.5792	$801.21		$160.24
1008F	Gi/renal risk assess		M					
10120	Remove foreign body		T	0006	1.463	$93.18		$18.64
10121	Remove foreign body		T	0021	16.5832	$1,056.23	$219.40	$211.25
10140	Drainage of hematoma/fluid		T	0007	12.5792	$801.21		$160.24
1015F	Copd symptoms assess		M					
10160	Puncture drainage of lesion	CH	T	0006	1.463	$93.18		$18.64
10180	Complex drainage, wound		T	0008	19.0457	$1,213.08		$242.62
1018F	Assess dyspnea not present		M					
1019F	Assess dyspnea present		M					
1022F	Pneumo imm status assess		M					
1026F	Co-morbid condition assess		M					
1030F	Influenza imm status assess		M					
1034F	Current tobacco smoker		M					
1035F	Smokeless tobacco user		M					
1036F	Tobacco non-user		M					
1038F	Persistent asthma		M					
1039F	Intermittent asthma		M					
1040F	Dsm-iv info mdd doc'd		M					
1050F	History of mole changes		M					
1055F	Visual funct status assess		M					
1060F	Doc perm/cont/parox atr. fib		M					
1061F	Doc lack perm+cont+parox fib		M					
1065F	Ischm stroke symp <3 hrs b/4		M					
1066F	Ischm stroke symp ?3 hrs b/4		M					
1070F	Alarm symp assessed-absent		M					
1071F	Alarm symp assessed-1+ prsnt		M					
1080F	Decis mkr/advncd plan doc'd		M					
1090F	Pres/absn urine incon assess		M					
1091F	Urine incon characterized		M					
11000	Debride infected skin		T	0013	0.8046	$51.25		$10.25
11001	Debride infected skin add-on	CH	T	0013	0.8046	$51.25		$10.25
11004	Debride genitalia & perineum		C					
11005	Debride abdom wall		C					
11006	Debride genit/per/abdom wall		C					
11008	Remove mesh from abd wall		C					
1100F	Pt falls assess-doc'd?2+/yr		M					
11010	Debride skin, fx		T	0019	4.4463	$283.20	$71.80	$56.64
11011	Debride skin/muscle, fx		T	0019	4.4463	$283.20	$71.80	$56.64
11012	Debride skin/muscle/bone, fx		T	0019	4.4463	$283.20	$71.80	$56.64
1101F	Pt falls assessed-doc'd?1/yr		M					
11040	Debride skin, partial		T	0015	1.5119	$96.30		$19.26
11041	Debride skin, full		T	0015	1.5119	$96.30		$19.26
11042	Debride skin/tissue		T	0016	2.7493	$175.11		$35.02
11043	Debride tissue/muscle		T	0016	2.7493	$175.11		$35.02
11044	Debride tissue/muscle/bone		T	0682	7.1126	$453.02	$158.60	$90.60
11055	Trim skin lesion	CH	T	0013	0.8046	$51.25		$10.25
11056	Trim skin lesions, 2 to 4	CH	T	0013	0.8046	$51.25		$10.25
11057	Trim skin lesions, over 4	CH	T	0015	1.5119	$96.30		$19.26
11100	Biopsy, skin lesion	CH	T	0013	0.8046	$51.25		$10.25
11101	Biopsy, skin add-on	CH	T	0013	0.8046	$51.25		$10.25
1110F	Pt lft inpt fac w/in 60 days		M					
1111F	Dschrg med/current med merge		M					
11200	Removal of skin tags		T	0013	0.8046	$51.25		$10.25
11201	Remove skin tags add-on		T	0015	1.5119	$96.30		$19.26

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
11300	Shave skin lesion	CH	T	0013	0.8046	$51.25		$10.25
11301	Shave skin lesion	CH	T	0013	0.8046	$51.25		$10.25
11302	Shave skin lesion		T	0013	0.8046	$51.25		$10.25
11303	Shave skin lesion		T	0015	1.5119	$96.30		$19.26
11305	Shave skin lesion		T	0013	0.8046	$51.25		$10.25
11306	Shave skin lesion		T	0013	0.8046	$51.25		$10.25
11307	Shave skin lesion		T	0013	0.8046	$51.25		$10.25
11308	Shave skin lesion		T	0013	0.8046	$51.25		$10.25
11310	Shave skin lesion		T	0013	0.8046	$51.25		$10.25
11311	Shave skin lesion		T	0013	0.8046	$51.25		$10.25
11312	Shave skin lesion		T	0013	0.8046	$51.25		$10.25
11313	Shave skin lesion	CH	T	0013	0.8046	$51.25		$10.25
11400	Exc tr-ext b9+marg 0.5 < cm		T	0019	4.4463	$283.20	$71.80	$56.64
11401	Exc tr-ext b9+marg 0.6-1 cm		T	0019	4.4463	$283.20	$71.80	$56.64
11402	Exc tr-ext b9+marg 1.1-2 cm		T	0019	4.4463	$283.20	$71.80	$56.64
11403	Exc tr-ext b9+marg 2.1-3 cm		T	0020	8.7155	$555.12		$111.02
11404	Exc tr-ext b9+marg 3.1-4 cm		T	0021	16.5832	$1,056.23	$219.40	$211.25
11406	Exc tr-ext b9+marg > 4.0 cm		T	0021	16.5832	$1,056.23	$219.40	$211.25
11420	Exc h-f-nk-sp b9+marg 0.5 <		T	0020	8.7155	$555.12		$111.02
11421	Exc h-f-nk-sp b9+marg 0.6-1		T	0020	8.7155	$555.12		$111.02
11422	Exc h-f-nk-sp b9+marg 1.1-2		T	0020	8.7155	$555.12		$111.02
11423	Exc h-f-nk-sp b9+marg 2.1-3		T	0021	16.5832	$1,056.23	$219.40	$211.25
11424	Exc h-f-nk-sp b9+marg 3.1-4		T	0021	16.5832	$1,056.23	$219.40	$211.25
11426	Exc h-f-nk-sp b9+marg > 4 cm		T	0022	21.4534	$1,366.43	$354.40	$273.29
11440	Exc face-mm b9+marg 0.5 < cm		T	0019	4.4463	$283.20	$71.80	$56.64
11441	Exc face-mm b9+marg 0.6-1 cm		T	0019	4.4463	$283.20	$71.80	$56.64
11442	Exc face-mm b9+marg 1.1-2 cm		T	0020	8.7155	$555.12		$111.02
11443	Exc face-mm b9+marg 2.1-3 cm		T	0020	8.7155	$555.12		$111.02
11444	Exc face-mm b9+marg 3.1-4 cm		T	0020	8.7155	$555.12		$111.02
11446	Exc face-mm b9+marg > 4 cm		T	0022	21.4534	$1,366.43	$354.40	$273.29
11450	Removal, sweat gland lesion		T	0022	21.4534	$1,366.43	$354.40	$273.29
11451	Removal, sweat gland lesion		T	0022	21.4534	$1,366.43	$354.40	$273.29
11462	Removal, sweat gland lesion		T	0022	21.4534	$1,366.43	$354.40	$273.29
11463	Removal, sweat gland lesion		T	0022	21.4534	$1,366.43	$354.40	$273.29
11470	Removal, sweat gland lesion		T	0022	21.4534	$1,366.43	$354.40	$273.29
11471	Removal, sweat gland lesion		T	0022	21.4534	$1,366.43	$354.40	$273.29
11600	Exc tr-ext mlg+marg 0.5 < cm		T	0019	4.4463	$283.20	$71.80	$56.64
11601	Exc tr-ext mlg+marg 0.6-1 cm		T	0019	4.4463	$283.20	$71.80	$56.64
11602	Exc tr-ext mlg+marg 1.1-2 cm		T	0019	4.4463	$283.20	$71.80	$56.64
11603	Exc tr-ext mlg+marg 2.1-3 cm		T	0020	8.7155	$555.12		$111.02
11604	Exc tr-ext mlg+marg 3.1-4 cm		T	0020	8.7155	$555.12		$111.02
11606	Exc tr-ext mlg+marg > 4 cm		T	0021	16.5832	$1,056.23	$219.40	$211.25
11620	Exc h-f-nk-sp mlg+marg 0.5 <		T	0020	8.7155	$555.12		$111.02
11621	Exc h-f-nk-sp mlg+marg 0.6-1		T	0019	4.4463	$283.20	$71.80	$56.64
11622	Exc h-f-nk-sp mlg+marg 1.1-2		T	0020	8.7155	$555.12		$111.02
11623	Exc h-f-nk-sp mlg+marg 2.1-3	CH	T	0020	8.7155	$555.12		$111.02
11624	Exc h-f-nk-sp mlg+marg 3.1-4		T	0021	16.5832	$1,056.23	$219.40	$211.25
11626	Exc h-f-nk-sp mlg+mar > 4 cm		T	0022	21.4534	$1,366.43	$354.40	$273.29
11640	Exc face-mm malig+marg 0.5 <	CH	T	0019	4.4463	$283.20	$71.80	$56.64
11641	Exc face-mm malig+marg 0.6-1	CH	T	0019	4.4463	$283.20	$71.80	$56.64
11642	Exc face-mm malig+marg 1.1-2		T	0020	8.7155	$555.12		$111.02
11643	Exc face-mm malig+marg 2.1-3		T	0020	8.7155	$555.12		$111.02
11644	Exc face-mm malig+marg 3.1-4		T	0021	16.5832	$1,056.23	$219.40	$211.25
11646	Exc face-mm mlg+marg > 4 cm		T	0022	21.4534	$1,366.43	$354.40	$273.29
11719	Trim nail(s)	CH	T	0013	0.8046	$51.25		$10.25
11720	Debride nail, 1-5	CH	T	0013	0.8046	$51.25		$10.25
11721	Debride nail, 6 or more	CH	T	0013	0.8046	$51.25		$10.25
11730	Removal of nail plate		T	0013	0.8046	$51.25		$10.25
11732	Remove nail plate, add-on	CH	T	0013	0.8046	$51.25		$10.25
11740	Drain blood from under nail	CH	T	0012	0.2682	$17.08		$3.42
11750	Removal of nail bed		T	0019	4.4463	$283.20	$71.80	$56.64
11752	Remove nail bed/finger tip		T	0022	21.4534	$1,366.43	$354.40	$273.29
11755	Biopsy, nail unit		T	0019	4.4463	$283.20	$71.80	$56.64
11760	Repair of nail bed	CH	T	0134	2.1114	$134.48	$42.36	$26.90
11762	Reconstruction of nail bed	CH	T	0136	15.4399	$983.41		$196.68
11765	Excision of nail fold, toe		T	0015	1.5119	$96.30		$19.26
11770	Removal of pilonidal lesion		T	0022	21.4534	$1,366.43	$354.40	$273.29
11771	Removal of pilonidal lesion		T	0022	21.4534	$1,366.43	$354.40	$273.29
11772	Removal of pilonidal lesion		T	0022	21.4534	$1,366.43	$354.40	$273.29
11900	Injection into skin lesions	CH	T	0013	0.8046	$51.25		$10.25
11901	Added skin lesions injection	CH	T	0013	0.8046	$51.25		$10.25
11920	Correct skin color defects	CH	T	0134	2.1114	$134.48	$42.36	$26.90
11921	Correct skin color defects	CH	T	0134	2.1114	$134.48	$42.36	$26.90
11922	Correct skin color defects	CH	T	0134	2.1114	$134.48	$42.36	$26.90
11950	Therapy for contour defects	CH	T	0133	1.334	$84.97	$26.76	$16.99
11951	Therapy for contour defects	CH	T	0133	1.334	$84.97	$26.76	$16.99
11952	Therapy for contour defects	CH	T	0133	1.334	$84.97	$26.76	$16.99
11954	Therapy for contour defects	CH	T	0133	1.334	$84.97	$26.76	$16.99

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
11960	Insert tissue expander(s)	CH	T	0137	20.9338	$1,333.34		$266.67
11970	Replace tissue expander		T	0051	43.5953	$2,776.72		$555.34
11971	Remove tissue expander(s)		T	0022	21.4534	$1,366.43	$354.40	$273.29
11975	Insert contraceptive cap		E					
11976	Removal of contraceptive cap		T	0019	4.4463	$283.20	$71.80	$56.64
11977	Removal/reinsert contra cap		E					
11980	Implant hormone pellet(s)		X	0340	0.6416	$40.87		$8.17
11981	Insert drug implant device		X	0340	0.6416	$40.87		$8.17
11982	Remove drug implant device		X	0340	0.6416	$40.87		$8.17
11983	Remove/insert drug implant		X	0340	0.6416	$40.87		$8.17
12001	Repair superficial wound(s)	CH	T	0133	1.334	$84.97	$26.76	$16.99
12002	Repair superficial wound(s)	CH	T	0133	1.334	$84.97	$26.76	$16.99
12004	Repair superficial wound(s)	CH	T	0133	1.334	$84.97	$26.76	$16.99
12005	Repair superficial wound(s)	CH	T	0133	1.334	$84.97	$26.76	$16.99
12006	Repair superficial wound(s)	CH	T	0133	1.334	$84.97	$26.76	$16.99
12007	Repair superficial wound(s)	CH	T	0133	1.334	$84.97	$26.76	$16.99
12011	Repair superficial wound(s)	CH	T	0133	1.334	$84.97	$26.76	$16.99
12013	Repair superficial wound(s)	CH	T	0133	1.334	$84.97	$26.76	$16.99
12014	Repair superficial wound(s)	CH	T	0133	1.334	$84.97	$26.76	$16.99
12015	Repair superficial wound(s)	CH	T	0133	1.334	$84.97	$26.76	$16.99
12016	Repair superficial wound(s)	CH	T	0133	1.334	$84.97	$26.76	$16.99
12017	Repair superficial wound(s)	CH	T	0133	1.334	$84.97	$26.76	$16.99
12018	Repair superficial wound(s)	CH	T	0133	1.334	$84.97	$26.76	$16.99
12020	Closure of split wound	CH	T	0135	4.6816	$298.19		$59.64
12021	Closure of split wound	CH	T	0135	4.6816	$298.19		$59.64
12031	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
12032	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
12034	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
12035	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
12036	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
12037	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
12041	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
12042	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
12044	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
12045	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
12046	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
12047	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
12051	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
12052	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
12053	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
12054	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
12055	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
12056	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
12057	Layer closure of wound(s)	CH	T	0134	2.1114	$134.48	$42.36	$26.90
13100	Repair of wound or lesion	CH	T	0135	4.6816	$298.19		$59.64
13101	Repair of wound or lesion	CH	T	0135	4.6816	$298.19		$59.64
13102	Repair wound/lesion add-on	CH	T	0135	4.6816	$298.19		$59.64
13120	Repair of wound or lesion	CH	T	0134	2.1114	$134.48	$42.36	$26.90
13121	Repair of wound or lesion	CH	T	0135	4.6816	$298.19		$59.64
13122	Repair wound/lesion add-on	CH	T	0134	2.1114	$134.48	$42.36	$26.90
13131	Repair of wound or lesion	CH	T	0135	4.6816	$298.19		$59.64
13132	Repair of wound or lesion	CH	T	0135	4.6816	$298.19		$59.64
13133	Repair wound/lesion add-on	CH	T	0135	4.6816	$298.19		$59.64
13150	Repair of wound or lesion	CH	T	0135	4.6816	$298.19		$59.64
13151	Repair of wound or lesion	CH	T	0135	4.6816	$298.19		$59.64
13152	Repair of wound or lesion	CH	T	0135	4.6816	$298.19		$59.64
13153	Repair wound/lesion add-on	CH	T	0134	2.1114	$134.48	$42.36	$26.90
13160	Late closure of wound	CH	T	0137	20.9338	$1,333.34		$266.67
14000	Skin tissue rearrangement	CH	T	0136	15.4399	$983.41		$196.68
14001	Skin tissue rearrangement	CH	T	0136	15.4399	$983.41		$196.68
14020	Skin tissue rearrangement	CH	T	0136	15.4399	$983.41		$196.68
14021	Skin tissue rearrangement	CH	T	0136	15.4399	$983.41		$196.68
14040	Skin tissue rearrangement	CH	T	0136	15.4399	$983.41		$196.68
14041	Skin tissue rearrangement	CH	T	0136	15.4399	$983.41		$196.68
14060	Skin tissue rearrangement	CH	T	0136	15.4399	$983.41		$196.68
14061	Skin tissue rearrangement	CH	T	0136	15.4399	$983.41		$196.68
14300	Skin tissue rearrangement	CH	T	0137	20.9338	$1,333.34		$266.67
14350	Skin tissue rearrangement	CH	T	0137	20.9338	$1,333.34		$266.67
15002	Wnd prep, ch/inf, trk/arm/lg	CH	T	0135	4.6816	$298.19		$59.64
15003	Wnd prep, ch/inf addl 100 cm	CH	T	0135	4.6816	$298.19		$59.64
15004	Wnd prep ch/inf, f/n/hf/g	CH	T	0135	4.6816	$298.19		$59.64
15005	Wnd prep, f/n/hf/g, addl cm	CH	T	0135	4.6816	$298.19		$59.64
15040	Harvest cultured skin graft	CH	T	0134	2.1114	$134.48	$42.36	$26.90
15050	Skin pinch graft	CH	T	0135	4.6816	$298.19		$59.64
15100	Skin splt grft, trnk/arm/leg	CH	T	0137	20.9338	$1,333.34		$266.67
15101	Skin splt grft t/a/l, add-on	CH	T	0137	20.9338	$1,333.34		$266.67
15110	Epidrm autogrft trnk/arm/leg	CH	T	0135	4.6816	$298.19		$59.64
15111	Epidrm autogrft t/a/l add-on	CH	T	0135	4.6816	$298.19		$59.64

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
15115	Epidrm a-grft face/nck/hf/g	CH	T	0135	4.6816	$298.19		$59.64
15116	Epidrm a-grft f/n/hf/g addl	CH	T	0135	4.6816	$298.19		$59.64
15120	Skn splt a-grft fac/nck/hf/g	CH	T	0137	20.9338	$1,333.34		$266.67
15121	Skn splt a-grft f/n/hf/g add	CH	T	0137	20.9338	$1,333.34		$266.67
15130	Derm autograft, trnk/arm/leg	CH	T	0136	15.4399	$983.41		$196.68
15131	Derm autograft t/a/l add-on	CH	T	0136	15.4399	$983.41		$196.68
15135	Derm autograft face/nck/hf/g	CH	T	0136	15.4399	$983.41		$196.68
15136	Derm autograft, f/n/hf/g add	CH	T	0136	15.4399	$983.41		$196.68
15150	Cult epiderm grft t/arm/leg	CH	T	0135	4.6816	$298.19		$59.64
15151	Cult epiderm grft t/a/l addl	CH	T	0135	4.6816	$298.19		$59.64
15152	Cult epiderm graft t/a/l +%	CH	T	0135	4.6816	$298.19		$59.64
15155	Cult epiderm graft, f/n/hf/g	CH	T	0135	4.6816	$298.19		$59.64
15156	Cult epidrm grft f/n/hfg add	CH	T	0135	4.6816	$298.19		$59.64
15157	Cult epiderm grft f/n/hfg +%	CH	T	0135	4.6816	$298.19		$59.64
15170	Acell graft trunk/arms/legs	CH	T	0134	2.1114	$134.48	$42.36	$26.90
15171	Acell graft t/arm/leg add-on	CH	T	0134	2.1114	$134.48	$42.36	$26.90
15175	Acellular graft, f/n/hf/g	CH	T	0135	4.6816	$298.19		$59.64
15176	Acell graft, f/n/hf/g add-on	CH	T	0135	4.6816	$298.19		$59.64
15200	Skin full graft, trunk	CH	T	0136	15.4399	$983.41		$196.68
15201	Skin full graft trunk add-on	CH	T	0136	15.4399	$983.41		$196.68
15220	Skin full graft sclp/arm/leg	CH	T	0136	15.4399	$983.41		$196.68
15221	Skin full graft add-on	CH	T	0135	4.6816	$298.19		$59.64
15240	Skin full grft face/genit/hf	CH	T	0136	15.4399	$983.41		$196.68
15241	Skin full graft add-on	CH	T	0135	4.6816	$298.19		$59.64
15260	Skin full graft een & lips	CH	T	0136	15.4399	$983.41		$196.68
15261	Skin full graft add-on	CH	T	0136	15.4399	$983.41		$196.68
15300	Apply skinallogrft, t/arm/lg	CH	T	0135	4.6816	$298.19		$59.64
15301	Apply sknallogrft t/a/l addl	CH	T	0135	4.6816	$298.19		$59.64
15320	Apply skin allogrft f/n/hf/g	CH	T	0135	4.6816	$298.19		$59.64
15321	Aply sknallogrft f/n/hfg add	CH	T	0135	4.6816	$298.19		$59.64
15330	Aply acell alogrft t/arm/leg	CH	T	0135	4.6816	$298.19		$59.64
15331	Aply acell grft t/a/l add-on	CH	T	0135	4.6816	$298.19		$59.64
15335	Apply acell graft, f/n/hf/g	CH	T	0135	4.6816	$298.19		$59.64
15336	Aply acell grft f/n/hf/g add	CH	T	0135	4.6816	$298.19		$59.64
15340	Apply cult skin substitute	CH	T	0134	2.1114	$134.48	$42.36	$26.90
15341	Apply cult skin sub add-on	CH	T	0134	2.1114	$134.48	$42.36	$26.90
15360	Apply cult derm sub, t/a/l	CH	T	0134	2.1114	$134.48	$42.36	$26.90
15361	Aply cult derm sub t/a/l add	CH	T	0134	2.1114	$134.48	$42.36	$26.90
15365	Apply cult derm sub f/n/hf/g	CH	T	0134	2.1114	$134.48	$42.36	$26.90
15366	Apply cult derm f/hf/g add	CH	T	0134	2.1114	$134.48	$42.36	$26.90
15400	Apply skin xenograft, t/a/l	CH	T	0135	4.6816	$298.19		$59.64
15401	Apply skn xenogrft t/a/l add	CH	T	0135	4.6816	$298.19		$59.64
15420	Apply skin xgraft, f/n/hf/g	CH	T	0135	4.6816	$298.19		$59.64
15421	Apply skn xgrft f/n/hf/g add	CH	T	0135	4.6816	$298.19		$59.64
15430	Apply acellular xenograft	CH	T	0135	4.6816	$298.19		$59.64
15431	Apply acellular xgraft add	CH	T	0135	4.6816	$298.19		$59.64
15570	Form skin pedicle flap	CH	T	0137	20.9338	$1,333.34		$266.67
15572	Form skin pedicle flap	CH	T	0137	20.9338	$1,333.34		$266.67
15574	Form skin pedicle flap	CH	T	0137	20.9338	$1,333.34		$266.67
15576	Form skin pedicle flap	CH	T	0137	20.9338	$1,333.34		$266.67
15600	Skin graft	CH	T	0137	20.9338	$1,333.34		$266.67
15610	Skin graft	CH	T	0137	20.9338	$1,333.34		$266.67
15620	Skin graft	CH	T	0137	20.9338	$1,333.34		$266.67
15630	Skin graft	CH	T	0137	20.9338	$1,333.34		$266.67
15650	Transfer skin pedicle flap	CH	T	0137	20.9338	$1,333.34		$266.67
15731	Forehead flap w/vasc pedicle	CH	T	0137	20.9338	$1,333.34		$266.67
15732	Muscle-skin graft, head/neck	CH	T	0137	20.9338	$1,333.34		$266.67
15734	Muscle-skin graft, trunk	CH	T	0137	20.9338	$1,333.34		$266.67
15736	Muscle-skin graft, arm	CH	T	0137	20.9338	$1,333.34		$266.67
15738	Muscle-skin graft, leg	CH	T	0137	20.9338	$1,333.34		$266.67
15740	Island pedicle flap graft	CH	T	0136	15.4399	$983.41		$196.68
15750	Neurovascular pedicle graft	CH	T	0137	20.9338	$1,333.34		$266.67
15756	Free myo/skin flap microvasc		C					
15757	Free skin flap, microvasc		C					
15758	Free fascial flap, microvasc		C					
15760	Composite skin graft	CH	T	0137	20.9338	$1,333.34		$266.67
15770	Derma-fat-fascia graft	CH	T	0137	20.9338	$1,333.34		$266.67
15775	Hair transplant punch grafts	CH	T	0133	1.334	$84.97	$26.76	$16.99
15776	Hair transplant punch grafts	CH	T	0133	1.334	$84.97	$26.76	$16.99
15780	Abrasion treatment of skin		T	0022	21.4534	$1,366.43	$354.40	$273.29
15781	Abrasion treatment of skin		T	0019	4.4463	$283.20	$71.80	$56.64
15782	Abrasion treatment of skin		T	0019	4.4463	$283.20	$71.80	$56.64
15783	Abrasion treatment of skin		T	0016	2.7493	$175.11		$35.02
15786	Abrasion, lesion, single		T	0013	0.8046	$51.25		$10.25
15787	Abrasion, lesions, add-on		T	0013	0.8046	$51.25		$10.25
15788	Chemical peel, face, epiderm	CH	T	0013	0.8046	$51.25		$10.25
15789	Chemical peel, face, dermal		T	0015	1.5119	$96.30		$19.26
15792	Chemical peel, nonfacial	CH	T	0015	1.5119	$96.30		$19.26

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
15793	Chemical peel, nonfacial	CH	T	0013	0.8046	$51.25		$10.25
15819	Plastic surgery, neck	CH	T	0134	2.1114	$134.48	$42.36	$26.90
15820	Revision of lower eyelid	CH	T	0137	20.9338	$1,333.34		$266.67
15821	Revision of lower eyelid	CH	T	0137	20.9338	$1,333.34		$266.67
15822	Revision of upper eyelid	CH	T	0137	20.9338	$1,333.34		$266.67
15823	Revision of upper eyelid	CH	T	0137	20.9338	$1,333.34		$266.67
15824	Removal of forehead wrinkles	CH	T	0137	20.9338	$1,333.34		$266.67
15825	Removal of neck wrinkles	CH	T	0137	20.9338	$1,333.34		$266.67
15826	Removal of brow wrinkles	CH	T	0137	20.9338	$1,333.34		$266.67
15828	Removal of face wrinkles	CH	T	0137	20.9338	$1,333.34		$266.67
15829	Removal of skin wrinkles	CH	T	0137	20.9338	$1,333.34		$266.67
15830	Exc skin abd		T	0022	21.4534	$1,366.43	$354.40	$273.29
15832	Excise excessive skin tissue		T	0022	21.4534	$1,366.43	$354.40	$273.29
15833	Excise excessive skin tissue		T	0022	21.4534	$1,366.43	$354.40	$273.29
15834	Excise excessive skin tissue		T	0022	21.4534	$1,366.43	$354.40	$273.29
15835	Excise excessive skin tissue	CH	T	0022	21.4534	$1,366.43	$354.40	$273.29
15836	Excise excessive skin tissue		T	0021	16.5832	$1,056.23	$219.40	$211.25
15837	Excise excessive skin tissue		T	0021	16.5832	$1,056.23	$219.40	$211.25
15838	Excise excessive skin tissue		T	0021	16.5832	$1,056.23	$219.40	$211.25
15839	Excise excessive skin tissue		T	0021	16.5832	$1,056.23	$219.40	$211.25
15840	Graft for face nerve palsy	CH	T	0137	20.9338	$1,333.34		$266.67
15841	Graft for face nerve palsy	CH	T	0137	20.9338	$1,333.34		$266.67
15842	Flap for face nerve palsy	CH	T	0137	20.9338	$1,333.34		$266.67
15845	Skin and muscle repair, face	CH	T	0137	20.9338	$1,333.34		$266.67
15847	Exc skin abd add-on		T	0022	21.4534	$1,366.43	$354.40	$273.29
15850	Removal of sutures		T	0016	2.7493	$175.11		$35.02
15851	Removal of sutures		T	0016	2.7493	$175.11		$35.02
15852	Dressing change not for burn		X	0340	0.6416	$40.87		$8.17
15860	Test for blood flow in graft		X	0340	0.6416	$40.87		$8.17
15876	Suction assisted lipectomy	CH	T	0137	20.9338	$1,333.34		$266.67
15877	Suction assisted lipectomy	CH	T	0137	20.9338	$1,333.34		$266.67
15878	Suction assisted lipectomy	CH	T	0137	20.9338	$1,333.34		$266.67
15879	Suction assisted lipectomy	CH	T	0137	20.9338	$1,333.34		$266.67
15920	Removal of tail bone ulcer		T	0019	4.4463	$283.20	$71.80	$56.64
15922	Removal of tail bone ulcer	CH	T	0137	20.9338	$1,333.34		$266.67
15931	Remove sacrum pressure sore		T	0022	21.4534	$1,366.43	$354.40	$273.29
15933	Remove sacrum pressure sore		T	0022	21.4534	$1,366.43	$354.40	$273.29
15934	Remove sacrum pressure sore	CH	T	0137	20.9338	$1,333.34		$266.67
15935	Remove sacrum pressure sore	CH	T	0137	20.9338	$1,333.34		$266.67
15936	Remove sacrum pressure sore	CH	T	0136	15.4399	$983.41		$196.68
15937	Remove sacrum pressure sore	CH	T	0137	20.9338	$1,333.34		$266.67
15940	Remove hip pressure sore		T	0022	21.4534	$1,366.43	$354.40	$273.29
15941	Remove hip pressure sore		T	0022	21.4534	$1,366.43	$354.40	$273.29
15944	Remove hip pressure sore	CH	T	0137	20.9338	$1,333.34		$266.67
15945	Remove hip pressure sore	CH	T	0137	20.9338	$1,333.34		$266.67
15946	Remove hip pressure sore	CH	T	0137	20.9338	$1,333.34		$266.67
15950	Remove thigh pressure sore		T	0022	21.4534	$1,366.43	$354.40	$273.29
15951	Remove thigh pressure sore		T	0022	21.4534	$1,366.43	$354.40	$273.29
15952	Remove thigh pressure sore	CH	T	0136	15.4399	$983.41		$196.68
15953	Remove thigh pressure sore	CH	T	0136	15.4399	$983.41		$196.68
15956	Remove thigh pressure sore	CH	T	0136	15.4399	$983.41		$196.68
15958	Remove thigh pressure sore	CH	T	0136	15.4399	$983.41		$196.68
15999	Removal of pressure sore		T	0019	4.4463	$283.20	$71.80	$56.64
16000	Initial treatment of burn(s)	CH	T	0013	0.8046	$51.25		$10.25
16020	Dress/debrid p-thick burn, s	CH	T	0015	1.5119	$96.30		$19.26
16025	Dress/debrid p-thick burn, m	CH	T	0016	2.7493	$175.11		$35.02
16030	Dress/debrid p-thick burn, l	CH	T	0016	2.7493	$175.11		$35.02
16035	Incision of burn scab, initi		T	0016	2.7493	$175.11		$35.02
16036	Escharotomy; add'l incision		C					
17000	Destruct premalg lesion	CH	T	0013	0.8046	$51.25		$10.25
17003	Destruct premalg les, 2-14	CH	T	0012	0.2682	$17.08		$3.42
17004	Destroy premlg lesions 15+	CH	T	0016	2.7493	$175.11		$35.02
17106	Destruction of skin lesions	CH	T	0016	2.7493	$175.11		$35.02
17107	Destruction of skin lesions	CH	T	0016	2.7493	$175.11		$35.02
17108	Destruction of skin lesions	CH	T	0016	2.7493	$175.11		$35.02
17110	Destruct b9 lesion, 1-14	CH	T	0013	0.8046	$51.25		$10.25
17111	Destruct lesion, 15 or more	CH	T	0015	1.5119	$96.30		$19.26
17250	Chemical cautery, tissue	CH	T	0015	1.5119	$96.30		$19.26
17260	Destruction of skin lesions		T	0015	1.5119	$96.30		$19.26
17261	Destruction of skin lesions		T	0015	1.5119	$96.30		$19.26
17262	Destruction of skin lesions		T	0015	1.5119	$96.30		$19.26
17263	Destruction of skin lesions		T	0015	1.5119	$96.30		$19.26
17264	Destruction of skin lesions		T	0015	1.5119	$96.30		$19.26
17266	Destruction of skin lesions		T	0016	2.7493	$175.11		$35.02
17270	Destruction of skin lesions		T	0015	1.5119	$96.30		$19.26
17271	Destruction of skin lesions	CH	T	0015	1.5119	$96.30		$19.26
17272	Destruction of skin lesions		T	0015	1.5119	$96.30		$19.26
17273	Destruction of skin lesions	CH	T	0016	2.7493	$175.11		$35.02

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
17274	Destruction of skin lesions		T	0016	2.7493	$175.11		$35.02
17276	Destruction of skin lesions		T	0016	2.7493	$175.11		$35.02
17280	Destruction of skin lesions		T	0015	1.5119	$96.30		$19.26
17281	Destruction of skin lesions	CH	T	0016	2.7493	$175.11		$35.02
17282	Destruction of skin lesions	CH	T	0016	2.7493	$175.11		$35.02
17283	Destruction of skin lesions	CH	T	0016	2.7493	$175.11		$35.02
17284	Destruction of skin lesions		T	0016	2.7493	$175.11		$35.02
17286	Destruction of skin lesions	CH	T	0016	2.7493	$175.11		$35.02
17311	Mohs, 1 stage, h/n/hf/g		T	0694	3.9713	$252.94	$91.60	$50.59
17312	Mohs addl stage		T	0694	3.9713	$252.94	$91.60	$50.59
17313	Mohs, 1 stage, t/a/l		T	0694	3.9713	$252.94	$91.60	$50.59
17314	Mohs, addl stage, t/a/l		T	0694	3.9713	$252.94	$91.60	$50.59
17315	Mohs surg, addl block		T	0694	3.9713	$252.94	$91.60	$50.59
17340	Cryotherapy of skin	CH	T	0013	0.8046	$51.25		$10.25
17360	Skin peel therapy		T	0013	0.8046	$51.25		$10.25
17380	Hair removal by electrolysis		T	0013	0.8046	$51.25		$10.25
17999	Skin tissue procedure		T	0012	0.2682	$17.08		$3.42
19000	Drainage of breast lesion		T	0004	4.5062	$287.01		$57.40
19001	Drain breast lesion add-on		T	0002	1.1915	$75.89		$15.18
19020	Incision of breast lesion		T	0008	19.0457	$1,213.08		$242.62
19030	Injection for breast x-ray		N					
19100	Bx breast percut w/o image	CH	T	0004	4.5062	$287.01		$57.40
19101	Biopsy of breast, open		T	0028	20.998	$1,337.43	$303.70	$267.49
19102	Bx breast percut w/image		T	0005	7.3012	$465.04		$93.01
19103	Bx breast percut w/device	CH	T	0037	13.9599	$889.15	$228.70	$177.83
19105	Cryosurg ablate fa, each		T	0029	32.494	$2,069.64	$581.50	$413.93
19110	Nipple exploration		T	0028	20.998	$1,337.43	$303.70	$267.49
19112	Excise breast duct fistula		T	0028	20.998	$1,337.43	$303.70	$267.49
19120	Removal of breast lesion		T	0028	20.998	$1,337.43	$303.70	$267.49
19125	Excision, breast lesion		T	0028	20.998	$1,337.43	$303.70	$267.49
19126	Excision, addl breast lesion		T	0028	20.998	$1,337.43	$303.70	$267.49
19260	Removal of chest wall lesion		T	0021	16.5832	$1,056.23	$219.40	$211.25
19271	Revision of chest wall		C					
19272	Extensive chest wall surgery		C					
19290	Place needle wire, breast		N					
19291	Place needle wire, breast		N					
19295	Place breast clip, percut	CH	N					
19296	Place po breast cath for rad		T	0648	52.9438	$3,372.15		$674.43
19297	Place breast cath for rad		T	0648	52.9438	$3,372.15		$674.43
19298	Place breast rad tube/caths	CH	T	0648	52.9438	$3,372.15		$674.43
19300	Removal of breast tissue		T	0028	20.998	$1,337.43	$303.70	$267.49
19301	Partical mastectomy		T	0028	20.998	$1,337.43	$303.70	$267.49
19302	P-mastectomy w/ln removal	CH	T	0030	40.4634	$2,577.24	$747.00	$515.45
19303	Mast, simple, complete		T	0029	32.494	$2,069.64	$581.50	$413.93
19304	Mast, subq		T	0029	32.494	$2,069.64	$581.50	$413.93
19305	Mast, radical		C					
19306	Mast, rad, urban type		C					
19307	Mast, mod rad		T	0030	40.4634	$2,577.24	$747.00	$515.45
19316	Suspension of breast		T	0029	32.494	$2,069.64	$581.50	$413.93
19318	Reduction of large breast	CH	T	0030	40.4634	$2,577.24	$747.00	$515.45
19324	Enlarge breast	CH	T	0030	40.4634	$2,577.24	$747.00	$515.45
19325	Enlarge breast with implant		T	0648	52.9438	$3,372.15		$674.43
19328	Removal of breast implant		T	0029	32.494	$2,069.64	$581.50	$413.93
19330	Removal of implant material		T	0029	32.494	$2,069.64	$581.50	$413.93
19340	Immediate breast prosthesis		T	0030	40.4634	$2,577.24	$747.00	$515.45
19342	Delayed breast prosthesis		T	0648	52.9438	$3,372.15		$674.43
19350	Breast reconstruction		T	0028	20.998	$1,337.43	$303.70	$267.49
19355	Correct inverted nipple(s)		T	0029	32.494	$2,069.64	$581.50	$413.93
19357	Breast reconstruction		T	0648	52.9438	$3,372.15		$674.43
19361	Breast reconstr w/lat flap		C					
19364	Breast reconstruction		C					
19366	Breast reconstruction		T	0029	32.494	$2,069.64	$581.50	$413.93
19367	Breast reconstruction		C					
19368	Breast reconstruction		C					
19369	Breast reconstruction		C					
19370	Surgery of breast capsule		T	0029	32.494	$2,069.64	$581.50	$413.93
19371	Removal of breast capsule		T	0029	32.494	$2,069.64	$581.50	$413.93
19380	Revise breast reconstruction		T	0030	40.4634	$2,577.24	$747.00	$515.45
19396	Design custom breast implant		T	0029	32.494	$2,069.64	$581.50	$413.93
19499	Breast surgery procedure		T	0028	20.998	$1,337.43	$303.70	$267.49
20000	Incision of abscess		T	0006	1.463	$93.18		$18.64
20005	Incision of deep abscess		T	0049	21.5761	$1,374.25		$274.85
2000F	Blood pressure measure		M					
2001F	Weight record		M					
2002F	Clin sign vol ovrld assess		M					
2004F	Initial exam involved joints		M					
20100	Explore wound, neck		T	0023	9.5721	$609.68		$121.94
20101	Explore wound, chest	CH	T	0137	20.9338	$1,333.34		$266.67

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
20102	Explore wound, abdomen	CH	T	0137	20.9338	$1,333.34		$266.67
20103	Explore wound, extremity		T	0023	9.5721	$609.68		$121.94
2010F	Vital signs recorded		M					
2014F	Mental status assess		M					
20150	Excise epiphyseal bar		T	0051	43.5953	$2,776.72		$555.34
2018F	Hydration status assess		M					
2019F	Dilated macul exam done		M					
20200	Muscle biopsy		T	0021	16.5832	$1,056.23	$219.40	$211.25
20205	Deep muscle biopsy		T	0021	16.5832	$1,056.23	$219.40	$211.25
20206	Needle biopsy, muscle		T	0005	7.3012	$465.04		$93.01
2020F	Dilated fundus eval done		M					
2021F	Dilat macul+exam done		M					
20220	Bone biopsy, trocar/needle	CH	T	0020	8.7155	$555.12		$111.02
20225	Bone biopsy, trocar/needle		T	0020	8.7155	$555.12		$111.02
2022F	Dil retina exam interp rev		M					
20240	Bone biopsy, excisional		T	0022	21.4534	$1,366.43	$354.40	$273.29
20245	Bone biopsy, excisional		T	0022	21.4534	$1,366.43	$354.40	$273.29
2024F	7 field photo interp doc rev		M					
20250	Open bone biopsy		T	0049	21.5761	$1,374.25		$274.85
20251	Open bone biopsy		T	0049	21.5761	$1,374.25		$274.85
2026F	Eye image valid to dx rev		M					
2027F	Optic nerve head eval done		M					
2028F	Foot exam performed		M					
2029F	Complete phys skin exam done		M					
2030F	H2O stat doc'd, normal		M					
2031F	H2O stat doc'd, dehydrated		M					
20500	Injection of sinus tract		T	0251	2.5765	$164.11		$32.82
20501	Inject sinus tract for x-ray		N					
20520	Removal of foreign body		T	0019	4.4463	$283.20	$71.80	$56.64
20525	Removal of foreign body		T	0022	21.4534	$1,366.43	$354.40	$273.29
20526	Ther injection, carp tunnel		T	0204	2.3254	$148.11	$40.10	$29.62
20550	Inj tendon sheath/ligament		T	0204	2.3254	$148.11	$40.10	$29.62
20551	Inj tendon origin/insertion		T	0204	2.3254	$148.11	$40.10	$29.62
20552	Inj trigger point, 1/2 muscl		T	0204	2.3254	$148.11	$40.10	$29.62
20553	Inject trigger points, =/> 3		T	0204	2.3254	$148.11	$40.10	$29.62
20600	Drain/inject, joint/bursa		T	0204	2.3254	$148.11	$40.10	$29.62
20605	Drain/inject, joint/bursa		T	0204	2.3254	$148.11	$40.10	$29.62
20610	Drain/inject, joint/bursa		T	0204	2.3254	$148.11	$40.10	$29.62
20612	Aspirate/inj ganglion cyst		T	0204	2.3254	$148.11	$40.10	$29.62
20615	Treatment of bone cyst		T	0004	4.5062	$287.01		$57.40
20650	Insert and remove bone pin		T	0049	21.5761	$1,374.25		$274.85
20660	Apply, rem fixation device		C					
20661	Application of head brace		C					
20662	Application of pelvis brace		T	0049	21.5761	$1,374.25		$274.85
20663	Application of thigh brace		T	0049	21.5761	$1,374.25		$274.85
20664	Halo brace application		C					
20665	Removal of fixation device		X	0340	0.6416	$40.87		$8.17
20670	Removal of support implant		T	0021	16.5832	$1,056.23	$219.40	$211.25
20680	Removal of support implant		T	0022	21.4534	$1,366.43	$354.40	$273.29
20690	Apply bone fixation device		T	0050	29.3263	$1,867.88		$373.58
20692	Apply bone fixation device		T	0050	29.3263	$1,867.88		$373.58
20693	Adjust bone fixation device		T	0049	21.5761	$1,374.25		$274.85
20694	Remove bone fixation device		T	0049	21.5761	$1,374.25		$274.85
20802	Replantation, arm, complete		C					
20805	Replant forearm, complete		C					
20808	Replantation hand, complete		C					
20816	Replantation digit, complete		C					
20822	Replantation digit, complete		T	0054	26.7322	$1,702.65		$340.53
20824	Replantation thumb, complete		C					
20827	Replantation thumb, complete		C					
20838	Replantation foot, complete		C					
20900	Removal of bone for graft		T	0050	29.3263	$1,867.88		$373.58
20902	Removal of bone for graft		T	0050	29.3263	$1,867.88		$373.58
20910	Remove cartilage for graft	CH	T	0137	20.9338	$1,333.34		$266.67
20912	Remove cartilage for graft	CH	T	0137	20.9338	$1,333.34		$266.67
20920	Removal of fascia for graft	CH	T	0136	15.4399	$983.41		$196.68
20922	Removal of fascia for graft	CH	T	0136	15.4399	$983.41		$196.68
20924	Removal of tendon for graft		T	0050	29.3263	$1,867.88		$373.58
20926	Removal of tissue for graft	CH	T	0135	4.6816	$298.19		$59.64
20930	Spinal bone allograft		C					
20931	Spinal bone allograft		C					
20936	Spinal bone autograft		C					
20937	Spinal bone autograft		C					
20938	Spinal bone autograft		C					
20950	Fluid pressure, muscle		T	0006	1.463	$93.18		$18.64
20955	Fibula bone graft, microvasc		C					
20956	Iliac bone graft, microvasc		C					
20957	Mt bone graft, microvasc		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
20962	Other bone graft, microvasc		C					
20969	Bone/skin graft, microvasc		C					
20970	Bone/skin graft, iliac crest		C					
20972	Bone/skin graft, metatarsal		T	0056	44.471	$2,832.49		$566.50
20973	Bone/skin graft, great toe		T	0056	44.471	$2,832.49		$566.50
20974	Electrical bone stimulation		A					
20975	Electrical bone stimulation	CH	N					
20979	Us bone stimulation		X	0340	0.6416	$40.87		$8.17
20982	Ablate, bone tumor(s) perq		T	0051	43.5953	$2,776.72		$555.34
20999	Musculoskeletal surgery		T	0049	21.5761	$1,374.25		$274.85
21010	Incision of jaw joint		T	0254	24.3535	$1,551.15	$321.30	$310.23
21015	Resection of facial tumor		T	0253	16.6341	$1,059.48	$282.20	$211.90
21025	Excision of bone, lower jaw		T	0256	40.5598	$2,583.38		$516.68
21026	Excision of facial bone(s)		T	0256	40.5598	$2,583.38		$516.68
21029	Contour of face bone lesion		T	0256	40.5598	$2,583.38		$516.68
21030	Excise max/zygoma b9 tumor		T	0254	24.3535	$1,551.15	$321.30	$310.23
21031	Remove exostosis, mandible		T	0254	24.3535	$1,551.15	$321.30	$310.23
21032	Remove exostosis, maxilla		T	0254	24.3535	$1,551.15	$321.30	$310.23
21034	Excise max/zygoma mlg tumor		T	0256	40.5598	$2,583.38		$516.68
21040	Excise mandible lesion		T	0254	24.3535	$1,551.15	$321.30	$310.23
21044	Removal of jaw bone lesion		T	0256	40.5598	$2,583.38		$516.68
21045	Extensive jaw surgery		C					
21046	Remove mandible cyst complex		T	0256	40.5598	$2,583.38		$516.68
21047	Excise lwr jaw cyst w/repair		T	0256	40.5598	$2,583.38		$516.68
21048	Remove maxilla cyst complex		T	0256	40.5598	$2,583.38		$516.68
21049	Excis uppr jaw cyst w/repair		T	0256	40.5598	$2,583.38		$516.68
21050	Removal of jaw joint		T	0256	40.5598	$2,583.38		$516.68
21060	Remove jaw joint cartilage		T	0256	40.5598	$2,583.38		$516.68
21070	Remove coronoid process		T	0256	40.5598	$2,583.38		$516.68
21076	Prepare face/oral prosthesis		T	0254	24.3535	$1,551.15	$321.30	$310.23
21077	Prepare face/oral prosthesis		T	0256	40.5598	$2,583.38		$516.68
21079	Prepare face/oral prosthesis		T	0256	40.5598	$2,583.38		$516.68
21080	Prepare face/oral prosthesis		T	0256	40.5598	$2,583.38		$516.68
21081	Prepare face/oral prosthesis		T	0256	40.5598	$2,583.38		$516.68
21082	Prepare face/oral prosthesis		T	0256	40.5598	$2,583.38		$516.68
21083	Prepare face/oral prosthesis		T	0256	40.5598	$2,583.38		$516.68
21084	Prepare face/oral prosthesis		T	0256	40.5598	$2,583.38		$516.68
21085	Prepare face/oral prosthesis		T	0253	16.6341	$1,059.48	$282.20	$211.90
21086	Prepare face/oral prosthesis		T	0256	40.5598	$2,583.38		$516.68
21087	Prepare face/oral prosthesis		T	0256	40.5598	$2,583.38		$516.68
21088	Prepare face/oral prosthesis		T	0256	40.5598	$2,583.38		$516.68
21089	Prepare face/oral prosthesis		T	0251	2.5765	$164.11		$32.82
21100	Maxillofacial fixation		T	0256	40.5598	$2,583.38		$516.68
21110	Interdental fixation		T	0252	7.6539	$487.50	$109.10	$97.50
21116	Injection, jaw joint x-ray		N					
21120	Reconstruction of chin		T	0254	24.3535	$1,551.15	$321.30	$310.23
21121	Reconstruction of chin		T	0254	24.3535	$1,551.15	$321.30	$310.23
21122	Reconstruction of chin		T	0254	24.3535	$1,551.15	$321.30	$310.23
21123	Reconstruction of chin		T	0254	24.3535	$1,551.15	$321.30	$310.23
21125	Augmentation, lower jaw bone		T	0254	24.3535	$1,551.15	$321.30	$310.23
21127	Augmentation, lower jaw bone		T	0256	40.5598	$2,583.38		$516.68
21137	Reduction of forehead		T	0254	24.3535	$1,551.15	$321.30	$310.23
21138	Reduction of forehead		T	0256	40.5598	$2,583.38		$516.68
21139	Reduction of forehead		T	0256	40.5598	$2,583.38		$516.68
21141	Reconstruct midface, lefort		C					
21142	Reconstruct midface, lefort		C					
21143	Reconstruct midface, lefort		C					
21145	Reconstruct midface, lefort		C					
21146	Reconstruct midface, lefort		C					
21147	Reconstruct midface, lefort		C					
21150	Reconstruct midface, lefort		T	0256	40.5598	$2,583.38		$516.68
21151	Reconstruct midface, lefort		C					
21154	Reconstruct midface, lefort		C					
21155	Reconstruct midface, lefort		C					
21159	Reconstruct midface, lefort		C					
21160	Reconstruct midface, lefort		C					
21172	Reconstruct orbit/forehead		C					
21175	Reconstruct orbit/forehead		T	0256	40.5598	$2,583.38		$516.68
21179	Reconstruct entire forehead		C					
21180	Reconstruct entire forehead		C					
21181	Contour cranial bone lesion		T	0254	24.3535	$1,551.15	$321.30	$310.23
21182	Reconstruct cranial bone		C					
21183	Reconstruct cranial bone		C					
21184	Reconstruct cranial bone		C					
21188	Reconstruction of midface		C					
21193	Reconst lwr jaw w/o graft		C					
21194	Reconst lwr jaw w/graft		C					
21195	Reconst lwr jaw w/o fixation		T	0256	40.5598	$2,583.38		$516.68

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
21196	Reconst lwr jaw w/fixation		C					
21198	Reconstr lwr jaw segment		T	0256	40.5598	$2,583.38		$516.68
21199	Reconstr lwr jaw w/advance		T	0256	40.5598	$2,583.38		$516.68
21206	Reconstruct upper jaw bone		T	0256	40.5598	$2,583.38		$516.68
21208	Augmentation of facial bones		T	0256	40.5598	$2,583.38		$516.68
21209	Reduction of facial bones		T	0256	40.5598	$2,583.38		$516.68
21210	Face bone graft		T	0256	40.5598	$2,583.38		$516.68
21215	Lower jaw bone graft		T	0256	40.5598	$2,583.38		$516.68
21230	Rib cartilage graft		T	0256	40.5598	$2,583.38		$516.68
21235	Ear cartilage graft		T	0254	24.3535	$1,551.15	$321.30	$310.23
21240	Reconstruction of jaw joint		T	0256	40.5598	$2,583.38		$516.68
21242	Reconstruction of jaw joint		T	0256	40.5598	$2,583.38		$516.68
21243	Reconstruction of jaw joint		T	0256	40.5598	$2,583.38		$516.68
21244	Reconstruction of lower jaw		T	0256	40.5598	$2,583.38		$516.68
21245	Reconstruction of jaw		T	0256	40.5598	$2,583.38		$516.68
21246	Reconstruction of jaw		T	0256	40.5598	$2,583.38		$516.68
21247	Reconstruct lower jaw bone		C					
21248	Reconstruction of jaw		T	0256	40.5598	$2,583.38		$516.68
21249	Reconstruction of jaw		T	0256	40.5598	$2,583.38		$516.68
21255	Reconstruct lower jaw bone		C					
21256	Reconstruction of orbit		C					
21260	Revise eye sockets		T	0256	40.5598	$2,583.38		$516.68
21261	Revise eye sockets		T	0256	40.5598	$2,583.38		$516.68
21263	Revise eye sockets		T	0256	40.5598	$2,583.38		$516.68
21267	Revise eye sockets		T	0256	40.5598	$2,583.38		$516.68
21268	Revise eye sockets		C					
21270	Augmentation, cheek bone		T	0256	40.5598	$2,583.38		$516.68
21275	Revision, orbitofacial bones		T	0256	40.5598	$2,583.38		$516.68
21280	Revision of eyelid		T	0256	40.5598	$2,583.38		$516.68
21282	Revision of eyelid		T	0253	16.6341	$1,059.48	$282.20	$211.90
21295	Revision of jaw muscle/bone		T	0252	7.6539	$487.50	$109.10	$97.50
21296	Revision of jaw muscle/bone		T	0254	24.3535	$1,551.15	$321.30	$310.23
21299	Cranio/maxillofacial surgery		T	0251	2.5765	$164.11		$32.82
21310	Treatment of nose fracture		T	0251	2.5765	$164.11		$32.82
21315	Treatment of nose fracture		T	0251	2.5765	$164.11		$32.82
21320	Treatment of nose fracture	CH	T	0253	16.6341	$1,059.48	$282.20	$211.90
21325	Treatment of nose fracture		T	0254	24.3535	$1,551.15	$321.30	$310.23
21330	Treatment of nose fracture		T	0254	24.3535	$1,551.15	$321.30	$310.23
21335	Treatment of nose fracture		T	0254	24.3535	$1,551.15	$321.30	$310.23
21336	Treat nasal septal fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
21337	Treat nasal septal fracture		T	0253	16.6341	$1,059.48	$282.20	$211.90
21338	Treat nasoethmoid fracture		T	0254	24.3535	$1,551.15	$321.30	$310.23
21339	Treat nasoethmoid fracture		T	0254	24.3535	$1,551.15	$321.30	$310.23
21340	Treatment of nose fracture		T	0256	40.5598	$2,583.38		$516.68
21343	Treatment of sinus fracture		C					
21344	Treatment of sinus fracture		C					
21345	Treat nose/jaw fracture		T	0254	24.3535	$1,551.15	$321.30	$310.23
21346	Treat nose/jaw fracture		C					
21347	Treat nose/jaw fracture		C					
21348	Treat nose/jaw fracture		C					
21355	Treat cheek bone fracture		T	0256	40.5598	$2,583.38		$516.68
21356	Treat cheek bone fracture		T	0254	24.3535	$1,551.15	$321.30	$310.23
21360	Treat cheek bone fracture	CH	T	0254	24.3535	$1,551.15	$321.30	$310.23
21365	Treat cheek bone fracture	CH	T	0256	40.5598	$2,583.38		$516.68
21366	Treat cheek bone fracture		C					
21385	Treat eye socket fracture	CH	T	0256	40.5598	$2,583.38		$516.68
21386	Treat eye socket fracture		C					
21387	Treat eye socket fracture		C					
21390	Treat eye socket fracture		T	0256	40.5598	$2,583.38		$516.68
21395	Treat eye socket fracture		C					
21400	Treat eye socket fracture		T	0252	7.6539	$487.50	$109.10	$97.50
21401	Treat eye socket fracture		T	0253	16.6341	$1,059.48	$282.20	$211.90
21406	Treat eye socket fracture		T	0256	40.5598	$2,583.38		$516.68
21407	Treat eye socket fracture		T	0256	40.5598	$2,583.38		$516.68
21408	Treat eye socket fracture		T	0256	40.5598	$2,583.38		$516.68
21421	Treat mouth roof fracture		T	0254	24.3535	$1,551.15	$321.30	$310.23
21422	Treat mouth roof fracture		C					
21423	Treat mouth roof fracture		C					
21431	Treat craniofacial fracture		C					
21432	Treat craniofacial fracture		C					
21433	Treat craniofacial fracture		C					
21435	Treat craniofacial fracture		C					
21436	Treat craniofacial fracture		C					
21440	Treat dental ridge fracture		T	0254	24.3535	$1,551.15	$321.30	$310.23
21445	Treat dental ridge fracture		T	0254	24.3535	$1,551.15	$321.30	$310.23
21450	Treat lower jaw fracture		T	0251	2.5765	$164.11		$32.82
21451	Treat lower jaw fracture		T	0252	7.6539	$487.50	$109.10	$97.50
21452	Treat lower jaw fracture		T	0253	16.6341	$1,059.48	$282.20	$211.90

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
21453	Treat lower jaw fracture		T	0256	40.5598	$2,583.38		$516.68
21454	Treat lower jaw fracture		T	0254	24.3535	$1,551.15	$321.30	$310.23
21461	Treat lower jaw fracture		T	0256	40.5598	$2,583.38		$516.68
21462	Treat lower jaw fracture		T	0256	40.5598	$2,583.38		$516.68
21465	Treat lower jaw fracture		T	0256	40.5598	$2,583.38		$516.68
21470	Treat lower jaw fracture		T	0256	40.5598	$2,583.38		$516.68
21480	Reset dislocated jaw		T	0251	2.5765	$164.11		$32.82
21485	Reset dislocated jaw		T	0253	16.6341	$1,059.48	$282.20	$211.90
21490	Repair dislocated jaw		T	0256	40.5598	$2,583.38		$516.68
21495	Treat hyoid bone fracture		T	0253	16.6341	$1,059.48	$282.20	$211.90
21497	Interdental wiring		T	0253	16.6341	$1,059.48	$282.20	$211.90
21499	Head surgery procedure		T	0251	2.5765	$164.11		$32.82
21501	Drain neck/chest lesion		T	0008	19.0457	$1,213.08		$242.62
21502	Drain chest lesion		T	0049	21.5761	$1,374.25		$274.85
21510	Drainage of bone lesion		C					
21550	Biopsy of neck/chest		T	0020	8.7155	$555.12		$111.02
21555	Remove lesion, neck/chest		T	0022	21.4534	$1,366.43	$354.40	$273.29
21556	Remove lesion, neck/chest		T	0022	21.4534	$1,366.43	$354.40	$273.29
21557	Remove tumor, neck/chest		T	0022	21.4534	$1,366.43	$354.40	$273.29
21600	Partial removal of rib		T	0050	29.3263	$1,867.88		$373.58
21610	Partial removal of rib		T	0050	29.3263	$1,867.88		$373.58
21615	Removal of rib		C					
21616	Removal of rib and nerves		C					
21620	Partial removal of sternum		C					
21627	Sternal debridement		C					
21630	Extensive sternum surgery		C					
21632	Extensive sternum surgery		C					
21685	Hyoid myotomy & suspension		T	0252	7.6539	$487.50	$109.10	$97.50
21700	Revision of neck muscle		T	0049	21.5761	$1,374.25		$274.85
21705	Revision of neck muscle/rib		C					
21720	Revision of neck muscle		T	0049	21.5761	$1,374.25		$274.85
21725	Revision of neck muscle		T	0006	1.463	$93.18		$18.64
21740	Reconstruction of sternum		C					
21742	Repair stern/nuss w/o scope		T	0051	43.5953	$2,776.72		$555.34
21743	Repair sternum/nuss w/scope		T	0051	43.5953	$2,776.72		$555.34
21750	Repair of sternum separation		C					
21800	Treatment of rib fracture		T	0043	1.8742	$119.37		$23.87
21805	Treatment of rib fracture		T	0062	26.3092	$1,675.71	$372.80	$335.14
21810	Treatment of rib fracture(s)		C					
21820	Treat sternum fracture		T	0043	1.8742	$119.37		$23.87
21825	Treat sternum fracture		C					
21899	Neck/chest surgery procedure		T	0251	2.5765	$164.11		$32.82
21920	Biopsy soft tissue of back		T	0020	8.7155	$555.12		$111.02
21925	Biopsy soft tissue of back		T	0022	21.4534	$1,366.43	$354.40	$273.29
21930	Remove lesion, back or flank		T	0022	21.4534	$1,366.43	$354.40	$273.29
21935	Remove tumor, back		T	0022	21.4534	$1,366.43	$354.40	$273.29
22010	I&d, p-spine, c/t/cerv-thor		C					
22015	I&d, p-spine, l/s/ls		C					
22100	Remove part of neck vertebra		T	0208	47.6714	$3,036.33		$607.27
22101	Remove part, thorax vertebra		T	0208	47.6714	$3,036.33		$607.27
22102	Remove part, lumbar vertebra		T	0208	47.6714	$3,036.33		$607.27
22103	Remove extra spine segment		T	0208	47.6714	$3,036.33		$607.27
22110	Remove part of neck vertebra		C					
22112	Remove part, thorax vertebra		C					
22114	Remove part, lumbar vertebra		C					
22116	Remove extra spine segment		C					
22210	Revision of neck spine		C					
22212	Revision of thorax spine		C					
22214	Revision of lumbar spine		C					
22216	Revise, extra spine segment		C					
22220	Revision of neck spine		C					
22222	Revision of thorax spine		T	0208	47.6714	$3,036.33		$607.27
22224	Revision of lumbar spine		C					
22226	Revise, extra spine segment		C					
22305	Treat spine process fracture		T	0043	1.8742	$119.37		$23.87
22310	Treat spine fracture		T	0043	1.8742	$119.37		$23.87
22315	Treat spine fracture		T	0043	1.8742	$119.37		$23.87
22318	Treat odontoid fx w/o graft		C					
22319	Treat odontoid fx w/graft		C					
22325	Treat spine fracture		C					
22326	Treat neck spine fracture		C					
22327	Treat thorax spine fracture		C					
22328	Treat each add spine fx		C					
22505	Manipulation of spine		T	0045	15.0176	$956.52	$268.40	$191.30
22520	Percut vertebroplasty thor		T	0050	29.3263	$1,867.88		$373.58
22521	Percut vertebroplasty lumb		T	0050	29.3263	$1,867.88		$373.58
22522	Percut vertebroplasty add'l		T	0050	29.3263	$1,867.88		$373.58
22523	Percut kyphoplasty, thor		T	0052	78.6518	$5,009.57		$1,001.91

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
22524	Percut kyphoplasty, lumbar		T	0052	78.6518	$5,009.57		$1,001.91
22525	Percut kyphoplasty, add-on		T	0052	78.6518	$5,009.57		$1,001.91
22526	Idet, single level		T	0050	29.3263	$1,867.88		$373.58
22527	Idet, 1 or more levels		T	0050	29.3263	$1,867.88		$373.58
22532	Lat thorax spine fusion		C					
22533	Lat lumbar spine fusion		C					
22534	Lat thor/lumb, add'l seg		C					
22548	Neck spine fusion		C					
22554	Neck spine fusion		C					
22556	Thorax spine fusion		C					
22558	Lumbar spine fusion		C					
22585	Additional spinal fusion		C					
22590	Spine & skull spinal fusion		C					
22595	Neck spinal fusion		C					
22600	Neck spine fusion		C					
22610	Thorax spine fusion		C					
22612	Lumbar spine fusion		T	0208	47.6714	$3,036.33		$607.27
22614	Spine fusion, extra segment		T	0208	47.6714	$3,036.33		$607.27
22630	Lumbar spine fusion		C					
22632	Spine fusion, extra segment		C					
22800	Fusion of spine		C					
22802	Fusion of spine		C					
22804	Fusion of spine		C					
22808	Fusion of spine		C					
22810	Fusion of spine		C					
22812	Fusion of spine		C					
22818	Kyphectomy, 1-2 segments		C					
22819	Kyphectomy, 3 or more		C					
22830	Exploration of spinal fusion		C					
22840	Insert spine fixation device		C					
22841	Insert spine fixation device		C					
22842	Insert spine fixation device		C					
22843	Insert spine fixation device		C					
22844	Insert spine fixation device		C					
22845	Insert spine fixation device		C					
22846	Insert spine fixation device		C					
22847	Insert spine fixation device		C					
22848	Insert pelv fixation device		C					
22849	Reinsert spinal fixation		C					
22850	Remove spine fixation device		C					
22851	Apply spine prosth device		T	0049	21.5761	$1,374.25		$274.85
22852	Remove spine fixation device		C					
22855	Remove spine fixation device		C					
22857	Lumbar artif diskectomy		C					
22862	Revise lumbar artif disc		C					
22865	Remove lumb artif disc		C					
22899	Spine surgery procedure		T	0049	21.5761	$1,374.25		$274.85
22900	Remove abdominal wall lesion		T	0022	21.4534	$1,366.43	$354.40	$273.29
22999	Abdomen surgery procedure		T	0049	21.5761	$1,374.25		$274.85
23000	Removal of calcium deposits		T	0021	16.5832	$1,056.23	$219.40	$211.25
23020	Release shoulder joint		T	0051	43.5953	$2,776.72		$555.34
23030	Drain shoulder lesion		T	0008	19.0457	$1,213.08		$242.62
23031	Drain shoulder bursa		T	0008	19.0457	$1,213.08		$242.62
23035	Drain shoulder bone lesion		T	0049	21.5761	$1,374.25		$274.85
23040	Exploratory shoulder surgery		T	0050	29.3263	$1,867.88		$373.58
23044	Exploratory shoulder surgery		T	0050	29.3263	$1,867.88		$373.58
23065	Biopsy shoulder tissues		T	0020	8.7155	$555.12		$111.02
23066	Biopsy shoulder tissues		T	0022	21.4534	$1,366.43	$354.40	$273.29
23075	Removal of shoulder lesion		T	0021	16.5832	$1,056.23	$219.40	$211.25
23076	Removal of shoulder lesion		T	0022	21.4534	$1,366.43	$354.40	$273.29
23077	Remove tumor of shoulder		T	0022	21.4534	$1,366.43	$354.40	$273.29
23100	Biopsy of shoulder joint		T	0049	21.5761	$1,374.25		$274.85
23101	Shoulder joint surgery		T	0050	29.3263	$1,867.88		$373.58
23105	Remove shoulder joint lining		T	0050	29.3263	$1,867.88		$373.58
23106	Incision of collarbone joint		T	0050	29.3263	$1,867.88		$373.58
23107	Explore treat shoulder joint		T	0050	29.3263	$1,867.88		$373.58
23120	Partial removal, collar bone	CH	T	0050	29.3263	$1,867.88		$373.58
23125	Removal of collar bone	CH	T	0050	29.3263	$1,867.88		$373.58
23130	Remove shoulder bone, part		T	0051	43.5953	$2,776.72		$555.34
23140	Removal of bone lesion		T	0049	21.5761	$1,374.25		$274.85
23145	Removal of bone lesion		T	0050	29.3263	$1,867.88		$373.58
23146	Removal of bone lesion		T	0050	29.3263	$1,867.88		$373.58
23150	Removal of humerus lesion		T	0050	29.3263	$1,867.88		$373.58
23155	Removal of humerus lesion		T	0050	29.3263	$1,867.88		$373.58
23156	Removal of humerus lesion		T	0050	29.3263	$1,867.88		$373.58
23170	Remove collar bone lesion		T	0050	29.3263	$1,867.88		$373.58
23172	Remove shoulder blade lesion		T	0050	29.3263	$1,867.88		$373.58
23174	Remove humerus lesion		T	0050	29.3263	$1,867.88		$373.58

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
23180	Remove collar bone lesion		T	0050	29.3263	$1,867.88		$373.58
23182	Remove shoulder blade lesion		T	0050	29.3263	$1,867.88		$373.58
23184	Remove humerus lesion		T	0050	29.3263	$1,867.88		$373.58
23190	Partial removal of scapula		T	0050	29.3263	$1,867.88		$373.58
23195	Removal of head of humerus		T	0050	29.3263	$1,867.88		$373.58
23200	Removal of collar bone		C					
23210	Removal of shoulder blade		C					
23220	Partial removal of humerus		C					
23221	Partial removal of humerus		C					
23222	Partial removal of humerus		C					
23330	Remove shoulder foreign body		T	0020	8.7155	$555.12		$111.02
23331	Remove shoulder foreign body		T	0022	21.4534	$1,366.43	$354.40	$273.29
23332	Remove shoulder foreign body		C					
23350	Injection for shoulder x-ray		N					
23395	Muscle transfer,shoulder/arm		T	0051	43.5953	$2,776.72		$555.34
23397	Muscle transfers		T	0052	78.6518	$5,009.57		$1,001.91
23400	Fixation of shoulder blade		T	0050	29.3263	$1,867.88		$373.58
23405	Incision of tendon & muscle		T	0050	29.3263	$1,867.88		$373.58
23406	Incise tendon(s) & muscle(s)		T	0050	29.3263	$1,867.88		$373.58
23410	Repair rotator cuff, acute		T	0051	43.5953	$2,776.72		$555.34
23412	Repair rotator cuff, chronic		T	0051	43.5953	$2,776.72		$555.34
23415	Release of shoulder ligament		T	0051	43.5953	$2,776.72		$555.34
23420	Repair of shoulder		T	0051	43.5953	$2,776.72		$555.34
23430	Repair biceps tendon		T	0051	43.5953	$2,776.72		$555.34
23440	Remove/transplant tendon		T	0051	43.5953	$2,776.72		$555.34
23450	Repair shoulder capsule		T	0052	78.6518	$5,009.57		$1,001.91
23455	Repair shoulder capsule		T	0052	78.6518	$5,009.57		$1,001.91
23460	Repair shoulder capsule		T	0052	78.6518	$5,009.57		$1,001.91
23462	Repair shoulder capsule		T	0051	43.5953	$2,776.72		$555.34
23465	Repair shoulder capsule		T	0052	78.6518	$5,009.57		$1,001.91
23466	Repair shoulder capsule		T	0051	43.5953	$2,776.72		$555.34
23470	Reconstruct shoulder joint		T	0425	113.6713	$7,240.07		$1,448.01
23472	Reconstruct shoulder joint		C					
23480	Revision of collar bone		T	0051	43.5953	$2,776.72		$555.34
23485	Revision of collar bone		T	0052	78.6518	$5,009.57		$1,001.91
23490	Reinforce clavicle		T	0051	43.5953	$2,776.72		$555.34
23491	Reinforce shoulder bones		T	0052	78.6518	$5,009.57		$1,001.91
23500	Treat clavicle fracture		T	0043	1.8742	$119.37		$23.87
23505	Treat clavicle fracture		T	0043	1.8742	$119.37		$23.87
23515	Treat clavicle fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
23520	Treat clavicle dislocation		T	0043	1.8742	$119.37		$23.87
23525	Treat clavicle dislocation		T	0043	1.8742	$119.37		$23.87
23530	Treat clavicle dislocation		T	0063	40.3466	$2,569.80	$548.30	$513.96
23532	Treat clavicle dislocation		T	0062	26.3092	$1,675.71	$372.80	$335.14
23540	Treat clavicle dislocation		T	0043	1.8742	$119.37		$23.87
23545	Treat clavicle dislocation		T	0043	1.8742	$119.37		$23.87
23550	Treat clavicle dislocation		T	0063	40.3466	$2,569.80	$548.30	$513.96
23552	Treat clavicle dislocation		T	0063	40.3466	$2,569.80	$548.30	$513.96
23570	Treat shoulder blade fx		T	0043	1.8742	$119.37		$23.87
23575	Treat shoulder blade fx		T	0043	1.8742	$119.37		$23.87
23585	Treat scapula fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
23600	Treat humerus fracture		T	0043	1.8742	$119.37		$23.87
23605	Treat humerus fracture		T	0043	1.8742	$119.37		$23.87
23615	Treat humerus fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
23616	Treat humerus fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
23620	Treat humerus fracture		T	0043	1.8742	$119.37		$23.87
23625	Treat humerus fracture		T	0043	1.8742	$119.37		$23.87
23630	Treat humerus fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
23650	Treat shoulder dislocation		T	0043	1.8742	$119.37		$23.87
23655	Treat shoulder dislocation		T	0045	15.0176	$956.52	$268.40	$191.30
23660	Treat shoulder dislocation		T	0063	40.3466	$2,569.80	$548.30	$513.96
23665	Treat dislocation/fracture		T	0043	1.8742	$119.37		$23.87
23670	Treat dislocation/fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
23675	Treat dislocation/fracture		T	0043	1.8742	$119.37		$23.87
23680	Treat dislocation/fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
23700	Fixation of shoulder		T	0045	15.0176	$956.52	$268.40	$191.30
23800	Fusion of shoulder joint		T	0052	78.6518	$5,009.57		$1,001.91
23802	Fusion of shoulder joint		T	0051	43.5953	$2,776.72		$555.34
23900	Amputation of arm & girdle		C					
23920	Amputation at shoulder joint		C					
23921	Amputation follow-up surgery	CH	T	0136	15.4399	$983.41		$196.68
23929	Shoulder surgery procedure		T	0043	1.8742	$119.37		$23.87
23930	Drainage of arm lesion		T	0008	19.0457	$1,213.08		$242.62
23931	Drainage of arm bursa		T	0008	19.0457	$1,213.08		$242.62
23935	Drain arm/elbow bone lesion		T	0049	21.5761	$1,374.25		$274.85
24000	Exploratory elbow surgery		T	0050	29.3263	$1,867.88		$373.58
24006	Release elbow joint		T	0050	29.3263	$1,867.88		$373.58
24065	Biopsy arm/elbow soft tissue		T	0021	16.5832	$1,056.23	$219.40	$211.25

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
24066	Biopsy arm/elbow soft tissue		T	0021	16.5832	$1,056.23	$219.40	$211.25
24075	Remove arm/elbow lesion		T	0021	16.5832	$1,056.23	$219.40	$211.25
24076	Remove arm/elbow lesion		T	0022	21.4534	$1,366.43	$354.40	$273.29
24077	Remove tumor of arm/elbow		T	0022	21.4534	$1,366.43	$354.40	$273.29
24100	Biopsy elbow joint lining		T	0049	21.5761	$1,374.25		$274.85
24101	Explore/treat elbow joint		T	0050	29.3263	$1,867.88		$373.58
24102	Remove elbow joint lining		T	0050	29.3263	$1,867.88		$373.58
24105	Removal of elbow bursa		T	0049	21.5761	$1,374.25		$274.85
24110	Remove humerus lesion		T	0049	21.5761	$1,374.25		$274.85
24115	Remove/graft bone lesion		T	0050	29.3263	$1,867.88		$373.58
24116	Remove/graft bone lesion		T	0050	29.3263	$1,867.88		$373.58
24120	Remove elbow lesion		T	0049	21.5761	$1,374.25		$274.85
24125	Remove/graft bone lesion		T	0050	29.3263	$1,867.88		$373.58
24126	Remove/graft bone lesion		T	0050	29.3263	$1,867.88		$373.58
24130	Removal of head of radius		T	0050	29.3263	$1,867.88		$373.58
24134	Removal of arm bone lesion		T	0050	29.3263	$1,867.88		$373.58
24136	Remove radius bone lesion		T	0050	29.3263	$1,867.88		$373.58
24138	Remove elbow bone lesion		T	0050	29.3263	$1,867.88		$373.58
24140	Partial removal of arm bone		T	0050	29.3263	$1,867.88		$373.58
24145	Partial removal of radius		T	0050	29.3263	$1,867.88		$373.58
24147	Partial removal of elbow		T	0050	29.3263	$1,867.88		$373.58
24149	Radical resection of elbow		T	0050	29.3263	$1,867.88		$373.58
24150	Extensive humerus surgery		T	0051	43.5953	$2,776.72		$555.34
24151	Extensive humerus surgery		T	0052	78.6518	$5,009.57		$1,001.91
24152	Extensive radius surgery		T	0051	43.5953	$2,776.72		$555.34
24153	Extensive radius surgery		T	0052	78.6518	$5,009.57		$1,001.91
24155	Removal of elbow joint		T	0051	43.5953	$2,776.72		$555.34
24160	Remove elbow joint implant		T	0050	29.3263	$1,867.88		$373.58
24164	Remove radius head implant		T	0050	29.3263	$1,867.88		$373.58
24200	Removal of arm foreign body		T	0019	4.4463	$283.20	$71.80	$56.64
24201	Removal of arm foreign body		T	0021	16.5832	$1,056.23	$219.40	$211.25
24220	Injection for elbow x-ray		N					
24300	Manipulate elbow w/anesth		T	0045	15.0176	$956.52	$268.40	$191.30
24301	Muscle/tendon transfer		T	0050	29.3263	$1,867.88		$373.58
24305	Arm tendon lengthening		T	0050	29.3263	$1,867.88		$373.58
24310	Revision of arm tendon		T	0049	21.5761	$1,374.25		$274.85
24320	Repair of arm tendon		T	0051	43.5953	$2,776.72		$555.34
24330	Revision of arm muscles		T	0052	78.6518	$5,009.57		$1,001.91
24331	Revision of arm muscles		T	0051	43.5953	$2,776.72		$555.34
24332	Tenolysis, triceps		T	0049	21.5761	$1,374.25		$274.85
24340	Repair of biceps tendon		T	0051	43.5953	$2,776.72		$555.34
24341	Repair arm tendon/muscle		T	0051	43.5953	$2,776.72		$555.34
24342	Repair of ruptured tendon		T	0051	43.5953	$2,776.72		$555.34
24343	Repr elbow lat ligmnt w/tiss		T	0050	29.3263	$1,867.88		$373.58
24344	Reconstruct elbow lat ligmnt		T	0052	78.6518	$5,009.57		$1,001.91
24345	Repr elbw med ligmnt w/tissu		T	0050	29.3263	$1,867.88		$373.58
24346	Reconstruct elbow med ligmnt		T	0051	43.5953	$2,776.72		$555.34
24350	Repair of tennis elbow		T	0050	29.3263	$1,867.88		$373.58
24351	Repair of tennis elbow		T	0050	29.3263	$1,867.88		$373.58
24352	Repair of tennis elbow		T	0050	29.3263	$1,867.88		$373.58
24354	Repair of tennis elbow		T	0050	29.3263	$1,867.88		$373.58
24356	Revision of tennis elbow		T	0050	29.3263	$1,867.88		$373.58
24360	Reconstruct elbow joint		T	0047	35.9249	$2,288.16	$537.00	$457.63
24361	Reconstruct elbow joint		T	0425	113.6713	$7,240.07		$1,448.01
24362	Reconstruct elbow joint		T	0048	51.0431	$3,251.09		$650.22
24363	Replace elbow joint		T	0425	113.6713	$7,240.07		$1,448.01
24365	Reconstruct head of radius		T	0047	35.9249	$2,288.16	$537.00	$457.63
24366	Reconstruct head of radius		T	0425	113.6713	$7,240.07		$1,448.01
24400	Revision of humerus		T	0050	29.3263	$1,867.88		$373.58
24410	Revision of humerus		T	0050	29.3263	$1,867.88		$373.58
24420	Revision of humerus		T	0051	43.5953	$2,776.72		$555.34
24430	Repair of humerus		T	0052	78.6518	$5,009.57		$1,001.91
24435	Repair humerus with graft		T	0052	78.6518	$5,009.57		$1,001.91
24470	Revision of elbow joint		T	0051	43.5953	$2,776.72		$555.34
24495	Decompression of forearm		T	0050	29.3263	$1,867.88		$373.58
24498	Reinforce humerus		T	0052	78.6518	$5,009.57		$1,001.91
24500	Treat humerus fracture		T	0043	1.8742	$119.37		$23.87
24505	Treat humerus fracture		T	0043	1.8742	$119.37		$23.87
24515	Treat humerus fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
24516	Treat humerus fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
24530	Treat humerus fracture		T	0043	1.8742	$119.37		$23.87
24535	Treat humerus fracture		T	0043	1.8742	$119.37		$23.87
24538	Treat humerus fracture		T	0062	26.3092	$1,675.71	$372.80	$335.14
24545	Treat humerus fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
24546	Treat humerus fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
24560	Treat humerus fracture		T	0043	1.8742	$119.37		$23.87
24565	Treat humerus fracture		T	0043	1.8742	$119.37		$23.87
24566	Treat humerus fracture		T	0062	26.3092	$1,675.71	$372.80	$335.14

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
24575	Treat humerus fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
24576	Treat humerus fracture		T	0043	1.8742	$119.37		$23.87
24577	Treat humerus fracture		T	0043	1.8742	$119.37		$23.87
24579	Treat humerus fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
24582	Treat humerus fracture		T	0062	26.3092	$1,675.71	$372.80	$335.14
24586	Treat elbow fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
24587	Treat elbow fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
24600	Treat elbow dislocation		T	0043	1.8742	$119.37		$23.87
24605	Treat elbow dislocation		T	0045	15.0176	$956.52	$268.40	$191.30
24615	Treat elbow dislocation		T	0064	60.0595	$3,825.37	$835.70	$765.07
24620	Treat elbow fracture		T	0043	1.8742	$119.37		$23.87
24635	Treat elbow fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
24640	Treat elbow dislocation		T	0043	1.8742	$119.37		$23.87
24650	Treat radius fracture		T	0043	1.8742	$119.37		$23.87
24655	Treat radius fracture		T	0043	1.8742	$119.37		$23.87
24665	Treat radius fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
24666	Treat radius fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
24670	Treat ulnar fracture		T	0043	1.8742	$119.37		$23.87
24675	Treat ulnar fracture		T	0043	1.8742	$119.37		$23.87
24685	Treat ulnar fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
24800	Fusion of elbow joint		T	0051	43.5953	$2,776.72		$555.34
24802	Fusion/graft of elbow joint		T	0051	43.5953	$2,776.72		$555.34
24900	Amputation of upper arm		C					
24920	Amputation of upper arm		C					
24925	Amputation follow-up surgery		T	0049	21.5761	$1,374.25		$274.85
24930	Amputation follow-up surgery		C					
24931	Amputate upper arm & implant		C					
24935	Revision of amputation		T	0052	78.6518	$5,009.57		$1,001.91
24940	Revision of upper arm		C					
24999	Upper arm/elbow surgery		T	0043	1.8742	$119.37		$23.87
25000	Incision of tendon sheath		T	0049	21.5761	$1,374.25		$274.85
25001	Incise flexor carpi radialis		T	0049	21.5761	$1,374.25		$274.85
25020	Decompress forearm 1 space		T	0049	21.5761	$1,374.25		$274.85
25023	Decompress forearm 1 space		T	0050	29.3263	$1,867.88		$373.58
25024	Decompress forearm 2 spaces		T	0050	29.3263	$1,867.88		$373.58
25025	Decompress forearm 2 spaces		T	0050	29.3263	$1,867.88		$373.58
25028	Drainage of forearm lesion		T	0049	21.5761	$1,374.25		$274.85
25031	Drainage of forearm bursa		T	0049	21.5761	$1,374.25		$274.85
25035	Treat forearm bone lesion		T	0049	21.5761	$1,374.25		$274.85
25040	Explore/treat wrist joint		T	0050	29.3263	$1,867.88		$373.58
25065	Biopsy forearm soft tissues		T	0020	8.7155	$555.12		$111.02
25066	Biopsy forearm soft tissues		T	0022	21.4534	$1,366.43	$354.40	$273.29
25075	Removal forearm lesion subcu		T	0021	16.5832	$1,056.23	$219.40	$211.25
25076	Removal forearm lesion deep		T	0022	21.4534	$1,366.43	$354.40	$273.29
25077	Remove tumor, forearm/wrist		T	0022	21.4534	$1,366.43	$354.40	$273.29
25085	Incision of wrist capsule		T	0049	21.5761	$1,374.25		$274.85
25100	Biopsy of wrist joint		T	0049	21.5761	$1,374.25		$274.85
25101	Explore/treat wrist joint		T	0050	29.3263	$1,867.88		$373.58
25105	Remove wrist joint lining		T	0050	29.3263	$1,867.88		$373.58
25107	Remove wrist joint cartilage		T	0050	29.3263	$1,867.88		$373.58
25109	Excise tendon forearm/wrist		T	0049	21.5761	$1,374.25		$274.85
25110	Remove wrist tendon lesion		T	0049	21.5761	$1,374.25		$274.85
25111	Remove wrist tendon lesion		T	0053	16.822	$1,071.44	$253.40	$214.29
25112	Reremove wrist tendon lesion		T	0053	16.822	$1,071.44	$253.40	$214.29
25115	Remove wrist/forearm lesion		T	0049	21.5761	$1,374.25		$274.85
25116	Remove wrist/forearm lesion		T	0049	21.5761	$1,374.25		$274.85
25118	Excise wrist tendon sheath		T	0050	29.3263	$1,867.88		$373.58
25119	Partial removal of ulna		T	0050	29.3263	$1,867.88		$373.58
25120	Removal of forearm lesion		T	0050	29.3263	$1,867.88		$373.58
25125	Remove/graft forearm lesion		T	0050	29.3263	$1,867.88		$373.58
25126	Remove/graft forearm lesion		T	0050	29.3263	$1,867.88		$373.58
25130	Removal of wrist lesion		T	0050	29.3263	$1,867.88		$373.58
25135	Remove & graft wrist lesion		T	0050	29.3263	$1,867.88		$373.58
25136	Remove & graft wrist lesion		T	0050	29.3263	$1,867.88		$373.58
25145	Remove forearm bone lesion		T	0050	29.3263	$1,867.88		$373.58
25150	Partial removal of ulna		T	0050	29.3263	$1,867.88		$373.58
25151	Partial removal of radius		T	0050	29.3263	$1,867.88		$373.58
25170	Extensive forearm surgery		T	0051	43.5953	$2,776.72		$555.34
25210	Removal of wrist bone		T	0054	26.7322	$1,702.65		$340.53
25215	Removal of wrist bones		T	0054	26.7322	$1,702.65		$340.53
25230	Partial removal of radius		T	0050	29.3263	$1,867.88		$373.58
25240	Partial removal of ulna		T	0050	29.3263	$1,867.88		$373.58
25246	Injection for wrist x-ray		N					
25248	Remove forearm foreign body		T	0049	21.5761	$1,374.25		$274.85
25250	Removal of wrist prosthesis		T	0050	29.3263	$1,867.88		$373.58
25251	Removal of wrist prosthesis		T	0050	29.3263	$1,867.88		$373.58
25259	Manipulate wrist w/anesthes		T	0043	1.8742	$119.37		$23.87
25260	Repair forearm tendon/muscle		T	0050	29.3263	$1,867.88		$373.58

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
25263	Repair forearm tendon/muscle		T	0050	29.3263	$1,867.88		$373.58
25265	Repair forearm tendon/muscle		T	0050	29.3263	$1,867.88		$373.58
25270	Repair forearm tendon/muscle		T	0050	29.3263	$1,867.88		$373.58
25272	Repair forearm tendon/muscle		T	0050	29.3263	$1,867.88		$373.58
25274	Repair forearm tendon/muscle		T	0050	29.3263	$1,867.88		$373.58
25275	Repair forearm tendon sheath		T	0050	29.3263	$1,867.88		$373.58
25280	Revise wrist/forearm tendon		T	0050	29.3263	$1,867.88		$373.58
25290	Incise wrist/forearm tendon		T	0050	29.3263	$1,867.88		$373.58
25295	Release wrist/forearm tendon		T	0049	21.5761	$1,374.25		$274.85
25300	Fusion of tendons at wrist		T	0050	29.3263	$1,867.88		$373.58
25301	Fusion of tendons at wrist		T	0050	29.3263	$1,867.88		$373.58
25310	Transplant forearm tendon		T	0051	43.5953	$2,776.72		$555.34
25312	Transplant forearm tendon		T	0051	43.5953	$2,776.72		$555.34
25315	Revise palsy hand tendon(s)		T	0051	43.5953	$2,776.72		$555.34
25316	Revise palsy hand tendon(s)		T	0052	78.6518	$5,009.57		$1,001.91
25320	Repair/revise wrist joint		T	0051	43.5953	$2,776.72		$555.34
25332	Revise wrist joint		T	0047	35.9249	$2,288.16	$537.00	$457.63
25335	Realignment of hand		T	0051	43.5953	$2,776.72		$555.34
25337	Reconstruct ulna/radioulnar		T	0051	43.5953	$2,776.72		$555.34
25350	Revision of radius		T	0052	78.6518	$5,009.57		$1,001.91
25355	Revision of radius		T	0051	43.5953	$2,776.72		$555.34
25360	Revision of ulna		T	0050	29.3263	$1,867.88		$373.58
25365	Revise radius & ulna		T	0050	29.3263	$1,867.88		$373.58
25370	Revise radius or ulna		T	0051	43.5953	$2,776.72		$555.34
25375	Revise radius & ulna		T	0051	43.5953	$2,776.72		$555.34
25390	Shorten radius or ulna		T	0050	29.3263	$1,867.88		$373.58
25391	Lengthen radius or ulna		T	0051	43.5953	$2,776.72		$555.34
25392	Shorten radius & ulna		T	0050	29.3263	$1,867.88		$373.58
25393	Lengthen radius & ulna		T	0051	43.5953	$2,776.72		$555.34
25394	Repair carpal bone, shorten		T	0053	16.822	$1,071.44	$253.40	$214.29
25400	Repair radius or ulna	CH	T	0052	78.6518	$5,009.57		$1,001.91
25405	Repair/graft radius or ulna	CH	T	0052	78.6518	$5,009.57		$1,001.91
25415	Repair radius & ulna	CH	T	0052	78.6518	$5,009.57		$1,001.91
25420	Repair/graft radius & ulna		T	0052	78.6518	$5,009.57		$1,001.91
25425	Repair/graft radius or ulna		T	0051	43.5953	$2,776.72		$555.34
25426	Repair/graft radius & ulna		T	0051	43.5953	$2,776.72		$555.34
25430	Vasc graft into carpal bone		T	0054	26.7322	$1,702.65		$340.53
25431	Repair nonunion carpal bone		T	0054	26.7322	$1,702.65		$340.53
25440	Repair/graft wrist bone		T	0052	78.6518	$5,009.57		$1,001.91
25441	Reconstruct wrist joint		T	0425	113.6713	$7,240.07		$1,448.01
25442	Reconstruct wrist joint		T	0425	113.6713	$7,240.07		$1,448.01
25443	Reconstruct wrist joint		T	0048	51.0431	$3,251.09		$650.22
25444	Reconstruct wrist joint		T	0048	51.0431	$3,251.09		$650.22
25445	Reconstruct wrist joint		T	0048	51.0431	$3,251.09		$650.22
25446	Wrist replacement		T	0425	113.6713	$7,240.07		$1,448.01
25447	Repair wrist joint(s)		T	0047	35.9249	$2,288.16	$537.00	$457.63
25449	Remove wrist joint implant		T	0047	35.9249	$2,288.16	$537.00	$457.63
25450	Revision of wrist joint		T	0051	43.5953	$2,776.72		$555.34
25455	Revision of wrist joint		T	0051	43.5953	$2,776.72		$555.34
25490	Reinforce radius		T	0051	43.5953	$2,776.72		$555.34
25491	Reinforce ulna		T	0051	43.5953	$2,776.72		$555.34
25492	Reinforce radius and ulna		T	0051	43.5953	$2,776.72		$555.34
25500	Treat fracture of radius		T	0043	1.8742	$119.37		$23.87
25505	Treat fracture of radius		T	0043	1.8742	$119.37		$23.87
25515	Treat fracture of radius		T	0063	40.3466	$2,569.80	$548.30	$513.96
25520	Treat fracture of radius		T	0043	1.8742	$119.37		$23.87
25525	Treat fracture of radius		T	0063	40.3466	$2,569.80	$548.30	$513.96
25526	Treat fracture of radius		T	0063	40.3466	$2,569.80	$548.30	$513.96
25530	Treat fracture of ulna		T	0043	1.8742	$119.37		$23.87
25535	Treat fracture of ulna		T	0043	1.8742	$119.37		$23.87
25545	Treat fracture of ulna		T	0063	40.3466	$2,569.80	$548.30	$513.96
25560	Treat fracture radius & ulna		T	0043	1.8742	$119.37		$23.87
25565	Treat fracture radius & ulna		T	0043	1.8742	$119.37		$23.87
25574	Treat fracture radius & ulna		T	0064	60.0595	$3,825.37	$835.70	$765.07
25575	Treat fracture radius/ulna		T	0064	60.0595	$3,825.37	$835.70	$765.07
25600	Treat fracture radius/ulna		T	0043	1.8742	$119.37		$23.87
25605	Treat fracture radius/ulna		T	0043	1.8742	$119.37		$23.87
25606	Treat fx distal radial		T	0062	26.3092	$1,675.71	$372.80	$335.14
25607	Treat fx rad extra-articul		T	0064	60.0595	$3,825.37	$835.70	$765.07
25608	Treat fx rad intra-articul		T	0064	60.0595	$3,825.37	$835.70	$765.07
25609	Treat fx radial 3+ frag		T	0064	60.0595	$3,825.37	$835.70	$765.07
25622	Treat wrist bone fracture		T	0043	1.8742	$119.37		$23.87
25624	Treat wrist bone fracture		T	0043	1.8742	$119.37		$23.87
25628	Treat wrist bone fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
25630	Treat wrist bone fracture		T	0043	1.8742	$119.37		$23.87
25635	Treat wrist bone fracture		T	0043	1.8742	$119.37		$23.87
25645	Treat wrist bone fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
25650	Treat wrist bone fracture		T	0043	1.8742	$119.37		$23.87

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
25651	Pin ulnar styloid fracture		T	0062	26.3092	$1,675.71	$372.80	$335.14
25652	Treat fracture ulnar styloid		T	0063	40.3466	$2,569.80	$548.30	$513.96
25660	Treat wrist dislocation		T	0043	1.8742	$119.37		$23.87
25670	Treat wrist dislocation		T	0062	26.3092	$1,675.71	$372.80	$335.14
25671	Pin radioulnar dislocation		T	0062	26.3092	$1,675.71	$372.80	$335.14
25675	Treat wrist dislocation		T	0043	1.8742	$119.37		$23.87
25676	Treat wrist dislocation		T	0062	26.3092	$1,675.71	$372.80	$335.14
25680	Treat wrist fracture		T	0043	1.8742	$119.37		$23.87
25685	Treat wrist fracture		T	0062	26.3092	$1,675.71	$372.80	$335.14
25690	Treat wrist dislocation		T	0043	1.8742	$119.37		$23.87
25695	Treat wrist dislocation		T	0062	26.3092	$1,675.71	$372.80	$335.14
25800	Fusion of wrist joint		T	0052	78.6518	$5,009.57		$1,001.91
25805	Fusion/graft of wrist joint		T	0051	43.5953	$2,776.72		$555.34
25810	Fusion/graft of wrist joint		T	0052	78.6518	$5,009.57		$1,001.91
25820	Fusion of hand bones		T	0053	16.822	$1,071.44	$253.40	$214.29
25825	Fuse hand bones with graft	CH	T	0052	78.6518	$5,009.57		$1,001.91
25830	Fusion, radioulnar jnt/ulna		T	0052	78.6518	$5,009.57		$1,001.91
25900	Amputation of forearm		C					
25905	Amputation of forearm		C					
25907	Amputation follow-up surgery		T	0049	21.5761	$1,374.25		$274.85
25909	Amputation follow-up surgery		C					
25915	Amputation of forearm		C					
25920	Amputate hand at wrist		C					
25922	Amputate hand at wrist		T	0049	21.5761	$1,374.25		$274.85
25924	Amputation follow-up surgery		C					
25927	Amputation of hand		C					
25929	Amputation follow-up surgery	CH	T	0136	15.4399	$983.41		$196.68
25931	Amputation follow-up surgery	CH	T	0049	21.5761	$1,374.25		$274.85
25999	Forearm or wrist surgery		T	0043	1.8742	$119.37		$23.87
26010	Drainage of finger abscess		T	0006	1.463	$93.18		$18.64
26011	Drainage of finger abscess		T	0007	12.5792	$801.21		$160.24
26020	Drain hand tendon sheath		T	0053	16.822	$1,071.44	$253.40	$214.29
26025	Drainage of palm bursa		T	0053	16.822	$1,071.44	$253.40	$214.29
26030	Drainage of palm bursa(s)		T	0053	16.822	$1,071.44	$253.40	$214.29
26034	Treat hand bone lesion		T	0053	16.822	$1,071.44	$253.40	$214.29
26035	Decompress fingers/hand		T	0053	16.822	$1,071.44	$253.40	$214.29
26037	Decompress fingers/hand		T	0053	16.822	$1,071.44	$253.40	$214.29
26040	Release palm contracture		T	0054	26.7322	$1,702.65		$340.53
26045	Release palm contracture		T	0054	26.7322	$1,702.65		$340.53
26055	Incise finger tendon sheath		T	0053	16.822	$1,071.44	$253.40	$214.29
26060	Incision of finger tendon		T	0053	16.822	$1,071.44	$253.40	$214.29
26070	Explore/treat hand joint		T	0053	16.822	$1,071.44	$253.40	$214.29
26075	Explore/treat finger joint		T	0053	16.822	$1,071.44	$253.40	$214.29
26080	Explore/treat finger joint		T	0053	16.822	$1,071.44	$253.40	$214.29
26100	Biopsy hand joint lining		T	0053	16.822	$1,071.44	$253.40	$214.29
26105	Biopsy finger joint lining		T	0053	16.822	$1,071.44	$253.40	$214.29
26110	Biopsy finger joint lining		T	0053	16.822	$1,071.44	$253.40	$214.29
26115	Removal hand lesion subcut		T	0022	21.4534	$1,366.43	$354.40	$273.29
26116	Removal hand lesion, deep		T	0022	21.4534	$1,366.43	$354.40	$273.29
26117	Remove tumor, hand/finger		T	0022	21.4534	$1,366.43	$354.40	$273.29
26121	Release palm contracture		T	0054	26.7322	$1,702.65		$340.53
26123	Release palm contracture		T	0054	26.7322	$1,702.65		$340.53
26125	Release palm contracture		T	0053	16.822	$1,071.44	$253.40	$214.29
26130	Remove wrist joint lining		T	0053	16.822	$1,071.44	$253.40	$214.29
26135	Revise finger joint, each		T	0054	26.7322	$1,702.65		$340.53
26140	Revise finger joint, each		T	0053	16.822	$1,071.44	$253.40	$214.29
26145	Tendon excision, palm/finger		T	0053	16.822	$1,071.44	$253.40	$214.29
26160	Remove tendon sheath lesion		T	0053	16.822	$1,071.44	$253.40	$214.29
26170	Removal of palm tendon, each		T	0053	16.822	$1,071.44	$253.40	$214.29
26180	Removal of finger tendon		T	0053	16.822	$1,071.44	$253.40	$214.29
26185	Remove finger bone		T	0053	16.822	$1,071.44	$253.40	$214.29
26200	Remove hand bone lesion		T	0053	16.822	$1,071.44	$253.40	$214.29
26205	Remove/graft bone lesion		T	0054	26.7322	$1,702.65		$340.53
26210	Removal of finger lesion		T	0053	16.822	$1,071.44	$253.40	$214.29
26215	Remove/graft finger lesion		T	0053	16.822	$1,071.44	$253.40	$214.29
26230	Partial removal of hand bone		T	0053	16.822	$1,071.44	$253.40	$214.29
26235	Partial removal, finger bone		T	0053	16.822	$1,071.44	$253.40	$214.29
26236	Partial removal, finger bone		T	0053	16.822	$1,071.44	$253.40	$214.29
26250	Extensive hand surgery		T	0053	16.822	$1,071.44	$253.40	$214.29
26255	Extensive hand surgery		T	0054	26.7322	$1,702.65		$340.53
26260	Extensive finger surgery		T	0053	16.822	$1,071.44	$253.40	$214.29
26261	Extensive finger surgery		T	0053	16.822	$1,071.44	$253.40	$214.29
26262	Partial removal of finger		T	0053	16.822	$1,071.44	$253.40	$214.29
26320	Removal of implant from hand		T	0021	16.5832	$1,056.23	$219.40	$211.25
26340	Manipulate finger w/anesth		T	0043	1.8742	$119.37		$23.87
26350	Repair finger/hand tendon		T	0054	26.7322	$1,702.65		$340.53
26352	Repair/graft hand tendon		T	0054	26.7322	$1,702.65		$340.53
26356	Repair finger/hand tendon		T	0054	26.7322	$1,702.65		$340.53

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
26357	Repair finger/hand tendon		T	0054	26.7322	$1,702.65		$340.53
26358	Repair/graft hand tendon		T	0054	26.7322	$1,702.65		$340.53
26370	Repair finger/hand tendon		T	0054	26.7322	$1,702.65		$340.53
26372	Repair/graft hand tendon		T	0054	26.7322	$1,702.65		$340.53
26373	Repair finger/hand tendon		T	0054	26.7322	$1,702.65		$340.53
26390	Revise hand/finger tendon		T	0054	26.7322	$1,702.65		$340.53
26392	Repair/graft hand tendon		T	0054	26.7322	$1,702.65		$340.53
26410	Repair hand tendon		T	0053	16.822	$1,071.44	$253.40	$214.29
26412	Repair/graft hand tendon		T	0054	26.7322	$1,702.65		$340.53
26415	Excision, hand/finger tendon		T	0054	26.7322	$1,702.65		$340.53
26416	Graft hand or finger tendon		T	0054	26.7322	$1,702.65		$340.53
26418	Repair finger tendon		T	0053	16.822	$1,071.44	$253.40	$214.29
26420	Repair/graft finger tendon		T	0054	26.7322	$1,702.65		$340.53
26426	Repair finger/hand tendon		T	0054	26.7322	$1,702.65		$340.53
26428	Repair/graft finger tendon		T	0054	26.7322	$1,702.65		$340.53
26432	Repair finger tendon		T	0053	16.822	$1,071.44	$253.40	$214.29
26433	Repair finger tendon		T	0053	16.822	$1,071.44	$253.40	$214.29
26434	Repair/graft finger tendon		T	0054	26.7322	$1,702.65		$340.53
26437	Realignment of tendons		T	0053	16.822	$1,071.44	$253.40	$214.29
26440	Release palm/finger tendon		T	0053	16.822	$1,071.44	$253.40	$214.29
26442	Release palm & finger tendon		T	0054	26.7322	$1,702.65		$340.53
26445	Release hand/finger tendon		T	0053	16.822	$1,071.44	$253.40	$214.29
26449	Release forearm/hand tendon		T	0054	26.7322	$1,702.65		$340.53
26450	Incision of palm tendon		T	0053	16.822	$1,071.44	$253.40	$214.29
26455	Incision of finger tendon		T	0053	16.822	$1,071.44	$253.40	$214.29
26460	Incise hand/finger tendon		T	0053	16.822	$1,071.44	$253.40	$214.29
26471	Fusion of finger tendons		T	0053	16.822	$1,071.44	$253.40	$214.29
26474	Fusion of finger tendons		T	0053	16.822	$1,071.44	$253.40	$214.29
26476	Tendon lengthening		T	0053	16.822	$1,071.44	$253.40	$214.29
26477	Tendon shortening		T	0053	16.822	$1,071.44	$253.40	$214.29
26478	Lengthening of hand tendon		T	0053	16.822	$1,071.44	$253.40	$214.29
26479	Shortening of hand tendon		T	0053	16.822	$1,071.44	$253.40	$214.29
26480	Transplant hand tendon		T	0054	26.7322	$1,702.65		$340.53
26483	Transplant/graft hand tendon		T	0054	26.7322	$1,702.65		$340.53
26485	Transplant palm tendon		T	0054	26.7322	$1,702.65		$340.53
26489	Transplant/graft palm tendon		T	0054	26.7322	$1,702.65		$340.53
26490	Revise thumb tendon		T	0054	26.7322	$1,702.65		$340.53
26492	Tendon transfer with graft		T	0054	26.7322	$1,702.65		$340.53
26494	Hand tendon/muscle transfer		T	0054	26.7322	$1,702.65		$340.53
26496	Revise thumb tendon		T	0054	26.7322	$1,702.65		$340.53
26497	Finger tendon transfer		T	0054	26.7322	$1,702.65		$340.53
26498	Finger tendon transfer		T	0054	26.7322	$1,702.65		$340.53
26499	Revision of finger		T	0054	26.7322	$1,702.65		$340.53
26500	Hand tendon reconstruction		T	0053	16.822	$1,071.44	$253.40	$214.29
26502	Hand tendon reconstruction		T	0054	26.7322	$1,702.65		$340.53
26508	Release thumb contracture		T	0053	16.822	$1,071.44	$253.40	$214.29
26510	Thumb tendon transfer		T	0054	26.7322	$1,702.65		$340.53
26516	Fusion of knuckle joint		T	0054	26.7322	$1,702.65		$340.53
26517	Fusion of knuckle joints		T	0054	26.7322	$1,702.65		$340.53
26518	Fusion of knuckle joints		T	0054	26.7322	$1,702.65		$340.53
26520	Release knuckle contracture		T	0053	16.822	$1,071.44	$253.40	$214.29
26525	Release finger contracture		T	0053	16.822	$1,071.44	$253.40	$214.29
26530	Revise knuckle joint		T	0047	35.9249	$2,288.16	$537.00	$457.63
26531	Revise knuckle with implant		T	0048	51.0431	$3,251.09		$650.22
26535	Revise finger joint		T	0047	35.9249	$2,288.16	$537.00	$457.63
26536	Revise/implant finger joint		T	0048	51.0431	$3,251.09		$650.22
26540	Repair hand joint		T	0053	16.822	$1,071.44	$253.40	$214.29
26541	Repair hand joint with graft		T	0054	26.7322	$1,702.65		$340.53
26542	Repair hand joint with graft		T	0053	16.822	$1,071.44	$253.40	$214.29
26545	Reconstruct finger joint		T	0054	26.7322	$1,702.65		$340.53
26546	Repair nonunion hand		T	0054	26.7322	$1,702.65		$340.53
26548	Reconstruct finger joint		T	0054	26.7322	$1,702.65		$340.53
26550	Construct thumb replacement		T	0054	26.7322	$1,702.65		$340.53
26551	Great toe-hand transfer		C					
26553	Single transfer, toe-hand		C					
26554	Double transfer, toe-hand		C					
26555	Positional change of finger		T	0054	26.7322	$1,702.65		$340.53
26556	Toe joint transfer		C					
26560	Repair of web finger		T	0053	16.822	$1,071.44	$253.40	$214.29
26561	Repair of web finger		T	0054	26.7322	$1,702.65		$340.53
26562	Repair of web finger		T	0054	26.7322	$1,702.65		$340.53
26565	Correct metacarpal flaw		T	0054	26.7322	$1,702.65		$340.53
26567	Correct finger deformity		T	0054	26.7322	$1,702.65		$340.53
26568	Lengthen metacarpal/finger		T	0054	26.7322	$1,702.65		$340.53
26580	Repair hand deformity		T	0053	16.822	$1,071.44	$253.40	$214.29
26587	Reconstruct extra finger		T	0053	16.822	$1,071.44	$253.40	$214.29
26590	Repair finger deformity		T	0053	16.822	$1,071.44	$253.40	$214.29
26591	Repair muscles of hand		T	0054	26.7322	$1,702.65		$340.53

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
26593	Release muscles of hand		T	0053	16.822	$1,071.44	$253.40	$214.29
26596	Excision constricting tissue		T	0053	16.822	$1,071.44	$253.40	$214.29
26600	Treat metacarpal fracture		T	0043	1.8742	$119.37		$23.87
26605	Treat metacarpal fracture		T	0043	1.8742	$119.37		$23.87
26607	Treat metacarpal fracture		T	0043	1.8742	$119.37		$23.87
26608	Treat metacarpal fracture		T	0062	26.3092	$1,675.71	$372.80	$335.14
26615	Treat metacarpal fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
26641	Treat thumb dislocation		T	0043	1.8742	$119.37		$23.87
26645	Treat thumb fracture		T	0043	1.8742	$119.37		$23.87
26650	Treat thumb fracture		T	0062	26.3092	$1,675.71	$372.80	$335.14
26665	Treat thumb fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
26670	Treat hand dislocation		T	0043	1.8742	$119.37		$23.87
26675	Treat hand dislocation		T	0043	1.8742	$119.37		$23.87
26676	Pin hand dislocation		T	0062	26.3092	$1,675.71	$372.80	$335.14
26685	Treat hand dislocation		T	0063	40.3466	$2,569.80	$548.30	$513.96
26686	Treat hand dislocation		T	0064	60.0595	$3,825.37	$835.70	$765.07
26700	Treat knuckle dislocation		T	0043	1.8742	$119.37		$23.87
26705	Treat knuckle dislocation		T	0043	1.8742	$119.37		$23.87
26706	Pin knuckle dislocation		T	0043	1.8742	$119.37		$23.87
26715	Treat knuckle dislocation		T	0063	40.3466	$2,569.80	$548.30	$513.96
26720	Treat finger fracture, each		T	0043	1.8742	$119.37		$23.87
26725	Treat finger fracture, each		T	0043	1.8742	$119.37		$23.87
26727	Treat finger fracture, each		T	0062	26.3092	$1,675.71	$372.80	$335.14
26735	Treat finger fracture, each		T	0063	40.3466	$2,569.80	$548.30	$513.96
26740	Treat finger fracture, each		T	0043	1.8742	$119.37		$23.87
26742	Treat finger fracture, each		T	0043	1.8742	$119.37		$23.87
26746	Treat finger fracture, each		T	0063	40.3466	$2,569.80	$548.30	$513.96
26750	Treat finger fracture, each		T	0043	1.8742	$119.37		$23.87
26755	Treat finger fracture, each		T	0043	1.8742	$119.37		$23.87
26756	Pin finger fracture, each		T	0062	26.3092	$1,675.71	$372.80	$335.14
26765	Treat finger fracture, each		T	0063	40.3466	$2,569.80	$548.30	$513.96
26770	Treat finger dislocation		T	0043	1.8742	$119.37		$23.87
26775	Treat finger dislocation		T	0045	15.0176	$956.52	$268.40	$191.30
26776	Pin finger dislocation		T	0062	26.3092	$1,675.71	$372.80	$335.14
26785	Treat finger dislocation		T	0062	26.3092	$1,675.71	$372.80	$335.14
26820	Thumb fusion with graft		T	0054	26.7322	$1,702.65		$340.53
26841	Fusion of thumb		T	0054	26.7322	$1,702.65		$340.53
26842	Thumb fusion with graft		T	0054	26.7322	$1,702.65		$340.53
26843	Fusion of hand joint		T	0054	26.7322	$1,702.65		$340.53
26844	Fusion/graft of hand joint		T	0054	26.7322	$1,702.65		$340.53
26850	Fusion of knuckle		T	0054	26.7322	$1,702.65		$340.53
26852	Fusion of knuckle with graft		T	0054	26.7322	$1,702.65		$340.53
26860	Fusion of finger joint		T	0054	26.7322	$1,702.65		$340.53
26861	Fusion of finger jnt, add-on		T	0054	26.7322	$1,702.65		$340.53
26862	Fusion/graft of finger joint		T	0054	26.7322	$1,702.65		$340.53
26863	Fuse/graft added joint		T	0054	26.7322	$1,702.65		$340.53
26910	Amputate metacarpal bone		T	0054	26.7322	$1,702.65		$340.53
26951	Amputation of finger/thumb		T	0053	16.822	$1,071.44	$253.40	$214.29
26952	Amputation of finger/thumb		T	0053	16.822	$1,071.44	$253.40	$214.29
26989	Hand/finger surgery		T	0043	1.8742	$119.37		$23.87
26990	Drainage of pelvis lesion		T	0049	21.5761	$1,374.25		$274.85
26991	Drainage of pelvis bursa		T	0049	21.5761	$1,374.25		$274.85
26992	Drainage of bone lesion		C					
27000	Incision of hip tendon		T	0049	21.5761	$1,374.25		$274.85
27001	Incision of hip tendon		T	0050	29.3263	$1,867.88		$373.58
27003	Incision of hip tendon		T	0050	29.3263	$1,867.88		$373.58
27005	Incision of hip tendon		C					
27006	Incision of hip tendons	CH	T	0050	29.3263	$1,867.88		$373.58
27025	Incision of hip/thigh fascia		C					
27030	Drainage of hip joint		C					
27033	Exploration of hip joint		T	0051	43.5953	$2,776.72		$555.34
27035	Denervation of hip joint		T	0051	43.5953	$2,776.72		$555.34
27036	Excision of hip joint/muscle		C					
27040	Biopsy of soft tissues		T	0020	8.7155	$555.12		$111.02
27041	Biopsy of soft tissues		T	0020	8.7155	$555.12		$111.02
27047	Remove hip/pelvis lesion		T	0022	21.4534	$1,366.43	$354.40	$273.29
27048	Remove hip/pelvis lesion		T	0022	21.4534	$1,366.43	$354.40	$273.29
27049	Remove tumor, hip/pelvis		T	0022	21.4534	$1,366.43	$354.40	$273.29
27050	Biopsy of sacroiliac joint		T	0049	21.5761	$1,374.25		$274.85
27052	Biopsy of hip joint		T	0049	21.5761	$1,374.25		$274.85
27054	Removal of hip joint lining		C					
27060	Removal of ischial bursa		T	0049	21.5761	$1,374.25		$274.85
27062	Remove femur lesion/bursa		T	0049	21.5761	$1,374.25		$274.85
27065	Removal of hip bone lesion		T	0049	21.5761	$1,374.25		$274.85
27066	Removal of hip bone lesion		T	0050	29.3263	$1,867.88		$373.58
27067	Remove/graft hip bone lesion		T	0050	29.3263	$1,867.88		$373.58
27070	Partial removal of hip bone		C					
27071	Partial removal of hip bone		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27075	Extensive hip surgery		C					
27076	Extensive hip surgery		C					
27077	Extensive hip surgery		C					
27078	Extensive hip surgery		C					
27079	Extensive hip surgery		C					
27080	Removal of tail bone		T	0050	29.3263	$1,867.88		$373.58
27086	Remove hip foreign body		T	0020	8.7155	$555.12		$111.02
27087	Remove hip foreign body		T	0049	21.5761	$1,374.25		$274.85
27090	Removal of hip prosthesis		C					
27091	Removal of hip prosthesis		C					
27093	Injection for hip x-ray		N					
27095	Injection for hip x-ray		N					
27096	Inject sacroiliac joint		B					
27097	Revision of hip tendon		T	0050	29.3263	$1,867.88		$373.58
27098	Transfer tendon to pelvis		T	0050	29.3263	$1,867.88		$373.58
27100	Transfer of abdominal muscle		T	0051	43.5953	$2,776.72		$555.34
27105	Transfer of spinal muscle		T	0051	43.5953	$2,776.72		$555.34
27110	Transfer of iliopsoas muscle		T	0051	43.5953	$2,776.72		$555.34
27111	Transfer of iliopsoas muscle		T	0051	43.5953	$2,776.72		$555.34
27120	Reconstruction of hip socket		C					
27122	Reconstruction of hip socket		C					
27125	Partial hip replacement		C					
27130	Total hip arthroplasty		C					
27132	Total hip arthroplasty		C					
27134	Revise hip joint replacement		C					
27137	Revise hip joint replacement		C					
27138	Revise hip joint replacement		C					
27140	Transplant femur ridge		C					
27146	Incision of hip bone		C					
27147	Revision of hip bone		C					
27151	Incision of hip bones		C					
27156	Revision of hip bones		C					
27158	Revision of pelvis		C					
27161	Incision of neck of femur		C					
27165	Incision/fixation of femur		C					
27170	Repair/graft femur head/neck		C					
27175	Treat slipped epiphysis		C					
27176	Treat slipped epiphysis		C					
27177	Treat slipped epiphysis		C					
27178	Treat slipped epiphysis		C					
27179	Revise head/neck of femur		C					
27181	Treat slipped epiphysis		C					
27185	Revision of femur epiphysis		C					
27187	Reinforce hip bones		C					
27193	Treat pelvic ring fracture		T	0043	1.8742	$119.37		$23.87
27194	Treat pelvic ring fracture		T	0045	15.0176	$956.52	$268.40	$191.30
27200	Treat tail bone fracture		T	0043	1.8742	$119.37		$23.87
27202	Treat tail bone fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
27215	Treat pelvic fracture(s)		C					
27216	Treat pelvic ring fracture		T	0050	29.3263	$1,867.88		$373.58
27217	Treat pelvic ring fracture		C					
27218	Treat pelvic ring fracture		C					
27220	Treat hip socket fracture		T	0043	1.8742	$119.37		$23.87
27222	Treat hip socket fracture		C					
27226	Treat hip wall fracture		C					
27227	Treat hip fracture(s)		C					
27228	Treat hip fracture(s)		C					
27230	Treat thigh fracture		T	0043	1.8742	$119.37		$23.87
27232	Treat thigh fracture		C					
27235	Treat thigh fracture		T	0050	29.3263	$1,867.88		$373.58
27236	Treat thigh fracture		C					
27238	Treat thigh fracture		T	0043	1.8742	$119.37		$23.87
27240	Treat thigh fracture		C					
27244	Treat thigh fracture		C					
27245	Treat thigh fracture		C					
27246	Treat thigh fracture		T	0043	1.8742	$119.37		$23.87
27248	Treat thigh fracture		C					
27250	Treat hip dislocation		T	0043	1.8742	$119.37		$23.87
27252	Treat hip dislocation		T	0045	15.0176	$956.52	$268.40	$191.30
27253	Treat hip dislocation		C					
27254	Treat hip dislocation		C					
27256	Treat hip dislocation		T	0043	1.8742	$119.37		$23.87
27257	Treat hip dislocation		T	0045	15.0176	$956.52	$268.40	$191.30
27258	Treat hip dislocation		C					
27259	Treat hip dislocation		C					
27265	Treat hip dislocation		T	0043	1.8742	$119.37		$23.87
27266	Treat hip dislocation		T	0045	15.0176	$956.52	$268.40	$191.30
27275	Manipulation of hip joint		T	0045	15.0176	$956.52	$268.40	$191.30

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27280	Fusion of sacroiliac joint		C					
27282	Fusion of pubic bones		C					
27284	Fusion of hip joint		C					
27286	Fusion of hip joint		C					
27290	Amputation of leg at hip		C					
27295	Amputation of leg at hip		C					
27299	Pelvis/hip joint surgery		T	0043	1.8742	$119.37		$23.87
27301	Drain thigh/knee lesion		T	0008	19.0457	$1,213.08		$242.62
27303	Drainage of bone lesion		C					
27305	Incise thigh tendon & fascia		T	0049	21.5761	$1,374.25		$274.85
27306	Incision of thigh tendon		T	0049	21.5761	$1,374.25		$274.85
27307	Incision of thigh tendons		T	0049	21.5761	$1,374.25		$274.85
27310	Exploration of knee joint		T	0050	29.3263	$1,867.88		$373.58
27323	Biopsy, thigh soft tissues		T	0020	8.7155	$555.12		$111.02
27324	Biopsy, thigh soft tissues		T	0022	21.4534	$1,366.43	$354.40	$273.29
27325	Neurectomy, hamstring		T	0220	18.5069	$1,178.76		$235.75
27326	Neurectomy, popliteal		T	0220	18.5069	$1,178.76		$235.75
27327	Removal of thigh lesion		T	0022	21.4534	$1,366.43	$354.40	$273.29
27328	Removal of thigh lesion		T	0022	21.4534	$1,366.43	$354.40	$273.29
27329	Remove tumor, thigh/knee		T	0022	21.4534	$1,366.43	$354.40	$273.29
27330	Biopsy, knee joint lining		T	0050	29.3263	$1,867.88		$373.58
27331	Explore/treat knee joint		T	0050	29.3263	$1,867.88		$373.58
27332	Removal of knee cartilage		T	0050	29.3263	$1,867.88		$373.58
27333	Removal of knee cartilage		T	0050	29.3263	$1,867.88		$373.58
27334	Remove knee joint lining		T	0050	29.3263	$1,867.88		$373.58
27335	Remove knee joint lining		T	0050	29.3263	$1,867.88		$373.58
27340	Removal of kneecap bursa		T	0049	21.5761	$1,374.25		$274.85
27345	Removal of knee cyst		T	0049	21.5761	$1,374.25		$274.85
27347	Remove knee cyst		T	0049	21.5761	$1,374.25		$274.85
27350	Removal of kneecap		T	0050	29.3263	$1,867.88		$373.58
27355	Remove femur lesion		T	0050	29.3263	$1,867.88		$373.58
27356	Remove femur lesion/graft		T	0050	29.3263	$1,867.88		$373.58
27357	Remove femur lesion/graft		T	0050	29.3263	$1,867.88		$373.58
27358	Remove femur lesion/fixation		T	0050	29.3263	$1,867.88		$373.58
27360	Partial removal, leg bone(s)		T	0050	29.3263	$1,867.88		$373.58
27365	Extensive leg surgery		C					
27370	Injection for knee x-ray		N					
27372	Removal of foreign body		T	0022	21.4534	$1,366.43	$354.40	$273.29
27380	Repair of kneecap tendon		T	0049	21.5761	$1,374.25		$274.85
27381	Repair/graft kneecap tendon		T	0049	21.5761	$1,374.25		$274.85
27385	Repair of thigh muscle		T	0049	21.5761	$1,374.25		$274.85
27386	Repair/graft of thigh muscle		T	0049	21.5761	$1,374.25		$274.85
27390	Incision of thigh tendon		T	0049	21.5761	$1,374.25		$274.85
27391	Incision of thigh tendons		T	0049	21.5761	$1,374.25		$274.85
27392	Incision of thigh tendons		T	0049	21.5761	$1,374.25		$274.85
27393	Lengthening of thigh tendon		T	0050	29.3263	$1,867.88		$373.58
27394	Lengthening of thigh tendons		T	0050	29.3263	$1,867.88		$373.58
27395	Lengthening of thigh tendons		T	0051	43.5953	$2,776.72		$555.34
27396	Transplant of thigh tendon		T	0050	29.3263	$1,867.88		$373.58
27397	Transplants of thigh tendons		T	0051	43.5953	$2,776.72		$555.34
27400	Revise thigh muscles/tendons		T	0051	43.5953	$2,776.72		$555.34
27403	Repair of knee cartilage		T	0050	29.3263	$1,867.88		$373.58
27405	Repair of knee ligament		T	0051	43.5953	$2,776.72		$555.34
27407	Repair of knee ligament		T	0052	78.6518	$5,009.57		$1,001.91
27409	Repair of knee ligaments		T	0051	43.5953	$2,776.72		$555.34
27412	Autochondrocyte implant knee		T	0042	47.7765	$3,043.03	$804.70	$608.61
27415	Osteochondral knee allograft		T	0042	47.7765	$3,043.03	$804.70	$608.61
27418	Repair degenerated kneecap		T	0051	43.5953	$2,776.72		$555.34
27420	Revision of unstable kneecap		T	0051	43.5953	$2,776.72		$555.34
27422	Revision of unstable kneecap		T	0051	43.5953	$2,776.72		$555.34
27424	Revision/removal of kneecap		T	0051	43.5953	$2,776.72		$555.34
27425	Lat retinacular release open		T	0050	29.3263	$1,867.88		$373.58
27427	Reconstruction, knee		T	0051	43.5953	$2,776.72		$555.34
27428	Reconstruction, knee		T	0052	78.6518	$5,009.57		$1,001.91
27429	Reconstruction, knee		T	0052	78.6518	$5,009.57		$1,001.91
27430	Revision of thigh muscles		T	0051	43.5953	$2,776.72		$555.34
27435	Incision of knee joint		T	0051	43.5953	$2,776.72		$555.34
27437	Revise kneecap		T	0047	35.9249	$2,288.16	$537.00	$457.63
27438	Revise kneecap with implant		T	0048	51.0431	$3,251.09		$650.22
27440	Revision of knee joint		T	0047	35.9249	$2,288.16	$537.00	$457.63
27441	Revision of knee joint		T	0047	35.9249	$2,288.16	$537.00	$457.63
27442	Revision of knee joint		T	0047	35.9249	$2,288.16	$537.00	$457.63
27443	Revision of knee joint		T	0047	35.9249	$2,288.16	$537.00	$457.63
27445	Revision of knee joint		C					
27446	Revision of knee joint		T	0681	191.2387	$12,180.57		$2,436.11
27447	Total knee arthroplasty		C					
27448	Incision of thigh		C					
27450	Incision of thigh		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27454	Realignment of thigh bone		C					
27455	Realignment of knee		C					
27457	Realignment of knee		C					
27465	Shortening of thigh bone		C					
27466	Lengthening of thigh bone		C					
27468	Shorten/lengthen thighs		C					
27470	Repair of thigh		C					
27472	Repair/graft of thigh		C					
27475	Surgery to stop leg growth		T	0050	29.3263	$1,867.88		$373.58
27477	Surgery to stop leg growth		C					
27479	Surgery to stop leg growth		C					
27485	Surgery to stop leg growth		C					
27486	Revise/replace knee joint		C					
27487	Revise/replace knee joint		C					
27488	Removal of knee prosthesis		C					
27495	Reinforce thigh		C					
27496	Decompression of thigh/knee		T	0049	21.5761	$1,374.25		$274.85
27497	Decompression of thigh/knee		T	0049	21.5761	$1,374.25		$274.85
27498	Decompression of thigh/knee		T	0049	21.5761	$1,374.25		$274.85
27499	Decompression of thigh/knee		T	0049	21.5761	$1,374.25		$274.85
27500	Treatment of thigh fracture		T	0043	1.8742	$119.37		$23.87
27501	Treatment of thigh fracture		T	0043	1.8742	$119.37		$23.87
27502	Treatment of thigh fracture		T	0043	1.8742	$119.37		$23.87
27503	Treatment of thigh fracture		T	0043	1.8742	$119.37		$23.87
27506	Treatment of thigh fracture		C					
27507	Treatment of thigh fracture		C					
27508	Treatment of thigh fracture		T	0043	1.8742	$119.37		$23.87
27509	Treatment of thigh fracture		T	0062	26.3092	$1,675.71	$372.80	$335.14
27510	Treatment of thigh fracture		T	0043	1.8742	$119.37		$23.87
27511	Treatment of thigh fracture		C					
27513	Treatment of thigh fracture		C					
27514	Treatment of thigh fracture		C					
27516	Treat thigh fx growth plate		T	0043	1.8742	$119.37		$23.87
27517	Treat thigh fx growth plate		T	0043	1.8742	$119.37		$23.87
27519	Treat thigh fx growth plate		C					
27520	Treat kneecap fracture		T	0043	1.8742	$119.37		$23.87
27524	Treat kneecap fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
27530	Treat knee fracture		T	0043	1.8742	$119.37		$23.87
27532	Treat knee fracture		T	0043	1.8742	$119.37		$23.87
27535	Treat knee fracture		C					
27536	Treat knee fracture		C					
27538	Treat knee fracture(s)		T	0043	1.8742	$119.37		$23.87
27540	Treat knee fracture		C					
27550	Treat knee dislocation		T	0043	1.8742	$119.37		$23.87
27552	Treat knee dislocation		T	0045	15.0176	$956.52	$268.40	$191.30
27556	Treat knee dislocation		C					
27557	Treat knee dislocation		C					
27558	Treat knee dislocation		C					
27560	Treat kneecap dislocation		T	0043	1.8742	$119.37		$23.87
27562	Treat kneecap dislocation		T	0045	15.0176	$956.52	$268.40	$191.30
27566	Treat kneecap dislocation		T	0063	40.3466	$2,569.80	$548.30	$513.96
27570	Fixation of knee joint		T	0045	15.0176	$956.52	$268.40	$191.30
27580	Fusion of knee		C					
27590	Amputate leg at thigh		C					
27591	Amputate leg at thigh		C					
27592	Amputate leg at thigh		C					
27594	Amputation follow-up surgery		T	0049	21.5761	$1,374.25		$274.85
27596	Amputation follow-up surgery		C					
27598	Amputate lower leg at knee		C					
27599	Leg surgery procedure		T	0043	1.8742	$119.37		$23.87
27600	Decompression of lower leg		T	0049	21.5761	$1,374.25		$274.85
27601	Decompression of lower leg		T	0049	21.5761	$1,374.25		$274.85
27602	Decompression of lower leg		T	0049	21.5761	$1,374.25		$274.85
27603	Drain lower leg lesion		T	0008	19.0457	$1,213.08		$242.62
27604	Drain lower leg bursa		T	0049	21.5761	$1,374.25		$274.85
27605	Incision of achilles tendon		T	0055	21.1762	$1,348.78	$355.30	$269.76
27606	Incision of achilles tendon		T	0049	21.5761	$1,374.25		$274.85
27607	Treat lower leg bone lesion		T	0049	21.5761	$1,374.25		$274.85
27610	Explore/treat ankle joint		T	0050	29.3263	$1,867.88		$373.58
27612	Exploration of ankle joint		T	0050	29.3263	$1,867.88		$373.58
27613	Biopsy lower leg soft tissue		T	0020	8.7155	$555.12		$111.02
27614	Biopsy lower leg soft tissue		T	0022	21.4534	$1,366.43	$354.40	$273.29
27615	Remove tumor, lower leg		T	0050	29.3263	$1,867.88		$373.58
27618	Remove lower leg lesion		T	0021	16.5832	$1,056.23	$219.40	$211.25
27619	Remove lower leg lesion		T	0022	21.4534	$1,366.43	$354.40	$273.29
27620	Explore/treat ankle joint		T	0050	29.3263	$1,867.88		$373.58
27625	Remove ankle joint lining		T	0050	29.3263	$1,867.88		$373.58
27626	Remove ankle joint lining		T	0050	29.3263	$1,867.88		$373.58

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27630	Removal of tendon lesion		T	0049	21.5761	$1,374.25		$274.85
27635	Remove lower leg bone lesion		T	0050	29.3263	$1,867.88		$373.58
27637	Remove/graft leg bone lesion		T	0050	29.3263	$1,867.88		$373.58
27638	Remove/graft leg bone lesion		T	0050	29.3263	$1,867.88		$373.58
27640	Partial removal of tibia		T	0051	43.5953	$2,776.72		$555.34
27641	Partial removal of fibula		T	0050	29.3263	$1,867.88		$373.58
27645	Extensive lower leg surgery		C					
27646	Extensive lower leg surgery		C					
27647	Extensive ankle/heel surgery		T	0051	43.5953	$2,776.72		$555.34
27648	Injection for ankle x-ray		N					
27650	Repair achilles tendon		T	0051	43.5953	$2,776.72		$555.34
27652	Repair/graft achilles tendon		T	0052	78.6518	$5,009.57		$1,001.91
27654	Repair of achilles tendon		T	0051	43.5953	$2,776.72		$555.34
27656	Repair leg fascia defect		T	0049	21.5761	$1,374.25		$274.85
27658	Repair of leg tendon, each		T	0049	21.5761	$1,374.25		$274.85
27659	Repair of leg tendon, each		T	0049	21.5761	$1,374.25		$274.85
27664	Repair of leg tendon, each		T	0049	21.5761	$1,374.25		$274.85
27665	Repair of leg tendon, each		T	0050	29.3263	$1,867.88		$373.58
27675	Repair lower leg tendons		T	0049	21.5761	$1,374.25		$274.85
27676	Repair lower leg tendons		T	0050	29.3263	$1,867.88		$373.58
27680	Release of lower leg tendon		T	0050	29.3263	$1,867.88		$373.58
27681	Release of lower leg tendons		T	0050	29.3263	$1,867.88		$373.58
27685	Revision of lower leg tendon		T	0050	29.3263	$1,867.88		$373.58
27686	Revise lower leg tendons		T	0050	29.3263	$1,867.88		$373.58
27687	Revision of calf tendon		T	0050	29.3263	$1,867.88		$373.58
27690	Revise lower leg tendon		T	0051	43.5953	$2,776.72		$555.34
27691	Revise lower leg tendon		T	0051	43.5953	$2,776.72		$555.34
27692	Revise additional leg tendon		T	0051	43.5953	$2,776.72		$555.34
27695	Repair of ankle ligament		T	0050	29.3263	$1,867.88		$373.58
27696	Repair of ankle ligaments		T	0050	29.3263	$1,867.88		$373.58
27698	Repair of ankle ligament		T	0050	29.3263	$1,867.88		$373.58
27700	Revision of ankle joint		T	0047	35.9249	$2,288.16	$537.00	$457.63
27702	Reconstruct ankle joint		C					
27703	Reconstruction, ankle joint		C					
27704	Removal of ankle implant		T	0049	21.5761	$1,374.25		$274.85
27705	Incision of tibia		T	0051	43.5953	$2,776.72		$555.34
27707	Incision of fibula		T	0049	21.5761	$1,374.25		$274.85
27709	Incision of tibia & fibula		T	0050	29.3263	$1,867.88		$373.58
27712	Realignment of lower leg		C					
27715	Revision of lower leg		C					
27720	Repair of tibia	CH	T	0063	40.3466	$2,569.80	$548.30	$513.96
27722	Repair/graft of tibia	CH	T	0064	60.0595	$3,825.37	$835.70	$765.07
27724	Repair/graft of tibia		C					
27725	Repair of lower leg		C					
27727	Repair of lower leg		C					
27730	Repair of tibia epiphysis		T	0050	29.3263	$1,867.88		$373.58
27732	Repair of fibula epiphysis		T	0050	29.3263	$1,867.88		$373.58
27734	Repair lower leg epiphyses		T	0050	29.3263	$1,867.88		$373.58
27740	Repair of leg epiphyses		T	0050	29.3263	$1,867.88		$373.58
27742	Repair of leg epiphyses		T	0051	43.5953	$2,776.72		$555.34
27745	Reinforce tibia		T	0052	78.6518	$5,009.57		$1,001.91
27750	Treatment of tibia fracture		T	0043	1.8742	$119.37		$23.87
27752	Treatment of tibia fracture		T	0043	1.8742	$119.37		$23.87
27756	Treatment of tibia fracture		T	0062	26.3092	$1,675.71	$372.80	$335.14
27758	Treatment of tibia fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
27759	Treatment of tibia fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
27760	Treatment of ankle fracture		T	0043	1.8742	$119.37		$23.87
27762	Treatment of ankle fracture		T	0043	1.8742	$119.37		$23.87
27766	Treatment of ankle fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
27780	Treatment of fibula fracture		T	0043	1.8742	$119.37		$23.87
27781	Treatment of fibula fracture		T	0043	1.8742	$119.37		$23.87
27784	Treatment of fibula fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
27786	Treatment of ankle fracture		T	0043	1.8742	$119.37		$23.87
27788	Treatment of ankle fracture		T	0043	1.8742	$119.37		$23.87
27792	Treatment of ankle fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
27808	Treatment of ankle fracture		T	0043	1.8742	$119.37		$23.87
27810	Treatment of ankle fracture		T	0043	1.8742	$119.37		$23.87
27814	Treatment of ankle fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
27816	Treatment of ankle fracture		T	0043	1.8742	$119.37		$23.87
27818	Treatment of ankle fracture		T	0043	1.8742	$119.37		$23.87
27822	Treatment of ankle fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
27823	Treatment of ankle fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
27824	Treat lower leg fracture		T	0043	1.8742	$119.37		$23.87
27825	Treat lower leg fracture		T	0043	1.8742	$119.37		$23.87
27826	Treat lower leg fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
27827	Treat lower leg fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
27828	Treat lower leg fracture		T	0064	60.0595	$3,825.37	$835.70	$765.07
27829	Treat lower leg joint		T	0063	40.3466	$2,569.80	$548.30	$513.96

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27830	Treat lower leg dislocation		T	0043	1.8742	$119.37		$23.87
27831	Treat lower leg dislocation		T	0043	1.8742	$119.37		$23.87
27832	Treat lower leg dislocation		T	0063	40.3466	$2,569.80	$548.30	$513.96
27840	Treat ankle dislocation		T	0043	1.8742	$119.37		$23.87
27842	Treat ankle dislocation		T	0045	15.0176	$956.52	$268.40	$191.30
27846	Treat ankle dislocation		T	0063	40.3466	$2,569.80	$548.30	$513.96
27848	Treat ankle dislocation		T	0063	40.3466	$2,569.80	$548.30	$513.96
27860	Fixation of ankle joint		T	0045	15.0176	$956.52	$268.40	$191.30
27870	Fusion of ankle joint, open		T	0052	78.6518	$5,009.57		$1,001.91
27871	Fusion of tibiofibular joint		T	0052	78.6518	$5,009.57		$1,001.91
27880	Amputation of lower leg		C					
27881	Amputation of lower leg		C					
27882	Amputation of lower leg		C					
27884	Amputation follow-up surgery		T	0049	21.5761	$1,374.25		$274.85
27886	Amputation follow-up surgery		C					
27888	Amputation of foot at ankle		C					
27889	Amputation of foot at ankle		T	0050	29.3263	$1,867.88		$373.58
27892	Decompression of leg		T	0049	21.5761	$1,374.25		$274.85
27893	Decompression of leg		T	0049	21.5761	$1,374.25		$274.85
27894	Decompression of leg		T	0049	21.5761	$1,374.25		$274.85
27899	Leg/ankle surgery procedure		T	0043	1.8742	$119.37		$23.87
28001	Drainage of bursa of foot		T	0007	12.5792	$801.21		$160.24
28002	Treatment of foot infection		T	0049	21.5761	$1,374.25		$274.85
28003	Treatment of foot infection		T	0049	21.5761	$1,374.25		$274.85
28005	Treat foot bone lesion		T	0055	21.1762	$1,348.78	$355.30	$269.76
28008	Incision of foot fascia		T	0055	21.1762	$1,348.78	$355.30	$269.76
28010	Incision of toe tendon		T	0055	21.1762	$1,348.78	$355.30	$269.76
28011	Incision of toe tendons		T	0055	21.1762	$1,348.78	$355.30	$269.76
28020	Exploration of foot joint		T	0055	21.1762	$1,348.78	$355.30	$269.76
28022	Exploration of foot joint		T	0055	21.1762	$1,348.78	$355.30	$269.76
28024	Exploration of toe joint		T	0055	21.1762	$1,348.78	$355.30	$269.76
28035	Decompression of tibia nerve		T	0220	18.5069	$1,178.76		$235.75
28043	Excision of foot lesion		T	0022	21.4534	$1,366.43	$354.40	$273.29
28045	Excision of foot lesion		T	0055	21.1762	$1,348.78	$355.30	$269.76
28046	Resection of tumor, foot		T	0055	21.1762	$1,348.78	$355.30	$269.76
28050	Biopsy of foot joint lining		T	0055	21.1762	$1,348.78	$355.30	$269.76
28052	Biopsy of foot joint lining		T	0055	21.1762	$1,348.78	$355.30	$269.76
28054	Biopsy of toe joint lining		T	0055	21.1762	$1,348.78	$355.30	$269.76
28055	Neurectomy, foot		T	0220	18.5069	$1,178.76		$235.75
28060	Partial removal, foot fascia		T	0055	21.1762	$1,348.78	$355.30	$269.76
28062	Removal of foot fascia		T	0055	21.1762	$1,348.78	$355.30	$269.76
28070	Removal of foot joint lining		T	0055	21.1762	$1,348.78	$355.30	$269.76
28072	Removal of foot joint lining		T	0055	21.1762	$1,348.78	$355.30	$269.76
28080	Removal of foot lesion		T	0055	21.1762	$1,348.78	$355.30	$269.76
28086	Excise foot tendon sheath		T	0055	21.1762	$1,348.78	$355.30	$269.76
28088	Excise foot tendon sheath		T	0055	21.1762	$1,348.78	$355.30	$269.76
28090	Removal of foot lesion		T	0055	21.1762	$1,348.78	$355.30	$269.76
28092	Removal of toe lesions		T	0055	21.1762	$1,348.78	$355.30	$269.76
28100	Removal of ankle/heel lesion		T	0055	21.1762	$1,348.78	$355.30	$269.76
28102	Remove/graft foot lesion		T	0056	44.471	$2,832.49		$566.50
28103	Remove/graft foot lesion		T	0056	44.471	$2,832.49		$566.50
28104	Removal of foot lesion		T	0055	21.1762	$1,348.78	$355.30	$269.76
28106	Remove/graft foot lesion		T	0056	44.471	$2,832.49		$566.50
28107	Remove/graft foot lesion		T	0056	44.471	$2,832.49		$566.50
28108	Removal of toe lesions		T	0055	21.1762	$1,348.78	$355.30	$269.76
28110	Part removal of metatarsal		T	0055	21.1762	$1,348.78	$355.30	$269.76
28111	Part removal of metatarsal		T	0055	21.1762	$1,348.78	$355.30	$269.76
28112	Part removal of metatarsal		T	0055	21.1762	$1,348.78	$355.30	$269.76
28113	Part removal of metatarsal		T	0055	21.1762	$1,348.78	$355.30	$269.76
28114	Removal of metatarsal heads		T	0055	21.1762	$1,348.78	$355.30	$269.76
28116	Revision of foot		T	0055	21.1762	$1,348.78	$355.30	$269.76
28118	Removal of heel bone		T	0055	21.1762	$1,348.78	$355.30	$269.76
28119	Removal of heel spur		T	0055	21.1762	$1,348.78	$355.30	$269.76
28120	Part removal of ankle/heel		T	0055	21.1762	$1,348.78	$355.30	$269.76
28122	Partial removal of foot bone		T	0055	21.1762	$1,348.78	$355.30	$269.76
28124	Partial removal of toe		T	0055	21.1762	$1,348.78	$355.30	$269.76
28126	Partial removal of toe		T	0055	21.1762	$1,348.78	$355.30	$269.76
28130	Removal of ankle bone		T	0055	21.1762	$1,348.78	$355.30	$269.76
28140	Removal of metatarsal		T	0055	21.1762	$1,348.78	$355.30	$269.76
28150	Removal of toe		T	0055	21.1762	$1,348.78	$355.30	$269.76
28153	Partial removal of toe		T	0055	21.1762	$1,348.78	$355.30	$269.76
28160	Partial removal of toe		T	0055	21.1762	$1,348.78	$355.30	$269.76
28171	Extensive foot surgery		T	0055	21.1762	$1,348.78	$355.30	$269.76
28173	Extensive foot surgery		T	0055	21.1762	$1,348.78	$355.30	$269.76
28175	Extensive foot surgery		T	0055	21.1762	$1,348.78	$355.30	$269.76
28190	Removal of foot foreign body		T	0019	4.4463	$283.20	$71.80	$56.64
28192	Removal of foot foreign body		T	0021	16.5832	$1,056.23	$219.40	$211.25
28193	Removal of foot foreign body		T	0020	8.7155	$555.12		$111.02

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
28200	Repair of foot tendon		T	0055	21.1762	$1,348.78	$355.30	$269.76
28202	Repair/graft of foot tendon		T	0055	21.1762	$1,348.78	$355.30	$269.76
28208	Repair of foot tendon		T	0055	21.1762	$1,348.78	$355.30	$269.76
28210	Repair/graft of foot tendon		T	0056	44.471	$2,832.49		$566.50
28220	Release of foot tendon		T	0055	21.1762	$1,348.78	$355.30	$269.76
28222	Release of foot tendons		T	0055	21.1762	$1,348.78	$355.30	$269.76
28225	Release of foot tendon		T	0055	21.1762	$1,348.78	$355.30	$269.76
28226	Release of foot tendons		T	0055	21.1762	$1,348.78	$355.30	$269.76
28230	Incision of foot tendon(s)		T	0055	21.1762	$1,348.78	$355.30	$269.76
28232	Incision of toe tendon		T	0055	21.1762	$1,348.78	$355.30	$269.76
28234	Incision of foot tendon		T	0055	21.1762	$1,348.78	$355.30	$269.76
28238	Revision of foot tendon		T	0056	44.471	$2,832.49		$566.50
28240	Release of big toe		T	0055	21.1762	$1,348.78	$355.30	$269.76
28250	Revision of foot fascia		T	0055	21.1762	$1,348.78	$355.30	$269.76
28260	Release of midfoot joint		T	0055	21.1762	$1,348.78	$355.30	$269.76
28261	Revision of foot tendon		T	0055	21.1762	$1,348.78	$355.30	$269.76
28262	Revision of foot and ankle		T	0055	21.1762	$1,348.78	$355.30	$269.76
28264	Release of midfoot joint		T	0056	44.471	$2,832.49		$566.50
28270	Release of foot contracture		T	0055	21.1762	$1,348.78	$355.30	$269.76
28272	Release of toe joint, each		T	0055	21.1762	$1,348.78	$355.30	$269.76
28280	Fusion of toes		T	0055	21.1762	$1,348.78	$355.30	$269.76
28285	Repair of hammertoe		T	0055	21.1762	$1,348.78	$355.30	$269.76
28286	Repair of hammertoe		T	0055	21.1762	$1,348.78	$355.30	$269.76
28288	Partial removal of foot bone		T	0055	21.1762	$1,348.78	$355.30	$269.76
28289	Repair hallux rigidus		T	0055	21.1762	$1,348.78	$355.30	$269.76
28290	Correction of bunion		T	0057	29.8356	$1,900.32	$475.90	$380.06
28292	Correction of bunion		T	0057	29.8356	$1,900.32	$475.90	$380.06
28293	Correction of bunion		T	0057	29.8356	$1,900.32	$475.90	$380.06
28294	Correction of bunion		T	0057	29.8356	$1,900.32	$475.90	$380.06
28296	Correction of bunion		T	0057	29.8356	$1,900.32	$475.90	$380.06
28297	Correction of bunion		T	0057	29.8356	$1,900.32	$475.90	$380.06
28298	Correction of bunion		T	0057	29.8356	$1,900.32	$475.90	$380.06
28299	Correction of bunion		T	0057	29.8356	$1,900.32	$475.90	$380.06
28300	Incision of heel bone		T	0056	44.471	$2,832.49		$566.50
28302	Incision of ankle bone		T	0055	21.1762	$1,348.78	$355.30	$269.76
28304	Incision of midfoot bones		T	0056	44.471	$2,832.49		$566.50
28305	Incise/graft midfoot bones		T	0056	44.471	$2,832.49		$566.50
28306	Incision of metatarsal		T	0055	21.1762	$1,348.78	$355.30	$269.76
28307	Incision of metatarsal		T	0055	21.1762	$1,348.78	$355.30	$269.76
28308	Incision of metatarsal		T	0055	21.1762	$1,348.78	$355.30	$269.76
28309	Incision of metatarsals		T	0056	44.471	$2,832.49		$566.50
28310	Revision of big toe		T	0055	21.1762	$1,348.78	$355.30	$269.76
28312	Revision of toe		T	0055	21.1762	$1,348.78	$355.30	$269.76
28313	Repair deformity of toe		T	0055	21.1762	$1,348.78	$355.30	$269.76
28315	Removal of sesamoid bone		T	0055	21.1762	$1,348.78	$355.30	$269.76
28320	Repair of foot bones		T	0056	44.471	$2,832.49		$566.50
28322	Repair of metatarsals		T	0056	44.471	$2,832.49		$566.50
28340	Resect enlarged toe tissue		T	0055	21.1762	$1,348.78	$355.30	$269.76
28341	Resect enlarged toe		T	0055	21.1762	$1,348.78	$355.30	$269.76
28344	Repair extra toe(s)		T	0055	21.1762	$1,348.78	$355.30	$269.76
28345	Repair webbed toe(s)		T	0055	21.1762	$1,348.78	$355.30	$269.76
28360	Reconstruct cleft foot		T	0056	44.471	$2,832.49		$566.50
28400	Treatment of heel fracture		T	0043	1.8742	$119.37		$23.87
28405	Treatment of heel fracture		T	0043	1.8742	$119.37		$23.87
28406	Treatment of heel fracture		T	0062	26.3092	$1,675.71	$372.80	$335.14
28415	Treat heel fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
28420	Treat/graft heel fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
28430	Treatment of ankle fracture		T	0043	1.8742	$119.37		$23.87
28435	Treatment of ankle fracture		T	0043	1.8742	$119.37		$23.87
28436	Treatment of ankle fracture		T	0062	26.3092	$1,675.71	$372.80	$335.14
28445	Treat ankle fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
28450	Treat midfoot fracture, each		T	0043	1.8742	$119.37		$23.87
28455	Treat midfoot fracture, each		T	0043	1.8742	$119.37		$23.87
28456	Treat midfoot fracture		T	0062	26.3092	$1,675.71	$372.80	$335.14
28465	Treat midfoot fracture, each		T	0063	40.3466	$2,569.80	$548.30	$513.96
28470	Treat metatarsal fracture		T	0043	1.8742	$119.37		$23.87
28475	Treat metatarsal fracture		T	0043	1.8742	$119.37		$23.87
28476	Treat metatarsal fracture		T	0062	26.3092	$1,675.71	$372.80	$335.14
28485	Treat metatarsal fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
28490	Treat big toe fracture		T	0043	1.8742	$119.37		$23.87
28495	Treat big toe fracture		T	0043	1.8742	$119.37		$23.87
28496	Treat big toe fracture		T	0062	26.3092	$1,675.71	$372.80	$335.14
28505	Treat big toe fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
28510	Treatment of toe fracture		T	0043	1.8742	$119.37		$23.87
28515	Treatment of toe fracture		T	0043	1.8742	$119.37		$23.87
28525	Treat toe fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96
28530	Treat sesamoid bone fracture		T	0043	1.8742	$119.37		$23.87
28531	Treat sesamoid bone fracture		T	0063	40.3466	$2,569.80	$548.30	$513.96

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
28540	Treat foot dislocation		T	0043	1.8742	$119.37		$23.87
28545	Treat foot dislocation		T	0062	26.3092	$1,675.71	$372.80	$335.14
28546	Treat foot dislocation		T	0062	26.3092	$1,675.71	$372.80	$335.14
28555	Repair foot dislocation		T	0063	40.3466	$2,569.80	$548.30	$513.96
28570	Treat foot dislocation		T	0043	1.8742	$119.37		$23.87
28575	Treat foot dislocation		T	0043	1.8742	$119.37		$23.87
28576	Treat foot dislocation		T	0062	26.3092	$1,675.71	$372.80	$335.14
28585	Repair foot dislocation		T	0063	40.3466	$2,569.80	$548.30	$513.96
28600	Treat foot dislocation		T	0043	1.8742	$119.37		$23.87
28605	Treat foot dislocation		T	0043	1.8742	$119.37		$23.87
28606	Treat foot dislocation		T	0062	26.3092	$1,675.71	$372.80	$335.14
28615	Repair foot dislocation		T	0063	40.3466	$2,569.80	$548.30	$513.96
28630	Treat toe dislocation		T	0043	1.8742	$119.37		$23.87
28635	Treat toe dislocation		T	0045	15.0176	$956.52	$268.40	$191.30
28636	Treat toe dislocation		T	0062	26.3092	$1,675.71	$372.80	$335.14
28645	Repair toe dislocation		T	0063	40.3466	$2,569.80	$548.30	$513.96
28660	Treat toe dislocation		T	0043	1.8742	$119.37		$23.87
28665	Treat toe dislocation		T	0045	15.0176	$956.52	$268.40	$191.30
28666	Treat toe dislocation		T	0062	26.3092	$1,675.71	$372.80	$335.14
28675	Repair of toe dislocation		T	0063	40.3466	$2,569.80	$548.30	$513.96
28705	Fusion of foot bones		T	0056	44.471	$2,832.49		$566.50
28715	Fusion of foot bones	CH	T	0052	78.6518	$5,009.57		$1,001.91
28725	Fusion of foot bones		T	0056	44.471	$2,832.49		$566.50
28730	Fusion of foot bones		T	0056	44.471	$2,832.49		$566.50
28735	Fusion of foot bones		T	0056	44.471	$2,832.49		$566.50
28737	Revision of foot bones		T	0056	44.471	$2,832.49		$566.50
28740	Fusion of foot bones		T	0056	44.471	$2,832.49		$566.50
28750	Fusion of big toe joint		T	0056	44.471	$2,832.49		$566.50
28755	Fusion of big toe joint		T	0055	21.1762	$1,348.78	$355.30	$269.76
28760	Fusion of big toe joint		T	0056	44.471	$2,832.49		$566.50
28800	Amputation of midfoot		C					
28805	Amputation thru metatarsal		C					
28810	Amputation toe & metatarsal		T	0055	21.1762	$1,348.78	$355.30	$269.76
28820	Amputation of toe		T	0055	21.1762	$1,348.78	$355.30	$269.76
28825	Partial amputation of toe		T	0055	21.1762	$1,348.78	$355.30	$269.76
28890	High energy eswt, plantar f		T	0050	29.3263	$1,867.88		$373.58
28899	Foot/toes surgery procedure		T	0043	1.8742	$119.37		$23.87
29000	Application of body cast		S	0058	1.1272	$71.79		$14.36
29010	Application of body cast		S	0426	2.2383	$142.56		$28.51
29015	Application of body cast		S	0426	2.2383	$142.56		$28.51
29020	Application of body cast		S	0058	1.1272	$71.79		$14.36
29025	Application of body cast		S	0058	1.1272	$71.79		$14.36
29035	Application of body cast		S	0426	2.2383	$142.56		$28.51
29040	Application of body cast		S	0058	1.1272	$71.79		$14.36
29044	Application of body cast		S	0426	2.2383	$142.56		$28.51
29046	Application of body cast		S	0426	2.2383	$142.56		$28.51
29049	Application of figure eight		S	0058	1.1272	$71.79		$14.36
29055	Application of shoulder cast		S	0426	2.2383	$142.56		$28.51
29058	Application of shoulder cast		S	0058	1.1272	$71.79		$14.36
29065	Application of long arm cast		S	0426	2.2383	$142.56		$28.51
29075	Application of forearm cast		S	0426	2.2383	$142.56		$28.51
29085	Apply hand/wrist cast		S	0058	1.1272	$71.79		$14.36
29086	Apply finger cast		S	0058	1.1272	$71.79		$14.36
29105	Apply long arm splint		S	0058	1.1272	$71.79		$14.36
29125	Apply forearm splint		S	0058	1.1272	$71.79		$14.36
29126	Apply forearm splint		S	0058	1.1272	$71.79		$14.36
29130	Application of finger splint		S	0058	1.1272	$71.79		$14.36
29131	Application of finger splint		S	0058	1.1272	$71.79		$14.36
29200	Strapping of chest		S	0058	1.1272	$71.79		$14.36
29220	Strapping of low back		S	0058	1.1272	$71.79		$14.36
29240	Strapping of shoulder		S	0058	1.1272	$71.79		$14.36
29260	Strapping of elbow or wrist		S	0058	1.1272	$71.79		$14.36
29280	Strapping of hand or finger		S	0058	1.1272	$71.79		$14.36
29305	Application of hip cast		S	0426	2.2383	$142.56		$28.51
29325	Application of hip casts		S	0426	2.2383	$142.56		$28.51
29345	Application of long leg cast		S	0426	2.2383	$142.56		$28.51
29355	Application of long leg cast		S	0426	2.2383	$142.56		$28.51
29358	Apply long leg cast brace		S	0426	2.2383	$142.56		$28.51
29365	Application of long leg cast		S	0426	2.2383	$142.56		$28.51
29405	Apply short leg cast		S	0426	2.2383	$142.56		$28.51
29425	Apply short leg cast		S	0426	2.2383	$142.56		$28.51
29435	Apply short leg cast		S	0426	2.2383	$142.56		$28.51
29440	Addition of walker to cast		S	0058	1.1272	$71.79		$14.36
29445	Apply rigid leg cast		S	0426	2.2383	$142.56		$28.51
29450	Application of leg cast		S	0058	1.1272	$71.79		$14.36
29505	Application, long leg splint		S	0058	1.1272	$71.79		$14.36
29515	Application lower leg splint		S	0058	1.1272	$71.79		$14.36
29520	Strapping of hip		S	0058	1.1272	$71.79		$14.36

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
29530	Strapping of knee		S	0058	1.1272	$71.79		$14.36
29540	Strapping of ankle and/or ft		S	0058	1.1272	$71.79		$14.36
29550	Strapping of toes		S	0058	1.1272	$71.79		$14.36
29580	Application of paste boot		S	0058	1.1272	$71.79		$14.36
29590	Application of foot splint		S	0058	1.1272	$71.79		$14.36
29700	Removal/revision of cast		S	0058	1.1272	$71.79		$14.36
29705	Removal/revision of cast		S	0058	1.1272	$71.79		$14.36
29710	Removal/revision of cast		S	0426	2.2383	$142.56		$28.51
29715	Removal/revision of cast		S	0058	1.1272	$71.79		$14.36
29720	Repair of body cast		S	0058	1.1272	$71.79		$14.36
29730	Windowing of cast		S	0058	1.1272	$71.79		$14.36
29740	Wedging of cast		S	0058	1.1272	$71.79		$14.36
29750	Wedging of clubfoot cast		S	0058	1.1272	$71.79		$14.36
29799	Casting/strapping procedure		S	0058	1.1272	$71.79		$14.36
29800	Jaw arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29804	Jaw arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29805	Shoulder arthroscopy, dx		T	0041	29.4467	$1,875.55		$375.11
29806	Shoulder arthroscopy/surgery		T	0042	47.7765	$3,043.03	$804.70	$608.61
29807	Shoulder arthroscopy/surgery		T	0042	47.7765	$3,043.03	$804.70	$608.61
29819	Shoulder arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29820	Shoulder arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29821	Shoulder arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29822	Shoulder arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29823	Shoulder arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29824	Shoulder arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29825	Shoulder arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29826	Shoulder arthroscopy/surgery		T	0042	47.7765	$3,043.03	$804.70	$608.61
29827	Arthroscop rotator cuff repr		T	0042	47.7765	$3,043.03	$804.70	$608.61
29830	Elbow arthroscopy		T	0041	29.4467	$1,875.55		$375.11
29834	Elbow arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29835	Elbow arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29836	Elbow arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29837	Elbow arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29838	Elbow arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29840	Wrist arthroscopy		T	0041	29.4467	$1,875.55		$375.11
29843	Wrist arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29844	Wrist arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29845	Wrist arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29846	Wrist arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29847	Wrist arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29848	Wrist endoscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29850	Knee arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29851	Knee arthroscopy/surgery		T	0042	47.7765	$3,043.03	$804.70	$608.61
29855	Tibial arthroscopy/surgery		T	0042	47.7765	$3,043.03	$804.70	$608.61
29856	Tibial arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29860	Hip arthroscopy, dx		T	0041	29.4467	$1,875.55		$375.11
29861	Hip arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29862	Hip arthroscopy/surgery		T	0042	47.7765	$3,043.03	$804.70	$608.61
29863	Hip arthroscopy/surgery		T	0042	47.7765	$3,043.03	$804.70	$608.61
29866	Autgrft implnt, knee w/scope		T	0042	47.7765	$3,043.03	$804.70	$608.61
29867	Allgrft implnt, knee w/scope		T	0042	47.7765	$3,043.03	$804.70	$608.61
29868	Meniscal trnspl, knee w/scpe		T	0042	47.7765	$3,043.03	$804.70	$608.61
29870	Knee arthroscopy, dx		T	0041	29.4467	$1,875.55		$375.11
29871	Knee arthroscopy/drainage		T	0041	29.4467	$1,875.55		$375.11
29873	Knee arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29874	Knee arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29875	Knee arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29876	Knee arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29877	Knee arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29879	Knee arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29880	Knee arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29881	Knee arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29882	Knee arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29883	Knee arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29884	Knee arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29885	Knee arthroscopy/surgery		T	0042	47.7765	$3,043.03	$804.70	$608.61
29886	Knee arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29887	Knee arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29888	Knee arthroscopy/surgery		T	0042	47.7765	$3,043.03	$804.70	$608.61
29889	Knee arthroscopy/surgery		T	0042	47.7765	$3,043.03	$804.70	$608.61
29891	Ankle arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29892	Ankle arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29893	Scope, plantar fasciotomy		T	0055	21.1762	$1,348.78	$355.30	$269.76
29894	Ankle arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29895	Ankle arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29897	Ankle arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29898	Ankle arthroscopy/surgery		T	0041	29.4467	$1,875.55		$375.11
29899	Ankle arthroscopy/surgery		T	0042	47.7765	$3,043.03	$804.70	$608.61

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
29900	Mcp joint arthroscopy, dx		T	0053	16.822	$1,071.44	$253.40	$214.29
29901	Mcp joint arthroscopy, surg		T	0053	16.822	$1,071.44	$253.40	$214.29
29902	Mcp joint arthroscopy, surg		T	0053	16.822	$1,071.44	$253.40	$214.29
29999	Arthroscopy of joint		T	0041	29.4467	$1,875.55		$375.11
30000	Drainage of nose lesion		T	0251	2.5765	$164.11		$32.82
30020	Drainage of nose lesion		T	0251	2.5765	$164.11		$32.82
3006F	Cxr doc rev		M					
30100	Intranasal biopsy		T	0252	7.6539	$487.50	$109.10	$97.50
30110	Removal of nose polyp(s)		T	0253	16.6341	$1,059.48	$282.20	$211.90
30115	Removal of nose polyp(s)		T	0253	16.6341	$1,059.48	$282.20	$211.90
30117	Removal of intranasal lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
30118	Removal of intranasal lesion		T	0254	24.3535	$1,551.15	$321.30	$310.23
3011F	Lipid panel doc rev		M					
30120	Revision of nose		T	0253	16.6341	$1,059.48	$282.20	$211.90
30124	Removal of nose lesion		T	0252	7.6539	$487.50	$109.10	$97.50
30125	Removal of nose lesion		T	0256	40.5598	$2,583.38		$516.68
30130	Excise inferior turbinate		T	0253	16.6341	$1,059.48	$282.20	$211.90
30140	Resect inferior turbinate		T	0254	24.3535	$1,551.15	$321.30	$310.23
3014F	Screen mammo doc rev		M					
30150	Partial removal of nose		T	0256	40.5598	$2,583.38		$516.68
30160	Removal of nose		T	0256	40.5598	$2,583.38		$516.68
3017F	Colorectal ca screen doc rev		M					
30200	Injection treatment of nose		T	0252	7.6539	$487.50	$109.10	$97.50
3020F	Lvf assess		M					
30210	Nasal sinus therapy		T	0252	7.6539	$487.50	$109.10	$97.50
3021F	Lvef mod/sever deprs syst		M					
30220	Insert nasal septal button		T	0252	7.6539	$487.50	$109.10	$97.50
3022F	Lvef =40% systolic		M					
3023F	Spirom doc rev		M					
3025F	Spirom fev/fvc<70% w copd		M					
3027F	Spirom fev/fvc=70%/ w/o copd		M					
3028F	O2 saturation doc rev		M					
30300	Remove nasal foreign body		X	0340	0.6416	$40.87		$8.17
30310	Remove nasal foreign body		T	0253	16.6341	$1,059.48	$282.20	$211.90
30320	Remove nasal foreign body		T	0253	16.6341	$1,059.48	$282.20	$211.90
3035F	O2 saturation =88% /pa0 =55		M					
3037F	O2 saturation> 88% /pao>55		M					
30400	Reconstruction of nose		T	0256	40.5598	$2,583.38		$516.68
3040F	Fev<40% predicted value		M					
30410	Reconstruction of nose		T	0256	40.5598	$2,583.38		$516.68
30420	Reconstruction of nose		T	0256	40.5598	$2,583.38		$516.68
3042F	Fev=40% predicted value		M					
30430	Revision of nose		T	0254	24.3535	$1,551.15	$321.30	$310.23
30435	Revision of nose		T	0256	40.5598	$2,583.38		$516.68
3044F	HG a1c level < 7.0%		M					
30450	Revision of nose		T	0256	40.5598	$2,583.38		$516.68
3045F	HG a1c level 7.0-9.0%		M					
30460	Revision of nose		T	0256	40.5598	$2,583.38		$516.68
30462	Revision of nose		T	0256	40.5598	$2,583.38		$516.68
30465	Repair nasal stenosis		T	0256	40.5598	$2,583.38		$516.68
3046F	Hemoglobin a1c level > 9.0%		M					
3048F	LDL-C <100 mg/dL		M					
3049F	LDL-C 100-129 mg/dL		M					
3050F	LDL-C = 130 mg/dL		M					
30520	Repair of nasal septum		T	0254	24.3535	$1,551.15	$321.30	$310.23
30540	Repair nasal defect		T	0256	40.5598	$2,583.38		$516.68
30545	Repair nasal defect		T	0256	40.5598	$2,583.38		$516.68
30560	Release of nasal adhesions		T	0251	2.5765	$164.11		$32.82
30580	Repair upper jaw fistula		T	0256	40.5598	$2,583.38		$516.68
30600	Repair mouth/nose fistula		T	0256	40.5598	$2,583.38		$516.68
3060F	Pos microalbuminuria rev		M					
3061F	Neg microalbuminuria rev		M					
30620	Intranasal reconstruction		T	0256	40.5598	$2,583.38		$516.68
3062F	Pos macroalbuminuria rev		M					
30630	Repair nasal septum defect		T	0254	24.3535	$1,551.15	$321.30	$310.23
3066F	Nephropathy doc tx		M					
3072F	Low risk for retinopathy		M					
3073F	Pre-surg eye measures doc'd		M					
3074F	Syst bp < 130 mm hg		M					
3075F	Syst bp ≧130-139 mm hg		M					
3077F	Syst bp = 140 mm hg		M					
3078F	Diast bp < 80 mm hg		M					
3079F	Diast bp 80-89 mm hg		M					
30801	Ablate inf turbinate, superf		T	0252	7.6539	$487.50	$109.10	$97.50
30802	Cauterization, inner nose		T	0252	7.6539	$487.50	$109.10	$97.50
3080F	Diast bp = 90 mm hg		M					
3082F	Kt/v <1.2		M					
3083F	Kt/v ≧ 1.2 and <1.7		M					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
3084F	Kt/v≧1.7		M					
3085F	Suicide risk assessed		M					
3088F	MDD, mild		M					
3089F	MDD, moderate		M					
30901	Control of nosebleed		T	0250	1.1708	$74.57	$25.30	$14.91
30903	Control of nosebleed		T	0250	1.1708	$74.57	$25.30	$14.91
30905	Control of nosebleed		T	0250	1.1708	$74.57	$25.30	$14.91
30906	Repeat control of nosebleed		T	0250	1.1708	$74.57	$25.30	$14.91
3090F	MDD, severe; w/o psych		M					
30915	Ligation, nasal sinus artery		T	0092	26.4396	$1,684.02		$336.80
3091F	MDD, severe; w/ psych		M					
30920	Ligation, upper jaw artery		T	0092	26.4396	$1,684.02		$336.80
3092F	MDD, in remission		M					
30930	Ther fx, nasal inf turbinate		T	0253	16.6341	$1,059.48	$282.20	$211.90
3093F	Doc new diag 1st/addl. mdd		M					
3095F	Central dexa results doc'd		M					
3096F	Central dexa ordered		M					
30999	Nasal surgery procedure		T	0251	2.5765	$164.11		$32.82
31000	Irrigation, maxillary sinus		T	0251	2.5765	$164.11		$32.82
31002	Irrigation, sphenoid sinus		T	0252	7.6539	$487.50	$109.10	$97.50
3100F	Carot blk doc'd w/ carot ref		M					
3101F	Intl carot blk 30-99% range		M					
31020	Exploration, maxillary sinus		T	0254	24.3535	$1,551.15	$321.30	$310.23
3102F	Int carot blk < 30%		M					
31030	Exploration, maxillary sinus		T	0256	40.5598	$2,583.38		$516.68
31032	Explore sinus, remove polyps		T	0256	40.5598	$2,583.38		$516.68
31040	Exploration behind upper jaw		T	0254	24.3535	$1,551.15	$321.30	$310.23
31050	Exploration, sphenoid sinus		T	0256	40.5598	$2,583.38		$516.68
31051	Sphenoid sinus surgery		T	0256	40.5598	$2,583.38		$516.68
31070	Exploration of frontal sinus		T	0254	24.3535	$1,551.15	$321.30	$310.23
31075	Exploration of frontal sinus		T	0256	40.5598	$2,583.38		$516.68
31080	Removal of frontal sinus		T	0256	40.5598	$2,583.38		$516.68
31081	Removal of frontal sinus		T	0256	40.5598	$2,583.38		$516.68
31084	Removal of frontal sinus		T	0256	40.5598	$2,583.38		$516.68
31085	Removal of frontal sinus		T	0256	40.5598	$2,583.38		$516.68
31086	Removal of frontal sinus		T	0256	40.5598	$2,583.38		$516.68
31087	Removal of frontal sinus		T	0256	40.5598	$2,583.38		$516.68
31090	Exploration of sinuses		T	0256	40.5598	$2,583.38		$516.68
3110F	Pres/absn hmrhg/lesion doc'd		M					
3111F	Ct/mri brain done w/in 24hrs		M					
3112F	Ct/mri brain done > 24 hrs		M					
31200	Removal of ethmoid sinus		T	0256	40.5598	$2,583.38		$516.68
31201	Removal of ethmoid sinus		T	0256	40.5598	$2,583.38		$516.68
31205	Removal of ethmoid sinus		T	0256	40.5598	$2,583.38		$516.68
3120F	12-lead ecg performed		M					
31225	Removal of upper jaw		C					
31230	Removal of upper jaw		C					
31231	Nasal endoscopy, dx		T	0072	1.573	$100.19	$21.20	$20.04
31233	Nasal/sinus endoscopy, dx		T	0072	1.573	$100.19	$21.20	$20.04
31235	Nasal/sinus endoscopy, dx		T	0074	17.4546	$1,111.74	$292.20	$222.35
31237	Nasal/sinus endoscopy, surg		T	0074	17.4546	$1,111.74	$292.20	$222.35
31238	Nasal/sinus endoscopy, surg		T	0074	17.4546	$1,111.74	$292.20	$222.35
31239	Nasal/sinus endoscopy, surg		T	0075	23.2819	$1,482.89	$445.90	$296.58
31240	Nasal/sinus endoscopy, surg		T	0074	17.4546	$1,111.74	$292.20	$222.35
31254	Revision of ethmoid sinus		T	0075	23.2819	$1,482.89	$445.90	$296.58
31255	Removal of ethmoid sinus		T	0075	23.2819	$1,482.89	$445.90	$296.58
31256	Exploration maxillary sinus		T	0075	23.2819	$1,482.89	$445.90	$296.58
31267	Endoscopy, maxillary sinus		T	0075	23.2819	$1,482.89	$445.90	$296.58
31276	Sinus endoscopy, surgical		T	0075	23.2819	$1,482.89	$445.90	$296.58
31287	Nasal/sinus endoscopy, surg		T	0075	23.2819	$1,482.89	$445.90	$296.58
31288	Nasal/sinus endoscopy, surg		T	0075	23.2819	$1,482.89	$445.90	$296.58
31290	Nasal/sinus endoscopy, surg		C					
31291	Nasal/sinus endoscopy, surg		C					
31292	Nasal/sinus endoscopy, surg		T	0075	23.2819	$1,482.89	$445.90	$296.58
31293	Nasal/sinus endoscopy, surg		T	0075	23.2819	$1,482.89	$445.90	$296.58
31294	Nasal/sinus endoscopy, surg		T	0075	23.2819	$1,482.89	$445.90	$296.58
31299	Sinus surgery procedure		T	0251	2.5765	$164.11		$32.82
31300	Removal of larynx lesion		T	0254	24.3535	$1,551.15	$321.30	$310.23
3130F	Upper gi endoscopy performed		M					
31320	Diagnostic incision, larynx		T	0256	40.5598	$2,583.38		$516.68
3132F	Doc ref. upper gi endoscopy		M					
31360	Removal of larynx		C					
31365	Removal of larynx		C					
31367	Partial removal of larynx		C					
31368	Partial removal of larynx		C					
31370	Partial removal of larynx		C					
31375	Partial removal of larynx		C					
31380	Partial removal of larynx		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
31382	Partial removal of larynx		C					
31390	Removal of larynx & pharynx		C					
31395	Reconstruct larynx & pharynx		C					
31400	Revision of larynx		T	0256	40.5598	$2,583.38		$516.68
3140F	Forceps esoph biopsy done		M					
3141F	Upper gi endo shows barrtt's		M					
31420	Removal of epiglottis		T	0256	40.5598	$2,583.38		$516.68
3142F	Upper gi endo not barrtt's		M					
3143F	Doc order barium swallow tst		M					
31500	Insert emergency airway		S	0094	2.5547	$162.72	$46.20	$32.54
31502	Change of windpipe airway	CH	S	0078	1.3636	$86.85		$17.37
31505	Diagnostic laryngoscopy		T	0071	0.8256	$52.58	$11.20	$10.52
31510	Laryngoscopy with biopsy		T	0074	17.4546	$1,111.74	$292.20	$222.35
31511	Remove foreign body, larynx		T	0072	1.573	$100.19	$21.20	$20.04
31512	Removal of larynx lesion		T	0074	17.4546	$1,111.74	$292.20	$222.35
31513	Injection into vocal cord		T	0072	1.573	$100.19	$21.20	$20.04
31515	Laryngoscopy for aspiration		T	0074	17.4546	$1,111.74	$292.20	$222.35
31520	Dx laryngoscopy, newborn		T	0072	1.573	$100.19	$21.20	$20.04
31525	Dx laryngoscopy excl nb		T	0074	17.4546	$1,111.74	$292.20	$222.35
31526	Dx laryngoscopy w/oper scope		T	0075	23.2819	$1,482.89	$445.90	$296.58
31527	Laryngoscopy for treatment		T	0075	23.2819	$1,482.89	$445.90	$296.58
31528	Laryngoscopy and dilation		T	0074	17.4546	$1,111.74	$292.20	$222.35
31529	Laryngoscopy and dilation		T	0074	17.4546	$1,111.74	$292.20	$222.35
31530	Laryngoscopy w/fb removal		T	0075	23.2819	$1,482.89	$445.90	$296.58
31531	Laryngoscopy w/fb & op scope		T	0075	23.2819	$1,482.89	$445.90	$296.58
31535	Laryngoscopy w/biopsy		T	0075	23.2819	$1,482.89	$445.90	$296.58
31536	Laryngoscopy w/bx & op scope		T	0075	23.2819	$1,482.89	$445.90	$296.58
31540	Laryngoscopy w/exc of tumor		T	0075	23.2819	$1,482.89	$445.90	$296.58
31541	Larynscop w/tumr exc + scope		T	0075	23.2819	$1,482.89	$445.90	$296.58
31545	Remove vc lesion w/scope		T	0075	23.2819	$1,482.89	$445.90	$296.58
31546	Remove vc lesion scope/graft		T	0075	23.2819	$1,482.89	$445.90	$296.58
31560	Laryngoscop w/arytenoidectom		T	0075	23.2819	$1,482.89	$445.90	$296.58
31561	Larynscop, remve cart + scop		T	0075	23.2819	$1,482.89	$445.90	$296.58
31570	Laryngoscope w/vc inj		T	0074	17.4546	$1,111.74	$292.20	$222.35
31571	Laryngoscop w/vc inj + scope		T	0075	23.2819	$1,482.89	$445.90	$296.58
31575	Diagnostic laryngoscopy		T	0072	1.573	$100.19	$21.20	$20.04
31576	Laryngoscopy with biopsy		T	0075	23.2819	$1,482.89	$445.90	$296.58
31577	Remove foreign body, larynx		T	0073	4.206	$267.89	$69.10	$53.58
31578	Removal of larynx lesion		T	0075	23.2819	$1,482.89	$445.90	$296.58
31579	Diagnostic laryngoscopy		T	0073	4.206	$267.89	$69.10	$53.58
31580	Revision of larynx		T	0256	40.5598	$2,583.38		$516.68
31582	Revision of larynx		T	0256	40.5598	$2,583.38		$516.68
31584	Treat larynx fracture		C					
31587	Revision of larynx		C					
31588	Revision of larynx		T	0256	40.5598	$2,583.38		$516.68
31590	Reinnervate larynx		T	0256	40.5598	$2,583.38		$516.68
31595	Larynx nerve surgery		T	0256	40.5598	$2,583.38		$516.68
31599	Larynx surgery procedure		T	0251	2.5765	$164.11		$32.82
31600	Incision of windpipe		T	0254	24.3535	$1,551.15	$321.30	$310.23
31601	Incision of windpipe		T	0254	24.3535	$1,551.15	$321.30	$310.23
31603	Incision of windpipe		T	0252	7.6539	$487.50	$109.10	$97.50
31605	Incision of windpipe		T	0252	7.6539	$487.50	$109.10	$97.50
31610	Incision of windpipe		T	0254	24.3535	$1,551.15	$321.30	$310.23
31611	Surgery/speech prosthesis		T	0254	24.3535	$1,551.15	$321.30	$310.23
31612	Puncture/clear windpipe		T	0254	24.3535	$1,551.15	$321.30	$310.23
31613	Repair windpipe opening		T	0254	24.3535	$1,551.15	$321.30	$310.23
31614	Repair windpipe opening		T	0256	40.5598	$2,583.38		$516.68
31615	Visualization of windpipe		T	0076	10.1732	$647.96	$189.80	$129.59
31620	Endobronchial us add-on	CH	N					
31622	Dx bronchoscope/wash		T	0076	10.1732	$647.96	$189.80	$129.59
31623	Dx bronchoscope/brush		T	0076	10.1732	$647.96	$189.80	$129.59
31624	Dx bronchoscope/lavage		T	0076	10.1732	$647.96	$189.80	$129.59
31625	Bronchoscopy w/biopsy(s)		T	0076	10.1732	$647.96	$189.80	$129.59
31628	Bronchoscopy/lung bx, each		T	0076	10.1732	$647.96	$189.80	$129.59
31629	Bronchoscopy/needle bx, each		T	0076	10.1732	$647.96	$189.80	$129.59
31630	Bronchoscopy dilate/fx repr		T	0415	24.2882	$1,546.99	$459.90	$309.40
31631	Bronchoscopy, dilate w/stent		T	0415	24.2882	$1,546.99	$459.90	$309.40
31632	Bronchoscopy/lung bx, add'l		T	0076	10.1732	$647.96	$189.80	$129.59
31633	Bronchoscopy/needle bx add'l		T	0076	10.1732	$647.96	$189.80	$129.59
31635	Bronchoscopy w/fb removal		T	0076	10.1732	$647.96	$189.80	$129.59
31636	Bronchoscopy, bronch stents		T	0415	24.2882	$1,546.99	$459.90	$309.40
31637	Bronchoscopy, stent add-on		T	0076	10.1732	$647.96	$189.80	$129.59
31638	Bronchoscopy, revise stent		T	0415	24.2882	$1,546.99	$459.90	$309.40
31640	Bronchoscopy w/tumor excise		T	0415	24.2882	$1,546.99	$459.90	$309.40
31641	Bronchoscopy, treat blockage		T	0415	24.2882	$1,546.99	$459.90	$309.40
31643	Diag bronchoscope/catheter		T	0076	10.1732	$647.96	$189.80	$129.59
31645	Bronchoscopy, clear airways		T	0076	10.1732	$647.96	$189.80	$129.59
31646	Bronchoscopy, reclear airway		T	0076	10.1732	$647.96	$189.80	$129.59

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
31656	Bronchoscopy, inj for x-ray		T	0076	10.1732	$647.96	$189.80	$129.59
31715	Injection for bronchus x-ray		N					
31717	Bronchial brush biopsy		T	0073	4.206	$267.89	$69.10	$53.58
31720	Clearance of airways	CH	S	0077	0.3904	$24.87	$7.70	$4.97
31725	Clearance of airways		C					
31730	Intro, windpipe wire/tube		T	0073	4.206	$267.89	$69.10	$53.58
31750	Repair of windpipe		T	0256	40.5598	$2,583.38		$516.68
31755	Repair of windpipe		T	0256	40.5598	$2,583.38		$516.68
31760	Repair of windpipe		C					
31766	Reconstruction of windpipe		C					
31770	Repair/graft of bronchus		C					
31775	Reconstruct bronchus		C					
31780	Reconstruct windpipe		C					
31781	Reconstruct windpipe		C					
31785	Remove windpipe lesion		T	0254	24.3535	$1,551.15	$321.30	$310.23
31786	Remove windpipe lesion		C					
31800	Repair of windpipe injury		C					
31805	Repair of windpipe injury		C					
31820	Closure of windpipe lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
31825	Repair of windpipe defect		T	0254	24.3535	$1,551.15	$321.30	$310.23
31830	Revise windpipe scar		T	0254	24.3535	$1,551.15	$321.30	$310.23
31899	Airways surgical procedure		T	0076	10.1732	$647.96	$189.80	$129.59
32000	Drainage of chest		T	0070	5.3095	$338.18		$67.64
32002	Treatment of collapsed lung		T	0070	5.3095	$338.18		$67.64
32005	Treat lung lining chemically		T	0070	5.3095	$338.18		$67.64
32019	Insert pleural catheter		T	0652	31.7598	$2,022.88		$404.58
32020	Insertion of chest tube		T	0070	5.3095	$338.18		$67.64
32035	Exploration of chest		C					
32036	Exploration of chest		C					
32095	Biopsy through chest wall		C					
32100	Exploration/biopsy of chest		C					
32110	Explore/repair chest		C					
32120	Re-exploration of chest		C					
32124	Explore chest free adhesions		C					
32140	Removal of lung lesion(s)		C					
32141	Remove/treat lung lesions		C					
32150	Removal of lung lesion(s)		C					
32151	Remove lung foreign body		C					
32160	Open chest heart massage		C					
32200	Drain, open, lung lesion		C					
32201	Drain, percut, lung lesion		T	0070	5.3095	$338.18		$67.64
32215	Treat chest lining		C					
32220	Release of lung		C					
32225	Partial release of lung		C					
32310	Removal of chest lining		C					
32320	Free/remove chest lining		C					
32400	Needle biopsy chest lining		T	0685	9.5741	$609.80		$121.96
32402	Open biopsy chest lining		C					
32405	Biopsy, lung or mediastinum		T	0685	9.5741	$609.80		$121.96
32420	Puncture/clear lung		T	0070	5.3095	$338.18		$67.64
32440	Removal of lung		C					
32442	Sleeve pneumonectomy		C					
32445	Removal of lung		C					
32480	Partial removal of lung		C					
32482	Bilobectomy		C					
32484	Segmentectomy		C					
32486	Sleeve lobectomy		C					
32488	Completion pneumonectomy		C					
32491	Lung volume reduction		C					
32500	Partial removal of lung		C					
32501	Repair bronchus add-on		C					
32503	Resect apical lung tumor		C					
32504	Resect apical lung tum/chest		C					
32540	Removal of lung lesion		C					
32601	Thoracoscopy, diagnostic		T	0069	33.1688	$2,112.62	$591.60	$422.52
32602	Thoracoscopy, diagnostic		T	0069	33.1688	$2,112.62	$591.60	$422.52
32603	Thoracoscopy, diagnostic		T	0069	33.1688	$2,112.62	$591.60	$422.52
32604	Thoracoscopy, diagnostic		T	0069	33.1688	$2,112.62	$591.60	$422.52
32605	Thoracoscopy, diagnostic		T	0069	33.1688	$2,112.62	$591.60	$422.52
32606	Thoracoscopy, diagnostic		T	0069	33.1688	$2,112.62	$591.60	$422.52
32650	Thoracoscopy, surgical		C					
32651	Thoracoscopy, surgical		C					
32652	Thoracoscopy, surgical		C					
32653	Thoracoscopy, surgical		C					
32654	Thoracoscopy, surgical		C					
32655	Thoracoscopy, surgical		C					
32656	Thoracoscopy, surgical		C					
32657	Thoracoscopy, surgical		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
32658	Thoracoscopy, surgical		C					
32659	Thoracoscopy, surgical		C					
32660	Thoracoscopy, surgical		C					
32661	Thoracoscopy, surgical		C					
32662	Thoracoscopy, surgical		C					
32663	Thoracoscopy, surgical		C					
32664	Thoracoscopy, surgical		C					
32665	Thoracoscopy, surgical		C					
32800	Repair lung hernia		C					
32810	Close chest after drainage		C					
32815	Close bronchial fistula		C					
32820	Reconstruct injured chest		C					
32850	Donor pneumonectomy		C					
32851	Lung transplant, single		C					
32852	Lung transplant with bypass		C					
32853	Lung transplant, double		C					
32854	Lung transplant with bypass		C					
32855	Prepare donor lung, single		C					
32856	Prepare donor lung, double		C					
32900	Removal of rib(s)		C					
32905	Revise & repair chest wall		C					
32906	Revise & repair chest wall		C					
32940	Revision of lung		C					
32960	Therapeutic pneumothorax		T	0070	5.3095	$338.18		$67.64
32997	Total lung lavage		C					
32998	Perq rf ablate tx, pul tumor		T	0423	44.1192	$2,810.08		$562.02
32999	Chest surgery procedure		T	0070	5.3095	$338.18		$67.64
33010	Drainage of heart sac		T	0070	5.3095	$338.18		$67.64
33011	Repeat drainage of heart sac		T	0070	5.3095	$338.18		$67.64
33015	Incision of heart sac		C					
33020	Incision of heart sac		C					
33025	Incision of heart sac		C					
33030	Partial removal of heart sac		C					
33031	Partial removal of heart sac		C					
33050	Removal of heart sac lesion		C					
33120	Removal of heart lesion		C					
33130	Removal of heart lesion		C					
33140	Heart revascularize (tmr)		C					
33141	Heart tmr w/other procedure		C					
33202	Insert epicard eltrd, open		C					
33203	Insert epicard eltrd, endo		C					
33206	Insertion of heart pacemaker		T	0089	122.5662	$7,806.61	$1,682.20	$1,561.32
33207	Insertion of heart pacemaker		T	0089	122.5662	$7,806.61	$1,682.20	$1,561.32
33208	Insertion of heart pacemaker		T	0655	144.2764	$9,189.40		$1,837.88
33210	Insertion of heart electrode		T	0106	75.0068	$4,777.41		$955.48
33211	Insertion of heart electrode		T	0106	75.0068	$4,777.41		$955.48
33212	Insertion of pulse generator		T	0090	99.8268	$6,358.27	$1,612.80	$1,271.65
33213	Insertion of pulse generator		T	0654	106.9053	$6,809.12		$1,361.82
33214	Upgrade of pacemaker system		T	0655	144.2764	$9,189.40		$1,837.88
33215	Reposition pacing-defib lead		T	0105	24.7274	$1,574.96	$370.40	$314.99
33216	Insert lead pace-defib, one		T	0106	75.0068	$4,777.41		$955.48
33217	Insert lead pace-defib, dual		T	0106	75.0068	$4,777.41		$955.48
33218	Repair lead pace-defib, one		T	0105	24.7274	$1,574.96	$370.40	$314.99
33220	Repair lead pace-defib, dual		T	0105	24.7274	$1,574.96	$370.40	$314.99
33222	Revise pocket, pacemaker	CH	T	0136	15.4399	$983.41		$196.68
33223	Revise pocket, pacing-defib	CH	T	0136	15.4399	$983.41		$196.68
33224	Insert pacing lead & connect		T	0418	250.5383	$15,957.54		$3,191.51
33225	L ventric pacing lead add-on		T	0418	250.5383	$15,957.54		$3,191.51
33226	Reposition l ventric lead		T	0105	24.7274	$1,574.96	$370.40	$314.99
33233	Removal of pacemaker system		T	0105	24.7274	$1,574.96	$370.40	$314.99
33234	Removal of pacemaker system		T	0105	24.7274	$1,574.96	$370.40	$314.99
33235	Removal pacemaker electrode		T	0105	24.7274	$1,574.96	$370.40	$314.99
33236	Remove electrode/thoracotomy		C					
33237	Remove electrode/thoracotomy		C					
33238	Remove electrode/thoracotomy		C					
33240	Insert pulse generator	CH	T	0107	353.1242	$22,491.54		$4,498.31
33241	Remove pulse generator		T	0105	24.7274	$1,574.96	$370.40	$314.99
33243	Remove eltrd/thoracotomy		C					
33244	Remove eltrd, transven		T	0105	24.7274	$1,574.96	$370.40	$314.99
33249	Eltrd/insert pace-defib	CH	T	0108	403.0232	$25,669.76		$5,133.95
33250	Ablate heart dysrhythm focus		C					
33251	Ablate heart dysrhythm focus		C					
33254	Ablate atria, lmtd		C					
33255	Ablate atria w/o bypass, ext		C					
33256	Ablate atria w/bypass, exten		C					
33261	Ablate heart dysrhythm focus		C					
33265	Ablate atria w/bypass, endo		C					
33266	Ablate atria w/o bypass endo		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
33282	Implant pat-active ht record		S	0680	71.6463	$4,563.37		$912.67
33284	Remove pat-active ht record		T	0109	6.1077	$389.02		$77.80
33300	Repair of heart wound		C					
33305	Repair of heart wound		C					
33310	Exploratory heart surgery		C					
33315	Exploratory heart surgery		C					
33320	Repair major blood vessel(s)		C					
33321	Repair major vessel		C					
33322	Repair major blood vessel(s)		C					
33330	Insert major vessel graft		C					
33332	Insert major vessel graft		C					
33335	Insert major vessel graft		C					
33400	Repair of aortic valve		C					
33401	Valvuloplasty, open		C					
33403	Valvuloplasty, w/cp bypass		C					
33404	Prepare heart-aorta conduit		C					
33405	Replacement of aortic valve		C					
33406	Replacement of aortic valve		C					
33410	Replacement of aortic valve		C					
33411	Replacement of aortic valve		C					
33412	Replacement of aortic valve		C					
33413	Replacement of aortic valve		C					
33414	Repair of aortic valve		C					
33415	Revision, subvalvular tissue		C					
33416	Revise ventricle muscle		C					
33417	Repair of aortic valve		C					
33420	Revision of mitral valve		C					
33422	Revision of mitral valve		C					
33425	Repair of mitral valve		C					
33426	Repair of mitral valve		C					
33427	Repair of mitral valve		C					
33430	Replacement of mitral valve		C					
33460	Revision of tricuspid valve		C					
33463	Valvuloplasty, tricuspid		C					
33464	Valvuloplasty, tricuspid		C					
33465	Replace tricuspid valve		C					
33468	Revision of tricuspid valve		C					
33470	Revision of pulmonary valve		C					
33471	Valvotomy, pulmonary valve		C					
33472	Revision of pulmonary valve		C					
33474	Revision of pulmonary valve		C					
33475	Replacement, pulmonary valve		C					
33476	Revision of heart chamber		C					
33478	Revision of heart chamber		C					
33496	Repair, prosth valve clot		C					
33500	Repair heart vessel fistula		C					
33501	Repair heart vessel fistula		C					
33502	Coronary artery correction		C					
33503	Coronary artery graft		C					
33504	Coronary artery graft		C					
33505	Repair artery w/tunnel		C					
33506	Repair artery, translocation		C					
33507	Repair art, intramural		C					
33508	Endoscopic vein harvest		N					
33510	CABG, vein, single		C					
33511	CABG, vein, two		C					
33512	CABG, vein, three		C					
33513	CABG, vein, four		C					
33514	CABG, vein, five		C					
33516	Cabg, vein, six or more		C					
33517	CABG, artery-vein, single		C					
33518	CABG, artery-vein, two		C					
33519	CABG, artery-vein, three		C					
33521	CABG, artery-vein, four		C					
33522	CABG, artery-vein, five		C					
33523	Cabg, art-vein, six or more		C					
33530	Coronary artery, bypass/reop		C					
33533	CABG, arterial, single		C					
33534	CABG, arterial, two		C					
33535	CABG, arterial, three		C					
33536	Cabg, arterial, four or more		C					
33542	Removal of heart lesion		C					
33545	Repair of heart damage		C					
33548	Restore/remodel, ventricle		C					
33572	Open coronary endarterectomy		C					
33600	Closure of valve		C					
33602	Closure of valve		C					
33606	Anastomosis/artery-aorta		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
33608	Repair anomaly w/conduit		C					
33610	Repair by enlargement		C					
33611	Repair double ventricle		C					
33612	Repair double ventricle		C					
33615	Repair, modified fontan		C					
33617	Repair single ventricle		C					
33619	Repair single ventricle		C					
33641	Repair heart septum defect		C					
33645	Revision of heart veins		C					
33647	Repair heart septum defects		C					
33660	Repair of heart defects		C					
33665	Repair of heart defects		C					
33670	Repair of heart chambers		C					
33675	Close mult vsd		C					
33676	Close mult vsd w/resection		C					
33677	Cl mult vsd w/rem pul band		C					
33681	Repair heart septum defect		C					
33684	Repair heart septum defect		C					
33688	Repair heart septum defect		C					
33690	Reinforce pulmonary artery		C					
33692	Repair of heart defects		C					
33694	Repair of heart defects		C					
33697	Repair of heart defects		C					
33702	Repair of heart defects		C					
33710	Repair of heart defects		C					
33720	Repair of heart defect		C					
33722	Repair of heart defect		C					
33724	Repair venous anomaly		C					
33726	Repair pul venous stenosis		C					
33730	Repair heart-vein defect(s)		C					
33732	Repair heart-vein defect		C					
33735	Revision of heart chamber		C					
33736	Revision of heart chamber		C					
33737	Revision of heart chamber		C					
33750	Major vessel shunt		C					
33755	Major vessel shunt		C					
33762	Major vessel shunt		C					
33764	Major vessel shunt & graft		C					
33766	Major vessel shunt		C					
33767	Major vessel shunt		C					
33768	Cavopulmonary shunting		C					
33770	Repair great vessels defect		C					
33771	Repair great vessels defect		C					
33774	Repair great vessels defect		C					
33775	Repair great vessels defect		C					
33776	Repair great vessels defect		C					
33777	Repair great vessels defect		C					
33778	Repair great vessels defect		C					
33779	Repair great vessels defect		C					
33780	Repair great vessels defect		C					
33781	Repair great vessels defect		C					
33786	Repair arterial trunk		C					
33788	Revision of pulmonary artery		C					
33800	Aortic suspension		C					
33802	Repair vessel defect		C					
33803	Repair vessel defect		C					
33813	Repair septal defect		C					
33814	Repair septal defect		C					
33820	Revise major vessel		C					
33822	Revise major vessel		C					
33824	Revise major vessel		C					
33840	Remove aorta constriction		C					
33845	Remove aorta constriction		C					
33851	Remove aorta constriction		C					
33852	Repair septal defect		C					
33853	Repair septal defect		C					
33860	Ascending aortic graft		C					
33861	Ascending aortic graft		C					
33863	Ascending aortic graft		C					
33870	Transverse aortic arch graft		C					
33875	Thoracic aortic graft		C					
33877	Thoracoabdominal graft		C					
33880	Endovasc taa repr incl subcl		C					
33881	Endovasc taa repr w/o subcl		C					
33883	Insert endovasc prosth, taa		C					
33884	Endovasc prosth, taa, add-on		C					
33886	Endovasc prosth, delayed		C					
33889	Artery transpose/endovas taa		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
33891	Car-car bp grft/endovas taa		C					
33910	Remove lung artery emboli		C					
33915	Remove lung artery emboli		C					
33916	Surgery of great vessel		C					
33917	Repair pulmonary artery		C					
33920	Repair pulmonary atresia		C					
33922	Transect pulmonary artery		C					
33924	Remove pulmonary shunt		C					
33925	Rpr pul art unifocal w/o cpb		C					
33926	Repr pul art, unifocal w/cpb		C					
33930	Removal of donor heart/lung		C					
33933	Prepare donor heart/lung		C					
33935	Transplantation, heart/lung		C					
33940	Removal of donor heart		C					
33944	Prepare donor heart		C					
33945	Transplantation of heart		C					
33960	External circulation assist		C					
33961	External circulation assist		C					
33967	Insert ia percut device		C					
33968	Remove aortic assist device		C					
33970	Aortic circulation assist		C					
33971	Aortic circulation assist		C					
33973	Insert balloon device		C					
33974	Remove intra-aortic balloon		C					
33975	Implant ventricular device		C					
33976	Implant ventricular device		C					
33977	Remove ventricular device		C					
33978	Remove ventricular device		C					
33979	Insert intracorporeal device		C					
33980	Remove intracorporeal device		C					
33999	Cardiac surgery procedure		T	0070	5.3095	$338.18		$67.64
34001	Removal of artery clot		C					
34051	Removal of artery clot		C					
34101	Removal of artery clot		T	0088	39.8001	$2,534.99	$655.20	$507.00
34111	Removal of arm artery clot		T	0088	39.8001	$2,534.99	$655.20	$507.00
34151	Removal of artery clot		C					
34201	Removal of artery clot		T	0088	39.8001	$2,534.99	$655.20	$507.00
34203	Removal of leg artery clot		T	0088	39.8001	$2,534.99	$655.20	$507.00
34401	Removal of vein clot		C					
34421	Removal of vein clot		T	0088	39.8001	$2,534.99	$655.20	$507.00
34451	Removal of vein clot		C					
34471	Removal of vein clot		T	0088	39.8001	$2,534.99	$655.20	$507.00
34490	Removal of vein clot		T	0088	39.8001	$2,534.99	$655.20	$507.00
34501	Repair valve, femoral vein		T	0088	39.8001	$2,534.99	$655.20	$507.00
34502	Reconstruct vena cava		C					
34510	Transposition of vein valve		T	0088	39.8001	$2,534.99	$655.20	$507.00
34520	Cross-over vein graft		T	0088	39.8001	$2,534.99	$655.20	$507.00
34530	Leg vein fusion		T	0088	39.8001	$2,534.99	$655.20	$507.00
34800	Endovas aaa repr w/sm tube		C					
34802	Endovas aaa repr w/2-p part		C					
34803	Endovas aaa repr w/3-p part		C					
34804	Endovas aaa repr w/1-p part		C					
34805	Endovas aaa repr w/long tube		C					
34808	Endovas iliac a device addon		C					
34812	Xpose for endoprosth, femorl		C					
34813	Femoral endovas graft add-on		C					
34820	Xpose for endoprosth, iliac		C					
34825	Endovasc extend prosth, init		C					
34826	Endovasc exten prosth, add'l		C					
34830	Open aortic tube prosth repr		C					
34831	Open aortoiliac prosth repr		C					
34832	Open aortofemor prosth repr		C					
34833	Xpose for endoprosth, iliac		C					
34834	Xpose, endoprosth, brachial		C					
34900	Endovasc iliac repr w/graft		C					
35001	Repair defect of artery		C					
35002	Repair artery rupture, neck		C					
35005	Repair defect of artery		C					
35011	Repair defect of artery		T	0653	41.0875	$2,616.99		$523.40
35013	Repair artery rupture, arm		C					
35021	Repair defect of artery		C					
35022	Repair artery rupture, chest		C					
35045	Repair defect of arm artery		C					
35081	Repair defect of artery		C					
35082	Repair artery rupture, aorta		C					
35091	Repair defect of artery		C					
35092	Repair artery rupture, aorta		C					
35102	Repair defect of artery		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
35103	Repair artery rupture, groin		C					
35111	Repair defect of artery		C					
35112	Repair artery rupture,spleen		C					
35121	Repair defect of artery		C					
35122	Repair artery rupture, belly		C					
35131	Repair defect of artery		C					
35132	Repair artery rupture, groin		C					
35141	Repair defect of artery		C					
35142	Repair artery rupture, thigh		C					
35151	Repair defect of artery		C					
35152	Repair artery rupture, knee		C					
35180	Repair blood vessel lesion		T	0093	30.8639	$1,965.81		$393.16
35182	Repair blood vessel lesion		C					
35184	Repair blood vessel lesion		T	0093	30.8639	$1,965.81		$393.16
35188	Repair blood vessel lesion		T	0088	39.8001	$2,534.99	$655.20	$507.00
35189	Repair blood vessel lesion		C					
35190	Repair blood vessel lesion		T	0093	30.8639	$1,965.81		$393.16
35201	Repair blood vessel lesion		T	0093	30.8639	$1,965.81		$393.16
35206	Repair blood vessel lesion		T	0093	30.8639	$1,965.81		$393.16
35207	Repair blood vessel lesion		T	0088	39.8001	$2,534.99	$655.20	$507.00
35211	Repair blood vessel lesion		C					
35216	Repair blood vessel lesion		C					
35221	Repair blood vessel lesion		C					
35226	Repair blood vessel lesion		T	0093	30.8639	$1,965.81		$393.16
35231	Repair blood vessel lesion		T	0093	30.8639	$1,965.81		$393.16
35236	Repair blood vessel lesion		T	0093	30.8639	$1,965.81		$393.16
35241	Repair blood vessel lesion		C					
35246	Repair blood vessel lesion		C					
35251	Repair blood vessel lesion		C					
35256	Repair blood vessel lesion		T	0093	30.8639	$1,965.81		$393.16
35261	Repair blood vessel lesion		T	0653	41.0875	$2,616.99		$523.40
35266	Repair blood vessel lesion		T	0653	41.0875	$2,616.99		$523.40
35271	Repair blood vessel lesion		C					
35276	Repair blood vessel lesion		C					
35281	Repair blood vessel lesion		C					
35286	Repair blood vessel lesion		T	0653	41.0875	$2,616.99		$523.40
35301	Rechanneling of artery		C					
35302	Rechanneling of artery		C					
35303	Rechanneling of artery		C					
35304	Rechanneling of artery		C					
35305	Rechanneling of artery		C					
35306	Rechanneling of artery		C					
35311	Rechanneling of artery		C					
35321	Rechanneling of artery		T	0093	30.8639	$1,965.81		$393.16
35331	Rechanneling of artery		C					
35341	Rechanneling of artery		C					
35351	Rechanneling of artery		C					
35355	Rechanneling of artery		C					
35361	Rechanneling of artery		C					
35363	Rechanneling of artery		C					
35371	Rechanneling of artery		C					
35372	Rechanneling of artery		C					
35390	Reoperation, carotid add-on		C					
35400	Angioscopy		C					
35450	Repair arterial blockage		C					
35452	Repair arterial blockage		C					
35454	Repair arterial blockage		C					
35456	Repair arterial blockage		C					
35458	Repair arterial blockage	CH	T	0083	46.0685	$2,934.24		$586.85
35459	Repair arterial blockage	CH	T	0083	46.0685	$2,934.24		$586.85
35460	Repair venous blockage	CH	T	0083	46.0685	$2,934.24		$586.85
35470	Repair arterial blockage	CH	T	0083	46.0685	$2,934.24		$586.85
35471	Repair arterial blockage	CH	T	0083	46.0685	$2,934.24		$586.85
35472	Repair arterial blockage	CH	T	0083	46.0685	$2,934.24		$586.85
35473	Repair arterial blockage	CH	T	0083	46.0685	$2,934.24		$586.85
35474	Repair arterial blockage	CH	T	0083	46.0685	$2,934.24		$586.85
35475	Repair arterial blockage	CH	T	0083	46.0685	$2,934.24		$586.85
35476	Repair venous blockage	CH	T	0083	46.0685	$2,934.24		$586.85
35480	Atherectomy, open		C					
35481	Atherectomy, open		C					
35482	Atherectomy, open		C					
35483	Atherectomy, open		C					
35484	Atherectomy, open	CH	T	0082	88.7717	$5,654.14		$1,130.83
35485	Atherectomy, open	CH	T	0082	88.7717	$5,654.14		$1,130.83
35490	Atherectomy, percutaneous	CH	T	0082	88.7717	$5,654.14		$1,130.83
35491	Atherectomy, percutaneous	CH	T	0082	88.7717	$5,654.14		$1,130.83
35492	Atherectomy, percutaneous	CH	T	0082	88.7717	$5,654.14		$1,130.83
35493	Atherectomy, percutaneous	CH	T	0082	88.7717	$5,654.14		$1,130.83

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
35494	Atherectomy, percutaneous	CH	T	0082	88.7717	$5,654.14		$1,130.83
35495	Atherectomy, percutaneous	CH	T	0082	88.7717	$5,654.14		$1,130.83
35500	Harvest vein for bypass	CH	T	0103	15.2572	$971.78		$194.36
35501	Artery bypass graft		C					
35506	Artery bypass graft		C					
35508	Artery bypass graft		C					
35509	Artery bypass graft		C					
35510	Artery bypass graft		C					
35511	Artery bypass graft		C					
35512	Artery bypass graft		C					
35515	Artery bypass graft		C					
35516	Artery bypass graft		C					
35518	Artery bypass graft		C					
35521	Artery bypass graft		C					
35522	Artery bypass graft		C					
35525	Artery bypass graft		C					
35526	Artery bypass graft		C					
35531	Artery bypass graft		C					
35533	Artery bypass graft		C					
35536	Artery bypass graft		C					
35537	Artery bypass graft		C					
35538	Artery bypass graft		C					
35539	Artery bypass graft		C					
35540	Artery bypass graft		C					
35548	Artery bypass graft		C					
35549	Artery bypass graft		C					
35551	Artery bypass graft		C					
35556	Artery bypass graft		C					
35558	Artery bypass graft		C					
35560	Artery bypass graft		C					
35563	Artery bypass graft		C					
35565	Artery bypass graft		C					
35566	Artery bypass graft		C					
35571	Artery bypass graft		C					
35572	Harvest femoropopliteal vein		N					
35583	Vein bypass graft		C					
35585	Vein bypass graft		C					
35587	Vein bypass graft		C					
35600	Harvest artery for cabg		C					
35601	Artery bypass graft		C					
35606	Artery bypass graft		C					
35612	Artery bypass graft		C					
35616	Artery bypass graft		C					
35621	Artery bypass graft		C					
35623	Bypass graft, not vein		C					
35626	Artery bypass graft		C					
35631	Artery bypass graft		C					
35636	Artery bypass graft		C					
35637	Artery bypass graft		C					
35638	Artery bypass graft		C					
35642	Artery bypass graft		C					
35645	Artery bypass graft		C					
35646	Artery bypass graft		C					
35647	Artery bypass graft		C					
35650	Artery bypass graft		C					
35651	Artery bypass graft		C					
35654	Artery bypass graft		C					
35656	Artery bypass graft		C					
35661	Artery bypass graft		C					
35663	Artery bypass graft		C					
35665	Artery bypass graft		C					
35666	Artery bypass graft		C					
35671	Artery bypass graft		C					
35681	Composite bypass graft		C					
35682	Composite bypass graft		C					
35683	Composite bypass graft		C					
35685	Bypass graft patency/patch		T	0093	30.8639	$1,965.81		$393.16
35686	Bypass graft/av fist patency		T	0093	30.8639	$1,965.81		$393.16
35691	Arterial transposition		C					
35693	Arterial transposition		C					
35694	Arterial transposition		C					
35695	Arterial transposition		C					
35697	Reimplant artery each		C					
35700	Reoperation, bypass graft		C					
35701	Exploration, carotid artery		C					
35721	Exploration, femoral artery		C					
35741	Exploration popliteal artery		C					
35761	Exploration of artery/vein		T	0115	30.5379	$1,945.05		$389.01

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
35800	Explore neck vessels		C					
35820	Explore chest vessels		C					
35840	Explore abdominal vessels		C					
35860	Explore limb vessels		T	0093	30.8639	$1,965.81		$393.16
35870	Repair vessel graft defect		C					
35875	Removal of clot in graft		T	0088	39.8001	$2,534.99	$655.20	$507.00
35876	Removal of clot in graft		T	0088	39.8001	$2,534.99	$655.20	$507.00
35879	Revise graft w/vein		T	0088	39.8001	$2,534.99	$655.20	$507.00
35881	Revise graft w/vein		T	0088	39.8001	$2,534.99	$655.20	$507.00
35883	Revise graft w/nonauto graft		T	0088	39.8001	$2,534.99	$655.20	$507.00
35884	Revise graft w/vein		T	0088	39.8001	$2,534.99	$655.20	$507.00
35901	Excision, graft, neck		C					
35903	Excision, graft, extremity		T	0115	30.5379	$1,945.05		$389.01
35905	Excision, graft, thorax		C					
35907	Excision, graft, abdomen		C					
36000	Place needle in vein		N					
36002	Pseudoaneurysm injection trt		S	0267	2.4859	$158.33	$60.50	$31.67
36005	Injection ext venography		N					
36010	Place catheter in vein		N					
36011	Place catheter in vein		N					
36012	Place catheter in vein		N					
36013	Place catheter in artery		N					
36014	Place catheter in artery		N					
36015	Place catheter in artery		N					
36100	Establish access to artery		N					
36120	Establish access to artery		N					
36140	Establish access to artery		N					
36145	Artery to vein shunt		N					
36160	Establish access to aorta		N					
36200	Place catheter in aorta		N					
36215	Place catheter in artery		N					
36216	Place catheter in artery		N					
36217	Place catheter in artery		N					
36218	Place catheter in artery		N					
36245	Place catheter in artery		N					
36246	Place catheter in artery		N					
36247	Place catheter in artery		N					
36248	Place catheter in artery		N					
36260	Insertion of infusion pump		T	0623	29.3210	$1,867.54		$373.51
36261	Revision of infusion pump		T	0623	29.3210	$1,867.54		$373.51
36262	Removal of infusion pump		T	0622	24.5273	$1,562.22		$312.44
36299	Vessel injection procedure		N					
36400	Bl draw < 3 yrs fem/jugular		N					
36405	Bl draw < 3 yrs scalp vein		N					
36406	Bl draw < 3 yrs other vein		N					
36410	Non-routine bl draw > 3 yrs		N					
36415	Routine venipuncture		A					
36416	Capillary blood draw		N					
36420	Vein access cutdown < 1 yr		T	0035	0.2091	$13.32		$2.66
36425	Vein access cutdown > 1 yr		T	0035	0.2091	$13.32		$2.66
36430	Blood transfusion service		S	0110	3.4924	$222.44		$44.49
36440	Bl push transfuse, 2 yr or <		S	0110	3.4924	$222.44		$44.49
36450	Bl exchange/transfuse, nb		S	0110	3.4924	$222.44		$44.49
36455	Bl exchange/transfuse non-nb		S	0110	3.4924	$222.44		$44.49
36460	Transfusion service, fetal		S	0110	3.4924	$222.44		$44.49
36468	Injection(s), spider veins	CH	T	0013	0.8046	$51.25		$10.25
36469	Injection(s), spider veins	CH	T	0013	0.8046	$51.25		$10.25
36470	Injection therapy of vein	CH	T	0013	0.8046	$51.25		$10.25
36471	Injection therapy of veins	CH	T	0013	0.8046	$51.25		$10.25
36475	Endovenous rf, 1st vein		T	0091	43.6609	$2,780.89		$556.18
36476	Endovenous rf, vein add-on	CH	T	0092	26.4396	$1,684.02		$336.80
36478	Endovenous laser, 1st vein		T	0092	26.4396	$1,684.02		$336.80
36479	Endovenous laser vein addon		T	0092	26.4396	$1,684.02		$336.80
36481	Insertion of catheter, vein		N					
36500	Insertion of catheter, vein		N					
36510	Insertion of catheter, vein		N					
36511	Apheresis wbc		S	0111	12.1982	$776.94	$198.40	$155.39
36512	Apheresis rbc		S	0111	12.1982	$776.94	$198.40	$155.39
36513	Apheresis platelets		S	0111	12.1982	$776.94	$198.40	$155.39
36514	Apheresis plasma		S	0111	12.1982	$776.94	$198.40	$155.39
36515	Apheresis, adsorp/reinfuse		S	0112	31.9648	$2,035.93	$433.20	$407.19
36516	Apheresis, selective		S	0112	31.9648	$2,035.93	$433.20	$407.19
36522	Photopheresis		S	0112	31.9648	$2,035.93	$433.20	$407.19
36540	Collect blood venous device		Q	0624	0.5763	$36.71	$12.60	$7.34
36550	Declot vascular device		T	0676	2.5179	$160.37		$32.07
36555	Insert non-tunnel cv cath		T	0621	11.0043	$700.90		$140.18
36556	Insert non-tunnel cv cath		T	0621	11.0043	$700.90		$140.18
36557	Insert tunneled cv cath		T	0622	24.5273	$1,562.22		$312.44

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
36558	Insert tunneled cv cath		T	0622	24.5273	$1,562.22		$312.44
36560	Insert tunneled cv cath		T	0623	29.3210	$1,867.54		$373.51
36561	Insert tunneled cv cath		T	0623	29.3210	$1,867.54		$373.51
36563	Insert tunneled cv cath		T	0623	29.3210	$1,867.54		$373.51
36565	Insert tunneled cv cath		T	0623	29.3210	$1,867.54		$373.51
36566	Insert tunneled cv cath		T	0625	87.32	$5,561.67		$1,112.33
36568	Insert picc cath		T	0621	11.0043	$700.90		$140.18
36569	Insert picc cath		T	0621	11.0043	$700.90		$140.18
36570	Insert picvad cath		T	0622	24.5273	$1,562.22		$312.44
36571	Insert picvad cath		T	0622	24.5273	$1,562.22		$312.44
36575	Repair tunneled cv cath	CH	T	0109	6.1077	$389.02		$77.80
36576	Repair tunneled cv cath		T	0621	11.0043	$700.90		$140.18
36578	Replace tunneled cv cath		T	0622	24.5273	$1,562.22		$312.44
36580	Replace cvad cath		T	0621	11.0043	$700.90		$140.18
36581	Replace tunneled cv cath		T	0622	24.5273	$1,562.22		$312.44
36582	Replace tunneled cv cath		T	0623	29.3210	$1,867.54		$373.51
36583	Replace tunneled cv cath		T	0623	29.3210	$1,867.54		$373.51
36584	Replace picc cath		T	0621	11.0043	$700.90		$140.18
36585	Replace picvad cath		T	0622	24.5273	$1,562.22		$312.44
36589	Removal tunneled cv cath	CH	T	0109	6.1077	$389.02		$77.80
36590	Removal tunneled cv cath		T	0621	11.0043	$700.90		$140.18
36595	Mech remov tunneled cv cath		T	0622	24.5273	$1,562.22		$312.44
36596	Mech remov tunneled cv cath		T	0621	11.0043	$700.90		$140.18
36597	Reposition venous catheter		T	0621	11.0043	$700.90		$140.18
36598	Inj w/fluor, eval cv device	CH	T	0676	2.5179	$160.37		$32.07
36600	Withdrawal of arterial blood		Q	0035	0.2091	$13.32		$2.66
36620	Insertion catheter, artery		N					
36625	Insertion catheter, artery		N					
36640	Insertion catheter, artery		T	0623	29.3210	$1,867.54		$373.51
36660	Insertion catheter, artery		C					
36680	Insert needle, bone cavity		T	0002	1.1915	$75.89		$15.18
36800	Insertion of cannula		T	0115	30.5379	$1,945.05		$389.01
36810	Insertion of cannula		T	0115	30.5379	$1,945.05		$389.01
36815	Insertion of cannula		T	0115	30.5379	$1,945.05		$389.01
36818	Av fuse, uppr arm, cephalic		T	0088	39.8001	$2,534.99	$655.20	$507.00
36819	Av fuse, uppr arm, basilic		T	0088	39.8001	$2,534.99	$655.20	$507.00
36820	Av fusion/forearm vein		T	0088	39.8001	$2,534.99	$655.20	$507.00
36821	Av fusion direct any site		T	0088	39.8001	$2,534.99	$655.20	$507.00
36822	Insertion of cannula(s)		C					
36823	Insertion of cannula(s)		C					
36825	Artery-vein autograft		T	0088	39.8001	$2,534.99	$655.20	$507.00
36830	Artery-vein nonautograft		T	0088	39.8001	$2,534.99	$655.20	$507.00
36831	Open thrombect av fistula		T	0088	39.8001	$2,534.99	$655.20	$507.00
36832	Av fistula revision, open		T	0088	39.8001	$2,534.99	$655.20	$507.00
36833	Av fistula revision		T	0088	39.8001	$2,534.99	$655.20	$507.00
36834	Repair A-V aneurysm		T	0088	39.8001	$2,534.99	$655.20	$507.00
36835	Artery to vein shunt		T	0115	30.5379	$1,945.05		$389.01
36838	Dist revas ligation, hemo		T	0088	39.8001	$2,534.99	$655.20	$507.00
36860	External cannula declotting		T	0676	2.5179	$160.37		$32.07
36861	Cannula declotting		T	0115	30.5379	$1,945.05		$389.01
36870	Percut thrombect av fistula		T	0653	41.0875	$2,616.99		$523.40
37140	Revision of circulation		C					
37145	Revision of circulation		C					
37160	Revision of circulation		C					
37180	Revision of circulation		C					
37181	Splice spleen/kidney veins		C					
37182	Insert hepatic shunt (tips)		C					
37183	Remove hepatic shunt (tips)		T	0229	89.7027	$5,713.43		$1,142.69
37184	Prim art mech thrombectomy		T	0088	39.8001	$2,534.99	$655.20	$507.00
37185	Prim art m-thrombect add-on		T	0088	39.8001	$2,534.99	$655.20	$507.00
37186	Sec art m-thrombect add-on		T	0088	39.8001	$2,534.99	$655.20	$507.00
37187	Venous mech thrombectomy		T	0088	39.8001	$2,534.99	$655.20	$507.00
37188	Venous m-thrombectomy add-on		T	0088	39.8001	$2,534.99	$655.20	$507.00
37195	Thrombolytic therapy, stroke		T	0676	2.5179	$160.37		$32.07
37200	Transcatheter biopsy	CH	T	0623	29.3210	$1,867.54		$373.51
37201	Transcatheter therapy infuse	CH	T	0103	15.2572	$971.78		$194.36
37202	Transcatheter therapy infuse	CH	T	0103	15.2572	$971.78		$194.36
37203	Transcatheter retrieval	CH	T	0623	29.3210	$1,867.54		$373.51
37204	Transcatheter occlusion	CH	T	0082	88.7717	$5,654.14		$1,130.83
37205	Transcath iv stent, percut		T	0229	89.7027	$5,713.43		$1,142.69
37206	Transcath iv stent/perc addl		T	0229	89.7027	$5,713.43		$1,142.69
37207	Transcath iv stent, open		T	0229	89.7027	$5,713.43		$1,142.69
37208	Transcath iv stent/open addl		T	0229	89.7027	$5,713.43		$1,142.69
37209	Change iv cath at thromb tx	CH	T	0623	29.3210	$1,867.54		$373.51
37210	Embolization uterine fibroid		T	0202	43.2255	$2,753.16	$981.50	$550.63
37215	Transcath stent, cca w/eps		C					
37216	Transcath stent, cca w/o eps		E					
37250	Iv us first vessel add-on	CH	N					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
37251	Iv us each add vessel add-on	CH	N					
37500	Endoscopy ligate perf veins		T	0091	43.6609	$2,780.89		$556.18
37501	Vascular endoscopy procedure		T	0092	26.4396	$1,684.02		$336.80
37565	Ligation of neck vein		T	0093	30.8639	$1,965.81		$393.16
37600	Ligation of neck artery		T	0093	30.8639	$1,965.81		$393.16
37605	Ligation of neck artery		T	0091	43.6609	$2,780.89		$556.18
37606	Ligation of neck artery		T	0092	26.4396	$1,684.02		$336.80
37607	Ligation of a-v fistula		T	0092	26.4396	$1,684.02		$336.80
37609	Temporal artery procedure		T	0021	16.5832	$1,056.23	$219.40	$211.25
37615	Ligation of neck artery		T	0092	26.4396	$1,684.02		$336.80
37616	Ligation of chest artery		C					
37617	Ligation of abdomen artery		C					
37618	Ligation of extremity artery		C					
37620	Revision of major vein		T	0091	43.6609	$2,780.89		$556.18
37650	Revision of major vein		T	0092	26.4396	$1,684.02		$336.80
37660	Revision of major vein		C					
37700	Revise leg vein	CH	T	0092	26.4396	$1,684.02		$336.80
37718	Ligate/strip short leg vein	CH	T	0092	26.4396	$1,684.02		$336.80
37722	Ligate/strip long leg vein		T	0091	43.6609	$2,780.89		$556.18
37735	Removal of leg veins/lesion		T	0091	43.6609	$2,780.89		$556.18
37760	Ligation, leg veins, open		T	0092	26.4396	$1,684.02		$336.80
37765	Phleb veins - extrem - to 20		T	0092	26.4396	$1,684.02		$336.80
37766	Phleb veins - extrem 20+		T	0092	26.4396	$1,684.02		$336.80
37780	Revision of leg vein		T	0092	26.4396	$1,684.02		$336.80
37785	Ligate/divide/excise vein		T	0092	26.4396	$1,684.02		$336.80
37788	Revascularization, penis		C					
37790	Penile venous occlusion		T	0181	35.1574	$2,239.28	$621.80	$447.86
37799	Vascular surgery procedure		T	0103	15.2572	$971.78		$194.36
38100	Removal of spleen, total		C					
38101	Removal of spleen, partial		C					
38102	Removal of spleen, total		C					
38115	Repair of ruptured spleen		C					
38120	Laparoscopy, splenectomy		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
38129	Laparoscope proc, spleen		T	0130	34.8153	$2,217.49	$659.50	$443.50
38200	Injection for spleen x-ray		N					
38204	Bl donor search management		N					
38205	Harvest allogenic stem cells		S	0111	12.1982	$776.94	$198.40	$155.39
38206	Harvest auto stem cells		S	0111	12.1982	$776.94	$198.40	$155.39
38207	Cryopreserve stem cells	CH	X	0344	0.8586	$54.69	$15.60	$10.94
38208	Thaw preserved stem cells	CH	X	0344	0.8586	$54.69	$15.60	$10.94
38209	Wash harvest stem cells	CH	X	0344	0.8586	$54.69	$15.60	$10.94
38210	T-cell depletion of harvest	CH	S	0110	3.4924	$222.44		$44.49
38211	Tumor cell deplete of harvst	CH	S	0110	3.4924	$222.44		$44.49
38212	Rbc depletion of harvest	CH	S	0110	3.4924	$222.44		$44.49
38213	Platelet deplete of harvest	CH	S	0110	3.4924	$222.44		$44.49
38214	Volume deplete of harvest	CH	S	0110	3.4924	$222.44		$44.49
38215	Harvest stem cell concentrte	CH	S	0110	3.4924	$222.44		$44.49
38220	Bone marrow aspiration		T	0003	3.239	$206.30		$41.26
38221	Bone marrow biopsy		T	0003	3.239	$206.30		$41.26
38230	Bone marrow collection	CH	S	0112	31.9648	$2,035.93	$433.20	$407.19
38240	Bone marrow/stem transplant	CH	S	0112	31.9648	$2,035.93	$433.20	$407.19
38241	Bone marrow/stem transplant	CH	S	0112	31.9648	$2,035.93	$433.20	$407.19
38242	Lymphocyte infuse transplant		S	0111	12.1982	$776.94	$198.40	$155.39
38300	Drainage, lymph node lesion		T	0007	12.5792	$801.21		$160.24
38305	Drainage, lymph node lesion		T	0008	19.0457	$1,213.08		$242.62
38308	Incision of lymph channels		T	0113	23.5105	$1,497.45		$299.49
38380	Thoracic duct procedure		C					
38381	Thoracic duct procedure		C					
38382	Thoracic duct procedure		C					
38500	Biopsy/removal, lymph nodes		T	0113	23.5105	$1,497.45		$299.49
38505	Needle biopsy, lymph nodes		T	0005	7.3012	$465.04		$93.01
38510	Biopsy/removal, lymph nodes		T	0113	23.5105	$1,497.45		$299.49
38520	Biopsy/removal, lymph nodes		T	0113	23.5105	$1,497.45		$299.49
38525	Biopsy/removal, lymph nodes		T	0113	23.5105	$1,497.45		$299.49
38530	Biopsy/removal, lymph nodes		T	0113	23.5105	$1,497.45		$299.49
38542	Explore deep node(s), neck		T	0114	45.1729	$2,877.20		$575.44
38550	Removal, neck/armpit lesion		T	0113	23.5105	$1,497.45		$299.49
38555	Removal, neck/armpit lesion		T	0113	23.5105	$1,497.45		$299.49
38562	Removal, pelvic lymph nodes		C					
38564	Removal, abdomen lymph nodes		C					
38570	Laparoscopy, lymph node biop		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
38571	Laparoscopy, lymphadenectomy		T	0132	71.0022	$4,522.34	$1,239.20	$904.47
38572	Laparoscopy, lymphadenectomy		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
38589	Laparoscope proc, lymphatic		T	0130	34.8153	$2,217.49	$659.50	$443.50
38700	Removal of lymph nodes, neck		T	0113	23.5105	$1,497.45		$299.49
38720	Removal of lymph nodes, neck		T	0113	23.5105	$1,497.45		$299.49
38724	Removal of lymph nodes, neck		C					
38740	Remove armpit lymph nodes		T	0114	45.1729	$2,877.20		$575.44

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
38745	Remove armpit lymph nodes		T	0114	45.1729	$2,877.20		$575.44
38746	Remove thoracic lymph nodes		C					
38747	Remove abdominal lymph nodes		C					
38760	Remove groin lymph nodes		T	0113	23.5105	$1,497.45		$299.49
38765	Remove groin lymph nodes		C					
38770	Remove pelvis lymph nodes		C					
38780	Remove abdomen lymph nodes		C					
38790	Inject for lymphatic x-ray		N					
38792	Identify sentinel node		Q	0389	1.5806	$100.67	$33.80	$20.13
38794	Access thoracic lymph duct		N					
38999	Blood/lymph system procedure		S	0110	3.4924	$222.44		$44.49
39000	Exploration of chest		C					
39010	Exploration of chest		C					
39200	Removal chest lesion		C					
39220	Removal chest lesion		C					
39400	Visualization of chest		T	0069	33.1688	$2,112.62	$591.60	$422.52
39499	Chest procedure		C					
39501	Repair diaphragm laceration		C					
39502	Repair paraesophageal hernia		C					
39503	Repair of diaphragm hernia		C					
39520	Repair of diaphragm hernia		C					
39530	Repair of diaphragm hernia		C					
39531	Repair of diaphragm hernia		C					
39540	Repair of diaphragm hernia		C					
39541	Repair of diaphragm hernia		C					
39545	Revision of diaphragm		C					
39560	Resect diaphragm, simple		C					
39561	Resect diaphragm, complex		C					
39599	Diaphragm surgery procedure		C					
4000F	Tobacco use txmnt counseling		M					
4001F	Tobacco use txmnt, pharmacol		M					
4002F	Statin therapy, rx		M					
4003F	Pt ed write/oral, pts w/ hf		M					
4005F	Pharm thx for op rx'd		M					
4006F	Beta-blocker therapy rx		M					
4007F	Antiox vit/min supp rx'd		M					
4009F	Ace/arb inhibitor therapy rx		M					
4011F	Oral antiplatelet therapy rx		M					
4012F	Warfarin therapy rx		M					
4014F	Written discharge instr prvd		M					
4015F	Persist asthma medicine ctrl		M					
4016F	Anti-inflm/anlgsc agent rx		M					
4017F	Gi prophylaxis for nsaid rx		M					
4018F	Therapy exercise joint rx		M					
4019F	Doc recpt counsl vit d/calc+		M					
4025F	Inhaled broncholidator rx		M					
4030F	Oxygen therapy rx		M					
4033F	Pulmonary rehab rec		M					
4035F	Influenza imm rec		M					
4037F	Influenza imm order/admin		M					
4040F	pneumoc imm order/admin		M					
4041F	Doc order cefazolin/cefurox		M					
4042F	Doc antibio not given		M					
4043F	Doc order given stop antibio		M					
4044F	Doc order given vte prophylx		M					
4045F	Empiric antibiotic rx		M					
4046F	Doc antibio given b/4 surg		M					
4047F	Doc antibio given b/4 surg		M					
4048F	Doc antibio given b/4 surg		M					
40490	Biopsy of lip		T	0251	2.5765	$164.11		$32.82
4049F	Doc order given stop antibio		M					
40500	Partial excision of lip		T	0253	16.6341	$1,059.48	$282.20	$211.90
4050F	Ht care plan doc		M					
40510	Partial excision of lip		T	0254	24.3535	$1,551.15	$321.30	$310.23
4051F	Referred for an av fistula		M					
40520	Partial excision of lip		T	0253	16.6341	$1,059.48	$282.20	$211.90
40525	Reconstruct lip with flap		T	0254	24.3535	$1,551.15	$321.30	$310.23
40527	Reconstruct lip with flap		T	0254	24.3535	$1,551.15	$321.30	$310.23
4052F	Hemodialysis via av fistula		M					
40530	Partial removal of lip		T	0254	24.3535	$1,551.15	$321.30	$310.23
4053F	Hemodialysis via av graft		M					
4054F	Hemodialysis via catheter		M					
4055F	Pt. rcvng periton dialysis		M					
4056F	Approp. oral rehyd. recomm'd		M					
4058F	Ped gastro ed given, caregvr		M					
4060F	Psych svcs provided		M					
4062F	Pt referral psych doc'd		M					
4064F	Antidepressant rx		M					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
40650	Repair lip		T	0252	7.6539	$487.50	$109.10	$97.50
40652	Repair lip		T	0252	7.6539	$487.50	$109.10	$97.50
40654	Repair lip		T	0252	7.6539	$487.50	$109.10	$97.50
4065F	Antipsychotic rx		M					
4066F	Ect provided		M					
4067F	Pt referral for ect doc'd		M					
40700	Repair cleft lip/nasal		T	0256	40.5598	$2,583.38		$516.68
40701	Repair cleft lip/nasal		T	0256	40.5598	$2,583.38		$516.68
40702	Repair cleft lip/nasal		T	0256	40.5598	$2,583.38		$516.68
4070F	Dvt prophylx recv'd day 2		M					
40720	Repair cleft lip/nasal		T	0256	40.5598	$2,583.38		$516.68
4073F	Oral antiplat thx rx dischrg		M					
4075F	Anticoag thx rx at dischrg		M					
40761	Repair cleft lip/nasal		T	0256	40.5598	$2,583.38		$516.68
4077F	Doc t-pa admin considered		M					
40799	Lip surgery procedure		T	0251	2.5765	$164.11		$32.82
4079F	Doc rehab svcs considered		M					
40800	Drainage of mouth lesion		T	0006	1.463	$93.18		$18.64
40801	Drainage of mouth lesion		T	0252	7.6539	$487.50	$109.10	$97.50
40804	Removal, foreign body, mouth		X	0340	0.6416	$40.87		$8.17
40805	Removal, foreign body, mouth		T	0252	7.6539	$487.50	$109.10	$97.50
40806	Incision of lip fold		T	0251	2.5765	$164.11		$32.82
40808	Biopsy of mouth lesion		T	0251	2.5765	$164.11		$32.82
40810	Excision of mouth lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
40812	Excise/repair mouth lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
40814	Excise/repair mouth lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
40816	Excision of mouth lesion		T	0254	24.3535	$1,551.15	$321.30	$310.23
40818	Excise oral mucosa for graft		T	0251	2.5765	$164.11		$32.82
40819	Excise lip or cheek fold		T	0252	7.6539	$487.50	$109.10	$97.50
40820	Treatment of mouth lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
40830	Repair mouth laceration		T	0251	2.5765	$164.11		$32.82
40831	Repair mouth laceration		T	0252	7.6539	$487.50	$109.10	$97.50
40840	Reconstruction of mouth		T	0254	24.3535	$1,551.15	$321.30	$310.23
40842	Reconstruction of mouth		T	0254	24.3535	$1,551.15	$321.30	$310.23
40843	Reconstruction of mouth		T	0254	24.3535	$1,551.15	$321.30	$310.23
40844	Reconstruction of mouth		T	0256	40.5598	$2,583.38		$516.68
40845	Reconstruction of mouth		T	0256	40.5598	$2,583.38		$516.68
4084F	Aspirin recv'd w/in 24 hrs		M					
40899	Mouth surgery procedure		T	0251	2.5765	$164.11		$32.82
41000	Drainage of mouth lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
41005	Drainage of mouth lesion		T	0251	2.5765	$164.11		$32.82
41006	Drainage of mouth lesion		T	0254	24.3535	$1,551.15	$321.30	$310.23
41007	Drainage of mouth lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
41008	Drainage of mouth lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
41009	Drainage of mouth lesion		T	0251	2.5765	$164.11		$32.82
41010	Incision of tongue fold		T	0252	7.6539	$487.50	$109.10	$97.50
41015	Drainage of mouth lesion		T	0251	2.5765	$164.11		$32.82
41016	Drainage of mouth lesion		T	0252	7.6539	$487.50	$109.10	$97.50
41017	Drainage of mouth lesion		T	0252	7.6539	$487.50	$109.10	$97.50
41018	Drainage of mouth lesion		T	0252	7.6539	$487.50	$109.10	$97.50
41100	Biopsy of tongue		T	0252	7.6539	$487.50	$109.10	$97.50
41105	Biopsy of tongue		T	0253	16.6341	$1,059.48	$282.20	$211.90
41108	Biopsy of floor of mouth		T	0252	7.6539	$487.50	$109.10	$97.50
41110	Excision of tongue lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
41112	Excision of tongue lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
41113	Excision of tongue lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
41114	Excision of tongue lesion		T	0254	24.3535	$1,551.15	$321.30	$310.23
41115	Excision of tongue fold		T	0252	7.6539	$487.50	$109.10	$97.50
41116	Excision of mouth lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
41120	Partial removal of tongue		T	0254	24.3535	$1,551.15	$321.30	$310.23
41130	Partial removal of tongue		C					
41135	Tongue and neck surgery		C					
41140	Removal of tongue		C					
41145	Tongue removal, neck surgery		C					
41150	Tongue, mouth, jaw surgery		C					
41153	Tongue, mouth, neck surgery		C					
41155	Tongue, jaw, & neck surgery		C					
41250	Repair tongue laceration		T	0251	2.5765	$164.11		$32.82
41251	Repair tongue laceration		T	0251	2.5765	$164.11		$32.82
41252	Repair tongue laceration		T	0252	7.6539	$487.50	$109.10	$97.50
41500	Fixation of tongue		T	0254	24.3535	$1,551.15	$321.30	$310.23
41510	Tongue to lip surgery		T	0253	16.6341	$1,059.48	$282.20	$211.90
41520	Reconstruction, tongue fold		T	0252	7.6539	$487.50	$109.10	$97.50
41599	Tongue and mouth surgery		T	0251	2.5765	$164.11		$32.82
41800	Drainage of gum lesion		T	0006	1.463	$93.18		$18.64
41805	Removal foreign body, gum		T	0254	24.3535	$1,551.15	$321.30	$310.23
41806	Removal foreign body,jawbone		T	0253	16.6341	$1,059.48	$282.20	$211.90
41820	Excision, gum, each quadrant		T	0252	7.6539	$487.50	$109.10	$97.50

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
41821	Excision of gum flap		T	0252	7.6539	$487.50	$109.10	$97.50
41822	Excision of gum lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
41823	Excision of gum lesion		T	0254	24.3535	$1,551.15	$321.30	$310.23
41825	Excision of gum lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
41826	Excision of gum lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
41827	Excision of gum lesion		T	0254	24.3535	$1,551.15	$321.30	$310.23
41828	Excision of gum lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
41830	Removal of gum tissue		T	0253	16.6341	$1,059.48	$282.20	$211.90
41850	Treatment of gum lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
41870	Gum graft		T	0254	24.3535	$1,551.15	$321.30	$310.23
41872	Repair gum		T	0253	16.6341	$1,059.48	$282.20	$211.90
41874	Repair tooth socket		T	0254	24.3535	$1,551.15	$321.30	$310.23
41899	Dental surgery procedure		T	0251	2.5765	$164.11		$32.82
42000	Drainage mouth roof lesion		T	0251	2.5765	$164.11		$32.82
42100	Biopsy roof of mouth		T	0252	7.6539	$487.50	$109.10	$97.50
42104	Excision lesion, mouth roof		T	0253	16.6341	$1,059.48	$282.20	$211.90
42106	Excision lesion, mouth roof		T	0253	16.6341	$1,059.48	$282.20	$211.90
42107	Excision lesion, mouth roof		T	0254	24.3535	$1,551.15	$321.30	$310.23
42120	Remove palate/lesion		T	0256	40.5598	$2,583.38		$516.68
42140	Excision of uvula		T	0252	7.6539	$487.50	$109.10	$97.50
42145	Repair palate, pharynx/uvula		T	0254	24.3535	$1,551.15	$321.30	$310.23
42160	Treatment mouth roof lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
42180	Repair palate		T	0251	2.5765	$164.11		$32.82
42182	Repair palate		T	0256	40.5598	$2,583.38		$516.68
42200	Reconstruct cleft palate		T	0256	40.5598	$2,583.38		$516.68
42205	Reconstruct cleft palate		T	0256	40.5598	$2,583.38		$516.68
42210	Reconstruct cleft palate		T	0256	40.5598	$2,583.38		$516.68
42215	Reconstruct cleft palate		T	0256	40.5598	$2,583.38		$516.68
42220	Reconstruct cleft palate		T	0256	40.5598	$2,583.38		$516.68
42225	Reconstruct cleft palate		T	0256	40.5598	$2,583.38		$516.68
42226	Lengthening of palate		T	0256	40.5598	$2,583.38		$516.68
42227	Lengthening of palate		T	0256	40.5598	$2,583.38		$516.68
42235	Repair palate		T	0253	16.6341	$1,059.48	$282.20	$211.90
42260	Repair nose to lip fistula		T	0254	24.3535	$1,551.15	$321.30	$310.23
42280	Preparation, palate mold		T	0251	2.5765	$164.11		$32.82
42281	Insertion, palate prosthesis		T	0253	16.6341	$1,059.48	$282.20	$211.90
42299	Palate/uvula surgery		T	0251	2.5765	$164.11		$32.82
42300	Drainage of salivary gland		T	0253	16.6341	$1,059.48	$282.20	$211.90
42305	Drainage of salivary gland		T	0253	16.6341	$1,059.48	$282.20	$211.90
42310	Drainage of salivary gland		T	0251	2.5765	$164.11		$32.82
42320	Drainage of salivary gland		T	0251	2.5765	$164.11		$32.82
42330	Removal of salivary stone		T	0253	16.6341	$1,059.48	$282.20	$211.90
42335	Removal of salivary stone		T	0253	16.6341	$1,059.48	$282.20	$211.90
42340	Removal of salivary stone		T	0253	16.6341	$1,059.48	$282.20	$211.90
42400	Biopsy of salivary gland		T	0005	7.3012	$465.04		$93.01
42405	Biopsy of salivary gland		T	0253	16.6341	$1,059.48	$282.20	$211.90
42408	Excision of salivary cyst		T	0253	16.6341	$1,059.48	$282.20	$211.90
42409	Drainage of salivary cyst		T	0253	16.6341	$1,059.48	$282.20	$211.90
42410	Excise parotid gland/lesion		T	0256	40.5598	$2,583.38		$516.68
42415	Excise parotid gland/lesion		T	0256	40.5598	$2,583.38		$516.68
42420	Excise parotid gland/lesion		T	0256	40.5598	$2,583.38		$516.68
42425	Excise parotid gland/lesion		T	0256	40.5598	$2,583.38		$516.68
42426	Excise parotid gland/lesion		C					
42440	Excise submaxillary gland		T	0256	40.5598	$2,583.38		$516.68
42450	Excise sublingual gland		T	0254	24.3535	$1,551.15	$321.30	$310.23
42500	Repair salivary duct		T	0254	24.3535	$1,551.15	$321.30	$310.23
42505	Repair salivary duct		T	0256	40.5598	$2,583.38		$516.68
42507	Parotid duct diversion		T	0256	40.5598	$2,583.38		$516.68
42508	Parotid duct diversion		T	0256	40.5598	$2,583.38		$516.68
42509	Parotid duct diversion		T	0256	40.5598	$2,583.38		$516.68
42510	Parotid duct diversion		T	0256	40.5598	$2,583.38		$516.68
42550	Injection for salivary x-ray		N					
42600	Closure of salivary fistula		T	0253	16.6341	$1,059.48	$282.20	$211.90
42650	Dilation of salivary duct		T	0252	7.6539	$487.50	$109.10	$97.50
42660	Dilation of salivary duct		T	0251	2.5765	$164.11		$32.82
42665	Ligation of salivary duct		T	0254	24.3535	$1,551.15	$321.30	$310.23
42699	Salivary surgery procedure		T	0251	2.5765	$164.11		$32.82
42700	Drainage of tonsil abscess		T	0251	2.5765	$164.11		$32.82
42720	Drainage of throat abscess		T	0253	16.6341	$1,059.48	$282.20	$211.90
42725	Drainage of throat abscess		T	0256	40.5598	$2,583.38		$516.68
42800	Biopsy of throat		T	0252	7.6539	$487.50	$109.10	$97.50
42802	Biopsy of throat		T	0253	16.6341	$1,059.48	$282.20	$211.90
42804	Biopsy of upper nose/throat		T	0253	16.6341	$1,059.48	$282.20	$211.90
42806	Biopsy of upper nose/throat		T	0254	24.3535	$1,551.15	$321.30	$310.23
42808	Excise pharynx lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
42809	Remove pharynx foreign body		X	0340	0.6416	$40.87		$8.17
42810	Excision of neck cyst		T	0254	24.3535	$1,551.15	$321.30	$310.23
42815	Excision of neck cyst		T	0256	40.5598	$2,583.38		$516.68

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
42820	Remove tonsils and adenoids		T	0258	22.9075	$1,459.05	$437.20	$291.81
42821	Remove tonsils and adenoids		T	0258	22.9075	$1,459.05	$437.20	$291.81
42825	Removal of tonsils		T	0258	22.9075	$1,459.05	$437.20	$291.81
42826	Removal of tonsils		T	0258	22.9075	$1,459.05	$437.20	$291.81
42830	Removal of adenoids		T	0258	22.9075	$1,459.05	$437.20	$291.81
42831	Removal of adenoids		T	0258	22.9075	$1,459.05	$437.20	$291.81
42835	Removal of adenoids		T	0258	22.9075	$1,459.05	$437.20	$291.81
42836	Removal of adenoids		T	0258	22.9075	$1,459.05	$437.20	$291.81
42842	Extensive surgery of throat		T	0254	24.3535	$1,551.15	$321.30	$310.23
42844	Extensive surgery of throat		T	0256	40.5598	$2,583.38		$516.68
42845	Extensive surgery of throat		C					
42860	Excision of tonsil tags		T	0258	22.9075	$1,459.05	$437.20	$291.81
42870	Excision of lingual tonsil		T	0258	22.9075	$1,459.05	$437.20	$291.81
42890	Partial removal of pharynx		T	0256	40.5598	$2,583.38		$516.68
42892	Revision of pharyngeal walls		T	0256	40.5598	$2,583.38		$516.68
42894	Revision of pharyngeal walls		C					
42900	Repair throat wound		T	0252	7.6539	$487.50	$109.10	$97.50
42950	Reconstruction of throat		T	0254	24.3535	$1,551.15	$321.30	$310.23
42953	Repair throat, esophagus		C					
42955	Surgical opening of throat		T	0254	24.3535	$1,551.15	$321.30	$310.23
42960	Control throat bleeding		T	0250	1.1708	$74.57	$25.30	$14.91
42961	Control throat bleeding		C					
42962	Control throat bleeding		T	0256	40.5598	$2,583.38		$516.68
42970	Control nose/throat bleeding		T	0250	1.1708	$74.57	$25.30	$14.91
42971	Control nose/throat bleeding		C					
42972	Control nose/throat bleeding		T	0253	16.6341	$1,059.48	$282.20	$211.90
42999	Throat surgery procedure		T	0251	2.5765	$164.11		$32.82
43020	Incision of esophagus		T	0252	7.6539	$487.50	$109.10	$97.50
43030	Throat muscle surgery		T	0253	16.6341	$1,059.48	$282.20	$211.90
43045	Incision of esophagus		C					
43100	Excision of esophagus lesion		C					
43101	Excision of esophagus lesion		C					
43107	Removal of esophagus		C					
43108	Removal of esophagus		C					
43112	Removal of esophagus		C					
43113	Removal of esophagus		C					
43116	Partial removal of esophagus		C					
43117	Partial removal of esophagus		C					
43118	Partial removal of esophagus		C					
43121	Partial removal of esophagus		C					
43122	Partial removal of esophagus		C					
43123	Partial removal of esophagus		C					
43124	Removal of esophagus		C					
43130	Removal of esophagus pouch		T	0256	40.5598	$2,583.38		$516.68
43135	Removal of esophagus pouch		C					
43200	Esophagus endoscopy		T	0141	8.673	$552.41	$143.30	$110.48
43201	Esoph scope w/submucous inj		T	0141	8.673	$552.41	$143.30	$110.48
43202	Esophagus endoscopy, biopsy		T	0141	8.673	$552.41	$143.30	$110.48
43204	Esoph scope w/sclerosis inj		T	0141	8.673	$552.41	$143.30	$110.48
43205	Esophagus endoscopy/ligation		T	0141	8.673	$552.41	$143.30	$110.48
43215	Esophagus endoscopy		T	0141	8.673	$552.41	$143.30	$110.48
43216	Esophagus endoscopy/lesion		T	0141	8.673	$552.41	$143.30	$110.48
43217	Esophagus endoscopy		T	0141	8.673	$552.41	$143.30	$110.48
43219	Esophagus endoscopy		T	0384	25.2289	$1,606.90		$321.38
43220	Esoph endoscopy, dilation		T	0141	8.673	$552.41	$143.30	$110.48
43226	Esoph endoscopy, dilation		T	0141	8.673	$552.41	$143.30	$110.48
43227	Esoph endoscopy, repair		T	0141	8.673	$552.41	$143.30	$110.48
43228	Esoph endoscopy, ablation		T	0422	24.648	$1,569.91	$445.06	$313.98
43231	Esoph endoscopy w/us exam		T	0141	8.673	$552.41	$143.30	$110.48
43232	Esoph endoscopy w/us fn bx		T	0141	8.673	$552.41	$143.30	$110.48
43234	Upper GI endoscopy, exam		T	0141	8.673	$552.41	$143.30	$110.48
43235	Uppr gi endoscopy, diagnosis		T	0141	8.673	$552.41	$143.30	$110.48
43236	Uppr gi scope w/submuc inj		T	0141	8.673	$552.41	$143.30	$110.48
43237	Endoscopic us exam, esoph		T	0141	8.673	$552.41	$143.30	$110.48
43238	Uppr gi endoscopy w/us fn bx		T	0141	8.673	$552.41	$143.30	$110.48
43239	Upper GI endoscopy, biopsy		T	0141	8.673	$552.41	$143.30	$110.48
43240	Esoph endoscope w/drain cyst		T	0141	8.673	$552.41	$143.30	$110.48
43241	Upper GI endoscopy with tube		T	0141	8.673	$552.41	$143.30	$110.48
43242	Uppr gi endoscopy w/us fn bx		T	0141	8.673	$552.41	$143.30	$110.48
43243	Upper gi endoscopy & inject		T	0141	8.673	$552.41	$143.30	$110.48
43244	Upper GI endoscopy/ligation		T	0141	8.673	$552.41	$143.30	$110.48
43245	Uppr gi scope dilate strictr		T	0141	8.673	$552.41	$143.30	$110.48
43246	Place gastrostomy tube		T	0141	8.673	$552.41	$143.30	$110.48
43247	Operative upper GI endoscopy		T	0141	8.673	$552.41	$143.30	$110.48
43248	Uppr gi endoscopy/guide wire		T	0141	8.673	$552.41	$143.30	$110.48
43249	Esoph endoscopy, dilation		T	0141	8.673	$552.41	$143.30	$110.48
43250	Upper GI endoscopy/tumor		T	0141	8.673	$552.41	$143.30	$110.48
43251	Operative upper GI endoscopy		T	0141	8.673	$552.41	$143.30	$110.48

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
43255	Operative upper GI endoscopy		T	0141	8.673	$552.41	$143.30	$110.48
43256	Uppr gi endoscopy w/stent		T	0384	25.2289	$1,606.90		$321.38
43257	Uppr gi scope w/thrml txmnt		T	0422	24.648	$1,569.91	$445.06	$313.98
43258	Operative upper GI endoscopy		T	0141	8.673	$552.41	$143.30	$110.48
43259	Endoscopic ultrasound exam		T	0141	8.673	$552.41	$143.30	$110.48
43260	Endo cholangiopancreatograph		T	0151	21.282	$1,355.51		$271.10
43261	Endo cholangiopancreatograph		T	0151	21.282	$1,355.51		$271.10
43262	Endo cholangiopancreatograph		T	0151	21.282	$1,355.51		$271.10
43263	Endo cholangiopancreatograph		T	0151	21.282	$1,355.51		$271.10
43264	Endo cholangiopancreatograph		T	0151	21.282	$1,355.51		$271.10
43265	Endo cholangiopancreatograph		T	0151	21.282	$1,355.51		$271.10
43267	Endo cholangiopancreatograph		T	0151	21.282	$1,355.51		$271.10
43268	Endo cholangiopancreatograph		T	0384	25.2289	$1,606.90		$321.38
43269	Endo cholangiopancreatograph		T	0384	25.2289	$1,606.90		$321.38
43271	Endo cholangiopancreatograph		T	0151	21.282	$1,355.51		$271.10
43272	Endo cholangiopancreatograph		T	0151	21.282	$1,355.51		$271.10
43280	Laparoscopy, fundoplasty		T	0132	71.0022	$4,522.34	$1,239.20	$904.47
43289	Laparoscope proc, esoph		T	0130	34.8153	$2,217.49	$659.50	$443.50
43300	Repair of esophagus		C					
43305	Repair esophagus and fistula		C					
43310	Repair of esophagus		C					
43312	Repair esophagus and fistula		C					
43313	Esophagoplasty congenital		C					
43314	Tracheo-esophagoplasty cong		C					
43320	Fuse esophagus & stomach		C					
43324	Revise esophagus & stomach		C					
43325	Revise esophagus & stomach		C					
43326	Revise esophagus & stomach		C					
43330	Repair of esophagus		C					
43331	Repair of esophagus		C					
43340	Fuse esophagus & intestine		C					
43341	Fuse esophagus & intestine		C					
43350	Surgical opening, esophagus		C					
43351	Surgical opening, esophagus		C					
43352	Surgical opening, esophagus		C					
43360	Gastrointestinal repair		C					
43361	Gastrointestinal repair		C					
43400	Ligate esophagus veins		C					
43401	Esophagus surgery for veins		C					
43405	Ligate/staple esophagus		C					
43410	Repair esophagus wound		C					
43415	Repair esophagus wound		C					
43420	Repair esophagus opening		C					
43425	Repair esophagus opening		C					
43450	Dilate esophagus		T	0140	6.0867	$387.68	$91.40	$77.54
43453	Dilate esophagus		T	0140	6.0867	$387.68	$91.40	$77.54
43456	Dilate esophagus		T	0140	6.0867	$387.68	$91.40	$77.54
43458	Dilate esophagus	CH	T	0141	8.673	$552.41	$143.30	$110.48
43460	Pressure treatment esophagus		C					
43496	Free jejunum flap, microvasc		C					
43499	Esophagus surgery procedure		T	0141	8.673	$552.41	$143.30	$110.48
43500	Surgical opening of stomach		C					
43501	Surgical repair of stomach		C					
43502	Surgical repair of stomach		C					
43510	Surgical opening of stomach		T	0141	8.673	$552.41	$143.30	$110.48
43520	Incision of pyloric muscle		C					
43600	Biopsy of stomach		T	0141	8.673	$552.41	$143.30	$110.48
43605	Biopsy of stomach		C					
43610	Excision of stomach lesion		C					
43611	Excision of stomach lesion		C					
43620	Removal of stomach		C					
43621	Removal of stomach		C					
43622	Removal of stomach		C					
43631	Removal of stomach, partial		C					
43632	Removal of stomach, partial		C					
43633	Removal of stomach, partial		C					
43634	Removal of stomach, partial		C					
43635	Removal of stomach, partial		C					
43640	Vagotomy & pylorus repair		C					
43641	Vagotomy & pylorus repair		C					
43644	Lap gastric bypass/roux-en-y		C					
43645	Lap gastr bypass incl smll i		C					
43647	Lap impl electrode, antrum		T	0130	34.8153	$2,217.49	$659.50	$443.50
43648	Lap revise/remv eltrd antrum		T	0130	34.8153	$2,217.49	$659.50	$443.50
43651	Laparoscopy, vagus nerve		T	0132	71.0022	$4,522.34	$1,239.20	$904.47
43652	Laparoscopy, vagus nerve		T	0132	71.0022	$4,522.34	$1,239.20	$904.47
43653	Laparoscopy, gastrostomy		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
43659	Laparoscope proc, stom		T	0130	34.8153	$2,217.49	$659.50	$443.50

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
43750	Place gastrostomy tube		T	0141	8.673	$552.41	$143.30	$110.48
43752	Nasal/orogastric w/stent		X	0272	1.327	$84.52	$31.60	$16.90
43760	Change gastrostomy tube		T	0121	3.2914	$209.64	$43.80	$41.93
43761	Reposition gastrostomy tube	CH	T	0141	8.673	$552.41	$143.30	$110.48
43770	Lap, place gastr adjust band		C					
43771	Lap, revise adjust gast band		C					
43772	Lap, remove adjust gast band		C					
43773	Lap, change adjust gast band		C					
43774	Lap remov adj gast band/port		C					
43800	Reconstruction of pylorus		C					
43810	Fusion of stomach and bowel		C					
43820	Fusion of stomach and bowel		C					
43825	Fusion of stomach and bowel		C					
43830	Place gastrostomy tube		T	0422	24.648	$1,569.91	$445.06	$313.98
43831	Place gastrostomy tube		T	0141	8.673	$552.41	$143.30	$110.48
43832	Place gastrostomy tube		C					
43840	Repair of stomach lesion		C					
43842	V-band gastroplasty		E					
43843	Gastroplasty w/o v-band		C					
43845	Gastroplasty duodenal switch		C					
43846	Gastric bypass for obesity		C					
43847	Gastric bypass incl small i		C					
43848	Revision gastroplasty		C					
43850	Revise stomach-bowel fusion		C					
43855	Revise stomach-bowel fusion		C					
43860	Revise stomach-bowel fusion		C					
43865	Revise stomach-bowel fusion		C					
43870	Repair stomach opening		T	0141	8.673	$552.41	$143.30	$110.48
43880	Repair stomach-bowel fistula		C					
43881	Impl/redo electrd, antrum		C					
43882	Revise/remove electrd antrum		C					
43886	Revise gastric port, open	CH	T	0137	20.9338	$1,333.34		$266.67
43887	Remove gastric port, open	CH	T	0135	4.6816	$298.19		$59.64
43888	Change gastric port, open	CH	T	0137	20.9338	$1,333.34		$266.67
43999	Stomach surgery procedure		T	0141	8.673	$552.41	$143.30	$110.48
44005	Freeing of bowel adhesion		C					
44010	Incision of small bowel		C					
44015	Insert needle cath bowel		C					
44020	Explore small intestine		C					
44021	Decompress small bowel		C					
44025	Incision of large bowel		C					
44050	Reduce bowel obstruction		C					
44055	Correct malrotation of bowel		C					
44100	Biopsy of bowel		T	0141	8.673	$552.41	$143.30	$110.48
44110	Excise intestine lesion(s)		C					
44111	Excision of bowel lesion(s)		C					
44120	Removal of small intestine		C					
44121	Removal of small intestine		C					
44125	Removal of small intestine		C					
44126	Enterectomy w/o taper, cong		C					
44127	Enterectomy w/taper, cong		C					
44128	Enterectomy cong, add-on		C					
44130	Bowel to bowel fusion		C					
44132	Enterectomy, cadaver donor		C					
44133	Enterectomy, live donor		C					
44135	Intestine transplnt, cadaver		C					
44136	Intestine transplant, live		C					
44137	Remove intestinal allograft		C					
44139	Mobilization of colon		C					
44140	Partial removal of colon		C					
44141	Partial removal of colon		C					
44143	Partial removal of colon		C					
44144	Partial removal of colon		C					
44145	Partial removal of colon		C					
44146	Partial removal of colon		C					
44147	Partial removal of colon		C					
44150	Removal of colon		C					
44151	Removal of colon/ileostomy		C					
44155	Removal of colon/ileostomy		C					
44156	Removal of colon/ileostomy		C					
44157	Colectomy w/ileoanal anast		C					
44158	Colectomy w/neo-rectum pouch		C					
44160	Removal of colon		C					
44180	Lap, enterolysis		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
44186	Lap, jejunostomy		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
44187	Lap, ileo/jejuno-stomy		C					
44188	Lap, colostomy		C					
44202	Lap, enterectomy		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
44203	Lap resect s/intestine, addl		C					
44204	Laparo partial colectomy		C					
44205	Lap colectomy part w/ileum		C					
44206	Lap part colectomy w/stoma		T	0132	71.0022	$4,522.34	$1,239.20	$904.47
44207	L colectomy/coloproctostomy		T	0132	71.0022	$4,522.34	$1,239.20	$904.47
44208	L colectomy/coloproctostomy		T	0132	71.0022	$4,522.34	$1,239.20	$904.47
44210	Laparo total proctocolectomy		C					
44211	Lap colectomy w/proctectomy		C					
44212	Laparo total proctocolectomy		C					
44213	Lap, mobil splenic fl add-on		T	0130	34.8153	$2,217.49	$659.50	$443.50
44227	Lap, close enterostomy		C					
44238	Laparoscope proc, intestine		T	0130	34.8153	$2,217.49	$659.50	$443.50
44300	Open bowel to skin		C					
44310	Ileostomy/jejunostomy		C					
44312	Revision of ileostomy	CH	T	0137	20.9338	$1,333.34		$266.67
44314	Revision of ileostomy		C					
44316	Devise bowel pouch		C					
44320	Colostomy		C					
44322	Colostomy with biopsies		C					
44340	Revision of colostomy	CH	T	0137	20.9338	$1,333.34		$266.67
44345	Revision of colostomy		C					
44346	Revision of colostomy		C					
44360	Small bowel endoscopy		T	0142	9.6264	$613.13	$152.70	$122.63
44361	Small bowel endoscopy/biopsy		T	0142	9.6264	$613.13	$152.70	$122.63
44363	Small bowel endoscopy		T	0142	9.6264	$613.13	$152.70	$122.63
44364	Small bowel endoscopy		T	0142	9.6264	$613.13	$152.70	$122.63
44365	Small bowel endoscopy		T	0142	9.6264	$613.13	$152.70	$122.63
44366	Small bowel endoscopy		T	0142	9.6264	$613.13	$152.70	$122.63
44369	Small bowel endoscopy		T	0142	9.6264	$613.13	$152.70	$122.63
44370	Small bowel endoscopy/stent		T	0384	25.2289	$1,606.90		$321.38
44372	Small bowel endoscopy		T	0142	9.6264	$613.13	$152.70	$122.63
44373	Small bowel endoscopy		T	0142	9.6264	$613.13	$152.70	$122.63
44376	Small bowel endoscopy		T	0142	9.6264	$613.13	$152.70	$122.63
44377	Small bowel endoscopy/biopsy		T	0142	9.6264	$613.13	$152.70	$122.63
44378	Small bowel endoscopy		T	0142	9.6264	$613.13	$152.70	$122.63
44379	S bowel endoscope w/stent		T	0384	25.2289	$1,606.90		$321.38
44380	Small bowel endoscopy		T	0142	9.6264	$613.13	$152.70	$122.63
44382	Small bowel endoscopy		T	0142	9.6264	$613.13	$152.70	$122.63
44383	Ileoscopy w/stent		T	0384	25.2289	$1,606.90		$321.38
44385	Endoscopy of bowel pouch		T	0143	9.036	$575.53	$186.00	$115.11
44386	Endoscopy, bowel pouch/biop		T	0143	9.036	$575.53	$186.00	$115.11
44388	Colonoscopy		T	0143	9.036	$575.53	$186.00	$115.11
44389	Colonoscopy with biopsy		T	0143	9.036	$575.53	$186.00	$115.11
44390	Colonoscopy for foreign body		T	0143	9.036	$575.53	$186.00	$115.11
44391	Colonoscopy for bleeding		T	0143	9.036	$575.53	$186.00	$115.11
44392	Colonoscopy & polypectomy		T	0143	9.036	$575.53	$186.00	$115.11
44393	Colonoscopy, lesion removal		T	0143	9.036	$575.53	$186.00	$115.11
44394	Colonoscopy w/snare		T	0143	9.036	$575.53	$186.00	$115.11
44397	Colonoscopy w/stent		T	0384	25.2289	$1,606.90		$321.38
44500	Intro, gastrointestinal tube		T	0121	3.2914	$209.64	$43.80	$41.93
44602	Suture, small intestine		C					
44603	Suture, small intestine		C					
44604	Suture, large intestine		C					
44605	Repair of bowel lesion		C					
44615	Intestinal stricturoplasty		C					
44620	Repair bowel opening		C					
44625	Repair bowel opening		C					
44626	Repair bowel opening		C					
44640	Repair bowel-skin fistula		C					
44650	Repair bowel fistula		C					
44660	Repair bowel-bladder fistula		C					
44661	Repair bowel-bladder fistula		C					
44680	Surgical revision, intestine		C					
44700	Suspend bowel w/prosthesis		C					
44701	Intraop colon lavage add-on		N					
44715	Prepare donor intestine		C					
44720	Prep donor intestine/venous		C					
44721	Prep donor intestine/artery		C					
44799	Unlisted procedure intestine		T	0153	25.4636	$1,621.85	$397.90	$324.37
44800	Excision of bowel pouch		C					
44820	Excision of mesentery lesion		C					
44850	Repair of mesentery		C					
44899	Bowel surgery procedure		C					
44900	Drain app abscess, open		C					
44901	Drain app abscess, percut		T	0037	13.9599	$889.15	$228.70	$177.83
44950	Appendectomy		C					
44955	Appendectomy add-on		C					
44960	Appendectomy		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
44970	Laparoscopy, appendectomy		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
44979	Laparoscope proc, app		T	0130	34.8153	$2,217.49	$659.50	$443.50
45000	Drainage of pelvic abscess	CH	T	0155	11.6524	$742.18		$148.44
45005	Drainage of rectal abscess		T	0155	11.6524	$742.18		$148.44
45020	Drainage of rectal abscess		T	0155	11.6524	$742.18		$148.44
45100	Biopsy of rectum		T	0149	23.2282	$1,479.47		$295.89
45108	Removal of anorectal lesion		T	0149	23.2282	$1,479.47		$295.89
45110	Removal of rectum		C					
45111	Partial removal of rectum		C					
45112	Removal of rectum		C					
45113	Partial proctectomy		C					
45114	Partial removal of rectum		C					
45116	Partial removal of rectum		C					
45119	Remove rectum w/reservoir		C					
45120	Removal of rectum		C					
45121	Removal of rectum and colon		C					
45123	Partial proctectomy		C					
45126	Pelvic exenteration		C					
45130	Excision of rectal prolapse		C					
45135	Excision of rectal prolapse		C					
45136	Excise ileoanal reservior		C					
45150	Excision of rectal stricture		T	0149	23.2282	$1,479.47		$295.89
45160	Excision of rectal lesion		T	0149	23.2282	$1,479.47		$295.89
45170	Excision of rectal lesion		T	0149	23.2282	$1,479.47		$295.89
45190	Destruction, rectal tumor		T	0149	23.2282	$1,479.47		$295.89
45300	Proctosigmoidoscopy dx		T	0146	5.1441	$327.64		$65.53
45303	Proctosigmoidoscopy dilate		T	0147	8.8611	$564.39		$112.88
45305	Proctosigmoidoscopy w/bx		T	0147	8.8611	$564.39		$112.88
45307	Proctosigmoidoscopy fb		T	0428	21.8923	$1,394.39		$278.88
45308	Proctosigmoidoscopy removal		T	0147	8.8611	$564.39		$112.88
45309	Proctosigmoidoscopy removal		T	0147	8.8611	$564.39		$112.88
45315	Proctosigmoidoscopy removal		T	0147	8.8611	$564.39		$112.88
45317	Proctosigmoidoscopy bleed		T	0147	8.8611	$564.39		$112.88
45320	Proctosigmoidoscopy ablate		T	0428	21.8923	$1,394.39		$278.88
45321	Proctosigmoidoscopy volvul		T	0428	21.8923	$1,394.39		$278.88
45327	Proctosigmoidoscopy w/stent		T	0384	25.2289	$1,606.90		$321.38
45330	Diagnostic sigmoidoscopy		T	0146	5.1441	$327.64		$65.53
45331	Sigmoidoscopy and biopsy		T	0146	5.1441	$327.64		$65.53
45332	Sigmoidoscopy w/fb removal		T	0146	5.1441	$327.64		$65.53
45333	Sigmoidoscopy & polypectomy		T	0147	8.8611	$564.39		$112.88
45334	Sigmoidoscopy for bleeding		T	0147	8.8611	$564.39		$112.88
45335	Sigmoidoscopy w/submuc inj		T	0146	5.1441	$327.64		$65.53
45337	Sigmoidoscopy & decompress		T	0146	5.1441	$327.64		$65.53
45338	Sigmoidoscopy w/tumr remove		T	0147	8.8611	$564.39		$112.88
45339	Sigmoidoscopy w/ablate tumr		T	0147	8.8611	$564.39		$112.88
45340	Sig w/balloon dilation		T	0147	8.8611	$564.39		$112.88
45341	Sigmoidoscopy w/ultrasound		T	0147	8.8611	$564.39		$112.88
45342	Sigmoidoscopy w/us guide bx		T	0147	8.8611	$564.39		$112.88
45345	Sigmoidoscopy w/stent		T	0384	25.2289	$1,606.90		$321.38
45355	Surgical colonoscopy		T	0143	9.036	$575.53	$186.00	$115.11
45378	Diagnostic colonoscopy		T	0143	9.036	$575.53	$186.00	$115.11
45379	Colonoscopy w/fb removal		T	0143	9.036	$575.53	$186.00	$115.11
45380	Colonoscopy and biopsy		T	0143	9.036	$575.53	$186.00	$115.11
45381	Colonoscopy, submucous inj		T	0143	9.036	$575.53	$186.00	$115.11
45382	Colonoscopy/control bleeding		T	0143	9.036	$575.53	$186.00	$115.11
45383	Lesion removal colonoscopy		T	0143	9.036	$575.53	$186.00	$115.11
45384	Lesion remove colonoscopy		T	0143	9.036	$575.53	$186.00	$115.11
45385	Lesion removal colonoscopy		T	0143	9.036	$575.53	$186.00	$115.11
45386	Colonoscopy dilate stricture		T	0143	9.036	$575.53	$186.00	$115.11
45387	Colonoscopy w/stent		T	0384	25.2289	$1,606.90		$321.38
45391	Colonoscopy w/endoscope us		T	0143	9.036	$575.53	$186.00	$115.11
45392	Colonoscopy w/endoscopic fnb		T	0143	9.036	$575.53	$186.00	$115.11
45395	Lap, removal of rectum		C					
45397	Lap, remove rectum w/pouch		C					
45400	Laparoscopic proc		C					
45402	Lap proctopexy w/sig resect		C					
45499	Laparoscope proc, rectum		T	0130	34.8153	$2,217.49	$659.50	$443.50
45500	Repair of rectum		T	0149	23.2282	$1,479.47		$295.89
45505	Repair of rectum		T	0150	30.5544	$1,946.10	$437.10	$389.22
45520	Treatment of rectal prolapse	CH	T	0013	0.8046	$51.25		$10.25
45540	Correct rectal prolapse		C					
45541	Correct rectal prolapse		T	0150	30.5544	$1,946.10	$437.10	$389.22
45550	Repair rectum/remove sigmoid		C					
45560	Repair of rectocele		T	0150	30.5544	$1,946.10	$437.10	$389.22
45562	Exploration/repair of rectum		C					
45563	Exploration/repair of rectum		C					
45800	Repair rect/bladder fistula		C					
45805	Repair fistula w/colostomy		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
45820	Repair rectourethral fistula		C					
45825	Repair fistula w/colostomy		C					
45900	Reduction of rectal prolapse		T	0148	4.5189	$287.82		$57.56
45905	Dilation of anal sphincter		T	0149	23.2282	$1,479.47		$295.89
45910	Dilation of rectal narrowing		T	0149	23.2282	$1,479.47		$295.89
45915	Remove rectal obstruction	CH	T	0155	11.6524	$742.18		$148.44
45990	Surg dx exam, anorectal	CH	T	0149	23.2282	$1,479.47		$295.89
45999	Rectum surgery procedure		T	0148	4.5189	$287.82		$57.56
46020	Placement of seton		T	0149	23.2282	$1,479.47		$295.89
46030	Removal of rectal marker		T	0148	4.5189	$287.82		$57.56
46040	Incision of rectal abscess		T	0149	23.2282	$1,479.47		$295.89
46045	Incision of rectal abscess		T	0149	23.2282	$1,479.47		$295.89
46050	Incision of anal abscess	CH	T	0155	11.6524	$742.18		$148.44
46060	Incision of rectal abscess		T	0149	23.2282	$1,479.47		$295.89
46070	Incision of anal septum		T	0155	11.6524	$742.18		$148.44
46080	Incision of anal sphincter		T	0149	23.2282	$1,479.47		$295.89
46083	Incise external hemorrhoid		T	0164	2.1659	$137.95		$27.59
46200	Removal of anal fissure		T	0149	23.2282	$1,479.47		$295.89
46210	Removal of anal crypt		T	0149	23.2282	$1,479.47		$295.89
46211	Removal of anal crypts		T	0149	23.2282	$1,479.47		$295.89
46220	Removal of anal tag		T	0149	23.2282	$1,479.47		$295.89
46221	Ligation of hemorrhoid(s)		T	0148	4.5189	$287.82		$57.56
46230	Removal of anal tags		T	0149	23.2282	$1,479.47		$295.89
46250	Hemorrhoidectomy		T	0149	23.2282	$1,479.47		$295.89
46255	Hemorrhoidectomy		T	0149	23.2282	$1,479.47		$295.89
46257	Remove hemorrhoids & fissure		T	0149	23.2282	$1,479.47		$295.89
46258	Remove hemorrhoids & fistula		T	0149	23.2282	$1,479.47		$295.89
46260	Hemorrhoidectomy		T	0149	23.2282	$1,479.47		$295.89
46261	Remove hemorrhoids & fissure		T	0149	23.2282	$1,479.47		$295.89
46262	Remove hemorrhoids & fistula		T	0149	23.2282	$1,479.47		$295.89
46270	Removal of anal fistula		T	0149	23.2282	$1,479.47		$295.89
46275	Removal of anal fistula		T	0149	23.2282	$1,479.47		$295.89
46280	Removal of anal fistula		T	0149	23.2282	$1,479.47		$295.89
46285	Removal of anal fistula		T	0149	23.2282	$1,479.47		$295.89
46288	Repair anal fistula		T	0149	23.2282	$1,479.47		$295.89
46320	Removal of hemorrhoid clot	CH	T	0149	23.2282	$1,479.47		$295.89
46500	Injection into hemorrhoid(s)		T	0155	11.6524	$742.18		$148.44
46505	Chemodenervation anal musc		T	0148	4.5189	$287.82		$57.56
46600	Diagnostic anoscopy		X	0340	0.6416	$40.87		$8.17
46604	Anoscopy and dilation		T	0147	8.8611	$564.39		$112.88
46606	Anoscopy and biopsy		T	0146	5.1441	$327.64		$65.53
46608	Anoscopy, remove for body		T	0147	8.8611	$564.39		$112.88
46610	Anoscopy, remove lesion		T	0428	21.8923	$1,394.39		$278.88
46611	Anoscopy		T	0147	8.8611	$564.39		$112.88
46612	Anoscopy, remove lesions		T	0428	21.8923	$1,394.39		$278.88
46614	Anoscopy, control bleeding		T	0146	5.1441	$327.64		$65.53
46615	Anoscopy		T	0428	21.8923	$1,394.39		$278.88
46700	Repair of anal stricture		T	0149	23.2282	$1,479.47		$295.89
46705	Repair of anal stricture		C					
46706	Repr of anal fistula w/glue		T	0150	30.5544	$1,946.10	$437.10	$389.22
46710	Repr per/vag pouch sngl proc		C					
46712	Repr per/vag pouch dbl proc		C					
46715	Rep perf anoper fistu		C					
46716	Rep perf anoper/vestib fistu		C					
46730	Construction of absent anus		C					
46735	Construction of absent anus		C					
46740	Construction of absent anus		C					
46742	Repair of imperforated anus		C					
46744	Repair of cloacal anomaly		C					
46746	Repair of cloacal anomaly		C					
46748	Repair of cloacal anomaly		C					
46750	Repair of anal sphincter	CH	T	0150	30.5544	$1,946.10	$437.10	$389.22
46751	Repair of anal sphincter		C					
46753	Reconstruction of anus		T	0149	23.2282	$1,479.47		$295.89
46754	Removal of suture from anus		T	0149	23.2282	$1,479.47		$295.89
46760	Repair of anal sphincter	CH	T	0150	30.5544	$1,946.10	$437.10	$389.22
46761	Repair of anal sphincter	CH	T	0150	30.5544	$1,946.10	$437.10	$389.22
46762	Implant artificial sphincter	CH	T	0150	30.5544	$1,946.10	$437.10	$389.22
46900	Destruction, anal lesion(s)		T	0016	2.7493	$175.11		$35.02
46910	Destruction, anal lesion(s)		T	0017	20.0977	$1,280.08		$256.02
46916	Cryosurgery, anal lesion(s)	CH	T	0015	1.5119	$96.30		$19.26
46917	Laser surgery, anal lesions	CH	T	0017	20.0977	$1,280.08		$256.02
46922	Excision of anal lesion(s)	CH	T	0017	20.0977	$1,280.08		$256.02
46924	Destruction, anal lesion(s)	CH	T	0017	20.0977	$1,280.08		$256.02
46934	Destruction of hemorrhoids		T	0155	11.6524	$742.18		$148.44
46935	Destruction of hemorrhoids		T	0155	11.6524	$742.18		$148.44
46936	Destruction of hemorrhoids		T	0149	23.2282	$1,479.47		$295.89
46937	Cryotherapy of rectal lesion		T	0149	23.2282	$1,479.47		$295.89

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
46938	Cryotherapy of rectal lesion		T	0150	30.5544	$1,946.10	$437.10	$389.22
46940	Treatment of anal fissure		T	0149	23.2282	$1,479.47		$295.89
46942	Treatment of anal fissure		T	0148	4.5189	$287.82		$57.56
46945	Ligation of hemorrhoids		T	0155	11.6524	$742.18		$148.44
46946	Ligation of hemorrhoids		T	0155	11.6524	$742.18		$148.44
46947	Hemorrhoidopexy by stapling		T	0150	30.5544	$1,946.10	$437.10	$389.22
46999	Anus surgery procedure		T	0148	4.5189	$287.82		$57.56
47000	Needle biopsy of liver		T	0685	9.5741	$609.80		$121.96
47001	Needle biopsy, liver add-on		N					
47010	Open drainage, liver lesion		C					
47011	Percut drain, liver lesion		T	0037	13.9599	$889.15	$228.70	$177.83
47015	Inject/aspirate liver cyst		C					
47100	Wedge biopsy of liver		C					
47120	Partial removal of liver		C					
47122	Extensive removal of liver		C					
47125	Partial removal of liver		C					
47130	Partial removal of liver		C					
47133	Removal of donor liver		C					
47135	Transplantation of liver		C					
47136	Transplantation of liver		C					
47140	Partial removal, donor liver		C					
47141	Partial removal, donor liver		C					
47142	Partial removal, donor liver		C					
47143	Prep donor liver, whole		C					
47144	Prep donor liver, 3-segment		C					
47145	Prep donor liver, lobe split		C					
47146	Prep donor liver/venous		C					
47147	Prep donor liver/arterial		C					
47300	Surgery for liver lesion		C					
47350	Repair liver wound		C					
47360	Repair liver wound		C					
47361	Repair liver wound		C					
47362	Repair liver wound		C					
47370	Laparo ablate liver tumor rf		T	0132	71.0022	$4,522.34	$1,239.20	$904.47
47371	Laparo ablate liver cryosurg		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
47379	Laparoscope procedure, liver		T	0130	34.8153	$2,217.49	$659.50	$443.50
47380	Open ablate liver tumor rf		C					
47381	Open ablate liver tumor cryo		C					
47382	Percut ablate liver rf		T	0423	44.1192	$2,810.08		$562.02
47399	Liver surgery procedure		T	0004	4.5062	$287.01		$57.40
47400	Incision of liver duct		C					
47420	Incision of bile duct		C					
47425	Incision of bile duct		C					
47460	Incise bile duct sphincter		C					
47480	Incision of gallbladder		C					
47490	Incision of gallbladder		T	0152	28.7304	$1,829.93		$365.99
47500	Injection for liver x-rays		N					
47505	Injection for liver x-rays		N					
47510	Insert catheter, bile duct		T	0152	28.7304	$1,829.93		$365.99
47511	Insert bile duct drain		T	0152	28.7304	$1,829.93		$365.99
47525	Change bile duct catheter		T	0427	14.8912	$948.47		$189.69
47530	Revise/reinsert bile tube		T	0427	14.8912	$948.47		$189.69
47550	Bile duct endoscopy add-on		C					
47552	Biliary endoscopy thru skin		T	0152	28.7304	$1,829.93		$365.99
47553	Biliary endoscopy thru skin		T	0152	28.7304	$1,829.93		$365.99
47554	Biliary endoscopy thru skin		T	0152	28.7304	$1,829.93		$365.99
47555	Biliary endoscopy thru skin		T	0152	28.7304	$1,829.93		$365.99
47556	Biliary endoscopy thru skin		T	0152	28.7304	$1,829.93		$365.99
47560	Laparoscopy w/cholangio		T	0130	34.8153	$2,217.49	$659.50	$443.50
47561	Laparo w/cholangio/biopsy		T	0130	34.8153	$2,217.49	$659.50	$443.50
47562	Laparoscopic cholecystectomy		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
47563	Laparo cholecystectomy/graph		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
47564	Laparo cholecystectomy/explr		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
47570	Laparo cholecystoenterostomy		C					
47579	Laparoscope proc, biliary		T	0130	34.8153	$2,217.49	$659.50	$443.50
47600	Removal of gallbladder		C					
47605	Removal of gallbladder		C					
47610	Removal of gallbladder		C					
47612	Removal of gallbladder		C					
47620	Removal of gallbladder		C					
47630	Remove bile duct stone		T	0152	28.7304	$1,829.93		$365.99
47700	Exploration of bile ducts		C					
47701	Bile duct revision		C					
47711	Excision of bile duct tumor		C					
47712	Excision of bile duct tumor		C					
47715	Excision of bile duct cyst		C					
47719	Fusion of bile duct cyst		C					
47720	Fuse gallbladder & bowel		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
47721	Fuse upper gi structures		C					
47740	Fuse gallbladder & bowel		C					
47741	Fuse gallbladder & bowel		C					
47760	Fuse bile ducts and bowel		C					
47765	Fuse liver ducts & bowel		C					
47780	Fuse bile ducts and bowel		C					
47785	Fuse bile ducts and bowel		C					
47800	Reconstruction of bile ducts		C					
47801	Placement, bile duct support		C					
47802	Fuse liver duct & intestine		C					
47900	Suture bile duct injury		C					
47999	Bile tract surgery procedure		T	0152	28.7304	$1,829.93		$365.99
48000	Drainage of abdomen		C					
48001	Placement of drain, pancreas		C					
48020	Removal of pancreatic stone		C					
48100	Biopsy of pancreas, open		C					
48102	Needle biopsy, pancreas		T	0685	9.5741	$609.80		$121.96
48105	Resect/debride pancreas		C					
48120	Removal of pancreas lesion		C					
48140	Partial removal of pancreas		C					
48145	Partial removal of pancreas		C					
48146	Pancreatectomy		C					
48148	Removal of pancreatic duct		C					
48150	Partial removal of pancreas		C					
48152	Pancreatectomy		C					
48153	Pancreatectomy		C					
48154	Pancreatectomy		C					
48155	Removal of pancreas		C					
48160	Pancreas removal/transplant		E					
48400	Injection, intraop add-on		C					
48500	Surgery of pancreatic cyst		C					
48510	Drain pancreatic pseudocyst		C					
48511	Drain pancreatic pseudocyst		T	0037	13.9599	$889.15	$228.70	$177.83
48520	Fuse pancreas cyst and bowel		C					
48540	Fuse pancreas cyst and bowel		C					
48545	Pancreatorrhaphy		C					
48547	Duodenal exclusion		C					
48548	Fuse pancreas and bowel		C					
48550	Donor pancreatectomy		E					
48551	Prep donor pancreas		C					
48552	Prep donor pancreas/venous		C					
48554	Transpl allograft pancreas		C					
48556	Removal, allograft pancreas		C					
48999	Pancreas surgery procedure		T	0004	4.5062	$287.01		$57.40
49000	Exploration of abdomen		C					
49002	Reopening of abdomen		C					
49010	Exploration behind abdomen		C					
49020	Drain abdominal abscess		C					
49021	Drain abdominal abscess		T	0037	13.9599	$889.15	$228.70	$177.83
49040	Drain, open, abdom abscess		C					
49041	Drain, percut, abdom abscess		T	0037	13.9599	$889.15	$228.70	$177.83
49060	Drain, open, retrop abscess		C					
49061	Drain, percut, retroper absc		T	0037	13.9599	$889.15	$228.70	$177.83
49062	Drain to peritoneal cavity		C					
49080	Puncture, peritoneal cavity		T	0070	5.3095	$338.18		$67.64
49081	Removal of abdominal fluid		T	0070	5.3095	$338.18		$67.64
49180	Biopsy, abdominal mass		T	0685	9.5741	$609.80		$121.96
49200	Removal of abdominal lesion		T	0130	34.8153	$2,217.49	$659.50	$443.50
49201	Remove abdom lesion, complex		C					
49215	Excise sacral spine tumor		C					
49220	Multiple surgery, abdomen		C					
49250	Excision of umbilicus		T	0153	25.4636	$1,621.85	$397.90	$324.37
49255	Removal of omentum		C					
49320	Diag laparo separate proc		T	0130	34.8153	$2,217.49	$659.50	$443.50
49321	Laparoscopy, biopsy		T	0130	34.8153	$2,217.49	$659.50	$443.50
49322	Laparoscopy, aspiration		T	0130	34.8153	$2,217.49	$659.50	$443.50
49323	Laparo drain lymphocele		T	0130	34.8153	$2,217.49	$659.50	$443.50
49324	Lap insertion perm ip cath		T	0130	34.8153	$2,217.49	$659.50	$443.50
49325	Lap revision perm ip cath		T	0130	34.8153	$2,217.49	$659.50	$443.50
49326	Lap w/omentopexy add-on		T	0130	34.8153	$2,217.49	$659.50	$443.50
49329	Laparo proc, abdm/per/oment		T	0130	34.8153	$2,217.49	$659.50	$443.50
49400	Air injection into abdomen		N					
49402	Remove foreign body, adbomen		T	0153	25.4636	$1,621.85	$397.90	$324.37
49419	Insrt abdom cath for chemotx		T	0115	30.5379	$1,945.05		$389.01
49420	Insert abdom drain, temp		T	0652	31.7598	$2,022.88		$404.58
49421	Insert abdom drain, perm		T	0652	31.7598	$2,022.88		$404.58
49422	Remove perm cannula/catheter		T	0105	24.7274	$1,574.96	$370.40	$314.99
49423	Exchange drainage catheter		T	0427	14.8912	$948.47		$189.69

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
49424	Assess cyst, contrast inject		N					
49425	Insert abdomen-venous drain		C					
49426	Revise abdomen-venous shunt		T	0153	25.4636	$1,621.85	$397.90	$324.37
49427	Injection, abdominal shunt		N					
49428	Ligation of shunt		C					
49429	Removal of shunt		T	0105	24.7274	$1,574.96	$370.40	$314.99
49435	Insert subq exten to ip cath		T	0427	14.8912	$948.47		$189.69
49436	Embedded ip cath exit-site		T	0427	14.8912	$948.47		$189.69
49491	Rpr hern preemie reduc		T	0154	31.1722	$1,985.45	$464.80	$397.09
49492	Rpr ing hern premie, blocked		T	0154	31.1722	$1,985.45	$464.80	$397.09
49495	Rpr ing hernia baby, reduc		T	0154	31.1722	$1,985.45	$464.80	$397.09
49496	Rpr ing hernia baby, blocked		T	0154	31.1722	$1,985.45	$464.80	$397.09
49500	Rpr ing hernia, init, reduce		T	0154	31.1722	$1,985.45	$464.80	$397.09
49501	Rpr ing hernia, init blocked		T	0154	31.1722	$1,985.45	$464.80	$397.09
49505	Prp i/hern init reduc >5 yr		T	0154	31.1722	$1,985.45	$464.80	$397.09
49507	Prp i/hern init block >5 yr		T	0154	31.1722	$1,985.45	$464.80	$397.09
49520	Rerepair ing hernia, reduce		T	0154	31.1722	$1,985.45	$464.80	$397.09
49521	Rerepair ing hernia, blocked		T	0154	31.1722	$1,985.45	$464.80	$397.09
49525	Repair ing hernia, sliding		T	0154	31.1722	$1,985.45	$464.80	$397.09
49540	Repair lumbar hernia		T	0154	31.1722	$1,985.45	$464.80	$397.09
49550	Rpr rem hernia, init, reduce		T	0154	31.1722	$1,985.45	$464.80	$397.09
49553	Rpr fem hernia, init blocked		T	0154	31.1722	$1,985.45	$464.80	$397.09
49555	Rerepair fem hernia, reduce		T	0154	31.1722	$1,985.45	$464.80	$397.09
49557	Rerepair fem hernia, blocked		T	0154	31.1722	$1,985.45	$464.80	$397.09
49560	Rpr ventral hern init, reduc		T	0154	31.1722	$1,985.45	$464.80	$397.09
49561	Rpr ventral hern init, block		T	0154	31.1722	$1,985.45	$464.80	$397.09
49565	Rerepair ventrl hern, reduce		T	0154	31.1722	$1,985.45	$464.80	$397.09
49566	Rerepair ventrl hern, block		T	0154	31.1722	$1,985.45	$464.80	$397.09
49568	Hernia repair w/mesh		T	0154	31.1722	$1,985.45	$464.80	$397.09
49570	Rpr epigastric hern, reduce		T	0154	31.1722	$1,985.45	$464.80	$397.09
49572	Rpr epigastric hern, blocked		T	0154	31.1722	$1,985.45	$464.80	$397.09
49580	Rpr umbil hern, reduc < 5 yr		T	0154	31.1722	$1,985.45	$464.80	$397.09
49582	Rpr umbil hern, block < 5 yr		T	0154	31.1722	$1,985.45	$464.80	$397.09
49585	Rpr umbil hern, reduc > 5 yr		T	0154	31.1722	$1,985.45	$464.80	$397.09
49587	Rpr umbil hern, block > 5 yr		T	0154	31.1722	$1,985.45	$464.80	$397.09
49590	Repair spigelian hernia		T	0154	31.1722	$1,985.45	$464.80	$397.09
49600	Repair umbilical lesion		T	0154	31.1722	$1,985.45	$464.80	$397.09
49605	Repair umbilical lesion		C					
49606	Repair umbilical lesion		C					
49610	Repair umbilical lesion		C					
49611	Repair umbilical lesion		C					
49650	Laparo hernia repair initial		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
49651	Laparo hernia repair recur		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
49659	Laparo proc, hernia repair		T	0130	34.8153	$2,217.49	$659.50	$443.50
49900	Repair of abdominal wall		C					
49904	Omental flap, extra-abdom		C					
49905	Omental flap, intra-abdom		C					
49906	Free omental flap, microvasc		C					
49999	Abdomen surgery procedure		T	0153	25.4636	$1,621.85	$397.90	$324.37
50010	Exploration of kidney		C					
50020	Renal abscess, open drain		T	0162	25.2775	$1,610.00		$322.00
50021	Renal abscess, percut drain		T	0037	13.9599	$889.15	$228.70	$177.83
50040	Drainage of kidney		C					
50045	Exploration of kidney		C					
5005F	Pt counsld on exam for moles		M					
50060	Removal of kidney stone		C					
50065	Incision of kidney		C					
50070	Incision of kidney		C					
50075	Removal of kidney stone		C					
50080	Removal of kidney stone		T	0429	45.9021	$2,923.64		$584.73
50081	Removal of kidney stone		T	0429	45.9021	$2,923.64		$584.73
50100	Revise kidney blood vessels		C					
5010F	Macul+fndngs to dr mng dm		M					
50120	Exploration of kidney		C					
50125	Explore and drain kidney		C					
50130	Removal of kidney stone		C					
50135	Exploration of kidney		C					
5015F	Doc fx & test/txmnt for op		M					
50200	Biopsy of kidney		T	0685	9.5741	$609.80		$121.96
50205	Biopsy of kidney		C					
50220	Remove kidney, open		C					
50225	Removal kidney open, complex		C					
50230	Removal kidney open, radical		C					
50234	Removal of kidney & ureter		C					
50236	Removal of kidney & ureter		C					
50240	Partial removal of kidney		C					
50250	Cryoablate renal mass open		C					
50280	Removal of kidney lesion		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
50290	Removal of kidney lesion		C					
50300	Remove cadaver donor kidney		C					
50320	Remove kidney, living donor		C					
50323	Prep cadaver renal allograft		C					
50325	Prep donor renal graft		C					
50327	Prep renal graft/venous		C					
50328	Prep renal graft/arterial		C					
50329	Prep renal graft/ureteral		C					
50340	Removal of kidney		C					
50360	Transplantation of kidney		C					
50365	Transplantation of kidney		C					
50370	Remove transplanted kidney		C					
50380	Reimplantation of kidney		C					
50382	Change ureter stent, percut	CH	T	0162	25.2775	$1,610.00		$322.00
50384	Remove ureter stent, percut		T	0161	18.1376	$1,155.24	$243.72	$231.05
50387	Change ext/int ureter stent	CH	T	0427	14.8912	$948.47		$189.69
50389	Remove renal tube w/fluoro	CH	T	0160	6.1077	$389.02		$77.80
50390	Drainage of kidney lesion		T	0685	9.5741	$609.80		$121.96
50391	Instll rx agnt into rnal tub		T	0126	1.085	$69.11	$16.40	$13.82
50392	Insert kidney drain		T	0161	18.1376	$1,155.24	$243.72	$231.05
50393	Insert ureteral tube	CH	T	0162	25.2775	$1,610.00		$322.00
50394	Injection for kidney x-ray		N					
50395	Create passage to kidney		T	0161	18.1376	$1,155.24	$243.72	$231.05
50396	Measure kidney pressure		T	0164	2.1659	$137.95		$27.59
50398	Change kidney tube	CH	T	0427	14.8912	$948.47		$189.69
50400	Revision of kidney/ureter		C					
50405	Revision of kidney/ureter		C					
50500	Repair of kidney wound		C					
50520	Close kidney-skin fistula		C					
50525	Repair renal-abdomen fistula		C					
50526	Repair renal-abdomen fistula		C					
50540	Revision of horseshoe kidney		C					
50541	Laparo ablate renal cyst		T	0130	34.8153	$2,217.49	$659.50	$443.50
50542	Laparo ablate renal mass		T	0132	71.0022	$4,522.34	$1,239.20	$904.47
50543	Laparo partial nephrectomy		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
50544	Laparoscopy, pyeloplasty		T	0130	34.8153	$2,217.49	$659.50	$443.50
50545	Laparo radical nephrectomy		C					
50546	Laparoscopic nephrectomy		C					
50547	Laparo removal donor kidney		C					
50548	Laparo remove w/ureter		C					
50549	Laparoscope proc, renal		T	0130	34.8153	$2,217.49	$659.50	$443.50
50551	Kidney endoscopy		T	0160	6.1077	$389.02		$77.80
50553	Kidney endoscopy	CH	T	0162	25.2775	$1,610.00		$322.00
50555	Kidney endoscopy & biopsy		T	0160	6.1077	$389.02		$77.80
50557	Kidney endoscopy & treatment		T	0162	25.2775	$1,610.00		$322.00
50561	Kidney endoscopy & treatment	CH	T	0162	25.2775	$1,610.00		$322.00
50562	Renal scope w/tumor resect		T	0160	6.1077	$389.02		$77.80
50570	Kidney endoscopy		T	0160	6.1077	$389.02		$77.80
50572	Kidney endoscopy		T	0160	6.1077	$389.02		$77.80
50574	Kidney endoscopy & biopsy		T	0160	6.1077	$389.02		$77.80
50575	Kidney endoscopy		T	0163	36.9175	$2,351.39		$470.28
50576	Kidney endoscopy & treatment		T	0161	18.1376	$1,155.24	$243.72	$231.05
50580	Kidney endoscopy & treatment	CH	T	0161	18.1376	$1,155.24	$243.72	$231.05
50590	Fragmenting of kidney stone		T	0169	43.0352	$2,741.04	$1,009.40	$548.21
50592	Perc rf ablate renal tumor		T	0423	44.1192	$2,810.08		$562.02
50600	Exploration of ureter		C					
50605	Insert ureteral support		C					
50610	Removal of ureter stone		C					
50620	Removal of ureter stone		C					
50630	Removal of ureter stone		C					
50650	Removal of ureter		C					
50660	Removal of ureter		C					
50684	Injection for ureter x-ray		N					
50686	Measure ureter pressure		T	0126	1.085	$69.11	$16.40	$13.82
50688	Change of ureter tube/stent	CH	T	0427	14.8912	$948.47		$189.69
50690	Injection for ureter x-ray		N					
50700	Revision of ureter		C					
50715	Release of ureter		C					
50722	Release of ureter		C					
50725	Release/revise ureter		C					
50727	Revise ureter		C					
50728	Revise ureter		C					
50740	Fusion of ureter & kidney		C					
50750	Fusion of ureter & kidney		C					
50760	Fusion of ureters		C					
50770	Splicing of ureters		C					
50780	Reimplant ureter in bladder		C					
50782	Reimplant ureter in bladder		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
50783	Reimplant ureter in bladder		C					
50785	Reimplant ureter in bladder		C					
50800	Implant ureter in bowel		C					
50810	Fusion of ureter & bowel		C					
50815	Urine shunt to intestine		C					
50820	Construct bowel bladder		C					
50825	Construct bowel bladder		C					
50830	Revise urine flow		C					
50840	Replace ureter by bowel		C					
50845	Appendico-vesicostomy		C					
50860	Transplant ureter to skin		C					
50900	Repair of ureter		C					
50920	Closure ureter/skin fistula		C					
50930	Closure ureter/bowel fistula		C					
50940	Release of ureter		C					
50945	Laparoscopy ureterolithotomy		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
50947	Laparo new ureter/bladder		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
50948	Laparo new ureter/bladder		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
50949	Laparoscope proc, ureter		T	0130	34.8153	$2,217.49	$659.50	$443.50
50951	Endoscopy of ureter		T	0160	6.1077	$389.02		$77.80
50953	Endoscopy of ureter		T	0160	6.1077	$389.02		$77.80
50955	Ureter endoscopy & biopsy	CH	T	0162	25.2775	$1,610.00		$322.00
50957	Ureter endoscopy & treatment	CH	T	0162	25.2775	$1,610.00		$322.00
50961	Ureter endoscopy & treatment	CH	T	0162	25.2775	$1,610.00		$322.00
50970	Ureter endoscopy		T	0160	6.1077	$389.02		$77.80
50972	Ureter endoscopy & catheter		T	0160	6.1077	$389.02		$77.80
50974	Ureter endoscopy & biopsy		T	0161	18.1376	$1,155.24	$243.72	$231.05
50976	Ureter endoscopy & treatment		T	0161	18.1376	$1,155.24	$243.72	$231.05
50980	Ureter endoscopy & treatment	CH	T	0162	25.2775	$1,610.00		$322.00
51000	Drainage of bladder		T	0164	2.1659	$137.95		$27.59
51005	Drainage of bladder		T	0126	1.085	$69.11	$16.40	$13.82
51010	Drainage of bladder		T	0165	19.6126	$1,249.19		$249.84
51020	Incise & treat bladder		T	0162	25.2775	$1,610.00		$322.00
51030	Incise & treat bladder		T	0162	25.2775	$1,610.00		$322.00
51040	Incise & drain bladder		T	0162	25.2775	$1,610.00		$322.00
51045	Incise bladder/drain ureter		T	0160	6.1077	$389.02		$77.80
51050	Removal of bladder stone		T	0162	25.2775	$1,610.00		$322.00
51060	Removal of ureter stone		C					
51065	Remove ureter calculus		T	0162	25.2775	$1,610.00		$322.00
51080	Drainage of bladder abscess		T	0008	19.0457	$1,213.08		$242.62
51500	Removal of bladder cyst		T	0154	31.1722	$1,985.45	$464.80	$397.09
51520	Removal of bladder lesion		T	0162	25.2775	$1,610.00		$322.00
51525	Removal of bladder lesion		C					
51530	Removal of bladder lesion		C					
51535	Repair of ureter lesion	CH	T	0162	25.2775	$1,610.00		$322.00
51550	Partial removal of bladder		C					
51555	Partial removal of bladder		C					
51565	Revise bladder & ureter(s)		C					
51570	Removal of bladder		C					
51575	Removal of bladder & nodes		C					
51580	Remove bladder/revise tract		C					
51585	Removal of bladder & nodes		C					
51590	Remove bladder/revise tract		C					
51595	Remove bladder/revise tract		C					
51596	Remove bladder/create pouch		C					
51597	Removal of pelvic structures		C					
51600	Injection for bladder x-ray		N					
51605	Preparation for bladder xray		N					
51610	Injection for bladder x-ray		N					
51700	Irrigation of bladder		T	0164	2.1659	$137.95		$27.59
51701	Insert bladder catheter		X	0340	0.6416	$40.87		$8.17
51702	Insert temp bladder cath		X	0340	0.6416	$40.87		$8.17
51703	Insert bladder cath, complex		T	0126	1.085	$69.11	$16.40	$13.82
51705	Change of bladder tube	CH	T	0164	2.1659	$137.95		$27.59
51710	Change of bladder tube	CH	T	0427	14.8912	$948.47		$189.69
51715	Endoscopic injection/implant		T	0168	30.1994	$1,923.49	$388.10	$384.70
51720	Treatment of bladder lesion		T	0164	2.1659	$137.95		$27.59
51725	Simple cystometrogram	CH	T	0156	3.0601	$194.91		$38.98
51726	Complex cystometrogram		T	0156	3.0601	$194.91		$38.98
51736	Urine flow measurement		T	0126	1.085	$69.11	$16.40	$13.82
51741	Electro-uroflowmetry, first		T	0126	1.085	$69.11	$16.40	$13.82
51772	Urethra pressure profile		T	0164	2.1659	$137.95		$27.59
51784	Anal/urinary muscle study		T	0126	1.085	$69.11	$16.40	$13.82
51785	Anal/urinary muscle study		T	0126	1.085	$69.11	$16.40	$13.82
51792	Urinary reflex study		T	0126	1.085	$69.11	$16.40	$13.82
51795	Urine voiding pressure study		T	0164	2.1659	$137.95		$27.59
51797	Intraabdominal pressure test		T	0164	2.1659	$137.95		$27.59
51798	Us urine capacity measure		X	0340	0.6416	$40.87		$8.17

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
51800	Revision of bladder/urethra		C					
51820	Revision of urinary tract		C					
51840	Attach bladder/urethra		C					
51841	Attach bladder/urethra		C					
51845	Repair bladder neck		C					
51860	Repair of bladder wound		C					
51865	Repair of bladder wound		C					
51880	Repair of bladder opening		T	0162	25.2775	$1,610.00		$322.00
51900	Repair bladder/vagina lesion		C					
51920	Close bladder-uterus fistula		C					
51925	Hysterectomy/bladder repair		C					
51940	Correction of bladder defect		C					
51960	Revision of bladder & bowel		C					
51980	Construct bladder opening		C					
51990	Laparo urethral suspension		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
51992	Laparo sling operation		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
51999	Laparoscope proc, bla		T	0130	34.8153	$2,217.49	$659.50	$443.50
52000	Cystoscopy		T	0160	6.1077	$389.02		$77.80
52001	Cystoscopy, removal of clots	CH	T	0161	18.1376	$1,155.24	$243.72	$231.05
52005	Cystoscopy & ureter catheter		T	0161	18.1376	$1,155.24	$243.72	$231.05
52007	Cystoscopy and biopsy	CH	T	0162	25.2775	$1,610.00		$322.00
52010	Cystoscopy & duct catheter		T	0160	6.1077	$389.02		$77.80
52204	Cystoscopy w/biopsy(s)		T	0161	18.1376	$1,155.24	$243.72	$231.05
52214	Cystoscopy and treatment		T	0162	25.2775	$1,610.00		$322.00
52224	Cystoscopy and treatment		T	0162	25.2775	$1,610.00		$322.00
52234	Cystoscopy and treatment		T	0162	25.2775	$1,610.00		$322.00
52235	Cystoscopy and treatment		T	0162	25.2775	$1,610.00		$322.00
52240	Cystoscopy and treatment		T	0162	25.2775	$1,610.00		$322.00
52250	Cystoscopy and radiotracer		T	0162	25.2775	$1,610.00		$322.00
52260	Cystoscopy and treatment		T	0161	18.1376	$1,155.24	$243.72	$231.05
52265	Cystoscopy and treatment		T	0160	6.1077	$389.02		$77.80
52270	Cystoscopy & revise urethra		T	0161	18.1376	$1,155.24	$243.72	$231.05
52275	Cystoscopy & revise urethra	CH	T	0162	25.2775	$1,610.00		$322.00
52276	Cystoscopy and treatment	CH	T	0162	25.2775	$1,610.00		$322.00
52277	Cystoscopy and treatment		T	0162	25.2775	$1,610.00		$322.00
52281	Cystoscopy and treatment		T	0161	18.1376	$1,155.24	$243.72	$231.05
52282	Cystoscopy, implant stent		T	0163	36.9175	$2,351.39		$470.28
52283	Cystoscopy and treatment	CH	T	0162	25.2775	$1,610.00		$322.00
52285	Cystoscopy and treatment		T	0161	18.1376	$1,155.24	$243.72	$231.05
52290	Cystoscopy and treatment		T	0161	18.1376	$1,155.24	$243.72	$231.05
52300	Cystoscopy and treatment	CH	T	0162	25.2775	$1,610.00		$322.00
52301	Cystoscopy and treatment	CH	T	0162	25.2775	$1,610.00		$322.00
52305	Cystoscopy and treatment	CH	T	0162	25.2775	$1,610.00		$322.00
52310	Cystoscopy and treatment	CH	T	0161	18.1376	$1,155.24	$243.72	$231.05
52315	Cystoscopy and treatment	CH	T	0162	25.2775	$1,610.00		$322.00
52317	Remove bladder stone		T	0162	25.2775	$1,610.00		$322.00
52318	Remove bladder stone		T	0162	25.2775	$1,610.00		$322.00
52320	Cystoscopy and treatment		T	0162	25.2775	$1,610.00		$322.00
52325	Cystoscopy, stone removal		T	0162	25.2775	$1,610.00		$322.00
52327	Cystoscopy, inject material		T	0162	25.2775	$1,610.00		$322.00
52330	Cystoscopy and treatment		T	0162	25.2775	$1,610.00		$322.00
52332	Cystoscopy and treatment		T	0162	25.2775	$1,610.00		$322.00
52334	Create passage to kidney		T	0162	25.2775	$1,610.00		$322.00
52341	Cysto w/ureter stricture tx		T	0162	25.2775	$1,610.00		$322.00
52342	Cysto w/up stricture tx		T	0162	25.2775	$1,610.00		$322.00
52343	Cysto w/renal stricture tx		T	0162	25.2775	$1,610.00		$322.00
52344	Cysto/uretero, stricture tx		T	0162	25.2775	$1,610.00		$322.00
52345	Cysto/uretero w/up stricture		T	0162	25.2775	$1,610.00		$322.00
52346	Cystouretero w/renal strict		T	0162	25.2775	$1,610.00		$322.00
52351	Cystouretero & or pyeloscope	CH	T	0162	25.2775	$1,610.00		$322.00
52352	Cystouretero w/stone remove		T	0162	25.2775	$1,610.00		$322.00
52353	Cystouretero w/lithotripsy		T	0163	36.9175	$2,351.39		$470.28
52354	Cystouretero w/biopsy		T	0162	25.2775	$1,610.00		$322.00
52355	Cystouretero w/excise tumor		T	0162	25.2775	$1,610.00		$322.00
52400	Cystouretero w/congen repr		T	0162	25.2775	$1,610.00		$322.00
52402	Cystourethro cut ejacul duct		T	0162	25.2775	$1,610.00		$322.00
52450	Incision of prostate		T	0162	25.2775	$1,610.00		$322.00
52500	Revision of bladder neck		T	0162	25.2775	$1,610.00		$322.00
52510	Dilation prostatic urethra	CH	T	0162	25.2775	$1,610.00		$322.00
52601	Prostatectomy (TURP)		T	0163	36.9175	$2,351.39		$470.28
52606	Control postop bleeding		T	0162	25.2775	$1,610.00		$322.00
52612	Prostatectomy, first stage		T	0163	36.9175	$2,351.39		$470.28
52614	Prostatectomy, second stage		T	0163	36.9175	$2,351.39		$470.28
52620	Remove residual prostate		T	0163	36.9175	$2,351.39		$470.28
52630	Remove prostate regrowth		T	0163	36.9175	$2,351.39		$470.28
52640	Relieve bladder contracture		T	0162	25.2775	$1,610.00		$322.00
52647	Laser surgery of prostate		T	0429	45.9021	$2,923.64		$584.73
52648	Laser surgery of prostate		T	0429	45.9021	$2,923.64		$584.73

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
52700	Drainage of prostate abscess		T	0162	25.2775	$1,610.00		$322.00
53000	Incision of urethra		T	0166	19.657	$1,252.01		$250.40
53010	Incision of urethra		T	0166	19.657	$1,252.01		$250.40
53020	Incision of urethra		T	0166	19.657	$1,252.01		$250.40
53025	Incision of urethra		T	0166	19.657	$1,252.01		$250.40
53040	Drainage of urethra abscess		T	0166	19.657	$1,252.01		$250.40
53060	Drainage of urethra abscess		T	0166	19.657	$1,252.01		$250.40
53080	Drainage of urinary leakage		T	0166	19.657	$1,252.01		$250.40
53085	Drainage of urinary leakage		T	0166	19.657	$1,252.01		$250.40
53200	Biopsy of urethra		T	0166	19.657	$1,252.01		$250.40
53210	Removal of urethra		T	0168	30.1994	$1,923.49	$388.10	$384.70
53215	Removal of urethra		T	0166	19.657	$1,252.01		$250.40
53220	Treatment of urethra lesion		T	0168	30.1994	$1,923.49	$388.10	$384.70
53230	Removal of urethra lesion		T	0168	30.1994	$1,923.49	$388.10	$384.70
53235	Removal of urethra lesion		T	0166	19.657	$1,252.01		$250.40
53240	Surgery for urethra pouch		T	0168	30.1994	$1,923.49	$388.10	$384.70
53250	Removal of urethra gland		T	0166	19.657	$1,252.01		$250.40
53260	Treatment of urethra lesion		T	0166	19.657	$1,252.01		$250.40
53265	Treatment of urethra lesion		T	0166	19.657	$1,252.01		$250.40
53270	Removal of urethra gland		T	0166	19.657	$1,252.01		$250.40
53275	Repair of urethra defect		T	0166	19.657	$1,252.01		$250.40
53400	Revise urethra, stage 1		T	0168	30.1994	$1,923.49	$388.10	$384.70
53405	Revise urethra, stage 2		T	0168	30.1994	$1,923.49	$388.10	$384.70
53410	Reconstruction of urethra		T	0168	30.1994	$1,923.49	$388.10	$384.70
53415	Reconstruction of urethra		C					
53420	Reconstruct urethra, stage 1		T	0168	30.1994	$1,923.49	$388.10	$384.70
53425	Reconstruct urethra, stage 2		T	0168	30.1994	$1,923.49	$388.10	$384.70
53430	Reconstruction of urethra		T	0168	30.1994	$1,923.49	$388.10	$384.70
53431	Reconstruct urethra/bladder		T	0168	30.1994	$1,923.49	$388.10	$384.70
53440	Male sling procedure		S	0385	85.3372	$5,435.38		$1,087.08
53442	Remove/revise male sling		T	0168	30.1994	$1,923.49	$388.10	$384.70
53444	Insert tandem cuff		S	0385	85.3372	$5,435.38		$1,087.08
53445	Insert uro/ves nck sphincter		S	0386	143.8001	$9,159.06		$1,831.81
53446	Remove uro sphincter		T	0168	30.1994	$1,923.49	$388.10	$384.70
53447	Remove/replace ur sphincter		S	0386	143.8001	$9,159.06		$1,831.81
53448	Remov/replc ur sphinctr comp		C					
53449	Repair uro sphincter		T	0168	30.1994	$1,923.49	$388.10	$384.70
53450	Revision of urethra		T	0168	30.1994	$1,923.49	$388.10	$384.70
53460	Revision of urethra		T	0166	19.657	$1,252.01		$250.40
53500	Urethrlys, transvag w/ scope		T	0168	30.1994	$1,923.49	$388.10	$384.70
53502	Repair of urethra injury		T	0166	19.657	$1,252.01		$250.40
53505	Repair of urethra injury		T	0168	30.1994	$1,923.49	$388.10	$384.70
53510	Repair of urethra injury		T	0166	19.657	$1,252.01		$250.40
53515	Repair of urethra injury		T	0168	30.1994	$1,923.49	$388.10	$384.70
53520	Repair of urethra defect		T	0168	30.1994	$1,923.49	$388.10	$384.70
53600	Dilate urethra stricture		T	0156	3.0601	$194.91		$38.98
53601	Dilate urethra stricture		T	0126	1.085	$69.11	$16.40	$13.82
53605	Dilate urethra stricture		T	0161	18.1376	$1,155.24	$243.72	$231.05
53620	Dilate urethra stricture		T	0165	19.6126	$1,249.19		$249.84
53621	Dilate urethra stricture		T	0164	2.1659	$137.95		$27.59
53660	Dilation of urethra		T	0126	1.085	$69.11	$16.40	$13.82
53661	Dilation of urethra		T	0126	1.085	$69.11	$16.40	$13.82
53665	Dilation of urethra		T	0166	19.657	$1,252.01		$250.40
53850	Prostatic microwave thermotx	CH	T	0163	36.9175	$2,351.39		$470.28
53852	Prostatic rf thermotx	CH	T	0163	36.9175	$2,351.39		$470.28
53853	Prostatic water thermother		T	0162	25.2775	$1,610.00		$322.00
53899	Urology surgery procedure		T	0126	1.085	$69.11	$16.40	$13.82
54000	Slitting of prepuce		T	0166	19.657	$1,252.01		$250.40
54001	Slitting of prepuce		T	0166	19.657	$1,252.01		$250.40
54015	Drain penis lesion		T	0008	19.0457	$1,213.08		$242.62
54050	Destruction, penis lesion(s)	CH	T	0015	1.5119	$96.30		$19.26
54055	Destruction, penis lesion(s)		T	0017	20.0977	$1,280.08		$256.02
54056	Cryosurgery, penis lesion(s)	CH	T	0013	0.8046	$51.25		$10.25
54057	Laser surg, penis lesion(s)		T	0017	20.0977	$1,280.08		$256.02
54060	Excision of penis lesion(s)		T	0017	20.0977	$1,280.08		$256.02
54065	Destruction, penis lesion(s)	CH	T	0017	20.0977	$1,280.08		$256.02
54100	Biopsy of penis		T	0021	16.5832	$1,056.23	$219.40	$211.25
54105	Biopsy of penis		T	0022	21.4534	$1,366.43	$354.40	$273.29
54110	Treatment of penis lesion		T	0181	35.1574	$2,239.28	$621.80	$447.86
54111	Treat penis lesion, graft		T	0181	35.1574	$2,239.28	$621.80	$447.86
54112	Treat penis lesion, graft		T	0181	35.1574	$2,239.28	$621.80	$447.86
54115	Treatment of penis lesion		T	0008	19.0457	$1,213.08		$242.62
54120	Partial removal of penis		T	0181	35.1574	$2,239.28	$621.80	$447.86
54125	Removal of penis		C					
54130	Remove penis & nodes		C					
54135	Remove penis & nodes		C					
54150	Circumcision w/regionl block	CH	T	0183	22.7802	$1,450.94		$290.19
54160	Circumcision, neonate	CH	T	0183	22.7802	$1,450.94		$290.19

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
54161	Circum 28 days or older	CH	T	0183	22.7802	$1,450.94		$290.19
54162	Lysis penil circumic lesion	CH	T	0183	22.7802	$1,450.94		$290.19
54163	Repair of circumcision	CH	T	0183	22.7802	$1,450.94		$290.19
54164	Frenulotomy of penis	CH	T	0183	22.7802	$1,450.94		$290.19
54200	Treatment of penis lesion		T	0164	2.1659	$137.95		$27.59
54205	Treatment of penis lesion		T	0181	35.1574	$2,239.28	$621.80	$447.86
54220	Treatment of penis lesion		T	0164	2.1659	$137.95		$27.59
54230	Prepare penis study		N					
54231	Dynamic cavernosometry		T	0165	19.6126	$1,249.19		$249.84
54235	Penile injection		T	0164	2.1659	$137.95		$27.59
54240	Penis study		T	0126	1.085	$69.11	$16.40	$13.82
54250	Penis study		T	0164	2.1659	$137.95		$27.59
54300	Revision of penis		T	0181	35.1574	$2,239.28	$621.80	$447.86
54304	Revision of penis		T	0181	35.1574	$2,239.28	$621.80	$447.86
54308	Reconstruction of urethra		T	0181	35.1574	$2,239.28	$621.80	$447.86
54312	Reconstruction of urethra		T	0181	35.1574	$2,239.28	$621.80	$447.86
54316	Reconstruction of urethra		T	0181	35.1574	$2,239.28	$621.80	$447.86
54318	Reconstruction of urethra		T	0181	35.1574	$2,239.28	$621.80	$447.86
54322	Reconstruction of urethra		T	0181	35.1574	$2,239.28	$621.80	$447.86
54324	Reconstruction of urethra		T	0181	35.1574	$2,239.28	$621.80	$447.86
54326	Reconstruction of urethra		T	0181	35.1574	$2,239.28	$621.80	$447.86
54328	Revise penis/urethra		T	0181	35.1574	$2,239.28	$621.80	$447.86
54332	Revise penis/urethra		C					
54336	Revise penis/urethra		C					
54340	Secondary urethral surgery		T	0181	35.1574	$2,239.28	$621.80	$447.86
54344	Secondary urethral surgery		T	0181	35.1574	$2,239.28	$621.80	$447.86
54348	Secondary urethral surgery		T	0181	35.1574	$2,239.28	$621.80	$447.86
54352	Reconstruct urethra/penis		T	0181	35.1574	$2,239.28	$621.80	$447.86
54360	Penis plastic surgery		T	0181	35.1574	$2,239.28	$621.80	$447.86
54380	Repair penis		T	0181	35.1574	$2,239.28	$621.80	$447.86
54385	Repair penis		T	0181	35.1574	$2,239.28	$621.80	$447.86
54390	Repair penis and bladder		C					
54400	Insert semi-rigid prosthesis		S	0385	85.3372	$5,435.38		$1,087.08
54401	Insert self-contd prosthesis		S	0386	143.8001	$9,159.06		$1,831.81
54405	Insert multi-comp penis pros		S	0386	143.8001	$9,159.06		$1,831.81
54406	Remove muti-comp penis pros		T	0181	35.1574	$2,239.28	$621.80	$447.86
54408	Repair multi-comp penis pros		T	0181	35.1574	$2,239.28	$621.80	$447.86
54410	Remove/replace penis prosth		S	0386	143.8001	$9,159.06		$1,831.81
54411	Remov/replc penis pros, comp		C					
54415	Remove self-contd penis pros		T	0181	35.1574	$2,239.28	$621.80	$447.86
54416	Remv/repl penis contain pros		S	0386	143.8001	$9,159.06		$1,831.81
54417	Remv/replc penis pros, compl		C					
54420	Revision of penis		T	0181	35.1574	$2,239.28	$621.80	$447.86
54430	Revision of penis		C					
54435	Revision of penis		T	0181	35.1574	$2,239.28	$621.80	$447.86
54440	Repair of penis		T	0181	35.1574	$2,239.28	$621.80	$447.86
54450	Preputial stretching		T	0156	3.0601	$194.91		$38.98
54500	Biopsy of testis		T	0037	13.9599	$889.15	$228.70	$177.83
54505	Biopsy of testis		T	0183	22.7802	$1,450.94		$290.19
54512	Excise lesion testis		T	0183	22.7802	$1,450.94		$290.19
54520	Removal of testis		T	0183	22.7802	$1,450.94		$290.19
54522	Orchiectomy, partial		T	0183	22.7802	$1,450.94		$290.19
54530	Removal of testis		T	0154	31.1722	$1,985.45	$464.80	$397.09
54535	Extensive testis surgery		C					
54550	Exploration for testis		T	0154	31.1722	$1,985.45	$464.80	$397.09
54560	Exploration for testis		T	0183	22.7802	$1,450.94		$290.19
54600	Reduce testis torsion		T	0183	22.7802	$1,450.94		$290.19
54620	Suspension of testis		T	0183	22.7802	$1,450.94		$290.19
54640	Suspension of testis		T	0154	31.1722	$1,985.45	$464.80	$397.09
54650	Orchiopexy (Fowler-Stephens)		C					
54660	Revision of testis		T	0183	22.7802	$1,450.94		$290.19
54670	Repair testis injury		T	0183	22.7802	$1,450.94		$290.19
54680	Relocation of testis(es)		T	0183	22.7802	$1,450.94		$290.19
54690	Laparoscopy, orchiectomy		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
54692	Laparoscopy, orchiopexy		T	0132	71.0022	$4,522.34	$1,239.20	$904.47
54699	Laparoscope proc, testis		T	0130	34.8153	$2,217.49	$659.50	$443.50
54700	Drainage of scrotum		T	0183	22.7802	$1,450.94		$290.19
54800	Biopsy of epididymis		T	0004	4.5062	$287.01		$57.40
54830	Remove epididymis lesion		T	0183	22.7802	$1,450.94		$290.19
54840	Remove epididymis lesion		T	0183	22.7802	$1,450.94		$290.19
54860	Removal of epididymis		T	0183	22.7802	$1,450.94		$290.19
54861	Removal of epididymis		T	0183	22.7802	$1,450.94		$290.19
54865	Explore epididymis		T	0183	22.7802	$1,450.94		$290.19
54900	Fusion of spermatic ducts		T	0183	22.7802	$1,450.94		$290.19
54901	Fusion of spermatic ducts		T	0183	22.7802	$1,450.94		$290.19
55000	Drainage of hydrocele		T	0004	4.5062	$287.01		$57.40
55040	Removal of hydrocele		T	0154	31.1722	$1,985.45	$464.80	$397.09
55041	Removal of hydroceles		T	0154	31.1722	$1,985.45	$464.80	$397.09

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
55060	Repair of hydrocele		T	0183	22.7802	$1,450.94		$290.19
55100	Drainage of scrotum abscess		T	0007	12.5792	$801.21		$160.24
55110	Explore scrotum		T	0183	22.7802	$1,450.94		$290.19
55120	Removal of scrotum lesion		T	0183	22.7802	$1,450.94		$290.19
55150	Removal of scrotum		T	0183	22.7802	$1,450.94		$290.19
55175	Revision of scrotum		T	0183	22.7802	$1,450.94		$290.19
55180	Revision of scrotum		T	0183	22.7802	$1,450.94		$290.19
55200	Incision of sperm duct		T	0183	22.7802	$1,450.94		$290.19
55250	Removal of sperm duct(s)		T	0183	22.7802	$1,450.94		$290.19
55300	Prepare, sperm duct x-ray		N					
55400	Repair of sperm duct		T	0183	22.7802	$1,450.94		$290.19
55450	Ligation of sperm duct		T	0183	22.7802	$1,450.94		$290.19
55500	Removal of hydrocele		T	0183	22.7802	$1,450.94		$290.19
55520	Removal of sperm cord lesion		T	0183	22.7802	$1,450.94		$290.19
55530	Revise spermatic cord veins		T	0183	22.7802	$1,450.94		$290.19
55535	Revise spermatic cord veins		T	0154	31.1722	$1,985.45	$464.80	$397.09
55540	Revise hernia & sperm veins		T	0154	31.1722	$1,985.45	$464.80	$397.09
55550	Laparo ligate spermatic vein		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
55559	Laparo proc, spermatic cord		T	0130	34.8153	$2,217.49	$659.50	$443.50
55600	Incise sperm duct pouch		T	0183	22.7802	$1,450.94		$290.19
55605	Incise sperm duct pouch		C					
55650	Remove sperm duct pouch		C					
55680	Remove sperm pouch lesion		T	0183	22.7802	$1,450.94		$290.19
55700	Biopsy of prostate		T	0184	11.3168	$720.80		$144.16
55705	Biopsy of prostate		T	0184	11.3168	$720.80		$144.16
55720	Drainage of prostate abscess		T	0162	25.2775	$1,610.00		$322.00
55725	Drainage of prostate abscess		T	0162	25.2775	$1,610.00		$322.00
55801	Removal of prostate		C					
55810	Extensive prostate surgery		C					
55812	Extensive prostate surgery		C					
55815	Extensive prostate surgery		C					
55821	Removal of prostate		C					
55831	Removal of prostate		C					
55840	Extensive prostate surgery		C					
55842	Extensive prostate surgery		C					
55845	Extensive prostate surgery		C					
55860	Surgical exposure, prostate		T	0165	19.6126	$1,249.19		$249.84
55862	Extensive prostate surgery		C					
55865	Extensive prostate surgery		C					
55866	Laparo radical prostatectomy		C					
55870	Electroejaculation	CH	T	0189	3.0466	$194.05		$38.81
55873	Cryoablate prostate		T	0674	123.7218	$7,880.21		$1,576.04
55875	Transperi needle place, pros	CH	Q	0163	36.9175	$2,351.39		$470.28
55876	Place rt device/marker, pros		T	0156	3.0601	$194.91		$38.98
55899	Genital surgery procedure		T	0126	1.085	$69.11	$16.40	$13.82
55970	Sex transformation, M to F		E					
55980	Sex transformation, F to M		E					
56405	I & D of vulva/perineum		T	0189	3.0466	$194.05		$38.81
56420	Drainage of gland abscess		T	0188	1.4138	$90.05		$18.01
56440	Surgery for vulva lesion	CH	T	0193	19.2052	$1,223.24		$244.65
56441	Lysis of labial lesion(s)		T	0193	19.2052	$1,223.24		$244.65
56442	Hymenotomy		T	0193	19.2052	$1,223.24		$244.65
56501	Destroy, vulva lesions, sim		T	0017	20.0977	$1,280.08		$256.02
56515	Destroy vulva lesion/s compl	CH	T	0017	20.0977	$1,280.08		$256.02
56605	Biopsy of vulva/perineum	CH	T	0189	3.0466	$194.05		$38.81
56606	Biopsy of vulva/perineum	CH	T	0188	1.4138	$90.05		$18.01
56620	Partial removal of vulva	CH	T	0193	19.2052	$1,223.24		$244.65
56625	Complete removal of vulva	CH	T	0193	19.2052	$1,223.24		$244.65
56630	Extensive vulva surgery		C					
56631	Extensive vulva surgery		C					
56632	Extensive vulva surgery		C					
56633	Extensive vulva surgery		C					
56634	Extensive vulva surgery		C					
56637	Extensive vulva surgery		C					
56640	Extensive vulva surgery		C					
56700	Partial removal of hymen	CH	T	0193	19.2052	$1,223.24		$244.65
56740	Remove vagina gland lesion	CH	T	0193	19.2052	$1,223.24		$244.65
56800	Repair of vagina	CH	T	0193	19.2052	$1,223.24		$244.65
56805	Repair clitoris		T	0193	19.2052	$1,223.24		$244.65
56810	Repair of perineum	CH	T	0193	19.2052	$1,223.24		$244.65
56820	Exam of vulva w/scope		T	0188	1.4138	$90.05		$18.01
56821	Exam/biopsy of vulva w/scope	CH	T	0188	1.4138	$90.05		$18.01
57000	Exploration of vagina		T	0193	19.2052	$1,223.24		$244.65
57010	Drainage of pelvic abscess		T	0193	19.2052	$1,223.24		$244.65
57020	Drainage of pelvic fluid		T	0192	7.4497	$474.49		$94.90
57022	I & d vaginal hematoma, pp		T	0007	12.5792	$801.21		$160.24
57023	I & d vag hematoma, non-ob		T	0008	19.0457	$1,213.08		$242.62
57061	Destroy vag lesions, simple	CH	T	0193	19.2052	$1,223.24		$244.65

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
57065	Destroy vag lesions, complex	CH	T	0193	19.2052	$1,223.24		$244.65
57100	Biopsy of vagina		T	0192	7.4497	$474.49		$94.90
57105	Biopsy of vagina	CH	T	0193	19.2052	$1,223.24		$244.65
57106	Remove vagina wall, partial	CH	T	0193	19.2052	$1,223.24		$244.65
57107	Remove vagina tissue, part		T	0195	32.9713	$2,100.04	$483.80	$420.01
57109	Vaginectomy partial w/nodes		T	0195	32.9713	$2,100.04	$483.80	$420.01
57110	Remove vagina wall, complete		C					
57111	Remove vagina tissue, compl		C					
57112	Vaginectomy w/nodes, compl		C					
57120	Closure of vagina		T	0195	32.9713	$2,100.04	$483.80	$420.01
57130	Remove vagina lesion	CH	T	0193	19.2052	$1,223.24		$244.65
57135	Remove vagina lesion	CH	T	0193	19.2052	$1,223.24		$244.65
57150	Treat vagina infection	CH	T	0188	1.4138	$90.05		$18.01
57155	Insert uteri tandems/ovoids		T	0192	7.4497	$474.49		$94.90
57160	Insert pessary/other device		T	0188	1.4138	$90.05		$18.01
57170	Fitting of diaphragm/cap		T	0191	0.1414	$9.01	$2.50	$1.80
57180	Treat vaginal bleeding	CH	T	0188	1.4138	$90.05		$18.01
57200	Repair of vagina	CH	T	0193	19.2052	$1,223.24		$244.65
57210	Repair vagina/perineum	CH	T	0193	19.2052	$1,223.24		$244.65
57220	Revision of urethra		T	0202	43.2255	$2,753.16	$981.50	$550.63
57230	Repair of urethral lesion		T	0195	32.9713	$2,100.04	$483.80	$420.01
57240	Repair bladder & vagina		T	0195	32.9713	$2,100.04	$483.80	$420.01
57250	Repair rectum & vagina		T	0195	32.9713	$2,100.04	$483.80	$420.01
57260	Repair of vagina		T	0195	32.9713	$2,100.04	$483.80	$420.01
57265	Extensive repair of vagina		T	0202	43.2255	$2,753.16	$981.50	$550.63
57267	Insert mesh/pelvic flr addon		T	0195	32.9713	$2,100.04	$483.80	$420.01
57268	Repair of bowel bulge		T	0195	32.9713	$2,100.04	$483.80	$420.01
57270	Repair of bowel pouch		C					
57280	Suspension of vagina		C					
57282	Colpopexy, extraperitoneal		T	0202	43.2255	$2,753.16	$981.50	$550.63
57283	Colpopexy, intraperitoneal		T	0202	43.2255	$2,753.16	$981.50	$550.63
57284	Repair paravaginal defect		T	0202	43.2255	$2,753.16	$981.50	$550.63
57287	Revise/remove sling repair		T	0195	32.9713	$2,100.04	$483.80	$420.01
57288	Repair bladder defect		T	0202	43.2255	$2,753.16	$981.50	$550.63
57289	Repair bladder & vagina		T	0195	32.9713	$2,100.04	$483.80	$420.01
57291	Construction of vagina		T	0195	32.9713	$2,100.04	$483.80	$420.01
57292	Construct vagina with graft		T	0195	32.9713	$2,100.04	$483.80	$420.01
57295	Revise vag graft via vagina	CH	T	0193	19.2052	$1,223.24		$244.65
57296	Revise vag graft, open abd		C					
57300	Repair rectum-vagina fistula		T	0195	32.9713	$2,100.04	$483.80	$420.01
57305	Repair rectum-vagina fistula		C					
57307	Fistula repair & colostomy		C					
57308	Fistula repair, transperine		C					
57310	Repair urethrovaginal lesion		T	0202	43.2255	$2,753.16	$981.50	$550.63
57311	Repair urethrovaginal lesion		C					
57320	Repair bladder-vagina lesion		T	0195	32.9713	$2,100.04	$483.80	$420.01
57330	Repair bladder-vagina lesion		T	0195	32.9713	$2,100.04	$483.80	$420.01
57335	Repair vagina		T	0195	32.9713	$2,100.04	$483.80	$420.01
57400	Dilation of vagina	CH	T	0193	19.2052	$1,223.24		$244.65
57410	Pelvic examination		T	0193	19.2052	$1,223.24		$244.65
57415	Remove vaginal foreign body	CH	T	0193	19.2052	$1,223.24		$244.65
57420	Exam of vagina w/scope		T	0189	3.0466	$194.05		$38.81
57421	Exam/biopsy of vag w/scope		T	0189	3.0466	$194.05		$38.81
57425	Laparoscopy, surg, colpopexy		T	0130	34.8153	$2,217.49	$659.50	$443.50
57452	Exam of cervix w/scope		T	0188	1.4138	$90.05		$18.01
57454	Bx/curett of cervix w/scope		T	0189	3.0466	$194.05		$38.81
57455	Biopsy of cervix w/scope		T	0189	3.0466	$194.05		$38.81
57456	Endocerv curettage w/scope		T	0189	3.0466	$194.05		$38.81
57460	Bx of cervix w/scope, leep		T	0193	19.2052	$1,223.24		$244.65
57461	Conz of cervix w/scope, leep	CH	T	0193	19.2052	$1,223.24		$244.65
57500	Biopsy of cervix		T	0189	3.0466	$194.05		$38.81
57505	Endocervical curettage		T	0189	3.0466	$194.05		$38.81
57510	Cauterization of cervix		T	0193	19.2052	$1,223.24		$244.65
57511	Cryocautery of cervix		T	0188	1.4138	$90.05		$18.01
57513	Laser surgery of cervix		T	0193	19.2052	$1,223.24		$244.65
57520	Conization of cervix	CH	T	0193	19.2052	$1,223.24		$244.65
57522	Conization of cervix	CH	T	0193	19.2052	$1,223.24		$244.65
57530	Removal of cervix		T	0195	32.9713	$2,100.04	$483.80	$420.01
57531	Removal of cervix, radical		C					
57540	Removal of residual cervix		C					
57545	Remove cervix/repair pelvis		C					
57550	Removal of residual cervix		T	0195	32.9713	$2,100.04	$483.80	$420.01
57555	Remove cervix/repair vagina		T	0195	32.9713	$2,100.04	$483.80	$420.01
57556	Remove cervix, repair bowel		T	0202	43.2255	$2,753.16	$981.50	$550.63
57558	D&c of cervical stump	CH	T	0193	19.2052	$1,223.24		$244.65
57700	Revision of cervix	CH	T	0193	19.2052	$1,223.24		$244.65
57720	Revision of cervix	CH	T	0193	19.2052	$1,223.24		$244.65
57800	Dilation of cervical canal		T	0193	19.2052	$1,223.24		$244.65

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
58100	Biopsy of uterus lining		T	0188	1.4138	$90.05		$18.01
58110	Bx done w/colposcopy add-on	CH	N					
58120	Dilation and curettage	CH	T	0193	19.2052	$1,223.24		$244.65
58140	Myomectomy abdom method		C					
58145	Myomectomy vag method		T	0195	32.9713	$2,100.04	$483.80	$420.01
58146	Myomectomy abdom complex		C					
58150	Total hysterectomy		C					
58152	Total hysterectomy		C					
58180	Partial hysterectomy		C					
58200	Extensive hysterectomy		C					
58210	Extensive hysterectomy		C					
58240	Removal of pelvis contents		C					
58260	Vaginal hysterectomy		T	0195	32.9713	$2,100.04	$483.80	$420.01
58262	Vag hyst including t/o		T	0195	32.9713	$2,100.04	$483.80	$420.01
58263	Vag hyst w/t/o & vag repair		T	0195	32.9713	$2,100.04	$483.80	$420.01
58267	Vag hyst w/urinary repair		C					
58270	Vag hyst w/enterocele repair		T	0195	32.9713	$2,100.04	$483.80	$420.01
58275	Hysterectomy/revise vagina		C					
58280	Hysterectomy/revise vagina		C					
58285	Extensive hysterectomy		C					
58290	Vag hyst complex		T	0202	43.2255	$2,753.16	$981.50	$550.63
58291	Vag hyst incl t/o, complex		T	0202	43.2255	$2,753.16	$981.50	$550.63
58292	Vag hyst t/o & repair, compl		T	0202	43.2255	$2,753.16	$981.50	$550.63
58293	Vag hyst w/uro repair, compl		C					
58294	Vag hyst w/enterocele, compl		T	0202	43.2255	$2,753.16	$981.50	$550.63
58300	Insert intrauterine device		E					
58301	Remove intrauterine device		T	0188	1.4138	$90.05		$18.01
58321	Artificial insemination	CH	T	0189	3.0466	$194.05		$38.81
58322	Artificial insemination	CH	T	0189	3.0466	$194.05		$38.81
58323	Sperm washing	CH	T	0189	3.0466	$194.05		$38.81
58340	Catheter for hysterography		N					
58345	Reopen fallopian tube		T	0193	19.2052	$1,223.24		$244.65
58346	Insert heyman uteri capsule		T	0193	19.2052	$1,223.24		$244.65
58350	Reopen fallopian tube		T	0195	32.9713	$2,100.04	$483.80	$420.01
58353	Endometr ablate, thermal		T	0195	32.9713	$2,100.04	$483.80	$420.01
58356	Endometrial cryoablation		T	0202	43.2255	$2,753.16	$981.50	$550.63
58400	Suspension of uterus		C					
58410	Suspension of uterus		C					
58520	Repair of ruptured uterus		C					
58540	Revision of uterus		C					
58541	Lsh, uterus 250 g or less		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
58542	Lsh w/t/o ut 250 g or less		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
58543	Lsh uterus above 250 g		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
58544	Lsh w/t/o uterus above 250 g		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
58545	Laparoscopic myomectomy		T	0130	34.8153	$2,217.49	$659.50	$443.50
58546	Laparo-myomectomy, complex		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
58548	Lap radical hyst		C					
58550	Laparo-asst vag hysterectomy		T	0132	71.0022	$4,522.34	$1,239.20	$904.47
58552	Laparo-vag hyst incl t/o		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
58553	Laparo-vag hyst, complex		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
58554	Laparo-vag hyst w/t/o, compl		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
58555	Hysteroscopy, dx, sep proc		T	0190	22.1171	$1,408.70	$424.20	$281.74
58558	Hysteroscopy, biopsy		T	0190	22.1171	$1,408.70	$424.20	$281.74
58559	Hysteroscopy, lysis		T	0190	22.1171	$1,408.70	$424.20	$281.74
58560	Hysteroscopy, resect septum		T	0387	34.8162	$2,217.55	$655.50	$443.51
58561	Hysteroscopy, remove myoma		T	0387	34.8162	$2,217.55	$655.50	$443.51
58562	Hysteroscopy, remove fb		T	0190	22.1171	$1,408.70	$424.20	$281.74
58563	Hysteroscopy, ablation		T	0387	34.8162	$2,217.55	$655.50	$443.51
58565	Hysteroscopy, sterilization		T	0202	43.2255	$2,753.16	$981.50	$550.63
58578	Laparo proc, uterus		T	0130	34.8153	$2,217.49	$659.50	$443.50
58579	Hysteroscope procedure		T	0190	22.1171	$1,408.70	$424.20	$281.74
58600	Division of fallopian tube		T	0195	32.9713	$2,100.04	$483.80	$420.01
58605	Division of fallopian tube		C					
58611	Ligate oviduct(s) add-on		C					
58615	Occlude fallopian tube(s)	CH	T	0193	19.2052	$1,223.24		$244.65
58660	Laparoscopy, lysis		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
58661	Laparoscopy, remove adnexa		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
58662	Laparoscopy, excise lesions		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
58670	Laparoscopy, tubal cautery		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
58671	Laparoscopy, tubal block		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
58672	Laparoscopy, fimbrioplasty		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
58673	Laparoscopy, salpingostomy		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
58679	Laparo proc, oviduct-ovary		T	0130	34.8153	$2,217.49	$659.50	$443.50
58700	Removal of fallopian tube		C					
58720	Removal of ovary/tube(s)		C					
58740	Revise fallopian tube(s)		C					
58750	Repair oviduct		C					
58752	Revise ovarian tube(s)		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
58760	Remove tubal obstruction		C					
58770	Create new tubal opening		T	0195	32.9713	$2,100.04	$483.80	$420.01
58800	Drainage of ovarian cyst(s)		T	0193	19.2052	$1,223.24		$244.65
58805	Drainage of ovarian cyst(s)	CH	T	0195	32.9713	$2,100.04	$483.80	$420.01
58820	Drain ovary abscess, open		T	0195	32.9713	$2,100.04	$483.80	$420.01
58822	Drain ovary abscess, percut		C					
58823	Drain pelvic abscess, percut		T	0193	19.2052	$1,223.24		$244.65
58825	Transposition, ovary(s)		C					
58900	Biopsy of ovary(s)		T	0193	19.2052	$1,223.24		$244.65
58920	Partial removal of ovary(s)		T	0195	32.9713	$2,100.04	$483.80	$420.01
58925	Removal of ovarian cyst(s)		T	0195	32.9713	$2,100.04	$483.80	$420.01
58940	Removal of ovary(s)		C					
58943	Removal of ovary(s)		C					
58950	Resect ovarian malignancy		C					
58951	Resect ovarian malignancy		C					
58952	Resect ovarian malignancy		C					
58953	Tah, rad dissect for debulk		C					
58954	Tah rad debulk/lymph remove		C					
58956	Bso, omentectomy w/tah		C					
58957	Resect recurrent gyn mal		C					
58958	Resect recur gyn mal w/lym		C					
58960	Exploration of abdomen		C					
58970	Retrieval of oocyte	CH	T	0189	3.0466	$194.05		$38.81
58974	Transfer of embryo	CH	T	0189	3.0466	$194.05		$38.81
58976	Transfer of embryo	CH	T	0189	3.0466	$194.05		$38.81
58999	Genital surgery procedure		T	0191	0.1414	$9.01	$2.50	$1.80
59000	Amniocentesis, diagnostic	CH	T	0189	3.0466	$194.05		$38.81
59001	Amniocentesis, therapeutic		T	0192	7.4497	$474.49		$94.90
59012	Fetal cord puncture,prenatal	CH	T	0189	3.0466	$194.05		$38.81
59015	Chorion biopsy	CH	T	0189	3.0466	$194.05		$38.81
59020	Fetal contract stress test	CH	T	0188	1.4138	$90.05		$18.01
59025	Fetal non-stress test	CH	T	0188	1.4138	$90.05		$18.01
59030	Fetal scalp blood sample	CH	T	0189	3.0466	$194.05		$38.81
59050	Fetal monitor w/report		M					
59051	Fetal monitor/interpret only		B					
59070	Transabdom amnioinfus w/us	CH	T	0189	3.0466	$194.05		$38.81
59072	Umbilical cord occlud w/us	CH	T	0189	3.0466	$194.05		$38.81
59074	Fetal fluid drainage w/us	CH	T	0189	3.0466	$194.05		$38.81
59076	Fetal shunt placement, w/us	CH	T	0189	3.0466	$194.05		$38.81
59100	Remove uterus lesion		T	0195	32.9713	$2,100.04	$483.80	$420.01
59120	Treat ectopic pregnancy		C					
59121	Treat ectopic pregnancy		C					
59130	Treat ectopic pregnancy		C					
59135	Treat ectopic pregnancy		C					
59136	Treat ectopic pregnancy		C					
59140	Treat ectopic pregnancy		C					
59150	Treat ectopic pregnancy		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
59151	Treat ectopic pregnancy		T	0131	46.1201	$2,937.53	$1,001.80	$587.51
59160	D & c after delivery	CH	T	0193	19.2052	$1,223.24		$244.65
59200	Insert cervical dilator		T	0189	3.0466	$194.05		$38.81
59300	Episiotomy or vaginal repair		T	0193	19.2052	$1,223.24		$244.65
59320	Revision of cervix	CH	T	0193	19.2052	$1,223.24		$244.65
59325	Revision of cervix		C					
59350	Repair of uterus		C					
59400	Obstetrical care		B					
59409	Obstetrical care	CH	T	0193	19.2052	$1,223.24		$244.65
59410	Obstetrical care		B					
59412	Antepartum manipulation	CH	T	0193	19.2052	$1,223.24		$244.65
59414	Deliver placenta		T	0193	19.2052	$1,223.24		$244.65
59425	Antepartum care only		B					
59426	Antepartum care only		B					
59430	Care after delivery		B					
59510	Cesarean delivery		B					
59514	Cesarean delivery only		C					
59515	Cesarean delivery		B					
59525	Remove uterus after cesarean		C					
59610	Vbac delivery		B					
59612	Vbac delivery only	CH	T	0193	19.2052	$1,223.24		$244.65
59614	Vbac care after delivery		B					
59618	Attempted vbac delivery		B					
59620	Attempted vbac delivery only		C					
59622	Attempted vbac after care		B					
59812	Treatment of miscarriage	CH	T	0193	19.2052	$1,223.24		$244.65
59820	Care of miscarriage	CH	T	0193	19.2052	$1,223.24		$244.65
59821	Treatment of miscarriage	CH	T	0193	19.2052	$1,223.24		$244.65
59830	Treat uterus infection		C					
59840	Abortion	CH	T	0193	19.2052	$1,223.24		$244.65
59841	Abortion	CH	T	0193	19.2052	$1,223.24		$244.65

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
59850	Abortion		C					
59851	Abortion		C					
59852	Abortion		C					
59855	Abortion		C					
59856	Abortion		C					
59857	Abortion		C					
59866	Abortion (mpr)	CH	T	0189	3.0466	$194.05		$38.81
59870	Evacuate mole of uterus	CH	T	0193	19.2052	$1,223.24		$244.65
59871	Remove cerclage suture	CH	T	0193	19.2052	$1,223.24		$244.65
59897	Fetal invas px w/us	CH	T	0189	3.0466	$194.05		$38.81
59898	Laparo proc, ob care/deliver		T	0130	34.8153	$2,217.49	$659.50	$443.50
59899	Maternity care procedure	CH	T	0191	0.1414	$9.01	$2.50	$1.80
60000	Drain thyroid/tongue cyst		T	0252	7.6539	$487.50	$109.10	$97.50
60001	Aspirate/inject thyriod cyst		T	0004	4.5062	$287.01		$57.40
6005F	Care level rationale doc		M					
60100	Biopsy of thyroid		T	0004	4.5062	$287.01		$57.40
6010F	Dysphag test done b/4 eating		M					
6015F	Pt recvng/OK for eating/swal		M					
60200	Remove thyroid lesion		T	0114	45.1729	$2,877.20		$575.44
6020F	NPO (nothing-mouth) ordered		M					
60210	Partial thyroid excision		T	0114	45.1729	$2,877.20		$575.44
60212	Partial thyroid excision		T	0114	45.1729	$2,877.20		$575.44
60220	Partial removal of thyroid		T	0114	45.1729	$2,877.20		$575.44
60225	Partial removal of thyroid		T	0114	45.1729	$2,877.20		$575.44
60240	Removal of thyroid		T	0114	45.1729	$2,877.20		$575.44
60252	Removal of thyroid		T	0256	40.5598	$2,583.38		$516.68
60254	Extensive thyroid surgery		C					
60260	Repeat thyroid surgery		T	0256	40.5598	$2,583.38		$516.68
60270	Removal of thyroid		C					
60271	Removal of thyroid	CH	T	0256	40.5598	$2,583.38		$516.68
60280	Remove thyroid duct lesion		T	0114	45.1729	$2,877.20		$575.44
60281	Remove thyroid duct lesion		T	0114	45.1729	$2,877.20		$575.44
60500	Explore parathyroid glands		T	0256	40.5598	$2,583.38		$516.68
60502	Re-explore parathyroids		T	0256	40.5598	$2,583.38		$516.68
60505	Explore parathyroid glands		C					
60512	Autotransplant parathyroid		T	0022	21.4534	$1,366.43	$354.40	$273.29
60520	Removal of thymus gland		T	0256	40.5598	$2,583.38		$516.68
60521	Removal of thymus gland		C					
60522	Removal of thymus gland		C					
60540	Explore adrenal gland		C					
60545	Explore adrenal gland		C					
60600	Remove carotid body lesion		C					
60605	Remove carotid body lesion		C					
60650	Laparoscopy adrenalectomy		C					
60659	Laparo proc, endocrine		T	0130	34.8153	$2,217.49	$659.50	$443.50
60699	Endocrine surgery procedure		T	0114	45.1729	$2,877.20		$575.44
61000	Remove cranial cavity fluid		T	0212	8.6797	$552.84		$110.57
61001	Remove cranial cavity fluid		T	0212	8.6797	$552.84		$110.57
61020	Remove brain cavity fluid		T	0212	8.6797	$552.84		$110.57
61026	Injection into brain canal		T	0212	8.6797	$552.84		$110.57
61050	Remove brain canal fluid		T	0212	8.6797	$552.84		$110.57
61055	Injection into brain canal		T	0212	8.6797	$552.84		$110.57
61070	Brain canal shunt procedure	CH	T	0121	3.2914	$209.64	$43.80	$41.93
61105	Twist drill hole		C					
61107	Drill skull for implantation		C					
61108	Drill skull for drainage		C					
61120	Burr hole for puncture		C					
61140	Pierce skull for biopsy		C					
61150	Pierce skull for drainage		C					
61151	Pierce skull for drainage		C					
61154	Pierce skull & remove clot		C					
61156	Pierce skull for drainage		C					
61210	Pierce skull, implant device		C					
61215	Insert brain-fluid device		T	0224	37.1117	$2,363.76		$472.75
61250	Pierce skull & explore		C					
61253	Pierce skull & explore		C					
61304	Open skull for exploration		C					
61305	Open skull for exploration		C					
61312	Open skull for drainage		C					
61313	Open skull for drainage		C					
61314	Open skull for drainage		C					
61315	Open skull for drainage		C					
61316	Implt cran bone flap to abdo		C					
61320	Open skull for drainage		C					
61321	Open skull for drainage		C					
61322	Decompressive craniotomy		C					
61323	Decompressive lobectomy		C					
61330	Decompress eye socket		T	0256	40.5598	$2,583.38		$516.68

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
61332	Explore/biopsy eye socket		C					
61333	Explore orbit/remove lesion		C					
61334	Explore orbit/remove object		T	0256	40.5598	$2,583.38		$516.68
61340	Subtemporal decompression		C					
61343	Incise skull (press relief)		C					
61345	Relieve cranial pressure		C					
61440	Incise skull for surgery		C					
61450	Incise skull for surgery		C					
61458	Incise skull for brain wound		C					
61460	Incise skull for surgery		C					
61470	Incise skull for surgery		C					
61480	Incise skull for surgery		C					
61490	Incise skull for surgery		C					
61500	Removal of skull lesion		C					
61501	Remove infected skull bone		C					
61510	Removal of brain lesion		C					
61512	Remove brain lining lesion		C					
61514	Removal of brain abscess		C					
61516	Removal of brain lesion		C					
61517	Implt brain chemotx add-on		C					
61518	Removal of brain lesion		C					
61519	Remove brain lining lesion		C					
61520	Removal of brain lesion		C					
61521	Removal of brain lesion		C					
61522	Removal of brain abscess		C					
61524	Removal of brain lesion		C					
61526	Removal of brain lesion		C					
61530	Removal of brain lesion		C					
61531	Implant brain electrodes		C					
61533	Implant brain electrodes		C					
61534	Removal of brain lesion		C					
61535	Remove brain electrodes		C					
61536	Removal of brain lesion		C					
61537	Removal of brain tissue		C					
61538	Removal of brain tissue		C					
61539	Removal of brain tissue		C					
61540	Removal of brain tissue		C					
61541	Incision of brain tissue		C					
61542	Removal of brain tissue		C					
61543	Removal of brain tissue		C					
61544	Remove & treat brain lesion		C					
61545	Excision of brain tumor		C					
61546	Removal of pituitary gland		C					
61548	Removal of pituitary gland		C					
61550	Release of skull seams		C					
61552	Release of skull seams		C					
61556	Incise skull/sutures		C					
61557	Incise skull/sutures		C					
61558	Excision of skull/sutures		C					
61559	Excision of skull/sutures		C					
61563	Excision of skull tumor		C					
61564	Excision of skull tumor		C					
61566	Removal of brain tissue		C					
61567	Incision of brain tissue		C					
61570	Remove foreign body, brain		C					
61571	Incise skull for brain wound		C					
61575	Skull base/brainstem surgery		C					
61576	Skull base/brainstem surgery		C					
61580	Craniofacial approach, skull		C					
61581	Craniofacial approach, skull		C					
61582	Craniofacial approach, skull		C					
61583	Craniofacial approach, skull		C					
61584	Orbitocranial approach/skull		C					
61585	Orbitocranial approach/skull		C					
61586	Resect nasopharynx, skull		C					
61590	Infratemporal approach/skull		C					
61591	Infratemporal approach/skull		C					
61592	Orbitocranial approach/skull		C					
61595	Transtemporal approach/skull		C					
61596	Transcochlear approach/skull		C					
61597	Transcondylar approach/skull		C					
61598	Transpetrosal approach/skull		C					
61600	Resect/excise cranial lesion		C					
61601	Resect/excise cranial lesion		C					
61605	Resect/excise cranial lesion		C					
61606	Resect/excise cranial lesion		C					
61607	Resect/excise cranial lesion		C					
61608	Resect/excise cranial lesion		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
61609	Transect artery, sinus		C					
61610	Transect artery, sinus		C					
61611	Transect artery, sinus		C					
61612	Transect artery, sinus		C					
61613	Remove aneurysm, sinus		C					
61615	Resect/excise lesion, skull		C					
61616	Resect/excise lesion, skull		C					
61618	Repair dura		C					
61619	Repair dura		C					
61623	Endovasc tempory vessel occl	CH	T	0082	88.7717	$5,654.14		$1,130.83
61624	Transcath occlusion, cns		C					
61626	Transcath occlusion, non-cns	CH	T	0082	88.7717	$5,654.14		$1,130.83
61630	Intracranial angioplasty		E					
61635	Intracran angioplsty w/stent		E					
61640	Dilate ic vasospasm, init		E					
61641	Dilate ic vasospasm add-on		E					
61642	Dilate ic vasospasm add-on		E					
61680	Intracranial vessel surgery		C					
61682	Intracranial vessel surgery		C					
61684	Intracranial vessel surgery		C					
61686	Intracranial vessel surgery		C					
61690	Intracranial vessel surgery		C					
61692	Intracranial vessel surgery		C					
61697	Brain aneurysm repr, complx		C					
61698	Brain aneurysm repr, complx		C					
61700	Brain aneurysm repr, simple		C					
61702	Inner skull vessel surgery		C					
61703	Clamp neck artery		C					
61705	Revise circulation to head		C					
61708	Revise circulation to head		C					
61710	Revise circulation to head		C					
61711	Fusion of skull arteries		C					
61720	Incise skull/brain surgery		T	0221	32.0518	$2,041.48	$463.60	$408.30
61735	Incise skull/brain surgery		C					
61750	Incise skull/brain biopsy		C					
61751	Brain biopsy w/ct/mr guide		C					
61760	Implant brain electrodes		C					
61770	Incise skull for treatment	CH	T	0221	32.0518	$2,041.48	$463.60	$408.30
61790	Treat trigeminal nerve		T	0220	18.5069	$1,178.76		$235.75
61791	Treat trigeminal tract	CH	T	0203	15.5687	$991.62	$240.30	$198.32
61793	Focus radiation beam		B					
61795	Brain surgery using computer	CH	N					
61850	Implant neuroelectrodes		C					
61860	Implant neuroelectrodes		C					
61863	Implant neuroelectrode		C					
61864	Implant neuroelectrde, addl		C					
61867	Implant neuroelectrode		C					
61868	Implant neuroelectrde, add'l		C					
61870	Implant neuroelectrodes		C					
61875	Implant neuroelectrodes		C					
61880	Revise/remove neuroelectrode		T	0687	24.1752	$1,539.79	$438.40	$307.96
61885	Insrt/redo neurostim 1 array		S	0039	197.4688	$12,577.38		$2,515.48
61886	Implant neurostim arrays		T	0315	262.8116	$16,739.26		$3,347.85
61888	Revise/remove neuroreceiver		T	0688	35.7248	$2,275.42	$874.50	$455.08
62000	Treat skull fracture		T	0254	24.3535	$1,551.15	$321.30	$310.23
62005	Treat skull fracture		C					
62010	Treatment of head injury		C					
62100	Repair brain fluid leakage		C					
62115	Reduction of skull defect		C					
62116	Reduction of skull defect		C					
62117	Reduction of skull defect		C					
62120	Repair skull cavity lesion		C					
62121	Incise skull repair		C					
62140	Repair of skull defect		C					
62141	Repair of skull defect		C					
62142	Remove skull plate/flap		C					
62143	Replace skull plate/flap		C					
62145	Repair of skull & brain		C					
62146	Repair of skull with graft		C					
62147	Repair of skull with graft		C					
62148	Retr bone flap to fix skull		C					
62160	Neuroendoscopy add-on	CH	N					
62161	Dissect brain w/scope		C					
62162	Remove colloid cyst w/scope		C					
62163	Neuroendoscopy w/fb removal		C					
62164	Remove brain tumor w/scope		C					
62165	Remove pituit tumor w/scope		C					
62180	Establish brain cavity shunt		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
62190	Establish brain cavity shunt		C					
62192	Establish brain cavity shunt		C					
62194	Replace/irrigate catheter	CH	T	0212	8.6797	$552.84		$110.57
62200	Establish brain cavity shunt		C					
62201	Brain cavity shunt w/scope		C					
62220	Establish brain cavity shunt		C					
62223	Establish brain cavity shunt		C					
62225	Replace/irrigate catheter		T	0427	14.8912	$948.47		$189.69
62230	Replace/revise brain shunt		T	0224	37.1117	$2,363.76		$472.75
62252	Csf shunt reprogram		S	0691	2.5849	$164.64	$56.08	$32.93
62256	Remove brain cavity shunt		C					
62258	Replace brain cavity shunt		C					
62263	Epidural lysis mult sessions		T	0203	15.5687	$991.62	$240.30	$198.32
62264	Epidural lysis on single day		T	0203	15.5687	$991.62	$240.30	$198.32
62268	Drain spinal cord cyst		T	0212	8.6797	$552.84		$110.57
62269	Needle biopsy, spinal cord		T	0685	9.5741	$609.80		$121.96
62270	Spinal fluid tap, diagnostic	CH	T	0206	4.1589	$264.89	$56.83	$52.98
62272	Drain cerebro spinal fluid	CH	T	0206	4.1589	$264.89	$56.83	$52.98
62273	Inject epidural patch		T	0206	4.1589	$264.89	$56.83	$52.98
62280	Treat spinal cord lesion		T	0207	7.137	$454.58		$90.92
62281	Treat spinal cord lesion		T	0207	7.137	$454.58		$90.92
62282	Treat spinal canal lesion		T	0207	7.137	$454.58		$90.92
62284	Injection for myelogram		N					
62287	Percutaneous diskectomy		T	0221	32.0518	$2,041.48	$463.60	$408.30
62290	Inject for spine disk x-ray		N					
62291	Inject for spine disk x-ray		N					
62292	Injection into disk lesion		T	0212	8.6797	$552.84		$110.57
62294	Injection into spinal artery		T	0212	8.6797	$552.84		$110.57
62310	Inject spine c/t		T	0207	7.137	$454.58		$90.92
62311	Inject spine l/s (cd)		T	0207	7.137	$454.58		$90.92
62318	Inject spine w/cath, c/t		T	0207	7.137	$454.58		$90.92
62319	Inject spine w/cath l/s (cd)		T	0207	7.137	$454.58		$90.92
62350	Implant spinal canal cath	CH	T	0224	37.1117	$2,363.76		$472.75
62351	Implant spinal canal cath		T	0208	47.6714	$3,036.33		$607.27
62355	Remove spinal canal catheter		T	0203	15.5687	$991.62	$240.30	$198.32
62360	Insert spine infusion device	CH	T	0224	37.1117	$2,363.76		$472.75
62361	Implant spine infusion pump		T	0227	178.7228	$11,383.39		$2,276.68
62362	Implant spine infusion pump		T	0227	178.7228	$11,383.39		$2,276.68
62365	Remove spine infusion device		T	0221	32.0518	$2,041.48	$463.60	$408.30
62367	Analyze spine infusion pump		S	0691	2.5849	$164.64	$56.08	$32.93
62368	Analyze spine infusion pump		S	0691	2.5849	$164.64	$56.08	$32.93
63001	Removal of spinal lamina		T	0208	47.6714	$3,036.33		$607.27
63003	Removal of spinal lamina		T	0208	47.6714	$3,036.33		$607.27
63005	Removal of spinal lamina		T	0208	47.6714	$3,036.33		$607.27
63011	Removal of spinal lamina		T	0208	47.6714	$3,036.33		$607.27
63012	Removal of spinal lamina		T	0208	47.6714	$3,036.33		$607.27
63015	Removal of spinal lamina		T	0208	47.6714	$3,036.33		$607.27
63016	Removal of spinal lamina		T	0208	47.6714	$3,036.33		$607.27
63017	Removal of spinal lamina		T	0208	47.6714	$3,036.33		$607.27
63020	Neck spine disk surgery		T	0208	47.6714	$3,036.33		$607.27
63030	Low back disk surgery		T	0208	47.6714	$3,036.33		$607.27
63035	Spinal disk surgery add-on		T	0208	47.6714	$3,036.33		$607.27
63040	Laminotomy, single cervical		T	0208	47.6714	$3,036.33		$607.27
63042	Laminotomy, single lumbar		T	0208	47.6714	$3,036.33		$607.27
63043	Laminotomy, add'l cervical		C					
63044	Laminotomy, add'l lumbar		C					
63045	Removal of spinal lamina		T	0208	47.6714	$3,036.33		$607.27
63046	Removal of spinal lamina		T	0208	47.6714	$3,036.33		$607.27
63047	Removal of spinal lamina		T	0208	47.6714	$3,036.33		$607.27
63048	Remove spinal lamina add-on		T	0208	47.6714	$3,036.33		$607.27
63050	Cervical laminoplasty		C					
63051	C-laminoplasty w/graft/plate		C					
63055	Decompress spinal cord		T	0208	47.6714	$3,036.33		$607.27
63056	Decompress spinal cord		T	0208	47.6714	$3,036.33		$607.27
63057	Decompress spine cord add-on		T	0208	47.6714	$3,036.33		$607.27
63064	Decompress spinal cord		T	0208	47.6714	$3,036.33		$607.27
63066	Decompress spine cord add-on		T	0208	47.6714	$3,036.33		$607.27
63075	Neck spine disk surgery		T	0208	47.6714	$3,036.33		$607.27
63076	Neck spine disk surgery		C					
63077	Spine disk surgery, thorax		C					
63078	Spine disk surgery, thorax		C					
63081	Removal of vertebral body		C					
63082	Remove vertebral body add-on		C					
63085	Removal of vertebral body		C					
63086	Remove vertebral body add-on		C					
63087	Removal of vertebral body		C					
63088	Remove vertebral body add-on		C					
63090	Removal of vertebral body		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
63091	Remove vertebral body add-on		C					
63101	Removal of vertebral body		C					
63102	Removal of vertebral body		C					
63103	Remove vertebral body add-on		C					
63170	Incise spinal cord tract(s)		C					
63172	Drainage of spinal cyst		C					
63173	Drainage of spinal cyst		C					
63180	Revise spinal cord ligaments		C					
63182	Revise spinal cord ligaments		C					
63185	Incise spinal column/nerves		C					
63190	Incise spinal column/nerves		C					
63191	Incise spinal column/nerves		C					
63194	Incise spinal column & cord		C					
63195	Incise spinal column & cord		C					
63196	Incise spinal column & cord		C					
63197	Incise spinal column & cord		C					
63198	Incise spinal column & cord		C					
63199	Incise spinal column & cord		C					
63200	Release of spinal cord		C					
63250	Revise spinal cord vessels		C					
63251	Revise spinal cord vessels		C					
63252	Revise spinal cord vessels		C					
63265	Excise intraspinal lesion		C					
63266	Excise intraspinal lesion		C					
63267	Excise intraspinal lesion		C					
63268	Excise intraspinal lesion		C					
63270	Excise intraspinal lesion		C					
63271	Excise intraspinal lesion		C					
63272	Excise intraspinal lesion		C					
63273	Excise intraspinal lesion		C					
63275	Biopsy/excise spinal tumor		C					
63276	Biopsy/excise spinal tumor		C					
63277	Biopsy/excise spinal tumor		C					
63278	Biopsy/excise spinal tumor		C					
63280	Biopsy/excise spinal tumor		C					
63281	Biopsy/excise spinal tumor		C					
63282	Biopsy/excise spinal tumor		C					
63283	Biopsy/excise spinal tumor		C					
63285	Biopsy/excise spinal tumor		C					
63286	Biopsy/excise spinal tumor		C					
63287	Biopsy/excise spinal tumor		C					
63290	Biopsy/excise spinal tumor		C					
63295	Repair of laminectomy defect		C					
63300	Removal of vertebral body		C					
63301	Removal of vertebral body		C					
63302	Removal of vertebral body		C					
63303	Removal of vertebral body		C					
63304	Removal of vertebral body		C					
63305	Removal of vertebral body		C					
63306	Removal of vertebral body		C					
63307	Removal of vertebral body		C					
63308	Remove vertebral body add-on		C					
63600	Remove spinal cord lesion		T	0220	18.5069	$1,178.76		$235.75
63610	Stimulation of spinal cord		T	0220	18.5069	$1,178.76		$235.75
63615	Remove lesion of spinal cord		T	0220	18.5069	$1,178.76		$235.75
63650	Implant neuroelectrodes		S	0040	63.7536	$4,060.66		$812.13
63655	Implant neuroelectrodes		S	0061	81.3252	$5,179.85		$1,035.97
63660	Revise/remove neuroelectrode		T	0687	24.1752	$1,539.79	$438.40	$307.96
63685	Insrt/redo spine n generator		T	0222	193.3327	$12,313.94		$2,462.79
63688	Revise/remove neuroreceiver		T	0688	35.7248	$2,275.42	$874.50	$455.08
63700	Repair of spinal herniation		C					
63702	Repair of spinal herniation		C					
63704	Repair of spinal herniation		C					
63706	Repair of spinal herniation		C					
63707	Repair spinal fluid leakage		C					
63709	Repair spinal fluid leakage		C					
63710	Graft repair of spine defect		C					
63740	Install spinal shunt		C					
63741	Install spinal shunt	CH	T	0224	37.1117	$2,363.76		$472.75
63744	Revision of spinal shunt	CH	T	0224	37.1117	$2,363.76		$472.75
63746	Removal of spinal shunt		T	0109	6.1077	$389.02		$77.80
64400	N block inj, trigeminal		T	0204	2.3254	$148.11	$40.10	$29.62
64402	N block inj, facial		T	0204	2.3254	$148.11	$40.10	$29.62
64405	N block inj, occipital	CH	T	0206	4.1589	$264.89	$56.83	$52.98
64408	N block inj, vagus	CH	T	0206	4.1589	$264.89	$56.83	$52.98
64410	N block inj, phrenic	CH	T	0207	7.137	$454.58		$90.92
64412	N block inj, spinal accessor	CH	T	0207	7.137	$454.58		$90.92
64413	N block inj, cervical plexus	CH	T	0206	4.1589	$264.89	$56.83	$52.98

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
64415	N block inj, brachial plexus	CH	T	0206	4.1589	$264.89	$56.83	$52.98
64416	N block cont infuse, b plex	CH	T	0207	7.137	$454.58		$90.92
64417	N block inj, axillary	CH	T	0206	4.1589	$264.89	$56.83	$52.98
64418	N block inj, suprascapular	CH	T	0206	4.1589	$264.89	$56.83	$52.98
64420	N block inj, intercost, sng	CH	T	0206	4.1589	$264.89	$56.83	$52.98
64421	N block inj, intercost, mlt		T	0206	4.1589	$264.89	$56.83	$52.98
64425	N block inj, ilio-ing/hypogi	CH	T	0206	4.1589	$264.89	$56.83	$52.98
64430	N block inj, pudendal	CH	T	0207	7.137	$454.58		$90.92
64435	N block inj, paracervical	CH	T	0206	4.1589	$264.89	$56.83	$52.98
64445	N block inj, sciatic, sng	CH	T	0206	4.1589	$264.89	$56.83	$52.98
64446	N blk inj, sciatic, cont inf	CH	T	0203	15.5687	$991.62	$240.30	$198.32
64447	N block inj fem, single	CH	T	0206	4.1589	$264.89	$56.83	$52.98
64448	N block inj fem, cont inf	CH	T	0206	4.1589	$264.89	$56.83	$52.98
64449	N block inj, lumbar plexus	CH	T	0207	7.137	$454.58		$90.92
64450	N block, other peripheral	CH	T	0206	4.1589	$264.89	$56.83	$52.98
64470	Inj paravertebral c/t		T	0207	7.137	$454.58		$90.92
64472	Inj paravertebral c/t add-on		T	0206	4.1589	$264.89	$56.83	$52.98
64475	Inj paravertebral l/s		T	0207	7.137	$454.58		$90.92
64476	Inj paravertebral l/s add-on		T	0206	4.1589	$264.89	$56.83	$52.98
64479	Inj foramen epidural c/t		T	0207	7.137	$454.58		$90.92
64480	Inj foramen epidural add-on	CH	T	0206	4.1589	$264.89	$56.83	$52.98
64483	Inj foramen epidural l/s		T	0207	7.137	$454.58		$90.92
64484	Inj foramen epidural add-on		T	0207	7.137	$454.58		$90.92
64505	N block, spenopalatine gangl		T	0204	2.3254	$148.11	$40.10	$29.62
64508	N block, carotid sinus s/p		T	0204	2.3254	$148.11	$40.10	$29.62
64510	N block, stellate ganglion		T	0207	7.137	$454.58		$90.92
64517	N block inj, hypogas plxs	CH	T	0207	7.137	$454.58		$90.92
64520	N block, lumbar/thoracic		T	0207	7.137	$454.58		$90.92
64530	N block inj, celiac pelus		T	0207	7.137	$454.58		$90.92
64550	Apply neurostimulator		A					
64553	Implant neuroelectrodes		S	0225	221.4181	$14,102.78		$2,820.56
64555	Implant neuroelectrodes		S	0040	63.7536	$4,060.66		$812.13
64560	Implant neuroelectrodes		S	0040	63.7536	$4,060.66		$812.13
64561	Implant neuroelectrodes		S	0040	63.7536	$4,060.66		$812.13
64565	Implant neuroelectrodes		S	0040	63.7536	$4,060.66		$812.13
64573	Implant neuroelectrodes		S	0225	221.4181	$14,102.78		$2,820.56
64575	Implant neuroelectrodes		S	0061	81.3252	$5,179.85		$1,035.97
64577	Implant neuroelectrodes		S	0061	81.3252	$5,179.85		$1,035.97
64580	Implant neuroelectrodes		S	0061	81.3252	$5,179.85		$1,035.97
64581	Implant neuroelectrodes		S	0061	81.3252	$5,179.85		$1,035.97
64585	Revise/remove neuroelectrode		T	0687	24.1752	$1,539.79	$438.40	$307.96
64590	Insrt/redo pn/gastr stimul		T	0222	193.3327	$12,313.94		$2,462.79
64595	Revise/rmv pn/gastr stimul		T	0688	35.7248	$2,275.42	$874.50	$455.08
64600	Injection treatment of nerve		T	0203	15.5687	$991.62	$240.30	$198.32
64605	Injection treatment of nerve		T	0203	15.5687	$991.62	$240.30	$198.32
64610	Injection treatment of nerve		T	0203	15.5687	$991.62	$240.30	$198.32
64612	Destroy nerve, face muscle		T	0204	2.3254	$148.11	$40.10	$29.62
64613	Destroy nerve, neck muscle		T	0204	2.3254	$148.11	$40.10	$29.62
64614	Destroy nerve, extrem musc		T	0204	2.3254	$148.11	$40.10	$29.62
64620	Injection treatment of nerve	CH	T	0207	7.137	$454.58		$90.92
64622	Destr paravertebrl nerve l/s	CH	T	0207	7.137	$454.58		$90.92
64623	Destr paravertebral n add-on		T	0207	7.137	$454.58		$90.92
64626	Destr paravertebrl nerve c/t	CH	T	0207	7.137	$454.58		$90.92
64627	Destr paravertebral n add-on	CH	T	0204	2.3254	$148.11	$40.10	$29.62
64630	Injection treatment of nerve	CH	T	0207	7.137	$454.58		$90.92
64640	Injection treatment of nerve	CH	T	0207	7.137	$454.58		$90.92
64650	Chemodenerv eccrine glands	CH	T	0206	4.1589	$264.89	$56.83	$52.98
64653	Chemodenerv eccrine glands	CH	T	0206	4.1589	$264.89	$56.83	$52.98
64680	Injection treatment of nerve		T	0207	7.137	$454.58		$90.92
64681	Injection treatment of nerve		T	0203	15.5687	$991.62	$240.30	$198.32
64702	Revise finger/toe nerve		T	0220	18.5069	$1,178.76		$235.75
64704	Revise hand/foot nerve		T	0220	18.5069	$1,178.76		$235.75
64708	Revise arm/leg nerve		T	0220	18.5069	$1,178.76		$235.75
64712	Revision of sciatic nerve		T	0220	18.5069	$1,178.76		$235.75
64713	Revision of arm nerve(s)		T	0220	18.5069	$1,178.76		$235.75
64714	Revise low back nerve(s)		T	0220	18.5069	$1,178.76		$235.75
64716	Revision of cranial nerve		T	0220	18.5069	$1,178.76		$235.75
64718	Revise ulnar nerve at elbow		T	0220	18.5069	$1,178.76		$235.75
64719	Revise ulnar nerve at wrist		T	0220	18.5069	$1,178.76		$235.75
64721	Carpal tunnel surgery		T	0220	18.5069	$1,178.76		$235.75
64722	Relieve pressure on nerve(s)		T	0220	18.5069	$1,178.76		$235.75
64726	Release foot/toe nerve		T	0220	18.5069	$1,178.76		$235.75
64727	Internal nerve revision		T	0220	18.5069	$1,178.76		$235.75
64732	Incision of brow nerve		T	0220	18.5069	$1,178.76		$235.75
64734	Incision of cheek nerve		T	0220	18.5069	$1,178.76		$235.75
64736	Incision of chin nerve		T	0220	18.5069	$1,178.76		$235.75
64738	Incision of jaw nerve		T	0220	18.5069	$1,178.76		$235.75
64740	Incision of tongue nerve		T	0220	18.5069	$1,178.76		$235.75

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
64742	Incision of facial nerve		T	0220	18.5069	$1,178.76		$235.75
64744	Incise nerve, back of head		T	0220	18.5069	$1,178.76		$235.75
64746	Incise diaphragm nerve		T	0220	18.5069	$1,178.76		$235.75
64752	Incision of vagus nerve		C					
64755	Incision of stomach nerves		C					
64760	Incision of vagus nerve		C					
64761	Incision of pelvis nerve		T	0220	18.5069	$1,178.76		$235.75
64763	Incise hip/thigh nerve		T	0220	18.5069	$1,178.76		$235.75
64766	Incise hip/thigh nerve		T	0221	32.0518	$2,041.48	$463.60	$408.30
64771	Sever cranial nerve		T	0220	18.5069	$1,178.76		$235.75
64772	Incision of spinal nerve		T	0220	18.5069	$1,178.76		$235.75
64774	Remove skin nerve lesion		T	0220	18.5069	$1,178.76		$235.75
64776	Remove digit nerve lesion		T	0220	18.5069	$1,178.76		$235.75
64778	Digit nerve surgery add-on		T	0220	18.5069	$1,178.76		$235.75
64782	Remove limb nerve lesion		T	0220	18.5069	$1,178.76		$235.75
64783	Limb nerve surgery add-on		T	0220	18.5069	$1,178.76		$235.75
64784	Remove nerve lesion		T	0220	18.5069	$1,178.76		$235.75
64786	Remove sciatic nerve lesion		T	0221	32.0518	$2,041.48	$463.60	$408.30
64787	Implant nerve end		T	0220	18.5069	$1,178.76		$235.75
64788	Remove skin nerve lesion		T	0220	18.5069	$1,178.76		$235.75
64790	Removal of nerve lesion		T	0220	18.5069	$1,178.76		$235.75
64792	Removal of nerve lesion		T	0221	32.0518	$2,041.48	$463.60	$408.30
64795	Biopsy of nerve		T	0220	18.5069	$1,178.76		$235.75
64802	Remove sympathetic nerves		T	0220	18.5069	$1,178.76		$235.75
64804	Remove sympathetic nerves		T	0220	18.5069	$1,178.76		$235.75
64809	Remove sympathetic nerves		C					
64818	Remove sympathetic nerves		C					
64820	Remove sympathetic nerves		T	0220	18.5069	$1,178.76		$235.75
64821	Remove sympathetic nerves		T	0054	26.7322	$1,702.65		$340.53
64822	Remove sympathetic nerves		T	0054	26.7322	$1,702.65		$340.53
64823	Remove sympathetic nerves		T	0054	26.7322	$1,702.65		$340.53
64831	Repair of digit nerve		T	0221	32.0518	$2,041.48	$463.60	$408.30
64832	Repair nerve add-on		T	0221	32.0518	$2,041.48	$463.60	$408.30
64834	Repair of hand or foot nerve		T	0221	32.0518	$2,041.48	$463.60	$408.30
64835	Repair of hand or foot nerve		T	0221	32.0518	$2,041.48	$463.60	$408.30
64836	Repair of hand or foot nerve		T	0221	32.0518	$2,041.48	$463.60	$408.30
64837	Repair nerve add-on		T	0221	32.0518	$2,041.48	$463.60	$408.30
64840	Repair of leg nerve		T	0221	32.0518	$2,041.48	$463.60	$408.30
64856	Repair/transpose nerve		T	0221	32.0518	$2,041.48	$463.60	$408.30
64857	Repair arm/leg nerve		T	0221	32.0518	$2,041.48	$463.60	$408.30
64858	Repair sciatic nerve		T	0221	32.0518	$2,041.48	$463.60	$408.30
64859	Nerve surgery		T	0221	32.0518	$2,041.48	$463.60	$408.30
64861	Repair of arm nerves		T	0221	32.0518	$2,041.48	$463.60	$408.30
64862	Repair of low back nerves		T	0221	32.0518	$2,041.48	$463.60	$408.30
64864	Repair of facial nerve		T	0221	32.0518	$2,041.48	$463.60	$408.30
64865	Repair of facial nerve		T	0221	32.0518	$2,041.48	$463.60	$408.30
64866	Fusion of facial/other nerve		C					
64868	Fusion of facial/other nerve		C					
64870	Fusion of facial/other nerve		T	0221	32.0518	$2,041.48	$463.60	$408.30
64872	Subsequent repair of nerve		T	0221	32.0518	$2,041.48	$463.60	$408.30
64874	Repair & revise nerve add-on		T	0221	32.0518	$2,041.48	$463.60	$408.30
64876	Repair nerve/shorten bone		T	0221	32.0518	$2,041.48	$463.60	$408.30
64885	Nerve graft, head or neck		T	0221	32.0518	$2,041.48	$463.60	$408.30
64886	Nerve graft, head or neck		T	0221	32.0518	$2,041.48	$463.60	$408.30
64890	Nerve graft, hand or foot		T	0221	32.0518	$2,041.48	$463.60	$408.30
64891	Nerve graft, hand or foot		T	0221	32.0518	$2,041.48	$463.60	$408.30
64892	Nerve graft, arm or leg		T	0221	32.0518	$2,041.48	$463.60	$408.30
64893	Nerve graft, arm or leg		T	0221	32.0518	$2,041.48	$463.60	$408.30
64895	Nerve graft, hand or foot		T	0221	32.0518	$2,041.48	$463.60	$408.30
64896	Nerve graft, hand or foot		T	0221	32.0518	$2,041.48	$463.60	$408.30
64897	Nerve graft, arm or leg		T	0221	32.0518	$2,041.48	$463.60	$408.30
64898	Nerve graft, arm or leg		T	0221	32.0518	$2,041.48	$463.60	$408.30
64901	Nerve graft add-on		T	0221	32.0518	$2,041.48	$463.60	$408.30
64902	Nerve graft add-on		T	0221	32.0518	$2,041.48	$463.60	$408.30
64905	Nerve pedicle transfer		T	0221	32.0518	$2,041.48	$463.60	$408.30
64907	Nerve pedicle transfer		T	0221	32.0518	$2,041.48	$463.60	$408.30
64910	Nerve repair w/allograft		T	0220	18.5069	$1,178.76		$235.75
64911	Neurorraphy w/vein autograft		T	0220	18.5069	$1,178.76		$235.75
64999	Nervous system surgery		T	0204	2.3254	$148.11	$40.10	$29.62
65091	Revise eye		T	0242	37.3504	$2,378.96	$597.30	$475.79
65093	Revise eye with implant		T	0242	37.3504	$2,378.96	$597.30	$475.79
65101	Removal of eye		T	0242	37.3504	$2,378.96	$597.30	$475.79
65103	Remove eye/insert implant		T	0242	37.3504	$2,378.96	$597.30	$475.79
65105	Remove eye/attach implant		T	0242	37.3504	$2,378.96	$597.30	$475.79
65110	Removal of eye		T	0242	37.3504	$2,378.96	$597.30	$475.79
65112	Remove eye/revise socket		T	0242	37.3504	$2,378.96	$597.30	$475.79
65114	Remove eye/revise socket		T	0242	37.3504	$2,378.96	$597.30	$475.79
65125	Revise ocular implant		T	0240	19.228	$1,224.69	$309.50	$244.94

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
65130	Insert ocular implant		T	0241	24.8916	$1,585.42	$384.40	$317.08
65135	Insert ocular implant		T	0241	24.8916	$1,585.42	$384.40	$317.08
65140	Attach ocular implant		T	0242	37.3504	$2,378.96	$597.30	$475.79
65150	Revise ocular implant		T	0241	24.8916	$1,585.42	$384.40	$317.08
65155	Reinsert ocular implant		T	0242	37.3504	$2,378.96	$597.30	$475.79
65175	Removal of ocular implant		T	0240	19.228	$1,224.69	$309.50	$244.94
65205	Remove foreign body from eye		S	0698	1.1576	$73.73		$14.75
65210	Remove foreign body from eye		S	0698	1.1576	$73.73		$14.75
65220	Remove foreign body from eye		S	0698	1.1576	$73.73		$14.75
65222	Remove foreign body from eye		S	0698	1.1576	$73.73		$14.75
65235	Remove foreign body from eye		T	0233	16.5252	$1,052.54	$266.30	$210.51
65260	Remove foreign body from eye		T	0236	18.8779	$1,202.39		$240.48
65265	Remove foreign body from eye		T	0237	29.0019	$1,847.22		$369.44
65270	Repair of eye wound		T	0240	19.228	$1,224.69	$309.50	$244.94
65272	Repair of eye wound		T	0234	24.0821	$1,533.86	$511.30	$306.77
65273	Repair of eye wound		C					
65275	Repair of eye wound		T	0234	24.0821	$1,533.86	$511.30	$306.77
65280	Repair of eye wound		T	0236	18.8779	$1,202.39		$240.48
65285	Repair of eye wound		T	0672	38.1121	$2,427.47		$485.49
65286	Repair of eye wound		T	0232	5.1145	$325.76	$81.59	$65.15
65290	Repair of eye socket wound		T	0243	24.392	$1,553.60	$430.30	$310.72
65400	Removal of eye lesion		T	0233	16.5252	$1,052.54	$266.30	$210.51
65410	Biopsy of cornea		T	0233	16.5252	$1,052.54	$266.30	$210.51
65420	Removal of eye lesion		T	0233	16.5252	$1,052.54	$266.30	$210.51
65426	Removal of eye lesion		T	0234	24.0821	$1,533.86	$511.30	$306.77
65430	Corneal smear		S	0698	1.1576	$73.73		$14.75
65435	Curette/treat cornea		T	0239	7.1099	$452.85		$90.57
65436	Curette/treat cornea		T	0233	16.5252	$1,052.54	$266.30	$210.51
65450	Treatment of corneal lesion		S	0231	2.3117	$147.24		$29.45
65600	Revision of cornea		T	0240	19.228	$1,224.69	$309.50	$244.94
65710	Corneal transplant		T	0244	38.2919	$2,438.93	$803.20	$487.79
65730	Corneal transplant		T	0244	38.2919	$2,438.93	$803.20	$487.79
65750	Corneal transplant		T	0244	38.2919	$2,438.93	$803.20	$487.79
65755	Corneal transplant		T	0244	38.2919	$2,438.93	$803.20	$487.79
65760	Revision of cornea		E					
65765	Revision of cornea		E					
65767	Corneal tissue transplant		E					
65770	Revise cornea with implant		T	0293	83.0605	$5,290.37	$1,128.20	$1,058.07
65771	Radial keratotomy		E					
65772	Correction of astigmatism		T	0233	16.5252	$1,052.54	$266.30	$210.51
65775	Correction of astigmatism		T	0233	16.5252	$1,052.54	$266.30	$210.51
65780	Ocular reconst, transplant		T	0244	38.2919	$2,438.93	$803.20	$487.79
65781	Ocular reconst, transplant		T	0244	38.2919	$2,438.93	$803.20	$487.79
65782	Ocular reconst, transplant		T	0244	38.2919	$2,438.93	$803.20	$487.79
65800	Drainage of eye		T	0233	16.5252	$1,052.54	$266.30	$210.51
65805	Drainage of eye		T	0233	16.5252	$1,052.54	$266.30	$210.51
65810	Drainage of eye		T	0234	24.0821	$1,533.86	$511.30	$306.77
65815	Drainage of eye		T	0234	24.0821	$1,533.86	$511.30	$306.77
65820	Relieve inner eye pressure		T	0232	5.1145	$325.76	$81.59	$65.15
65850	Incision of eye		T	0234	24.0821	$1,533.86	$511.30	$306.77
65855	Laser surgery of eye		T	0247	5.2389	$333.68	$104.30	$66.74
65860	Incise inner eye adhesions		T	0247	5.2389	$333.68	$104.30	$66.74
65865	Incise inner eye adhesions		T	0233	16.5252	$1,052.54	$266.30	$210.51
65870	Incise inner eye adhesions		T	0234	24.0821	$1,533.86	$511.30	$306.77
65875	Incise inner eye adhesions		T	0234	24.0821	$1,533.86	$511.30	$306.77
65880	Incise inner eye adhesions		T	0233	16.5252	$1,052.54	$266.30	$210.51
65900	Remove eye lesion		T	0233	16.5252	$1,052.54	$266.30	$210.51
65920	Remove implant of eye		T	0234	24.0821	$1,533.86	$511.30	$306.77
65930	Remove blood clot from eye		T	0234	24.0821	$1,533.86	$511.30	$306.77
66020	Injection treatment of eye		T	0233	16.5252	$1,052.54	$266.30	$210.51
66030	Injection treatment of eye		T	0232	5.1145	$325.76	$81.59	$65.15
66130	Remove eye lesion		T	0234	24.0821	$1,533.86	$511.30	$306.77
66150	Glaucoma surgery		T	0234	24.0821	$1,533.86	$511.30	$306.77
66155	Glaucoma surgery		T	0234	24.0821	$1,533.86	$511.30	$306.77
66160	Glaucoma surgery		T	0234	24.0821	$1,533.86	$511.30	$306.77
66165	Glaucoma surgery		T	0234	24.0821	$1,533.86	$511.30	$306.77
66170	Glaucoma surgery		T	0234	24.0821	$1,533.86	$511.30	$306.77
66172	Incision of eye		T	0234	24.0821	$1,533.86	$511.30	$306.77
66180	Implant eye shunt		T	0673	40.8481	$2,601.74	$649.50	$520.35
66185	Revise eye shunt		T	0673	40.8481	$2,601.74	$649.50	$520.35
66220	Repair eye lesion		T	0672	38.1121	$2,427.47		$485.49
66225	Repair/graft eye lesion		T	0673	40.8481	$2,601.74	$649.50	$520.35
66250	Follow-up surgery of eye		T	0233	16.5252	$1,052.54	$266.30	$210.51
66500	Incision of iris		T	0232	5.1145	$325.76	$81.59	$65.15
66505	Incision of iris		T	0232	5.1145	$325.76	$81.59	$65.15
66600	Remove iris and lesion		T	0234	24.0821	$1,533.86	$511.30	$306.77
66605	Removal of iris		T	0234	24.0821	$1,533.86	$511.30	$306.77
66625	Removal of iris		T	0232	5.1145	$325.76	$81.59	$65.15

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
66630	Removal of iris		T	0234	24.0821	$1,533.86	$511.30	$306.77
66635	Removal of iris		T	0234	24.0821	$1,533.86	$511.30	$306.77
66680	Repair iris & ciliary body		T	0234	24.0821	$1,533.86	$511.30	$306.77
66682	Repair iris & ciliary body		T	0234	24.0821	$1,533.86	$511.30	$306.77
66700	Destruction, ciliary body		T	0233	16.5252	$1,052.54	$266.30	$210.51
66710	Ciliary transsleral therapy		T	0233	16.5252	$1,052.54	$266.30	$210.51
66711	Ciliary endoscopic ablation		T	0233	16.5252	$1,052.54	$266.30	$210.51
66720	Destruction, ciliary body		T	0233	16.5252	$1,052.54	$266.30	$210.51
66740	Destruction, ciliary body		T	0234	24.0821	$1,533.86	$511.30	$306.77
66761	Revision of iris		T	0247	5.2389	$333.68	$104.30	$66.74
66762	Revision of iris		T	0247	5.2389	$333.68	$104.30	$66.74
66770	Removal of inner eye lesion		T	0247	5.2389	$333.68	$104.30	$66.74
66820	Incision, secondary cataract		T	0232	5.1145	$325.76	$81.59	$65.15
66821	After cataract laser surgery		T	0247	5.2389	$333.68	$104.30	$66.74
66825	Reposition intraocular lens		T	0234	24.0821	$1,533.86	$511.30	$306.77
66830	Removal of lens lesion		T	0232	5.1145	$325.76	$81.59	$65.15
66840	Removal of lens material		T	0245	14.9022	$949.17	$217.00	$189.83
66850	Removal of lens material		T	0249	29.7487	$1,894.78	$524.60	$378.96
66852	Removal of lens material		T	0249	29.7487	$1,894.78	$524.60	$378.96
66920	Extraction of lens		T	0249	29.7487	$1,894.78	$524.60	$378.96
66930	Extraction of lens		T	0249	29.7487	$1,894.78	$524.60	$378.96
66940	Extraction of lens		T	0245	14.9022	$949.17	$217.00	$189.83
66982	Cataract surgery, complex		T	0246	24.2197	$1,542.63	$495.90	$308.53
66983	Cataract surg w/iol, 1 stage		T	0246	24.2197	$1,542.63	$495.90	$308.53
66984	Cataract surg w/iol, 1 stage		T	0246	24.2197	$1,542.63	$495.90	$308.53
66985	Insert lens prosthesis		T	0246	24.2197	$1,542.63	$495.90	$308.53
66986	Exchange lens prosthesis		T	0246	24.2197	$1,542.63	$495.90	$308.53
66990	Ophthalmic endoscope add-on		N					
66999	Eye surgery procedure		T	0232	5.1145	$325.76	$81.59	$65.15
67005	Partial removal of eye fluid		T	0237	29.0019	$1,847.22		$369.44
67010	Partial removal of eye fluid		T	0237	29.0019	$1,847.22		$369.44
67015	Release of eye fluid		T	0237	29.0019	$1,847.22		$369.44
67025	Replace eye fluid		T	0237	29.0019	$1,847.22		$369.44
67027	Implant eye drug system		T	0672	38.1121	$2,427.47		$485.49
67028	Injection eye drug	CH	S	0231	2.3117	$147.24		$29.45
67030	Incise inner eye strands		T	0236	18.8779	$1,202.39		$240.48
67031	Laser surgery, eye strands		T	0247	5.2389	$333.68	$104.30	$66.74
67036	Removal of inner eye fluid		T	0672	38.1121	$2,427.47		$485.49
67038	Strip retinal membrane		T	0672	38.1121	$2,427.47		$485.49
67039	Laser treatment of retina		T	0672	38.1121	$2,427.47		$485.49
67040	Laser treatment of retina		T	0672	38.1121	$2,427.47		$485.49
67101	Repair detached retina		T	0236	18.8779	$1,202.39		$240.48
67105	Repair detached retina	CH	T	0247	5.2389	$333.68	$104.30	$66.74
67107	Repair detached retina		T	0672	38.1121	$2,427.47		$485.49
67108	Repair detached retina		T	0672	38.1121	$2,427.47		$485.49
67110	Repair detached retina		T	0236	18.8779	$1,202.39		$240.48
67112	Rerepair detached retina		T	0672	38.1121	$2,427.47		$485.49
67115	Release encircling material		T	0236	18.8779	$1,202.39		$240.48
67120	Remove eye implant material		T	0236	18.8779	$1,202.39		$240.48
67121	Remove eye implant material		T	0237	29.0019	$1,847.22		$369.44
67141	Treatment of retina		T	0235	4.01	$255.41	$58.90	$51.08
67145	Treatment of retina	CH	T	0247	5.2389	$333.68	$104.30	$66.74
67208	Treatment of retinal lesion		T	0236	18.8779	$1,202.39		$240.48
67210	Treatment of retinal lesion	CH	T	0247	5.2389	$333.68	$104.30	$66.74
67218	Treatment of retinal lesion		T	0236	18.8779	$1,202.39		$240.48
67220	Treatment of choroid lesion		T	0235	4.01	$255.41	$58.90	$51.08
67221	Ocular photodynamic ther		T	0235	4.01	$255.41	$58.90	$51.08
67225	Eye photodynamic ther add-on		T	0235	4.01	$255.41	$58.90	$51.08
67227	Treatment of retinal lesion		T	0237	29.0019	$1,847.22		$369.44
67228	Treatment of retinal lesion	CH	T	0247	5.2389	$333.68	$104.30	$66.74
67250	Reinforce eye wall		T	0240	19.228	$1,224.69	$309.50	$244.94
67255	Reinforce/graft eye wall		T	0237	29.0019	$1,847.22		$369.44
67299	Eye surgery procedure		T	0235	4.01	$255.41	$58.90	$51.08
67311	Revise eye muscle		T	0243	24.392	$1,553.60	$430.30	$310.72
67312	Revise two eye muscles		T	0243	24.392	$1,553.60	$430.30	$310.72
67314	Revise eye muscle		T	0243	24.392	$1,553.60	$430.30	$310.72
67316	Revise two eye muscles		T	0243	24.392	$1,553.60	$430.30	$310.72
67318	Revise eye muscle(s)		T	0243	24.392	$1,553.60	$430.30	$310.72
67320	Revise eye muscle(s) add-on		T	0243	24.392	$1,553.60	$430.30	$310.72
67331	Eye surgery follow-up add-on		T	0243	24.392	$1,553.60	$430.30	$310.72
67332	Rerevise eye muscles add-on		T	0243	24.392	$1,553.60	$430.30	$310.72
67334	Revise eye muscle w/suture		T	0243	24.392	$1,553.60	$430.30	$310.72
67335	Eye suture during surgery		T	0243	24.392	$1,553.60	$430.30	$310.72
67340	Revise eye muscle add-on		T	0243	24.392	$1,553.60	$430.30	$310.72
67343	Release eye tissue		T	0243	24.392	$1,553.60	$430.30	$310.72
67345	Destroy nerve of eye muscle		T	0238	2.8636	$182.39		$36.48
67346	Biopsy, eye muscle		T	0699	14.2784	$909.43		$181.89
67399	Eye muscle surgery procedure		T	0243	24.392	$1,553.60	$430.30	$310.72

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
67400	Explore/biopsy eye socket		T	0241	24.8916	$1,585.42	$384.40	$317.08
67405	Explore/drain eye socket		T	0241	24.8916	$1,585.42	$384.40	$317.08
67412	Explore/treat eye socket		T	0241	24.8916	$1,585.42	$384.40	$317.08
67413	Explore/treat eye socket		T	0241	24.8916	$1,585.42	$384.40	$317.08
67414	Explr/decompress eye socket		T	0242	37.3504	$2,378.96	$597.30	$475.79
67415	Aspiration, orbital contents		T	0240	19.228	$1,224.69	$309.50	$244.94
67420	Explore/treat eye socket		T	0242	37.3504	$2,378.96	$597.30	$475.79
67430	Explore/treat eye socket		T	0242	37.3504	$2,378.96	$597.30	$475.79
67440	Explore/drain eye socket		T	0242	37.3504	$2,378.96	$597.30	$475.79
67445	Explr/decompress eye socket		T	0242	37.3504	$2,378.96	$597.30	$475.79
67450	Explore/biopsy eye socket		T	0242	37.3504	$2,378.96	$597.30	$475.79
67500	Inject/treat eye socket		S	0231	2.3117	$147.24		$29.45
67505	Inject/treat eye socket		T	0238	2.8636	$182.39		$36.48
67515	Inject/treat eye socket		T	0238	2.8636	$182.39		$36.48
67550	Insert eye socket implant		T	0242	37.3504	$2,378.96	$597.30	$475.79
67560	Revise eye socket implant		T	0241	24.8916	$1,585.42	$384.40	$317.08
67570	Decompress optic nerve		T	0242	37.3504	$2,378.96	$597.30	$475.79
67599	Orbit surgery procedure		T	0238	2.8636	$182.39		$36.48
67700	Drainage of eyelid abscess		T	0238	2.8636	$182.39		$36.48
67710	Incision of eyelid		T	0239	7.1099	$452.85		$90.57
67715	Incision of eyelid fold		T	0240	19.228	$1,224.69	$309.50	$244.94
67800	Remove eyelid lesion		T	0238	2.8636	$182.39		$36.48
67801	Remove eyelid lesions		T	0239	7.1099	$452.85		$90.57
67805	Remove eyelid lesions		T	0238	2.8636	$182.39		$36.48
67808	Remove eyelid lesion(s)		T	0240	19.228	$1,224.69	$309.50	$244.94
67810	Biopsy of eyelid		T	0238	2.8636	$182.39		$36.48
67820	Revise eyelashes		S	0698	1.1576	$73.73		$14.75
67825	Revise eyelashes		T	0238	2.8636	$182.39		$36.48
67830	Revise eyelashes		T	0239	7.1099	$452.85		$90.57
67835	Revise eyelashes		T	0240	19.228	$1,224.69	$309.50	$244.94
67840	Remove eyelid lesion		T	0239	7.1099	$452.85		$90.57
67850	Treat eyelid lesion		T	0239	7.1099	$452.85		$90.57
67875	Closure of eyelid by suture		T	0239	7.1099	$452.85		$90.57
67880	Revision of eyelid		T	0233	16.5252	$1,052.54	$266.30	$210.51
67882	Revision of eyelid		T	0240	19.228	$1,224.69	$309.50	$244.94
67900	Repair brow defect		T	0240	19.228	$1,224.69	$309.50	$244.94
67901	Repair eyelid defect		T	0240	19.228	$1,224.69	$309.50	$244.94
67902	Repair eyelid defect		T	0240	19.228	$1,224.69	$309.50	$244.94
67903	Repair eyelid defect		T	0240	19.228	$1,224.69	$309.50	$244.94
67904	Repair eyelid defect		T	0240	19.228	$1,224.69	$309.50	$244.94
67906	Repair eyelid defect		T	0240	19.228	$1,224.69	$309.50	$244.94
67908	Repair eyelid defect		T	0240	19.228	$1,224.69	$309.50	$244.94
67909	Revise eyelid defect		T	0240	19.228	$1,224.69	$309.50	$244.94
67911	Revise eyelid defect		T	0240	19.228	$1,224.69	$309.50	$244.94
67912	Correction eyelid w/implant		T	0240	19.228	$1,224.69	$309.50	$244.94
67914	Repair eyelid defect		T	0240	19.228	$1,224.69	$309.50	$244.94
67915	Repair eyelid defect		T	0240	19.228	$1,224.69	$309.50	$244.94
67916	Repair eyelid defect		T	0240	19.228	$1,224.69	$309.50	$244.94
67917	Repair eyelid defect		T	0240	19.228	$1,224.69	$309.50	$244.94
67921	Repair eyelid defect		T	0240	19.228	$1,224.69	$309.50	$244.94
67922	Repair eyelid defect		T	0240	19.228	$1,224.69	$309.50	$244.94
67923	Repair eyelid defect		T	0240	19.228	$1,224.69	$309.50	$244.94
67924	Repair eyelid defect		T	0240	19.228	$1,224.69	$309.50	$244.94
67930	Repair eyelid wound		T	0240	19.228	$1,224.69	$309.50	$244.94
67935	Repair eyelid wound		T	0240	19.228	$1,224.69	$309.50	$244.94
67938	Remove eyelid foreign body		S	0698	1.1576	$73.73		$14.75
67950	Revision of eyelid		T	0240	19.228	$1,224.69	$309.50	$244.94
67961	Revision of eyelid		T	0240	19.228	$1,224.69	$309.50	$244.94
67966	Revision of eyelid		T	0240	19.228	$1,224.69	$309.50	$244.94
67971	Reconstruction of eyelid		T	0241	24.8916	$1,585.42	$384.40	$317.08
67973	Reconstruction of eyelid		T	0241	24.8916	$1,585.42	$384.40	$317.08
67974	Reconstruction of eyelid		T	0241	24.8916	$1,585.42	$384.40	$317.08
67975	Reconstruction of eyelid		T	0240	19.228	$1,224.69	$309.50	$244.94
67999	Revision of eyelid		T	0238	2.8636	$182.39		$36.48
68020	Incise/drain eyelid lining		T	0240	19.228	$1,224.69	$309.50	$244.94
68040	Treatment of eyelid lesions		S	0698	1.1576	$73.73		$14.75
68100	Biopsy of eyelid lining		T	0232	5.1145	$325.76	$81.59	$65.15
68110	Remove eyelid lining lesion		T	0699	14.2784	$909.43		$181.89
68115	Remove eyelid lining lesion		T	0240	19.228	$1,224.69	$309.50	$244.94
68130	Remove eyelid lining lesion		T	0233	16.5252	$1,052.54	$266.30	$210.51
68135	Remove eyelid lining lesion		T	0239	7.1099	$452.85		$90.57
68200	Treat eyelid by injection		S	0230	0.7379	$47.00		$9.40
68320	Revise/graft eyelid lining		T	0240	19.228	$1,224.69	$309.50	$244.94
68325	Revise/graft eyelid lining		T	0241	24.8916	$1,585.42	$384.40	$317.08
68326	Revise/graft eyelid lining		T	0241	24.8916	$1,585.42	$384.40	$317.08
68328	Revise/graft eyelid lining		T	0241	24.8916	$1,585.42	$384.40	$317.08
68330	Revise eyelid lining		T	0234	24.0821	$1,533.86	$511.30	$306.77
68335	Revise/graft eyelid lining		T	0241	24.8916	$1,585.42	$384.40	$317.08

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
68340	Separate eyelid adhesions		T	0240	19.228	$1,224.69	$309.50	$244.94
68360	Revise eyelid lining		T	0234	24.0821	$1,533.86	$511.30	$306.77
68362	Revise eyelid lining		T	0234	24.0821	$1,533.86	$511.30	$306.77
68371	Harvest eye tissue, alograft		T	0233	16.5252	$1,052.54	$266.30	$210.51
68399	Eyelid lining surgery		T	0238	2.8636	$182.39		$36.48
68400	Incise/drain tear gland		T	0238	2.8636	$182.39		$36.48
68420	Incise/drain tear sac		T	0240	19.228	$1,224.69	$309.50	$244.94
68440	Incise tear duct opening		T	0238	2.8636	$182.39		$36.48
68500	Removal of tear gland		T	0241	24.8916	$1,585.42	$384.40	$317.08
68505	Partial removal, tear gland		T	0241	24.8916	$1,585.42	$384.40	$317.08
68510	Biopsy of tear gland		T	0240	19.228	$1,224.69	$309.50	$244.94
68520	Removal of tear sac		T	0241	24.8916	$1,585.42	$384.40	$317.08
68525	Biopsy of tear sac		T	0240	19.228	$1,224.69	$309.50	$244.94
68530	Clearance of tear duct		T	0240	19.228	$1,224.69	$309.50	$244.94
68540	Remove tear gland lesion		T	0241	24.8916	$1,585.42	$384.40	$317.08
68550	Remove tear gland lesion		T	0241	24.8916	$1,585.42	$384.40	$317.08
68700	Repair tear ducts		T	0241	24.8916	$1,585.42	$384.40	$317.08
68705	Revise tear duct opening		T	0238	2.8636	$182.39		$36.48
68720	Create tear sac drain		T	0241	24.8916	$1,585.42	$384.40	$317.08
68745	Create tear duct drain		T	0241	24.8916	$1,585.42	$384.40	$317.08
68750	Create tear duct drain		T	0241	24.8916	$1,585.42	$384.40	$317.08
68760	Close tear duct opening		S	0231	2.3117	$147.24		$29.45
68761	Close tear duct opening		S	0231	2.3117	$147.24		$29.45
68770	Close tear system fistula		T	0240	19.228	$1,224.69	$309.50	$244.94
68801	Dilate tear duct opening		S	0698	1.1576	$73.73		$14.75
68810	Probe nasolacrimal duct		S	0231	2.3117	$147.24		$29.45
68811	Probe nasolacrimal duct		T	0240	19.228	$1,224.69	$309.50	$244.94
68815	Probe nasolacrimal duct		T	0240	19.228	$1,224.69	$309.50	$244.94
68840	Explore/irrigate tear ducts		S	0698	1.1576	$73.73		$14.75
68850	Injection for tear sac x-ray		N					
68899	Tear duct system surgery		T	0238	2.8636	$182.39		$36.48
69000	Drain external ear lesion		T	0006	1.463	$93.18		$18.64
69005	Drain external ear lesion		T	0008	19.0457	$1,213.08		$242.62
69020	Drain outer ear canal lesion		T	0006	1.463	$93.18		$18.64
69090	Pierce earlobes		E					
69100	Biopsy of external ear	CH	T	0251	2.5765	$164.11		$32.82
69105	Biopsy of external ear canal		T	0253	16.6341	$1,059.48	$282.20	$211.90
69110	Remove external ear, partial		T	0021	16.5832	$1,056.23	$219.40	$211.25
69120	Removal of external ear		T	0254	24.3535	$1,551.15	$321.30	$310.23
69140	Remove ear canal lesion(s)		T	0254	24.3535	$1,551.15	$321.30	$310.23
69145	Remove ear canal lesion(s)		T	0021	16.5832	$1,056.23	$219.40	$211.25
69150	Extensive ear canal surgery		T	0252	7.6539	$487.50	$109.10	$97.50
69155	Extensive ear/neck surgery		C					
69200	Clear outer ear canal		X	0340	0.6416	$40.87		$8.17
69205	Clear outer ear canal		T	0022	21.4534	$1,366.43	$354.40	$273.29
69210	Remove impacted ear wax		X	0340	0.6416	$40.87		$8.17
69220	Clean out mastoid cavity	CH	T	0013	0.8046	$51.25		$10.25
69222	Clean out mastoid cavity	CH	T	0253	16.6341	$1,059.48	$282.20	$211.90
69300	Revise external ear		T	0254	24.3535	$1,551.15	$321.30	$310.23
69310	Rebuild outer ear canal		T	0256	40.5598	$2,583.38		$516.68
69320	Rebuild outer ear canal		T	0256	40.5598	$2,583.38		$516.68
69399	Outer ear surgery procedure		T	0251	2.5765	$164.11		$32.82
69400	Inflate middle ear canal		T	0251	2.5765	$164.11		$32.82
69401	Inflate middle ear canal		T	0251	2.5765	$164.11		$32.82
69405	Catheterize middle ear canal		T	0252	7.6539	$487.50	$109.10	$97.50
69420	Incision of eardrum		T	0251	2.5765	$164.11		$32.82
69421	Incision of eardrum		T	0253	16.6341	$1,059.48	$282.20	$211.90
69424	Remove ventilating tube	CH	T	0253	16.6341	$1,059.48	$282.20	$211.90
69433	Create eardrum opening		T	0252	7.6539	$487.50	$109.10	$97.50
69436	Create eardrum opening		T	0253	16.6341	$1,059.48	$282.20	$211.90
69440	Exploration of middle ear		T	0254	24.3535	$1,551.15	$321.30	$310.23
69450	Eardrum revision		T	0256	40.5598	$2,583.38		$516.68
69501	Mastoidectomy		T	0256	40.5598	$2,583.38		$516.68
69502	Mastoidectomy		T	0254	24.3535	$1,551.15	$321.30	$310.23
69505	Remove mastoid structures		T	0256	40.5598	$2,583.38		$516.68
69511	Extensive mastoid surgery		T	0256	40.5598	$2,583.38		$516.68
69530	Extensive mastoid surgery		T	0256	40.5598	$2,583.38		$516.68
69535	Remove part of temporal bone		C					
69540	Remove ear lesion		T	0253	16.6341	$1,059.48	$282.20	$211.90
69550	Remove ear lesion		T	0256	40.5598	$2,583.38		$516.68
69552	Remove ear lesion		T	0256	40.5598	$2,583.38		$516.68
69554	Remove ear lesion		C					
69601	Mastoid surgery revision		T	0256	40.5598	$2,583.38		$516.68
69602	Mastoid surgery revision		T	0256	40.5598	$2,583.38		$516.68
69603	Mastoid surgery revision		T	0256	40.5598	$2,583.38		$516.68
69604	Mastoid surgery revision		T	0256	40.5598	$2,583.38		$516.68
69605	Mastoid surgery revision		T	0256	40.5598	$2,583.38		$516.68
69610	Repair of eardrum		T	0254	24.3535	$1,551.15	$321.30	$310.23

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
69620	Repair of eardrum		T	0254	24.3535	$1,551.15	$321.30	$310.23
69631	Repair eardrum structures		T	0256	40.5598	$2,583.38		$516.68
69632	Rebuild eardrum structures		T	0256	40.5598	$2,583.38		$516.68
69633	Rebuild eardrum structures		T	0256	40.5598	$2,583.38		$516.68
69635	Repair eardrum structures		T	0256	40.5598	$2,583.38		$516.68
69636	Rebuild eardrum structures		T	0256	40.5598	$2,583.38		$516.68
69637	Rebuild eardrum structures		T	0256	40.5598	$2,583.38		$516.68
69641	Revise middle ear & mastoid		T	0256	40.5598	$2,583.38		$516.68
69642	Revise middle ear & mastoid		T	0256	40.5598	$2,583.38		$516.68
69643	Revise middle ear & mastoid		T	0256	40.5598	$2,583.38		$516.68
69644	Revise middle ear & mastoid		T	0256	40.5598	$2,583.38		$516.68
69645	Revise middle ear & mastoid		T	0256	40.5598	$2,583.38		$516.68
69646	Revise middle ear & mastoid		T	0256	40.5598	$2,583.38		$516.68
69650	Release middle ear bone		T	0254	24.3535	$1,551.15	$321.30	$310.23
69660	Revise middle ear bone		T	0256	40.5598	$2,583.38		$516.68
69661	Revise middle ear bone		T	0256	40.5598	$2,583.38		$516.68
69662	Revise middle ear bone		T	0256	40.5598	$2,583.38		$516.68
69666	Repair middle ear structures		T	0256	40.5598	$2,583.38		$516.68
69667	Repair middle ear structures		T	0256	40.5598	$2,583.38		$516.68
69670	Remove mastoid air cells		T	0256	40.5598	$2,583.38		$516.68
69676	Remove middle ear nerve		T	0256	40.5598	$2,583.38		$516.68
69700	Close mastoid fistula		T	0256	40.5598	$2,583.38		$516.68
69710	Implant/replace hearing aid		E					
69711	Remove/repair hearing aid		T	0256	40.5598	$2,583.38		$516.68
69714	Implant temple bone w/stimul		T	0256	40.5598	$2,583.38		$516.68
69715	Temple bne implnt w/stimulat		T	0256	40.5598	$2,583.38		$516.68
69717	Temple bone implant revision		T	0256	40.5598	$2,583.38		$516.68
69718	Revise temple bone implant		T	0256	40.5598	$2,583.38		$516.68
69720	Release facial nerve		T	0256	40.5598	$2,583.38		$516.68
69725	Release facial nerve		T	0256	40.5598	$2,583.38		$516.68
69740	Repair facial nerve		T	0256	40.5598	$2,583.38		$516.68
69745	Repair facial nerve		T	0256	40.5598	$2,583.38		$516.68
69799	Middle ear surgery procedure		T	0251	2.5765	$164.11		$32.82
69801	Incise inner ear		T	0256	40.5598	$2,583.38		$516.68
69802	Incise inner ear		T	0256	40.5598	$2,583.38		$516.68
69805	Explore inner ear		T	0256	40.5598	$2,583.38		$516.68
69806	Explore inner ear		T	0256	40.5598	$2,583.38		$516.68
69820	Establish inner ear window		T	0256	40.5598	$2,583.38		$516.68
69840	Revise inner ear window		T	0256	40.5598	$2,583.38		$516.68
69905	Remove inner ear		T	0256	40.5598	$2,583.38		$516.68
69910	Remove inner ear & mastoid		T	0256	40.5598	$2,583.38		$516.68
69915	Incise inner ear nerve		T	0256	40.5598	$2,583.38		$516.68
69930	Implant cochlear device		T	0259	404.3379	$25,753.49	$8,698.40	$5,150.70
69949	Inner ear surgery procedure		T	0251	2.5765	$164.11		$32.82
69950	Incise inner ear nerve		C					
69955	Release facial nerve		T	0256	40.5598	$2,583.38		$516.68
69960	Release inner ear canal		T	0256	40.5598	$2,583.38		$516.68
69970	Remove inner ear lesion	CH	T	0256	40.5598	$2,583.38		$516.68
69979	Temporal bone surgery		T	0251	2.5765	$164.11		$32.82
69990	Microsurgery add-on		N					
70010	Contrast x-ray of brain	CH	Q	0274	3.9008	$248.45	$62.80	$49.69
70015	Contrast x-ray of brain	CH	Q	0274	3.9008	$248.45	$62.80	$49.69
70030	X-ray eye for foreign body		X	0260	0.7259	$46.23		$9.25
70100	X-ray exam of jaw		X	0260	0.7259	$46.23		$9.25
70110	X-ray exam of jaw		X	0260	0.7259	$46.23		$9.25
70120	X-ray exam of mastoids		X	0260	0.7259	$46.23		$9.25
70130	X-ray exam of mastoids		X	0260	0.7259	$46.23		$9.25
70134	X-ray exam of middle ear		X	0261	1.2024	$76.58		$15.32
70140	X-ray exam of facial bones		X	0260	0.7259	$46.23		$9.25
70150	X-ray exam of facial bones		X	0260	0.7259	$46.23		$9.25
70160	X-ray exam of nasal bones		X	0260	0.7259	$46.23		$9.25
70170	X-ray exam of tear duct	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
70190	X-ray exam of eye sockets		X	0260	0.7259	$46.23		$9.25
70200	X-ray exam of eye sockets		X	0260	0.7259	$46.23		$9.25
70210	X-ray exam of sinuses		X	0260	0.7259	$46.23		$9.25
70220	X-ray exam of sinuses		X	0260	0.7259	$46.23		$9.25
70240	X-ray exam, pituitary saddle		X	0260	0.7259	$46.23		$9.25
70250	X-ray exam of skull		X	0260	0.7259	$46.23		$9.25
70260	X-ray exam of skull		X	0261	1.2024	$76.58		$15.32
70300	X-ray exam of teeth		X	0262	0.5739	$36.55		$7.31
70310	X-ray exam of teeth		X	0262	0.5739	$36.55		$7.31
70320	Full mouth x-ray of teeth		X	0262	0.5739	$36.55		$7.31
70328	X-ray exam of jaw joint		X	0260	0.7259	$46.23		$9.25
70330	X-ray exam of jaw joints		X	0260	0.7259	$46.23		$9.25
70332	X-ray exam of jaw joint	CH	Q	0275	2.2785	$145.12	$44.13	$29.02
70336	Magnetic image, jaw joint		S	0335	5.0067	$318.89	$111.90	$63.78
70350	X-ray head for orthodontia		X	0260	0.7259	$46.23		$9.25
70355	Panoramic x-ray of jaws		X	0260	0.7259	$46.23		$9.25

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
70360	X-ray exam of neck		X	0260	0.7259	$46.23		$9.25
70370	Throat x-ray & fluoroscopy		X	0272	1.327	$84.52	$31.60	$16.90
70371	Speech evaluation, complex		X	0272	1.327	$84.52	$31.60	$16.90
70373	Contrast x-ray of larynx	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
70380	X-ray exam of salivary gland		X	0260	0.7259	$46.23		$9.25
70390	X-ray exam of salivary duct	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
70450	Ct head/brain w/o dye		S	0332	3.1487	$200.55	$75.20	$40.11
70460	Ct head/brain w/dye		S	0283	4.5485	$289.71	$100.30	$57.94
70470	Ct head/brain w/o & w/dye		S	0333	5.3374	$339.96	$119.00	$67.99
70480	Ct orbit/ear/fossa w/o dye		S	0332	3.1487	$200.55	$75.20	$40.11
70481	Ct orbit/ear/fossa w/dye		S	0283	4.5485	$289.71	$100.30	$57.94
70482	Ct orbit/ear/fossa w/o&w/dye		S	0333	5.3374	$339.96	$119.00	$67.99
70486	Ct maxillofacial w/o dye		S	0332	3.1487	$200.55	$75.20	$40.11
70487	Ct maxillofacial w/dye		S	0283	4.5485	$289.71	$100.30	$57.94
70488	Ct maxillofacial w/o & w/dye		S	0333	5.3374	$339.96	$119.00	$67.99
70490	Ct soft tissue neck w/o dye		S	0332	3.1487	$200.55	$75.20	$40.11
70491	Ct soft tissue neck w/dye		S	0283	4.5485	$289.71	$100.30	$57.94
70492	Ct sft tsue nck w/o & w/dye		S	0333	5.3374	$339.96	$119.00	$67.99
70496	Ct angiography, head		S	0662	5.2818	$336.41	$118.80	$67.28
70498	Ct angiography, neck		S	0662	5.2818	$336.41	$118.80	$67.28
70540	Mri orbit/face/neck w/o dye		S	0336	5.7101	$363.69	$139.50	$72.74
70542	Mri orbit/face/neck w/dye		S	0284	6.7963	$432.88	$148.40	$86.58
70543	Mri orbt/fac/nck w/o & w/dye		S	0337	8.6689	$552.15	$199.50	$110.43
70544	Mr angiography head w/o dye		S	0336	5.7101	$363.69	$139.50	$72.74
70545	Mr angiography head w/dye		S	0284	6.7963	$432.88	$148.40	$86.58
70546	Mr angiograph head w/o&w/dye		S	0337	8.6689	$552.15	$199.50	$110.43
70547	Mr angiography neck w/o dye		S	0336	5.7101	$363.69	$139.50	$72.74
70548	Mr angiography neck w/dye		S	0284	6.7963	$432.88	$148.40	$86.58
70549	Mr angiograph neck w/o&w/dye		S	0337	8.6689	$552.15	$199.50	$110.43
70551	Mri brain w/o dye		S	0336	5.7101	$363.69	$139.50	$72.74
70552	Mri brain w/dye		S	0284	6.7963	$432.88	$148.40	$86.58
70553	Mri brain w/o & w/dye		S	0337	8.6689	$552.15	$199.50	$110.43
70554	Fmri brain by tech		S	0336	5.7101	$363.69	$139.50	$72.74
70555	Fmri brain by phys/psych		S	0336	5.7101	$363.69	$139.50	$72.74
70557	Mri brain w/o dye		S	0336	5.7101	$363.69	$139.50	$72.74
70558	Mri brain w/dye		S	0284	6.7963	$432.88	$148.40	$86.58
70559	Mri brain w/o & w/dye		S	0337	8.6689	$552.15	$199.50	$110.43
71010	Chest x-ray		X	0260	0.7259	$46.23		$9.25
71015	Chest x-ray		X	0260	0.7259	$46.23		$9.25
71020	Chest x-ray		X	0260	0.7259	$46.23		$9.25
71021	Chest x-ray		X	0260	0.7259	$46.23		$9.25
71022	Chest x-ray		X	0260	0.7259	$46.23		$9.25
71023	Chest x-ray and fluoroscopy		X	0272	1.327	$84.52	$31.60	$16.90
71030	Chest x-ray		X	0260	0.7259	$46.23		$9.25
71034	Chest x-ray and fluoroscopy		X	0272	1.327	$84.52	$31.60	$16.90
71035	Chest x-ray		X	0260	0.7259	$46.23		$9.25
71040	Contrast x-ray of bronchi	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
71060	Contrast x-ray of bronchi	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
71090	X-ray & pacemaker insertion	CH	N					
71100	X-ray exam of ribs		X	0260	0.7259	$46.23		$9.25
71101	X-ray exam of ribs/chest		X	0260	0.7259	$46.23		$9.25
71110	X-ray exam of ribs		X	0260	0.7259	$46.23		$9.25
71111	X-ray exam of ribs/chest		X	0261	1.2024	$76.58		$15.32
71120	X-ray exam of breastbone		X	0260	0.7259	$46.23		$9.25
71130	X-ray exam of breastbone		X	0260	0.7259	$46.23		$9.25
71250	Ct thorax w/o dye		S	0332	3.1487	$200.55	$75.20	$40.11
71260	Ct thorax w/dye		S	0283	4.5485	$289.71	$100.30	$57.94
71270	Ct thorax w/o & w/dye		S	0333	5.3374	$339.96	$119.00	$67.99
71275	Ct angiography, chest		S	0662	5.2818	$336.41	$118.80	$67.28
71550	Mri chest w/o dye		S	0336	5.7101	$363.69	$139.50	$72.74
71551	Mri chest w/dye		S	0284	6.7963	$432.88	$148.40	$86.58
71552	Mri chest w/o & w/dye		S	0337	8.6689	$552.15	$199.50	$110.43
71555	Mri angio chest w or w/o dye		B					
72010	X-ray exam of spine		X	0260	0.7259	$46.23		$9.25
72020	X-ray exam of spine		X	0260	0.7259	$46.23		$9.25
72040	X-ray exam of neck spine		X	0260	0.7259	$46.23		$9.25
72050	X-ray exam of neck spine		X	0261	1.2024	$76.58		$15.32
72052	X-ray exam of neck spine		X	0261	1.2024	$76.58		$15.32
72069	X-ray exam of trunk spine		X	0260	0.7259	$46.23		$9.25
72070	X-ray exam of thoracic spine		X	0260	0.7259	$46.23		$9.25
72072	X-ray exam of thoracic spine		X	0260	0.7259	$46.23		$9.25
72074	X-ray exam of thoracic spine		X	0260	0.7259	$46.23		$9.25
72080	X-ray exam of trunk spine		X	0260	0.7259	$46.23		$9.25
72090	X-ray exam of trunk spine		X	0261	1.2024	$76.58		$15.32
72100	X-ray exam of lower spine		X	0260	0.7259	$46.23		$9.25
72110	X-ray exam of lower spine		X	0261	1.2024	$76.58		$15.32
72114	X-ray exam of lower spine		X	0261	1.2024	$76.58		$15.32
72120	X-ray exam of lower spine		X	0261	1.2024	$76.58		$15.32

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
72125	Ct neck spine w/o dye		S	0332	3.1487	$200.55	$75.20	$40.11
72126	Ct neck spine w/dye	CH	S	0316	11.7923	$751.09	$300.26	$150.22
72127	Ct neck spine w/o & w/dye		S	0333	5.3374	$339.96	$119.00	$67.99
72128	Ct chest spine w/o dye		S	0332	3.1487	$200.55	$75.20	$40.11
72129	Ct chest spine w/dye		S	0283	4.5485	$289.71	$100.30	$57.94
72130	Ct chest spine w/o & w/dye		S	0333	5.3374	$339.96	$119.00	$67.99
72131	Ct lumbar spine w/o dye		S	0332	3.1487	$200.55	$75.20	$40.11
72132	Ct lumbar spine w/dye	CH	S	0316	11.7923	$751.09	$300.26	$150.22
72133	Ct lumbar spine w/o & w/dye		S	0333	5.3374	$339.96	$119.00	$67.99
72141	Mri neck spine w/o dye		S	0336	5.7101	$363.69	$139.50	$72.74
72142	Mri neck spine w/dye		S	0284	6.7963	$432.88	$148.40	$86.58
72146	Mri chest spine w/o dye		S	0336	5.7101	$363.69	$139.50	$72.74
72147	Mri chest spine w/dye		S	0284	6.7963	$432.88	$148.40	$86.58
72148	Mri lumbar spine w/o dye		S	0336	5.7101	$363.69	$139.50	$72.74
72149	Mri lumbar spine w/dye		S	0284	6.7963	$432.88	$148.40	$86.58
72156	Mri neck spine w/o & w/dye		S	0337	8.6689	$552.15	$199.50	$110.43
72157	Mri chest spine w/o & w/dye		S	0337	8.6689	$552.15	$199.50	$110.43
72158	Mri lumbar spine w/o & w/dye		S	0337	8.6689	$552.15	$199.50	$110.43
72159	Mr angio spine w/o&w/dye		E					
72170	X-ray exam of pelvis		X	0260	0.7259	$46.23		$9.25
72190	X-ray exam of pelvis		X	0260	0.7259	$46.23		$9.25
72191	Ct angiograph pelv w/o&w/dye		S	0662	5.2818	$336.41	$118.80	$67.28
72192	Ct pelvis w/o dye		S	0332	3.1487	$200.55	$75.20	$40.11
72193	Ct pelvis w/dye		S	0283	4.5485	$289.71	$100.30	$57.94
72194	Ct pelvis w/o & w/dye		S	0333	5.3374	$339.96	$119.00	$67.99
72195	Mri pelvis w/o dye		S	0336	5.7101	$363.69	$139.50	$72.74
72196	Mri pelvis w/dye		S	0284	6.7963	$432.88	$148.40	$86.58
72197	Mri pelvis w/o & w/dye		S	0337	8.6689	$552.15	$199.50	$110.43
72198	Mr angio pelvis w/o & w/dye		B					
72200	X-ray exam sacroiliac joints		X	0260	0.7259	$46.23		$9.25
72202	X-ray exam sacroiliac joints		X	0260	0.7259	$46.23		$9.25
72220	X-ray exam of tailbone		X	0260	0.7259	$46.23		$9.25
72240	Contrast x-ray of neck spine	CH	Q	0274	3.9008	$248.45	$62.80	$49.69
72255	Contrast x-ray, thorax spine	CH	Q	0274	3.9008	$248.45	$62.80	$49.69
72265	Contrast x-ray, lower spine	CH	Q	0274	3.9008	$248.45	$62.80	$49.69
72270	Contrast x-ray, spine	CH	Q	0274	3.9008	$248.45	$62.80	$49.69
72275	Epidurography	CH	N					
72285	X-ray c/t spine disk	CH	Q	0388	9.03	$575.15	$169.68	$115.03
72291	Perq vertebroplasty, fluor	CH	N					
72292	Perq vertebroplasty, ct	CH	N					
72295	X-ray of lower spine disk	CH	Q	0388	9.03	$575.15	$169.68	$115.03
73000	X-ray exam of collar bone		X	0260	0.7259	$46.23		$9.25
73010	X-ray exam of shoulder blade		X	0260	0.7259	$46.23		$9.25
73020	X-ray exam of shoulder		X	0260	0.7259	$46.23		$9.25
73030	X-ray exam of shoulder		X	0260	0.7259	$46.23		$9.25
73040	Contrast x-ray of shoulder	CH	Q	0275	2.2785	$145.12	$44.13	$29.02
73050	X-ray exam of shoulders		X	0260	0.7259	$46.23		$9.25
73060	X-ray exam of humerus		X	0260	0.7259	$46.23		$9.25
73070	X-ray exam of elbow		X	0260	0.7259	$46.23		$9.25
73080	X-ray exam of elbow		X	0260	0.7259	$46.23		$9.25
73085	Contrast x-ray of elbow	CH	Q	0275	2.2785	$145.12	$44.13	$29.02
73090	X-ray exam of forearm		X	0260	0.7259	$46.23		$9.25
73092	X-ray exam of arm, infant		X	0260	0.7259	$46.23		$9.25
73100	X-ray exam of wrist		X	0260	0.7259	$46.23		$9.25
73110	X-ray exam of wrist		X	0260	0.7259	$46.23		$9.25
73115	Contrast x-ray of wrist	CH	Q	0275	2.2785	$145.12	$44.13	$29.02
73120	X-ray exam of hand		X	0260	0.7259	$46.23		$9.25
73130	X-ray exam of hand		X	0260	0.7259	$46.23		$9.25
73140	X-ray exam of finger(s)		X	0260	0.7259	$46.23		$9.25
73200	Ct upper extremity w/o dye		S	0332	3.1487	$200.55	$75.20	$40.11
73201	Ct upper extremity w/dye		S	0283	4.5485	$289.71	$100.30	$57.94
73202	Ct uppr extremity w/o&w/dye		S	0333	5.3374	$339.96	$119.00	$67.99
73206	Ct angio upr extrm w/o&w/dye		S	0662	5.2818	$336.41	$118.80	$67.28
73218	Mri upper extremity w/o dye		S	0336	5.7101	$363.69	$139.50	$72.74
73219	Mri upper extremity w/dye		S	0284	6.7963	$432.88	$148.40	$86.58
73220	Mri uppr extremity w/o&w/dye		S	0337	8.6689	$552.15	$199.50	$110.43
73221	Mri joint upr extrem w/o dye		S	0336	5.7101	$363.69	$139.50	$72.74
73222	Mri joint upr extrem w/dye		S	0284	6.7963	$432.88	$148.40	$86.58
73223	Mri joint upr extr w/o&w/dye		S	0337	8.6689	$552.15	$199.50	$110.43
73225	Mr angio upr extr w/o&w/dye		E					
73500	X-ray exam of hip		X	0260	0.7259	$46.23		$9.25
73510	X-ray exam of hip		X	0260	0.7259	$46.23		$9.25
73520	X-ray exam of hips		X	0261	1.2024	$76.58		$15.32
73525	Contrast x-ray of hip	CH	Q	0275	2.2785	$145.12	$44.13	$29.02
73530	X-ray exam of hip	CH	N					
73540	X-ray exam of pelvis & hips		X	0260	0.7259	$46.23		$9.25
73542	X-ray exam, sacroiliac joint	CH	Q	0275	2.2785	$145.12	$44.13	$29.02
73550	X-ray exam of thigh		X	0260	0.7259	$46.23		$9.25

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
73560	X-ray exam of knee, 1 or 2		X	0260	0.7259	$46.23		$9.25
73562	X-ray exam of knee, 3		X	0260	0.7259	$46.23		$9.25
73564	X-ray exam, knee, 4 or more		X	0260	0.7259	$46.23		$9.25
73565	X-ray exam of knees		X	0260	0.7259	$46.23		$9.25
73580	Contrast x-ray of knee joint	CH	Q	0275	2.2785	$145.12	$44.13	$29.02
73590	X-ray exam of lower leg		X	0260	0.7259	$46.23		$9.25
73592	X-ray exam of leg, infant		X	0260	0.7259	$46.23		$9.25
73600	X-ray exam of ankle		X	0260	0.7259	$46.23		$9.25
73610	X-ray exam of ankle		X	0260	0.7259	$46.23		$9.25
73615	Contrast x-ray of ankle	CH	Q	0275	2.2785	$145.12	$44.13	$29.02
73620	X-ray exam of foot		X	0260	0.7259	$46.23		$9.25
73630	X-ray exam of foot		X	0260	0.7259	$46.23		$9.25
73650	X-ray exam of heel		X	0260	0.7259	$46.23		$9.25
73660	X-ray exam of toe(s)		X	0260	0.7259	$46.23		$9.25
73700	Ct lower extremity w/o dye		S	0332	3.1487	$200.55	$75.20	$40.11
73701	Ct lower extremity w/dye		S	0283	4.5485	$289.71	$100.30	$57.94
73702	Ct lwr extremity w/o&w/dye		S	0333	5.3374	$339.96	$119.00	$67.99
73706	Ct angio lwr extr w/o&w/dye		S	0662	5.2818	$336.41	$118.80	$67.28
73718	Mri lower extremity w/o dye		S	0336	5.7101	$363.69	$139.50	$72.74
73719	Mri lower extremity w/dye		S	0284	6.7963	$432.88	$148.40	$86.58
73720	Mri lwr extremity w/o&w/dye		S	0337	8.6689	$552.15	$199.50	$110.43
73721	Mri jnt of lwr extre w/o dye		S	0336	5.7101	$363.69	$139.50	$72.74
73722	Mri joint of lwr extr w/dye		S	0284	6.7963	$432.88	$148.40	$86.58
73723	Mri joint lwr extr w/o&w/dye		S	0337	8.6689	$552.15	$199.50	$110.43
73725	Mr ang lwr ext w or w/o dye		B					
74000	X-ray exam of abdomen		X	0260	0.7259	$46.23		$9.25
74010	X-ray exam of abdomen		X	0260	0.7259	$46.23		$9.25
74020	X-ray exam of abdomen		X	0260	0.7259	$46.23		$9.25
74022	X-ray exam series, abdomen		X	0261	1.2024	$76.58		$15.32
74150	Ct abdomen w/o dye		S	0332	3.1487	$200.55	$75.20	$40.11
74160	Ct abdomen w/dye		S	0283	4.5485	$289.71	$100.30	$57.94
74170	Ct abdomen w/o & w/dye		S	0333	5.3374	$339.96	$119.00	$67.99
74175	Ct angio abdom w/o & w/dye		S	0662	5.2818	$336.41	$118.80	$67.28
74181	Mri abdomen w/o dye		S	0336	5.7101	$363.69	$139.50	$72.74
74182	Mri abdomen w/dye		S	0284	6.7963	$432.88	$148.40	$86.58
74183	Mri abdomen w/o & w/dye		S	0337	8.6689	$552.15	$199.50	$110.43
74185	Mri angio, abdom w orw/o dye		B					
74190	X-ray exam of peritoneum	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
74210	Contrst x-ray exam of throat		S	0276	1.4387	$91.64	$34.90	$18.33
74220	Contrast x-ray, esophagus		S	0276	1.4387	$91.64	$34.90	$18.33
74230	Cine/vid x-ray, throat/esoph		S	0276	1.4387	$91.64	$34.90	$18.33
74235	Remove esophagus obstruction	CH	N					
74240	X-ray exam, upper gi tract		S	0276	1.4387	$91.64	$34.90	$18.33
74241	X-ray exam, upper gi tract		S	0276	1.4387	$91.64	$34.90	$18.33
74245	X-ray exam, upper gi tract		S	0277	2.2875	$145.70	$54.50	$29.14
74246	Contrst x-ray uppr gi tract		S	0276	1.4387	$91.64	$34.90	$18.33
74247	Contrst x-ray uppr gi tract		S	0276	1.4387	$91.64	$34.90	$18.33
74249	Contrst x-ray uppr gi tract		S	0277	2.2875	$145.70	$54.50	$29.14
74250	X-ray exam of small bowel		S	0276	1.4387	$91.64	$34.90	$18.33
74251	X-ray exam of small bowel		S	0277	2.2875	$145.70	$54.50	$29.14
74260	X-ray exam of small bowel		S	0276	1.4387	$91.64	$34.90	$18.33
74270	Contrast x-ray exam of colon		S	0276	1.4387	$91.64	$34.90	$18.33
74280	Contrast x-ray exam of colon		S	0277	2.2875	$145.70	$54.50	$29.14
74283	Contrast x-ray exam of colon		S	0276	1.4387	$91.64	$34.90	$18.33
74290	Contrast x-ray, gallbladder		S	0276	1.4387	$91.64	$34.90	$18.33
74291	Contrast x-rays, gallbladder		S	0276	1.4387	$91.64	$34.90	$18.33
74300	X-ray bile ducts/pancreas	CH	N					
74301	X-rays at surgery add-on	CH	N					
74305	X-ray bile ducts/pancreas	CH	N					
74320	Contrast x-ray of bile ducts	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
74327	X-ray bile stone removal	CH	N					
74328	X-ray bile duct endoscopy		N					
74329	X-ray for pancreas endoscopy		N					
74330	X-ray bile/panc endoscopy		N					
74340	X-ray guide for GI tube	CH	N					
74350	X-ray guide, stomach tube	CH	N					
74355	X-ray guide, intestinal tube	CH	N					
74360	X-ray guide, GI dilation	CH	N					
74363	X-ray, bile duct dilation	CH	N					
74400	Contrst x-ray, urinary tract		S	0278	2.6114	$166.33	$59.40	$33.27
74410	Contrst x-ray, urinary tract		S	0278	2.6114	$166.33	$59.40	$33.27
74415	Contrst x-ray, urinary tract		S	0278	2.6114	$166.33	$59.40	$33.27
74420	Contrst x-ray, urinary tract		S	0278	2.6114	$166.33	$59.40	$33.27
74425	Contrst x-ray, urinary tract	CH	Q	0278	2.6114	$166.33	$59.40	$33.27
74430	Contrast x-ray, bladder	CH	Q	0278	2.6114	$166.33	$59.40	$33.27
74440	X-ray, male genital tract	CH	Q	0278	2.6114	$166.33	$59.40	$33.27
74445	X-ray exam of penis	CH	Q	0278	2.6114	$166.33	$59.40	$33.27
74450	X-ray, urethra/bladder	CH	Q	0278	2.6114	$166.33	$59.40	$33.27

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
74455	X-ray, urethra/bladder	CH	Q	0278	2.6114	$166.33	$59.40	$33.27
74470	X-ray exam of kidney lesion	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
74475	X-ray control, cath insert	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
74480	X-ray control, cath insert	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
74485	X-ray guide, GU dilation	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
74710	X-ray measurement of pelvis		X	0261	1.2024	$76.58		$15.32
74740	X-ray, female genital tract	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
74742	X-ray, fallopian tube	CH	N					
74775	X-ray exam of perineum		S	0278	2.6114	$166.33	$59.40	$33.27
75552	Heart mri for morph w/o dye		S	0336	5.7101	$363.69	$139.50	$72.74
75553	Heart mri for morph w/dye		S	0284	6.7963	$432.88	$148.40	$86.58
75554	Cardiac MRI/function		S	0336	5.7101	$363.69	$139.50	$72.74
75555	Cardiac MRI/limited study		S	0336	5.7101	$363.69	$139.50	$72.74
75556	Cardiac MRI/flow mapping		E					
75600	Contrast x-ray exam of aorta	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75605	Contrast x-ray exam of aorta	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75625	Contrast x-ray exam of aorta	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75630	X-ray aorta, leg arteries	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75635	Ct angio abdominal arteries	CH	Q	0662	5.2818	$336.41	$118.80	$67.28
75650	Artery x-rays, head & neck	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75658	Artery x-rays, arm	CH	Q	0279	5.9365	$378.11	$97.07	$75.62
75660	Artery x-rays, head & neck	CH	Q	0668	3.3354	$212.44	$48.81	$42.49
75662	Artery x-rays, head & neck	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75665	Artery x-rays, head & neck	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75671	Artery x-rays, head & neck	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75676	Artery x-rays, neck	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75680	Artery x-rays, neck	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75685	Artery x-rays, spine	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75705	Artery x-rays, spine	CH	Q	0668	3.3354	$212.44	$48.81	$42.49
75710	Artery x-rays, arm/leg	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75716	Artery x-rays, arms/legs	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75722	Artery x-rays, kidney	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75724	Artery x-rays, kidneys	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75726	Artery x-rays, abdomen	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75731	Artery x-rays, adrenal gland	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75733	Artery x-rays, adrenals	CH	Q	0668	3.3354	$212.44	$48.81	$42.49
75736	Artery x-rays, pelvis	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75741	Artery x-rays, lung	CH	Q	0279	5.9365	$378.11	$97.07	$75.62
75743	Artery x-rays, lungs	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75746	Artery x-rays, lung	CH	Q	0279	5.9365	$378.11	$97.07	$75.62
75756	Artery x-rays, chest	CH	Q	0279	5.9365	$378.11	$97.07	$75.62
75774	Artery x-ray, each vessel	CH	N					
75790	Visualize A-V shunt	CH	Q	0279	5.9365	$378.11	$97.07	$75.62
75801	Lymph vessel x-ray, arm/leg	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
75803	Lymph vessel x-ray,arms/legs	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
75805	Lymph vessel x-ray, trunk	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
75807	Lymph vessel x-ray, trunk	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
75809	Nonvascular shunt, x-ray	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
75810	Vein x-ray, spleen/liver	CH	Q	0279	5.9365	$378.11	$97.07	$75.62
75820	Vein x-ray, arm/leg	CH	Q	0668	3.3354	$212.44	$48.81	$42.49
75822	Vein x-ray, arms/legs	CH	Q	0668	3.3354	$212.44	$48.81	$42.49
75825	Vein x-ray, trunk	CH	Q	0279	5.9365	$378.11	$97.07	$75.62
75827	Vein x-ray, chest	CH	Q	0279	5.9365	$378.11	$97.07	$75.62
75831	Vein x-ray, kidney	CH	Q	0279	5.9365	$378.11	$97.07	$75.62
75833	Vein x-ray, kidneys	CH	Q	0279	5.9365	$378.11	$97.07	$75.62
75840	Vein x-ray, adrenal gland	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75842	Vein x-ray, adrenal glands	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75860	Vein x-ray, neck	CH	Q	0668	3.3354	$212.44	$48.81	$42.49
75870	Vein x-ray, skull	CH	Q	0668	3.3354	$212.44	$48.81	$42.49
75872	Vein x-ray, skull	CH	Q	0279	5.9365	$378.11	$97.07	$75.62
75880	Vein x-ray, eye socket	CH	Q	0668	3.3354	$212.44	$48.81	$42.49
75885	Vein x-ray, liver	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75887	Vein x-ray, liver	CH	Q	0279	5.9365	$378.11	$97.07	$75.62
75889	Vein x-ray, liver	CH	Q	0280	11.3221	$721.14	$199.34	$144.23
75891	Vein x-ray, liver	CH	Q	0279	5.9365	$378.11	$97.07	$75.62
75893	Venous sampling by catheter		Q	0668	3.3354	$212.44	$48.81	$42.49
75894	X-rays, transcath therapy	CH	N					
75896	X-rays, transcath therapy	CH	N					
75898	Follow-up angiography	CH	N					
75900	Intravascular cath exchange		C					
75901	Remove cva device obstruct	CH	N					
75902	Remove cva lumen obstruct	CH	N					
75940	X-ray placement, vein filter	CH	N					
75945	Intravascular us	CH	Q	0267	2.4859	$158.33	$60.50	$31.67
75946	Intravascular us add-on	CH	N					
75952	Endovasc repair abdom aorta		C					
75953	Abdom aneurysm endovas rpr		C					
75954	Iliac aneurysm endovas rpr		C					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
75956	Xray, endovasc thor ao repr		C					
75957	Xray, endovasc thor ao repr		C					
75958	Xray, place prox ext thor ao		C					
75959	Xray, place dist ext thor ao		C					
75960	Transcath iv stent rs&i	CH	N					
75961	Retrieval, broken catheter	CH	N					
75962	Repair arterial blockage	CH	Q	0668	3.3354	$212.44	$48.81	$42.49
75964	Repair artery blockage, each	CH	N					
75966	Repair arterial blockage	CH	Q	0668	3.3354	$212.44	$48.81	$42.49
75968	Repair artery blockage, each	CH	N					
75970	Vascular biopsy	CH	N					
75978	Repair venous blockage	CH	Q	0668	3.3354	$212.44	$48.81	$42.49
75980	Contrast xray exam bile duct	CH	N					
75982	Contrast xray exam bile duct	CH	N					
75984	Xray control catheter change	CH	N					
75989	Abscess drainage under x-ray		N					
75992	Atherectomy, x-ray exam	CH	N					
75993	Atherectomy, x-ray exam	CH	N					
75994	Atherectomy, x-ray exam	CH	N					
75995	Atherectomy, x-ray exam	CH	N					
75996	Atherectomy, x-ray exam	CH	N					
76000	Fluoroscope examination	CH	Q	0272	1.327	$84.52	$31.60	$16.90
76001	Fluoroscope exam, extensive		N					
76010	X-ray, nose to rectum		X	0260	0.7259	$46.23		$9.25
76080	X-ray exam of fistula	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
76098	X-ray exam, breast specimen		X	0260	0.7259	$46.23		$9.25
76100	X-ray exam of body section		X	0261	1.2024	$76.58		$15.32
76101	Complex body section x-ray		X	0263	1.4802	$94.28	$21.44	$18.86
76102	Complex body section x-rays	CH	X	0263	1.4802	$94.28	$21.44	$18.86
76120	Cine/video x-rays		X	0272	1.327	$84.52	$31.60	$16.90
76125	Cine/video x-rays add-on	CH	N					
76140	X-ray consultation		E					
76150	X-ray exam, dry process		X	0260	0.7259	$46.23		$9.25
76350	Special x-ray contrast study		N					
76376	3d render w/o postprocess	CH	N					
76377	3d rendering w/postprocess	CH	N					
76380	CAT scan follow-up study		S	0282	1.6768	$106.80	$37.80	$21.36
76390	Mr spectroscopy		E					
76496	Fluoroscopic procedure		X	0272	1.327	$84.52	$31.60	$16.90
76497	Ct procedure		S	0282	1.6768	$106.80	$37.80	$21.36
76498	Mri procedure		S	0335	5.0067	$318.89	$111.90	$63.78
76499	Radiographic procedure		X	0260	0.7259	$46.23		$9.25
76506	Echo exam of head		S	0265	0.9925	$63.22	$23.60	$12.64
76510	Ophth us, b & quant a	CH	T	0232	5.1145	$325.76	$81.59	$65.15
76511	Ophth us, quant a only		S	0266	1.5657	$99.72	$37.80	$19.94
76512	Ophth us, b w/non-quant a		S	0266	1.5657	$99.72	$37.80	$19.94
76513	Echo exam of eye, water bath		S	0266	1.5657	$99.72	$37.80	$19.94
76514	Echo exam of eye, thickness		X	0340	0.6416	$40.87		$8.17
76516	Echo exam of eye		S	0265	0.9925	$63.22	$23.60	$12.64
76519	Echo exam of eye		S	0266	1.5657	$99.72	$37.80	$19.94
76529	Echo exam of eye		S	0265	0.9925	$63.22	$23.60	$12.64
76536	Us exam of head and neck		S	0266	1.5657	$99.72	$37.80	$19.94
76604	Us exam, chest		S	0265	0.9925	$63.22	$23.60	$12.64
76645	Us exam, breast(s)		S	0265	0.9925	$63.22	$23.60	$12.64
76700	Us exam, abdom, complete		S	0266	1.5657	$99.72	$37.80	$19.94
76705	Echo exam of abdomen		S	0266	1.5657	$99.72	$37.80	$19.94
76770	Us exam abdo back wall, comp		S	0266	1.5657	$99.72	$37.80	$19.94
76775	Us exam abdo back wall, lim		S	0266	1.5657	$99.72	$37.80	$19.94
76776	Us exam k transpl w/doppler		S	0266	1.5657	$99.72	$37.80	$19.94
76800	Us exam, spinal canal		S	0266	1.5657	$99.72	$37.80	$19.94
76801	Ob us < 14 wks, single fetus		S	0266	1.5657	$99.72	$37.80	$19.94
76802	Ob us < 14 wks, add'l fetus		S	0265	0.9925	$63.22	$23.60	$12.64
76805	Ob us >/= 14 wks, sngl fetus		S	0266	1.5657	$99.72	$37.80	$19.94
76810	Ob us >/= 14 wks, addl fetus		S	0266	1.5657	$99.72	$37.80	$19.94
76811	Ob us, detailed, sngl fetus		S	0267	2.4859	$158.33	$60.50	$31.67
76812	Ob us, detailed, addl fetus		S	0265	0.9925	$63.22	$23.60	$12.64
76813	Ob us nuchal meas, 1 gest		S	0266	1.5657	$99.72	$37.80	$19.94
76814	Ob us nuchal meas, add-on		S	0265	0.9925	$63.22	$23.60	$12.64
76815	Ob us, limited, fetus(s)		S	0265	0.9925	$63.22	$23.60	$12.64
76816	Ob us, follow-up, per fetus		S	0265	0.9925	$63.22	$23.60	$12.64
76817	Transvaginal us, obstetric		S	0265	0.9925	$63.22	$23.60	$12.64
76818	Fetal biophys profile w/nst		S	0266	1.5657	$99.72	$37.80	$19.94
76819	Fetal biophys profil w/o nst		S	0266	1.5657	$99.72	$37.80	$19.94
76820	Umbilical artery echo		S	0096	1.5254	$97.16	$37.60	$19.43
76821	Middle cerebral artery echo		S	0096	1.5254	$97.16	$37.60	$19.43
76825	Echo exam of fetal heart	CH	S	0266	1.5657	$99.72	$37.80	$19.94
76826	Echo exam of fetal heart	CH	S	0265	0.9925	$63.22	$23.60	$12.64
76827	Echo exam of fetal heart	CH	S	0265	0.9925	$63.22	$23.60	$12.64

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
76828	Echo exam of fetal heart	CH	S	0265	0.9925	$63.22	$23.60	$12.64
76830	Transvaginal us, non-ob		S	0266	1.5657	$99.72	$37.80	$19.94
76831	Echo exam, uterus		S	0267	2.4859	$158.33	$60.50	$31.67
76856	Us exam, pelvic, complete		S	0266	1.5657	$99.72	$37.80	$19.94
76857	Us exam, pelvic, limited		S	0265	0.9925	$63.22	$23.60	$12.64
76870	Us exam, scrotum		S	0266	1.5657	$99.72	$37.80	$19.94
76872	Us, transrectal		S	0266	1.5657	$99.72	$37.80	$19.94
76873	Echograp trans r, pros study		S	0266	1.5657	$99.72	$37.80	$19.94
76880	Us exam, extremity		S	0266	1.5657	$99.72	$37.80	$19.94
76885	Us exam infant hips, dynamic		S	0265	0.9925	$63.22	$23.60	$12.64
76886	Us exam infant hips, static		S	0265	0.9925	$63.22	$23.60	$12.64
76930	Echo guide, cardiocentesis	CH	N					
76932	Echo guide for heart biopsy	CH	N					
76936	Echo guide for artery repair	CH	N					
76937	Us guide, vascular access		N					
76940	Us guide, tissue ablation	CH	N					
76941	Echo guide for transfusion	CH	N					
76942	Echo guide for biopsy	CH	N					
76945	Echo guide, villus sampling	CH	N					
76946	Echo guide for amniocentesis	CH	N					
76948	Echo guide, ova aspiration	CH	N					
76950	Echo guidance radiotherapy	CH	N					
76965	Echo guidance radiotherapy	CH	N					
76970	Ultrasound exam follow-up		S	0265	0.9925	$63.22	$23.60	$12.64
76975	GI endoscopic ultrasound	CH	Q	0267	2.4859	$158.33	$60.50	$31.67
76977	Us bone density measure		X	0340	0.6416	$40.87		$8.17
76998	Us guide, intraop	CH	N					
76999	Echo examination procedure		S	0265	0.9925	$63.22	$23.60	$12.64
77001	Fluoroguide for vein device		N					
77002	Needle localization by xray		N					
77003	Fluoroguide for spine inject		N					
77011	Ct scan for localization	CH	N					
77012	Ct scan for needle biopsy	CH	N					
77013	Ct guide for tissue ablation	CH	N					
77014	Ct scan for therapy guide	CH	N					
77021	Mr guidance for needle place	CH	N					
77022	Mri for tissue ablation	CH	N					
77031	Stereotact guide for brst bx	CH	N					
77032	Guidance for needle, breast	CH	N					
77051	Computer dx mammogram add-on		A					
77052	Comp screen mammogram add-on		A					
77053	X-ray of mammary duct	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
77054	X-ray of mammary ducts	CH	Q	0263	1.4802	$94.28	$21.44	$18.86
77055	Mammogram, one breast		A					
77056	Mammogram, both breasts		A					
77057	Mammogram, screening		A					
77058	Mri, one breast		B					
77059	Mri, both breasts		B					
77071	X-ray stress view		X	0260	0.7259	$46.23		$9.25
77072	X-rays for bone age		X	0260	0.7259	$46.23		$9.25
77073	X-rays, bone length studies		X	0260	0.7259	$46.23		$9.25
77074	X-rays, bone survey, limited		X	0261	1.2024	$76.58		$15.32
77075	X-rays, bone survey complete		X	0261	1.2024	$76.58		$15.32
77076	X-rays, bone survey, infant		X	0260	0.7259	$46.23		$9.25
77077	Joint survey, single view		X	0260	0.7259	$46.23		$9.25
77078	Ct bone density, axial		S	0288	1.192	$75.92	$28.90	$15.18
77079	Ct bone density, peripheral		S	0282	1.6768	$106.80	$37.80	$21.36
77080	Dxa bone density, axial		S	0288	1.192	$75.92	$28.90	$15.18
77081	Dxa bone density/peripheral		S	0665	0.5225	$33.28	$13.31	$6.66
77082	Dxa bone density, vert fx		X	0260	0.7259	$46.23		$9.25
77083	Radiographic absorptiometry		X	0261	1.2024	$76.58		$15.32
77084	Magnetic image, bone marrow		S	0335	5.0067	$318.89	$111.90	$63.78
77261	Radiation therapy planning		B					
77262	Radiation therapy planning		B					
77263	Radiation therapy planning		B					
77280	Set radiation therapy field		X	0304	1.6409	$104.51	$38.60	$20.90
77285	Set radiation therapy field		X	0305	4.1775	$266.08	$91.30	$53.22
77290	Set radiation therapy field		X	0305	4.1775	$266.08	$91.30	$53.22
77295	Set radiation therapy field		X	0310	14.0797	$896.78	$325.20	$179.36
77299	Radiation therapy planning		X	0304	1.6409	$104.51	$38.60	$20.90
77300	Radiation therapy dose plan		X	0304	1.6409	$104.51	$38.60	$20.90
77301	Radiotherapy dose plan, imrt		X	0310	14.0797	$896.78	$325.20	$179.36
77305	Teletx isodose plan simple		X	0304	1.6409	$104.51	$38.60	$20.90
77310	Teletx isodose plan intermed		X	0305	4.1775	$266.08	$91.30	$53.22
77315	Teletx isodose plan complex		X	0305	4.1775	$266.08	$91.30	$53.22
77321	Special teletx port plan		X	0305	4.1775	$266.08	$91.30	$53.22
77326	Brachytx isodose calc simp		X	0304	1.6409	$104.51	$38.60	$20.90
77327	Brachytx isodose calc interm		X	0305	4.1775	$266.08	$91.30	$53.22

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
77328	Brachytx isodose plan compl		X	0305	4.1775	$266.08	$91.30	$53.22
77331	Special radiation dosimetry		X	0304	1.6409	$104.51	$38.60	$20.90
77332	Radiation treatment aid(s)		X	0303	3.0657	$195.26	$66.90	$39.05
77333	Radiation treatment aid(s)		X	0303	3.0657	$195.26	$66.90	$39.05
77334	Radiation treatment aid(s)		X	0303	3.0657	$195.26	$66.90	$39.05
77336	Radiation physics consult		X	0304	1.6409	$104.51	$38.60	$20.90
77370	Radiation physics consult		X	0304	1.6409	$104.51	$38.60	$20.90
77371	Srs, multisource		S	0127	123.4696	$7,864.15		$1,572.83
77372	Srs, linear based		B					
77373	Sbrt delivery		B					
77399	External radiation dosimetry		X	0304	1.6409	$104.51	$38.60	$20.90
77401	Radiation treatment delivery		S	0300	1.5	$95.54		$19.11
77402	Radiation treatment delivery		S	0300	1.5	$95.54		$19.11
77403	Radiation treatment delivery		S	0300	1.5	$95.54		$19.11
77404	Radiation treatment delivery		S	0300	1.5	$95.54		$19.11
77406	Radiation treatment delivery		S	0300	1.5	$95.54		$19.11
77407	Radiation treatment delivery		S	0300	1.5	$95.54		$19.11
77408	Radiation treatment delivery		S	0300	1.5	$95.54		$19.11
77409	Radiation treatment delivery		S	0300	1.5	$95.54		$19.11
77411	Radiation treatment delivery		S	0301	2.2933	$146.07		$29.21
77412	Radiation treatment delivery		S	0301	2.2933	$146.07		$29.21
77413	Radiation treatment delivery		S	0301	2.2933	$146.07		$29.21
77414	Radiation treatment delivery		S	0301	2.2933	$146.07		$29.21
77416	Radiation treatment delivery		S	0301	2.2933	$146.07		$29.21
77417	Radiology port film(s)	CH	N					
77418	Radiation tx delivery, imrt		S	0412	5.7275	$364.80		$72.96
77421	Stereoscopic x-ray guidance	CH	N					
77422	Neutron beam tx, simple		S	0301	2.2933	$146.07		$29.21
77423	Neutron beam tx, complex		S	0301	2.2933	$146.07		$29.21
77427	Radiation tx management, x5		B					
77431	Radiation therapy management		B					
77432	Stereotactic radiation trmt		B					
77435	Sbrt management		N					
77470	Special radiation treatment		S	0299	6.0275	$383.91		$76.78
77499	Radiation therapy management		B					
77520	Proton trmt, simple w/o comp		S	0664	13.2746	$845.50		$169.10
77522	Proton trmt, simple w/comp		S	0664	13.2746	$845.50		$169.10
77523	Proton trmt, intermediate		S	0667	15.8841	$1,011.71		$202.34
77525	Proton treatment, complex		S	0667	15.8841	$1,011.71		$202.34
77600	Hyperthermia treatment	CH	S	0299	6.0275	$383.91		$76.78
77605	Hyperthermia treatment	CH	S	0299	6.0275	$383.91		$76.78
77610	Hyperthermia treatment	CH	S	0299	6.0275	$383.91		$76.78
77615	Hyperthermia treatment	CH	S	0299	6.0275	$383.91		$76.78
77620	Hyperthermia treatment	CH	S	0299	6.0275	$383.91		$76.78
77750	Infuse radioactive materials		S	0301	2.2933	$146.07		$29.21
77761	Apply intrcav radiat simple		S	0312	8.3915	$534.48		$106.90
77762	Apply intrcav radiat interm		S	0312	8.3915	$534.48		$106.90
77763	Apply intrcav radiat compl		S	0312	8.3915	$534.48		$106.90
77776	Apply interstit radiat simpl		S	0312	8.3915	$534.48		$106.90
77777	Apply interstit radiat inter		S	0312	8.3915	$534.48		$106.90
77778	Apply interstit radiat compl	CH	Q	0651	15.4158	$981.88		$196.38
77781	High intensity brachytherapy		S	0313	11.6098	$739.46		$147.89
77782	High intensity brachytherapy		S	0313	11.6098	$739.46		$147.89
77783	High intensity brachytherapy		S	0313	11.6098	$739.46		$147.89
77784	High intensity brachytherapy		S	0313	11.6098	$739.46		$147.89
77789	Apply surface radiation		S	0300	1.5	$95.54		$19.11
77790	Radiation handling		N					
77799	Radium/radioisotope therapy		S	0312	8.3915	$534.48		$106.90
78000	Thyroid, single uptake		S	0389	1.5806	$100.67	$33.80	$20.13
78001	Thyroid, multiple uptakes		S	0389	1.5806	$100.67	$33.80	$20.13
78003	Thyroid suppress/stimul		S	0392	3.281	$208.98	$49.30	$41.80
78006	Thyroid imaging with uptake		S	0390	2.8272	$180.07	$57.60	$36.01
78007	Thyroid image, mult uptakes		S	0391	3.654	$232.73	$66.10	$46.55
78010	Thyroid imaging		S	0390	2.8272	$180.07	$57.60	$36.01
78011	Thyroid imaging with flow		S	0390	2.8272	$180.07	$57.60	$36.01
78015	Thyroid met imaging		S	0406	4.4988	$286.54	$98.10	$57.31
78016	Thyroid met imaging/studies		S	0406	4.4988	$286.54	$98.10	$57.31
78018	Thyroid met imaging, body		S	0406	4.4988	$286.54	$98.10	$57.31
78020	Thyroid met uptake	CH	N					
78070	Parathyroid nuclear imaging		S	0391	3.654	$232.73	$66.10	$46.55
78075	Adrenal nuclear imaging		S	0391	3.654	$232.73	$66.10	$46.55
78099	Endocrine nuclear procedure		S	0390	2.8272	$180.07	$57.60	$36.01
78102	Bone marrow imaging, ltd		S	0400	4.1916	$266.98	$93.20	$53.40
78103	Bone marrow imaging, mult		S	0400	4.1916	$266.98	$93.20	$53.40
78104	Bone marrow imaging, body		S	0400	4.1916	$266.98	$93.20	$53.40
78110	Plasma volume, single		S	0393	5.526	$351.97	$82.00	$70.39
78111	Plasma volume, multiple		S	0393	5.526	$351.97	$82.00	$70.39
78120	Red cell mass, single		S	0393	5.526	$351.97	$82.00	$70.39

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
78121	Red cell mass, multiple		S	0393	5.526	$351.97	$82.00	$70.39
78122	Blood volume		S	0393	5.526	$351.97	$82.00	$70.39
78130	Red cell survival study		S	0393	5.526	$351.97	$82.00	$70.39
78135	Red cell survival kinetics		S	0393	5.526	$351.97	$82.00	$70.39
78140	Red cell sequestration		S	0393	5.526	$351.97	$82.00	$70.39
78185	Spleen imaging		S	0400	4.1916	$266.98	$93.20	$53.40
78190	Platelet survival, kinetics		S	0392	3.281	$208.98	$49.30	$41.80
78191	Platelet survival		S	0392	3.281	$208.98	$49.30	$41.80
78195	Lymph system imaging		S	0400	4.1916	$266.98	$93.20	$53.40
78199	Blood/lymph nuclear exam		S	0400	4.1916	$266.98	$93.20	$53.40
78201	Liver imaging		S	0394	4.5297	$288.51	$102.60	$57.70
78202	Liver imaging with flow		S	0394	4.5297	$288.51	$102.60	$57.70
78205	Liver imaging (3D)		S	0394	4.5297	$288.51	$102.60	$57.70
78206	Liver image (3d) with flow		S	0394	4.5297	$288.51	$102.60	$57.70
78215	Liver and spleen imaging		S	0394	4.5297	$288.51	$102.60	$57.70
78216	Liver & spleen image/flow		S	0394	4.5297	$288.51	$102.60	$57.70
78220	Liver function study		S	0394	4.5297	$288.51	$102.60	$57.70
78223	Hepatobiliary imaging		S	0394	4.5297	$288.51	$102.60	$57.70
78230	Salivary gland imaging		S	0395	3.8546	$245.51	$89.70	$49.10
78231	Serial salivary imaging		S	0395	3.8546	$245.51	$89.70	$49.10
78232	Salivary gland function exam		S	0395	3.8546	$245.51	$89.70	$49.10
78258	Esophageal motility study		S	0395	3.8546	$245.51	$89.70	$49.10
78261	Gastric mucosa imaging		S	0395	3.8546	$245.51	$89.70	$49.10
78262	Gastroesophageal reflux exam		S	0395	3.8546	$245.51	$89.70	$49.10
78264	Gastric emptying study		S	0395	3.8546	$245.51	$89.70	$49.10
78267	Breath tst attain/anal c-14		A					
78268	Breath test analysis, c-14		A					
78270	Vit B-12 absorption exam		S	0392	3.281	$208.98	$49.30	$41.80
78271	Vit b-12 absrp exam, int fac		S	0392	3.281	$208.98	$49.30	$41.80
78272	Vit B-12 absorp, combined		S	0392	3.281	$208.98	$49.30	$41.80
78278	Acute GI blood loss imaging		S	0395	3.8546	$245.51	$89.70	$49.10
78282	GI protein loss exam		S	0395	3.8546	$245.51	$89.70	$49.10
78290	Meckel'ts divert exam		S	0395	3.8546	$245.51	$89.70	$49.10
78291	Leveen/shunt patency exam		S	0395	3.8546	$245.51	$89.70	$49.10
78299	GI nuclear procedure		S	0395	3.8546	$245.51	$89.70	$49.10
78300	Bone imaging, limited area		S	0396	3.9566	$252.01	$95.00	$50.40
78305	Bone imaging, multiple areas		S	0396	3.9566	$252.01	$95.00	$50.40
78306	Bone imaging, whole body		S	0396	3.9566	$252.01	$95.00	$50.40
78315	Bone imaging, 3 phase		S	0396	3.9566	$252.01	$95.00	$50.40
78320	Bone imaging (3D)		S	0396	3.9566	$252.01	$95.00	$50.40
78350	Bone mineral, single photon		E					
78351	Bone mineral, dual photon		E					
78399	Musculoskeletal nuclear exam		S	0396	3.9566	$252.01	$95.00	$50.40
78414	Non-imaging heart function		S	0398	5.4404	$346.52	$100.00	$69.30
78428	Cardiac shunt imaging		S	0398	5.4404	$346.52	$100.00	$69.30
78445	Vascular flow imaging		S	0397	3.0424	$193.78	$49.50	$38.76
78456	Acute venous thrombus image		S	0397	3.0424	$193.78	$49.50	$38.76
78457	Venous thrombosis imaging		S	0397	3.0424	$193.78	$49.50	$38.76
78458	Ven thrombosis images, bilat		S	0397	3.0424	$193.78	$49.50	$38.76
78459	Heart muscle imaging (PET)		S	0307	42.5674	$2,711.25		$542.25
78460	Heart muscle blood, single		S	0398	5.4404	$346.52	$100.00	$69.30
78461	Heart muscle blood, multiple	CH	S	0398	5.4404	$346.52	$100.00	$69.30
78464	Heart image (3d), single		S	0398	5.4404	$346.52	$100.00	$69.30
78465	Heart image (3d), multiple		S	0377	12.0147	$765.25	$158.80	$153.05
78466	Heart infarct image		S	0398	5.4404	$346.52	$100.00	$69.30
78468	Heart infarct image (ef)		S	0398	5.4404	$346.52	$100.00	$69.30
78469	Heart infarct image (3D)		S	0398	5.4404	$346.52	$100.00	$69.30
78472	Gated heart, planar, single		S	0398	5.4404	$346.52	$100.00	$69.30
78473	Gated heart, multiple	CH	S	0398	5.4404	$346.52	$100.00	$69.30
78478	Heart wall motion add-on	CH	N					
78480	Heart function add-on	CH	N					
78481	Heart first pass, single		S	0398	5.4404	$346.52	$100.00	$69.30
78483	Heart first pass, multiple	CH	S	0398	5.4404	$346.52	$100.00	$69.30
78491	Heart image (pet), single		S	0307	42.5674	$2,711.25		$542.25
78492	Heart image (pet), multiple		S	0307	42.5674	$2,711.25		$542.25
78494	Heart image, spect		S	0398	5.4404	$346.52	$100.00	$69.30
78496	Heart first pass add-on	CH	N					
78499	Cardiovascular nuclear exam		S	0398	5.4404	$346.52	$100.00	$69.30
78580	Lung perfusion imaging		S	0401	3.2976	$210.03	$78.10	$42.01
78584	Lung V/Q image single breath		S	0378	5.1617	$328.76	$125.30	$65.75
78585	Lung V/Q imaging		S	0378	5.1617	$328.76	$125.30	$65.75
78586	Aerosol lung image, single		S	0401	3.2976	$210.03	$78.10	$42.01
78587	Aerosol lung image, multiple		S	0401	3.2976	$210.03	$78.10	$42.01
78588	Perfusion lung image		S	0378	5.1617	$328.76	$125.30	$65.75
78591	Vent image, 1 breath, 1 proj		S	0401	3.2976	$210.03	$78.10	$42.01
78593	Vent image, 1 proj, gas		S	0401	3.2976	$210.03	$78.10	$42.01
78594	Vent image, mult proj, gas		S	0401	3.2976	$210.03	$78.10	$42.01
78596	Lung differential function		S	0378	5.1617	$328.76	$125.30	$65.75

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
78599	Respiratory nuclear exam		S	0401	3.2976	$210.03	$78.10	$42.01
78600	Brain imaging, ltd static	CH	S	0403	3.3325	$212.26	$82.39	$42.45
78601	Brain imaging, ltd w/flow	CH	S	0403	3.3325	$212.26	$82.39	$42.45
78605	Brain imaging, complete	CH	S	0403	3.3325	$212.26	$82.39	$42.45
78606	Brain imaging, compl w/flow		S	0402	8.8414	$563.14	$114.10	$112.63
78607	Brain imaging (3D)		S	0402	8.8414	$563.14	$114.10	$112.63
78608	Brain imaging (PET)		S	0308	17.3837	$1,107.22		$221.44
78609	Brain imaging (PET)		E					
78610	Brain flow imaging only		S	0402	8.8414	$563.14	$114.10	$112.63
78615	Cerebral vascular flow image		S	0402	8.8414	$563.14	$114.10	$112.63
78630	Cerebrospinal fluid scan	CH	S	0402	8.8414	$563.14	$114.10	$112.63
78635	CSF ventriculography	CH	S	0402	8.8414	$563.14	$114.10	$112.63
78645	CSF shunt evaluation		S	0403	3.3325	$212.26	$82.39	$42.45
78647	Cerebrospinal fluid scan	CH	S	0402	8.8414	$563.14	$114.10	$112.63
78650	CSF leakage imaging	CH	S	0402	8.8414	$563.14	$114.10	$112.63
78660	Nuclear exam of tear flow		S	0403	3.3325	$212.26	$82.39	$42.45
78699	Nervous system nuclear exam	CH	S	0403	3.3325	$212.26	$82.39	$42.45
78700	Kidney imaging, morphol		S	0404	5.0935	$324.42	$84.10	$64.88
78701	Kidney imaging with flow		S	0404	5.0935	$324.42	$84.10	$64.88
78707	K flow/funct image w/o drug		S	0404	5.0935	$324.42	$84.10	$64.88
78708	K flow/funct image w/drug	CH	S	0404	5.0935	$324.42	$84.10	$64.88
78709	K flow/funct image, multiple	CH	S	0404	5.0935	$324.42	$84.10	$64.88
78710	Kidney imaging (3D)		S	0404	5.0935	$324.42	$84.10	$64.88
78725	Kidney function study		S	0389	1.5806	$100.67	$33.80	$20.13
78730	Urinary bladder retention		X	0340	0.6416	$40.87		$8.17
78740	Ureteral reflux study		S	0404	5.0935	$324.42	$84.10	$64.88
78761	Testicular imaging w/flow		S	0404	5.0935	$324.42	$84.10	$64.88
78799	Genitourinary nuclear exam		S	0404	5.0935	$324.42	$84.10	$64.88
78800	Tumor imaging, limited area		S	0406	4.4988	$286.54	$98.10	$57.31
78801	Tumor imaging, mult areas		S	0406	4.4988	$286.54	$98.10	$57.31
78802	Tumor imaging, whole body	CH	S	0414	7.4985	$477.60	$190.92	$95.52
78803	Tumor imaging (3D)	CH	S	0414	7.4985	$477.60	$190.92	$95.52
78804	Tumor imaging, whole body		S	0408	16.0595	$1,022.88		$204.58
78805	Abscess imaging, ltd area	CH	S	0414	7.4985	$477.60	$190.92	$95.52
78806	Abscess imaging, whole body	CH	S	0414	7.4985	$477.60	$190.92	$95.52
78807	Nuclear localization/abscess	CH	S	0414	7.4985	$477.60	$190.92	$95.52
78811	Tumor imaging (pet), limited		S	0308	17.3837	$1,107.22		$221.44
78812	Tumor image (pet)/skul-thigh		S	0308	17.3837	$1,107.22		$221.44
78813	Tumor image (pet) full body		S	0308	17.3837	$1,107.22		$221.44
78814	Tumor image pet/ct, limited	CH	S	0308	17.3837	$1,107.22		$221.44
78815	Tumorimage pet/ct skul-thigh	CH	S	0308	17.3837	$1,107.22		$221.44
78816	Tumor image pet/ct full body	CH	S	0308	17.3837	$1,107.22		$221.44
78890	Nuclear medicine data proc		N					
78891	Nuclear med data proc		N					
78999	Nuclear diagnostic exam		S	0389	1.5806	$100.67	$33.80	$20.13
79005	Nuclear rx, oral admin		S	0407	3.4563	$220.14	$78.10	$44.03
79101	Nuclear rx, iv admin		S	0407	3.4563	$220.14	$78.10	$44.03
79200	Nuclear rx, intracav admin		S	0413	5.4891	$349.62		$69.92
79300	Nuclr rx, interstit colloid		S	0407	3.4563	$220.14	$78.10	$44.03
79403	Hematopoietic nuclear tx		S	0413	5.4891	$349.62		$69.92
79440	Nuclear rx, intra-articular		S	0413	5.4891	$349.62		$69.92
79445	Nuclear rx, intra-arterial		S	0407	3.4563	$220.14	$78.10	$44.03
79999	Nuclear medicine therapy		S	0407	3.4563	$220.14	$78.10	$44.03
80048	Basic metabolic panel		A					
80050	General health panel		E					
80051	Electrolyte panel		A					
80053	Comprehen metabolic panel		A					
80055	Obstetric panel		E					
80061	Lipid panel		A					
80069	Renal function panel		A					
80074	Acute hepatitis panel		A					
80076	Hepatic function panel		A					
80100	Drug screen, qualitate/multi		A					
80101	Drug screen, single		A					
80102	Drug confirmation		A					
80103	Drug analysis, tissue prep		N					
80150	Assay of amikacin		A					
80152	Assay of amitriptyline		A					
80154	Assay of benzodiazepines		A					
80156	Assay, carbamazepine, total		A					
80157	Assay, carbamazepine, free		A					
80158	Assay of cyclosporine		A					
80160	Assay of desipramine		A					
80162	Assay of digoxin		A					
80164	Assay, dipropylacetic acid		A					
80166	Assay of doxepin		A					
80168	Assay of ethosuximide		A					
80170	Assay of gentamicin		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
80172	Assay of gold		A					
80173	Assay of haloperidol		A					
80174	Assay of imipramine		A					
80176	Assay of lidocaine		A					
80178	Assay of lithium		A					
80182	Assay of nortriptyline		A					
80184	Assay of phenobarbital		A					
80185	Assay of phenytoin, total		A					
80186	Assay of phenytoin, free		A					
80188	Assay of primidone		A					
80190	Assay of procainamide		A					
80192	Assay of procainamide		A					
80194	Assay of quinidine		A					
80195	Assay of sirolimus		A					
80196	Assay of salicylate		A					
80197	Assay of tacrolimus		A					
80198	Assay of theophylline		A					
80200	Assay of tobramycin		A					
80201	Assay of topiramate		A					
80202	Assay of vancomycin		A					
80299	Quantitative assay, drug		A					
80400	Acth stimulation panel		A					
80402	Acth stimulation panel		A					
80406	Acth stimulation panel		A					
80408	Aldosterone suppression eval		A					
80410	Calcitonin stimul panel		A					
80412	CRH stimulation panel		A					
80414	Testosterone response		A					
80415	Estradiol response panel		A					
80416	Renin stimulation panel		A					
80417	Renin stimulation panel		A					
80418	Pituitary evaluation panel		A					
80420	Dexamethasone panel		A					
80422	Glucagon tolerance panel		A					
80424	Glucagon tolerance panel		A					
80426	Gonadotropin hormone panel		A					
80428	Growth hormone panel		A					
80430	Growth hormone panel		A					
80432	Insulin suppression panel		A					
80434	Insulin tolerance panel		A					
80435	Insulin tolerance panel		A					
80436	Metyrapone panel		A					
80438	TRH stimulation panel		A					
80439	TRH stimulation panel		A					
80440	TRH stimulation panel		A					
80500	Lab pathology consultation		X	0433	0.2482	$15.81	$5.90	$3.16
80502	Lab pathology consultation		X	0342	0.0928	$5.91	$2.00	$1.18
81000	Urinalysis, nonauto w/scope		A					
81001	Urinalysis, auto w/scope		A					
81002	Urinalysis nonauto w/o scope		A					
81003	Urinalysis, auto, w/o scope		A					
81005	Urinalysis		A					
81007	Urine screen for bacteria		A					
81015	Microscopic exam of urine		A					
81020	Urinalysis, glass test		A					
81025	Urine pregnancy test		A					
81050	Urinalysis, volume measure		A					
81099	Urinalysis test procedure		A					
82000	Assay of blood acetaldehyde		A					
82003	Assay of acetaminophen		A					
82009	Test for acetone/ketones		A					
82010	Acetone assay		A					
82013	Acetylcholinesterase assay		A					
82016	Acylcarnitines, qual		A					
82017	Acylcarnitines, quant		A					
82024	Assay of acth		A					
82030	Assay of adp & amp		A					
82040	Assay of serum albumin		A					
82042	Assay of urine albumin		A					
82043	Microalbumin, quantitative		A					
82044	Microalbumin, semiquant		A					
82045	Albumin, ischemia modified		A					
82055	Assay of ethanol		A					
82075	Assay of breath ethanol		A					
82085	Assay of aldolase		A					
82088	Assay of aldosterone		A					
82101	Assay of urine alkaloids		A					
82103	Alpha-1-antitrypsin, total		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
82104	Alpha-1-antitrypsin, pheno		A					
82105	Alpha-fetoprotein, serum		A					
82106	Alpha-fetoprotein, amniotic		A					
82107	Alpha-fetoprotein l3		A					
82108	Assay of aluminum		A					
82120	Amines, vaginal fluid qual		A					
82127	Amino acid, single qual		A					
82128	Amino acids, mult qual		A					
82131	Amino acids, single quant		A					
82135	Assay, aminolevulinic acid		A					
82136	Amino acids, quant, 2-5		A					
82139	Amino acids, quan, 6 or more		A					
82140	Assay of ammonia		A					
82143	Amniotic fluid scan		A					
82145	Assay of amphetamines		A					
82150	Assay of amylase		A					
82154	Androstanediol glucuronide		A					
82157	Assay of androstenedione		A					
82160	Assay of androsterone		A					
82163	Assay of angiotensin II		A					
82164	Angiotensin I enzyme test		A					
82172	Assay of apolipoprotein		A					
82175	Assay of arsenic		A					
82180	Assay of ascorbic acid		A					
82190	Atomic absorption		A					
82205	Assay of barbiturates		A					
82232	Assay of beta-2 protein		A					
82239	Bile acids, total		A					
82240	Bile acids, cholylglycine		A					
82247	Bilirubin, total		A					
82248	Bilirubin, direct		A					
82252	Fecal bilirubin test		A					
82261	Assay of biotinidase		A					
82270	Occult blood, feces		A					
82271	Occult blood, other sources		A					
82272	Occult blood, feces, single		A					
82274	Assay test for blood, fecal		A					
82286	Assay of bradykinin		A					
82300	Assay of cadmium		A					
82306	Assay of vitamin D		A					
82307	Assay of vitamin D		A					
82308	Assay of calcitonin		A					
82310	Assay of calcium		A					
82330	Assay of calcium		A					
82331	Calcium infusion test		A					
82340	Assay of calcium in urine		A					
82355	Calculus analysis, qual		A					
82360	Calculus assay, quant		A					
82365	Calculus spectroscopy		A					
82370	X-ray assay, calculus		A					
82373	Assay, c-d transfer measure		A					
82374	Assay, blood carbon dioxide		A					
82375	Assay, blood carbon monoxide		A					
82376	Test for carbon monoxide		A					
82378	Carcinoembryonic antigen		A					
82379	Assay of carnitine		A					
82380	Assay of carotene		A					
82382	Assay, urine catecholamines		A					
82383	Assay, blood catecholamines		A					
82384	Assay, three catecholamines		A					
82387	Assay of cathepsin-d		A					
82390	Assay of ceruloplasmin		A					
82397	Chemiluminescent assay		A					
82415	Assay of chloramphenicol		A					
82435	Assay of blood chloride		A					
82436	Assay of urine chloride		A					
82438	Assay, other fluid chlorides		A					
82441	Test for chlorohydrocarbons		A					
82465	Assay, bld/serum cholesterol		A					
82480	Assay, serum cholinesterase		A					
82482	Assay, rbc cholinesterase		A					
82485	Assay, chondroitin sulfate		A					
82486	Gas/liquid chromatography		A					
82487	Paper chromatography		A					
82488	Paper chromatography		A					
82489	Thin layer chromatography		A					
82491	Chromotography, quant, sing		A					
82492	Chromotography, quant, mult		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
82495	Assay of chromium		A					
82507	Assay of citrate		A					
82520	Assay of cocaine		A					
82523	Collagen crosslinks		A					
82525	Assay of copper		A					
82528	Assay of corticosterone		A					
82530	Cortisol, free		A					
82533	Total cortisol		A					
82540	Assay of creatine		A					
82541	Column chromotography, qual		A					
82542	Column chromotography, quant		A					
82543	Column chromotograph/isotope		A					
82544	Column chromotograph/isotope		A					
82550	Assay of ck (cpk)		A					
82552	Assay of cpk in blood		A					
82553	Creatine, MB fraction		A					
82554	Creatine, isoforms		A					
82565	Assay of creatinine		A					
82570	Assay of urine creatinine		A					
82575	Creatinine clearance test		A					
82585	Assay of cryofibrinogen		A					
82595	Assay of cryoglobulin		A					
82600	Assay of cyanide		A					
82607	Vitamin B-12		A					
82608	B-12 binding capacity		A					
82615	Test for urine cystines		A					
82626	Dehydroepiandrosterone		A					
82627	Dehydroepiandrosterone		A					
82633	Desoxycorticosterone		A					
82634	Deoxycortisol		A					
82638	Assay of dibucaine number		A					
82646	Assay of dihydrocodeinone		A					
82649	Assay of dihydromorphinone		A					
82651	Assay of dihydrotestosterone		A					
82652	Assay of dihydroxyvitamin d		A					
82654	Assay of dimethadione		A					
82656	Pancreatic elastase, fecal		A					
82657	Enzyme cell activity		A					
82658	Enzyme cell activity, ra		A					
82664	Electrophoretic test		A					
82666	Assay of epiandrosterone		A					
82668	Assay of erythropoietin		A					
82670	Assay of estradiol		A					
82671	Assay of estrogens		A					
82672	Assay of estrogen		A					
82677	Assay of estriol		A					
82679	Assay of estrone		A					
82690	Assay of ethchlorvynol		A					
82693	Assay of ethylene glycol		A					
82696	Assay of etiocholanolone		A					
82705	Fats/lipids, feces, qual		A					
82710	Fats/lipids, feces, quant		A					
82715	Assay of fecal fat		A					
82725	Assay of blood fatty acids		A					
82726	Long chain fatty acids		A					
82728	Assay of ferritin		A					
82731	Assay of fetal fibronectin		A					
82735	Assay of fluoride		A					
82742	Assay of flurazepam		A					
82746	Blood folic acid serum		A					
82747	Assay of folic acid, rbc		A					
82757	Assay of semen fructose		A					
82759	Assay of rbc galactokinase		A					
82760	Assay of galactose		A					
82775	Assay galactose transferase		A					
82776	Galactose transferase test		A					
82784	Assay of gammaglobulin igm		A					
82785	Assay of gammaglobulin ige		A					
82787	Igg 1, 2, 3 or 4, each		A					
82800	Blood pH		A					
82803	Blood gases: pH, pO2 & pCO2		A					
82805	Blood gases W/02 saturation		A					
82810	Blood gases, O2 sat only		A					
82820	Hemoglobin-oxygen affinity		A					
82926	Assay of gastric acid		A					
82928	Assay of gastric acid		A					
82938	Gastrin test		A					
82941	Assay of gastrin		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
82943	Assay of glucagon		A					
82945	Glucose other fluid		A					
82946	Glucagon tolerance test		A					
82947	Assay, glucose, blood quant		A					
82948	Reagent strip/blood glucose		A					
82950	Glucose test		A					
82951	Glucose tolerance test (GTT)		A					
82952	GTT-added samples		A					
82953	Glucose-tolbutamide test		A					
82955	Assay of g6pd enzyme		A					
82960	Test for G6PD enzyme		A					
82962	Glucose blood test		A					
82963	Assay of glucosidase		A					
82965	Assay of gdh enzyme		A					
82975	Assay of glutamine		A					
82977	Assay of GGT		A					
82978	Assay of glutathione		A					
82979	Assay, rbc glutathione		A					
82980	Assay of glutethimide		A					
82985	Glycated protein		A					
83001	Gonadotropin (FSH)		A					
83002	Gonadotropin (LH)		A					
83003	Assay, growth hormone (hgh)		A					
83008	Assay of guanosine		A					
83009	H pylori (c-13), blood		A					
83010	Assay of haptoglobin, quant		A					
83012	Assay of haptoglobins		A					
83013	H pylori (c-13), breath		A					
83014	H pylori drug admin		A					
83015	Heavy metal screen		A					
83018	Quantitative screen, metals		A					
83020	Hemoglobin electrophoresis		A					
83021	Hemoglobin chromotography		A					
83026	Hemoglobin, copper sulfate		A					
83030	Fetal hemoglobin, chemical		A					
83033	Fetal hemoglobin assay, qual		A					
83036	Glycosylated hemoglobin test		A					
83037	Glycosylated hb, home device		A					
83045	Blood methemoglobin test		A					
83050	Blood methemoglobin assay		A					
83051	Assay of plasma hemoglobin		A					
83055	Blood sulfhemoglobin test		A					
83060	Blood sulfhemoglobin assay		A					
83065	Assay of hemoglobin heat		A					
83068	Hemoglobin stability screen		A					
83069	Assay of urine hemoglobin		A					
83070	Assay of hemosiderin, qual		A					
83071	Assay of hemosiderin, quant		A					
83080	Assay of b hexosaminidase		A					
83088	Assay of histamine		A					
83090	Assay of homocystine		A					
83150	Assay of for hva		A					
83491	Assay of corticosteroids		A					
83497	Assay of 5-hiaa		A					
83498	Assay of progesterone		A					
83499	Assay of progesterone		A					
83500	Assay, free hydroxyproline		A					
83505	Assay, total hydroxyproline		A					
83516	Immunoassay, nonantibody		A					
83518	Immunoassay, dipstick		A					
83519	Immunoassay, nonantibody		A					
83520	Immunoassay, RIA		A					
83525	Assay of insulin		A					
83527	Assay of insulin		A					
83528	Assay of intrinsic factor		A					
83540	Assay of iron		A					
83550	Iron binding test		A					
83570	Assay of idh enzyme		A					
83582	Assay of ketogenic steroids		A					
83586	Assay 17- ketosteroids		A					
83593	Fractionation, ketosteroids		A					
83605	Assay of lactic acid		A					
83615	Lactate (LD) (LDH) enzyme		A					
83625	Assay of ldh enzymes		A					
83630	Lactoferrin, fecal (qual)		A					
83631	Lactoferrin, fecal (quant)		A					
83632	Placental lactogen		A					
83633	Test urine for lactose		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
83634	Assay of urine for lactose		A					
83655	Assay of lead		A					
83661	L/s ratio, fetal lung		A					
83662	Foam stability, fetal lung		A					
83663	Fluoro polarize, fetal lung		A					
83664	Lamellar bdy, fetal lung		A					
83670	Assay of lap enzyme		A					
83690	Assay of lipase		A					
83695	Assay of lipoprotein(a)		A					
83698	Assay lipoprotein pla2		A					
83700	Lipopro bld, electrophoretic		A					
83701	Lipoprotein bld, hr fraction		A					
83704	Lipoprotein, bld, by nmr		A					
83718	Assay of lipoprotein		A					
83719	Assay of blood lipoprotein		A					
83721	Assay of blood lipoprotein		A					
83727	Assay of lrh hormone		A					
83735	Assay of magnesium		A					
83775	Assay of md enzyme		A					
83785	Assay of manganese		A					
83788	Mass spectrometry qual		A					
83789	Mass spectrometry quant		A					
83805	Assay of meprobamate		A					
83825	Assay of mercury		A					
83835	Assay of metanephrines		A					
83840	Assay of methadone		A					
83857	Assay of methemalbumin		A					
83858	Assay of methsuximide		A					
83864	Mucopolysaccharides		A					
83866	Mucopolysaccharides screen		A					
83872	Assay synovial fluid mucin		A					
83873	Assay of csf protein		A					
83874	Assay of myoglobin		A					
83880	Natriuretic peptide		A					
83883	Assay, nephelometry not spec		A					
83885	Assay of nickel		A					
83887	Assay of nicotine		A					
83890	Molecule isolate		A					
83891	Molecule isolate nucleic		A					
83892	Molecular diagnostics		A					
83893	Molecule dot/slot/blot		A					
83894	Molecule gel electrophor		A					
83896	Molecular diagnostics		A					
83897	Molecule nucleic transfer		A					
83898	Molecule nucleic ampli, each		A					
83900	Molecule nucleic ampli 2 seq		A					
83901	Molecule nucleic ampli addon		A					
83902	Molecular diagnostics		A					
83903	Molecule mutation scan		A					
83904	Molecule mutation identify		A					
83905	Molecule mutation identify		A					
83906	Molecule mutation identify		A					
83907	Lyse cells for nucleic ext		A					
83908	Nucleic acid, signal ampli		A					
83909	Nucleic acid, high resolute		A					
83912	Genetic examination		A					
83913	Molecular, rna stabilization		A					
83914	Mutation ident ola/sbce/aspe		A					
83915	Assay of nucleotidase		A					
83916	Oligoclonal bands		A					
83918	Organic acids, total, quant		A					
83919	Organic acids, qual, each		A					
83921	Organic acid, single, quant		A					
83925	Assay of opiates		A					
83930	Assay of blood osmolality		A					
83935	Assay of urine osmolality		A					
83937	Assay of osteocalcin		A					
83945	Assay of oxalate		A					
83950	Oncoprotein, her-2/neu		A					
83970	Assay of parathormone		A					
83986	Assay of body fluid acidity		A					
83992	Assay for phencyclidine		A					
84022	Assay of phenothiazine		A					
84030	Assay of blood pku		A					
84035	Assay of phenylketones		A					
84060	Assay acid phosphatase		A					
84061	Phosphatase, forensic exam		A					
84066	Assay prostate phosphatase		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
84075	Assay alkaline phosphatase		A					
84078	Assay alkaline phosphatase		A					
84080	Assay alkaline phosphatases		A					
84081	Amniotic fluid enzyme test		A					
84085	Assay of rbc pg6d enzyme		A					
84087	Assay phosphohexose enzymes		A					
84100	Assay of phosphorus		A					
84105	Assay of urine phosphorus		A					
84106	Test for porphobilinogen		A					
84110	Assay of porphobilinogen		A					
84119	Test urine for porphyrins		A					
84120	Assay of urine porphyrins		A					
84126	Assay of feces porphyrins		A					
84127	Assay of feces porphyrins		A					
84132	Assay of serum potassium		A					
84133	Assay of urine potassium		A					
84134	Assay of prealbumin		A					
84135	Assay of pregnanediol		A					
84138	Assay of pregnanetriol		A					
84140	Assay of pregnenolone		A					
84143	Assay of 17-hydroxypregneno		A					
84144	Assay of progesterone		A					
84146	Assay of prolactin		A					
84150	Assay of prostaglandin		A					
84152	Assay of psa, complexed		A					
84153	Assay of psa, total		A					
84154	Assay of psa, free		A					
84155	Assay of protein, serum		A					
84156	Assay of protein, urine		A					
84157	Assay of protein, other		A					
84160	Assay of protein, any source		A					
84163	Pappa, serum		A					
84165	Protein e-phoresis, serum		A					
84166	Protein e-phoresis/urine/csf		A					
84181	Western blot test		A					
84182	Protein, western blot test		A					
84202	Assay RBC protoporphyrin		A					
84203	Test RBC protoporphyrin		A					
84206	Assay of proinsulin		A					
84207	Assay of vitamin b-6		A					
84210	Assay of pyruvate		A					
84220	Assay of pyruvate kinase		A					
84228	Assay of quinine		A					
84233	Assay of estrogen		A					
84234	Assay of progesterone		A					
84235	Assay of endocrine hormone		A					
84238	Assay, nonendocrine receptor		A					
84244	Assay of renin		A					
84252	Assay of vitamin b-2		A					
84255	Assay of selenium		A					
84260	Assay of serotonin		A					
84270	Assay of sex hormone globul		A					
84275	Assay of sialic acid		A					
84285	Assay of silica		A					
84295	Assay of serum sodium		A					
84300	Assay of urine sodium		A					
84302	Assay of sweat sodium		A					
84305	Assay of somatomedin		A					
84307	Assay of somatostatin		A					
84311	Spectrophotometry		A					
84315	Body fluid specific gravity		A					
84375	Chromatogram assay, sugars		A					
84376	Sugars, single, qual		A					
84377	Sugars, multiple, qual		A					
84378	Sugars, single, quant		A					
84379	Sugars multiple quant		A					
84392	Assay of urine sulfate		A					
84402	Assay of testosterone		A					
84403	Assay of total testosterone		A					
84425	Assay of vitamin b-1		A					
84430	Assay of thiocyanate		A					
84432	Assay of thyroglobulin		A					
84436	Assay of total thyroxine		A					
84437	Assay of neonatal thyroxine		A					
84439	Assay of free thyroxine		A					
84442	Assay of thyroid activity		A					
84443	Assay thyroid stim hormone		A					
84445	Assay of tsi		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
84446	Assay of vitamin e		A					
84449	Assay of transcortin		A					
84450	Transferase (AST) (SGOT)		A					
84460	Alanine amino (ALT) (SGPT)		A					
84466	Assay of transferrin		A					
84478	Assay of triglycerides		A					
84479	Assay of thyroid (t3 or t4)		A					
84480	Assay, triiodothyronine (t3)		A					
84481	Free assay (FT-3)		A					
84482	T3 reverse		A					
84484	Assay of troponin, quant		A					
84485	Assay duodenal fluid trypsin		A					
84488	Test feces for trypsin		A					
84490	Assay of feces for trypsin		A					
84510	Assay of tyrosine		A					
84512	Assay of troponin, qual		A					
84520	Assay of urea nitrogen		A					
84525	Urea nitrogen semi-quant		A					
84540	Assay of urine/urea-n		A					
84545	Urea-N clearance test		A					
84550	Assay of blood/uric acid		A					
84560	Assay of urine/uric acid		A					
84577	Assay of feces/urobilinogen		A					
84578	Test urine urobilinogen		A					
84580	Assay of urine urobilinogen		A					
84583	Assay of urine urobilinogen		A					
84585	Assay of urine vma		A					
84586	Assay of vip		A					
84588	Assay of vasopressin		A					
84590	Assay of vitamin a		A					
84591	Assay of nos vitamin		A					
84597	Assay of vitamin k		A					
84600	Assay of volatiles		A					
84620	Xylose tolerance test		A					
84630	Assay of zinc		A					
84681	Assay of c-peptide		A					
84702	Chorionic gonadotropin test		A					
84703	Chorionic gonadotropin assay		A					
84830	Ovulation tests		A					
84999	Clinical chemistry test		A					
85002	Bleeding time test		A					
85004	Automated diff wbc count		A					
85007	Bl smear w/diff wbc count		A					
85008	Bl smear w/o diff wbc count		A					
85009	Manual diff wbc count b-coat		A					
85013	Spun microhematocrit		A					
85014	Hematocrit		A					
85018	Hemoglobin		A					
85025	Complete cbc w/auto diff wbc		A					
85027	Complete cbc, automated		A					
85032	Manual cell count, each		A					
85041	Automated rbc count		A					
85044	Manual reticulocyte count		A					
85045	Automated reticulocyte count		A					
85046	Reticyte/hgb concentrate		A					
85048	Automated leukocyte count		A					
85049	Automated platelet count		A					
85055	Reticulated platelet assay		A					
85060	Blood smear interpretation		B					
85097	Bone marrow interpretation		X	0343	0.5372	$34.22	$10.80	$6.84
85130	Chromogenic substrate assay		A					
85170	Blood clot retraction		A					
85175	Blood clot lysis time		A					
85210	Blood clot factor II test		A					
85220	Blood clot factor V test		A					
85230	Blood clot factor VII test		A					
85240	Blood clot factor VIII test		A					
85244	Blood clot factor VIII test		A					
85245	Blood clot factor VIII test		A					
85246	Blood clot factor VIII test		A					
85247	Blood clot factor VIII test		A					
85250	Blood clot factor IX test		A					
85260	Blood clot factor X test		A					
85270	Blood clot factor XI test		A					
85280	Blood clot factor XII test		A					
85290	Blood clot factor XIII test		A					
85291	Blood clot factor XIII test		A					
85292	Blood clot factor assay		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
85293	Blood clot factor assay		A					
85300	Antithrombin III test		A					
85301	Antithrombin III test		A					
85302	Blood clot inhibitor antigen		A					
85303	Blood clot inhibitor test		A					
85305	Blood clot inhibitor assay		A					
85306	Blood clot inhibitor test		A					
85307	Assay activated protein c		A					
85335	Factor inhibitor test		A					
85337	Thrombomodulin		A					
85345	Coagulation time		A					
85347	Coagulation time		A					
85348	Coagulation time		A					
85360	Euglobulin lysis		A					
85362	Fibrin degradation products		A					
85366	Fibrinogen test		A					
85370	Fibrinogen test		A					
85378	Fibrin degrade, semiquant		A					
85379	Fibrin degradation, quant		A					
85380	Fibrin degradation, vte		A					
85384	Fibrinogen		A					
85385	Fibrinogen		A					
85390	Fibrinolysins screen		A					
85396	Clotting assay, whole blood		N					
85400	Fibrinolytic plasmin		A					
85410	Fibrinolytic antiplasmin		A					
85415	Fibrinolytic plasminogen		A					
85420	Fibrinolytic plasminogen		A					
85421	Fibrinolytic plasminogen		A					
85441	Heinz bodies, direct		A					
85445	Heinz bodies, induced		A					
85460	Hemoglobin, fetal		A					
85461	Hemoglobin, fetal		A					
85475	Hemolysin		A					
85520	Heparin assay		A					
85525	Heparin neutralization		A					
85530	Heparin-protamine tolerance		A					
85536	Iron stain peripheral blood		A					
85540	Wbc alkaline phosphatase		A					
85547	RBC mechanical fragility		A					
85549	Muramidase		A					
85555	RBC osmotic fragility		A					
85557	RBC osmotic fragility		A					
85576	Blood platelet aggregation		A					
85597	Platelet neutralization		A					
85610	Prothrombin time		A					
85611	Prothrombin test		A					
85612	Viper venom prothrombin time		A					
85613	Russell viper venom, diluted		A					
85635	Reptilase test		A					
85651	Rbc sed rate, nonautomated		A					
85652	Rbc sed rate, automated		A					
85660	RBC sickle cell test		A					
85670	Thrombin time, plasma		A					
85675	Thrombin time, titer		A					
85705	Thromboplastin inhibition		A					
85730	Thromboplastin time, partial		A					
85732	Thromboplastin time, partial		A					
85810	Blood viscosity examination		A					
85999	Hematology procedure		A					
86000	Agglutinins, febrile		A					
86001	Allergen specific igg		A					
86003	Allergen specific IgE		A					
86005	Allergen specific IgE		A					
86021	WBC antibody identification		A					
86022	Platelet antibodies		A					
86023	Immunoglobulin assay		A					
86038	Antinuclear antibodies		A					
86039	Antinuclear antibodies (ANA)		A					
86060	Antistreptolysin o, titer		A					
86063	Antistreptolysin o, screen		A					
86077	Physician blood bank service		X	0433	0.2482	$15.81	$5.90	$3.16
86078	Physician blood bank service		X	0343	0.5372	$34.22	$10.80	$6.84
86079	Physician blood bank service		X	0433	0.2482	$15.81	$5.90	$3.16
86140	C-reactive protein		A					
86141	C-reactive protein, hs		A					
86146	Glycoprotein antibody		A					
86147	Cardiolipin antibody		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
86148	Phospholipid antibody		A					
86155	Chemotaxis assay		A					
86156	Cold agglutinin, screen		A					
86157	Cold agglutinin, titer		A					
86160	Complement, antigen		A					
86161	Complement/function activity		A					
86162	Complement, total (CH50)		A					
86171	Complement fixation, each		A					
86185	Counterimmunoelectrophoresis		A					
86200	Ccp antibody		A					
86215	Deoxyribonuclease, antibody		A					
86225	DNA antibody		A					
86226	DNA antibody, single strand		A					
86235	Nuclear antigen antibody		A					
86243	Fc receptor		A					
86255	Fluorescent antibody, screen		A					
86256	Fluorescent antibody, titer		A					
86277	Growth hormone antibody		A					
86280	Hemagglutination inhibition		A					
86294	Immunoassay, tumor, qual		A					
86300	Immunoassay, tumor, ca 15-3		A					
86301	Immunoassay, tumor, ca 19-9		A					
86304	Immunoassay, tumor, ca 125		A					
86308	Heterophile antibodies		A					
86309	Heterophile antibodies		A					
86310	Heterophile antibodies		A					
86316	Immunoassay, tumor other		A					
86317	Immunoassay,infectious agent		A					
86318	Immunoassay,infectious agent		A					
86320	Serum immunoelectrophoresis		A					
86325	Other immunoelectrophoresis		A					
86327	Immunoelectrophoresis assay		A					
86329	Immunodiffusion		A					
86331	Immunodiffusion ouchterlony		A					
86332	Immune complex assay		A					
86334	Immunofix e-phoresis, serum		A					
86335	Immunfix e-phorsis/urine/csf		A					
86336	Inhibin A		A					
86337	Insulin antibodies		A					
86340	Intrinsic factor antibody		A					
86341	Islet cell antibody		A					
86343	Leukocyte histamine release		A					
86344	Leukocyte phagocytosis		A					
86353	Lymphocyte transformation		A					
86355	B cells, total count		A					
86357	Nk cells, total count		A					
86359	T cells, total count		A					
86360	T cell, absolute count/ratio		A					
86361	T cell, absolute count		A					
86367	Stem cells, total count		A					
86376	Microsomal antibody		A					
86378	Migration inhibitory factor		A					
86382	Neutralization test, viral		A					
86384	Nitroblue tetrazolium dye		A					
86403	Particle agglutination test		A					
86406	Particle agglutination test		A					
86430	Rheumatoid factor test		A					
86431	Rheumatoid factor, quant		A					
86480	Tb test, cell immun measure		A					
86485	Skin test, candida		X	0341	0.0879	$5.60	$2.20	$1.12
86490	Coccidioidomycosis skin test		X	0341	0.0879	$5.60	$2.20	$1.12
86510	Histoplasmosis skin test		X	0341	0.0879	$5.60	$2.20	$1.12
86580	TB intradermal test		X	0341	0.0879	$5.60	$2.20	$1.12
86586	Skin test, unlisted		A					
86590	Streptokinase, antibody		A					
86592	Blood serology, qualitative		A					
86593	Blood serology, quantitative		A					
86602	Antinomyces antibody		A					
86603	Adenovirus antibody		A					
86606	Aspergillus antibody		A					
86609	Bacterium antibody		A					
86611	Bartonella antibody		A					
86612	Blastomyces antibody		A					
86615	Bordetella antibody		A					
86617	Lyme disease antibody		A					
86618	Lyme disease antibody		A					
86619	Borrelia antibody		A					
86622	Brucella antibody		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
86625	Campylobacter antibody		A					
86628	Candida antibody		A					
86631	Chlamydia antibody		A					
86632	Chlamydia igm antibody		A					
86635	Coccidioides antibody		A					
86638	Q fever antibody		A					
86641	Cryptococcus antibody		A					
86644	CMV antibody		A					
86645	CMV antibody, IgM		A					
86648	Diphtheria antibody		A					
86651	Encephalitis antibody		A					
86652	Encephalitis antibody		A					
86653	Encephalitis antibody		A					
86654	Encephalitis antibody		A					
86658	Enterovirus antibody		A					
86663	Epstein-barr antibody		A					
86664	Epstein-barr antibody		A					
86665	Epstein-barr antibody		A					
86666	Ehrlichia antibody		A					
86668	Francisella tularensis		A					
86671	Fungus antibody		A					
86674	Giardia lamblia antibody		A					
86677	Helicobacter pylori		A					
86682	Helminth antibody		A					
86684	Hemophilus influenza		A					
86687	Htlv-i antibody		A					
86688	Htlv-ii antibody		A					
86689	HTLV/HIV confirmatory test		A					
86692	Hepatitis, delta agent		A					
86694	Herpes simplex test		A					
86695	Herpes simplex test		A					
86696	Herpes simplex type 2		A					
86698	Histoplasma		A					
86701	HIV-1		A					
86702	HIV-2		A					
86703	HIV-1/HIV-2, single assay		A					
86704	Hep b core antibody, total		A					
86705	Hep b core antibody, igm		A					
86706	Hep b surface antibody		A					
86707	Hep be antibody		A					
86708	Hep a antibody, total		A					
86709	Hep a antibody, igm		A					
86710	Influenza virus antibody		A					
86713	Legionella antibody		A					
86717	Leishmania antibody		A					
86720	Leptospira antibody		A					
86723	Listeria monocytogenes ab		A					
86727	Lymph choriomeningitis ab		A					
86729	Lympho venereum antibody		A					
86732	Mucormycosis antibody		A					
86735	Mumps antibody		A					
86738	Mycoplasma antibody		A					
86741	Neisseria meningitidis		A					
86744	Nocardia antibody		A					
86747	Parvovirus antibody		A					
86750	Malaria antibody		A					
86753	Protozoa antibody nos		A					
86756	Respiratory virus antibody		A					
86757	Rickettsia antibody		A					
86759	Rotavirus antibody		A					
86762	Rubella antibody		A					
86765	Rubeola antibody		A					
86768	Salmonella antibody		A					
86771	Shigella antibody		A					
86774	Tetanus antibody		A					
86777	Toxoplasma antibody		A					
86778	Toxoplasma antibody, igm		A					
86781	Treponema pallidum, confirm		A					
86784	Trichinella antibody		A					
86787	Varicella-zoster antibody		A					
86788	West nile virus ab, igm		A					
86789	West nile virus antibody		A					
86790	Virus antibody nos		A					
86793	Yersinia antibody		A					
86800	Thyroglobulin antibody		A					
86803	Hepatitis c ab test		A					
86804	Hep c ab test, confirm		A					
86805	Lymphocytotoxicity assay		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
86806	Lymphocytotoxicity assay		A					
86807	Cytotoxic antibody screening		A					
86808	Cytotoxic antibody screening		A					
86812	HLA typing, A, B, or C		A					
86813	HLA typing, A, B, or C		A					
86816	HLA typing, DR/DQ		A					
86817	HLA typing, DR/DQ		A					
86821	Lymphocyte culture, mixed		A					
86822	Lymphocyte culture, primed		A					
86849	Immunology procedure		A					
86850	RBC antibody screen		X	0345	0.2211	$14.08		$2.82
86860	RBC antibody elution		X	0346	0.3464	$22.06		$4.41
86870	RBC antibody identification		X	0346	0.3464	$22.06		$4.41
86880	Coombs test, direct		X	0409	0.1246	$7.94	$2.20	$1.59
86885	Coombs test, indirect, qual		X	0409	0.1246	$7.94	$2.20	$1.59
86886	Coombs test, indirect, titer		X	0409	0.1246	$7.94	$2.20	$1.59
86890	Autologous blood process		X	0347	0.8166	$52.01	$11.20	$10.40
86891	Autologous blood, op salvage		X	0346	0.3464	$22.06		$4.41
86900	Blood typing, ABO		X	0409	0.1246	$7.94	$2.20	$1.59
86901	Blood typing, Rh (D)		X	0409	0.1246	$7.94	$2.20	$1.59
86903	Blood typing, antigen screen		X	0345	0.2211	$14.08		$2.82
86904	Blood typing, patient serum		X	0346	0.3464	$22.06		$4.41
86905	Blood typing, RBC antigens		X	0345	0.2211	$14.08		$2.82
86906	Blood typing, Rh phenotype		X	0345	0.2211	$14.08		$2.82
86910	Blood typing, paternity test		E					
86911	Blood typing, antigen system		E					
86920	Compatibility test, spin		X	0346	0.3464	$22.06		$4.41
86921	Compatibility test, incubate		X	0345	0.2211	$14.08		$2.82
86922	Compatibility test, antiglob		X	0346	0.3464	$22.06		$4.41
86923	Compatibility test, electric		X	0345	0.2211	$14.08		$2.82
86927	Plasma, fresh frozen		X	0345	0.2211	$14.08		$2.82
86930	Frozen blood prep		X	0347	0.8166	$52.01	$11.20	$10.40
86931	Frozen blood thaw		X	0347	0.8166	$52.01	$11.20	$10.40
86932	Frozen blood freeze/thaw		X	0347	0.8166	$52.01	$11.20	$10.40
86940	Hemolysins/agglutinins, auto		A					
86941	Hemolysins/agglutinins		A					
86945	Blood product/irradiation		X	0345	0.2211	$14.08		$2.82
86950	Leukacyte transfusion		X	0345	0.2211	$14.08		$2.82
86960	Vol reduction of blood/prod		X	0345	0.2211	$14.08		$2.82
86965	Pooling blood platelets		X	0346	0.3464	$22.06		$4.41
86970	RBC pretreatment		X	0345	0.2211	$14.08		$2.82
86971	RBC pretreatment		X	0345	0.2211	$14.08		$2.82
86972	RBC pretreatment		X	0346	0.3464	$22.06		$4.41
86975	RBC pretreatment, serum		X	0346	0.3464	$22.06		$4.41
86976	RBC pretreatment, serum		X	0345	0.2211	$14.08		$2.82
86977	RBC pretreatment, serum		X	0346	0.3464	$22.06		$4.41
86978	RBC pretreatment, serum		X	0346	0.3464	$22.06		$4.41
86985	Split blood or products		X	0345	0.2211	$14.08		$2.82
86999	Transfusion procedure		X	0345	0.2211	$14.08		$2.82
87001	Small animal inoculation		A					
87003	Small animal inoculation		A					
87015	Specimen concentration		A					
87040	Blood culture for bacteria		A					
87045	Feces culture, bacteria		A					
87046	Stool cultr, bacteria, each		A					
87070	Culture, bacteria, other		A					
87071	Culture bacteri aerobic othr		A					
87073	Culture bacteria anaerobic		A					
87075	Cultr bacteria, except blood		A					
87076	Culture anaerobe ident, each		A					
87077	Culture aerobic identify		A					
87081	Culture screen only		A					
87084	Culture of specimen by kit		A					
87086	Urine culture/colony count		A					
87088	Urine bacteria culture		A					
87101	Skin fungi culture		A					
87102	Fungus isolation culture		A					
87103	Blood fungus culture		A					
87106	Fungi identification, yeast		A					
87107	Fungi identification, mold		A					
87109	Mycoplasma		A					
87110	Chlamydia culture		A					
87116	Mycobacteria culture		A					
87118	Mycobacteric identification		A					
87140	Culture type immunofluoresc		A					
87143	Culture typing, glc/hplc		A					
87147	Culture type, immunologic		A					
87149	Culture type, nucleic acid		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
87152	Culture type pulse field gel		A					
87158	Culture typing, added method		A					
87164	Dark field examination		A					
87166	Dark field examination		A					
87168	Macroscopic exam arthropod		A					
87169	Macroscopic exam parasite		A					
87172	Pinworm exam		A					
87176	Tissue homogenization, cultr		A					
87177	Ova and parasites smears		A					
87181	Microbe susceptible, diffuse		A					
87184	Microbe susceptible, disk		A					
87185	Microbe susceptible, enzyme		A					
87186	Microbe susceptible, mic		A					
87187	Microbe susceptible, mlc		A					
87188	Microbe suscept, macrobroth		A					
87190	Microbe suscept, mycobacteri		A					
87197	Bactericidal level, serum		A					
87205	Smear, gram stain		A					
87206	Smear, fluorescent/acid stai		A					
87207	Smear, special stain		A					
87209	Smear, complex stain		A					
87210	Smear, wet mount, saline/ink		A					
87220	Tissue exam for fungi		A					
87230	Assay, toxin or antitoxin		A					
87250	Virus inoculate, eggs/animal		A					
87252	Virus inoculation, tissue		A					
87253	Virus inoculate tissue, addl		A					
87254	Virus inoculation, shell via		A					
87255	Genet virus isolate, hsv		A					
87260	Adenovirus ag, if		A					
87265	Pertussis ag, if		A					
87267	Enterovirus antibody, dfa		A					
87269	Giardia ag, if		A					
87270	Chlamydia trachomatis ag, if		A					
87271	Cryptosporidum/gardia ag, if		A					
87272	Cryptosporidium ag, if		A					
87273	Herpes simplex 2, ag, if		A					
87274	Herpes simplex 1, ag, if		A					
87275	Influenza b, ag, if		A					
87276	Influenza a, ag, if		A					
87277	Legionella micdadei, ag, if		A					
87278	Legion pneumophilia ag, if		A					
87279	Parainfluenza, ag, if		A					
87280	Respiratory syncytial ag, if		A					
87281	Pneumocystis carinii, ag, if		A					
87283	Rubeola, ag, if		A					
87285	Treponema pallidum, ag, if		A					
87290	Varicella zoster, ag, if		A					
87299	Antibody detection, nos, if		A					
87300	Ag detection, polyval, if		A					
87301	Adenovirus ag, eia		A					
87305	Aspergillus ag, eia		A					
87320	Chylmd trach ag, eia		A					
87324	Clostridium ag, eia		A					
87327	Cryptococcus neoform ag, eia		A					
87328	Cryptosporidium ag, eia		A					
87329	Giardia ag, eia		A					
87332	Cytomegalovirus ag, eia		A					
87335	E coli 0157 ag, eia		A					
87336	Entamoeb hist dispr, ag, eia		A					
87337	Entamoeb hist group, ag, eia		A					
87338	Hpylori, stool, eia		A					
87339	H pylori ag, eia		A					
87340	Hepatitis b surface ag, eia		A					
87341	Hepatitis b surface, ag, eia		A					
87350	Hepatitis be ag, eia		A					
87380	Hepatitis delta ag, eia		A					
87385	Histoplasma capsul ag, eia		A					
87390	Hiv-1 ag, eia		A					
87391	Hiv-2 ag, eia		A					
87400	Influenza a/b, ag, eia		A					
87420	Resp syncytial ag, eia		A					
87425	Rotavirus ag, eia		A					
87427	Shiga-like toxin ag, eia		A					
87430	Strep a ag, eia		A					
87449	Ag detect nos, eia, mult		A					
87450	Ag detect nos, eia, single		A					
87451	Ag detect polyval, eia, mult		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
87470	Bartonella, dna, dir probe		A					
87471	Bartonella, dna, amp probe		A					
87472	Bartonella, dna, quant		A					
87475	Lyme dis, dna, dir probe		A					
87476	Lyme dis, dna, amp probe		A					
87477	Lyme dis, dna, quant		A					
87480	Candida, dna, dir probe		A					
87481	Candida, dna, amp probe		A					
87482	Candida, dna, quant		A					
87485	Chylmd pneum, dna, dir probe		A					
87486	Chylmd pneum, dna, amp probe		A					
87487	Chylmd pneum, dna, quant		A					
87490	Chylmd trach, dna, dir probe		A					
87491	Chylmd trach, dna, amp probe		A					
87492	Chylmd trach, dna, quant		A					
87495	Cytomeg, dna, dir probe		A					
87496	Cytomeg, dna, amp probe		A					
87497	Cytomeg, dna, quant		A					
87498	Enterovirus, dna, amp probe		A					
87510	Gardner vag, dna, dir probe		A					
87511	Gardner vag, dna, amp probe		A					
87512	Gardner vag, dna, quant		A					
87515	Hepatitis b, dna, dir probe		A					
87516	Hepatitis b, dna, amp probe		A					
87517	Hepatitis b, dna, quant		A					
87520	Hepatitis c, rna, dir probe		A					
87521	Hepatitis c, rna, amp probe		A					
87522	Hepatitis c, rna, quant		A					
87525	Hepatitis g, dna, dir probe		A					
87526	Hepatitis g, dna, amp probe		A					
87527	Hepatitis g, dna, quant		A					
87528	Hsv, dna, dir probe		A					
87529	Hsv, dna, amp probe		A					
87530	Hsv, dna, quant		A					
87531	Hhv-6, dna, dir probe		A					
87532	Hhv-6, dna, amp probe		A					
87533	Hhv-6, dna, quant		A					
87534	Hiv-1, dna, dir probe		A					
87535	Hiv-1, dna, amp probe		A					
87536	Hiv-1, dna, quant		A					
87537	Hiv-2, dna, dir probe		A					
87538	Hiv-2, dna, amp probe		A					
87539	Hiv-2, dna, quant		A					
87540	Legion pneumo, dna, dir prob		A					
87541	Legion pneumo, dna, amp prob		A					
87542	Legion pneumo, dna, quant		A					
87550	Mycobacteria, dna, dir probe		A					
87551	Mycobacteria, dna, amp probe		A					
87552	Mycobacteria, dna, quant		A					
87555	M.tuberculo, dna, dir probe		A					
87556	M.tuberculo, dna, amp probe		A					
87557	M.tuberculo, dna, quant		A					
87560	M.avium-intra, dna, dir prob		A					
87561	M.avium-intra, dna, amp prob		A					
87562	M.avium-intra, dna, quant		A					
87580	M.pneumon, dna, dir probe		A					
87581	M.pneumon, dna, amp probe		A					
87582	M.pneumon, dna, quant		A					
87590	N.gonorrhoeae, dna, dir prob		A					
87591	N.gonorrhoeae, dna, amp prob		A					
87592	N.gonorrhoeae, dna, quant		A					
87620	Hpv, dna, dir probe		A					
87621	Hpv, dna, amp probe		A					
87622	Hpv, dna, quant		A					
87640	Staph a, dna, amp probe		A					
87641	Mr-staph, dna, amp probe		A					
87650	Strep a, dna, dir probe		A					
87651	Strep a, dna, amp probe		A					
87652	Strep a, dna, quant		A					
87653	Strep b, dna, amp probe		A					
87660	Trichomonas vagin, dir probe		A					
87797	Detect agent nos, dna, dir		A					
87798	Detect agent nos, dna, amp		A					
87799	Detect agent nos, dna, quant		A					
87800	Detect agnt mult, dna, direc		A					
87801	Detect agnt mult, dna, ampli		A					
87802	Strep b assay w/optic		A					
87803	Clostridium toxin a w/optic		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
87804	Influenza assay w/optic		A					
87807	Rsv assay w/optic		A					
87808	Trichomonas assay w/optic		A					
87810	Chylmd trach assay w/optic		A					
87850	N. gonorrhoeae assay w/optic		A					
87880	Strep a assay w/optic		A					
87899	Agent nos assay w/optic		A					
87900	Phenotype, infect agent drug		A					
87901	Genotype, dna, hiv reverse t		A					
87902	Genotype, dna, hepatitis C		A					
87903	Phenotype, dna hiv w/culture		A					
87904	Phenotype, dna hiv w/clt add		A					
87999	Microbiology procedure		A					
88000	Autopsy (necropsy), gross		E					
88005	Autopsy (necropsy), gross		E					
88007	Autopsy (necropsy), gross		E					
88012	Autopsy (necropsy), gross		E					
88014	Autopsy (necropsy), gross		E					
88016	Autopsy (necropsy), gross		E					
88020	Autopsy (necropsy), complete		E					
88025	Autopsy (necropsy), complete		E					
88027	Autopsy (necropsy), complete		E					
88028	Autopsy (necropsy), complete		E					
88029	Autopsy (necropsy), complete		E					
88036	Limited autopsy		E					
88037	Limited autopsy		E					
88040	Forensic autopsy (necropsy)		E					
88045	Coroner's autopsy (necropsy)		E					
88099	Necropsy (autopsy) procedure		E					
88104	Cytopath fl nongyn, smears		X	0433	0.2482	$15.81	$5.90	$3.16
88106	Cytopath fl nongyn, filter		X	0433	0.2482	$15.81	$5.90	$3.16
88107	Cytopath fl nongyn, sm/fltr	CH	X	0343	0.5372	$34.22	$10.80	$6.84
88108	Cytopath, concentrate tech	CH	X	0343	0.5372	$34.22	$10.80	$6.84
88112	Cytopath, cell enhance tech		X	0343	0.5372	$34.22	$10.80	$6.84
88125	Forensic cytopathology		X	0433	0.2482	$15.81	$5.90	$3.16
88130	Sex chromatin identification		A					
88140	Sex chromatin identification		A					
88141	Cytopath, c/v, interpret		N					
88142	Cytopath, c/v, thin layer		A					
88143	Cytopath c/v thin layer redo		A					
88147	Cytopath, c/v, automated		A					
88148	Cytopath, c/v, auto rescreen		A					
88150	Cytopath, c/v, manual		A					
88152	Cytopath, c/v, auto redo		A					
88153	Cytopath, c/v, redo		A					
88154	Cytopath, c/v, select		A					
88155	Cytopath, c/v, index add-on		A					
88160	Cytopath smear, other source		X	0433	0.2482	$15.81	$5.90	$3.16
88161	Cytopath smear, other source		X	0433	0.2482	$15.81	$5.90	$3.16
88162	Cytopath smear, other source	CH	X	0343	0.5372	$34.22	$10.80	$6.84
88164	Cytopath tbs, c/v, manual		A					
88165	Cytopath tbs, c/v, redo		A					
88166	Cytopath tbs, c/v, auto redo		A					
88167	Cytopath tbs, c/v, select		A					
88172	Cytopathology eval of fna		X	0343	0.5372	$34.22	$10.80	$6.84
88173	Cytopath eval, fna, report		X	0343	0.5372	$34.22	$10.80	$6.84
88174	Cytopath, c/v auto, in fluid		A					
88175	Cytopath c/v auto fluid redo		A					
88182	Cell marker study		X	0343	0.5372	$34.22	$10.80	$6.84
88184	Flowcytometry/ tc, 1 marker		X	0433	0.2482	$15.81	$5.90	$3.16
88185	Flowcytometry/tc, add-on		X	0433	0.2482	$15.81	$5.90	$3.16
88187	Flowcytometry/read, 2-8		X	0433	0.2482	$15.81	$5.90	$3.16
88188	Flowcytometry/read, 9-15		X	0433	0.2482	$15.81	$5.90	$3.16
88189	Flowcytometry/read, 16 & >		X	0343	0.5372	$34.22	$10.80	$6.84
88199	Cytopathology procedure		X	0342	0.0928	$5.91	$2.00	$1.18
88230	Tissue culture, lymphocyte		A					
88233	Tissue culture, skin/biopsy		A					
88235	Tissue culture, placenta		A					
88237	Tissue culture, bone marrow		A					
88239	Tissue culture, tumor		A					
88240	Cell cryopreserve/storage		A					
88241	Frozen cell preparation		A					
88245	Chromosome analysis, 20-25		A					
88248	Chromosome analysis, 50-100		A					
88249	Chromosome analysis, 100		A					
88261	Chromosome analysis, 5		A					
88262	Chromosome analysis, 15-20		A					
88263	Chromosome analysis, 45		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
88264	Chromosome analysis, 20-25		A					
88267	Chromosome analys, placenta		A					
88269	Chromosome analys, amniotic		A					
88271	Cytogenetics, dna probe		A					
88272	Cytogenetics, 3-5		A					
88273	Cytogenetics, 10-30		A					
88274	Cytogenetics, 25-99		A					
88275	Cytogenetics, 100-300		A					
88280	Chromosome karyotype study		A					
88283	Chromosome banding study		A					
88285	Chromosome count, additional		A					
88289	Chromosome study, additional		A					
88291	Cyto/molecular report		M					
88299	Cytogenetic study		X	0342	0.0928	$5.91	$2.00	$1.18
88300	Surgical path, gross		X	0433	0.2482	$15.81	$5.90	$3.16
88302	Tissue exam by pathologist		X	0433	0.2482	$15.81	$5.90	$3.16
88304	Tissue exam by pathologist		X	0343	0.5372	$34.22	$10.80	$6.84
88305	Tissue exam by pathologist		X	0343	0.5372	$34.22	$10.80	$6.84
88307	Tissue exam by pathologist		X	0344	0.8586	$54.69	$15.60	$10.94
88309	Tissue exam by pathologist		X	0344	0.8586	$54.69	$15.60	$10.94
88311	Decalcify tissue		X	0433	0.2482	$15.81	$5.90	$3.16
88312	Special stains		X	0433	0.2482	$15.81	$5.90	$3.16
88313	Special stains		X	0433	0.2482	$15.81	$5.90	$3.16
88314	Histochemical stain	CH	X	0433	0.2482	$15.81	$5.90	$3.16
88318	Chemical histochemistry		X	0433	0.2482	$15.81	$5.90	$3.16
88319	Enzyme histochemistry		X	0343	0.5372	$34.22	$10.80	$6.84
88321	Microslide consultation		X	0433	0.2482	$15.81	$5.90	$3.16
88323	Microslide consultation		X	0343	0.5372	$34.22	$10.80	$6.84
88325	Comprehensive review of data		X	0344	0.8586	$54.69	$15.60	$10.94
88329	Path consult introp		X	0433	0.2482	$15.81	$5.90	$3.16
88331	Path consult intraop, 1 bloc		X	0343	0.5372	$34.22	$10.80	$6.84
88332	Path consult intraop, add'l		X	0433	0.2482	$15.81	$5.90	$3.16
88333	Intraop cyto path consult, 1		X	0343	0.5372	$34.22	$10.80	$6.84
88334	Intraop cyto path consult, 2		X	0433	0.2482	$15.81	$5.90	$3.16
88342	Immunohistochemistry		X	0343	0.5372	$34.22	$10.80	$6.84
88346	Immunofluorescent study		X	0343	0.5372	$34.22	$10.80	$6.84
88347	Immunofluorescent study		X	0343	0.5372	$34.22	$10.80	$6.84
88348	Electron microscopy		X	0661	2.8336	$180.48	$62.00	$36.10
88349	Scanning electron microscopy		X	0661	2.8336	$180.48	$62.00	$36.10
88355	Analysis, skeletal muscle		X	0343	0.5372	$34.22	$10.80	$6.84
88356	Analysis, nerve		X	0344	0.8586	$54.69	$15.60	$10.94
88358	Analysis, tumor		X	0344	0.8586	$54.69	$15.60	$10.94
88360	Tumor immunohistochem/manual		X	0343	0.5372	$34.22	$10.80	$6.84
88361	Tumor immunohistochem/comput		X	0344	0.8586	$54.69	$15.60	$10.94
88362	Nerve teasing preparations		X	0344	0.8586	$54.69	$15.60	$10.94
88365	Insitu hybridization (fish)		X	0344	0.8586	$54.69	$15.60	$10.94
88367	Insitu hybridization, auto		X	0344	0.8586	$54.69	$15.60	$10.94
88368	Insitu hybridization, manual	CH	X	0343	0.5372	$34.22	$10.80	$6.84
88371	Protein, western blot tissue		A					
88372	Protein analysis w/probe		A					
88380	Microdissection		N					
88384	Eval molecular probes, 11-50		X	0433	0.2482	$15.81	$5.90	$3.16
88385	Eval molecul probes, 51-250		X	0343	0.5372	$34.22	$10.80	$6.84
88386	Eval molecul probes, 251-500		X	0344	0.8586	$54.69	$15.60	$10.94
88399	Surgical pathology procedure		X	0342	0.0928	$5.91	$2.00	$1.18
88400	Bilirubin total transcut		A					
89049	Chct for mal hyperthermia		X	0343	0.5372	$34.22	$10.80	$6.84
89050	Body fluid cell count		A					
89051	Body fluid cell count		A					
89055	Leukocyte assessment, fecal		A					
89060	Exam,synovial fluid crystals		A					
89100	Sample intestinal contents		X	0360	1.6383	$104.35	$33.80	$20.87
89105	Sample intestinal contents		X	0360	1.6383	$104.35	$33.80	$20.87
89125	Specimen fat stain		A					
89130	Sample stomach contents		X	0360	1.6383	$104.35	$33.80	$20.87
89132	Sample stomach contents		X	0360	1.6383	$104.35	$33.80	$20.87
89135	Sample stomach contents		X	0360	1.6383	$104.35	$33.80	$20.87
89136	Sample stomach contents		X	0360	1.6383	$104.35	$33.80	$20.87
89140	Sample stomach contents		X	0360	1.6383	$104.35	$33.80	$20.87
89141	Sample stomach contents		X	0360	1.6383	$104.35	$33.80	$20.87
89160	Exam feces for meat fibers		A					
89190	Nasal smear for eosinophils		A					
89220	Sputum specimen collection		X	0343	0.5372	$34.22	$10.80	$6.84
89225	Starch granules, feces		A					
89230	Collect sweat for test	CH	X	0343	0.5372	$34.22	$10.80	$6.84
89235	Water load test		A					
89240	Pathology lab procedure		X	0342	0.0928	$5.91	$2.00	$1.18
89250	Cultr oocyte/embryo <4 days	CH	X	0344	0.8586	$54.69	$15.60	$10.94

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
89251	Cultr oocyte/embryo <4 days	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89253	Embryo hatching	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89254	Oocyte identification	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89255	Prepare embryo for transfer	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89257	Sperm identification	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89258	Cryopreservation; embryo(s)	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89259	Cryopreservation, sperm	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89260	Sperm isolation, simple	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89261	Sperm isolation, complex	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89264	Identify sperm tissue	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89268	Insemination of oocytes	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89272	Extended culture of oocytes	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89280	Assist oocyte fertilization	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89281	Assist oocyte fertilization	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89290	Biopsy, oocyte polar body	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89291	Biopsy, oocyte polar body	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89300	Semen analysis w/huhner		A					
89310	Semen analysis w/count		A					
89320	Semen analysis, complete		A					
89321	Semen analysis & motility		A					
89325	Sperm antibody test		A					
89329	Sperm evaluation test		A					
89330	Evaluation, cervical mucus		A					
89335	Cryopreserve testicular tiss	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89342	Storage/year; embryo(s)	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89343	Storage/year; sperm/semen	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89344	Storage/year; reprod tissue	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89346	Storage/year; oocyte(s)	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89352	Thawing cryopresrved; embryo	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89353	Thawing cryopresrved; sperm	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89354	Thaw cryoprsvrd; reprod tiss	CH	X	0344	0.8586	$54.69	$15.60	$10.94
89356	Thawing cryopresrved; oocyte	CH	X	0344	0.8586	$54.69	$15.60	$10.94
90281	Human ig, im		E					
90283	Human ig, iv		E					
90287	Botulinum antitoxin		E					
90288	Botulism ig, iv		E					
90291	Cmv ig, iv		E					
90296	Diphtheria antitoxin		N					
90371	Hep b ig, im		K	1630		$132.42		$26.48
90375	Rabies ig, im/sc		K	9133		$64.82		$12.96
90376	Rabies ig, heat treated		K	9134		$69.40		$13.88
90378	Rsv ig, im, 50mg		E					
90379	Rsv ig, iv		E					
90384	Rh ig, full-dose, im		E					
90385	Rh ig, minidose, im		N					
90386	Rh ig, iv		E					
90389	Tetanus ig, im		E					
90393	Vaccina ig, im		N					
90396	Varicella-zoster ig, im		K	9135		$121.58		$24.32
90399	Immune globulin		E					
90465	Immune admin 1 inj, < 8 yrs		B					
90466	Immune admin addl inj, < 8 y		B					
90467	Immune admin o or n, < 8 yrs		B					
90468	Immune admin o/n, addl < 8 y		B					
90471	Immunization admin		S	0437	0.4037	$25.71		$5.14
90472	Immunization admin, each add		S	0436	0.2201	$14.02		$2.80
90473	Immune admin oral/nasal		S	0436	0.2201	$14.02		$2.80
90474	Immune admin oral/nasal addl		S	0436	0.2201	$14.02		$2.80
90476	Adenovirus vaccine, type 4		N					
90477	Adenovirus vaccine, type 7		N					
90581	Anthrax vaccine, sc		N					
90585	Bcg vaccine, percut		K	9137		$112.56		$22.51
90586	Bcg vaccine, intravesical		B					
90632	Hep a vaccine, adult im		N					
90633	Hep a vacc, ped/adol, 2 dose		N					
90634	Hep a vacc, ped/adol, 3 dose		N					
90636	Hep a/hep b vacc, adult im		N					
90645	Hib vaccine, hboc, im		N					
90646	Hib vaccine, prp-d, im		N					
90647	Hib vaccine, prp-omp, im		N					
90648	Hib vaccine, prp-t, im		N					
90649	H papilloma vacc 3 dose im		B					
90655	Flu vaccine no preserv 6-35m		L					
90656	Flu vaccine no preserv 3 & >		L					
90657	Flu vaccine, 3 yrs, im		L					
90658	Flu vaccine, 3 yrs & >, im		L					
90660	Flu vaccine, nasal		L					
90665	Lyme disease vaccine, im		N					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
90669	Pneumococcal vacc, ped <5		E					
90675	Rabies vaccine, im		K	9139		$145.53		$29.11
90676	Rabies vaccine, id		K	9140	1.9483	$124.09		$24.82
90680	Rotovirus vacc 3 dose, oral		N					
90690	Typhoid vaccine, oral		N					
90691	Typhoid vaccine, im		N					
90692	Typhoid vaccine, h-p, sc/id		N					
90693	Typhoid vaccine, akd, sc		B					
90698	Dtap-hib-ip vaccine, im		N					
90700	Dtap vaccine, < 7 yrs, im		N					
90701	Dtp vaccine, im		N					
90702	Dt vaccine < 7, im		N					
90703	Tetanus vaccine, im		N					
90704	Mumps vaccine, sc		N					
90705	Measles vaccine, sc		N					
90706	Rubella vaccine, sc		N					
90707	Mmr vaccine, sc		N					
90708	Measles-rubella vaccine, sc		K	9141	0.9593	$61.10		$12.22
90710	Mmrv vaccine, sc		N					
90712	Oral poliovirus vaccine		N					
90713	Poliovirus, ipv, sc/im		N					
90714	Td vaccine no prsrv >/= 7 im		N					
90715	Tdap vaccine >7 im		N					
90716	Chicken pox vaccine, sc		B					
90717	Yellow fever vaccine, sc		N					
90718	Td vaccine > 7, im		N					
90719	Diphtheria vaccine, im		N					
90720	Dtp/hib vaccine, im	CH	N					
90721	Dtap/hib vaccine, im		N					
90723	Dtap-hep b-ipv vaccine, im		E					
90725	Cholera vaccine, injectable		N					
90727	Plague vaccine, im	CH	N					
90732	Pneumococcal vaccine		L					
90733	Meningococcal vaccine, sc		K	9143		$88.59		$17.72
90734	Meningococcal vaccine, im		K	9145	1.1309	$72.03		$14.41
90735	Encephalitis vaccine, sc		K	9144		$98.17		$19.63
90736	Zoster vacc, sc		B					
90740	Hepb vacc, ill pat 3 dose im		F					
90743	Hep b vacc, adol, 2 dose, im		F					
90744	Hepb vacc ped/adol 3 dose im		F					
90746	Hep b vaccine, adult, im		F					
90747	Hepb vacc, ill pat 4 dose im		F					
90748	Hep b/hib vaccine, im		E					
90749	Vaccine toxoid		N					
90760	Hydration iv infusion, init		S	0440	1.831	$116.62		$23.32
90761	Hydrate iv infusion, add-on		S	0437	0.4037	$25.71		$5.14
90765	Ther/proph/diag iv inf, init		S	0440	1.831	$116.62		$23.32
90766	Ther/proph/dg iv inf, add-on		S	0437	0.4037	$25.71		$5.14
90767	Tx/proph/dg addl seq iv inf		S	0437	0.4037	$25.71		$5.14
90768	Ther/diag concurrent inf		N					
90772	Ther/proph/diag inj, sc/im		S	0437	0.4037	$25.71		$5.14
90773	Ther/proph/diag inj, ia		S	0438	0.831	$52.93		$10.59
90774	Ther/proph/diag inj, iv push		S	0438	0.831	$52.93		$10.59
90775	Ther/proph/diag inj add-on		S	0438	0.831	$52.93		$10.59
90779	Ther/prop/diag inj/inf proc		S	0436	0.2201	$14.02		$2.80
90801	Psy dx interview	CH	Q	0323	1.672	$106.49		$21.30
90802	Intac psy dx interview	CH	Q	0323	1.672	$106.49		$21.30
90804	Psytx, office, 20-30 min	CH	Q	0322	1.2454	$79.32		$15.86
90805	Psytx, off, 20-30 min w/e&m	CH	Q	0322	1.2454	$79.32		$15.86
90806	Psytx, off, 45-50 min	CH	Q	0323	1.672	$106.49		$21.30
90807	Psytx, off, 45-50 min w/e&m	CH	Q	0323	1.672	$106.49		$21.30
90808	Psytx, office, 75-80 min	CH	Q	0323	1.672	$106.49		$21.30
90809	Psytx, off, 75-80, w/e&m	CH	Q	0323	1.672	$106.49		$21.30
90810	Intac psytx, off, 20-30 min	CH	Q	0322	1.2454	$79.32		$15.86
90811	Intac psytx, 20-30, w/e&m	CH	Q	0322	1.2454	$79.32		$15.86
90812	Intac psytx, off, 45-50 min	CH	Q	0323	1.672	$106.49		$21.30
90813	Intac psytx, 45-50 min w/e&m	CH	Q	0323	1.672	$106.49		$21.30
90814	Intac psytx, off, 75-80 min	CH	Q	0323	1.672	$106.49		$21.30
90815	Intac psytx, 75-80 w/e&m	CH	Q	0323	1.672	$106.49		$21.30
90816	Psytx, hosp, 20-30 min	CH	Q	0322	1.2454	$79.32		$15.86
90817	Psytx, hosp, 20-30 min w/e&m	CH	Q	0322	1.2454	$79.32		$15.86
90818	Psytx, hosp, 45-50 min	CH	Q	0323	1.672	$106.49		$21.30
90819	Psytx, hosp, 45-50 min w/e&m	CH	Q	0323	1.672	$106.49		$21.30
90821	Psytx, hosp, 75-80 min	CH	Q	0323	1.672	$106.49		$21.30
90822	Psytx, hosp, 75-80 min w/e&m	CH	Q	0323	1.672	$106.49		$21.30
90823	Intac psytx, hosp, 20-30 min	CH	Q	0322	1.2454	$79.32		$15.86
90824	Intac psytx, hsp 20-30 w/e&m	CH	Q	0322	1.2454	$79.32		$15.86
90826	Intac psytx, hosp, 45-50 min	CH	Q	0323	1.672	$106.49		$21.30

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
90827	Intac psytx, hsp 45-50 w/e&m	CH	Q	0323	1.672	$106.49		$21.30
90828	Intac psytx, hosp, 75-80 min	CH	Q	0323	1.672	$106.49		$21.30
90829	Intac psytx, hsp 75-80 w/e&m	CH	Q	0323	1.672	$106.49		$21.30
90845	Psychoanalysis	CH	Q	0323	1.672	$106.49		$21.30
90846	Family psytx w/o patient	CH	Q	0324	2.2233	$141.61		$28.32
90847	Family psytx w/patient	CH	Q	0324	2.2233	$141.61		$28.32
90849	Multiple family group psytx	CH	Q	0325	1.0119	$64.45	$14.04	$12.89
90853	Group psychotherapy	CH	Q	0325	1.0119	$64.45	$14.04	$12.89
90857	Intac group psytx	CH	Q	0325	1.0119	$64.45	$14.04	$12.89
90862	Medication management	CH	Q	0605	1.0016	$63.79		$12.76
90865	Narcosynthesis	CH	Q	0323	1.672	$106.49		$21.30
90870	Electroconvulsive therapy		S	0320	5.9448	$378.64	$80.00	$75.73
90875	Psychophysiological therapy		E					
90876	Psychophysiological therapy		E					
90880	Hypnotherapy	CH	Q	0323	1.672	$106.49		$21.30
90882	Environmental manipulation		E					
90885	Psy evaluation of records		N					
90887	Consultation with family		N					
90889	Preparation of report		N					
90899	Psychiatric service/therapy	CH	Q	0322	1.2454	$79.32		$15.86
90901	Biofeedback train, any meth		A					
90911	Biofeedback peri/uro/rectal	CH	T	0126	1.085	$69.11	$16.40	$13.82
90918	ESRD related services, month		E					
90919	ESRD related services, month		E					
90920	ESRD related services, month		E					
90921	ESRD related services, month		E					
90922	ESRD related services, day		E					
90923	Esrd related services, day		E					
90924	Esrd related services, day		E					
90925	Esrd related services, day		E					
90935	Hemodialysis, one evaluation		S	0170	6.7915	$432.57		$86.51
90937	Hemodialysis, repeated eval		B					
90940	Hemodialysis access study		N					
90945	Dialysis, one evaluation		S	0170	6.7915	$432.57		$86.51
90947	Dialysis, repeated eval		B					
90989	Dialysis training, complete		B					
90993	Dialysis training, incompl		B					
90997	Hemoperfusion		B					
90999	Dialysis procedure		B					
91000	Esophageal intubation		X	0361	4.0867	$260.29	$83.20	$52.06
91010	Esophagus motility study		X	0361	4.0867	$260.29	$83.20	$52.06
91011	Esophagus motility study		X	0361	4.0867	$260.29	$83.20	$52.06
91012	Esophagus motility study		X	0361	4.0867	$260.29	$83.20	$52.06
91020	Gastric motility studies		X	0361	4.0867	$260.29	$83.20	$52.06
91022	Duodenal motility study		X	0361	4.0867	$260.29	$83.20	$52.06
91030	Acid perfusion of esophagus		X	0361	4.0867	$260.29	$83.20	$52.06
91034	Gastroesophageal reflux test		X	0361	4.0867	$260.29	$83.20	$52.06
91035	G-esoph reflx tst w/electrod		X	0361	4.0867	$260.29	$83.20	$52.06
91037	Esoph imped function test		X	0361	4.0867	$260.29	$83.20	$52.06
91038	Esoph imped funct test > 1h		X	0361	4.0867	$260.29	$83.20	$52.06
91040	Esoph balloon distension tst		X	0360	1.6383	$104.35	$33.80	$20.87
91052	Gastric analysis test		X	0361	4.0867	$260.29	$83.20	$52.06
91055	Gastric intubation for smear		X	0360	1.6383	$104.35	$33.80	$20.87
91065	Breath hydrogen test		X	0360	1.6383	$104.35	$33.80	$20.87
91100	Pass intestine bleeding tube		X	0360	1.6383	$104.35	$33.80	$20.87
91105	Gastric intubation treatment		X	0360	1.6383	$104.35	$33.80	$20.87
91110	Gi tract capsule endoscopy		T	0142	9.6264	$613.13	$152.70	$122.63
91111	Esophageal capsule endoscopy		T	0141	8.673	$552.41	$143.30	$110.48
91120	Rectal sensation test		T	0126	1.085	$69.11	$16.40	$13.82
91122	Anal pressure record		T	0164	2.1659	$137.95		$27.59
91123	Irrigate fecal impaction		N					
91132	Electrogastrography		X	0360	1.6383	$104.35	$33.80	$20.87
91133	Electrogastrography w/test		X	0360	1.6383	$104.35	$33.80	$20.87
91299	Gastroenterology procedure		X	0360	1.6383	$104.35	$33.80	$20.87
92002	Eye exam, new patient		V	0605	1.0016	$63.79		$12.76
92004	Eye exam, new patient		V	0606	1.3665	$87.04		$17.41
92012	Eye exam established pat		V	0604	0.8381	$53.38		$10.68
92014	Eye exam & treatment		V	0605	1.0016	$63.79		$12.76
92015	Refraction		E					
92018	New eye exam & treatment		T	0699	14.2784	$909.43		$181.89
92019	Eye exam & treatment		T	0699	14.2784	$909.43		$181.89
92020	Special eye evaluation		S	0230	0.7379	$47.00		$9.40
92025	Corneal topography		S	0698	1.1576	$73.73		$14.75
92060	Special eye evaluation		S	0230	0.7379	$47.00		$9.40
92065	Orthoptic/pleoptic training		S	0230	0.7379	$47.00		$9.40
92070	Fitting of contact lens		N					
92081	Visual field examination(s)		S	0230	0.7379	$47.00		$9.40
92082	Visual field examination(s)		S	0230	0.7379	$47.00		$9.40

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
92083	Visual field examination(s)		S	0230	0.7379	$47.00		$9.40
92100	Serial tonometry exam(s)		N					
92120	Tonography & eye evaluation		S	0230	0.7379	$47.00		$9.40
92130	Water provocation tonography		S	0230	0.7379	$47.00		$9.40
92135	Opthalmic dx imaging		S	0230	0.7379	$47.00		$9.40
92136	Ophthalmic biometry		S	0698	1.1576	$73.73		$14.75
92140	Glaucoma provocative tests		S	0230	0.7379	$47.00		$9.40
92225	Special eye exam, initial		S	0230	0.7379	$47.00		$9.40
92226	Special eye exam, subsequent		S	0230	0.7379	$47.00		$9.40
92230	Eye exam with photos		S	0231	2.3117	$147.24		$29.45
92235	Eye exam with photos		S	0231	2.3117	$147.24		$29.45
92240	Icg angiography		S	0231	2.3117	$147.24		$29.45
92250	Eye exam with photos		S	0230	0.7379	$47.00		$9.40
92260	Ophthalmoscopy/dynamometry		S	0230	0.7379	$47.00		$9.40
92265	Eye muscle evaluation		S	0230	0.7379	$47.00		$9.40
92270	Electro-oculography		S	0230	0.7379	$47.00		$9.40
92275	Electroretinography		S	0231	2.3117	$147.24		$29.45
92283	Color vision examination		S	0230	0.7379	$47.00		$9.40
92284	Dark adaptation eye exam		S	0698	1.1576	$73.73		$14.75
92285	Eye photography		S	0230	0.7379	$47.00		$9.40
92286	Internal eye photography		S	0698	1.1576	$73.73		$14.75
92287	Internal eye photography		S	0698	1.1576	$73.73		$14.75
92310	Contact lens fitting		E					
92311	Contact lens fitting	CH	S	0230	0.7379	$47.00		$9.40
92312	Contact lens fitting	CH	S	0230	0.7379	$47.00		$9.40
92313	Contact lens fitting	CH	S	0230	0.7379	$47.00		$9.40
92314	Prescription of contact lens		E					
92315	Prescription of contact lens	CH	S	0230	0.7379	$47.00		$9.40
92316	Prescription of contact lens	CH	S	0230	0.7379	$47.00		$9.40
92317	Prescription of contact lens	CH	S	0230	0.7379	$47.00		$9.40
92325	Modification of contact lens	CH	S	0230	0.7379	$47.00		$9.40
92326	Replacement of contact lens	CH	S	0230	0.7379	$47.00		$9.40
92340	Fitting of spectacles		E					
92341	Fitting of spectacles		E					
92342	Fitting of spectacles		E					
92352	Special spectacles fitting	CH	S	0230	0.7379	$47.00		$9.40
92353	Special spectacles fitting	CH	S	0230	0.7379	$47.00		$9.40
92354	Special spectacles fitting	CH	S	0230	0.7379	$47.00		$9.40
92355	Special spectacles fitting	CH	S	0230	0.7379	$47.00		$9.40
92358	Eye prosthesis service	CH	S	0230	0.7379	$47.00		$9.40
92370	Repair & adjust spectacles		E					
92371	Repair & adjust spectacles	CH	S	0230	0.7379	$47.00		$9.40
92499	Eye service or procedure		S	0230	0.7379	$47.00		$9.40
92502	Ear and throat examination		T	0251	2.5765	$164.11		$32.82
92504	Ear microscopy examination		N					
92506	Speech/hearing evaluation		A					
92507	Speech/hearing therapy		A					
92508	Speech/hearing therapy		A					
92511	Nasopharyngoscopy		T	0071	0.8256	$52.58	$11.20	$10.52
92512	Nasal function studies		X	0363	0.8542	$54.41	$17.40	$10.88
92516	Facial nerve function test		X	0660	1.4408	$91.77	$28.00	$18.35
92520	Laryngeal function studies		X	0660	1.4408	$91.77	$28.00	$18.35
92526	Oral function therapy		A					
92531	Spontaneous nystagmus study		N					
92532	Positional nystagmus test		N					
92533	Caloric vestibular test		N					
92534	Optokinetic nystagmus test		N					
92541	Spontaneous nystagmus test		X	0363	0.8542	$54.41	$17.40	$10.88
92542	Positional nystagmus test		X	0363	0.8542	$54.41	$17.40	$10.88
92543	Caloric vestibular test		X	0660	1.4408	$91.77	$28.00	$18.35
92544	Optokinetic nystagmus test		X	0363	0.8542	$54.41	$17.40	$10.88
92545	Oscillating tracking test		X	0363	0.8542	$54.41	$17.40	$10.88
92546	Sinusoidal rotational test		X	0660	1.4408	$91.77	$28.00	$18.35
92547	Supplemental electrical test	CH	N					
92548	Posturography		X	0660	1.4408	$91.77	$28.00	$18.35
92551	Pure tone hearing test, air		E					
92552	Pure tone audiometry, air		X	0364	0.4448	$28.33	$6.98	$5.67
92553	Audiometry, air & bone		X	0365	1.281	$81.59	$18.50	$16.32
92555	Speech threshold audiometry		X	0364	0.4448	$28.33	$6.98	$5.67
92556	Speech audiometry, complete		X	0364	0.4448	$28.33	$6.98	$5.67
92557	Comprehensive hearing test		X	0365	1.281	$81.59	$18.50	$16.32
92559	Group audiometric testing		E					
92560	Bekesy audiometry, screen		E					
92561	Bekesy audiometry, diagnosis		X	0364	0.4448	$28.33	$6.98	$5.67
92562	Loudness balance test		X	0364	0.4448	$28.33	$6.98	$5.67
92563	Tone decay hearing test		X	0364	0.4448	$28.33	$6.98	$5.67
92564	Sisi hearing test		X	0364	0.4448	$28.33	$6.98	$5.67
92565	Stenger test, pure tone		X	0364	0.4448	$28.33	$6.98	$5.67

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
92567	Tympanometry		X	0364	0.4448	$28.33	$6.98	$5.67
92568	Acoustic refl threshold tst		X	0364	0.4448	$28.33	$6.98	$5.67
92569	Acoustic reflex decay test		X	0364	0.4448	$28.33	$6.98	$5.67
92571	Filtered speech hearing test		X	0364	0.4448	$28.33	$6.98	$5.67
92572	Staggered spondaic word test		X	0366	1.8646	$118.76	$26.10	$23.75
92575	Sensorineural acuity test		X	0364	0.4448	$28.33	$6.98	$5.67
92576	Synthetic sentence test		X	0364	0.4448	$28.33	$6.98	$5.67
92577	Stenger test, speech		X	0366	1.8646	$118.76	$26.10	$23.75
92579	Visual audiometry (vra)		X	0365	1.281	$81.59	$18.50	$16.32
92582	Conditioning play audiometry		X	0365	1.281	$81.59	$18.50	$16.32
92583	Select picture audiometry		X	0364	0.4448	$28.33	$6.98	$5.67
92584	Electrocochleography	CH	S	0216	2.768	$176.30		$35.26
92585	Auditor evoke potent, compre		S	0216	2.768	$176.30		$35.26
92586	Auditor evoke potent, limit		S	0218	1.1861	$75.55		$15.11
92587	Evoked auditory test		X	0363	0.8542	$54.41	$17.40	$10.88
92588	Evoked auditory test		X	0660	1.4408	$91.77	$28.00	$18.35
92590	Hearing aid exam, one ear		E					
92591	Hearing aid exam, both ears		E					
92592	Hearing aid check, one ear		E					
92593	Hearing aid check, both ears		E					
92594	Electro hearng aid test, one		E					
92595	Electro hearng aid tst, both		E					
92596	Ear protector evaluation		X	0364	0.4448	$28.33	$6.98	$5.67
92597	Oral speech device eval		A					
92601	Cochlear implt f/up exam < 7		X	0366	1.8646	$118.76	$26.10	$23.75
92602	Reprogram cochlear implt < 7		X	0366	1.8646	$118.76	$26.10	$23.75
92603	Cochlear implt f/up exam 7 >		X	0366	1.8646	$118.76	$26.10	$23.75
92604	Reprogram cochlear implt 7 >		X	0366	1.8646	$118.76	$26.10	$23.75
92605	Eval for nonspeech device rx		A					
92606	Non-speech device service		A					
92607	Ex for speech device rx, 1hr		A					
92608	Ex for speech device rx addl		A					
92609	Use of speech device service		A					
92610	Evaluate swallowing function		A					
92611	Motion fluoroscopy/swallow		A					
92612	Endoscopy swallow tst (fees)		A					
92613	Endoscopy swallow tst (fees)		B					
92614	Laryngoscopic sensory test		A					
92615	Eval laryngoscopy sense tst		E					
92616	Fees w/laryngeal sense test		A					
92617	Interprt fees/laryngeal test		E					
92620	Auditory function, 60 min		X	0365	1.281	$81.59	$18.50	$16.32
92621	Auditory function, + 15 min		N					
92625	Tinnitus assessment		X	0365	1.281	$81.59	$18.50	$16.32
92626	Eval aud rehab status		X	0365	1.281	$81.59	$18.50	$16.32
92627	Eval aud status rehab add-on		N					
92630	Aud rehab pre-ling hear loss		E					
92633	Aud rehab postling hear loss		E					
92640	Aud brainstem implt programg		X	0365	1.281	$81.59	$18.50	$16.32
92700	Ent procedure/service		X	0364	0.4448	$28.33	$6.98	$5.67
92950	Heart/lung resuscitation cpr		S	0094	2.5547	$162.72	$46.20	$32.54
92953	Temporary external pacing		S	0094	2.5547	$162.72	$46.20	$32.54
92960	Cardioversion electric, ext		S	0679	5.5905	$356.08	$95.30	$71.22
92961	Cardioversion, electric, int		S	0679	5.5905	$356.08	$95.30	$71.22
92970	Cardioassist, internal		C					
92971	Cardioassist, external		C					
92973	Percut coronary thrombectomy		T	0088	39.8001	$2,534.99	$655.20	$507.00
92974	Cath place, cardio brachytx		T	0103	15.2572	$971.78		$194.36
92975	Dissolve clot, heart vessel		C					
92977	Dissolve clot, heart vessel		T	0676	2.5179	$160.37		$32.07
92978	Intravasc us, heart add-on	CH	N					
92979	Intravasc us, heart add-on	CH	N					
92980	Insert intracoronary stent		T	0104	89.0212	$5,670.03		$1,134.01
92981	Insert intracoronary stent		T	0104	89.0212	$5,670.03		$1,134.01
92982	Coronary artery dilation		T	0083	46.0685	$2,934.24		$586.85
92984	Coronary artery dilation		T	0083	46.0685	$2,934.24		$586.85
92986	Revision of aortic valve		T	0083	46.0685	$2,934.24		$586.85
92987	Revision of mitral valve		T	0083	46.0685	$2,934.24		$586.85
92990	Revision of pulmonary valve		T	0083	46.0685	$2,934.24		$586.85
92992	Revision of heart chamber		C					
92993	Revision of heart chamber		C					
92995	Coronary atherectomy		T	0082	88.7717	$5,654.14		$1,130.83
92996	Coronary atherectomy add-on		T	0082	88.7717	$5,654.14		$1,130.83
92997	Pul art balloon repr, percut	CH	T	0083	46.0685	$2,934.24		$586.85
92998	Pul art balloon repr, percut	CH	T	0083	46.0685	$2,934.24		$586.85
93000	Electrocardiogram, complete		B					
93005	Electrocardiogram, tracing		S	0099	0.3912	$24.92		$4.98
93010	Electrocardiogram report		B					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
93012	Transmission of ecg		N					
93014	Report on transmitted ecg		B					
93015	Cardiovascular stress test		B					
93016	Cardiovascular stress test		B					
93017	Cardiovascular stress test		X	0100	2.8631	$182.36	$41.40	$36.47
93018	Cardiovascular stress test		B					
93024	Cardiac drug stress test		X	0100	2.8631	$182.36	$41.40	$36.47
93025	Microvolt t-wave assess		X	0100	2.8631	$182.36	$41.40	$36.47
93040	Rhythm ECG with report		B					
93041	Rhythm ECG, tracing		S	0099	0.3912	$24.92		$4.98
93042	Rhythm ECG, report		B					
93224	ECG monitor/report, 24 hrs		B					
93225	ECG monitor/record, 24 hrs		X	0097	1.0396	$66.22	$23.70	$13.24
93226	ECG monitor/report, 24 hrs		X	0097	1.0396	$66.22	$23.70	$13.24
93227	ECG monitor/review, 24 hrs		B					
93230	ECG monitor/report, 24 hrs		B					
93231	Ecg monitor/record, 24 hrs		X	0097	1.0396	$66.22	$23.70	$13.24
93232	ECG monitor/report, 24 hrs		X	0097	1.0396	$66.22	$23.70	$13.24
93233	ECG monitor/review, 24 hrs		B					
93235	ECG monitor/report, 24 hrs		B					
93236	ECG monitor/report, 24 hrs		X	0097	1.0396	$66.22	$23.70	$13.24
93237	ECG monitor/review, 24 hrs		B					
93268	ECG record/review		B					
93270	ECG recording		X	0097	1.0396	$66.22	$23.70	$13.24
93271	Ecg/monitoring and analysis		X	0097	1.0396	$66.22	$23.70	$13.24
93272	Ecg/review, interpret only		B					
93278	ECG/signal-averaged	CH	X	0340	0.6416	$40.87		$8.17
93303	Echo transthoracic		S	0269	6.5908	$419.79		$83.96
93304	Echo transthoracic		S	0697	4.8072	$306.18		$61.24
93307	Echo exam of heart		S	0269	6.5908	$419.79		$83.96
93308	Echo exam of heart		S	0697	4.8072	$306.18		$61.24
93312	Echo transesophageal		S	0270	8.42	$536.30	$141.30	$107.26
93313	Echo transesophageal		S	0270	8.42	$536.30	$141.30	$107.26
93314	Echo transesophageal		N					
93315	Echo transesophageal		S	0270	8.42	$536.30	$141.30	$107.26
93316	Echo transesophageal		S	0270	8.42	$536.30	$141.30	$107.26
93317	Echo transesophageal		N					
93318	Echo transesophageal intraop		S	0270	8.42	$536.30	$141.30	$107.26
93320	Doppler echo exam, heart	CH	N					
93321	Doppler echo exam, heart	CH	N					
93325	Doppler color flow add-on	CH	N					
93350	Echo transthoracic	CH	S	0697	4.8072	$306.18		$61.24
93501	Right heart catheterization		T	0080	39.8631	$2,539.00	$838.90	$507.80
93503	Insert/place heart catheter		T	0103	15.2572	$971.78		$194.36
93505	Biopsy of heart lining		T	0103	15.2572	$971.78		$194.36
93508	Cath placement, angiography		T	0080	39.8631	$2,539.00	$838.90	$507.80
93510	Left heart catheterization		T	0080	39.8631	$2,539.00	$838.90	$507.80
93511	Left heart catheterization		T	0080	39.8631	$2,539.00	$838.90	$507.80
93514	Left heart catheterization		T	0080	39.8631	$2,539.00	$838.90	$507.80
93524	Left heart catheterization		T	0080	39.8631	$2,539.00	$838.90	$507.80
93526	Rt & lT heart catheters		T	0080	39.8631	$2,539.00	$838.90	$507.80
93527	Rt & lT heart catheters		T	0080	39.8631	$2,539.00	$838.90	$507.80
93528	Rt & lT heart catheters		T	0080	39.8631	$2,539.00	$838.90	$507.80
93529	Rt, lt heart catheterization		T	0080	39.8631	$2,539.00	$838.90	$507.80
93530	Rt heart cath, congenital		T	0080	39.8631	$2,539.00	$838.90	$507.80
93531	R & l heart cath, congenital		T	0080	39.8631	$2,539.00	$838.90	$507.80
93532	R & l heart cath, congenital		T	0080	39.8631	$2,539.00	$838.90	$507.80
93533	R & l heart cath, congenital		T	0080	39.8631	$2,539.00	$838.90	$507.80
93539	Injection, cardiac cath		N					
93540	Injection, cardiac cath		N					
93541	Injection for lung angiogram		N					
93542	Injection for heart x-rays		N					
93543	Injection for heart x-rays		N					
93544	Injection for aortography		N					
93545	Inject for coronary x-rays		N					
93555	Imaging, cardiac cath		N					
93556	Imaging, cardiac cath		N					
93561	Cardiac output measurement		N					
93562	Cardiac output measurement		N					
93571	Heart flow reserve measure	CH	N					
93572	Heart flow reserve measure	CH	N					
93580	Transcath closure of asd		T	0434	141.9601	$9,041.86		$1,808.37
93581	Transcath closure of vsd		T	0434	141.9601	$9,041.86		$1,808.37
93600	Bundle of His recording	CH	S	0084	10.2918	$655.52		$131.10
93602	Intra-atrial recording	CH	S	0084	10.2918	$655.52		$131.10
93603	Right ventricular recording	CH	S	0084	10.2918	$655.52		$131.10
93609	Map tachycardia, add-on	CH	N					
93610	Intra-atrial pacing	CH	S	0084	10.2918	$655.52		$131.10

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
93612	Intraventricular pacing	CH	S	0084	10.2918	$655.52		$131.10
93613	Electrophys map 3d, add-on	CH	N					
93615	Esophageal recording	CH	S	0084	10.2918	$655.52		$131.10
93616	Esophageal recording	CH	S	0084	10.2918	$655.52		$131.10
93618	Heart rhythm pacing	CH	S	0084	10.2918	$655.52		$131.10
93619	Electrophysiology evaluation	CH	Q	0085	48.6296	$3,097.37		$619.47
93620	Electrophysiology evaluation	CH	Q	0085	48.6296	$3,097.37		$619.47
93621	Electrophysiology evaluation	CH	N					
93622	Electrophysiology evaluation	CH	N					
93623	Stimulation, pacing heart	CH	N					
93624	Electrophysiologic study		T	0085	48.6296	$3,097.37		$619.47
93631	Heart pacing, mapping	CH	N					
93640	Evaluation heart device		N					
93641	Electrophysiology evaluation		N					
93642	Electrophysiology evaluation		S	0084	10.2918	$655.52		$131.10
93650	Ablate heart dysrhythm focus	CH	Q	0085	48.6296	$3,097.37		$619.47
93651	Ablate heart dysrhythm focus	CH	Q	0086	90.7639	$5,781.03		$1,156.21
93652	Ablate heart dysrhythm focus	CH	Q	0086	90.7639	$5,781.03		$1,156.21
93660	Tilt table evaluation		S	0101	4.4249	$281.84	$100.20	$56.37
93662	Intracardiac ecg (ice)	CH	N					
93668	Peripheral vascular rehab		E					
93701	Bioimpedance, thoracic		S	0099	0.3912	$24.92		$4.98
93720	Total body plethysmography		B					
93721	Plethysmography tracing		X	0368	0.9541	$60.77	$22.70	$12.15
93722	Plethysmography report		B					
93724	Analyze pacemaker system		S	0690	0.359	$22.87	$8.60	$4.57
93727	Analyze ilr system		S	0690	0.359	$22.87	$8.60	$4.57
93731	Analyze pacemaker system		S	0690	0.359	$22.87	$8.60	$4.57
93732	Analyze pacemaker system		S	0690	0.359	$22.87	$8.60	$4.57
93733	Telephone analy, pacemaker		S	0690	0.359	$22.87	$8.60	$4.57
93734	Analyze pacemaker system		S	0690	0.359	$22.87	$8.60	$4.57
93735	Analyze pacemaker system		S	0690	0.359	$22.87	$8.60	$4.57
93736	Telephonic analy, pacemaker		S	0690	0.359	$22.87	$8.60	$4.57
93740	Temperature gradient studies		X	0368	0.9541	$60.77	$22.70	$12.15
93741	Analyze ht pace device sngl		S	0689	0.5936	$37.81		$7.56
93742	Analyze ht pace device sngl		S	0689	0.5936	$37.81		$7.56
93743	Analyze ht pace device dual		S	0689	0.5936	$37.81		$7.56
93744	Analyze ht pace device dual		S	0689	0.5936	$37.81		$7.56
93745	Set-up cardiovert-defibrill		S	0689	0.5936	$37.81		$7.56
93760	Cephalic thermogram		E					
93762	Peripheral thermogram		E					
93770	Measure venous pressure		N					
93784	Ambulatory BP monitoring		E					
93786	Ambulatory BP recording		X	0097	1.0396	$66.22	$23.70	$13.24
93788	Ambulatory BP analysis		X	0097	1.0396	$66.22	$23.70	$13.24
93790	Review/report BP recording		B					
93797	Cardiac rehab	CH	B					
93798	Cardiac rehab/monitor	CH	B					
93799	Cardiovascular procedure		X	0097	1.0396	$66.22	$23.70	$13.24
93875	Extracranial study		S	0096	1.5254	$97.16	$37.60	$19.43
93880	Extracranial study		S	0267	2.4859	$158.33	$60.50	$31.67
93882	Extracranial study		S	0267	2.4859	$158.33	$60.50	$31.67
93886	Intracranial study		S	0267	2.4859	$158.33	$60.50	$31.67
93888	Intracranial study		S	0265	0.9925	$63.22	$23.60	$12.64
93890	Tcd, vasoreactivity study		S	0266	1.5657	$99.72	$37.80	$19.94
93892	Tcd, emboli detect w/o inj		S	0266	1.5657	$99.72	$37.80	$19.94
93893	Tcd, emboli detect w/inj		S	0266	1.5657	$99.72	$37.80	$19.94
93922	Extremity study		S	0096	1.5254	$97.16	$37.60	$19.43
93923	Extremity study		S	0096	1.5254	$97.16	$37.60	$19.43
93924	Extremity study		S	0096	1.5254	$97.16	$37.60	$19.43
93925	Lower extremity study		S	0267	2.4859	$158.33	$60.50	$31.67
93926	Lower extremity study		S	0266	1.5657	$99.72	$37.80	$19.94
93930	Upper extremity study		S	0267	2.4859	$158.33	$60.50	$31.67
93931	Upper extremity study		S	0266	1.5657	$99.72	$37.80	$19.94
93965	Extremity study		S	0096	1.5254	$97.16	$37.60	$19.43
93970	Extremity study		S	0267	2.4859	$158.33	$60.50	$31.67
93971	Extremity study		S	0266	1.5657	$99.72	$37.80	$19.94
93975	Vascular study		S	0267	2.4859	$158.33	$60.50	$31.67
93976	Vascular study		S	0267	2.4859	$158.33	$60.50	$31.67
93978	Vascular study	CH	S	0267	2.4859	$158.33	$60.50	$31.67
93979	Vascular study		S	0266	1.5657	$99.72	$37.80	$19.94
93980	Penile vascular study		S	0267	2.4859	$158.33	$60.50	$31.67
93981	Penile vascular study	CH	S	0267	2.4859	$158.33	$60.50	$31.67
93990	Doppler flow testing		S	0266	1.5657	$99.72	$37.80	$19.94
94002	Vent mgmt inpat, init day		S	0079	2.6745	$170.35		$34.07
94003	Vent mgmt inpat, subq day		S	0079	2.6745	$170.35		$34.07
94004	Vent mgmt nf per day		B					
94005	Home vent mgmt supervision		B					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
94010	Breathing capacity test		X	0368	0.9541	$60.77	$22.70	$12.15
94014	Patient recorded spirometry		X	0367	0.5955	$37.93	$14.38	$7.59
94015	Patient recorded spirometry		X	0367	0.5955	$37.93	$14.38	$7.59
94016	Review patient spirometry		A					
94060	Evaluation of wheezing		X	0368	0.9541	$60.77	$22.70	$12.15
94070	Evaluation of wheezing		X	0369	2.7874	$177.54	$44.10	$35.51
94150	Vital capacity test		X	0367	0.5955	$37.93	$14.38	$7.59
94200	Lung function test (MBC/MVV)		X	0367	0.5955	$37.93	$14.38	$7.59
94240	Residual lung capacity		X	0368	0.9541	$60.77	$22.70	$12.15
94250	Expired gas collection		X	0367	0.5955	$37.93	$14.38	$7.59
94260	Thoracic gas volume		X	0368	0.9541	$60.77	$22.70	$12.15
94350	Lung nitrogen washout curve		X	0368	0.9541	$60.77	$22.70	$12.15
94360	Measure airflow resistance		X	0367	0.5955	$37.93	$14.38	$7.59
94370	Breath airway closing volume		X	0367	0.5955	$37.93	$14.38	$7.59
94375	Respiratory flow volume loop	CH	X	0368	0.9541	$60.77	$22.70	$12.15
94400	CO2 breathing response curve		X	0367	0.5955	$37.93	$14.38	$7.59
94450	Hypoxia response curve		X	0368	0.9541	$60.77	$22.70	$12.15
94452	Hast w/report		X	0368	0.9541	$60.77	$22.70	$12.15
94453	Hast w/oxygen titrate		X	0367	0.5955	$37.93	$14.38	$7.59
94610	Surfactant admin thru tube		S	0077	0.3904	$24.87	$7.70	$4.97
94620	Pulmonary stress test/simple		X	0368	0.9541	$60.77	$22.70	$12.15
94621	Pulm stress test/complex		X	0369	2.7874	$177.54	$44.10	$35.51
94640	Airway inhalation treatment		S	0077	0.3904	$24.87	$7.70	$4.97
94642	Aerosol inhalation treatment		S	0078	1.3636	$86.85		$17.37
94644	Cbt, 1st hour		S	0078	1.3636	$86.85		$17.37
94645	Cbt, each addl hour		S	0078	1.3636	$86.85		$17.37
94660	Pos airway pressure, CPAP	CH	S	0078	1.3636	$86.85		$17.37
94662	Neg press ventilation, cnp		S	0079	2.6745	$170.35		$34.07
94664	Evaluate pt use of inhaler		S	0077	0.3904	$24.87	$7.70	$4.97
94667	Chest wall manipulation		S	0077	0.3904	$24.87	$7.70	$4.97
94668	Chest wall manipulation		S	0077	0.3904	$24.87	$7.70	$4.97
94680	Exhaled air analysis, o2	CH	X	0368	0.9541	$60.77	$22.70	$12.15
94681	Exhaled air analysis, o2/co2		X	0368	0.9541	$60.77	$22.70	$12.15
94690	Exhaled air analysis		X	0367	0.5955	$37.93	$14.38	$7.59
94720	Monoxide diffusing capacity		X	0368	0.9541	$60.77	$22.70	$12.15
94725	Membrane diffusion capacity		X	0368	0.9541	$60.77	$22.70	$12.15
94750	Pulmonary compliance study	CH	X	0368	0.9541	$60.77	$22.70	$12.15
94760	Measure blood oxygen level		N					
94761	Measure blood oxygen level		N					
94762	Measure blood oxygen level	CH	Q	0097	1.0396	$66.22	$23.70	$13.24
94770	Exhaled carbon dioxide test		X	0367	0.5955	$37.93	$14.38	$7.59
94772	Breath recording, infant		X	0369	2.7874	$177.54	$44.10	$35.51
94774	Ped home apnea rec, compl		B					
94775	Ped home apnea rec, hk-up		X	0097	1.0396	$66.22	$23.70	$13.24
94776	Ped home apnea rec, downld		X	0097	1.0396	$66.22	$23.70	$13.24
94777	Ped home apnea rec, report		B					
94799	Pulmonary service/procedure		X	0367	0.5955	$37.93	$14.38	$7.59
95004	Percut allergy skin tests		X	0381	0.3014	$19.20		$3.84
95010	Percut allergy titrate test		X	0381	0.3014	$19.20		$3.84
95012	Exhaled nitric oxide meas		X	0367	0.5955	$37.93	$14.38	$7.59
95015	Id allergy titrate-drug/bug		X	0381	0.3014	$19.20		$3.84
95024	Id allergy test, drug/bug		X	0381	0.3014	$19.20		$3.84
95027	Id allergy titrate-airborne		X	0381	0.3014	$19.20		$3.84
95028	Id allergy test-delayed type		X	0381	0.3014	$19.20		$3.84
95044	Allergy patch tests		X	0381	0.3014	$19.20		$3.84
95052	Photo patch test		X	0381	0.3014	$19.20		$3.84
95056	Photosensitivity tests		X	0370	1.1024	$70.22		$14.04
95060	Eye allergy tests		X	0370	1.1024	$70.22		$14.04
95065	Nose allergy test		X	0381	0.3014	$19.20		$3.84
95070	Bronchial allergy tests		X	0369	2.7874	$177.54	$44.10	$35.51
95071	Bronchial allergy tests		X	0369	2.7874	$177.54	$44.10	$35.51
95075	Ingestion challenge test		X	0361	4.0867	$260.29	$83.20	$52.06
95115	Immunotherapy, one injection		S	0436	0.2201	$14.02		$2.80
95117	Immunotherapy injections		S	0437	0.4037	$25.71		$5.14
95120	Immunotherapy, one injection		B					
95125	Immunotherapy, many antigens		B					
95130	Immunotherapy, insect venom		B					
95131	Immunotherapy, insect venoms		B					
95132	Immunotherapy, insect venoms		B					
95133	Immunotherapy, insect venoms		B					
95134	Immunotherapy, insect venoms		B					
95144	Antigen therapy services		S	0437	0.4037	$25.71		$5.14
95145	Antigen therapy services		S	0437	0.4037	$25.71		$5.14
95146	Antigen therapy services		S	0437	0.4037	$25.71		$5.14
95147	Antigen therapy services		S	0437	0.4037	$25.71		$5.14
95148	Antigen therapy services		S	0437	0.4037	$25.71		$5.14
95149	Antigen therapy services		S	0437	0.4037	$25.71		$5.14
95165	Antigen therapy services		S	0437	0.4037	$25.71		$5.14

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
95170	Antigen therapy services		S	0437	0.4037	$25.71		$5.14
95180	Rapid desensitization		X	0370	1.1024	$70.22		$14.04
95199	Allergy immunology services		X	0381	0.3014	$19.20		$3.84
95250	Glucose monitoring, cont	CH	X	0097	1.0396	$66.22	$23.70	$13.24
95251	Gluc monitor, cont, phys i&r		B					
95805	Multiple sleep latency test		S	0209	11.5647	$736.59	$268.70	$147.32
95806	Sleep study, unattended		S	0213	2.3476	$149.53	$53.50	$29.91
95807	Sleep study, attended		S	0209	11.5647	$736.59	$268.70	$147.32
95808	Polysomnography, 1-3		S	0209	11.5647	$736.59	$268.70	$147.32
95810	Polysomnography, 4 or more		S	0209	11.5647	$736.59	$268.70	$147.32
95811	Polysomnography w/cpap		S	0209	11.5647	$736.59	$268.70	$147.32
95812	Eeg, 41-60 minutes		S	0213	2.3476	$149.53	$53.50	$29.91
95813	Eeg, over 1 hour		S	0213	2.3476	$149.53	$53.50	$29.91
95816	Eeg, awake and drowsy		S	0213	2.3476	$149.53	$53.50	$29.91
95819	Eeg, awake and asleep		S	0213	2.3476	$149.53	$53.50	$29.91
95822	Eeg, coma or sleep only		S	0213	2.3476	$149.53	$53.50	$29.91
95824	Eeg, cerebral death only	CH	S	0216	2.768	$176.30		$35.26
95827	Eeg, all night recording		S	0213	2.3476	$149.53	$53.50	$29.91
95829	Surgery electrocorticogram	CH	N					
95830	Insert electrodes for EEG		B					
95831	Limb muscle testing, manual		A					
95832	Hand muscle testing, manual		A					
95833	Body muscle testing, manual		A					
95834	Body muscle testing, manual		A					
95851	Range of motion measurements		A					
95852	Range of motion measurements		A					
95857	Tensilon test		S	0218	1.1861	$75.55		$15.11
95860	Muscle test, one limb		S	0218	1.1861	$75.55		$15.11
95861	Muscle test, 2 limbs		S	0218	1.1861	$75.55		$15.11
95863	Muscle test, 3 limbs		S	0218	1.1861	$75.55		$15.11
95864	Muscle test, 4 limbs		S	0218	1.1861	$75.55		$15.11
95865	Muscle test, larynx		S	0218	1.1861	$75.55		$15.11
95866	Muscle test, hemidiaphragm		S	0218	1.1861	$75.55		$15.11
95867	Muscle test cran nerv unilat		S	0218	1.1861	$75.55		$15.11
95868	Muscle test cran nerve bilat		S	0218	1.1861	$75.55		$15.11
95869	Muscle test, thor paraspinal	CH	S	0218	1.1861	$75.55		$15.11
95870	Muscle test, nonparaspinal		S	0215	0.5746	$36.60		$7.32
95872	Muscle test, one fiber		S	0218	1.1861	$75.55		$15.11
95873	Guide nerv destr, elec stim	CH	N					
95874	Guide nerv destr, needle emg	CH	N					
95875	Limb exercise test		S	0215	0.5746	$36.60		$7.32
95900	Motor nerve conduction test		S	0215	0.5746	$36.60		$7.32
95903	Motor nerve conduction test		S	0215	0.5746	$36.60		$7.32
95904	Sense nerve conduction test		S	0215	0.5746	$36.60		$7.32
95920	Intraop nerve test add-on	CH	N					
95921	Autonomic nerv function test		S	0215	0.5746	$36.60		$7.32
95922	Autonomic nerv function test		S	0215	0.5746	$36.60		$7.32
95923	Autonomic nerv function test	CH	S	0218	1.1861	$75.55		$15.11
95925	Somatosensory testing		S	0216	2.768	$176.30		$35.26
95926	Somatosensory testing		S	0216	2.768	$176.30		$35.26
95927	Somatosensory testing		S	0216	2.768	$176.30		$35.26
95928	C motor evoked, uppr limbs		S	0218	1.1861	$75.55		$15.11
95929	C motor evoked, lwr limbs		S	0218	1.1861	$75.55		$15.11
95930	Visual evoked potential test		S	0216	2.768	$176.30		$35.26
95933	Blink reflex test		S	0215	0.5746	$36.60		$7.32
95934	H-reflex test		S	0215	0.5746	$36.60		$7.32
95936	H-reflex test		S	0215	0.5746	$36.60		$7.32
95937	Neuromuscular junction test	CH	S	0218	1.1861	$75.55		$15.11
95950	Ambulatory eeg monitoring		S	0209	11.5647	$736.59	$268.70	$147.32
95951	EEG monitoring/videorecord		S	0209	11.5647	$736.59	$268.70	$147.32
95953	EEG monitoring/computer		S	0209	11.5647	$736.59	$268.70	$147.32
95954	EEG monitoring/giving drugs	CH	S	0218	1.1861	$75.55		$15.11
95955	EEG during surgery	CH	N					
95956	Eeg monitoring, cable/radio		S	0209	11.5647	$736.59	$268.70	$147.32
95957	EEG digital analysis	CH	N					
95958	EEG monitoring/function test		S	0213	2.3476	$149.53	$53.50	$29.91
95961	Electrode stimulation, brain		S	0216	2.768	$176.30		$35.26
95962	Electrode stim, brain add-on		S	0216	2.768	$176.30		$35.26
95965	Meg, spontaneous	CH	S	0067	61.5205	$3,918.43		$783.69
95966	Meg, evoked, single	CH	S	0065	17.1992	$1,095.47		$219.09
95967	Meg, evoked, each add'l	CH	S	0065	17.1992	$1,095.47		$219.09
95970	Analyze neurostim, no prog		S	0218	1.1861	$75.55		$15.11
95971	Analyze neurostim, simple		S	0692	1.9206	$122.33	$30.10	$24.47
95972	Analyze neurostim, complex	CH	S	0663	1.6671	$106.18		$21.24
95973	Analyze neurostim, complex		S	0663	1.6671	$106.18		$21.24
95974	Cranial neurostim, complex	CH	S	0663	1.6671	$106.18		$21.24
95975	Cranial neurostim, complex		S	0692	1.9206	$122.33	$30.10	$24.47
95978	Analyze neurostim brain/1h		S	0692	1.9206	$122.33	$30.10	$24.47

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
95979	Analyz neurostim brain addon		S	0663	1.6671	$106.18		$21.24
95990	Spin/brain pump refil & main		T	0125	2.3262	$148.16		$29.63
95991	Spin/brain pump refil & main		T	0125	2.3262	$148.16		$29.63
95999	Neurological procedure		S	0215	0.5746	$36.60		$7.32
96000	Motion analysis, video/3d		S	0216	2.768	$176.30		$35.26
96001	Motion test w/ft press meas		S	0216	2.768	$176.30		$35.26
96002	Dynamic surface emg		S	0218	1.1861	$75.55		$15.11
96003	Dynamic fine wire emg		S	0215	0.5746	$36.60		$7.32
96004	Phys review of motion tests		B					
96020	Functional brain mapping	CH	N					
96040	Genetic counseling, 30 min		B					
96101	Psycho testing by psych/phys	CH	Q	0382	2.6763	$170.46		$34.09
96102	Psycho testing by technician	CH	Q	0373	1.8183	$115.81		$23.16
96103	Psycho testing admin by comp	CH	Q	0373	1.8183	$115.81		$23.16
96105	Assessment of aphasia		A					
96110	Developmental test, lim	CH	Q	0373	1.8183	$115.81		$23.16
96111	Developmental test, extend	CH	Q	0382	2.6763	$170.46		$34.09
96116	Neurobehavioral status exam	CH	Q	0382	2.6763	$170.46		$34.09
96118	Neuropsych tst by psych/phys	CH	Q	0382	2.6763	$170.46		$34.09
96119	Neuropsych testing by tec	CH	Q	0382	2.6763	$170.46		$34.09
96120	Neuropsych tst admin w/comp	CH	Q	0373	1.8183	$115.81		$23.16
96150	Assess hlth/behave, init	CH	Q	0432	0.302	$19.24		$3.85
96151	Assess hlth/behave, subseq	CH	Q	0432	0.302	$19.24		$3.85
96152	Intervene hlth/behave, indiv	CH	Q	0432	0.302	$19.24		$3.85
96153	Intervene hlth/behave, group	CH	Q	0432	0.302	$19.24		$3.85
96154	Interv hlth/behav, fam w/pt	CH	Q	0432	0.302	$19.24		$3.85
96155	Interv hlth/behav fam no pt		E					
96401	Chemo, anti-neopl, sq/im		S	0438	0.831	$52.93		$10.59
96402	Chemo hormon antineopl sq/im		S	0438	0.831	$52.93		$10.59
96405	Chemo intralesional, up to 7		S	0438	0.831	$52.93		$10.59
96406	Chemo intralesional over 7		S	0438	0.831	$52.93		$10.59
96409	Chemo, iv push, sngl drug		S	0439	1.7152	$109.25		$21.85
96411	Chemo, iv push, addl drug		S	0439	1.7152	$109.25		$21.85
96413	Chemo, iv infusion, 1 hr		S	0441	2.4378	$155.27		$31.05
96415	Chemo, iv infusion, addl hr		S	0438	0.831	$52.93		$10.59
96416	Chemo prolong infuse w/pump		S	0441	2.4378	$155.27		$31.05
96417	Chemo iv infus each addl seq		S	0438	0.831	$52.93		$10.59
96420	Chemo, ia, push tecnique		S	0439	1.7152	$109.25		$21.85
96422	Chemo ia infusion up to 1 hr		S	0441	2.4378	$155.27		$31.05
96423	Chemo ia infuse each addl hr		S	0438	0.831	$52.93		$10.59
96425	Chemotherapy,infusion method		S	0441	2.4378	$155.27		$31.05
96440	Chemotherapy, intracavitary		S	0441	2.4378	$155.27		$31.05
96445	Chemotherapy, intracavitary		S	0441	2.4378	$155.27		$31.05
96450	Chemotherapy, into CNS		S	0441	2.4378	$155.27		$31.05
96521	Refill/maint, portable pump		S	0440	1.831	$116.62		$23.32
96522	Refill/maint pump/resvr syst		S	0440	1.831	$116.62		$23.32
96523	Irrig drug delivery device		Q	0624	0.5763	$36.71	$12.60	$7.34
96542	Chemotherapy injection		S	0438	0.831	$52.93		$10.59
96549	Chemotherapy, unspecified		S	0436	0.2201	$14.02		$2.80
96567	Photodynamic tx, skin	CH	T	0013	0.8046	$51.25		$10.25
96570	Photodynamic tx, 30 min		T	0015	1.5119	$96.30		$19.26
96571	Photodynamic tx, addl 15 min		T	0015	1.5119	$96.30		$19.26
96900	Ultraviolet light therapy		S	0001	0.5204	$33.15	$7.00	$6.63
96902	Trichogram		N					
96904	Whole body photography		N					
96910	Photochemotherapy with UV-B		S	0001	0.5204	$33.15	$7.00	$6.63
96912	Photochemotherapy with UV-A		S	0001	0.5204	$33.15	$7.00	$6.63
96913	Photochemotherapy, UV-A or B		S	0683	2.9292	$186.57		$37.31
96920	Laser tx, skin < 250 sq cm	CH	T	0015	1.5119	$96.30		$19.26
96921	Laser tx, skin 250-500 sq cm	CH	T	0015	1.5119	$96.30		$19.26
96922	Laser tx, skin > 500 sq cm	CH	T	0015	1.5119	$96.30		$19.26
96999	Dermatological procedure	CH	T	0012	0.2682	$17.08		$3.42
97001	Pt evaluation		A					
97002	Pt re-evaluation		A					
97003	Ot evaluation		A					
97004	Ot re-evaluation		A					
97005	Athletic train eval		E					
97006	Athletic train reeval		E					
97010	Hot or cold packs therapy		A					
97012	Mechanical traction therapy		A					
97014	Electric stimulation therapy		E					
97016	Vasopneumatic device therapy		A					
97018	Paraffin bath therapy		A					
97022	Whirlpool therapy		A					
97024	Diathermy eg, microwave		A					
97026	Infrared therapy		A					
97028	Ultraviolet therapy		A					
97032	Electrical stimulation		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
97033	Electric current therapy		A					
97034	Contrast bath therapy		A					
97035	Ultrasound therapy		A					
97036	Hydrotherapy		A					
97039	Physical therapy treatment		A					
97110	Therapeutic exercises		A					
97112	Neuromuscular reeducation		A					
97113	Aquatic therapy/exercises		A					
97116	Gait training therapy		A					
97124	Massage therapy		A					
97139	Physical medicine procedure		A					
97140	Manual therapy		A					
97150	Group therapeutic procedures		A					
97530	Therapeutic activities		A					
97532	Cognitive skills development		A					
97533	Sensory integration		A					
97535	Self care mngment training		A					
97537	Community/work reintegration		A					
97542	Wheelchair mngment training		A					
97545	Work hardening		A					
97546	Work hardening add-on		A					
97597	Active wound care/20 cm or <	CH	T	0015	1.5119	$96.30		$19.26
97598	Active wound care > 20 cm	CH	T	0015	1.5119	$96.30		$19.26
97602	Wound(s) care non-selective	CH	T	0015	1.5119	$96.30		$19.26
97605	Neg press wound tx, < 50 cm	CH	T	0013	0.8046	$51.25		$10.25
97606	Neg press wound tx, > 50 cm	CH	T	0015	1.5119	$96.30		$19.26
97750	Physical performance test		A					
97755	Assistive technology assess		A					
97760	Orthotic mgmt and training		A					
97761	Prosthetic training		A					
97762	C/o for orthotic/prosth use		A					
97799	Physical medicine procedure		A					
97802	Medical nutrition, indiv, in		A					
97803	Med nutrition, indiv, subseq		A					
97804	Medical nutrition, group		A					
97810	Acupunct w/o stimul 15 min		E					
97811	Acupunct w/o stimul addl 15m		E					
97813	Acupunct w/stimul 15 min		E					
97814	Acupunct w/stimul addl 15m		E					
98925	Osteopathic manipulation		S	0060	0.4877	$31.06		$6.21
98926	Osteopathic manipulation		S	0060	0.4877	$31.06		$6.21
98927	Osteopathic manipulation		S	0060	0.4877	$31.06		$6.21
98928	Osteopathic manipulation		S	0060	0.4877	$31.06		$6.21
98929	Osteopathic manipulation		S	0060	0.4877	$31.06		$6.21
98940	Chiropractic manipulation		S	0060	0.4877	$31.06		$6.21
98941	Chiropractic manipulation		S	0060	0.4877	$31.06		$6.21
98942	Chiropractic manipulation		S	0060	0.4877	$31.06		$6.21
98943	Chiropractic manipulation		E					
98960	Self-mgmt educ & train, 1 pt		E					
98961	Self-mgmt educ/train, 2-4 pt		E					
98962	Self-mgmt educ/train, 5-8 pt		E					
99000	Specimen handling		E					
99001	Specimen handling		E					
99002	Device handling		B					
99024	Postop follow-up visit		B					
99026	In-hospital on call service		E					
99027	Out-of-hosp on call service		E					
99050	Medical services after hrs		B					
99051	Med serv, eve/wkend/holiday		B					
99053	Med serv 10pm-8am, 24 hr fac		B					
99056	Med service out of office		B					
99058	Office emergency care		B					
99060	Out of office emerg med serv		B					
99070	Special supplies		B					
99071	Patient education materials		B					
99075	Medical testimony		E					
99078	Group health education		N					
99080	Special reports or forms		B					
99082	Unusual physician travel		B					
99090	Computer data analysis		B					
99091	Collect/review data from pt		N					
99100	Special anesthesia service		B					
99116	Anesthesia with hypothermia		B					
99135	Special anesthesia procedure		B					
99140	Emergency anesthesia		B					
99143	Mod cs by same phys, < 5 yrs		N					
99144	Mod cs by same phys, 5 yrs +		N					
99145	Mod cs by same phys add-on		N					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
99148	Mod cs diff phys < 5 yrs		N					
99149	Mod cs diff phys 5 yrs +		N					
99150	Mod cs diff phys add-on		N					
99170	Anogenital exam, child		T	0191	0.1414	$9.01	$2.50	$1.80
99172	Ocular function screen		E					
99173	Visual acuity screen		E					
99175	Induction of vomiting		N					
99183	Hyperbaric oxygen therapy		B					
99185	Regional hypothermia		N					
99186	Total body hypothermia		N					
99190	Special pump services		C					
99191	Special pump services		C					
99192	Special pump services		C					
99195	Phlebotomy	CH	X	0624	0.5763	$36.71	$12.60	$7.34
99199	Special service/proc/report		B					
99201	Office/outpatient visit, new		V	0604	0.8381	$53.38		$10.68
99202	Office/outpatient visit, new		V	0605	1.0016	$63.79		$12.76
99203	Office/outpatient visit, new		V	0606	1.3665	$87.04		$17.41
99204	Office/outpatient visit, new		V	0607	1.7181	$109.43		$21.89
99205	Office/outpatient visit, new		V	0608	2.2077	$140.62		$28.12
99211	Office/outpatient visit, est		V	0604	0.8381	$53.38		$10.68
99212	Office/outpatient visit, est		V	0605	1.0016	$63.79		$12.76
99213	Office/outpatient visit, est		V	0605	1.0016	$63.79		$12.76
99214	Office/outpatient visit, est		V	0606	1.3665	$87.04		$17.41
99215	Office/outpatient visit, est		V	0607	1.7181	$109.43		$21.89
99217	Observation care discharge		B					
99218	Observation care		B					
99219	Observation care		B					
99220	Observation care		B					
99221	Initial hospital care		B					
99222	Initial hospital care		B					
99223	Initial hospital care		B					
99231	Subsequent hospital care		B					
99232	Subsequent hospital care		B					
99233	Subsequent hospital care		B					
99234	Observ/hosp same date		B					
99235	Observ/hosp same date		B					
99236	Observ/hosp same date		B					
99238	Hospital discharge day		B					
99239	Hospital discharge day		B					
99241	Office consultation	CH	B					
99242	Office consultation	CH	B					
99243	Office consultation	CH	B					
99244	Office consultation	CH	B					
99245	Office consultation	CH	B					
99251	Inpatient consultation		C					
99252	Inpatient consultation		C					
99253	Inpatient consultation		C					
99254	Inpatient consultation		C					
99255	Inpatient consultation		C					
99281	Emergency dept visit		V	0609	0.8271	$52.68	$12.70	$10.54
99282	Emergency dept visit		V	0613	1.3789	$87.83	$21.00	$17.57
99283	Emergency dept visit		V	0614	2.1716	$138.32	$34.50	$27.66
99284	Emergency dept visit		V	0615	3.5191	$224.14	$48.40	$44.83
99285	Emergency dept visit		V	0616	5.4765	$348.81	$75.10	$69.76
99288	Direct advanced life support		B					
99289	Ped crit care transport		N					
99290	Ped crit care transport addl		N					
99291	Critical care, first hour		S	0617	6.8478	$436.16	$111.50	$87.23
99292	Critical care, add'l 30 min		N					
99293	Ped critical care, initial		C					
99294	Ped critical care, subseq		C					
99295	Neonate crit care, initial		C					
99296	Neonate critical care subseq		C					
99298	Ic for lbw infant < 1500 gm		C					
99299	Ic, lbw infant 1500-2500 gm		C					
99300	Ic, infant pbw 2501-5000 gm		N					
99304	Nursing facility care, init		B					
99305	Nursing facility care, init		B					
99306	Nursing facility care, init		B					
99307	Nursing fac care, subseq		B					
99308	Nursing fac care, subseq		B					
99309	Nursing fac care, subseq		B					
99310	Nursing fac care, subseq		B					
99315	Nursing fac discharge day		B					
99316	Nursing fac discharge day		B					
99318	Annual nursing fac assessmnt		B					
99324	Domicil/r-home visit new pat		B					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
99325	Domicil/r-home visit new pat		B					
99326	Domicil/r-home visit new pat		B					
99327	Domicil/r-home visit new pat		B					
99328	Domicil/r-home visit new pat		B					
99334	Domicil/r-home visit est pat		B					
99335	Domicil/r-home visit est pat		B					
99336	Domicil/r-home visit est pat		B					
99337	Domicil/r-home visit est pat		B					
99339	Domicil/r-home care supervis		B					
99340	Domicil/r-home care supervis		B					
99341	Home visit, new patient		B					
99342	Home visit, new patient		B					
99343	Home visit, new patient		B					
99344	Home visit, new patient		B					
99345	Home visit, new patient		B					
99347	Home visit, est patient		B					
99348	Home visit, est patient		B					
99349	Home visit, est patient		B					
99350	Home visit, est patient		B					
99354	Prolonged service, office		N					
99355	Prolonged service, office		N					
99356	Prolonged service, inpatient		C					
99357	Prolonged service, inpatient		C					
99358	Prolonged serv, w/o contact		N					
99359	Prolonged serv, w/o contact		N					
99360	Physician standby services		B					
99361	Physician/team conference		N					
99362	Physician/team conference		N					
99363	Anticoag mgmt, init		B					
99364	Anticoag mgmt, subseq		B					
99371	Physician phone consultation		B					
99372	Physician phone consultation		B					
99373	Physician phone consultation		B					
99374	Home health care supervision		B					
99375	Home health care supervision		E					
99377	Hospice care supervision		B					
99378	Hospice care supervision		E					
99379	Nursing fac care supervision		B					
99380	Nursing fac care supervision		B					
99381	Init pm e/m, new pat, inf		E					
99382	Init pm e/m, new pat 1-4 yrs		E					
99383	Prev visit, new, age 5-11		E					
99384	Prev visit, new, age 12-17		E					
99385	Prev visit, new, age 18-39		E					
99386	Prev visit, new, age 40-64		E					
99387	Init pm e/m, new pat 65+ yrs		E					
99391	Per pm reeval, est pat, inf		E					
99392	Prev visit, est, age 1-4		E					
99393	Prev visit, est, age 5-11		E					
99394	Prev visit, est, age 12-17		E					
99395	Prev visit, est, age 18-39		E					
99396	Prev visit, est, age 40-64		E					
99397	Per pm reeval est pat 65+ yr		E					
99401	Preventive counseling, indiv		E					
99402	Preventive counseling, indiv		E					
99403	Preventive counseling, indiv		E					
99404	Preventive counseling, indiv		E					
99411	Preventive counseling, group		E					
99412	Preventive counseling, group		E					
99420	Health risk assessment test		E					
99429	Unlisted preventive service		E					
99431	Initial care, normal newborn		V	0605	1.0016	$63.79		$12.76
99432	Newborn care, not in hosp		N					
99433	Normal newborn care/hospital		C					
99435	Newborn discharge day hosp		B					
99436	Attendance, birth		N					
99440	Newborn resuscitation		S	0094	2.5547	$162.72	$46.20	$32.54
99450	Basic life disability exam		E					
99455	Work related disability exam		B					
99456	Disability examination		B					
99499	Unlisted e&m service		B					
99500	Home visit, prenatal		E					
99501	Home visit, postnatal		E					
99502	Home visit, nb care		E					
99503	Home visit, resp therapy		E					
99504	Home visit mech ventilator		E					
99505	Home visit, stoma care		E					
99506	Home visit, im injection		E					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
99507	Home visit, cath maintain		E					
99509	Home visit day life activity		E					
99510	Home visit, sing/m/fam couns		E					
99511	Home visit, fecal/enema mgmt		E					
99512	Home visit for hemodialysis		E					
99600	Home visit nos		E					
99601	Home infusion/visit, 2 hrs		E					
99602	Home infusion, each addtl hr		E					
A0021	Outside state ambulance serv		E					
A0080	Noninterest escort in non er		E					
A0090	Interest escort in non er		E					
A0100	Nonemergency transport taxi		E					
A0110	Nonemergency transport bus		E					
A0120	Noner transport mini-bus		E					
A0130	Noner transport wheelch van		E					
A0140	Nonemergency transport air		E					
A0160	Noner transport case worker		E					
A0170	Transport parking fees/tolls		E					
A0180	Noner transport lodgng recip		E					
A0190	Noner transport meals recip		E					
A0200	Noner transport lodgng escrt		E					
A0210	Noner transport meals escort		E					
A0225	Neonatal emergency transport		A					
A0380	Basic life support mileage		A					
A0382	Basic support routine suppls		A					
A0384	Bls defibrillation supplies		A					
A0390	Advanced life support mileag		A					
A0392	Als defibrillation supplies		A					
A0394	Als IV drug therapy supplies		A					
A0396	Als esophageal intub suppls		A					
A0398	Als routine disposble suppls		A					
A0420	Ambulance waiting 1/2 hr		A					
A0422	Ambulance 02 life sustaining		A					
A0424	Extra ambulance attendant		A					
A0425	Ground mileage		A					
A0426	Als 1		A					
A0427	ALS1-emergency		A					
A0428	bls		A					
A0429	BLS-emergency		A					
A0430	Fixed wing air transport		A					
A0431	Rotary wing air transport		A					
A0432	PI volunteer ambulance co		A					
A0433	als 2		A					
A0434	Specialty care transport		A					
A0435	Fixed wing air mileage		A					
A0436	Rotary wing air mileage		A					
A0888	Noncovered ambulance mileage		E					
A0998	Ambulance response/treatment		E					
A0999	Unlisted ambulance service		A					
A4206	1 CC sterile syringe&needle		E					
A4207	2 CC sterile syringe&needle		E					
A4208	3 CC sterile syringe&needle		E					
A4209	5+ CC sterile syringe&needle		E					
A4210	Nonneedle injection device		E					
A4211	Supp for self-adm injections		E					
A4212	Non coring needle or stylet		B					
A4213	20+ CC syringe only		E					
A4215	Sterile needle		E					
A4216	Sterile water/saline, 10 ml		A					
A4217	Sterile water/saline, 500 ml		A					
A4218	Sterile saline or water		N					
A4220	Infusion pump refill kit		N					
A4221	Maint drug infus cath per wk		Y					
A4222	Infusion supplies with pump		Y					
A4223	Infusion supplies w/o pump		E					
A4230	Infus insulin pump non needl		Y					
A4231	Infusion insulin pump needle		Y					
A4232	Syringe w/needle insulin 3cc		E					
A4233	Alkalin batt for glucose mon		Y					
A4234	J-cell batt for glucose mon		Y					
A4235	Lithium batt for glucose mon		Y					
A4236	Silvr oxide batt glucose mon		Y					
A4244	Alcohol or peroxide per pint		E					
A4245	Alcohol wipes per box		E					
A4246	Betadine/phisohex solution		E					
A4247	Betadine/iodine swabs/wipes		E					
A4248	Chlorhexidine antisept		N					
A4250	Urine reagent strips/tablets		E					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A4253	Blood glucose/reagent strips		Y					
A4255	Glucose monitor platforms		Y					
A4256	Calibrator solution/chips		Y					
A4257	Replace Lensshield Cartridge		Y					
A4258	Lancet device each		Y					
A4259	Lancets per box		Y					
A4261	Cervical cap contraceptive		E					
A4262	Temporary tear duct plug		N					
A4263	Permanent tear duct plug		N					
A4265	Paraffin		Y					
A4266	Diaphragm		E					
A4267	Male condom		E					
A4268	Female condom		E					
A4269	Spermicide		E					
A4270	Disposable endoscope sheath		N					
A4280	Brst prsths adhsv attchmnt		A					
A4281	Replacement breastpump tube		E					
A4282	Replacement breastpump adpt		E					
A4283	Replacement breastpump cap		E					
A4284	Replcmnt breast pump shield		E					
A4285	Replcmnt breast pump bottle		E					
A4286	Replcmnt breastpump lok ring		E					
A4290	Sacral nerve stim test lead		B					
A4300	Cath impl vasc access portal		N					
A4301	Implantable access syst perc		N					
A4305	Drug delivery system ≧50 ML		N					
A4306	Drug delivery system ≦50 ml		N					
A4310	Insert tray w/o bag/cath		A					
A4311	Catheter w/o bag 2-way latex		A					
A4312	Cath w/o bag 2-way silicone		A					
A4313	Catheter w/bag 3-way		A					
A4314	Cath w/drainage 2-way latex		A					
A4315	Cath w/drainage 2-way silcne		A					
A4316	Cath w/drainage 3-way		A					
A4320	Irrigation tray		A					
A4321	Cath therapeutic irrig agent		A					
A4322	Irrigation syringe		A					
A4326	Male external catheter		A					
A4327	Fem urinary collect dev cup		A					
A4328	Fem urinary collect pouch		A					
A4330	Stool collection pouch		A					
A4331	Extension drainage tubing		A					
A4332	Lube sterile packet		A					
A4333	Urinary cath anchor device		A					
A4334	Urinary cath leg strap		A					
A4335	Incontinence supply		A					
A4338	Indwelling catheter latex		A					
A4340	Indwelling catheter special		A					
A4344	Cath indw foley 2 way silicn		A					
A4346	Cath indw foley 3 way		A					
A4349	Disposable male external cat		A					
A4351	Straight tip urine catheter		A					
A4352	Coude tip urinary catheter		A					
A4353	Intermittent urinary cath		A					
A4354	Cath insertion tray w/bag		A					
A4355	Bladder irrigation tubing		A					
A4356	Ext ureth clmp or compr dvc		A					
A4357	Bedside drainage bag		A					
A4358	Urinary leg or abdomen bag		A					
A4361	Ostomy face plate		A					
A4362	Solid skin barrier		A					
A4363	Ostomy clamp, replacement		A					
A4364	Adhesive, liquid or equal		A					
A4365	Adhesive remover wipes		A					
A4366	Ostomy vent		A					
A4367	Ostomy belt		A					
A4368	Ostomy filter		A					
A4369	Skin barrier liquid per oz		A					
A4371	Skin barrier powder per oz		A					
A4372	Skin barrier solid 4x4 equiv		A					
A4373	Skin barrier with flange		A					
A4375	Drainable plastic pch w fcpl		A					
A4376	Drainable rubber pch w fcplt		A					
A4377	Drainable plstic pch w/o fp		A					
A4378	Drainable rubber pch w/o fp		A					
A4379	Urinary plastic pouch w fcpl		A					
A4380	Urinary rubber pouch w fcplt		A					
A4381	Urinary plastic pouch w/o fp		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A4382	Urinary hvy plstc pch w/o fp		A					
A4383	Urinary rubber pouch w/o fp		A					
A4384	Ostomy faceplt/silicone ring		A					
A4385	Ost skn barrier sld ext wear		A					
A4387	Ost clsd pouch w att st barr		A					
A4388	Drainable pch w ex wear barr		A					
A4389	Drainable pch w st wear barr		A					
A4390	Drainable pch ex wear convex		A					
A4391	Urinary pouch w ex wear barr		A					
A4392	Urinary pouch w st wear barr		A					
A4393	Urine pch w ex wear bar conv		A					
A4394	Ostomy pouch liq deodorant		A					
A4395	Ostomy pouch solid deodorant		A					
A4396	Peristomal hernia supprt blt		A					
A4397	Irrigation supply sleeve		A					
A4398	Ostomy irrigation bag		A					
A4399	Ostomy irrig cone/cath w brs		A					
A4400	Ostomy irrigation set		A					
A4402	Lubricant per ounce		A					
A4404	Ostomy ring each		A					
A4405	Nonpectin based ostomy paste		A					
A4406	Pectin based ostomy paste		A					
A4407	Ext wear ost skn barr ≦4sq″		A					
A4408	Ext wear ost skn barr >4sq″		A					
A4409	Ost skn barr convex ≦4 sq i		A					
A4410	Ost skn barr extnd >4 sq		A					
A4411	Ost skn barr extnd =4sq		A					
A4412	Ost pouch drain high output		A					
A4413	2 pc drainable ost pouch		A					
A4414	Ost sknbar w/o conv≦4 sq in		A					
A4415	Ost skn barr w/o conv >4 sqi		A					
A4416	Ost pch clsd w barrier/filtr		A					
A4417	Ost pch w bar/bltinconv/fltr		A					
A4418	Ost pch clsd w/o bar w filtr		A					
A4419	Ost pch for bar w flange/flt		A					
A4420	Ost pch clsd for bar w lk fl		A					
A4421	Ostomy supply misc		E					
A4422	Ost pouch absorbent material		A					
A4423	Ost pch for bar w lk fl/fltr		A					
A4424	Ost pch drain w bar & filter		A					
A4425	Ost pch drain for barrier fl		A					
A4426	Ost pch drain 2 piece system		A					
A4427	Ost pch drain/barr lk flng/f		A					
A4428	Urine ost pouch w faucet/tap		A					
A4429	Urine ost pouch w bltinconv		A					
A4430	Ost urine pch w b/bltin conv		A					
A4431	Ost pch urine w barrier/tapv		A					
A4432	Os pch urine w bar/fange/tap		A					
A4433	Urine ost pch bar w lock fln		A					
A4434	Ost pch urine w lock flng/ft		A					
A4450	Non-waterproof tape		A					
A4452	Waterproof tape		A					
A4455	Adhesive remover per ounce		A					
A4458	Reusable enema bag		E					
A4461	Surgicl dress hold non-reuse		A					
A4463	Surgical dress holder reuse		A					
A4465	Non-elastic extremity binder		A					
A4470	Gravlee jet washer		A					
A4480	Vabra aspirator		A					
A4481	Tracheostoma filter		A					
A4483	Moisture exchanger		A					
A4490	Above knee surgical stocking		E					
A4495	Thigh length surg stocking		E					
A4500	Below knee surgical stocking		E					
A4510	Full length surg stocking		E					
A4520	Incontinence garment anytype		E					
A4550	Surgical trays		B					
A4554	Disposable underpads		E					
A4556	Electrodes, pair		Y					
A4557	Lead wires, pair		Y					
A4558	Conductive gel or paste		Y					
A4559	Coupling gel or paste		Y					
A4561	Pessary rubber, any type		N					
A4562	Pessary, non rubber,any type		N					
A4565	Slings		A					
A4570	Splint		E					
A4575	Hyperbaric o2 chamber disps		E					
A4580	Cast supplies (plaster)		E					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A4590	Special casting material		E					
A4595	TENS suppl 2 lead per month		Y					
A4600	Sleeve, inter limb comp dev		Y					
A4601	Lith ion batt, non-pros use		Y					
A4604	Tubing with heating element		Y					
A4605	Trach suction cath close sys		Y					
A4606	Oxygen probe used w oximeter		A					
A4608	Transtracheal oxygen cath		Y					
A4611	Heavy duty battery		Y					
A4612	Battery cables		Y					
A4613	Battery charger		Y					
A4614	Hand-held PEFR meter		N					
A4615	Cannula nasal		Y					
A4616	Tubing (oxygen) per foot		Y					
A4617	Mouth piece		Y					
A4618	Breathing circuits		Y					
A4619	Face tent		Y					
A4620	Variable concentration mask		Y					
A4623	Tracheostomy inner cannula		A					
A4624	Tracheal suction tube		Y					
A4625	Trach care kit for new trach		A					
A4626	Tracheostomy cleaning brush		A					
A4627	Spacer bag/reservoir		E					
A4628	Oropharyngeal suction cath		Y					
A4629	Tracheostomy care kit		A					
A4630	Repl bat t.e.n.s. own by pt		Y					
A4633	Uvl replacement bulb		Y					
A4634	Replacement bulb th lightbox		A					
A4635	Underarm crutch pad		Y					
A4636	Handgrip for cane etc		Y					
A4637	Repl tip cane/crutch/walker		Y					
A4638	Repl batt pulse gen sys		Y					
A4639	Infrared ht sys replcmnt pad		Y					
A4640	Alternating pressure pad		Y					
A4641	Radiopharm dx agent noc		N					
A4642	In111 satumomab	CH	N					
A4649	Surgical supplies		A					
A4651	Calibrated microcap tube		A					
A4652	Microcapillary tube sealant		A					
A4653	PD catheter anchor belt		A					
A4657	Syringe w/wo needle		A					
A4660	Sphyg/bp app w cuff and stet		A					
A4663	Dialysis blood pressure cuff		A					
A4670	Automatic bp monitor, dial		E					
A4671	Disposable cycler set		B					
A4672	Drainage ext line, dialysis		B					
A4673	Ext line w easy lock connect		B					
A4674	Chem/antisept solution, 8oz		B					
A4680	Activated carbon filter, ea		A					
A4690	Dialyzer, each		A					
A4706	Bicarbonate conc sol per gal		A					
A4707	Bicarbonate conc pow per pac		A					
A4708	Acetate conc sol per gallon		A					
A4709	Acid conc sol per gallon		A					
A4714	Treated water per gallon		A					
A4719	"Y set" tubing		A					
A4720	Dialysat sol fld vol > 249cc		A					
A4721	Dialysat sol fld vol > 999cc		A					
A4722	Dialys sol fld vol > 1999cc		A					
A4723	Dialys sol fld vol > 2999cc		A					
A4724	Dialys sol fld vol > 3999cc		A					
A4725	Dialys sol fld vol > 4999cc		A					
A4726	Dialys sol fld vol > 5999cc		A					
A4728	Dialysate solution, non-dex		B					
A4730	Fistula cannulation set, ea		A					
A4736	Topical anesthetic, per gram		A					
A4737	Inj anesthetic per 10 ml		A					
A4740	Shunt accessory		A					
A4750	Art or venous blood tubing		A					
A4755	Comb art/venous blood tubing		A					
A4760	Dialysate sol test kit, each		A					
A4765	Dialysate conc pow per pack		A					
A4766	Dialysate conc sol add 10 ml		A					
A4770	Blood collection tube/vacuum		A					
A4771	Serum clotting time tube		A					
A4772	Blood glucose test strips		A					
A4773	Occult blood test strips		A					
A4774	Ammonia test strips		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A4802	Protamine sulfate per 50 mg		A					
A4860	Disposable catheter tips		A					
A4870	Plumb/elec wk hm hemo equip		A					
A4890	Repair/maint cont hemo equip		A					
A4911	Drain bag/bottle		A					
A4913	Misc dialysis supplies noc		A					
A4918	Venous pressure clamp		A					
A4927	Non-sterile gloves		A					
A4928	Surgical mask		A					
A4929	Tourniquet for dialysis, ea		A					
A4930	Sterile, gloves per pair		A					
A4931	Reusable oral thermometer		A					
A4932	Reusable rectal thermometer		E					
A5051	Pouch clsd w barr attached		A					
A5052	Clsd ostomy pouch w/o barr		A					
A5053	Clsd ostomy pouch faceplate		A					
A5054	Clsd ostomy pouch w/flange		A					
A5055	Stoma cap		A					
A5061	Pouch drainable w barrier at		A					
A5062	Drnble ostomy pouch w/o barr		A					
A5063	Drain ostomy pouch w/flange		A					
A5071	Urinary pouch w/barrier		A					
A5072	Urinary pouch w/o barrier		A					
A5073	Urinary pouch on barr w/flng		A					
A5081	Continent stoma plug		A					
A5082	Continent stoma catheter		A					
A5093	Ostomy accessory convex inse		A					
A5102	Bedside drain btl w/wo tube		A					
A5105	Urinary suspensory		A					
A5112	Urinary leg bag		A					
A5113	Latex leg strap		A					
A5114	Foam/fabric leg strap		A					
A5120	Skin barrier, wipe or swab		A					
A5121	Solid skin barrier 6x6		A					
A5122	Solid skin barrier 8x8		A					
A5126	Disk/foam pad +or- adhesive		A					
A5131	Appliance cleaner		A					
A5200	Percutaneous catheter anchor		A					
A5500	Diab shoe for density insert		Y					
A5501	Diabetic custom molded shoe		Y					
A5503	Diabetic shoe w/roller/rockr		Y					
A5504	Diabetic shoe with wedge		Y					
A5505	Diab shoe w/metatarsal bar		Y					
A5506	Diabetic shoe w/off set heel		Y					
A5507	Modification diabetic shoe		Y					
A5508	Diabetic deluxe shoe		Y					
A5510	Compression form shoe insert		E					
A5512	Multi den insert direct form		Y					
A5513	Multi den insert custom mold		Y					
A6000	Wound warming wound cover		E					
A6010	Collagen based wound filler		A					
A6011	Collagen gel/paste wound fil		A					
A6021	Collagen dressing ≦16 sq in		A					
A6022	Collagen drsg>6≦48 sq in		A					
A6023	Collagen dressing >48 sq in		A					
A6024	Collagen dsg wound filler		A					
A6025	Silicone gel sheet, each		E					
A6154	Wound pouch each		A					
A6196	Alginate dressing ≦16 sq in		A					
A6197	Alginate drsg >16 ≦48 sq in		A					
A6198	alginate dressing > 48 sq in		A					
A6199	Alginate drsg wound filler		A					
A6200	Compos drsg ≦16 no border		A					
A6201	Compos drsg >16≦48 no bdr		A					
A6202	Compos drsg >48 no border		A					
A6203	Composite drsg ≦ 16 sq in		A					
A6204	Composite drsg >16≦48 sq in		A					
A6205	Composite drsg > 48 sq in		A					
A6206	Contact layer ≦ 16 sq in		A					
A6207	Contact layer >16≦ 48 sq in		A					
A6208	Contact layer > 48 sq in		A					
A6209	Foam drsg ≦16 sq in w/o bdr		A					
A6210	Foam drg >16≦48 sq in w/o b		A					
A6211	Foam drg > 48 sq in w/o brdr		A					
A6212	Foam drg ≦16 sq in w/border		A					
A6213	Foam drg >16≦48 sq in w/bdr		A					
A6214	Foam drg > 48 sq in w/border		A					
A6215	Foam dressing wound filler		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A6216	Non-sterile gauze≦16 sq in		A					
A6217	Non-sterile gauze>16≦48 sq		A					
A6218	Non-sterile gauze > 48 sq in		A					
A6219	Gauze ≦ 16 sq in w/border		A					
A6220	Gauze >16 ≦48 sq in w/bordr		A					
A6221	Gauze > 48 sq in w/border		A					
A6222	Gauze ≦16 in no w/sal w/o b		A					
A6223	Gauze >16≦48 no w/sal w/o b		A					
A6224	Gauze > 48 in no w/sal w/o b		A					
A6228	Gauze ≦ 16 sq in water/sal		A					
A6229	Gauze >16≦48 sq in watr/sal		A					
A6230	Gauze > 48 sq in water/salne		A					
A6231	Hydrogel dsg≦16 sq in		A					
A6232	Hydrogel dsg>16≦48 sq in		A					
A6233	Hydrogel dressing >48 sq in		A					
A6234	Hydrocolld drg ≦16 w/o bdr		A					
A6235	Hydrocolld drg >16≦48 w/o b		A					
A6236	Hydrocolld drg > 48 in w/o b		A					
A6237	Hydrocolld drg ≦16 in w/bdr		A					
A6238	Hydrocolld drg >16≦48 w/bdr		A					
A6239	Hydrocolld drg > 48 in w/bdr		A					
A6240	Hydrocolld drg filler paste		A					
A6241	Hydrocolloid drg filler dry		A					
A6242	Hydrogel drg ≦16 in w/o bdr		A					
A6243	Hydrogel drg >16≦48 w/o bdr		A					
A6244	Hydrogel drg >48 in w/o bdr		A					
A6245	Hydrogel drg ≦ 16 in w/bdr		A					
A6246	Hydrogel drg >16≦48 in w/b		A					
A6247	Hydrogel drg > 48 sq in w/b		A					
A6248	Hydrogel drsg gel filler		A					
A6250	Skin seal protect moisturizr		A					
A6251	Absorpt drg ≦16 sq in w/o b		A					
A6252	Absorpt drg >16 ≦48 w/o bdr		A					
A6253	Absorpt drg > 48 sq in w/o b		A					
A6254	Absorpt drg ≦16 sq in w/bdr		A					
A6255	Absorpt drg >16≦48 in w/bdr		A					
A6256	Absorpt drg > 48 sq in w/bdr		A					
A6257	Transparent film ≦ 16 sq in		A					
A6258	Transparent film >16≦48 in		A					
A6259	Transparent film > 48 sq in		A					
A6260	Wound cleanser any type/size		A					
A6261	Wound filler gel/paste /oz		A					
A6262	Wound filler dry form / gram		A					
A6266	Impreg gauze no h20/sal/yard		A					
A6402	Sterile gauze ≦ 16 sq in		A					
A6403	Sterile gauze>16 ≦ 48 sq in		A					
A6404	Sterile gauze > 48 sq in		A					
A6407	Packing strips, non-impreg		A					
A6410	Sterile eye pad		A					
A6411	Non-sterile eye pad		A					
A6412	Occlusive eye patch		E					
A6441	Pad band w≧3″ <5″/yd		A					
A6442	Conform band n/s w<3″/yd		A					
A6443	Conform band n/s w≧3″<5″/yd		A					
A6444	Conform band n/s w≧5″/yd		A					
A6445	Conform band s w <3″/yd		A					
A6446	Conform band s w≧3″ <5″/yd		A					
A6447	Conform band s w ≧5″/yd		A					
A6448	Lt compres band <3″/yd		A					
A6449	Lt compres band ≧3″ <5″/yd		A					
A6450	Lt compres band ≧5″/yd		A					
A6451	Mod compres band w≧3″<5″/yd		A					
A6452	High compres band w≧3″<5″yd		A					
A6453	Self-adher band w <3″/yd		A					
A6454	Self-adher band w≧3″ <5″/yd		A					
A6455	Self-adher band ≧5″/yd		A					
A6456	Zinc paste band w ≧3″<5″/yd		A					
A6457	Tubular dressing		A					
A6501	Compres burngarment bodysuit		A					
A6502	Compres burngarment chinstrp		A					
A6503	Compres burngarment facehood		A					
A6504	Cmprsburngarment glove-wrist		A					
A6505	Cmprsburngarment glove-elbow		A					
A6506	Cmprsburngrmnt glove-axilla		A					
A6507	Cmprs burngarment foot-knee		A					
A6508	Cmprs burngarment foot-thigh		A					
A6509	Compres burn garment jacket		A					
A6510	Compres burn garment leotard		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A6511	Compres burn garment panty		A					
A6512	Compres burn garment, noc		A					
A6513	Compress burn mask face/neck		B					
A6530	Compression stocking BK18-30		E					
A6531	Compression stocking BK30-40		A					
A6532	Compression stocking BK40-50		A					
A6533	Gc stocking thighlngth 18-30		E					
A6534	Gc stocking thighlngth 30-40		E					
A6535	Gc stocking thighlngth 40-50		E					
A6536	Gc stocking full lngth 18-30		E					
A6537	Gc stocking full lngth 30-40		E					
A6538	Gc stocking full lngth 40-50		E					
A6539	Gc stocking waistlngth 18-30		E					
A6540	Gc stocking waistlngth 30-40		E					
A6541	Gc stocking waistlngth 40-50		E					
A6542	Gc stocking custom made		E					
A6543	Gc stocking lymphedema		E					
A6544	Gc stocking garter belt		E					
A6549	G compression stocking		E					
A6550	Neg pres wound ther drsg set		Y					
A7000	Disposable canister for pump		Y					
A7001	Nondisposable pump canister		Y					
A7002	Tubing used w suction pump		Y					
A7003	Nebulizer administration set		Y					
A7004	Disposable nebulizer sml vol		Y					
A7005	Nondisposable nebulizer set		Y					
A7006	Filtered nebulizer admin set		Y					
A7007	Lg vol nebulizer disposable		Y					
A7008	Disposable nebulizer prefill		Y					
A7009	Nebulizer reservoir bottle		Y					
A7010	Disposable corrugated tubing		Y					
A7011	Nondispos corrugated tubing		Y					
A7012	Nebulizer water collec devic		Y					
A7013	Disposable compressor filter		Y					
A7014	Compressor nondispos filter		Y					
A7015	Aerosol mask used w nebulize		Y					
A7016	Nebulizer dome & mouthpiece		Y					
A7017	Nebulizer not used w oxygen		Y					
A7018	Water distilled w/nebulizer		Y					
A7025	Replace chest compress vest		Y					
A7026	Replace chst cmprss sys hose		Y					
A7030	CPAP full face mask		Y					
A7031	Replacement facemask interfa		Y					
A7032	Replacement nasal cushion		Y					
A7033	Replacement nasal pillows		Y					
A7034	Nasal application device		Y					
A7035	Pos airway press headgear		Y					
A7036	Pos airway press chinstrap		Y					
A7037	Pos airway pressure tubing		Y					
A7038	Pos airway pressure filter		Y					
A7039	Filter, non disposable w pap		Y					
A7040	One way chest drain valve		A					
A7041	Water seal drain container		A					
A7042	Implanted pleural catheter		A					
A7043	Vacuum drainagebottle/tubing		A					
A7044	PAP oral interface		Y					
A7045	Repl exhalation port for PAP		Y					
A7046	Repl water chamber, PAP dev		Y					
A7501	Tracheostoma valve w diaphra		A					
A7502	Replacement diaphragm/fplate		A					
A7503	HMES filter holder or cap		A					
A7504	Tracheostoma HMES filter		A					
A7505	HMES or trach valve housing		A					
A7506	HMES/trachvalve adhesivedisk		A					
A7507	Integrated filter & holder		A					
A7508	Housing & Integrated Adhesiv		A					
A7509	Heat & moisture exchange sys		A					
A7520	Trach/laryn tube non-cuffed		A					
A7521	Trach/laryn tube cuffed		A					
A7522	Trach/laryn tube stainless		A					
A7523	Tracheostomy shower protect		A					
A7524	Tracheostoma stent/stud/bttn		A					
A7525	Tracheostomy mask		A					
A7526	Tracheostomy tube collar		A					
A7527	Trach/laryn tube plug/stop		A					
A8000	Soft protect helmet prefab		Y					
A8001	Hard protect helmet prefab		Y					
A8002	Soft protect helmet custom		Y					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A8003	Hard protect helmet custom		Y					
A8004	Repl soft interface, helmet		Y					
A9150	Misc/exper non-prescript dru		B					
A9152	Single vitamin nos		E					
A9153	Multi-vitamin nos		E					
A9180	Lice treatment, topical		E					
A9270	Non-covered item or service		E					
A9275	Disp home glucose monitor		E					
A9279	Monitoring feature/deviceNOC		E					
A9280	Alert device, noc		E					
A9281	Reaching/grabbing device		E					
A9282	Wig any type		E					
A9300	Exercise equipment		E					
A9500	Tc99m sestamibi	CH	N					
A9502	Tc99m tetrofosmin	CH	N					
A9503	Tc99m medronate		N					
A9504	Tc99m apcitide		N					
A9505	TL201 thallium	CH	N					
A9507	In111 capromab	CH	N					
A9508	I131 iodobenguate, dx	CH	N					
A9510	Tc99m disofenin		N					
A9512	Tc99m pertechnetate		N					
A9516	I123 iodide cap, dx	CH	N					
A9517	I131 iodide cap, rx	CH	K	1064		$16.22		$3.24
A9521	Tc99m exametazime	CH	N					
A9524	I131 serum albumin, dx	CH	N					
A9526	Nitrogen N-13 ammonia	CH	N					
A9527	Iodine I-125 sodium iodide	CH	K	2632	0.4494	$28.62		$5.72
A9528	Iodine I-131 iodide cap, dx	CH	N					
A9529	I131 iodide sol, dx		N					
A9530	I131 iodide sol, rx	CH	K	1150		$11.74		$2.35
A9531	I131 max 100uCi		N					
A9532	I125 serum albumin, dx		N					
A9535	Injection, methylene blue		N					
A9536	Tc99m depreotide	CH	N					
A9537	Tc99m mebrofenin		N					
A9538	Tc99m pyrophosphate		N					
A9539	Tc99m pentetate	CH	N					
A9540	Tc99m MAA		N					
A9541	Tc99m sulfur colloid		N					
A9542	In111 ibritumomab, dx	CH	N					
A9543	Y90 ibritumomab, rx	CH	K	1643		$12,030.02		$2,406.00
A9544	I131 tositumomab, dx	CH	N					
A9545	I131 tositumomab, rx	CH	K	1645		$8,283.41		$1,656.68
A9546	Co57/58	CH	N					
A9547	In111 oxyquinoline	CH	N					
A9548	In111 pentetate	CH	N					
A9550	Tc99m gluceptate	CH	N					
A9551	Tc99m succimer	CH	N					
A9552	F18 fdg	CH	N					
A9553	Cr51 chromate	CH	N					
A9554	I125 iothalamate, dx		N					
A9555	Rb82 rubidium	CH	N					
A9556	Ga67 gallium	CH	N					
A9557	Tc99m bicisate	CH	N					
A9558	Xe133 xenon 10mci		N					
A9559	Co57 cyano	CH	N					
A9560	Tc99m labeled rbc	CH	N					
A9561	Tc99m oxidronate		N					
A9562	Tc99m mertiatide	CH	N					
A9563	P32 Na phosphate	CH	K	1675		$118.02		$23.60
A9564	P32 chromic phosphate	CH	K	1676		$122.17		$24.43
A9565	In111 pentetreotide	CH	N					
A9566	Tc99m fanolesomab	CH	N					
A9567	Technetium TC-99m aerosol	CH	N					
A9568	Technetium tc99m arcitumomab	CH	N					
A9600	Sr89 strontium	CH	K	0701		$610.07		$122.01
A9605	Sm 153 lexidronm	CH	K	0702		$1,446.05		$289.21
A9698	Non-rad contrast materialNOC		N					
A9699	Radiopharm rx agent noc		N					
A9700	Echocardiography Contrast		B					
A9900	Supply/accessory/service		Y					
A9901	Delivery/set up/dispensing		A					
A9999	DME supply or accessory, nos		Y					
B4034	Enter feed supkit syr by day		Y					
B4035	Enteral feed supp pump per d		Y					
B4036	Enteral feed sup kit grav by		Y					
B4081	Enteral ng tubing w/ stylet		Y					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
B4082	Enteral ng tubing w/o stylet		Y					
B4083	Enteral stomach tube levine		Y					
B4086	Gastrostomy/jejunostomy tube		Y					
B4100	Food thickener oral		E					
B4102	EF adult fluids and electro		Y					
B4103	EF ped fluid and electrolyte		Y					
B4104	Additive for enteral formula		E					
B4149	EF blenderized foods		Y					
B4150	EF complet w/intact nutrient		Y					
B4152	EF calorie dense>/=1.5Kcal		Y					
B4153	EF hydrolyzed/amino acids		Y					
B4154	EF spec metabolic noninherit		Y					
B4155	EF incomplete/modular		Y					
B4157	EF special metabolic inherit		Y					
B4158	EF ped complete intact nut		Y					
B4159	EF ped complete soy based		Y					
B4160	EF ped caloric dense>/=0.7kc		Y					
B4161	EF ped hydrolyzed/amino acid		Y					
B4162	EF ped specmetabolic inherit		Y					
B4164	Parenteral 50% dextrose solu		Y					
B4168	Parenteral sol amino acid 3.		Y					
B4172	Parenteral sol amino acid 5.		Y					
B4176	Parenteral sol amino acid 7-		Y					
B4178	Parenteral sol amino acid >		Y					
B4180	Parenteral sol carb > 50%		Y					
B4185	Parenteral sol 10 gm lipids		B					
B4189	Parenteral sol amino acid &		Y					
B4193	Parenteral sol 52-73 gm prot		Y					
B4197	Parenteral sol 74-100 gm pro		Y					
B4199	Parenteral sol > 100gm prote		Y					
B4216	Parenteral nutrition additiv		Y					
B4220	Parenteral supply kit premix		Y					
B4222	Parenteral supply kit homemi		Y					
B4224	Parenteral administration ki		Y					
B5000	Parenteral sol renal-amirosy		Y					
B5100	Parenteral sol hepatic-fream		Y					
B5200	Parenteral sol stres-brnch c		Y					
B9000	Enter infusion pump w/o alrm		Y					
B9002	Enteral infusion pump w/ ala		Y					
B9004	Parenteral infus pump portab		Y					
B9006	Parenteral infus pump statio		Y					
B9998	Enteral supp not otherwise c		Y					
B9999	Parenteral supp not othrws c		Y					
C1300	HYPERBARIC Oxygen		S	0659	1.5679	$99.86		$19.97
C1713	Anchor/screw bn/bn,tis/bn		N					
C1714	Cath, trans atherectomy, dir		N					
C1715	Brachytherapy needle		N					
C1716	Brachytx source, Gold 198	CH	K	1716	0.5016	$31.95		$6.39
C1717	Brachytx source, HDR Ir-192	CH	K	1717	2.7225	$173.40		$34.68
C1718	Brachytx source, Iodine 125	CH	B					
C1719	Brachytx sour,Non-HDR Ir-192	CH	K	1719	0.9012	$57.40		$11.48
C1720	Brachytx sour, Palladium 103	CH	B					
C1721	AICD, dual chamber		N					
C1722	AICD, single chamber		N					
C1724	Cath, trans atherec,rotation		N					
C1725	Cath, translumin non-laser		N					
C1726	Cath, bal dil, non-vascular		N					
C1727	Cath, bal tis dis, non-vas		N					
C1728	Cath, brachytx seed adm		N					
C1729	Cath, drainage		N					
C1730	Cath, EP, 19 or few elect		N					
C1731	Cath, EP, 20 or more elec		N					
C1732	Cath, EP, diag/abl, 3D/vect		N					
C1733	Cath, EP, othr than cool-tip		N					
C1750	Cath, hemodialysis,long-term		N					
C1751	Cath, inf, per/cent/midline		N					
C1752	Cath,hemodialysis,short-term		N					
C1753	Cath, intravas ultrasound		N					
C1754	Catheter, intradiscal		N					
C1755	Catheter, intraspinal		N					
C1756	Cath, pacing, transesoph		N					
C1757	Cath, thrombectomy/embolect		N					
C1758	Catheter, ureteral		N					
C1759	Cath, intra echocardiography		N					
C1760	Closure dev, vasc		N					
C1762	Conn tiss, human(inc fascia)		N					
C1763	Conn tiss, non-human		N					
C1764	Event recorder, cardiac		N					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
C1765	Adhesion barrier		N					
C1766	Intro/sheath,strble,non-peel		N					
C1767	Generator, neuro non-recharg		N					
C1768	Graft, vascular		N					
C1769	Guide wire		N					
C1770	Imaging coil, MR, insertable		N					
C1771	Rep dev, urinary, w/sling		N					
C1772	Infusion pump, programmable		N					
C1773	Ret dev, insertable		N					
C1776	Joint device (implantable)		N					
C1777	Lead, AICD, endo single coil		N					
C1778	Lead, neurostimulator		N					
C1779	Lead, pmkr, transvenous VDD		N					
C1780	Lens, intraocular (new tech)		N					
C1781	Mesh (implantable)		N					
C1782	Morcellator		N					
C1783	Ocular imp, aqueous drain de		N					
C1784	Ocular dev, intraop, det ret		N					
C1785	Pmkr, dual, rate-resp		N					
C1786	Pmkr, single, rate-resp		N					
C1787	Patient progr, neurostim		N					
C1788	Port, indwelling, imp		N					
C1789	Prosthesis, breast, imp		N					
C1813	Prosthesis, penile, inflatab		N					
C1814	Retinal tamp, silicone oil		N					
C1815	Pros, urinary sph, imp		N					
C1816	Receiver/transmitter, neuro		N					
C1817	Septal defect imp sys		N					
C1818	Integrated keratoprosthesis		N					
C1819	Tissue localization-excision		N					
C1820	Generator neuro rechg bat sy	CH	N					
C1821	Interspinous implant		H	1821				
C1874	Stent, coated/cov w/del sys		N					
C1875	Stent, coated/cov w/o del sy		N					
C1876	Stent, non-coa/non-cov w/del		N					
C1877	Stent, non-coat/cov w/o del		N					
C1878	Matrl for vocal cord		N					
C1879	Tissue marker, implantable		N					
C1880	Vena cava filter		N					
C1881	Dialysis access system		N					
C1882	AICD, other than sing/dual		N					
C1883	Adapt/ext, pacing/neuro lead		N					
C1884	Embolization Protect syst		N					
C1885	Cath, translumin angio laser		N					
C1887	Catheter, guiding		N					
C1888	Endovas non-cardiac abl cath		N					
C1891	Infusion pump,non-prog, perm		N					
C1892	Intro/sheath,fixed,peel-away		N					
C1893	Intro/sheath, fixed,non-peel		N					
C1894	Intro/sheath, non-laser		N					
C1895	Lead, AICD, endo dual coil		N					
C1896	Lead, AICD, non sing/dual		N					
C1897	Lead, neurostim test kit		N					
C1898	Lead, pmkr, other than trans		N					
C1899	Lead, pmkr/AICD combination		N					
C1900	Lead, coronary venous		N					
C2614	Probe, perc lumb disc		N					
C2615	Sealant, pulmonary, liquid		N					
C2616	Brachytx source, Yttrium-90	CH	K	2616	187.5212	$11,943.79		$2,388.76
C2617	Stent, non-cor, tem w/o del		N					
C2618	Probe, cryoablation		N					
C2619	Pmkr, dual, non rate-resp		N					
C2620	Pmkr, single, non rate-resp		N					
C2621	Pmkr, other than sing/dual		N					
C2622	Prosthesis, penile, non-inf		N					
C2625	Stent, non-cor, tem w/del sy		N					
C2626	Infusion pump, non-prog,temp		N					
C2627	Cath, suprapubic/cystoscopic		N					
C2628	Catheter, occlusion		N					
C2629	Intro/sheath, laser		N					
C2630	Cath, EP, cool-tip		N					
C2631	Rep dev, urinary, w/o sling		N					
C2633	Brachytx source, Cesium-131	CH	B					
C2634	Brachytx source, HA, I-125	CH	K	2634	0.4699	$29.93		$5.99
C2635	Brachytx source, HA, P-103	CH	K	2635	0.7389	$47.06		$9.41
C2636	Brachytx linear source,P-103	CH	K	2636	0.5824	$37.09		$7.42
C2637	Brachytx, Ytterbium-169	CH	B					
C8900	MRA w/cont, abd		S	0284	6.7963	$432.88	$148.40	$86.58

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
C8901	MRA w/o cont, abd		S	0336	5.7101	$363.69	$139.50	$72.74
C8902	MRA w/o fol w/cont, abd		S	0337	8.6689	$552.15	$199.50	$110.43
C8903	MRI w/cont, breast, uni		S	0284	6.7963	$432.88	$148.40	$86.58
C8904	MRI w/o cont, breast, uni		S	0336	5.7101	$363.69	$139.50	$72.74
C8905	MRI w/o fol w/cont, brst, un		S	0337	8.6689	$552.15	$199.50	$110.43
C8906	MRI w/cont, breast, bi		S	0284	6.7963	$432.88	$148.40	$86.58
C8907	MRI w/o cont, breast, bi		S	0336	5.7101	$363.69	$139.50	$72.74
C8908	MRI w/o fol w/cont, breast,		S	0337	8.6689	$552.15	$199.50	$110.43
C8909	MRA w/cont, chest		S	0284	6.7963	$432.88	$148.40	$86.58
C8910	MRA w/o cont, chest		S	0336	5.7101	$363.69	$139.50	$72.74
C8911	MRA w/o fol w/cont, chest		S	0337	8.6689	$552.15	$199.50	$110.43
C8912	MRA w/cont, lwr ext		S	0284	6.7963	$432.88	$148.40	$86.58
C8913	MRA w/o cont, lwr ext		S	0336	5.7101	$363.69	$139.50	$72.74
C8914	MRA w/o fol w/cont, lwr ext		S	0337	8.6689	$552.15	$199.50	$110.43
C8918	MRA w/cont, pelvis		S	0284	6.7963	$432.88	$148.40	$86.58
C8919	MRA w/o cont, pelvis		S	0336	5.7101	$363.69	$139.50	$72.74
C8920	MRA w/o fol w/cont, pelvis		S	0337	8.6689	$552.15	$199.50	$110.43
C8957	Prolonged IV inf, req pump		S	0441	2.4378	$155.27		$31.05
C9003	Palivizumab, per 50 mg		K	9003		$677.97		$135.59
C9113	Inj pantoprazole sodium, via		N					
C9121	Injection, argatroban		K	9121		$17.87		$3.57
C9232	Injection, idursulfase		G	9232		$455.03		$91.01
C9233	Injection, ranibizumab		G	9233		$2,030.92		$406.18
C9234	Inj, alglucosidase alfa		K	9234		$126.00		$25.20
C9235	Injection, panitumumab		G	9235		$84.80		$16.96
C9350	Porous collagen tube per cm		G	9350		$485.91		$97.18
C9351	Acellular derm tissue percm2		G	9351		$41.59		$8.32
C9399	Unclassified drugs or biolog		A					
C9716	Radiofrequency energy to anu		T	0150	30.5544	$1,946.10	$437.10	$389.22
C9723	Dyn IR Perf Img		S	1502		$75.00		$15.00
C9724	EPS gast cardia plic		T	0422	24.648	$1,569.91	$445.06	$313.98
C9725	Place endorectal app		S	1507		$550.00		$110.00
C9726	Rxt breast appl place/remov		S	1508		$650.00		$130.00
C9727	Insert palate implants		S	1510		$850.00		$170.00
D0120	Periodic oral evaluation		E					
D0140	Limit oral eval problm focus		E					
D0145	Oral evaluation, pt < 3yrs		E					
D0150	Comprehensve oral evaluation		S	0330	9.278	$590.94		$118.19
D0160	Extensv oral eval prob focus		E					
D0170	Re-eval,est pt,problem focus		E					
D0180	Comp periodontal evaluation		E					
D0210	Intraor complete film series		E					
D0220	Intraoral periapical first f		E					
D0230	Intraoral periapical ea add		E					
D0240	Intraoral occlusal film		S	0330	9.278	$590.94		$118.19
D0250	Extraoral first film		S	0330	9.278	$590.94		$118.19
D0260	Extraoral ea additional film		S	0330	9.278	$590.94		$118.19
D0270	Dental bitewing single film		S	0330	9.278	$590.94		$118.19
D0272	Dental bitewings two films		S	0330	9.278	$590.94		$118.19
D0273	Bitewings - three films		E					
D0274	Dental bitewings four films		S	0330	9.278	$590.94		$118.19
D0277	Vert bitewings-sev to eight		S	0330	9.278	$590.94		$118.19
D0290	Dental film skull/facial bon		E					
D0310	Dental saliography		E					
D0320	Dental tmj arthrogram incl i		E					
D0321	Dental other tmj films		E					
D0322	Dental tomographic survey		E					
D0330	Dental panoramic film		E					
D0340	Dental cephalometric film		E					
D0350	Oral/facial photo images		E					
D0360	Cone beam ct		E					
D0362	Cone beam, two dimensional		E					
D0363	Cone beam, three dimensional		E					
D0415	Collection of microorganisms		E					
D0416	Viral culture		B					
D0421	Gen tst suscept oral disease		B					
D0425	Caries susceptibility test		E					
D0431	Diag tst detect mucos abnorm		B					
D0460	Pulp vitality test		S	0330	9.278	$590.94		$118.19
D0470	Diagnostic casts		E					
D0472	Gross exam, prep & report		B					
D0473	Micro exam, prep & report		B					
D0474	Micro w exam of surg margins		B					
D0475	Decalcification procedure		B					
D0476	Spec stains for microorganis		B					
D0477	Spec stains not for microorg		B					
D0478	Immunohistochemical stains		B					
D0479	Tissue in-situ hybridization		B					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D0480	Cytopath smear prep & report		B					
D0481	Electron microscopy diagnost		B					
D0482	Direct immunofluorescence		B					
D0483	Indirect immunofluorescence		B					
D0484	Consult slides prep elsewher		B					
D0485	Consult inc prep of slides		B					
D0486	Accession of brush biopsy		E					
D0502	Other oral pathology procedu		B					
D0999	Unspecified diagnostic proce		B					
D1110	Dental prophylaxis adult		E					
D1120	Dental prophylaxis child		E					
D1203	Topical fluor w/o prophy chi		E					
D1204	Topical fluor w/o prophy adu		E					
D1206	Topical fluoride varnish		E					
D1310	Nutri counsel-control caries		E					
D1320	Tobacco counseling		E					
D1330	Oral hygiene instruction		E					
D1351	Dental sealant per tooth		E					
D1510	Space maintainer fxd unilat		S	0330	9.278	$590.94		$118.19
D1515	Fixed bilat space maintainer		S	0330	9.278	$590.94		$118.19
D1520	Remove unilat space maintain		S	0330	9.278	$590.94		$118.19
D1525	Remove bilat space maintain		S	0330	9.278	$590.94		$118.19
D1550	Recement space maintainer		S	0330	9.278	$590.94		$118.19
D1555	Remove fix space maintainer		E					
D2140	Amalgam one surface permanen		E					
D2150	Amalgam two surfaces permane		E					
D2160	Amalgam three surfaces perma		E					
D2161	Amalgam 4 or > surfaces perm		E					
D2330	Resin one surface-anterior		E					
D2331	Resin two surfaces-anterior		E					
D2332	Resin three surfaces-anterio		E					
D2335	Resin 4/> surf or w incis an		E					
D2390	Ant resin-based cmpst crown		E					
D2391	Post 1 srfc resinbased cmpst		E					
D2392	Post 2 srfc resinbased cmpst		E					
D2393	Post 3 srfc resinbased cmpst		E					
D2394	Post ≧4srfc resinbase cmpst		E					
D2410	Dental gold foil one surface		E					
D2420	Dental gold foil two surface		E					
D2430	Dental gold foil three surfa		E					
D2510	Dental inlay metalic 1 surf		E					
D2520	Dental inlay metallic 2 surf		E					
D2530	Dental inlay metl 3/more sur		E					
D2542	Dental onlay metallic 2 surf		E					
D2543	Dental onlay metallic 3 surf		E					
D2544	Dental onlay metl 4/more sur		E					
D2610	Inlay porcelain/ceramic 1 su		E					
D2620	Inlay porcelain/ceramic 2 su		E					
D2630	Dental onlay porc 3/more sur		E					
D2642	Dental onlay porcelin 2 surf		E					
D2643	Dental onlay porcelin 3 surf		E					
D2644	Dental onlay porc 4/more sur		E					
D2650	Inlay composite/resin one su		E					
D2651	Inlay composite/resin two su		E					
D2652	Dental inlay resin 3/mre sur		E					
D2662	Dental onlay resin 2 surface		E					
D2663	Dental onlay resin 3 surface		E					
D2664	Dental onlay resin 4/mre sur		E					
D2710	Crown resin-based indirect		E					
D2712	Crown 3/4 resin-based compos		E					
D2720	Crown resin w/ high noble me		E					
D2721	Crown resin w/ base metal		E					
D2722	Crown resin w/ noble metal		E					
D2740	Crown porcelain/ceramic subs		E					
D2750	Crown porcelain w/ h noble m		E					
D2751	Crown porcelain fused base m		E					
D2752	Crown porcelain w/ noble met		E					
D2780	Crown 3/4 cast hi noble met		E					
D2781	Crown 3/4 cast base metal		E					
D2782	Crown 3/4 cast noble metal		E					
D2783	Crown 3/4 porcelain/ceramic		E					
D2790	Crown full cast high noble m		E					
D2791	Crown full cast base metal		E					
D2792	Crown full cast noble metal		E					
D2794	Crown-titanium		E					
D2799	Provisional crown		E					
D2910	Recement inlay onlay or part		E					
D2915	Recement cast or prefab post		E					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D2920	Dental recement crown		E					
D2930	Prefab stnlss steel crwn pri		E					
D2931	Prefab stnlss steel crown pe		E					
D2932	Prefabricated resin crown		E					
D2933	Prefab stainless steel crown		E					
D2934	Prefab steel crown primary		E					
D2940	Dental sedative filling		E					
D2950	Core build-up incl any pins		E					
D2951	Tooth pin retention		E					
D2952	Post and core cast + crown		E					
D2953	Each addtnl cast post		E					
D2954	Prefab post/core + crown		E					
D2955	Post removal		E					
D2957	Each addtnl prefab post		E					
D2960	Laminate labial veneer		E					
D2961	Lab labial veneer resin		E					
D2962	Lab labial veneer porcelain		E					
D2971	Add proc construct new crown		E					
D2975	Coping		E					
D2980	Crown repair		E					
D2999	Dental unspec restorative pr		S	0330	9.278	$590.94		$118.19
D3110	Pulp cap direct		E					
D3120	Pulp cap indirect		E					
D3220	Therapeutic pulpotomy		E					
D3221	Gross pulpal debridement		E					
D3230	Pulpal therapy anterior prim		E					
D3240	Pulpal therapy posterior pri		E					
D3310	Anterior		E					
D3320	Root canal therapy 2 canals		E					
D3330	Root canal therapy 3 canals		E					
D3331	Non-surg tx root canal obs		E					
D3332	Incomplete endodontic tx		E					
D3333	Internal root repair		E					
D3346	Retreat root canal anterior		E					
D3347	Retreat root canal bicuspid		E					
D3348	Retreat root canal molar		E					
D3351	Apexification/recalc initial		E					
D3352	Apexification/recalc interim		E					
D3353	Apexification/recalc final		E					
D3410	Apicoect/perirad surg anter		E					
D3421	Root surgery bicuspid		E					
D3425	Root surgery molar		E					
D3426	Root surgery ea add root		E					
D3430	Retrograde filling		E					
D3450	Root amputation		E					
D3460	Endodontic endosseous implan		S	0330	9.278	$590.94		$118.19
D3470	Intentional replantation		E					
D3910	Isolation- tooth w rubb dam		E					
D3920	Tooth splitting		E					
D3950	Canal prep/fitting of dowel		E					
D3999	Endodontic procedure		S	0330	9.278	$590.94		$118.19
D4210	Gingivectomy/plasty per quad		E					
D4211	Gingivectomy/plasty per toot		E					
D4230	Ana crown exp 4 or> per quad		E					
D4231	Ana crown exp 1-3 per quad		E					
D4240	Gingival flap proc w/ planin		E					
D4241	Gngvl flap w rootplan 1-3 th		E					
D4245	Apically positioned flap		E					
D4249	Crown lengthen hard tissue		E					
D4260	Osseous surgery per quadrant		S	0330	9.278	$590.94		$118.19
D4261	Osseous surgl-3teethperquad		E					
D4263	Bone replce graft first site		S	0330	9.278	$590.94		$118.19
D4264	Bone replce graft each add		S	0330	9.278	$590.94		$118.19
D4265	Bio mtrls to aid soft/os reg		E					
D4266	Guided tiss regen resorble		E					
D4267	Guided tiss regen nonresorb		E					
D4268	Surgical revision procedure		S	0330	9.278	$590.94		$118.19
D4270	Pedicle soft tissue graft pr		S	0330	9.278	$590.94		$118.19
D4271	Free soft tissue graft proc		S	0330	9.278	$590.94		$118.19
D4273	Subepithelial tissue graft		S	0330	9.278	$590.94		$118.19
D4274	Distal/proximal wedge proc		E					
D4275	Soft tissue allograft		E					
D4276	Con tissue w dble ped graft		E					
D4320	Provision splnt intracoronal		E					
D4321	Provisional splint extracoro		E					
D4341	Periodontal scaling & root		E					
D4342	Periodontal scaling 1-3teeth		E					
D4355	Full mouth debridement		S	0330	9.278	$590.94		$118.19

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D4381	Localized delivery antimicro		S	0330	9.278	$590.94		$118.19
D4910	Periodontal maint procedures		E					
D4920	Unscheduled dressing change		E					
D4999	Unspecified periodontal proc		E					
D5110	Dentures complete maxillary		E					
D5120	Dentures complete mandible		E					
D5130	Dentures immediat maxillary		E					
D5140	Dentures immediat mandible		E					
D5211	Dentures maxill part resin		E					
D5212	Dentures mand part resin		E					
D5213	Dentures maxill part metal		E					
D5214	Dentures mandibl part metal		E					
D5225	Maxillary part denture flex		E					
D5226	Mandibular part denture flex		E					
D5281	Removable partial denture		E					
D5410	Dentures adjust cmplt maxil		E					
D5411	Dentures adjust cmplt mand		E					
D5421	Dentures adjust part maxill		E					
D5422	Dentures adjust part mandbl		E					
D5510	Dentur repr broken compl bas		E					
D5520	Replace denture teeth complt		E					
D5610	Dentures repair resin base		E					
D5620	Rep part denture cast frame		E					
D5630	Rep partial denture clasp		E					
D5640	Replace part denture teeth		E					
D5650	Add tooth to partial denture		E					
D5660	Add clasp to partial denture		E					
D5670	Replc tth&acrlc on mtl frmwk		E					
D5671	Replc tth&acrlc mandibular		E					
D5710	Dentures rebase cmplt maxil		E					
D5711	Dentures rebase cmplt mand		E					
D5720	Dentures rebase part maxill		E					
D5721	Dentures rebase part mandbl		E					
D5730	Denture reln cmplt maxil ch		E					
D5731	Denture reln cmplt mand chr		E					
D5740	Denture reln part maxil chr		E					
D5741	Denture reln part mand chr		E					
D5750	Denture reln cmplt max lab		E					
D5751	Denture reln cmplt mand lab		E					
D5760	Denture reln part maxil lab		E					
D5761	Denture reln part mand lab		E					
D5810	Denture interm cmplt maxill		E					
D5811	Denture interm cmplt mandbl		E					
D5820	Denture interm part maxill		E					
D5821	Denture interm part mandbl		E					
D5850	Denture tiss conditn maxill		E					
D5851	Denture tiss condtin mandbl		E					
D5860	Overdenture complete		E					
D5861	Overdenture partial		E					
D5862	Precision attachment		E					
D5867	Replacement of precision att		E					
D5875	Prosthesis modification		E					
D5899	Removable prosthodontic proc		E					
D5911	Facial moulage sectional		S	0330	9.278	$590.94		$118.19
D5912	Facial moulage complete		S	0330	9.278	$590.94		$118.19
D5913	Nasal prosthesis		E					
D5914	Auricular prosthesis		E					
D5915	Orbital prosthesis		E					
D5916	Ocular prosthesis		E					
D5919	Facial prosthesis		E					
D5922	Nasal septal prosthesis		E					
D5923	Ocular prosthesis interim		E					
D5924	Cranial prosthesis		E					
D5925	Facial augmentation implant		E					
D5926	Replacement nasal prosthesis		E					
D5927	Auricular replacement		E					
D5928	Orbital replacement		E					
D5929	Facial replacement		E					
D5931	Surgical obturator		E					
D5932	Postsurgical obturator		E					
D5933	Refitting of obturator		E					
D5934	Mandibular flange prosthesis		E					
D5935	Mandibular denture prosth		E					
D5936	Temp obturator prosthesis		E					
D5937	Trismus appliance		E					
D5951	Feeding aid		E					
D5952	Pediatric speech aid		E					
D5953	Adult speech aid		E					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D5954	Superimposed prosthesis		E					
D5955	Palatal lift prosthesis		E					
D5958	Intraoral con def inter plt		E					
D5959	Intraoral con def mod palat		E					
D5960	Modify speech aid prosthesis		E					
D5982	Surgical stent		E					
D5983	Radiation applicator		S	0330	9.278	$590.94		$118.19
D5984	Radiation shield		S	0330	9.278	$590.94		$118.19
D5985	Radiation cone locator		S	0330	9.278	$590.94		$118.19
D5986	Fluoride applicator		E					
D5987	Commissure splint		S	0330	9.278	$590.94		$118.19
D5988	Surgical splint		E					
D5999	Maxillofacial prosthesis		E					
D6010	Odontics endosteal implant		E					
D6012	Endosteal implant		E					
D6040	Odontics eposteal implant		E					
D6050	Odontics transosteal implnt		E					
D6053	Implnt/abtmnt spprt remv dnt		E					
D6054	Implnt/abtmnt spprt remvprtl		E					
D6055	Implant connecting bar		E					
D6056	Prefabricated abutment		E					
D6057	Custom abutment		E					
D6058	Abutment supported crown		E					
D6059	Abutment supported mtl crown		E					
D6060	Abutment supported mtl crown		E					
D6061	Abutment supported mtl crown		E					
D6062	Abutment supported mtl crown		E					
D6063	Abutment supported mtl crown		E					
D6064	Abutment supported mtl crown		E					
D6065	Implant supported crown		E					
D6066	Implant supported mtl crown		E					
D6067	Implant supported mtl crown		E					
D6068	Abutment supported retainer		E					
D6069	Abutment supported retainer		E					
D6070	Abutment supported retainer		E					
D6071	Abutment supported retainer		E					
D6072	Abutment supported retainer		E					
D6073	Abutment supported retainer		E					
D6074	Abutment supported retainer		E					
D6075	Implant supported retainer		E					
D6076	Implant supported retainer		E					
D6077	Implant supported retainer		E					
D6078	Implnt/abut suprtd fixd dent		E					
D6079	Implnt/abut suprtd fixd dent		E					
D6080	Implant maintenance		E					
D6090	Repair implant		E					
D6091	Repl semi/precision attach		E					
D6092	Recement supp crown		E					
D6093	Recement supp part denture		E					
D6094	Abut support crown titanium		E					
D6095	Odontics repr abutment		E					
D6100	Removal of implant		E					
D6190	Radio/surgical implant index		E					
D6194	Abut support retainer titani		E					
D6199	Implant procedure		E					
D6205	Pontic-indirect resin based		E					
D6210	Prosthodont high noble metal		E					
D6211	Bridge base metal cast		E					
D6212	Bridge noble metal cast		E					
D6214	Pontic titanium		E					
D6240	Bridge porcelain high noble		E					
D6241	Bridge porcelain base metal		E					
D6242	Bridge porcelain nobel metal		E					
D6245	Bridge porcelain/ceramic		E					
D6250	Bridge resin w/high noble		E					
D6251	Bridge resin base metal		E					
D6252	Bridge resin w/noble metal		E					
D6253	Provisional pontic		E					
D6545	Dental retainr cast metl		E					
D6548	Porcelain/ceramic retainer		E					
D6600	Porcelain/ceramic inlay 2srf		E					
D6601	Porc/ceram inlay ≧ 3 surfac		E					
D6602	Cst hgh nble mtl inlay 2 srf		E					
D6603	Cst hgh nble mtl inlay ≧3sr		E					
D6604	Cst bse mtl inlay 2 surfaces		E					
D6605	Cst bse mtl inlay ≧ 3 surfa		E					
D6606	Cast noble metal inlay 2 sur		E					
D6607	Cst noble mtl inlay ≧3 surf		E					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D6608	Onlay porc/crmc 2 surfaces		E					
D6609	Onlay porc/crmc ≧3 surfaces		E					
D6610	Onlay cst hgh nbl mtl 2 srfc		E					
D6611	Onlay cst hgh nbl mtl ≧3srf		E					
D6612	Onlay cst base mtl 2 surface		E					
D6613	Onlay cst base mtl ≧3 surfa		E					
D6614	Onlay cst nbl mtl 2 surfaces		E					
D6615	Onlay cst nbl mtl ≧3 surfac		E					
D6624	Inlay titanium		E					
D6634	Onlay titanium		E					
D6710	Crown-indirect resin based		E					
D6720	Retain crown resin w hi nble		E					
D6721	Crown resin w/base metal		E					
D6722	Crown resin w/noble metal		E					
D6740	Crown porcelain/ceramic		E					
D6750	Crown porcelain high noble		E					
D6751	Crown porcelain base metal		E					
D6752	Crown porcelain noble metal		E					
D6780	Crown 3/4 high noble metal		E					
D6781	Crown 3/4 cast based metal		E					
D6782	Crown 3/4 cast noble metal		E					
D6783	Crown 3/4 porcelain/ceramic		E					
D6790	Crown full high noble metal		E					
D6791	Crown full base metal cast		E					
D6792	Crown full noble metal cast		E					
D6793	Provisional retainer crown		E					
D6794	Crown titanium		E					
D6920	Dental connector bar		S	0330	9.278	$590.94		$118.19
D6930	Dental recement bridge		E					
D6940	Stress breaker		E					
D6950	Precision attachment		E					
D6970	Post & core plus retainer		E					
D6972	Prefab post & core plus reta		E					
D6973	Core build up for retainer		E					
D6975	Coping metal		E					
D6976	Each addtnl cast post		E					
D6977	Each addtl prefab post		E					
D6980	Bridge repair		E					
D6985	Pediatric partial denture fx		E					
D6999	Fixed prosthodontic proc		E					
D7111	Extraction coronal remnants		S	0330	9.278	$590.94		$118.19
D7140	Extraction erupted tooth/exr		S	0330	9.278	$590.94		$118.19
D7210	Rem imp tooth w mucoper flp		S	0330	9.278	$590.94		$118.19
D7220	Impact tooth remov soft tiss		S	0330	9.278	$590.94		$118.19
D7230	Impact tooth remov part bony		S	0330	9.278	$590.94		$118.19
D7240	Impact tooth remov comp bony		S	0330	9.278	$590.94		$118.19
D7241	Impact tooth rem bony w/comp		S	0330	9.278	$590.94		$118.19
D7250	Tooth root removal		S	0330	9.278	$590.94		$118.19
D7260	Oral antral fistula closure		S	0330	9.278	$590.94		$118.19
D7261	Primary closure sinus perf		S	0330	9.278	$590.94		$118.19
D7270	Tooth reimplantation		E					
D7272	Tooth transplantation		E					
D7280	Exposure impact tooth orthod		E					
D7282	Mobilize erupted/malpos toot		E					
D7283	Place device impacted tooth		B					
D7285	Biopsy of oral tissue hard		E					
D7286	Biopsy of oral tissue soft		E					
D7287	Exfoliative cytolog collect		E					
D7288	Brush biopsy		B					
D7290	Repositioning of teeth		E					
D7291	Transseptal fiberotomy		S	0330	9.278	$590.94		$118.19
D7292	Screw retained plate		E					
D7293	Temp anchorage dev w flap		E					
D7294	Temp anchorage dev w/o flap		E					
D7310	Alveoplasty w/ extraction		E					
D7311	Alveoloplasty w/extract 1-3		E					
D7320	Alveoplasty w/o extraction		E					
D7321	Alveoloplasty not w/extracts		B					
D7340	Vestibuloplasty ridge extens		E					
D7350	Vestibuloplasty exten graft		E					
D7410	Rad exc lesion up to 1.25 cm		E					
D7411	Excision benign lesion>1.25c		E					
D7412	Excision benign lesion compl		E					
D7413	Excision malig lesion≦1.25c		E					
D7414	Excision malig lesion>1.25cm		E					
D7415	Excision malig les complicat		E					
D7440	Malig tumor exc to 1.25 cm		E					
D7441	Malig tumor > 1.25 cm		E					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D7450	Rem odontogen cyst to 1.25cm		E					
D7451	Rem odontogen cyst > 1.25 cm		E					
D7460	Rem nonodonto cyst to 1.25cm		E					
D7461	Rem nonodonto cyst > 1.25 cm		E					
D7465	Lesion destruction		E					
D7471	Rem exostosis any site		E					
D7472	Removal of torus palatinus		E					
D7473	Remove torus mandibularis		E					
D7485	Surg reduct osseoustuberosit		E					
D7490	Maxilla or mandible resectio		E					
D7510	I&d absc intraoral soft tiss		E					
D7511	Incision/drain abscess intra		B					
D7520	I&d abscess extraoral		E					
D7521	Incision/drain abscess extra		B					
D7530	Removal fb skin/areolar tiss		E					
D7540	Removal of fb reaction		E					
D7550	Removal of sloughed off bone		E					
D7560	Maxillary sinusotomy		E					
D7610	Maxilla open reduct simple		E					
D7620	Clsd reduct simpl maxilla fx		E					
D7630	Open red simpl mandible fx		E					
D7640	Clsd red simpl mandible fx		E					
D7650	Open red simp malar/zygom fx		E					
D7660	Clsd red simp malar/zygom fx		E					
D7670	Closd rductn splint alveolus		E					
D7671	Alveolus open reduction		E					
D7680	Reduct simple facial bone fx		E					
D7710	Maxilla open reduct compound		E					
D7720	Clsd reduct compd maxilla fx		E					
D7730	Open reduct compd mandble fx		E					
D7740	Clsd reduct compd mandble fx		E					
D7750	Open red comp malar/zygma fx		E					
D7760	Clsd red comp malar/zygma fx		E					
D7770	Open reduc compd alveolus fx		E					
D7771	Alveolus clsd reduc stblz te		E					
D7780	Reduct compnd facial bone fx		E					
D7810	Tmj open reduct-dislocation		E					
D7820	Closed tmp manipulation		E					
D7830	Tmj manipulation under anest		E					
D7840	Removal of tmj condyle		E					
D7850	Tmj meniscectomy		E					
D7852	Tmj repair of joint disc		E					
D7854	Tmj excisn of joint membrane		E					
D7856	Tmj cutting of a muscle		E					
D7858	Tmj reconstruction		E					
D7860	Tmj cutting into joint		E					
D7865	Tmj reshaping components		E					
D7870	Tmj aspiration joint fluid		E					
D7871	Lysis + lavage w catheters		E					
D7872	Tmj diagnostic arthroscopy		E					
D7873	Tmj arthroscopy lysis adhesn		E					
D7874	Tmj arthroscopy disc reposit		E					
D7875	Tmj arthroscopy synovectomy		E					
D7876	Tmj arthroscopy discectomy		E					
D7877	Tmj arthroscopy debridement		E					
D7880	Occlusal orthotic appliance		E					
D7899	Tmj unspecified therapy		E					
D7910	Dent sutur recent wnd to 5cm		E					
D7911	Dental suture wound to 5 cm		E					
D7912	Suture complicate wnd > 5 cm		E					
D7920	Dental skin graft		E					
D7940	Reshaping bone orthognathic		S	0330	9.278	$590.94		$118.19
D7941	Bone cutting ramus closed		E					
D7943	Cutting ramus open w/graft		E					
D7944	Bone cutting segmented		E					
D7945	Bone cutting body mandible		E					
D7946	Reconstruction maxilla total		E					
D7947	Reconstruct maxilla segment		E					
D7948	Reconstruct midface no graft		E					
D7949	Reconstruct midface w/graft		E					
D7950	Mandible graft		E					
D7951	Sinus aug w bone/bone sup		E					
D7953	Bone replacement graft		E					
D7955	Repair maxillofacial defects		E					
D7960	Frenulectomy/frenulotomy		E					
D7963	Frenuloplasty		E					
D7970	Excision hyperplastic tissue		E					
D7971	Excision pericoronal gingiva		E					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D7972	Surg redct fibrous tuberosit		E					
D7980	Sialolithotomy		E					
D7981	Excision of salivary gland		E					
D7982	Sialodochoplasty		E					
D7983	Closure of salivary fistula		E					
D7990	Emergency tracheotomy		E					
D7991	Dental coronoidectomy		E					
D7995	Synthetic graft facial bones		E					
D7996	Implant mandible for augment		E					
D7997	Appliance removal		E					
D7998	Intraoral place of fix dev		E					
D7999	Oral surgery procedure		E					
D8010	Limited dental tx primary		E					
D8020	Limited dental tx transition		E					
D8030	Limited dental tx adolescent		E					
D8040	Limited dental tx adult		E					
D8050	Intercep dental tx primary		E					
D8060	Intercep dental tx transitn		E					
D8070	Compre dental tx transition		E					
D8080	Compre dental tx adolescent		E					
D8090	Compre dental tx adult		E					
D8210	Orthodontic rem appliance tx		E					
D8220	Fixed appliance therapy habt		E					
D8660	Preorthodontic tx visit		E					
D8670	Periodic orthodontc tx visit		E					
D8680	Orthodontic retention		E					
D8690	Orthodontic treatment		E					
D8691	Repair ortho appliance		E					
D8692	Replacement retainer		E					
D8693	Rebond/cement/repair retain		E					
D8999	Orthodontic procedure		E					
D9110	Tx dental pain minor proc		N					
D9120	Fix partial denture section		E					
D9210	Dent anesthesia w/o surgery		E					
D9211	Regional block anesthesia		E					
D9212	Trigeminal block anesthesia		E					
D9215	Local anesthesia		E					
D9220	General anesthesia		E					
D9221	General anesthesia ea ad 15m		E					
D9230	Analgesia		N					
D9241	Intravenous sedation		E					
D9242	IV sedation ea ad 30 m		E					
D9248	Sedation (non-iv)		N					
D9310	Dental consultation		E					
D9410	Dental house call		E					
D9420	Hospital call		E					
D9430	Office visit during hours		E					
D9440	Office visit after hours		E					
D9450	Case presentation tx plan		E					
D9610	Dent therapeutic drug inject		E					
D9612	Thera par drugs 2 or > admin		E					
D9630	Other drugs/medicaments		S	0330	9.278	$590.94		$118.19
D9910	Dent appl desensitizing med		E					
D9911	Appl desensitizing resin		E					
D9920	Behavior management		E					
D9930	Treatment of complications		S	0330	9.278	$590.94		$118.19
D9940	Dental occlusal guard		S	0330	9.278	$590.94		$118.19
D9941	Fabrication athletic guard		E					
D9942	Repair/reline occlusal guard		E					
D9950	Occlusion analysis		S	0330	9.278	$590.94		$118.19
D9951	Limited occlusal adjustment		S	0330	9.278	$590.94		$118.19
D9952	Complete occlusal adjustment		S	0330	9.278	$590.94		$118.19
D9970	Enamel microabrasion		E					
D9971	Odontoplasty 1-2 teeth		E					
D9972	Extrnl bleaching per arch		E					
D9973	Extrnl bleaching per tooth		E					
D9974	Intrnl bleaching per tooth		E					
D9999	Adjunctive procedure		E					
E0100	Cane adjust/fixed with tip		Y					
E0105	Cane adjust/fixed quad/3 pro		Y					
E0110	Crutch forearm pair		Y					
E0111	Crutch forearm each		Y					
E0112	Crutch underarm pair wood		Y					
E0113	Crutch underarm each wood		Y					
E0114	Crutch underarm pair no wood		Y					
E0116	Crutch underarm each no wood		Y					
E0117	Underarm springassist crutch		Y					
E0118	Crutch substitute		E					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E0130	Walker rigid adjust/fixed ht		Y					
E0135	Walker folding adjust/fixed		Y					
E0140	Walker w trunk support		Y					
E0141	Rigid wheeled walker adj/fix		Y					
E0143	Walker folding wheeled w/o s		Y					
E0144	Enclosed walker w rear seat		Y					
E0147	Walker variable wheel resist		Y					
E0148	Heavyduty walker no wheels		Y					
E0149	Heavy duty wheeled walker		Y					
E0153	Forearm crutch platform atta		Y					
E0154	Walker platform attachment		Y					
E0155	Walker wheel attachment,pair		Y					
E0156	Walker seat attachment		Y					
E0157	Walker crutch attachment		Y					
E0158	Walker leg extenders set of4		Y					
E0159	Brake for wheeled walker		Y					
E0160	Sitz type bath or equipment		Y					
E0161	Sitz bath/equipment w/faucet		Y					
E0162	Sitz bath chair		Y					
E0163	Commode chair with fixed arm		Y					
E0165	Commode chair with detacharm		Y					
E0167	Commode chair pail or pan		Y					
E0168	Heavyduty/wide commode chair		Y					
E0170	Commode chair electric		Y					
E0171	Commode chair non-electric		Y					
E0172	Seat lift mechanism toilet		E					
E0175	Commode chair foot rest		Y					
E0181	Press pad alternating w/ pum		Y					
E0182	Replace pump, alt press pad		Y					
E0184	Dry pressure mattress		Y					
E0185	Gel pressure mattress pad		Y					
E0186	Air pressure mattress		Y					
E0187	Water pressure mattress		Y					
E0188	Synthetic sheepskin pad		Y					
E0189	Lambswool sheepskin pad		Y					
E0190	Positioning cushion		E					
E0191	Protector heel or elbow		Y					
E0193	Powered air flotation bed		Y					
E0194	Air fluidized bed		Y					
E0196	Gel pressure mattress		Y					
E0197	Air pressure pad for mattres		Y					
E0198	Water pressure pad for mattr		Y					
E0199	Dry pressure pad for mattres		Y					
E0200	Heat lamp without stand		Y					
E0202	Phototherapy light w/ photom		Y					
E0203	Therapeutic lightbox tabletp		A					
E0205	Heat lamp with stand		Y					
E0210	Electric heat pad standard		Y					
E0215	Electric heat pad moist		Y					
E0217	Water circ heat pad w pump		Y					
E0218	Water circ cold pad w pump		Y					
E0220	Hot water bottle		Y					
E0221	Infrared heating pad system		Y					
E0225	Hydrocollator unit		Y					
E0230	Ice cap or collar		Y					
E0231	Wound warming device		E					
E0232	Warming card for NWT		E					
E0235	Paraffin bath unit portable		Y					
E0236	Pump for water circulating p		Y					
E0238	Heat pad non-electric moist		Y					
E0239	Hydrocollator unit portable		Y					
E0240	Bath/shower chair		E					
E0241	Bath tub wall rail		E					
E0242	Bath tub rail floor		E					
E0243	Toilet rail		E					
E0244	Toilet seat raised		E					
E0245	Tub stool or bench		E					
E0246	Transfer tub rail attachment		E					
E0247	Trans bench w/wo comm open		E					
E0248	HDtrans bench w/wo comm open		E					
E0249	Pad water circulating heat u		Y					
E0250	Hosp bed fixed ht w/ mattres		E					
E0251	Hosp bed fixd ht w/o mattres		E					
E0255	Hospital bed var ht w/ mattr		E					
E0256	Hospital bed var ht w/o matt		E					
E0260	Hosp bed semi-electr w/ matt		E					
E0261	Hosp bed semi-electr w/o mat		E					
E0265	Hosp bed total electr w/ mat		E					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E0266	Hosp bed total elec w/o matt		E					
E0270	Hospital bed institutional t		E					
E0271	Mattress innerspring		E					
E0272	Mattress foam rubber		E					
E0273	Bed board		E					
E0274	Over-bed table		E					
E0275	Bed pan standard		Y					
E0276	Bed pan fracture		Y					
E0277	Powered pres-redu air mattrs		Y					
E0280	Bed cradle		Y					
E0290	Hosp bed fx ht w/o rails w/m		E					
E0291	Hosp bed fx ht w/o rail w/o		Y					
E0292	Hosp bed var ht w/o rail w/o		E					
E0293	Hosp bed var ht w/o rail w/		Y					
E0294	Hosp bed semi-elect w/ mattr		E					
E0295	Hosp bed semi-elect w/o matt		Y					
E0296	Hosp bed total elect w/ matt		E					
E0297	Hosp bed total elect w/o mat		Y					
E0300	Enclosed ped crib hosp grade		Y					
E0301	HD hosp bed, 350-600 lbs		Y					
E0302	Ex hd hosp bed > 600 lbs		Y					
E0303	Hosp bed hvy dty xtra wide		E					
E0304	Hosp bed xtra hvy dty x wide		E					
E0305	Rails bed side half length		E					
E0310	Rails bed side full length		E					
E0315	Bed accessory brd/tbl/supprt		E					
E0316	Bed safety enclosure		Y					
E0325	Urinal male jug-type		Y					
E0326	Urinal female jug-type		Y					
E0350	Control unit bowel system		E					
E0352	Disposable pack w/bowel syst		E					
E0370	Air elevator for heel		E					
E0371	Nonpower mattress overlay		Y					
E0372	Powered air mattress overlay		Y					
E0373	Nonpowered pressure mattress		Y					
E0424	Stationary compressed gas 02		Y					
E0425	Gas system stationary compre		E					
E0430	Oxygen system gas portable		E					
E0431	Portable gaseous 02		Y					
E0434	Portable liquid 02		Y					
E0435	Oxygen system liquid portabl		E					
E0439	Stationary liquid 02		Y					
E0440	Oxygen system liquid station		E					
E0441	Oxygen contents, gaseous		Y					
E0442	Oxygen contents, liquid		Y					
E0443	Portable 02 contents, gas		Y					
E0444	Portable 02 contents, liquid		Y					
E0445	Oximeter non-invasive		A					
E0450	Vol control vent invasiv int		Y					
E0455	Oxygen tent excl croup/ped t		Y					
E0457	Chest shell		Y					
E0459	Chest wrap		Y					
E0460	Neg press vent portabl/statn		Y					
E0461	Vol control vent noninv int		Y					
E0462	Rocking bed w/ or w/o side r		Y					
E0463	Press supp vent invasive int		Y					
E0464	Press supp vent noninv int		Y					
E0470	RAD w/o backup non-inv intfc		Y					
E0471	RAD w/backup non inv intrfc		Y					
E0472	RAD w backup invasive intrfc		Y					
E0480	Percussor elect/pneum home m		Y					
E0481	Intrpulmnry percuss vent sys		E					
E0482	Cough stimulating device		Y					
E0483	Chest compression gen system		Y					
E0484	Non-elec oscillatory pep dvc		Y					
E0485	Oral device/appliance prefab		Y					
E0486	Oral device/appliance cusfab		Y					
E0500	Ippb all types		Y					
E0550	Humidif extens supple w ippb		Y					
E0555	Humidifier for use w/ regula		Y					
E0560	Humidifier supplemental w/ i		Y					
E0561	Humidifier nonheated w PAP		Y					
E0562	Humidifier heated used w PAP		Y					
E0565	Compressor air power source		Y					
E0570	Nebulizer with compression		Y					
E0571	Aerosol compressor for svneb		Y					
E0572	Aerosol compressor adjust pr		Y					
E0574	Ultrasonic generator w svneb		Y					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E0575	Nebulizer ultrasonic		Y					
E0580	Nebulizer for use w/ regulat		Y					
E0585	Nebulizer w/ compressor & he		Y					
E0600	Suction pump portab hom modl		Y					
E0601	Cont airway pressure device		Y					
E0602	Manual breast pump		Y					
E0603	Electric breast pump		A					
E0604	Hosp grade elec breast pump		A					
E0605	Vaporizer room type		Y					
E0606	Drainage board postural		Y					
E0607	Blood glucose monitor home		Y					
E0610	Pacemaker monitr audible/vis		Y					
E0615	Pacemaker monitr digital/vis		Y					
E0616	Cardiac event recorder		N					
E0617	Automatic ext defibrillator		Y					
E0618	Apnea monitor		A					
E0619	Apnea monitor w recorder		A					
E0620	Cap bld skin piercing laser		Y					
E0621	Patient lift sling or seat		Y					
E0625	Patient lift bathroom or toi		E					
E0627	Seat lift incorp lift-chair		Y					
E0628	Seat lift for pt furn-electr		Y					
E0629	Seat lift for pt furn-non-el		Y					
E0630	Patient lift hydraulic		Y					
E0635	Patient lift electric		Y					
E0636	PT support & positioning sys		Y					
E0637	Combination sit to stand sys		E					
E0638	Standing frame sys		E					
E0639	Moveable patient lift system		E					
E0640	Fixed patient lift system		E					
E0641	Multi-position stnd fram sys		E					
E0642	Dynamic standing frame		E					
E0650	Pneuma compresor non-segment		Y					
E0651	Pneum compressor segmental		Y					
E0652	Pneum compres w/cal pressure		Y					
E0655	Pneumatic appliance half arm		Y					
E0660	Pneumatic appliance full leg		Y					
E0665	Pneumatic appliance full arm		Y					
E0666	Pneumatic appliance half leg		Y					
E0667	Seg pneumatic appl full leg		Y					
E0668	Seg pneumatic appl full arm		Y					
E0669	Seg pneumatic appli half leg		Y					
E0671	Pressure pneum appl full leg		Y					
E0672	Pressure pneum appl full arm		Y					
E0673	Pressure pneum appl half leg		Y					
E0675	Pneumatic compression device		Y					
E0676	Inter limb compress dev NOS		Y					
E0691	Uvl pnl 2 sq ft or less		Y					
E0692	Uvl sys panel 4 ft		Y					
E0693	Uvl sys panel 6 ft		Y					
E0694	Uvl md cabinet sys 6 ft		Y					
E0700	Safety equipment		E					
E0705	Transfer board or device		B					
E0710	Restraints any type		E					
E0720	Tens two lead		Y					
E0730	Tens four lead		Y					
E0731	Conductive garment for tens/		Y					
E0740	Incontinence treatment systm		Y					
E0744	Neuromuscular stim for scoli		Y					
E0745	Neuromuscular stim for shock		Y					
E0746	Electromyograph biofeedback		A					
E0747	Elec osteogen stim not spine		Y					
E0748	Elec osteogen stim spinal		Y					
E0749	Elec osteogen stim implanted		N					
E0755	Electronic salivary reflex s		E					
E0760	Osteogen ultrasound stimltor		Y					
E0761	Nontherm electromgntc device		E					
E0762	Trans elec jt stim dev sys		B					
E0764	Functional neuromuscularstim		Y					
E0765	Nerve stimulator for tx n&v		Y					
E0769	Electric wound treatment dev		B					
E0776	Iv pole		Y					
E0779	Amb infusion pump mechanical		Y					
E0780	Mech amb infusion pump <8hrs		Y					
E0781	External ambulatory infus pu		Y					
E0782	Non-programble infusion pump		N					
E0783	Programmable infusion pump		N					
E0784	Ext amb infusn pump insulin		Y					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E0785	Replacement impl pump cathet		N					
E0786	Implantable pump replacement		N					
E0791	Parenteral infusion pump sta		Y					
E0830	Ambulatory traction device		N					
E0840	Tract frame attach headboard		Y					
E0849	Cervical pneum trac equip		Y					
E0850	Traction stand free standing		Y					
E0855	Cervical traction equipment		Y					
E0860	Tract equip cervical tract		Y					
E0870	Tract frame attach footboard		Y					
E0880	Trac stand free stand extrem		Y					
E0890	Traction frame attach pelvic		Y					
E0900	Trac stand free stand pelvic		Y					
E0910	Trapeze bar attached to bed		Y					
E0911	HD trapeze bar attach to bed		Y					
E0912	HD trapeze bar free standing		Y					
E0920	Fracture frame attached to b		Y					
E0930	Fracture frame free standing		Y					
E0935	Cont pas motion exercise dev		Y					
E0936	CPM device, other than knee		E					
E0940	Trapeze bar free standing		Y					
E0941	Gravity assisted traction de		Y					
E0942	Cervical head harness/halter		Y					
E0944	Pelvic belt/harness/boot		Y					
E0945	Belt/harness extremity		Y					
E0946	Fracture frame dual w cross		Y					
E0947	Fracture frame attachmnts pe		Y					
E0948	Fracture frame attachmnts ce		Y					
E0950	Tray		A					
E0951	Loop heel		A					
E0952	Toe loop/holder, each		A					
E0955	Cushioned headrest		Y					
E0956	W/c lateral trunk/hip suppor		Y					
E0957	W/c medial thigh support		Y					
E0958	Whlchr att- conv 1 arm drive		A					
E0959	Amputee adapter		B					
E0960	W/c shoulder harness/straps		Y					
E0961	Wheelchair brake extension		B					
E0966	Wheelchair head rest extensi		B					
E0967	Manual wc hand rim w project		Y					
E0968	Wheelchair commode seat		Y					
E0969	Wheelchair narrowing device		Y					
E0970	Wheelchair no. 2 footplates		B					
E0971	Wheelchair anti-tipping devi		B					
E0973	W/Ch access det adj armrest		B					
E0974	W/Ch access anti-rollback		B					
E0978	W/C acc,saf belt pelv strap		B					
E0980	Wheelchair safety vest		Y					
E0981	Seat upholstery, replacement		Y					
E0982	Back upholstery, replacement		Y					
E0983	Add pwr joystick		Y					
E0984	Add pwr tiller		Y					
E0985	W/c seat lift mechanism		Y					
E0986	Man w/c push-rim pow assist		Y					
E0990	Wheelchair elevating leg res		B					
E0992	Wheelchair solid seat insert		B					
E0994	Wheelchair arm rest		Y					
E0995	Wheelchair calf rest		B					
E1002	Pwr seat tilt		Y					
E1003	Pwr seat recline		Y					
E1004	Pwr seat recline mech		Y					
E1005	Pwr seat recline pwr		Y					
E1006	Pwr seat combo w/o shear		Y					
E1007	Pwr seat combo w/shear		Y					
E1008	Pwr seat combo pwr shear		Y					
E1009	Add mech leg elevation		Y					
E1010	Add pwr leg elevation		Y					
E1011	Ped wc modify width adjustm		Y					
E1014	Reclining back add ped w/c		Y					
E1015	Shock absorber for man w/c		Y					
E1016	Shock absorber for power w/c		Y					
E1017	HD shck absrbr for hd man wc		Y					
E1018	HD shck absrber for hd powwc		Y					
E1020	Residual limb support system		Y					
E1028	W/c manual swingaway		Y					
E1029	W/c vent tray fixed		Y					
E1030	W/c vent tray gimbaled		Y					
E1031	Rollabout chair with casters		Y					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E1035	Patient transfer system		Y					
E1037	Transport chair, ped size		Y					
E1038	Transport chair pt wt≦300lb		Y					
E1039	Transport chair pt wt >300lb		Y					
E1050	Whelchr fxd full length arms		A					
E1060	Wheelchair detachable arms		A					
E1070	Wheelchair detachable foot r		A					
E1083	Hemi-wheelchair fixed arms		A					
E1084	Hemi-wheelchair detachable a		A					
E1085	Hemi-wheelchair fixed arms		A					
E1086	Hemi-wheelchair detachable a		A					
E1087	Wheelchair lightwt fixed arm		A					
E1088	Wheelchair lightweight det a		A					
E1089	Wheelchair lightwt fixed arm		A					
E1090	Wheelchair lightweight det a		A					
E1092	Wheelchair wide w/ leg rests		A					
E1093	Wheelchair wide w/ foot rest		A					
E1100	Whchr s-recl fxd arm leg res		A					
E1110	Wheelchair semi-recl detach		A					
E1130	Whlchr stand fxd arm ft rest		A					
E1140	Wheelchair standard detach a		A					
E1150	Wheelchair standard w/ leg r		Y					
E1160	Wheelchair fixed arms		A					
E1161	Manual adult wc w tiltinspac		A					
E1170	Whlchr ampu fxd arm leg rest		A					
E1171	Wheelchair amputee w/o leg r		A					
E1172	Wheelchair amputee detach ar		A					
E1180	Wheelchair amputee w/ foot r		A					
E1190	Wheelchair amputee w/ leg re		A					
E1195	Wheelchair amputee heavy dut		A					
E1200	Wheelchair amputee fixed arm		A					
E1220	Whlchr special size/constrc		A					
E1221	Wheelchair spec size w foot		A					
E1222	Wheelchair spec size w/ leg		A					
E1223	Wheelchair spec size w foot		A					
E1224	Wheelchair spec size w/ leg		A					
E1225	Manual semi-reclining back		Y					
E1226	Manual fully reclining back		B					
E1227	Wheelchair spec sz spec ht a		Y					
E1228	Wheelchair spec sz spec ht b		Y					
E1229	Pediatric wheelchair NOS		Y					
E1230	Power operated vehicle		Y					
E1231	Rigid ped w/c tilt-in-space		Y					
E1232	Folding ped wc tilt-in-space		Y					
E1233	Rig ped wc tltnspc w/o seat		Y					
E1234	Fld ped wc tltnspc w/o seat		Y					
E1235	Rigid ped wc adjustable		Y					
E1236	Folding ped wc adjustable		Y					
E1237	Rgd ped wc adjstabl w/o seat		Y					
E1238	Fld ped wc adjstabl w/o seat		Y					
E1239	Ped power wheelchair NOS		Y					
E1240	Whchr litwt det arm leg rest		A					
E1250	Wheelchair lightwt fixed arm		A					
E1260	Wheelchair lightwt foot rest		A					
E1270	Wheelchair lightweight leg r		A					
E1280	Whchr h-duty det arm leg res		A					
E1285	Wheelchair heavy duty fixed		A					
E1290	Wheelchair hvy duty detach a		A					
E1295	Wheelchair heavy duty fixed		A					
E1296	Wheelchair special seat heig		Y					
E1297	Wheelchair special seat dept		Y					
E1298	Wheelchair spec seat depth/w		Y					
E1300	Whirlpool portable		E					
E1310	Whirlpool non-portable		Y					
E1340	Repair for DME, per 15 min		Y					
E1353	Oxygen supplies regulator		Y					
E1355	Oxygen supplies stand/rack		Y					
E1372	Oxy suppl heater for nebuliz		Y					
E1390	Oxygen concentrator		Y					
E1391	Oxygen concentrator, dual		Y					
E1392	Portable oxygen concentrator		Y					
E1399	Durable medical equipment mi		Y					
E1405	O2/water vapor enrich w/heat		Y					
E1406	O2/water vapor enrich w/o he		Y					
E1500	Centrifuge		A					
E1510	Kidney dialysate delivry sys		A					
E1520	Heparin infusion pump		A					
E1530	Replacement air bubble detec		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E1540	Replacement pressure alarm		A					
E1550	Bath conductivity meter		A					
E1560	Replace blood leak detector		A					
E1570	Adjustable chair for esrd pt		A					
E1575	Transducer protect/fld bar		A					
E1580	Unipuncture control system		A					
E1590	Hemodialysis machine		A					
E1592	Auto interm peritoneal dialy		A					
E1594	Cycler dialysis machine		A					
E1600	Deli/install chrg hemo equip		A					
E1610	Reverse osmosis h2o puri sys		A					
E1615	Deionizer H2O puri system		A					
E1620	Replacement blood pump		A					
E1625	Water softening system		A					
E1630	Reciprocating peritoneal dia		A					
E1632	Wearable artificial kidney		A					
E1634	Peritoneal dialysis clamp		B					
E1635	Compact travel hemodialyzer		A					
E1636	Sorbent cartridges per 10		A					
E1637	Hemostats for dialysis, each		A					
E1639	Dialysis scale		A					
E1699	Dialysis equipment noc		A					
E1700	Jaw motion rehab system		Y					
E1701	Repl cushions for jaw motion		Y					
E1702	Repl measr scales jaw motion		Y					
E1800	Adjust elbow ext/flex device		Y					
E1801	SPS elbow device		Y					
E1802	Adjst forearm pro/sup device		Y					
E1805	Adjust wrist ext/flex device		Y					
E1806	SPS wrist device		Y					
E1810	Adjust knee ext/flex device		Y					
E1811	SPS knee device		Y					
E1812	Knee ext/flex w act res ctrl		Y					
E1815	Adjust ankle ext/flex device		Y					
E1816	SPS ankle device		Y					
E1818	SPS forearm device		Y					
E1820	Soft interface material		Y					
E1821	Replacement interface SPSD		Y					
E1825	Adjust finger ext/flex devc		Y					
E1830	Adjust toe ext/flex device		Y					
E1840	Adj shoulder ext/flex device		Y					
E1841	Static str shldr dev rom adj		Y					
E1902	AAC non-electronic board		A					
E2000	Gastric suction pump hme mdl		Y					
E2100	Bld glucose monitor w voice		Y					
E2101	Bld glucose monitor w lance		Y					
E2120	Pulse gen sys tx endolymp fl		Y					
E2201	Man w/ch acc seat w≧20″<24″		Y					
E2202	Seat width 24-27 in		Y					
E2203	Frame depth less than 22 in		Y					
E2204	Frame depth 22 to 25 in		Y					
E2205	Manual wc accessory, handrim		Y					
E2206	Complete wheel lock assembly		Y					
E2207	Crutch and cane holder		Y					
E2208	Cylinder tank carrier		Y					
E2209	Arm trough each		Y					
E2210	Wheelchair bearings		Y					
E2211	Pneumatic propulsion tire		Y					
E2212	Pneumatic prop tire tube		Y					
E2213	Pneumatic prop tire insert		Y					
E2214	Pneumatic caster tire each		Y					
E2215	Pneumatic caster tire tube		Y					
E2216	Foam filled propulsion tire		Y					
E2217	Foam filled caster tire each		Y					
E2218	Foam propulsion tire each		Y					
E2219	Foam caster tire any size ea		Y					
E2220	Solid propulsion tire each		Y					
E2221	Solid caster tire each		Y					
E2222	Solid caster integrated whl		Y					
E2223	Valve replacement only each		Y					
E2224	Propulsion whl excludes tire		Y					
E2225	Caster wheel excludes tire		Y					
E2226	Caster fork replacement only		Y					
E2291	Planar back for ped size wc		Y					
E2292	Planar seat for ped size wc		Y					
E2293	Contour back for ped size wc		Y					
E2294	Contour seat for ped size wc		Y					
E2300	Pwr seat elevation sys		Y					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E2301	Pwr standing		Y					
E2310	Electro connect btw control		Y					
E2311	Electro connect btw 2 sys		Y					
E2321	Hand interface joystick		Y					
E2322	Mult mech switches		Y					
E2323	Special joystick handle		Y					
E2324	Chin cup interface		Y					
E2325	Sip and puff interface		Y					
E2326	Breath tube kit		Y					
E2327	Head control interface mech		Y					
E2328	Head/extremity control inter		Y					
E2329	Head control nonproportional		Y					
E2330	Head control proximity switc		Y					
E2331	Attendant control		Y					
E2340	W/c wdth 20-23 in seat frame		Y					
E2341	W/c wdth 24-27 in seat frame		Y					
E2342	W/c dpth 20-21 in seat frame		Y					
E2343	W/c dpth 22-25 in seat frame		Y					
E2351	Electronic SGD interface		Y					
E2360	22nf nonsealed leadacid		Y					
E2361	22nf sealed leadacid battery		Y					
E2362	Gr24 nonsealed leadacid		Y					
E2363	Gr24 sealed leadacid battery		Y					
E2364	U1nonsealed leadacid battery		Y					
E2365	U1 sealed leadacid battery		Y					
E2366	Battery charger, single mode		Y					
E2367	Battery charger, dual mode		Y					
E2368	Power wc motor replacement		Y					
E2369	Pwr wc gear box replacement		Y					
E2370	Pwr wc motor/gear box combo		Y					
E2371	Gr27 sealed leadacid battery		Y					
E2372	Gr27 non-sealed leadacid		Y					
E2373	Hand/chin ctrl spec joystick		Y					
E2374	Hand/chin ctrl std joystick		Y					
E2375	Non-expandable controller		Y					
E2376	Expandable controller, repl		Y					
E2377	Expandable controller, initl		Y					
E2381	Pneum drive wheel tire		Y					
E2382	Tube, pneum wheel drive tire		Y					
E2383	Insert, pneum wheel drive		Y					
E2384	Pneumatic caster tire		Y					
E2385	Tube, pneumatic caster tire		Y					
E2386	Foam filled drive wheel tire		Y					
E2387	Foam filled caster tire		Y					
E2388	Foam drive wheel tire		Y					
E2389	Foam caster tire		Y					
E2390	Solid drive wheel tire		Y					
E2391	Solid caster tire		Y					
E2392	Solid caster tire, integrate		Y					
E2393	Valve, pneumatic tire tube		Y					
E2394	Drive wheel excludes tire		Y					
E2395	Caster wheel excludes tire		Y					
E2396	Caster fork		Y					
E2399	Noc interface		Y					
E2402	Neg press wound therapy pump		Y					
E2500	SGD digitized pre-rec ≦8min		Y					
E2502	SGD prerec msg >8min ≦20min		Y					
E2504	SGD prerec msg>20min ≦40min		Y					
E2506	SGD prerec msg > 40 min		Y					
E2508	SGD spelling phys contact		Y					
E2510	SGD w multi methods msg/accs		Y					
E2511	SGD sftwre prgrm for PC/PDA		Y					
E2512	SGD accessory, mounting sys		Y					
E2599	SGD accessory noc		Y					
E2601	Gen w/c cushion wdth < 22 in		Y					
E2602	Gen w/c cushion wdth ≧22 in		Y					
E2603	Skin protect wc cus wd <22in		Y					
E2604	Skin protect wc cus wd≧22in		Y					
E2605	Position wc cush wdth <22 in		Y					
E2606	Position wc cush wdth≧22 in		Y					
E2607	Skin pro/pos wc cus wd <22in		Y					
E2608	Skin pro/pos wc cus wd≧22in		Y					
E2609	Custom fabricate w/c cushion		Y					
E2610	Powered w/c cushion		B					
E2611	Gen use back cush wdth <22in		Y					
E2612	Gen use back cush wdth≧22in		Y					
E2613	Position back cush wd <22in		Y					
E2614	Position back cush wd≧22in		Y					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E2615	Pos back post/lat wdth <22in		Y					
E2616	Pos back post/lat wdth≧22in		Y					
E2617	Custom fab w/c back cushion		Y					
E2618	Wc acc solid seat supp base		Y					
E2619	Replace cover w/c seat cush		Y					
E2620	WC planar back cush wd <22in		Y					
E2621	WC planar back cush wd≧22in		Y					
E8000	Posterior gait trainer		E					
E8001	Upright gait trainer		E					
E8002	Anterior gait trainer		E					
G0008	Admin influenza virus vac		S	0350	0.4037	$25.71		
G0009	Admin pneumococcal vaccine		S	0350	0.4037	$25.71		
G0010	Admin hepatitis b vaccine		B					
G0027	Semen analysis		A					
G0101	CA screen;pelvic/breast exam		V	0604	0.8381	$53.38		$10.68
G0102	Prostate ca screening; dre		N					
G0103	PSA screening		A					
G0104	CA screen;flexi sigmoidscope		S	0159	4.7799	$304.45		$76.11
G0105	Colorectal scrn; hi risk ind		T	0158	8.0134	$510.40		$127.60
G0106	Colon CA screen;barium enema		S	0157	2.2613	$144.03		$28.81
G0108	Diab manage trn per indiv		A					
G0109	Diab manage trn ind/group		A					
G0117	Glaucoma scrn hgh risk direc		S	0230	0.7379	$47.00		$9.40
G0118	Glaucoma scrn hgh risk direc		S	0230	0.7379	$47.00		$9.40
G0120	Colon ca scrn; barium enema		S	0157	2.2613	$144.03		$28.81
G0121	Colon ca scrn not hi rsk ind		T	0158	8.0134	$510.40		$127.60
G0122	Colon ca scrn; barium enema		E					
G0123	Screen cerv/vag thin layer		A					
G0124	Screen c/v thin layer by MD		B					
G0127	Trim nail(s)	CH	T	0013	0.8046	$51.25		$10.25
G0128	CORF skilled nursing service		B					
G0129	Partial hosp prog service		P	0033				
G0130	Single energy x-ray study		X	0260	0.7259	$46.23		$9.25
G0141	Scr c/v cyto,autosys and md		B					
G0143	Scr c/v cyto,thinlayer,rescr		A					
G0144	Scr c/v cyto,thinlayer,rescr		A					
G0145	Scr c/v cyto,thinlayer,rescr		A					
G0147	Scr c/v cyto, automated sys		A					
G0148	Scr c/v cyto, autosys, rescr		A					
G0151	HHCP-serv of pt,ea 15 min		B					
G0152	HHCP-serv of ot,ea 15 min		B					
G0153	HHCP-svs of s/l path,ea 15mn		B					
G0154	HHCP-svs of rn,ea 15 min		B					
G0155	HHCP-svs of csw,ea 15 min		B					
G0156	HHCP-svs of aide,ea 15 min		B					
G0166	Extrnl counterpulse, per tx		T	0678	1.7081	$108.79		$21.76
G0168	Wound closure by adhesive		B					
G0173	Linear acc stereo radsur com		S	0067	61.5205	$3,918.43		$783.69
G0175	OPPS Service,sched team conf		V	0608	2.2077	$140.62		$28.12
G0176	OPPS/PHP;activity therapy		P	0033				
G0177	OPPS/PHP; train & educ serv	CH	N					
G0179	MD recertification HHA PT		M					
G0180	MD certification HHA patient		M					
G0181	Home health care supervision		M					
G0182	Hospice care supervision		M					
G0186	Dstry eye lesn,fdr vssl tech		T	0235	4.01	$255.41	$58.90	$51.08
G0202	Screeningmammographydigital		A					
G0204	Diagnosticmammographydigital		A					
G0206	Diagnosticmammographydigital		A					
G0219	PET img wholbod melano nonco		E					
G0235	PET not otherwise specified		E					
G0237	Therapeutic procd strg endur	CH	S	0077	0.3904	$24.87	$7.70	$4.97
G0238	Oth resp proc, indiv	CH	S	0077	0.3904	$24.87	$7.70	$4.97
G0239	Oth resp proc, group	CH	S	0077	0.3904	$24.87	$7.70	$4.97
G0245	Initial foot exam pt lops		V	0604	0.8381	$53.38		$10.68
G0246	Followup eval of foot pt lop		V	0605	1.0016	$63.79		$12.76
G0247	Routine footcare pt w lops	CH	T	0013	0.8046	$51.25		$10.25
G0248	Demonstrate use home inr mon	CH	X	0097	1.0396	$66.22	$23.70	$13.24
G0249	Provide test material,equipm	CH	X	0097	1.0396	$66.22	$23.70	$13.24
G0250	MD review interpret of test		M					
G0251	Linear acc based stero radio		S	0065	17.1992	$1,095.47		$219.09
G0252	PET imaging initial dx		E					
G0255	Current percep threshold tst		E					
G0257	Unsched dialysis ESRD pt hos		S	0170	6.7915	$432.57		$86.51
G0259	Inject for sacroiliac joint		N					
G0260	Inj for sacroiliac jt anesth	CH	T	0207	7.137	$454.58		$90.92
G0265	Cryopresevation Freeze+stora	CH	B					
G0266	Thawing + expansion froz cel	CH	B					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G0267	Bone marrow or psc harvest	CH	B					
G0268	Removal of impacted wax md	CH	N					
G0269	Occlusive device in vein art		N					
G0270	MNT subs tx for change dx		A					
G0271	Group MNT 2 or more 30 mins		A					
G0275	Renal angio, cardiac cath		N					
G0278	Iliac art angio,cardiac cath		N					
G0281	Elec stim unattend for press		A					
G0282	Elect stim wound care not pd		E					
G0283	Elec stim other than wound		A					
G0288	Recon, CTA for surg plan	CH	Q	0417	2.3401	$149.05		$29.81
G0289	Arthro, loose body + chondro		N					
G0290	Drug-eluting stents, single		T	0656	118.8818	$7,571.94		$1,514.39
G0291	Drug-eluting stents,each add		T	0656	118.8818	$7,571.94		$1,514.39
G0293	Non-cov surg proc,clin trial		X	0340	0.6416	$40.87		$8.17
G0294	Non-cov proc, clinical trial		X	0340	0.6416	$40.87		$8.17
G0295	Electromagnetic therapy onc		E					
G0297	Insert single chamber/cd	CH	B					
G0298	Insert dual chamber/cd	CH	B					
G0299	Inser/repos single icd+leads	CH	B					
G0300	Insert reposit lead dual+gen	CH	B					
G0302	Pre-op service LVRS complete	CH	S	0209	11.5647	$736.59	$268.70	$147.32
G0303	Pre-op service LVRS 10-15dos	CH	S	0209	11.5647	$736.59	$268.70	$147.32
G0304	Pre-op service LVRS 1-9 dos	CH	S	0213	2.3476	$149.53	$53.50	$29.91
G0305	Post op service LVRS min 6	CH	S	0213	2.3476	$149.53	$53.50	$29.91
G0306	CBC/diffwbc w/o platelet		A					
G0307	CBC without platelet		A					
G0308	ESRD related svc 4+mo < 2yrs		B					
G0309	ESRD related svc 2-3mo <2yrs		B					
G0310	ESRD related svc 1 vst <2yrs		B					
G0311	ESRD related svs 4+mo 2-11yr		B					
G0312	ESRD relate svs 2-3 mo 2-11y		B					
G0313	ESRD related svs 1 mon 2-11y		B					
G0314	ESRD related svs 4+ mo 12-19		B					
G0315	ESRD related svs 2-3mo/12-19		B					
G0316	ESRD related svs 1vis/12-19y		B					
G0317	ESRD related svs 4+mo 20+yrs		B					
G0318	ESRD related svs 2-3 mo 20+y		B					
G0319	ESRD related svs 1visit 20+y		B					
G0320	ESD related svs home undr 2		B					
G0321	ESRDrelatedsvs home mo 2-11y		B					
G0322	ESRD related svs hom mo12-19		B					
G0323	ESRD related svs home mo 20+		B					
G0324	ESRD relate svs home/dy <2yr		B					
G0325	ESRD relate home/day/ 2-11yr		B					
G0326	ESRD relate home/dy 12-19yr		B					
G0327	ESRD relate home/dy 20+yrs		B					
G0328	Fecal blood scrn immunoassay		A					
G0329	Electromagntic tx for ulcers		A					
G0332	Preadmin IV immunoglobulin	CH	S	0430	0.6123	$39.00		$7.80
G0333	Dispense fee initial 30 day		M					
G0337	Hospice evaluation preelecti		B					
G0339	Robot lin-radsurg com, first		S	0067	61.5205	$3,918.43		$783.69
G0340	Robt lin-radsurg fractx 2-5		S	0066	47.3767	$3,017.56		$603.51
G0341	Percutaneous islet celltrans		C					
G0342	Laparoscopy islet cell trans		C					
G0343	Laparotomy islet cell transp		C					
G0344	Initial preventive exam		V	0605	1.0016	$63.79		$12.76
G0364	Bone marrow aspirate &biopsy		T	0002	1.1915	$75.89		$15.18
G0365	Vessel mapping hemo access		S	0267	2.4859	$158.33	$60.50	$31.67
G0366	EKG for initial prevent exam		B					
G0367	EKG tracing for initial prev		S	0099	0.3912	$24.92		$4.98
G0368	EKG interpret & report preve		M					
G0372	MD service required for PMD		M					
G0375	Smoke/tobacco counselng 3-10		X	0031	0.166	$10.57		$2.11
G0376	Smoke/tobacco counseling >10		X	0031	0.166	$10.57		$2.11
G0377	Administra Part D vaccine		S	0437	0.4037	$25.71		$5.14
G0378	Hospital observation per hr	CH	N					
G0379	Direct admit hospital observ		Q	0604	0.8381	$53.38		$10.68
G0380	Lev 1 hosp type B ED visit		V	0604	0.8381	$53.38		$10.68
G0381	Lev 2 hosp type B ED visit		V	0605	1.0016	$63.79		$12.76
G0382	Lev 3 hosp type B ED visit		V	0606	1.3665	$87.04		$17.41
G0383	Lev 4 hosp type B ED visit		V	0607	1.7181	$109.43		$21.89
G0384	Lev 5 hosp type B ED visit		V	0608	2.2077	$140.62		$28.12
G0389	Ultrasound exam AAA screen		S	0266	1.5657	$99.72	$37.80	$19.94
G0390	Trauma Respons w/hosp criti		S	0618	5.6539	$360.11	$144.04	$72.02
G0392	AV fistula or graft arterial	CH	T	0083	46.0685	$2,934.24		$586.85
G0393	AV fistula or graft venous	CH	T	0083	46.0685	$2,934.24		$586.85

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G0394	Blood occult test,colorectal		A					
G3001	Admin + supply, tositumomab		S	0442	30.2249	$1,925.11		$385.02
G8006	AMI pt recd aspirin at arriv		M					
G8007	AMI pt did not receiv aspiri		M					
G8008	AMI pt ineligible for aspiri		M					
G8009	AMI pt recd Bblock at arr		M					
G8010	AMI pt did not rec bblock		M					
G8011	AMI pt inelig Bbloc at arriv		M					
G8012	Pneum pt recv antibiotic 4 h		M					
G8013	Pneum pt w/o antibiotic 4 hr		M					
G8014	Pneum pt not elig antibiotic		M					
G8015	Diabetic pt w/ HBA1c>9%		M					
G8016	Diabetic pt w/ HBA1c<or=9%		M					
G8017	DM pt inelig for HBA1c measu		M					
G8018	Care not provided for HbA1c		M					
G8019	Diabetic pt w/LDL≧ 100mg/dl		M					
G8020	Diab pt w/LDL< 100mg/dl		M					
G8021	Diab pt inelig for LDL meas		M					
G8022	Care not provided for LDL		M					
G8023	DM pt w BP≧140/80		M					
G8024	Diabetic pt wBP<140/80		M					
G8025	Diabetic pt inelig for BP me		M					
G8026	Diabet pt w no care re BP me		M					
G8027	HF p w/LVSD on ACE-I/ARB		M					
G8028	HF pt w/LVSD not on ACE-I/AR		M					
G8029	HF pt not elig for ACE-I/ARB		M					
G8030	HF pt w/LVSD on Bblocker		M					
G8031	HF pt w/LVSD not on Bblocker		M					
G8032	HF pt not elig for Bblocker		M					
G8033	PMI-CAD pt on Bblocker		M					
G8034	PMI-CAD pt not on Bblocker		M					
G8035	PMI-CAD pt inelig Bblocker		M					
G8036	AMI-CAD pt doc on antiplatel		M					
G8037	AMI-CAD pt not docu on antip		M					
G8038	AMI-CAD inelig antiplate mea		M					
G8039	CAD pt w/LDL>100mg/dl		M					
G8040	CAD pt w/LDL<or=100mg/dl		M					
G8041	CAD pt not eligible for LDL		M					
G8051	Osteoporosis assess		M					
G8052	Osteopor pt not assess		M					
G8053	Pt inelig for osteopor meas		M					
G8054	Falls assess not docum 12 mo		M					
G8055	Falls assess w/ 12 mon		M					
G8056	Not elig for falls assessmen		M					
G8057	Hearing assess receive		M					
G8058	Pt w/o hearing assess		M					
G8059	Pt inelig for hearing assess		M					
G8060	Urinary incont pt assess		M					
G8061	Pt not assess for urinary in		M					
G8062	Pt not elig for urinary inco		M					
G8075	ESRD pt w/ dialy of URR≧65%		M					
G8076	ESRD pt w/ dialy of URR<65%		M					
G8077	ESRD pt not elig for URR/KtV		M					
G8078	ESRD pt w/Hct>or=33		M					
G8079	ESRD pt w/Hct<33		M					
G8080	ESRD pt inelig for HCT/Hgb		M					
G8081	ESRD pt w/ auto AV fistula		M					
G8082	ESRD pt w other fistula		M					
G8085	ESRD PT inelig auto AV FISTU		M					
G8093	COPD pt rec smoking cessat		M					
G8094	COPD pt w/o smoke cessat int		M					
G8099	Osteopo pt given Ca+VitD sup		M					
G8100	Osteop pt inelig for Ca+VitD		M					
G8103	New dx osteo pt w/antiresorp		M					
G8104	Osteo pt inelig for antireso		M					
G8106	Bone dens meas test perf		M					
G8107	Bone dens meas test inelig		M					
G8108	Pt receiv influenza vacc		M					
G8109	Pt w/o influenza vacc		M					
G8110	Pt inelig for influenza vacc		M					
G8111	Pt receiv mammogram		M					
G8112	Pt not doc mammogram		M					
G8113	Pt ineligible mammography		M					
G8114	Care not provided for mamogr		M					
G8115	Pt receiv pneumo vacc		M					
G8116	Pt did not rec pneumo vacc		M					
G8117	Pt was inelig for pneumo vac		M					
G8126	Pt treat w/antidepress12wks		M					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G8127	Pt not treat w/antidepres12w		M					
G8128	Pt inelig for antidepres med		M					
G8129	Pt treat w/antidepres for 6m		M					
G8130	Pt not treat w/antidepres 6m		M					
G8131	Pt inelig for antidepres med		M					
G8152	Pt w/AB 1 hr prior to incisi		M					
G8153	Pt not doc for AB 1 hr prior		M					
G8154	Pt ineligi for AB therapy		M					
G8155	Pt recd thromboemb prophylax		M					
G8156	Pt did not rec thromboembo		M					
G8157	Pt ineligi for thrombolism		M					
G8158	Pt recd CABG w/ IMA		M					
G8159	Pt w/CABG w/o IMA		M					
G8160	Pt inelig for CABG w/IMA		M					
G8161	Iso CABG pt rec preop bblock		M					
G8162	Iso CABG pt w/o preop Bblock		M					
G8163	Iso CABG pt inelig for preo		M					
G8164	Iso CABG pt w/prolng intub		M					
G8165	Iso CABG pt w/o prolng intub		M					
G8166	Iso CABG req surg rexpo		M					
G8167	Iso CABG w/o surg explo		M					
G8170	CEA/ext bypass pt on aspirin		M					
G8171	Pt w/carot endarct/ext bypas		M					
G8172	CEA/ext bypass pt not on asp		M					
G8182	CAD pt care not prov LDL		M					
G8183	HF/atrial fib pt on warfarin		M					
G8184	HF/atrial fib pt inelig warf		M					
G8185	Osteoarth pt w/ assess pain		M					
G8186	Osteoarth pt inelig assess		M					
G8191	Antibiotic given prior surg		M					
G8192	Antib given prior surg incis		M					
G8193	Antibio not doc prior surg		M					
G8194	Pt not elig for antibiotic		M					
G8195	Antibiotic given prior surg		M					
G8196	Antibio not docum prior surg		M					
G8197	Antib order prior to surg		M					
G8198	Cefazolin documented ordered		M					
G8199	Cefazolin given prophylaxis		M					
G8200	Cefazolin not docum prophy		M					
G8201	Pt not eligi for cefazolin		M					
G8202	Order given to d/c antibio		M					
G8203	Antib was D/C 24hrs surg tim		M					
G8204	MD not doc order to d/c anti		M					
G8205	Pt not eligi for proph antib		M					
G8206	MD doc prophylactic AB given		M					
G8207	Clini doc order to D/C antib		M					
G8208	Clini doc AB was D/C 48 h		M					
G8209	Clinician did not doc		M					
G8210	Clini doc pt ineligib anti		M					
G8211	Clini doc proph AB giv		M					
G8212	Clini order given for VTE		M					
G8213	Clini given VTE prop		M					
G8214	Clini not doc order VTE		M					
G8215	Clini doc pt inelig VTE		M					
G8216	Pt received DVT prophylaxis		M					
G8217	Pt not received DVT proph		M					
G8218	Pt inelig DVT prophylaxis		M					
G8219	Received DVT proph day 2		M					
G8220	Pt not rec DVT proph day 2		M					
G8221	Pt inelig for DVT proph		M					
G8222	Pt prescribe platelet at D/C		M					
G8223	Pt not doc for presc antipla		M					
G8224	Pt inelig for antiplat proph		M					
G8225	Pt prescrib anticoag at D/C		M					
G8226	Pt no prescr anticoa at D/C		M					
G8227	Pt not doc to have perm/AF		M					
G8228	Clin pt inelig anticoag D/C		M					
G8229	Pt doc to have admin t-PA		M					
G8230	Pt inelig t-PA isch strok>3h		M					
G8231	Pt not doc for admin t-PA		M					
G8232	Pt received dysphagia screen		M					
G8234	Pt not doc dysphagia screen		M					
G8235	Pt received NPO		M					
G8236	Pt inelig dysphagia screen		M					
G8237	Pt doc rec rehab serv		M					
G8238	Pt not doc to rec rehab serv		M					
G8239	Inter carotid stenosis <30%		M					
G8240	Inter carotid stenosis 30-99%		M					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G8241	Pt inelig candidate ito meas		M					
G8242	Pt doc to have CT/MRI w/les		M					
G8243	Pt not doc MRI/CT w/o lesion		M					
G8245	Clini doc prese/abs alarm		M					
G8246	Pt inelig hx w new/chg mole		M					
G8247	Pt w/alarm symp upper endo		M					
G8248	Pt w/one alarm symp not doc		M					
G8249	Pt inelig for upper endo		M					
G8250	Pt w/Barretts esoph endo re		M					
G8251	Pt not doc w/Barretts, endo		M					
G8252	Pt inelig for esophag biop		M					
G8253	Pt rec order for barium		M					
G8254	Pt w/no doc order for barium		M					
G8255	Clini doc pt inelig bar swal		M					
G8256	Clini doc rev D/C meds w/med		M					
G8257	Pt not doc rev meds D/C		M					
G8258	Pt inelig for d/c meds rev		M					
G8259	Pt doc to hav decision maker		M					
G8260	Pt not doc to have dec maker		M					
G8261	Clin doc pt inelig dec maker		M					
G8262	Pt doc assess uriny incon		M					
G8263	Pt not doc assess urinary in		M					
G8264	Pt inelig assess urinary inc		M					
G8265	Pt doc rec charc urin incon		M					
G8266	Pt not doc charc urin incon		M					
G8267	Pt doc rec plan urinary inco		M					
G8268	Pt not doc rec care urin inc		M					
G8269	Clin not prov care urin inco		M					
G8270	Pt receiv screen for fall		M					
G8271	Pt no doc screen fall		M					
G8272	Clin doc pt inelig fall risk		M					
G8273	Clin not prov care scre fall		M					
G8274	Clini not doc pres/abs alarm		M					
G8275	Pt hx w/ new moles		M					
G8276	Pt not doc mole change		M					
G8277	Pt inelig for assess mole		M					
G8278	Pt doc rec PE skin		M					
G8279	Pt not doc rec PE		M					
G8280	Pt inelig PE skin		M					
G8281	Pt rec counsel for self-exam		M					
G8282	Pt not doc to rec couns		M					
G8283	Pt inelig for counsel		M					
G8284	Pt doc to rec pres osteo		M					
G8285	Pt did not rec pres osteo		M					
G8286	Pt inelig to rec pres osteo		M					
G8287	Clin not prov care for pharm		M					
G8288	Pt doc rec Ca/Vit D		M					
G8289	Pt not doc rec Ca/Vit D		M					
G8290	Clin doc pt inelig Ca/Vit D		M					
G8291	Clin no pro care pt Ca/Vit D		M					
G8292	COPD pt w/spir results		M					
G8293	COPD pt w/o spir results		M					
G8294	COPD pt inelig spir results		M					
G8295	COPD pt doc bronch ther		M					
G8296	COPD pt not doc bronch ther		M					
G8297	COPD pt inelig bronch therap		M					
G8298	Pt doc optic nerve eval		M					
G8299	Pt not doc optic nerv eval		M					
G8300	Pt inelig for optic nerv eva		M					
G8301	Clin not prov care POAG		M					
G8302	Pt doc w/ target IOP		M					
G8303	Pt not doc w/ IOP		M					
G8304	Clin doc pt inelig IOP		M					
G8305	Clin not prov care POAG		M					
G8306	POAG w/ IOP rec care plan		M					
G8307	POAG w/ IOP no care plan		M					
G8308	POAG w/ IOP not doc plan		M					
G8309	Pt doc rec antioxidant		M					
G8310	Pt not doc rec antiox		M					
G8311	Pt inelig for antioxidant		M					
G8312	Clin no prov care for antiox		M					
G8313	Pt doc rec macular exam		M					
G8314	Pt not doc to rec mac exam		M					
G8315	Clin doc pt inelig mac exam		M					
G8316	Clin no pro care for mac deg		M					
G8317	Pt doc to have visual func		M					
G8318	Pt doc not have visual func		M					
G8319	Pt inelig for vis func stat		M					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G8320	Clin not prov care catarac		M					
G8321	Pt doc to pre axial leng		M					
G8322	Pt not doc pre axial leng		M					
G8323	Pt inelig for pre surg axial		M					
G8324	Clin not prov care for IOL		M					
G8325	Pt rec fund exam prior surg		M					
G8326	Pt not doc rec fundus exam		M					
G8327	Pt inelig for pre surg fundu		M					
G8328	Clin not prov care fund eval		M					
G8329	Pt doc rec dilated macular		M					
G8330	Pt not doc rec dilated mac		M					
G8331	Pt inelig dilate fundus		M					
G8332	Clin prov no care diabetic r		M					
G8333	Pt doc to have macular exam		M					
G8334	Doc of macular not giv MD		M					
G8335	Clin doc pt inelig macular		M					
G8336	Clin did not pro care diabet		M					
G8337	Clin doc pt was test osteo		M					
G8338	Clin not doc pt test osteo		M					
G8339	Pt inelig for test osteo		M					
G8340	Pt doc have DEXA		M					
G8341	Pt not doc for DEXA		M					
G8342	Clin doc pt inelig DEXA		M					
G8343	Clin not prov care DEXA		M					
G8344	Pt doc have DEXA perform		M					
G8345	Pt not doc have DEXA		M					
G8346	Clin doc pt inelig DEXA		M					
G8347	Clin not prov care DEXA		M					
G8348	Int carotid stenosis meas		M					
G8349	Pt inelig for doc of alarm		M					
G8350	Pt doc 12 lead ECG		M					
G8351	Pt not doc ECG		M					
G8352	Pt inelig for ECG		M					
G8353	Pt doc rec aspirin 24hrs ER		M					
G8354	Pt not rec aspirin prior ER		M					
G8355	Clin doc pt inelig aspirin		M					
G8356	Pt doc to have ECG		M					
G8357	Pt not doc to have ECG		M					
G8358	Clin doc pt inelig ECG		M					
G8359	Pt doc vital signs recorded		M					
G8360	Pt not doc vital signs recor		M					
G8361	Pt doc to have 02 SAT assess		M					
G8362	Pt not doc 02 SAT assess		M					
G8363	Clin doc pt inelig 02 SAT		M					
G8364	Pt doc mental status assess		M					
G8365	Pt not doc mental status		M					
G8366	Pt doc to have empiric AB		M					
G8367	Pt not doc have empiric AB		M					
G8368	Clin doc pt inelig empiri AB		M					
G9001	MCCD, initial rate		B					
G9002	MCCD,maintenance rate		B					
G9003	MCCD, risk adj hi, initial		B					
G9004	MCCD, risk adj lo, initial		B					
G9005	MCCD, risk adj, maintenance		B					
G9006	MCCD, Home monitoring		B					
G9007	MCCD, sch team conf		B					
G9008	Mccd,phys coor-care ovrsght		B					
G9009	MCCD, risk adj, level 3		B					
G9010	MCCD, risk adj, level 4		B					
G9011	MCCD, risk adj, level 5		B					
G9012	Other Specified Case Mgmt		B					
G9013	ESRD demo bundle level I		E					
G9014	ESRD demo bundle-level II		E					
G9016	Demo-smoking cessation coun		E					
G9017	Amantadine HCL 100mg oral		A					
G9018	Zanamivir,inhalation pwd 10m		A					
G9019	Oseltamivir phosphate 75mg		A					
G9020	Rimantadine HCL 100mg oral		A					
G9033	Amantadine HCL oral brand		A					
G9034	Zanamivir, inh pwdr, brand		A					
G9035	Oseltamivir phosp, brand		A					
G9036	Rimantadine HCL, brand		A					
G9041	Low vision rehab occupationa		A					
G9042	Low vision rehab orient/mobi		A					
G9043	Low vision lowvision therapi		A					
G9044	Low vision rehabilate teache		A					
G9050	Oncology work-up evaluation		E					
G9051	Oncology tx decision-mgmt		E					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G9052	Onc surveillance for disease		E					
G9053	Onc expectant management pt		E					
G9054	Onc supervision palliative		E					
G9055	Onc visit unspecified NOS		E					
G9056	Onc prac mgmt adheres guide		E					
G9057	Onc pract mgmt differs trial		E					
G9058	Onc prac mgmt disagree w/gui		E					
G9059	Onc prac mgmt pt opt alterna		E					
G9060	Onc prac mgmt dif pt comorb		E					
G9061	Onc prac cond noadd by guide		E					
G9062	Onc prac guide differs nos		E					
G9063	Onc dx nsclc stgI no progres		M					
G9064	Onc dx nsclc stg2 no progres		M					
G9065	Onc dx nsclc stg3A no progre		M					
G9066	Onc dx nsclc stg3B-4 metasta		M					
G9067	Onc dx nsclc dx unknown nos		M					
G9068	Onc dx sclc/nsclc limited		M					
G9069	Onc dx sclc/nsclc ext at dx		M					
G9070	Onc dx sclc/nsclc ext unknwn		M					
G9071	Onc dx brst stg1-2B HR,nopro		M					
G9072	Onc dx brst stg1-2 noprogres		M					
G9073	Onc dx brst stg3-HR, no pro		M					
G9074	Onc dx brst stg3-noprogress		M					
G9075	Onc dx brst metastic/ recur		M					
G9077	Onc dx prostate T1no progres		M					
G9078	Onc dx prostate T2no progres		M					
G9079	Onc dx prostate T3b-T4noprog		M					
G9080	Onc dx prostate w/rise PSA		M					
G9083	Onc dx prostate unknown NOS		M					
G9084	Onc dx colon t1-3,n1-2,no pr		M					
G9085	Onc dx colon T4, N0 w/o prog		M					
G9086	Onc dx colon T1-4 no dx prog		M					
G9087	Onc dx colon metas evid dx		M					
G9088	Onc dx colon metas noevid dx		M					
G9089	Onc dx colon extent unknown		M					
G9090	Onc dx rectal T1-2 no progr		M					
G9091	Onc dx rectal T3 N0 no prog		M					
G9092	Onc dx rectal T1-3,N1-2noprg		M					
G9093	Onc dx rectal T4,N,M0 no prg		M					
G9094	Onc dx rectal M1 w/mets prog		M					
G9095	Onc dx rectal extent unknwn		M					
G9096	Onc dx esophag T1-T3 noprog		M					
G9097	Onc dx esophageal T4 no prog		M					
G9098	Onc dx esophageal mets recur		M					
G9099	Onc dx esophageal unknown		M					
G9100	Onc dx gastric no recurrence		M					
G9101	Onc dx gastric p R1-R2noprog		M					
G9102	Onc dx gastric unresectable		M					
G9103	Onc dx gastric recurrent		M					
G9104	Onc dx gastric unknown NOS		M					
G9105	Onc dx pancreatc p R0 res no		M					
G9106	Onc dx pancreatc p R1/R2 no		M					
G9107	Onc dx pancreatic unresectab		M					
G9108	Onc dx pancreatic unknwn NOS		M					
G9109	Onc dx head/neck T1-T2no prg		M					
G9110	Onc dx head/neck T3-4 noprog		M					
G9111	Onc dx head/neck M1 mets rec		M					
G9112	Onc dx head/neck ext unknown		M					
G9113	Onc dx ovarian stg1A-B no pr		M					
G9114	Onc dx ovarian stg1A-B or 2		M					
G9115	Onc dx ovarian stg3/4 noprog		M					
G9116	Onc dx ovarian recurrence		M					
G9117	Onc dx ovarian unknown NOS		M					
G9123	Onc dx CML chronic phase		M					
G9124	Onc dx CML acceler phase		M					
G9125	Onc dx CML blast phase		M					
G9126	Onc dx CML remission		M					
G9128	Onc dx multi myeloma stage I		M					
G9129	Onc dx mult myeloma stg2 hig		M					
G9130	Onc dx multi myeloma unknown		M					
G9131	Onc dx brst unknown NOS		M					
G9132	Onc dx prostate mets no cast		M					
G9133	Onc dx prostate clinical met		M					
G9134	Onc NHLstg 1-2 no relap no		M					
G9135	Onc dx NHL stg 3-4 not relap		M					
G9136	Onc dx NHL trans to lg Bcell		M					
G9137	Onc dx NHL relapse/refractor		M					
G9138	Onc dx NHL stg unknown		M					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G9139	Onc dx CML dx status unknown		M					
GXXX1	MD serv cardiac rehab w/o EC		S	0095	0.5868	$37.38	$13.80	$7.48
GXXX2	MD serv cardiac rehab w ECG		S	0095	0.5868	$37.38	$13.80	$7.48
J0120	Tetracyclin injection		N					
J0128	Abarelix injection		K	9216		$67.97		$13.59
J0129	Abatacept injection		G	9230		$18.69		$3.74
J0130	Abciximab injection		K	1605		$409.26		$81.85
J0132	Acetylcysteine injection	CH	N					
J0133	Acyclovir injection		N					
J0135	Adalimumab injection		K	1083		$316.02		$63.20
J0150	Injection adenosine 6 MG		K	0379		$22.65		$4.53
J0152	Adenosine injection		K	0917		$68.50		$13.70
J0170	Adrenalin epinephrin inject		N					
J0180	Agalsidase beta injection		K	9208		$126.00		$25.20
J0190	Inj biperiden lactate/5 mg	CH	N					
J0200	Alatrofloxacin mesylate		N					
J0205	Alglucerase injection		K	0900		$38.85		$7.77
J0207	Amifostine		K	7000		$476.10		$95.22
J0210	Methyldopate hcl injection		K	2210		$10.01		$2.00
J0215	Alefacept		K	1633		$25.82		$5.16
J0256	Alpha 1 proteinase inhibitor		K	0901		$3.24		$0.65
J0270	Alprostadil for injection		B					
J0275	Alprostadil urethral suppos		B					
J0278	Amikacin sulfate injection		N					
J0280	Aminophyllin 250 MG inj		N					
J0282	Amiodarone HCl		N					
J0285	Amphotericin B		N					
J0287	Amphotericin b lipid complex		K	9024		$10.28		$2.06
J0288	Ampho b cholesteryl sulfate		K	0735		$11.89		$2.38
J0289	Amphotericin b liposome inj		K	0736		$17.07		$3.41
J0290	Ampicillin 500 MG inj		N					
J0295	Ampicillin sodium per 1.5 gm		N					
J0300	Amobarbital 125 MG inj		N					
J0330	Succinycholine chloride inj		N					
J0348	Anadulafungin injection		G	0760		$1.91		$0.38
J0350	Injection anistreplase 30 u		K	1606	42.2935	$2,693.80		$538.76
J0360	Hydralazine hcl injection		N					
J0364	Apomorphine hydrochloride	CH	N					
J0365	Aprotonin, 10,000 kiu		K	1682		$2.50		$0.50
J0380	Inj metaraminol bitartrate	CH	N					
J0390	Chloroquine injection		N					
J0395	Arbutamine HCl injection	CH	N					
J0456	Azithromycin		N					
J0460	Atropine sulfate injection		N					
J0470	Dimecaprol injection		N					
J0475	Baclofen 10 MG injection		K	9032		$195.18		$39.04
J0476	Baclofen intrathecal trial		K	1631		$70.92		$14.18
J0480	Basiliximab		K	1683		$1,347.14		$269.43
J0500	Dicyclomine injection		N					
J0515	Inj benztropine mesylate		N					
J0520	Bethanechol chloride inject	CH	K	0879	0.5128	$32.66		$6.53
J0530	Penicillin g benzathine inj		N					
J0540	Penicillin g benzathine inj		N					
J0550	Penicillin g benzathine inj		N					
J0560	Penicillin g benzathine inj		N					
J0570	Penicillin g benzathine inj		N					
J0580	Penicillin g benzathine inj		N					
J0583	Bivalirudin		K	3041		$1.72		$0.34
J0585	Botulinum toxin a per unit		K	0902		$5.05		$1.01
J0587	Botulinum toxin type B		K	9018		$8.30		$1.66
J0592	Buprenorphine hydrochloride		N					
J0594	Busulfan injection		K	1178		$8.80		$1.76
J0595	Butorphanol tartrate 1 mg		N					
J0600	Edetate calcium disodium inj	CH	N					
J0610	Calcium gluconate injection		N					
J0620	Calcium glycer & lact/10 ML		N					
J0630	Calcitonin salmon injection		N					
J0636	Inj calcitriol per 0.1 mcg		N					
J0637	Caspofungin acetate		K	9019		$30.07		$6.01
J0640	Leucovorin calcium injection		N					
J0670	Inj mepivacaine HCL/10 ml		N					
J0690	Cefazolin sodium injection		N					
J0692	Cefepime HCl for injection		N					
J0694	Cefoxitin sodium injection		N					
J0696	Ceftriaxone sodium injection		N					
J0697	Sterile cefuroxime injection		N					
J0698	Cefotaxime sodium injection		N					
J0702	Betamethasone acet&sod phosp		N					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J0704	Betamethasone sod phosp/4 MG		N					
J0706	Caffeine citrate injection	CH	N					
J0710	Cephapirin sodium injection		N					
J0713	Inj ceftazidime per 500 mg		N					
J0715	Ceftizoxime sodium / 500 MG		N					
J0720	Chloramphenicol sodium injec		N					
J0725	Chorionic gonadotropin/1000u		N					
J0735	Clonidine hydrochloride		K	0935		$62.86		$12.57
J0740	Cidofovir injection		K	9033		$754.62		$150.92
J0743	Cilastatin sodium injection		N					
J0744	Ciprofloxacin iv		N					
J0745	Inj codeine phosphate /30 MG		N					
J0760	Colchicine injection		N					
J0770	Colistimethate sodium inj		N					
J0780	Prochlorperazine injection		N					
J0795	Corticorelin ovine triflutal		K	1684		$4.26		$0.85
J0800	Corticotropin injection		K	1280		$126.52		$25.30
J0835	Inj cosyntropin per 0.25 MG		K	0835		$63.25		$12.65
J0850	Cytomegalovirus imm IV /vial		K	0903		$859.86		$171.97
J0878	Daptomycin injection		K	9124		$0.33		$0.07
J0881	Darbepoetin alfa, non-esrd		K	1685		$3.11		$0.62
J0882	Darbepoetin alfa, esrd use		A					
J0885	Epoetin alfa, non-esrd		K	1686		$9.36		$1.87
J0886	Epoetin alfa 1000 units ESRD		A					
J0894	Decitabine injection		G	9231	0.4157	$26.48		$5.30
J0895	Deferoxamine mesylate inj	CH	N					
J0900	Testosterone enanthate inj		N					
J0945	Brompheniramine maleate inj		N					
J0970	Estradiol valerate injection		N					
J1000	Depo-estradiol cypionate inj		N					
J1020	Methylprednisolone 20 MG inj		N					
J1030	Methylprednisolone 40 MG inj		N					
J1040	Methylprednisolone 80 MG inj		N					
J1051	Medroxyprogesterone inj		N					
J1055	Medrxyprogester acetate inj		E					
J1056	MA/EC contraceptiveinjection		E					
J1060	Testosterone cypionate 1 ML		N					
J1070	Testosterone cypionat 100 MG		N					
J1080	Testosterone cypionat 200 MG		N					
J1094	Inj dexamethasone acetate		N					
J1100	Dexamethasone sodium phos		N					
J1110	Inj dihydroergotamine mesylt		N					
J1120	Acetazolamid sodium injectio		N					
J1160	Digoxin injection		N					
J1162	Digoxin immune fab (ovine)		K	1687		$511.48		$102.30
J1165	Phenytoin sodium injection		N					
J1170	Hydromorphone injection		N					
J1180	Dyphylline injection		N					
J1190	Dexrazoxane HCl injection		K	0726		$172.43		$34.49
J1200	Diphenhydramine hcl injectio		N					
J1205	Chlorothiazide sodium inj		K	0747		$122.67		$24.53
J1212	Dimethyl sulfoxide 50% 50 ML		N					
J1230	Methadone injection		N					
J1240	Dimenhydrinate injection		N					
J1245	Dipyridamole injection		N					
J1250	Inj dobutamine HCL/250 mg		N					
J1260	Dolasetron mesylate		K	0750		$6.05		$1.21
J1265	Dopamine injection		N					
J1270	Injection, doxercalciferol		N					
J1320	Amitriptyline injection		N					
J1324	Enfuvirtide injection		K	0767		$22.69		$4.54
J1325	Epoprostenol injection		N					
J1327	Eptifibatide injection		K	1607		$15.90		$3.18
J1330	Ergonovine maleate injection	CH	N					
J1335	Ertapenem injection		N					
J1364	Erythro lactobionate /500 MG		N					
J1380	Estradiol valerate 10 MG inj		N					
J1390	Estradiol valerate 20 MG inj		N					
J1410	Inj estrogen conjugate 25 MG		K	9038		$60.32		$12.06
J1430	Ethanolamine oleate 100 mg		K	1688		$78.26		$15.65
J1435	Injection estrone per 1 MG		N					
J1436	Etidronate disodium inj		K	1436		$70.73		$14.15
J1438	Etanercept injection		K	1608		$160.03		$32.01
J1440	Filgrastim 300 mcg injection		K	0728		$187.68		$37.54
J1441	Filgrastim 480 mcg injection		K	7049		$297.75		$59.55
J1450	Fluconazole		N					
J1451	Fomepizole, 15 mg		K	1689		$12.28		$2.46
J1452	Intraocular Fomivirsen na	CH	N					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J1455	Foscarnet sodium injection	CH	N					
J1457	Gallium nitrate injection	CH	K	0878		$1.47		$0.29
J1458	Galsulfase injection		K	9224		$297.09		$59.42
J1460	Gamma globulin 1 CC inj		K	3043		$11.31		$2.26
J1470	Gamma globulin 2 CC inj	CH	K	0898		$22.63		$4.53
J1480	Gamma globulin 3 CC inj	CH	K	0899		$33.93		$6.79
J1490	Gamma globulin 4 CC inj	CH	K	0904		$45.25		$9.05
J1500	Gamma globulin 5 CC inj	CH	K	0919		$56.56		$11.31
J1510	Gamma globulin 6 CC inj	CH	K	0920		$67.91		$13.58
J1520	Gamma globulin 7 CC inj	CH	K	0921		$79.14		$15.83
J1530	Gamma globulin 8 CC inj	CH	K	0922		$90.50		$18.10
J1540	Gamma globulin 9 CC inj	CH	K	0923		$101.88		$20.38
J1550	Gamma globulin 10 CC inj	CH	K	0924		$113.13		$22.63
J1560	Gamma globulin > 10 CC inj	CH	K	0933		$113.13		$22.63
J1562	Immune globulin subcutaneous		K	0804		$12.60		$2.52
J1565	RSV-ivig		K	0906		$16.02		$3.20
J1566	Immune globulin, powder		K	2731		$25.48		$5.10
J1567	Immune globulin, liquid		K	2732		$30.28		$6.06
J1570	Ganciclovir sodium injection		N					
J1580	Garamycin gentamicin inj		N					
J1590	Gatifloxacin injection		N					
J1595	Injection glatiramer acetate		N					
J1600	Gold sodium thiomaleate inj		N					
J1610	Glucagon hydrochloride/1 MG		K	9042		$65.64		$13.13
J1620	Gonadorelin hydroch/ 100 mcg		K	7005		$178.59		$35.72
J1626	Granisetron HCl injection		K	0764		$7.43		$1.49
J1630	Haloperidol injection		N					
J1631	Haloperidol decanoate inj		N					
J1640	Hemin, 1 mg		K	1690		$6.74		$1.35
J1642	Inj heparin sodium per 10 u		N					
J1644	Inj heparin sodium per 1000u		N					
J1645	Dalteparin sodium		N					
J1650	Inj enoxaparin sodium		N					
J1652	Fondaparinux sodium	CH	K	0883		$5.82		$1.16
J1655	Tinzaparin sodium injection	CH	N					
J1670	Tetanus immune globulin inj		K	1670		$96.35		$19.27
J1675	Histrelin acetate		B					
J1700	Hydrocortisone acetate inj		N					
J1710	Hydrocortisone sodium ph inj		N					
J1720	Hydrocortisone sodium succ i		N					
J1730	Diazoxide injection		K	1740		$113.24		$22.65
J1740	Ibandronate sodium injection		G	9229		$138.71		$27.74
J1742	Ibutilide fumarate injection		K	9044		$264.40		$52.88
J1745	Infliximab injection		K	7043		$53.25		$10.65
J1751	Iron dextran 165 injection		K	1691		$11.61		$2.32
J1752	Iron dextran 267 injection		K	1692		$10.32		$2.06
J1756	Iron sucrose injection		K	9046		$0.37		$0.08
J1785	Injection imiglucerase /unit		K	0916		$3.89		$0.78
J1790	Droperidol injection		N					
J1800	Propranolol injection		N					
J1810	Droperidol/fentanyl inj		E					
J1815	Insulin injection		N					
J1817	Insulin for insulin pump use		N					
J1825	Interferon beta-1a		E					
J1830	Interferon beta-1b / .25 MG		K	0910		$84.12		$16.82
J1835	Itraconazole injection		K	9047		$38.05		$7.61
J1840	Kanamycin sulfate 500 MG inj		N					
J1850	Kanamycin sulfate 75 MG inj		N					
J1885	Ketorolac tromethamine inj		N					
J1890	Cephalothin sodium injection		N					
J1931	Laronidase injection		K	9209		$23.64		$4.73
J1940	Furosemide injection		N					
J1945	Lepirudin		K	1693		$153.42		$30.68
J1950	Leuprolide acetate /3.75 MG		K	0800		$429.83		$85.97
J1955	Inj levocarnitine per 1 gm		B					
J1956	Levofloxacin injection		N					
J1960	Levorphanol tartrate inj		N					
J1980	Hyoscyamine sulfate inj		N					
J1990	Chlordiazepoxide injection		N					
J2001	Lidocaine injection		N					
J2010	Lincomycin injection		N					
J2020	Linezolid injection		K	9001		$24.93		$4.99
J2060	Lorazepam injection		N					
J2150	Mannitol injection		N					
J2170	Mecasermin injection		K	0805		$11.81		$2.36
J2175	Meperidine hydrochl /100 MG		N					
J2180	Meperidine/promethazine inj		N					
J2185	Meropenem	CH	N					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J2210	Methylergonovin maleate inj		N					
J2248	Micafungin sodium injection		G	9227		$1.71		$0.34
J2250	Inj midazolam hydrochloride		N					
J2260	Inj milrinone lactate / 5 MG		N					
J2270	Morphine sulfate injection		N					
J2271	Morphine so4 injection 100mg		N					
J2275	Morphine sulfate injection		N					
J2278	Ziconotide injection	CH	K	1694		$6.46		$1.29
J2280	Inj, moxifloxacin 100 mg		N					
J2300	Inj nalbuphine hydrochloride		N					
J2310	Inj naloxone hydrochloride		N					
J2315	Naltrexone, depot form		K	0759		$1.88		$0.38
J2320	Nandrolone decanoate 50 MG		N					
J2321	Nandrolone decanoate 100 MG		N					
J2322	Nandrolone decanoate 200 MG		N					
J2325	Nesiritide injection		K	1695		$31.36		$6.27
J2353	Octreotide injection, depot		K	1207		$95.86		$19.17
J2354	Octreotide inj, non-depot		N					
J2355	Oprelvekin injection		K	7011		$244.98		$49.00
J2357	Omalizumab injection		K	9300		$16.79		$3.36
J2360	Orphenadrine injection		N					
J2370	Phenylephrine hcl injection		N					
J2400	Chloroprocaine hcl injection		N					
J2405	Ondansetron hcl injection		K	0768		$3.37		$0.67
J2410	Oxymorphone hcl injection		N					
J2425	Palifermin injection		K	1696		$11.32		$2.26
J2430	Pamidronate disodium /30 MG		K	0730		$30.49		$6.10
J2440	Papaverin hcl injection		N					
J2460	Oxytetracycline injection		N					
J2469	Palonosetron HCl		K	9210		$15.85		$3.17
J2501	Paricalcitol		N					
J2503	Pegaptanib sodium injection	CH	K	1697		$1,054.70		$210.94
J2504	Pegademase bovine, 25 iu		K	1739		$176.16		$35.23
J2505	Injection, pegfilgrastim 6mg		K	9119		$2,142.92		$428.58
J2510	Penicillin g procaine inj		N					
J2513	Pentastarch 10% solution	CH	K	0880	0.3707	$23.61		$4.72
J2515	Pentobarbital sodium inj		N					
J2540	Penicillin g potassium inj		N					
J2543	Piperacillin/tazobactam		N					
J2545	Pentamidine isethionte/300mg		B					
J2550	Promethazine hcl injection		N					
J2560	Phenobarbital sodium inj		N					
J2590	Oxytocin injection		N					
J2597	Inj desmopressin acetate		N					
J2650	Prednisolone acetate inj		N					
J2670	Totazoline hcl injection		N					
J2675	Inj progesterone per 50 MG		N					
J2680	Fluphenazine decanoate 25 MG		N					
J2690	Procainamide hcl injection		N					
J2700	Oxacillin sodium injeciton		N					
J2710	Neostigmine methylslfte inj		N					
J2720	Inj protamine sulfate/10 MG		N					
J2725	Inj protirelin per 250 mcg		N					
J2730	Pralidoxime chloride inj		N					
J2760	Phentolaine mesylate inj		N					
J2765	Metoclopramide hcl injection		N					
J2770	Quinupristin/dalfopristin		K	2770		$116.70		$23.34
J2780	Ranitidine hydrochloride inj		N					
J2783	Rasburicase		K	0738		$131.28		$26.26
J2788	Rho d immune globulin 50 mcg		K	9023		$26.41		$5.28
J2790	Rho d immune globulin inj		K	0884		$80.71		$16.14
J2792	Rho(D) immune globulin h, sd		K	1609		$15.76		$3.15
J2794	Risperidone, long acting		K	9125		$4.80		$0.96
J2795	Ropivacaine HCl injection		N					
J2800	Methocarbamol injection		N					
J2805	Sincalide injection		N					
J2810	Inj theophylline per 40 MG		N					
J2820	Sargramostim injection		K	0731		$25.08		$5.02
J2850	Inj secretin synthetic human		K	1700		$20.12		$4.02
J2910	Aurothioglucose injeciton		N					
J2916	Na ferric gluconate complex		N					
J2920	Methylprednisolone injection		N					
J2930	Methylprednisolone injection		N					
J2940	Somatrem injection		K	2940	1.0916	$69.53		$13.91
J2941	Somatropin injection		K	7034		$46.75		$9.35
J2950	Promazine hcl injection		N					
J2993	Reteplase injection		K	9005		$891.03		$178.21
J2995	Inj streptokinase /250000 IU		K	0911	1.1851	$75.48		$15.10

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J2997	Alteplase recombinant		K	7048		$32.48		$6.50
J3000	Streptomycin injection		N					
J3010	Fentanyl citrate injeciton		N					
J3030	Sumatriptan succinate / 6 MG		K	3030		$58.82		$11.76
J3070	Pentazocine injection		N					
J3100	Tenecteplase injection		K	9002		$2,024.13		$404.83
J3105	Terbutaline sulfate inj		N					
J3110	Teriparatide injection		B					
J3120	Testosterone enanthate inj		N					
J3130	Testosterone enanthate inj		N					
J3140	Testosterone suspension inj		N					
J3150	Testosteron propionate inj		N					
J3230	Chlorpromazine hcl injection		N					
J3240	Thyrotropin injection		K	9108		$758.16		$151.63
J3243	Tigecycline injection		G	9228		$0.91		$0.18
J3246	Tirofiban HCl		K	7041		$7.66		$1.53
J3250	Trimethobenzamide hcl inj		N					
J3260	Tobramycin sulfate injection		N					
J3265	Injection torsemide 10 mg/ml		N					
J3280	Thiethylperazine maleate inj		N					
J3285	Treprostinil injection		K	1701		$55.36		$11.07
J3301	Triamcinolone acetonide inj		N					
J3302	Triamcinolone diacetate inj		N					
J3303	Triamcinolone hexacetonl inj		N					
J3305	Inj trimetrexate glucoronate		K	7045		$143.89		$28.78
J3310	Perphenazine injeciton		N					
J3315	Triptorelin pamoate		K	9122		$153.97		$30.79
J3320	Spectinomycn di-hcl inj	CH	N					
J3350	Urea injection		K	9051		$73.46		$14.69
J3355	Urofollitropin, 75 iu		K	1741		$50.22		$10.04
J3360	Diazepam injection		N					
J3364	Urokinase 5000 IU injection	CH	K	0881		$9.07		$1.81
J3365	Urokinase 250,000 IU inj		K	7036		$453.41		$90.68
J3370	Vancomycin hcl injection		N					
J3396	Verteporfin injection		K	1203		$8.84		$1.77
J3400	Triflupromazine hcl inj		N					
J3410	Hydroxyzine hcl injection		N					
J3411	Thiamine hcl 100 mg		N					
J3415	Pyridoxine hcl 100 mg		N					
J3420	Vitamin b12 injection		N					
J3430	Vitamin k phytonadione inj		N					
J3465	Injection, voriconazole		K	1052		$4.94		$0.99
J3470	Hyaluronidase injection		N					
J3471	Ovine, up to 999 USP units		N					
J3472	Ovine, 1000 USP units		K	1703		$133.77		$26.75
J3473	Hyaluronidase recombinant		G	0806		$0.40		$0.08
J3475	Inj magnesium sulfate		N					
J3480	Inj potassium chloride		N					
J3485	Zidovudine		N					
J3486	Ziprasidone mesylate		N					
J3487	Zoledronic acid		K	9115		$204.09		$40.82
J3490	Drugs unclassified injection		N					
J3520	Edetate disodium per 150 mg		E					
J3530	Nasal vaccine inhalation		N					
J3535	Metered dose inhaler drug		E					
J3570	Laetrile amygdalin vit B17		E					
J3590	Unclassified biologics		N					
J7030	Normal saline solution infus		N					
J7040	Normal saline solution infus		N					
J7042	5% dextrose/normal saline		N					
J7050	Normal saline solution infus		N					
J7060	5% dextrose/water		N					
J7070	D5w infusion		N					
J7100	Dextran 40 infusion		N					
J7110	Dextran 75 infusion		N					
J7120	Ringers lactate infusion		N					
J7130	Hypertonic saline solution		N					
J7187	Inj Vonwillebrand factor IU		K	1704		$0.88		$0.18
J7189	Factor viia		K	1705		$1.11		$0.22
J7190	Factor viii		K	0925		$0.70		$0.14
J7191	Factor VIII (porcine)	CH	N					
J7192	Factor viii recombinant		K	0927		$1.07		$0.21
J7193	Factor IX non-recombinant		K	0931		$0.89		$0.18
J7194	Factor ix complex		K	0928		$0.75		$0.15
J7195	Factor IX recombinant		K	0932		$0.99		$0.20
J7197	Antithrombin iii injection		K	0930		$1.62		$0.32
J7198	Anti-inhibitor		K	0929		$1.35		$0.27
J7199	Hemophilia clot factor noc		B					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J7300	Intraut copper contraceptive		E					
J7302	Levonorgestrel iu contracept		E					
J7303	Contraceptive vaginal ring		E					
J7304	Contraceptive hormone patch		E					
J7306	Levonorgestrel implant sys		E					
J7308	Aminolevulinic acid hcl top		K	7308		$104.43		$20.89
J7310	Ganciclovir long act implant		K	0913		$4,707.42		$941.48
J7311	Fluocinolone acetonide implt	CH	K	9225		$19,162.50		$3,832.50
J7319	Sodium Hyaluronate Injection		E					
J7330	Cultured chondrocytes implnt		B					
J7340	Metabolic active D/E tissue		K	1632		$28.51		$5.70
J7341	Non-human, metabolic tissue	CH	N					
J7342	Metabolically active tissue		K	9054		$31.36		$6.27
J7343	Nonmetabolic act d/e tissue		K	1629		$18.13		$3.63
J7344	Nonmetabolic active tissue		K	9156		$88.37		$17.67
J7345	Non-human, non-metab tissue		K	0837		$35.76		$7.15
J7346	Injectable human tissue		K	9222		$728.44		$145.69
J7500	Azathioprine oral 50mg		N					
J7501	Azathioprine parenteral		K	0887		$47.99		$9.60
J7502	Cyclosporine oral 100 mg		K	0888		$3.57		$0.71
J7504	Lymphocyte immune globulin		K	0890		$314.19		$62.84
J7505	Monoclonal antibodies		K	7038		$886.70		$177.34
J7506	Prednisone oral		N					
J7507	Tacrolimus oral per 1 MG		K	0891		$3.63		$0.73
J7509	Methylprednisolone oral		N					
J7510	Prednisolone oral per 5 mg		N					
J7511	Antithymocyte globuln rabbit		K	9104		$324.66		$64.93
J7513	Daclizumab, parenteral		K	1612		$297.03		$59.41
J7515	Cyclosporine oral 25 mg		N					
J7516	Cyclosporin parenteral 250mg		N					
J7517	Mycophenolate mofetil oral		K	9015		$2.60		$0.52
J7518	Mycophenolic acid		K	9219		$2.25		$0.45
J7520	Sirolimus, oral		K	9020		$7.15		$1.43
J7525	Tacrolimus injection		K	9006		$139.11		$27.82
J7599	Immunosuppressive drug noc		N					
J7607	Levalbuterol comp con		B					
J7608	Acetylcysteine inh sol u d		B					
J7609	Albuterol comp unit		B					
J7610	Albuterol comp con		B					
J7611	Albuterol non-comp con		B					
J7612	Levalbuterol non-comp con		B					
J7613	Albuterol non-comp unit		B					
J7614	Levalbuterol non-comp unit		B					
J7615	Levalbuterol comp unit		B					
J7620	Albuterol ipratrop non-comp		B					
J7622	Beclomethasone comp unit		B					
J7624	Betamethasone comp unit		B					
J7626	Budesonide non-comp unit		B					
J7627	Budesonide comp unit		B					
J7628	Bitolterol mesylate comp con		B					
J7629	Bitolterol mesylate comp unt		B					
J7631	Cromolyn sodium inh sol u d		B					
J7633	Budesonide non-comp con		B					
J7634	Budesonide comp con		B					
J7635	Atropine comp con		B					
J7636	Atropine comp unit		B					
J7637	Dexamethasone comp con		B					
J7638	Dexamethasone comp unit		B					
J7639	Dornase alpha inhal sol u d		B					
J7640	Formoterol comp unit		E					
J7641	Flunisolide comp unit		B					
J7642	Glycopyrrolate comp con		B					
J7643	Glycopyrrolate comp unit		B					
J7644	Ipratropium bromide non-comp		B					
J7645	Ipratropium bromide comp		B					
J7647	Isoetharine comp con		B					
J7648	Isoetharine non-comp con		B					
J7649	Isoetharine non-comp unit		B					
J7650	Isoetharine comp unit		B					
J7657	Isoproterenol comp con		B					
J7658	Isoproterenol non-comp con		B					
J7659	Isoproterenol non-comp unit		B					
J7660	Isoproterenol comp unit		B					
J7667	Metaproterenol comp con		B					
J7668	Metaproterenol non-comp con		B					
J7669	Metaproterenol non-comp unit		B					
J7670	Metaproterenol comp unit		B					
J7674	Methacholine chloride, neb		N					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J7680	Terbutaline sulf comp con		B					
J7681	Terbutaline sulf comp unit		B					
J7682	Tobramycin non-comp unit		B					
J7683	Triamcinolone comp con		B					
J7684	Triamcinolone comp unit		B					
J7685	Tobramycin comp unit		B					
J7699	Inhalation solution for DME		Y					
J7799	Non-inhalation drug for DME		N					
J8498	Antiemetic rectal/supp NOS		B					
J8499	Oral prescrip drug non chemo		E					
J8501	Oral aprepitant	CH	K	0868		$5.02		$1.00
J8510	Oral busulfan		K	7015		$2.12		$0.42
J8515	Cabergoline, oral 0.25mg		E					
J8520	Capecitabine, oral, 150 mg		K	7042		$3.94		$0.79
J8521	Capecitabine, oral, 500 mg	CH	K	0934		$13.12		$2.62
J8530	Cyclophosphamide oral 25 MG		N					
J8540	Oral dexamethasone		N					
J8560	Etoposide oral 50 MG		K	0802		$29.32		$5.86
J8565	Gefitinib oral		E					
J8597	Antiemetic drug oral NOS		N					
J8600	Melphalan oral 2 MG	CH	K	0882	0.0681	$4.34		$0.87
J8610	Methotrexate oral 2.5 MG		N					
J8650	Nabilone oral		K	0808		$16.80		$3.36
J8700	Temozolomide		K	1086		$7.34		$1.47
J8999	Oral prescription drug chemo		B					
J9000	Doxorubic hcl 10 MG vl chemo	CH	N					
J9001	Doxorubicin hcl liposome inj		K	7046		$385.81		$77.16
J9010	Alemtuzumab injection		K	9110		$536.10		$107.22
J9015	Aldesleukin/single use vial		K	0807		$755.78		$151.16
J9017	Arsenic trioxide		K	9012		$33.84		$6.77
J9020	Asparaginase injection		K	0814		$54.20		$10.84
J9025	Azacitidine injection		K	1709		$4.26		$0.85
J9027	Clofarabine injection	CH	K	1710		$115.64		$23.13
J9031	Bcg live intravesical vac		K	0809		$109.63		$21.93
J9035	Bevacizumab injection		K	9214		$56.98		$11.40
J9040	Bleomycin sulfate injection		K	0748		$35.52		$7.10
J9041	Bortezomib injection		K	9207		$32.37		$6.47
J9045	Carboplatin injection		K	0811		$8.38		$1.68
J9050	Carmus bischl nitro inj		K	0812		$138.52		$27.70
J9055	Cetuximab injection		K	9215		$49.34		$9.87
J9060	Cisplatin 10 MG injection		N					
J9062	Cisplatin 50 MG injection	CH	N					
J9065	Inj cladribine per 1 MG		K	0858		$35.78		$7.16
J9070	Cyclophosphamide 100 MG inj		N					
J9080	Cyclophosphamide 200 MG inj	CH	N					
J9090	Cyclophosphamide 500 MG inj	CH	N					
J9091	Cyclophosphamide 1.0 grm inj	CH	N					
J9092	Cyclophosphamide 2.0 grm inj	CH	N					
J9093	Cyclophosphamide lyophilized	CH	N					
J9094	Cyclophosphamide lyophilized	CH	N					
J9095	Cyclophosphamide lyophilized	CH	N					
J9096	Cyclophosphamide lyophilized	CH	N					
J9097	Cyclophosphamide lyophilized	CH	N					
J9098	Cytarabine liposome		K	1166		$391.31		$78.26
J9100	Cytarabine hcl 100 MG inj		N					
J9110	Cytarabine hcl 500 MG inj	CH	N					
J9120	Dactinomycin actinomycin d		K	0752		$488.78		$97.76
J9130	Dacarbazine 100 mg inj	CH	N					
J9140	Dacarbazine 200 MG inj	CH	N					
J9150	Daunorubicin		K	0820		$20.28		$4.06
J9151	Daunorubicin citrate liposom		K	0821		$55.40		$11.08
J9160	Denileukin diftitox, 300 mcg		K	1084		$1,393.32		$278.66
J9165	Diethylstilbestrol injection		N					
J9170	Docetaxel		K	0823		$303.92		$60.78
J9175	Elliotts b solution per ml		N					
J9178	Inj, epirubicin hcl, 2 mg		K	1167		$21.01		$4.20
J9181	Etoposide 10 MG inj		N					
J9182	Etoposide 100 MG inj	CH	N					
J9185	Fludarabine phosphate inj		K	0842		$234.21		$46.84
J9190	Fluorouracil injection		N					
J9200	Floxuridine injection		K	0827		$50.82		$10.16
J9201	Gemcitabine HCl		K	0828		$123.98		$24.80
J9202	Goserelin acetate implant		K	0810		$196.81		$39.36
J9206	Irinotecan injection		K	0830		$124.81		$24.96
J9208	Ifosfomide injection		K	0831		$46.15		$9.23
J9209	Mesna injection		K	0732		$8.89		$1.78
J9211	Idarubicin hcl injection		K	0832		$301.74		$60.35
J9212	Interferon alfacon-1		K	0912		$4.60		$0.92

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J9213	Interferon alfa-2a inj		K	0834		$37.53		$7.51
J9214	Interferon alfa-2b inj		K	0836		$13.75		$2.75
J9215	Interferon alfa-n3 inj		K	0865		$9.03		$1.81
J9216	Interferon gamma 1-b inj		K	0838		$287.13		$57.43
J9217	Leuprolide acetate suspnsion		K	9217		$227.34		$45.47
J9218	Leuprolide acetate injeciton		K	0861		$8.79		$1.76
J9219	Leuprolide acetate implant		K	7051		$1,696.96		$339.39
J9225	Histrelin implant		K	1711		$1,446.98		$289.40
J9230	Mechlorethamine hcl inj		K	0751		$140.27		$28.05
J9245	Inj melphalan hydrochl 50 MG		K	0840		$1,272.00		$254.40
J9250	Methotrexate sodium inj		N					
J9260	Methotrexate sodium inj	CH	N					
J9261	Nelarabine injection		K	0825		$82.54		$16.51
J9263	Oxaliplatin		K	1738		$8.89		$1.78
J9264	Paclitaxel protein bound	CH	K	1712		$7.03		$1.41
J9265	Paclitaxel injection		K	0863		$12.47		$2.49
J9266	Pegaspargase/singl dose vial		K	0843		$1,667.61		$333.52
J9268	Pentostatin injection		K	0844		$1,916.66		$383.33
J9270	Plicamycin (mithramycin) inj	CH	N					
J9280	Mitomycin 5 MG inj		K	0862		$15.98		$3.20
J9290	Mitomycin 20 MG inj	CH	K	0941		$63.93		$12.79
J9291	Mitomycin 40 MG inj	CH	K	0942		$127.85		$25.57
J9293	Mitoxantrone hydrochl / 5 MG		K	0864		$166.64		$33.33
J9300	Gemtuzumab ozogamicin		K	9004		$2,334.75		$466.95
J9305	Pemetrexed injection		K	9213		$43.38		$8.68
J9310	Rituximab cancer treatment		K	0849		$491.54		$98.31
J9320	Streptozocin injection		K	0850		$152.28		$30.46
J9340	Thiotepa injection		K	0851		$40.32		$8.06
J9350	Topotecan		K	0852		$822.90		$164.58
J9355	Trastuzumab		K	1613		$57.33		$11.47
J9357	Valrubicin, 200 mg		K	9167	3.4445	$219.39		$43.88
J9360	Vinblastine sulfate inj		N					
J9370	Vincristine sulfate 1 MG inj		N					
J9375	Vincristine sulfate 2 MG inj	CH	N					
J9380	Vincristine sulfate 5 MG inj	CH	N					
J9390	Vinorelbine tartrate/10 mg		K	0855		$19.88		$3.98
J9395	Injection, Fulvestrant		K	9120		$79.80		$15.96
J9600	Porfimer sodium		K	0856		$2,539.13		$507.83
J9999	Chemotherapy drug		N					
K0001	Standard wheelchair		Y					
K0002	Stnd hemi (low seat) whlchr		Y					
K0003	Lightweight wheelchair		Y					
K0004	High strength ltwt whlchr		Y					
K0005	Ultralightweight wheelchair		Y					
K0006	Heavy duty wheelchair		Y					
K0007	Extra heavy duty wheelchair		Y					
K0009	Other manual wheelchair/base		Y					
K0010	Stnd wt frame power whlchr		Y					
K0011	Stnd wt pwr whlchr w control		Y					
K0012	Ltwt portbl power whlchr		Y					
K0014	Other power whlchr base		Y					
K0015	Detach non-adjus hght armrst		Y					
K0017	Detach adjust armrest base		Y					
K0018	Detach adjust armrst upper		Y					
K0019	Arm pad each		Y					
K0020	Fixed adjust armrest pair		Y					
K0037	High mount flip-up footrest		Y					
K0038	Leg strap each		Y					
K0039	Leg strap h style each		Y					
K0040	Adjustable angle footplate		Y					
K0041	Large size footplate each		Y					
K0042	Standard size footplate each		Y					
K0043	Ftrst lower extension tube		Y					
K0044	Ftrst upper hanger bracket		Y					
K0045	Footrest complete assembly		Y					
K0046	Elevat legrst low extension		Y					
K0047	Elevat legrst up hangr brack		Y					
K0050	Ratchet assembly		Y					
K0051	Cam relese assem ftrst/lgrst		Y					
K0052	Swingaway detach footrest		Y					
K0053	Elevate footrest articulate		Y					
K0056	Seat ht <17 or ≧21 ltwt wc		Y					
K0065	Spoke protectors		Y					
K0069	Rear whl complete solid tire		Y					
K0070	Rear whl compl pneum tire		Y					
K0071	Front castr compl pneum tire		Y					
K0072	Frnt cstr cmpl sem-pneum tir		Y					
K0073	Caster pin lock each		Y					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
K0077	Front caster assem complete		Y					
K0098	Drive belt power wheelchair		Y					
K0105	Iv hanger		Y					
K0108	W/c component-accessory NOS		Y					
K0195	Elevating whlchair leg rests		Y					
K0455	Pump uninterrupted infusion		Y					
K0462	Temporary replacement eqpmnt		Y					
K0552	Supply/ext inf pump syr type		Y					
K0601	Repl batt silver oxide 1.5 v		Y					
K0602	Repl batt silver oxide 3 v		Y					
K0603	Repl batt alkaline 1.5 v		Y					
K0604	Repl batt lithium 3.6 v		Y					
K0605	Repl batt lithium 4.5 v		Y					
K0606	AED garment w elec analysis		Y					
K0607	Repl batt for AED		Y					
K0608	Repl garment for AED		Y					
K0609	Repl electrode for AED		Y					
K0669	Seat/back cus no sadmerc ver		Y					
K0730	Ctrl dose inh drug deliv sys		Y					
K0733	12-24hr sealed lead acid		Y					
K0734	Adj skin pro w/c cus wd<22in		Y					
K0735	Adj skin pro wc cus wd≧22in		Y					
K0736	Adj skin pro/pos wc cus<22in		Y					
K0737	Adj skin pro/pos wc cus≧22≧		Y					
K0738	Portable gas oxygen system		Y					
K0800	POV group 1 std up to 300lbs		Y					
K0801	POV group 1 hd 301-450 lbs		Y					
K0802	POV group 1 vhd 451-600 lbs		Y					
K0806	POV group 2 std up to 300lbs		Y					
K0807	POV group 2 hd 301-450 lbs		Y					
K0808	POV group 2 vhd 451-600 lbs		Y					
K0812	Power operated vehicle NOC		Y					
K0813	PWC gp 1 std port seat/back		Y					
K0814	PWC gp 1 std port cap chair		Y					
K0815	PWC gp 1 std seat/back		Y					
K0816	PWC gp 1 std cap chair		Y					
K0820	PWC gp 2 std port seat/back		Y					
K0821	PWC gp 2 std port cap chair		Y					
K0822	PWC gp 2 std seat/back		Y					
K0823	PWC gp 2 std cap chair		Y					
K0824	PWC gp 2 hd seat/back		Y					
K0825	PWC gp 2 hd cap chair		Y					
K0826	PWC gp 2 vhd seat/back		Y					
K0827	PWC gp vhd cap chair		Y					
K0828	PWC gp 2 xtra hd seat/back		Y					
K0829	PWC gp 2 xtra hd cap chair		Y					
K0830	PWC gp2 std seat elevate s/b		Y					
K0831	PWC gp2 std seat elevate cap		Y					
K0835	PWC gp2 std sing pow opt s/b		Y					
K0836	PWC gp2 std sing pow opt cap		Y					
K0837	PWC gp 2 hd sing pow opt s/b		Y					
K0838	PWC gp 2 hd sing pow opt cap		Y					
K0839	PWC gp2 vhd sing pow opt s/b		Y					
K0840	PWC gp2 xhd sing pow opt s/b		Y					
K0841	PWC gp2 std mult pow opt s/b		Y					
K0842	PWC gp2 std mult pow opt cap		Y					
K0843	PWC gp2 hd mult pow opt s/b		Y					
K0848	PWC gp 3 std seat/back		Y					
K0849	PWC gp 3 std cap chair		Y					
K0850	PWC gp 3 hd seat/back		Y					
K0851	PWC gp 3 hd cap chair		Y					
K0852	PWC gp 3 vhd seat/back		Y					
K0853	PWC gp 3 vhd cap chair		Y					
K0854	PWC gp 3 xhd seat/back		Y					
K0855	PWC gp 3 xhd cap chair		Y					
K0856	PWC gp3 std sing pow opt s/b		Y					
K0857	PWC gp3 std sing pow opt cap		Y					
K0858	PWC gp3 hd sing pow opt s/b		Y					
K0859	PWC gp3 hd sing pow opt cap		Y					
K0860	PWC gp3 vhd sing pow opt s/b		Y					
K0861	PWC gp3 std mult pow opt s/b		Y					
K0862	PWC gp3 hd mult pow opt s/b		Y					
K0863	PWC gp3 vhd mult pow opt s/b		Y					
K0864	PWC gp3 xhd mult pow opt s/b		Y					
K0868	PWC gp 4 std seat/back		Y					
K0869	PWC gp 4 std cap chair		Y					
K0870	PWC gp 4 hd seat/back		Y					
K0871	PWC gp 4 vhd seat/back		Y					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
K0877	PWC gp4 std sing pow opt s/b		Y					
K0878	PWC gp4 std sing pow opt cap		Y					
K0879	PWC gp4 hd sing pow opt s/b		Y					
K0880	PWC gp4 vhd sing pow opt s/b		Y					
K0884	PWc gp4 std mult pow opt s/b		Y					
K0885	PWC gp4 std mult pow opt cap		Y					
K0886	PWC gp4 hd mult pow s/b		Y					
K0890	PWC gp5 ped sing pow opt s/b		Y					
K0891	PWC gp5 ped mult pow opt s/b		Y					
K0898	Power wheelchair NOC		Y					
K0899	Pow mobil dev no SADMERC		Y					
L0112	Cranial cervical orthosis		A					
L0120	Cerv flexible non-adjustable		A					
L0130	Flex thermoplastic collar mo		A					
L0140	Cervical semi-rigid adjustab		A					
L0150	Cerv semi-rig adj molded chn		A					
L0160	Cerv semi-rig wire occ/mand		A					
L0170	Cervical collar molded to pt		A					
L0172	Cerv col thermplas foam 2 pi		A					
L0174	Cerv col foam 2 piece w thor		A					
L0180	Cer post col occ/man sup adj		A					
L0190	Cerv collar supp adj cerv ba		A					
L0200	Cerv col supp adj bar & thor		A					
L0210	Thoracic rib belt		A					
L0220	Thor rib belt custom fabrica		A					
L0430	Dewall posture protector		A					
L0450	TLSO flex prefab thoracic		A					
L0452	tlso flex custom fab thoraci		A					
L0454	TLSO flex prefab sacrococ-T9		A					
L0456	TLSO flex prefab		A					
L0458	TLSO 2Mod symphis-xipho pre		A					
L0460	TLSO2Mod symphysis-stern pre		A					
L0462	TLSO 3Mod sacro-scap pre		A					
L0464	TLSO 4Mod sacro-scap pre		A					
L0466	TLSO rigid frame pre soft ap		A					
L0468	TLSO rigid frame prefab pelv		A					
L0470	TLSO rigid frame pre subclav		A					
L0472	TLSO rigid frame hyperex pre		A					
L0480	TLSO rigid plastic custom fa		A					
L0482	TLSO rigid lined custom fab		A					
L0484	TLSO rigid plastic cust fab		A					
L0486	TLSO rigidlined cust fab two		A					
L0488	TLSO rigid lined pre one pie		A					
L0490	TLSO rigid plastic pre one		A					
L0491	TLSO 2 piece rigid shell		A					
L0492	TLSO 3 piece rigid shell		A					
L0621	SIO flex pelvisacral prefab		A					
L0622	SIO flex pelvisacral custom		A					
L0623	SIO panel prefab		A					
L0624	SIO panel custom		A					
L0625	LO flexibl L1-below L5 pre		A					
L0626	LO sag stays/panels pre-fab		A					
L0627	LO sagitt rigid panel prefab		A					
L0628	LO flex w/o rigid stays pre		A					
L0629	LSO flex w/rigid stays cust		A					
L0630	LSO post rigid panel pre		A					
L0631	LSO sag-coro rigid frame pre		A					
L0632	LSO sag rigid frame cust		A					
L0633	LSO flexion control prefab		A					
L0634	LSO flexion control custom		A					
L0635	LSO sagit rigid panel prefab		A					
L0636	LSO sagittal rigid panel cus		A					
L0637	LSO sag-coronal panel prefab		A					
L0638	LSO sag-coronal panel custom		A					
L0639	LSO s/c shell/panel prefab		A					
L0640	LSO s/c shell/panel custom		A					
L0700	Ctlso a-p-l control molded		A					
L0710	Ctlso a-p-l control w/ inter		A					
L0810	Halo cervical into jckt vest		A					
L0820	Halo cervical into body jack		A					
L0830	Halo cerv into milwaukee typ		A					
L0859	MRI compatible system		A					
L0861	Halo repl liner/interface		A					
L0960	Post surgical support pads		A					
L0970	Tlso corset front		A					
L0972	Lso corset front		A					
L0974	Tlso full corset		A					
L0976	Lso full corset		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L0978	Axillary crutch extension		A					
L0980	Peroneal straps pair		A					
L0982	Stocking supp grips set of f		A					
L0984	Protective body sock each		A					
L0999	Add to spinal orthosis NOS		A					
L1000	Ctlso milwauke initial model		A					
L1001	CTLSO infant immobilizer		A					
L1005	Tension based scoliosis orth		A					
L1010	Ctlso axilla sling		A					
L1020	Kyphosis pad		A					
L1025	Kyphosis pad floating		A					
L1030	Lumbar bolster pad		A					
L1040	Lumbar or lumbar rib pad		A					
L1050	Sternal pad		A					
L1060	Thoracic pad		A					
L1070	Trapezius sling		A					
L1080	Outrigger		A					
L1085	Outrigger bil w/ vert extens		A					
L1090	Lumbar sling		A					
L1100	Ring flange plastic/leather		A					
L1110	Ring flange plas/leather mol		A					
L1120	Covers for upright each		A					
L1200	Furnsh initial orthosis only		A					
L1210	Lateral thoracic extension		A					
L1220	Anterior thoracic extension		A					
L1230	Milwaukee type superstructur		A					
L1240	Lumbar derotation pad		A					
L1250	Anterior asis pad		A					
L1260	Anterior thoracic derotation		A					
L1270	Abdominal pad		A					
L1280	Rib gusset (elastic) each		A					
L1290	Lateral trochanteric pad		A					
L1300	Body jacket mold to patient		A					
L1310	Post-operative body jacket		A					
L1499	Spinal orthosis NOS		A					
L1500	Thkao mobility frame		A					
L1510	Thkao standing frame		A					
L1520	Thkao swivel walker		A					
L1600	Abduct hip flex frejka w cvr		A					
L1610	Abduct hip flex frejka covr		A					
L1620	Abduct hip flex pavlik harne		A					
L1630	Abduct control hip semi-flex		A					
L1640	Pelv band/spread bar thigh c		A					
L1650	HO abduction hip adjustable		A					
L1652	HO bi thighcuffs w sprdr bar		A					
L1660	HO abduction static plastic		A					
L1680	Pelvic & hip control thigh c		A					
L1685	Post-op hip abduct custom fa		A					
L1686	HO post-op hip abduction		A					
L1690	Combination bilateral HO		A					
L1700	Leg perthes orth toronto typ		A					
L1710	Legg perthes orth newington		A					
L1720	Legg perthes orthosis trilat		A					
L1730	Legg perthes orth scottish r		A					
L1755	Legg perthes patten bottom t		A					
L1800	Knee orthoses elas w stays		A					
L1810	Ko elastic with joints		A					
L1815	Elastic with condylar pads		A					
L1820	Ko elas w/ condyle pads & jo		A					
L1825	Ko elastic knee cap		A					
L1830	Ko immobilizer canvas longit		A					
L1831	Knee orth pos locking joint		A					
L1832	KO adj jnt pos rigid support		A					
L1834	Ko w/0 joint rigid molded to		A					
L1836	Rigid KO wo joints		A					
L1840	Ko derot ant cruciate custom		A					
L1843	KO single upright custom fit		A					
L1844	Ko w/adj jt rot cntrl molded		A					
L1845	Ko w/ adj flex/ext rotat cus		A					
L1846	Ko w adj flex/ext rotat mold		A					
L1847	KO adjustable w air chambers		A					
L1850	Ko swedish type		A					
L1855	Ko plas doub upright jnt mol		A					
L1858	Ko polycentric pneumatic pad		A					
L1860	Ko supracondylar socket mold		A					
L1870	Ko doub upright lacers molde		A					
L1880	Ko doub upright cuffs/lacers		A					
L1900	Afo sprng wir drsflx calf bd		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L1901	Prefab ankle orthosis		A					
L1902	Afo ankle gauntlet		A					
L1904	Afo molded ankle gauntlet		A					
L1906	Afo multiligamentus ankle su		A					
L1907	AFO supramalleolar custom		A					
L1910	Afo sing bar clasp attach sh		A					
L1920	Afo sing upright w/ adjust s		A					
L1930	Afo plastic		A					
L1932	Afo rig ant tib prefab TCF/=		A					
L1940	Afo molded to patient plasti		A					
L1945	Afo molded plas rig ant tib		A					
L1950	Afo spiral molded to pt plas		A					
L1951	AFO spiral prefabricated		A					
L1960	Afo pos solid ank plastic mo		A					
L1970	Afo plastic molded w/ankle j		A					
L1971	AFO w/ankle joint, prefab		A					
L1980	Afo sing solid stirrup calf		A					
L1990	Afo doub solid stirrup calf		A					
L2000	Kafo sing fre stirr thi/calf		A					
L2005	KAFO sng/dbl mechanical act		A					
L2010	Kafo sng solid stirrup w/o j		A					
L2020	Kafo dbl solid stirrup band/		A					
L2030	Kafo dbl solid stirrup w/o j		A					
L2034	KAFO pla sin up w/wo k/a cus		A					
L2035	KAFO plastic pediatric size		A					
L2036	Kafo plas doub free knee mol		A					
L2037	Kafo plas sing free knee mol		A					
L2038	Kafo w/o joint multi-axis an		A					
L2040	Hkafo torsion bil rot straps		A					
L2050	Hkafo torsion cable hip pelv		A					
L2060	Hkafo torsion ball bearing j		A					
L2070	Hkafo torsion unilat rot str		A					
L2080	Hkafo unilat torsion cable		A					
L2090	Hkafo unilat torsion ball br		A					
L2106	Afo tib fx cast plaster mold		A					
L2108	Afo tib fx cast molded to pt		A					
L2112	Afo tibial fracture soft		A					
L2114	Afo tib fx semi-rigid		A					
L2116	Afo tibial fracture rigid		A					
L2126	Kafo fem fx cast thermoplas		A					
L2128	Kafo fem fx cast molded to p		A					
L2132	Kafo femoral fx cast soft		A					
L2134	Kafo fem fx cast semi-rigid		A					
L2136	Kafo femoral fx cast rigid		A					
L2180	Plas shoe insert w ank joint		A					
L2182	Drop lock knee		A					
L2184	Limited motion knee joint		A					
L2186	Adj motion knee jnt lerman t		A					
L2188	Quadrilateral brim		A					
L2190	Waist belt		A					
L2192	Pelvic band & belt thigh fla		A					
L2200	Limited ankle motion ea jnt		A					
L2210	Dorsiflexion assist each joi		A					
L2220	Dorsi & plantar flex ass/res		A					
L2230	Split flat caliper stirr & p		A					
L2232	Rocker bottom, contact AFO		A					
L2240	Round caliper and plate atta		A					
L2250	Foot plate molded stirrup at		A					
L2260	Reinforced solid stirrup		A					
L2265	Long tongue stirrup		A					
L2270	Varus/valgus strap padded/li		A					
L2275	Plastic mod low ext pad/line		A					
L2280	Molded inner boot		A					
L2300	Abduction bar jointed adjust		A					
L2310	Abduction bar-straight		A					
L2320	Non-molded lacer		A					
L2330	Lacer molded to patient mode		A					
L2335	Anterior swing band		A					
L2340	Pre-tibial shell molded to p		A					
L2350	Prosthetic type socket molde		A					
L2360	Extended steel shank		A					
L2370	Patten bottom		A					
L2375	Torsion ank & half solid sti		A					
L2380	Torsion straight knee joint		A					
L2385	Straight knee joint heavy du		A					
L2387	Add LE poly knee custom KAFO		A					
L2390	Offset knee joint each		A					
L2395	Offset knee joint heavy duty		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L2397	Suspension sleeve lower ext		A					
L2405	Knee joint drop lock ea jnt		A					
L2415	Knee joint cam lock each joi		A					
L2425	Knee disc/dial lock/adj flex		A					
L2430	Knee jnt ratchet lock ea jnt		A					
L2492	Knee lift loop drop lock rin		A					
L2500	Thi/glut/ischia wgt bearing		A					
L2510	Th/wght bear quad-lat brim m		A					
L2520	Th/wght bear quad-lat brim c		A					
L2525	Th/wght bear nar m-l brim mo		A					
L2526	Th/wght bear nar m-l brim cu		A					
L2530	Thigh/wght bear lacer non-mo		A					
L2540	Thigh/wght bear lacer molded		A					
L2550	Thigh/wght bear high roll cu		A					
L2570	Hip clevis type 2 posit jnt		A					
L2580	Pelvic control pelvic sling		A					
L2600	Hip clevis/thrust bearing fr		A					
L2610	Hip clevis/thrust bearing lo		A					
L2620	Pelvic control hip heavy dut		A					
L2622	Hip joint adjustable flexion		A					
L2624	Hip adj flex ext abduct cont		A					
L2627	Plastic mold recipro hip & c		A					
L2628	Metal frame recipro hip & ca		A					
L2630	Pelvic control band & belt u		A					
L2640	Pelvic control band & belt b		A					
L2650	Pelv & thor control gluteal		A					
L2660	Thoracic control thoracic ba		A					
L2670	Thorac cont paraspinal uprig		A					
L2680	Thorac cont lat support upri		A					
L2750	Plating chrome/nickel pr bar		A					
L2755	Carbon graphite lamination		A					
L2760	Extension per extension per		A					
L2768	Ortho sidebar disconnect		A					
L2770	Low ext orthosis per bar/jnt		A					
L2780	Non-corrosive finish		A					
L2785	Drop lock retainer each		A					
L2795	Knee control full kneecap		A					
L2800	Knee cap medial or lateral p		A					
L2810	Knee control condylar pad		A					
L2820	Soft interface below knee se		A					
L2830	Soft interface above knee se		A					
L2840	Tibial length sock fx or equ		A					
L2850	Femoral lgth sock fx or equa		A					
L2860	Torsion mechanism knee/ankle		A					
L2999	Lower extremity orthosis NOS		A					
L3000	Ft insert ucb berkeley shell		A					
L3001	Foot insert remov molded spe		A					
L3002	Foot insert plastazote or eq		A					
L3003	Foot insert silicone gel eac		A					
L3010	Foot longitudinal arch suppo		A					
L3020	Foot longitud/metatarsal sup		A					
L3030	Foot arch support remov prem		A					
L3031	Foot lamin/prepreg composite		A					
L3040	Ft arch suprt premold longit		A					
L3050	Foot arch supp premold metat		A					
L3060	Foot arch supp longitud/meta		A					
L3070	Arch suprt att to sho longit		A					
L3080	Arch supp att to shoe metata		A					
L3090	Arch supp att to shoe long/m		A					
L3100	Hallus-valgus nght dynamic s		A					
L3140	Abduction rotation bar shoe		A					
L3150	Abduct rotation bar w/o shoe		A					
L3160	Shoe styled positioning dev		A					
L3170	Foot plastic heel stabilizer		A					
L3201	Oxford w supinat/pronat inf		A					
L3202	Oxford w/ supinat/pronator c		A					
L3203	Oxford w/ supinator/pronator		A					
L3204	Hightop w/ supp/pronator inf		A					
L3206	Hightop w/ supp/pronator chi		A					
L3207	Hightop w/ supp/pronator jun		A					
L3208	Surgical boot each infant		A					
L3209	Surgical boot each child		A					
L3211	Surgical boot each junior		A					
L3212	Benesch boot pair infant		A					
L3213	Benesch boot pair child		A					
L3214	Benesch boot pair junior		A					
L3215	Orthopedic ftwear ladies oxf		A					
L3216	Orthoped ladies shoes dpth i		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L3217	Ladies shoes hightop depth i		A					
L3219	Orthopedic mens shoes oxford		A					
L3221	Orthopedic mens shoes dpth i		A					
L3222	Mens shoes hightop depth inl		A					
L3224	Woman's shoe oxford brace		A					
L3225	Man's shoe oxford brace		A					
L3230	Custom shoes depth inlay		A					
L3250	Custom mold shoe remov prost		A					
L3251	Shoe molded to pt silicone s		A					
L3252	Shoe molded plastazote cust		A					
L3253	Shoe molded plastazote cust		A					
L3254	Orth foot non-stndard size/w		A					
L3255	Orth foot non-standard size/		A					
L3257	Orth foot add charge split s		A					
L3260	Ambulatory surgical boot eac		E					
L3265	Plastazote sandal each		A					
L3300	Sho lift taper to metatarsal		A					
L3310	Shoe lift elev heel/sole neo		A					
L3320	Shoe lift elev heel/sole cor		A					
L3330	Lifts elevation metal extens		A					
L3332	Shoe lifts tapered to one-ha		A					
L3334	Shoe lifts elevation heel /i		A					
L3340	Shoe wedge sach		A					
L3350	Shoe heel wedge		A					
L3360	Shoe sole wedge outside sole		A					
L3370	Shoe sole wedge between sole		A					
L3380	Shoe clubfoot wedge		A					
L3390	Shoe outflare wedge		A					
L3400	Shoe metatarsal bar wedge ro		A					
L3410	Shoe metatarsal bar between		A					
L3420	Full sole/heel wedge btween		A					
L3430	Sho heel count plast reinfor		A					
L3440	Heel leather reinforced		A					
L3450	Shoe heel sach cushion type		A					
L3455	Shoe heel new leather standa		A					
L3460	Shoe heel new rubber standar		A					
L3465	Shoe heel thomas with wedge		A					
L3470	Shoe heel thomas extend to b		A					
L3480	Shoe heel pad & depress for		A					
L3485	Shoe heel pad removable for		A					
L3500	Ortho shoe add leather insol		A					
L3510	Orthopedic shoe add rub insl		A					
L3520	O shoe add felt w leath insl		A					
L3530	Ortho shoe add half sole		A					
L3540	Ortho shoe add full sole		A					
L3550	O shoe add standard toe tap		A					
L3560	O shoe add horseshoe toe tap		A					
L3570	O shoe add instep extension		A					
L3580	O shoe add instep velcro clo		A					
L3590	O shoe convert to sof counte		A					
L3595	Ortho shoe add march bar		A					
L3600	Trans shoe calip plate exist		A					
L3610	Trans shoe caliper plate new		A					
L3620	Trans shoe solid stirrup exi		A					
L3630	Trans shoe solid stirrup new		A					
L3640	Shoe dennis browne splint bo		A					
L3649	Orthopedic shoe modifica NOS		A					
L3650	Shlder fig 8 abduct restrain		A					
L3651	Prefab shoulder orthosis		A					
L3652	Prefab dbl shoulder orthosis		A					
L3660	Abduct restrainer canvas&web		A					
L3670	Acromio/clavicular canvas&we		A					
L3671	SO cap design w/o jnts CF		A					
L3672	SO airplane w/o jnts CF		A					
L3673	SO airplane w/joint CF		A					
L3675	Canvas vest SO		A					
L3677	SO hard plastic stabilizer		E					
L3700	Elbow orthoses elas w stays		A					
L3701	Prefab elbow orthosis		A					
L3702	EO w/o joints CF		A					
L3710	Elbow elastic with metal joi		A					
L3720	Forearm/arm cuffs free motio		A					
L3730	Forearm/arm cuffs ext/flex a		A					
L3740	Cuffs adj lock w/ active con		A					
L3760	EO withjoint, Prefabricated		A					
L3762	Rigid EO wo joints		A					
L3763	EWHO rigid w/o jnts CF		A					
L3764	EWHO w/joint(s) CF		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L3765	EWHFO rigid w/o jnts CF		A					
L3766	EWHFO w/joint(s) CF		A					
L3800	Whfo short opponen no attach		A					
L3805	Whfo long opponens no attach		A					
L3806	WHFO w/joint(s) custom fab		A					
L3807	WHFO,no joint, prefabricated		A					
L3808	WHFO, rigid w/o joints		A					
L3810	Whfo thumb abduction bar		A					
L3815	Whfo second m.p. abduction a		A					
L3820	Whfo ip ext asst w/ mp ext s		A					
L3825	Whfo m.p. extension stop		A					
L3830	Whfo m.p. extension assist		A					
L3835	Whfo m.p. spring extension a		A					
L3840	Whfo spring swivel thumb		A					
L3845	Whfo thumb ip ext ass w/ mp		A					
L3850	Action wrist w/ dorsiflex as		A					
L3855	Whfo adj m.p. flexion contro		A					
L3860	Whfo adj m.p. flex ctrl & i.		A					
L3890	Torsion mechanism wrist/elbo		B					
L3900	Hinge extension/flex wrist/f		A					
L3901	Hinge ext/flex wrist finger		A					
L3904	Whfo electric custom fitted		A					
L3905	WHO w/nontorsion jnt(s) CF		A					
L3906	WHO w/o joints CF		A					
L3907	Whfo wrst gauntlt thmb spica		A					
L3908	Wrist cock-up non-molded		A					
L3909	Prefab wrist orthosis		A					
L3910	Whfo swanson design		A					
L3911	Prefab hand finger orthosis		A					
L3912	Flex glove w/elastic finger		A					
L3913	HFO w/o joints CF		A					
L3915	WHO w nontor jnt(s) prefab		A					
L3916	Whfo wrist extens w/ outrigg		A					
L3917	Prefab metacarpl fx orthosis		A					
L3918	HFO knuckle bender		A					
L3919	HO w/o joints CF		A					
L3920	Knuckle bender with outrigge		A					
L3921	HFO w/joint(s) CF		A					
L3922	Knuckle bend 2 seg to flex j		A					
L3923	HFO w/o joints PF		A					
L3924	Oppenheimer		A					
L3926	Thomas suspension		A					
L3928	Finger extension w/ clock sp		A					
L3930	Finger extension with wrist		A					
L3932	Safety pin spring wire		A					
L3933	FO w/o joints CF		A					
L3934	Safety pin modified		A					
L3935	FO nontorsion joint CF		A					
L3936	Palmer		A					
L3938	Dorsal wrist		A					
L3940	Dorsal wrist w/ outrigger at		A					
L3942	Reverse knuckle bender		A					
L3944	Reverse knuckle bend w/ outr		A					
L3946	HFO composite elastic		A					
L3948	Finger knuckle bender		A					
L3950	Oppenheimer w/ knuckle bend		A					
L3952	Oppenheimer w/ rev knuckle 2		A					
L3954	Spreading hand		A					
L3956	Add joint upper ext orthosis		A					
L3960	Sewho airplan desig abdu pos		A					
L3961	SEWHO cap design w/o jnts CF		A					
L3962	Sewho erbs palsey design abd		A					
L3964	Seo mobile arm sup att to wc		Y					
L3965	Arm supp att to wc rancho ty		Y					
L3966	Mobile arm supports reclinin		Y					
L3967	SEWHO airplane w/o jnts CF		A					
L3968	Friction dampening arm supp		Y					
L3969	Monosuspension arm/hand supp		Y					
L3970	Elevat proximal arm support		Y					
L3971	SEWHO cap design w/jnt(s) CF		A					
L3972	Offset/lat rocker arm w/ ela		Y					
L3973	SEWHO airplane w/jnt(s) CF		A					
L3974	Mobile arm support supinator		Y					
L3975	SEWHFO cap design w/o jnt CF		A					
L3976	SEWHFO airplane w/o jnts CF		A					
L3977	SEWHFO cap desgn w/jnt(s) CF		A					
L3978	SEWHFO airplane w/jnt(s) CF		A					
L3980	Upp ext fx orthosis humeral		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L3982	Upper ext fx orthosis rad/ul		A					
L3984	Upper ext fx orthosis wrist		A					
L3985	Forearm hand fx orth w/ wr h		A					
L3986	Humeral rad/ulna wrist fx or		A					
L3995	Sock fracture or equal each		A					
L3999	Upper limb orthosis NOS		A					
L4000	Repl girdle milwaukee orth		A					
L4002	Replace strap, any orthosis		A					
L4010	Replace trilateral socket br		A					
L4020	Replace quadlat socket brim		A					
L4030	Replace socket brim cust fit		A					
L4040	Replace molded thigh lacer		A					
L4045	Replace non-molded thigh lac		A					
L4050	Replace molded calf lacer		A					
L4055	Replace non-molded calf lace		A					
L4060	Replace high roll cuff		A					
L4070	Replace prox & dist upright		A					
L4080	Repl met band kafo-afo prox		A					
L4090	Repl met band kafo-afo calf/		A					
L4100	Repl leath cuff kafo prox th		A					
L4110	Repl leath cuff kafo-afo cal		A					
L4130	Replace pretibial shell		A					
L4205	Ortho dvc repair per 15 min		A					
L4210	Orth dev repair/repl minor p		A					
L4350	Ankle control orthosi prefab		A					
L4360	Pneumati walking boot prefab		A					
L4370	Pneumatic full leg splint		A					
L4380	Pneumatic knee splint		A					
L4386	Non-pneum walk boot prefab		A					
L4392	Replace AFO soft interface		A					
L4394	Replace foot drop spint		A					
L4396	Static AFO		A					
L4398	Foot drop splint recumbent		A					
L5000	Sho insert w arch toe filler		A					
L5010	Mold socket ank hgt w/ toe f		A					
L5020	Tibial tubercle hgt w/ toe f		A					
L5050	Ank symes mold sckt sach ft		A					
L5060	Symes met fr leath socket ar		A					
L5100	Molded socket shin sach foot		A					
L5105	Plast socket jts/thgh lacer		A					
L5150	Mold sckt ext knee shin sach		A					
L5160	Mold socket bent knee shin s		A					
L5200	Kne sing axis fric shin sach		A					
L5210	No knee/ankle joints w/ ft b		A					
L5220	No knee joint with artic ali		A					
L5230	Fem focal defic constant fri		A					
L5250	Hip canad sing axi cons fric		A					
L5270	Tilt table locking hip sing		A					
L5280	Hemipelvect canad sing axis		A					
L5301	BK mold socket SACH ft endo		A					
L5311	Knee disart, SACH ft, endo		A					
L5321	AK open end SACH		A					
L5331	Hip disart canadian SACH ft		A					
L5341	Hemipelvectomy canadian SACH		A					
L5400	Postop dress & 1 cast chg bk		A					
L5410	Postop dsg bk ea add cast ch		A					
L5420	Postop dsg & 1 cast chg ak/d		A					
L5430	Postop dsg ak ea add cast ch		A					
L5450	Postop app non-wgt bear dsg		A					
L5460	Postop app non-wgt bear dsg		A					
L5500	Init bk ptb plaster direct		A					
L5505	Init ak ischal plstr direct		A					
L5510	Prep BK ptb plaster molded		A					
L5520	Perp BK ptb thermopls direct		A					
L5530	Prep BK ptb thermopls molded		A					
L5535	Prep BK ptb open end socket		A					
L5540	Prep BK ptb laminated socket		A					
L5560	Prep AK ischial plast molded		A					
L5570	Prep AK ischial direct form		A					
L5580	Prep AK ischial thermo mold		A					
L5585	Prep AK ischial open end		A					
L5590	Prep AK ischial laminated		A					
L5595	Hip disartic sach thermopls		A					
L5600	Hip disart sach laminat mold		A					
L5610	Above knee hydracadence		A					
L5611	Ak 4 bar link w/fric swing		A					
L5613	Ak 4 bar ling w/hydraul swig		A					
L5614	4-bar link above knee w/swng		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L5616	Ak univ multiplex sys frict		A					
L5617	AK/BK self-aligning unit ea		A					
L5618	Test socket symes		A					
L5620	Test socket below knee		A					
L5622	Test socket knee disarticula		A					
L5624	Test socket above knee		A					
L5626	Test socket hip disarticulat		A					
L5628	Test socket hemipelvectomy		A					
L5629	Below knee acrylic socket		A					
L5630	Syme typ expandabl wall sckt		A					
L5631	Ak/knee disartic acrylic soc		A					
L5632	Symes type ptb brim design s		A					
L5634	Symes type poster opening so		A					
L5636	Symes type medial opening so		A					
L5637	Below knee total contact		A					
L5638	Below knee leather socket		A					
L5639	Below knee wood socket		A					
L5640	Knee disarticulat leather so		A					
L5642	Above knee leather socket		A					
L5643	Hip flex inner socket ext fr		A					
L5644	Above knee wood socket		A					
L5645	Bk flex inner socket ext fra		A					
L5646	Below knee cushion socket		A					
L5647	Below knee suction socket		A					
L5648	Above knee cushion socket		A					
L5649	Isch containmt/narrow m-l so		A					
L5650	Tot contact ak/knee disart s		A					
L5651	Ak flex inner socket ext fra		A					
L5652	Suction susp ak/knee disart		A					
L5653	Knee disart expand wall sock		A					
L5654	Socket insert symes		A					
L5655	Socket insert below knee		A					
L5656	Socket insert knee articulat		A					
L5658	Socket insert above knee		A					
L5661	Multi-durometer symes		A					
L5665	Multi-durometer below knee		A					
L5666	Below knee cuff suspension		A					
L5668	Socket insert w/o lock lower		A					
L5670	Bk molded supracondylar susp		A					
L5671	BK/AK locking mechanism		A					
L5672	Bk removable medial brim sus		A					
L5673	Socket insert w lock mech		A					
L5676	Bk knee joints single axis p		A					
L5677	Bk knee joints polycentric p		A					
L5678	Bk joint covers pair		A					
L5679	Socket insert w/o lock mech		A					
L5680	Bk thigh lacer non-molded		A					
L5681	Intl custm cong/latyp insert		A					
L5682	Bk thigh lacer glut/ischia m		A					
L5683	Initial custom socket insert		A					
L5684	Bk fork strap		A					
L5685	Below knee sus/seal sleeve		A					
L5686	Bk back check		A					
L5688	Bk waist belt webbing		A					
L5690	Bk waist belt padded and lin		A					
L5692	Ak pelvic control belt light		A					
L5694	Ak pelvic control belt pad/l		A					
L5695	Ak sleeve susp neoprene/equa		A					
L5696	Ak/knee disartic pelvic join		A					
L5697	Ak/knee disartic pelvic band		A					
L5698	Ak/knee disartic silesian ba		A					
L5699	Shoulder harness		A					
L5700	Replace socket below knee		A					
L5701	Replace socket above knee		A					
L5702	Replace socket hip		A					
L5703	Symes ankle w/o (SACH) foot		A					
L5704	Custom shape cover BK		A					
L5705	Custom shape cover AK		A					
L5706	Custom shape cvr knee disart		A					
L5707	Custom shape cvr hip disart		A					
L5710	Kne-shin exo sng axi mnl loc		A					
L5711	Knee-shin exo mnl lock ultra		A					
L5712	Knee-shin exo frict swg & st		A					
L5714	Knee-shin exo variable frict		A					
L5716	Knee-shin exo mech stance ph		A					
L5718	Knee-shin exo frct swg & sta		A					
L5722	Knee-shin pneum swg frct exo		A					
L5724	Knee-shin exo fluid swing ph		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L5726	Knee-shin ext jnts fld swg e		A					
L5728	Knee-shin fluid swg & stance		A					
L5780	Knee-shin pneum/hydra pneum		A					
L5781	Lower limb pros vacuum pump		A					
L5782	HD low limb pros vacuum pump		A					
L5785	Exoskeletal bk ultralt mater		A					
L5790	Exoskeletal ak ultra-light m		A					
L5795	Exoskel hip ultra-light mate		A					
L5810	Endoskel knee-shin mnl lock		A					
L5811	Endo knee-shin mnl lck ultra		A					
L5812	Endo knee-shin frct swg & st		A					
L5814	Endo knee-shin hydral swg ph		A					
L5816	Endo knee-shin polyc mch sta		A					
L5818	Endo knee-shin frct swg & st		A					
L5822	Endo knee-shin pneum swg frc		A					
L5824	Endo knee-shin fluid swing p		A					
L5826	Miniature knee joint		A					
L5828	Endo knee-shin fluid swg/sta		A					
L5830	Endo knee-shin pneum/swg pha		A					
L5840	Multi-axial knee/shin system		A					
L5845	Knee-shin sys stance flexion		A					
L5848	Knee-shin sys hydraul stance		A					
L5850	Endo ak/hip knee extens assi		A					
L5855	Mech hip extension assist		A					
L5856	Elec knee-shin swing/stance		A					
L5857	Elec knee-shin swing only		A					
L5858	Stance phase only		A					
L5910	Endo below knee alignable sy		A					
L5920	Endo ak/hip alignable system		A					
L5925	Above knee manual lock		A					
L5930	High activity knee frame		A					
L5940	Endo bk ultra-light material		A					
L5950	Endo ak ultra-light material		A					
L5960	Endo hip ultra-light materia		A					
L5962	Below knee flex cover system		A					
L5964	Above knee flex cover system		A					
L5966	Hip flexible cover system		A					
L5968	Multiaxial ankle w dorsiflex		A					
L5970	Foot external keel sach foot		A					
L5971	SACH foot, replacement		A					
L5972	Flexible keel foot		A					
L5974	Foot single axis ankle/foot		A					
L5975	Combo ankle/foot prosthesis		A					
L5976	Energy storing foot		A					
L5978	Ft prosth multiaxial ankl/ft		A					
L5979	Multi-axial ankle/ft prosth		A					
L5980	Flex foot system		A					
L5981	Flex-walk sys low ext prosth		A					
L5982	Exoskeletal axial rotation u		A					
L5984	Endoskeletal axial rotation		A					
L5985	Lwr ext dynamic prosth pylon		A					
L5986	Multi-axial rotation unit		A					
L5987	Shank ft w vert load pylon		A					
L5988	Vertical shock reducing pylo		A					
L5990	User adjustable heel height		A					
L5993	Heavy duty feature, foot		A					
L5994	Heavy duty feature, knee		A					
L5995	Lower ext pros heavyduty fea		A					
L5999	Lowr extremity prosthes NOS		A					
L6000	Par hand robin-aids thum rem		A					
L6010	Hand robin-aids little/ring		A					
L6020	Part hand robin-aids no fing		A					
L6025	Part hand disart myoelectric		A					
L6050	Wrst MLd sck flx hng tri pad		A					
L6055	Wrst mold sock w/exp interfa		A					
L6100	Elb mold sock flex hinge pad		A					
L6110	Elbow mold sock suspension t		A					
L6120	Elbow mold doub splt soc ste		A					
L6130	Elbow stump activated lock h		A					
L6200	Elbow mold outsid lock hinge		A					
L6205	Elbow molded w/ expand inter		A					
L6250	Elbow inter loc elbow forarm		A					
L6300	Shlder disart int lock elbow		A					
L6310	Shoulder passive restor comp		A					
L6320	Shoulder passive restor cap		A					
L6350	Thoracic intern lock elbow		A					
L6360	Thoracic passive restor comp		A					
L6370	Thoracic passive restor cap		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L6380	Postop dsg cast chg wrst/elb		A					
L6382	Postop dsg cast chg elb dis/		A					
L6384	Postop dsg cast chg shlder/t		A					
L6386	Postop ea cast chg & realign		A					
L6388	Postop applicat rigid dsg on		A					
L6400	Below elbow prosth tiss shap		A					
L6450	Elb disart prosth tiss shap		A					
L6500	Above elbow prosth tiss shap		A					
L6550	Shldr disar prosth tiss shap		A					
L6570	Scap thorac prosth tiss shap		A					
L6580	Wrist/elbow bowden cable mol		A					
L6582	Wrist/elbow bowden cbl dir f		A					
L6584	Elbow fair lead cable molded		A					
L6586	Elbow fair lead cable dir fo		A					
L6588	Shdr fair lead cable molded		A					
L6590	Shdr fair lead cable direct		A					
L6600	Polycentric hinge pair		A					
L6605	Single pivot hinge pair		A					
L6610	Flexible metal hinge pair		A					
L6611	Additional switch, ext power		A					
L6615	Disconnect locking wrist uni		A					
L6616	Disconnect insert locking wr		A					
L6620	Flexion/extension wrist unit		A					
L6621	Flex/ext wrist w/wo friction		A					
L6623	Spring-ass rot wrst w/ latch		A					
L6624	Flex/ext/rotation wrist unit		A					
L6625	Rotation wrst w/ cable lock		A					
L6628	Quick disconn hook adapter o		A					
L6629	Lamination collar w/ couplin		A					
L6630	Stainless steel any wrist		A					
L6632	Latex suspension sleeve each		A					
L6635	Lift assist for elbow		A					
L6637	Nudge control elbow lock		A					
L6638	Elec lock on manual pw elbow		A					
L6639	Heavy duty elbow feature		A					
L6640	Shoulder abduction joint pai		A					
L6641	Excursion amplifier pulley t		A					
L6642	Excursion amplifier lever ty		A					
L6645	Shoulder flexion-abduction j		A					
L6646	Multipo locking shoulder jnt		A					
L6647	Shoulder lock actuator		A					
L6648	Ext pwrd shlder lock/unlock		A					
L6650	Shoulder universal joint		A					
L6655	Standard control cable extra		A					
L6660	Heavy duty control cable		A					
L6665	Teflon or equal cable lining		A					
L6670	Hook to hand cable adapter		A					
L6672	Harness chest/shlder saddle		A					
L6675	Harness figure of 8 sing con		A					
L6676	Harness figure of 8 dual con		A					
L6677	UE triple control harness		A					
L6680	Test sock wrist disart/bel e		A					
L6682	Test sock elbw disart/above		A					
L6684	Test socket shldr disart/tho		A					
L6686	Suction socket		A					
L6687	Frame typ socket bel elbow/w		A					
L6688	Frame typ sock above elb/dis		A					
L6689	Frame typ socket shoulder di		A					
L6690	Frame typ sock interscap-tho		A					
L6691	Removable insert each		A					
L6692	Silicone gel insert or equal		A					
L6693	Lockingelbow forearm cntrbal		A					
L6694	Elbow socket ins use w/lock		A					
L6695	Elbow socket ins use w/o lck		A					
L6696	Cus elbo skt in for con/atyp		A					
L6697	Cus elbo skt in not con/atyp		A					
L6698	Below/above elbow lock mech		A					
L6703	Term dev, passive hand mitt		A					
L6704	Term dev, sport/rec/work att		A					
L6706	Term dev mech hook vol open		A					
L6707	Term dev mech hook vol close		A					
L6708	Term dev mech hand vol open		A					
L6709	Term dev mech hand vol close		A					
L6805	Term dev modifier wrist unit		A					
L6810	Term dev precision pinch dev		A					
L6881	Term dev auto grasp feature		A					
L6882	Microprocessor control uplmb		A					
L6883	Replc sockt below e/w disa		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L6884	Replc sockt above elbow disa		A					
L6885	Replc sockt shldr dis/interc		A					
L6890	Prefab glove for term device		A					
L6895	Custom glove for term device		A					
L6900	Hand restorat thumb/1 finger		A					
L6905	Hand restoration multiple fi		A					
L6910	Hand restoration no fingers		A					
L6915	Hand restoration replacmnt g		A					
L6920	Wrist disarticul switch ctrl		A					
L6925	Wrist disart myoelectronic c		A					
L6930	Below elbow switch control		A					
L6935	Below elbow myoelectronic ct		A					
L6940	Elbow disarticulation switch		A					
L6945	Elbow disart myoelectronic c		A					
L6950	Above elbow switch control		A					
L6955	Above elbow myoelectronic ct		A					
L6960	Shldr disartic switch contro		A					
L6965	Shldr disartic myoelectronic		A					
L6970	Interscapular-thor switch ct		A					
L6975	Interscap-thor myoelectronic		A					
L7007	Adult electric hand		A					
L7008	Pediatric electric hand		A					
L7009	Adult electric hook		A					
L7040	Prehensile actuator		A					
L7045	Pediatric electric hook		A					
L7170	Electronic elbow hosmer swit		A					
L7180	Electronic elbow sequential		A					
L7181	Electronic elbo simultaneous		A					
L7185	Electron elbow adolescent sw		A					
L7186	Electron elbow child switch		A					
L7190	Elbow adolescent myoelectron		A					
L7191	Elbow child myoelectronic ct		A					
L7260	Electron wrist rotator otto		A					
L7261	Electron wrist rotator utah		A					
L7266	Servo control steeper or equ		A					
L7272	Analogue control unb or equa		A					
L7274	Proportional ctl 12 volt uta		A					
L7360	Six volt bat otto bock/eq ea		A					
L7362	Battery chrgr six volt otto		A					
L7364	Twelve volt battery utah/equ		A					
L7366	Battery chrgr 12 volt utah/e		A					
L7367	Replacemnt lithium ionbatter		A					
L7368	Lithium ion battery charger		A					
L7400	Add UE prost be/wd, ultlite		A					
L7401	Add UE prost a/e ultlite mat		A					
L7402	Add UE prost s/d ultlite mat		A					
L7403	Add UE prost b/e acrylic		A					
L7404	Add UE prost a/e acrylic		A					
L7405	Add UE prost s/d acrylic		A					
L7499	Upper extremity prosthes NOS		A					
L7500	Prosthetic dvc repair hourly		A					
L7510	Prosthetic device repair rep		A					
L7520	Repair prosthesis per 15 min		A					
L7600	Prosthetic donning sleeve		A					
L7900	Male vacuum erection system		A					
L8000	Mastectomy bra		A					
L8001	Breast prosthesis bra & form		A					
L8002	Brst prsth bra & bilat form		A					
L8010	Mastectomy sleeve		A					
L8015	Ext breastprosthesis garment		A					
L8020	Mastectomy form		A					
L8030	Breast prosthesis silicone/e		A					
L8035	Custom breast prosthesis		A					
L8039	Breast prosthesis NOS		A					
L8040	Nasal prosthesis		A					
L8041	Midfacial prosthesis		A					
L8042	Orbital prosthesis		A					
L8043	Upper facial prosthesis		A					
L8044	Hemi-facial prosthesis		A					
L8045	Auricular prosthesis		A					
L8046	Partial facial prosthesis		A					
L8047	Nasal septal prosthesis		A					
L8048	Unspec maxillofacial prosth		A					
L8049	Repair maxillofacial prosth		A					
L8300	Truss single w/ standard pad		A					
L8310	Truss double w/ standard pad		A					
L8320	Truss addition to std pad wa		A					
L8330	Truss add to std pad scrotal		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L8400	Sheath below knee		A					
L8410	Sheath above knee		A					
L8415	Sheath upper limb		A					
L8417	Pros sheath/sock w gel cushn		A					
L8420	Prosthetic sock multi ply BK		A					
L8430	Prosthetic sock multi ply AK		A					
L8435	Pros sock multi ply upper lm		A					
L8440	Shrinker below knee		A					
L8460	Shrinker above knee		A					
L8465	Shrinker upper limb		A					
L8470	Pros sock single ply BK		A					
L8480	Pros sock single ply AK		A					
L8485	Pros sock single ply upper l		A					
L8499	Unlisted misc prosthetic ser		A					
L8500	Artificial larynx		A					
L8501	Tracheostomy speaking valve		A					
L8505	Artificial larynx, accessory		A					
L8507	Trach-esoph voice pros pt in		A					
L8509	Trach-esoph voice pros md in		A					
L8510	Voice amplifier		A					
L8511	Indwelling trach insert		A					
L8512	Gel cap for trach voice pros		A					
L8513	Trach pros cleaning device		A					
L8514	Repl trach puncture dilator		A					
L8515	Gel cap app device for trach		A					
L8600	Implant breast silicone/eq		N					
L8603	Collagen imp urinary 2.5 ml		N					
L8606	Synthetic implnt urinary 1ml		N					
L8609	Artificial cornea		N					
L8610	Ocular implant		N					
L8612	Aqueous shunt prosthesis		N					
L8613	Ossicular implant		N					
L8614	Cochlear device		N					
L8615	Coch implant headset replace		A					
L8616	Coch implant microphone repl		A					
L8617	Coch implant trans coil repl		A					
L8618	Coch implant tran cable repl		A					
L8619	Replace cochlear processor		A					
L8621	Repl zinc air battery		A					
L8622	Repl alkaline battery		A					
L8623	Lith ion batt CID,non-earlvl		A					
L8624	Lith ion batt CID, ear level		A					
L8630	Metacarpophalangeal implant		N					
L8631	MCP joint repl 2 pc or more		N					
L8641	Metatarsal joint implant		N					
L8642	Hallux implant		N					
L8658	Interphalangeal joint spacer		N					
L8659	Interphalangeal joint repl		N					
L8670	Vascular graft, synthetic		N					
L8680	Implt neurostim elctr each		B					
L8681	Pt prgrm for implt neurostim		A					
L8682	Implt neurostim radiofq rec		N					
L8683	Radiofq trsmtr for implt neu		A					
L8684	Radiof trsmtr implt scrl neu		A					
L8685	Implt nrostm pls gen sng rec		B					
L8686	Implt nrostm pls gen sng non		B					
L8687	Implt nrostm pls gen dua rec		B					
L8688	Implt nrostm pls gen dua non		B					
L8689	External recharg sys intern		A					
L8690	Aud osseo dev, int/ext comp		H	1032				
L8691	Aud osseo dev ext snd proces		A					
L8695	External recharg sys extern		A					
L8699	Prosthetic implant NOS		N					
L9900	O&P supply/accessory/service		A					
M0064	Visit for drug monitoring	CH	Q	0605	1.0016	$63.79		$12.76
M0075	Cellular therapy		E					
M0076	Prolotherapy		E					
M0100	Intragastric hypothermia		E					
M0300	IV chelationtherapy		E					
M0301	Fabric wrapping of aneurysm		E					
P2028	Cephalin floculation test		A					
P2029	Congo red blood test		A					
P2031	Hair analysis		E					
P2033	Blood thymol turbidity		A					
P2038	Blood mucoprotein		A					
P3000	Screen pap by tech w md supv		A					
P3001	Screening pap smear by phys		B					
P7001	Culture bacterial urine		E					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
P9010	Whole blood for transfusion		K	0950	4.4374	$282.63		$56.53
P9011	Blood split unit		K	0967	2.1237	$135.26		$27.05
P9012	Cryoprecipitate each unit		K	0952	0.6843	$43.59		$8.72
P9016	RBC leukocytes reduced		K	0954	2.959	$188.47		$37.69
P9017	Plasma 1 donor frz w/in 8 hr		K	9508	1.0902	$69.44		$13.89
P9019	Platelets, each unit		K	0957	1.0834	$69.00		$13.80
P9020	Plaelet rich plasma unit		K	0958	5.3744	$342.31		$68.46
P9021	Red blood cells unit		K	0959	2.0343	$129.57		$25.91
P9022	Washed red blood cells unit		K	0960	4.2092	$268.10		$53.62
P9023	Frozen plasma, pooled, sd		K	0949	1.1981	$76.31		$15.26
P9031	Platelets leukocytes reduced		K	1013	1.7207	$109.60		$21.92
P9032	Platelets, irradiated		K	9500	2.0742	$132.11		$26.42
P9033	Platelets leukoreduced irrad		K	0968	2.028	$129.17		$25.83
P9034	Platelets, pheresis		K	9507	7.0406	$448.44		$89.69
P9035	Platelet pheres leukoreduced		K	9501	7.9954	$509.25		$101.85
P9036	Platelet pheresis irradiated		K	9502	7.0075	$446.33		$89.27
P9037	Plate pheres leukoredu irrad		K	1019	10.0408	$639.53		$127.91
P9038	RBC irradiated		K	9505	3.3259	$211.84		$42.37
P9039	RBC deglycerolized		K	9504	5.7938	$369.02		$73.80
P9040	RBC leukoreduced irradiated		K	0969	3.8191	$243.25		$48.65
P9041	Albumin (human),5%, 50ml		K	0961	0.3757	$23.93		$4.79
P9043	Plasma protein fract,5%,50ml		K	0956	1.4392	$91.67		$18.33
P9044	Cryoprecipitatereducedplasma		K	1009	1.3131	$83.64		$16.73
P9045	Albumin (human), 5%, 250 ml		K	0963	1.1351	$72.30		$14.46
P9046	Albumin (human), 25%, 20 ml		K	0964	0.4448	$28.33		$5.67
P9047	Albumin (human), 25%, 50ml		K	0965	1.1679	$74.39		$14.88
P9048	Plasmaprotein fract,5%,250ml		K	0966	3.9009	$248.46		$49.69
P9050	Granulocytes, pheresis unit		K	9506	15.5519	$990.55		$198.11
P9051	Blood, l/r, cmv-neg		K	1010	2.3865	$152.00		$30.40
P9052	Platelets, hla-m, l/r, unit		K	1011	9.6766	$616.33		$123.27
P9053	Plt, pher, l/r cmv-neg, irr		K	1020	10.7802	$686.62		$137.32
P9054	Blood, l/r, froz/degly/wash		K	1016	3.352	$213.50		$42.70
P9055	Plt, aph/pher, l/r, cmv-neg		K	1017	7.7915	$496.26		$99.25
P9056	Blood, l/r, irradiated		K	1018	2.4372	$155.23		$31.05
P9057	RBC, frz/deg/wsh, l/r, irrad		K	1021	6.4694	$412.06		$82.41
P9058	RBC, l/r, cmv-neg, irrad		K	1022	4.6286	$294.81		$58.96
P9059	Plasma, frz between 8-24hour		K	0955	1.2456	$79.34		$15.87
P9060	Fr frz plasma donor retested		K	9503	1.1632	$74.09		$14.82
P9603	One-way allow prorated miles		A					
P9604	One-way allow prorated trip		A					
P9612	Catheterize for urine spec		A					
P9615	Urine specimen collect mult		N					
Q0035	Cardiokymography		X	0100	2.8631	$182.36	$41.40	$36.47
Q0081	Infusion ther other than che		B					
Q0083	Chemo by other than infusion		B					
Q0084	Chemotherapy by infusion		B					
Q0085	Chemo by both infusion and o		B					
Q0091	Obtaining screen pap smear		T	0191	0.1414	$9.01	$2.50	$1.80
Q0092	Set up port xray equipment		N					
Q0111	Wet mounts/ w preparations		A					
Q0112	Potassium hydroxide preps		A					
Q0113	Pinworm examinations		A					
Q0114	Fern test		A					
Q0115	Post-coital mucous exam		A					
Q0144	Azithromycin dihydrate, oral		E					
Q0163	Diphenhydramine HCl 50mg		N					
Q0164	Prochlorperazine maleate 5mg		N					
Q0165	Prochlorperazine maleate10mg		B					
Q0166	Granisetron HCl 1 mg oral		K	0765		$44.44		$8.89
Q0167	Dronabinol 2.5mg oral		N					
Q0168	Dronabinol 5mg oral		B					
Q0169	Promethazine HCl 12.5mg oral		N					
Q0170	Promethazine HCl 25 mg oral		B					
Q0171	Chlorpromazine HCl 10mg oral		N					
Q0172	Chlorpromazine HCl 25mg oral		B					
Q0173	Trimethobenzamide HCl 250mg		N					
Q0174	Thiethylperazine maleate10mg		N					
Q0175	Perphenazine 4mg oral		N					
Q0176	Perphenazine 8mg oral		B					
Q0177	Hydroxyzine pamoate 25mg		N					
Q0178	Hydroxyzine pamoate 50mg		B					
Q0179	Ondansetron HCl 8mg oral		K	0769		$36.21		$7.24
Q0180	Dolasetron mesylate oral		K	0763		$47.07		$9.41
Q0181	Unspecified oral anti-emetic		E					
Q0480	Driver pneumatic vad, rep		A					
Q0481	Microprcsr cu elec vad, rep		A					
Q0482	Microprcsr cu combo vad, rep		A					
Q0483	Monitor elec vad, rep		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
Q0484	Monitor elec or comb vad rep		A					
Q0485	Monitor cable elec vad, rep		A					
Q0486	Mon cable elec/pneum vad rep		A					
Q0487	Leads any type vad, rep only		A					
Q0488	Pwr pack base elec vad, rep		A					
Q0489	Pwr pck base combo vad, rep		A					
Q0490	Emr pwr source elec vad, rep		A					
Q0491	Emr pwr source combo vad rep		A					
Q0492	Emr pwr cbl elec vad, rep		A					
Q0493	Emr pwr cbl combo vad, rep		A					
Q0494	Emr hd pmp elec/combo, rep		A					
Q0495	Charger elec/combo vad, rep		A					
Q0496	Battery elec/combo vad, rep		A					
Q0497	Bat clps elec/comb vad, rep		A					
Q0498	Holster elec/combo vad, rep		A					
Q0499	Belt/vest elec/combo vad rep		A					
Q0500	Filters elec/combo vad, rep		A					
Q0501	Shwr cov elec/combo vad, rep		A					
Q0502	Mobility cart pneum vad, rep		A					
Q0503	Battery pneum vad replacemnt		A					
Q0504	Pwr adpt pneum vad, rep veh		A					
Q0505	Miscl supply/accessory vad		A					
Q0510	Dispens fee immunosupressive		B					
Q0511	Sup fee antiem,antica,immuno		B					
Q0512	Px sup fee anti-can sub pres		B					
Q0513	Disp fee inhal drugs/30 days		B					
Q0514	Disp fee inhal drugs/90 days		B					
Q0515	Sermorelin acetate injection		K	3050		$1.74		$0.35
Q1003	NTIOL category 3		N					
Q1004	Ntiol category 4		N					
Q1005	Ntiol category 5		N					
Q2004	Bladder calculi irrig sol		N					
Q2009	Fosphenytoin, 50 mg		K	7028		$5.50		$1.10
Q2017	Teniposide, 50 mg		K	7035		$261.93		$52.39
Q3001	Brachytherapy Radioelements		B					
Q3014	Telehealth facility fee		A					
Q3025	IM inj interferon beta 1-a		K	9022		$113.49		$22.70
Q3026	Subc inj interferon beta-1a		E					
Q3031	Collagen skin test		N					
Q4001	Cast sup body cast plaster		B					
Q4002	Cast sup body cast fiberglas		B					
Q4003	Cast sup shoulder cast plstr		B					
Q4004	Cast sup shoulder cast fbrgl		B					
Q4005	Cast sup long arm adult plst		B					
Q4006	Cast sup long arm adult fbrg		B					
Q4007	Cast sup long arm ped plster		B					
Q4008	Cast sup long arm ped fbrgls		B					
Q4009	Cast sup sht arm adult plstr		B					
Q4010	Cast sup sht arm adult fbrgl		B					
Q4011	Cast sup sht arm ped plaster		B					
Q4012	Cast sup sht arm ped fbrglas		B					
Q4013	Cast sup gauntlet plaster		B					
Q4014	Cast sup gauntlet fiberglass		B					
Q4015	Cast sup gauntlet ped plster		B					
Q4016	Cast sup gauntlet ped fbrgls		B					
Q4017	Cast sup lng arm splint plst		B					
Q4018	Cast sup lng arm splint fbrg		B					
Q4019	Cast sup lng arm splnt ped p		B					
Q4020	Cast sup lng arm splnt ped f		B					
Q4021	Cast sup sht arm splint plst		B					
Q4022	Cast sup sht arm splint fbrg		B					
Q4023	Cast sup sht arm splnt ped p		B					
Q4024	Cast sup sht arm splnt ped f		B					
Q4025	Cast sup hip spica plaster		B					
Q4026	Cast sup hip spica fiberglas		B					
Q4027	Cast sup hip spica ped plstr		B					
Q4028	Cast sup hip spica ped fbrgl		B					
Q4029	Cast sup long leg plaster		B					
Q4030	Cast sup long leg fiberglass		B					
Q4031	Cast sup lng leg ped plaster		B					
Q4032	Cast sup lng leg ped fbrgls		B					
Q4033	Cast sup lng leg cylinder pl		B					
Q4034	Cast sup lng leg cylinder fb		B					
Q4035	Cast sup lngleg cylndr ped p		B					
Q4036	Cast sup lngleg cylndr ped f		B					
Q4037	Cast sup shrt leg plaster		B					
Q4038	Cast sup shrt leg fiberglass		B					
Q4039	Cast sup shrt leg ped plster		B					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
Q4040	Cast sup shrt leg ped fbrgls		B					
Q4041	Cast sup lng leg splnt plstr		B					
Q4042	Cast sup lng leg splnt fbrgl		B					
Q4043	Cast sup lng leg splnt ped p		B					
Q4044	Cast sup lng leg splnt ped f		B					
Q4045	Cast sup sht leg splnt plstr		B					
Q4046	Cast sup sht leg splnt fbrgl		B					
Q4047	Cast sup sht leg splnt ped p		B					
Q4048	Cast sup sht leg splnt ped f		B					
Q4049	Finger splint, static		B					
Q4050	Cast supplies unlisted		B					
Q4051	Splint supplies misc		B					
Q4079	Natalizumab injection	CH	K	9126		$7.45		$1.49
Q4080	Iloprost inhalation solution		Y					
Q4081	Epoetin alfa, 100 units ESRD		A					
Q4082	Drug/bio NOC part B drug CAP		B					
Q4083	Hyalgan/supartz inj per dose		K	0873		$103.86		$20.77
Q4084	Synvisc inj per dose		K	0874		$184.89		$36.98
Q4085	Euflexxa inj per dose		K	0875		$115.19		$23.04
Q4086	Orthovisc inj per dose		K	0877		$196.47		$39.29
Q5001	Hospice in patient home		B					
Q5002	Hospice in assisted living		B					
Q5003	Hospice in LT/non-skilled NF		B					
Q5004	Hospice in SNF		B					
Q5005	Hospice, inpatient hospital		B					
Q5006	Hospice in hospice facility		B					
Q5007	Hospice in LTCH		B					
Q5008	Hospice in inpatient psych		B					
Q5009	Hospice care, NOS		B					
Q9945	LOCM ≤149 mg/ml iodine, 1ml	CH	N					
Q9946	LOCM 150-199mg/ml iodine,1ml	CH	N					
Q9947	LOCM 200-249mg/ml iodine,1ml	CH	N					
Q9948	LOCM 250-299mg/ml iodine,1ml	CH	N					
Q9949	LOCM 300-349mg/ml iodine,1ml	CH	N					
Q9950	LOCM 350-399mg/ml iodine,1ml	CH	N					
Q9951	LOCM ≧ 400 mg/ml iodine,1ml	CH	N					
Q9952	Inj Gad-base MR contrast,1ml	CH	N					
Q9953	Inj Fe-based MR contrast,1ml	CH	N					
Q9954	Oral MR contrast, 100 ml	CH	N					
Q9955	Inj perflexane lip micros,ml	CH	N					
Q9956	Inj octafluoropropane mic,ml	CH	N					
Q9957	Inj perflutren lip micros,ml	CH	N					
Q9958	HOCM ≤149 mg/ml iodine, 1ml		N					
Q9959	HOCM 150-199mg/ml iodine,1ml		N					
Q9960	HOCM 200-249mg/ml iodine,1ml		N					
Q9961	HOCM 250-299mg/ml iodine,1ml		N					
Q9962	HOCM 300-349mg/ml iodine,1ml		N					
Q9963	HOCM 350-399mg/ml iodine,1ml		N					
Q9964	HOCM≧ 400mg/ml iodine, 1ml		N					
R0070	Transport portable x-ray		B					
R0075	Transport port x-ray multipl		B					
R0076	Transport portable EKG		B					
V2020	Vision svcs frames purchases		A					
V2025	Eyeglasses delux frames		E					
V2100	Lens spher single plano 4.00		A					
V2101	Single visn sphere 4.12-7.00		A					
V2102	Singl visn sphere 7.12-20.00		A					
V2103	Spherocylindr 4.00d/12-2.00d		A					
V2104	Spherocylindr 4.00d/2.12-4d		A					
V2105	Spherocylinder 4.00d/4.25-6d		A					
V2106	Spherocylinder 4.00d/>6.00d		A					
V2107	Spherocylinder 4.25d/12-2d		A					
V2108	Spherocylinder 4.25d/2.12-4d		A					
V2109	Spherocylinder 4.25d/4.25-6d		A					
V2110	Spherocylinder 4.25d/over 6d		A					
V2111	Spherocylindr 7.25d/.25-2.25		A					
V2112	Spherocylindr 7.25d/2.25-4d		A					
V2113	Spherocylindr 7.25d/4.25-6d		A					
V2114	Spherocylinder over 12.00d		A					
V2115	Lens lenticular bifocal		A					
V2118	Lens aniseikonic single		A					
V2121	Lenticular lens, single		A					
V2199	Lens single vision not oth c		A					
V2200	Lens spher bifoc plano 4.00d		A					
V2201	Lens sphere bifocal 4.12-7.0		A					
V2202	Lens sphere bifocal 7.12-20.		A					
V2203	Lens sphcyl bifocal 4.00d/.1		A					
V2204	Lens sphcy bifocal 4.00d/2.1		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
V2205	Lens sphcy bifocal 4.00d/4.2		A					
V2206	Lens sphcy bifocal 4.00d/ove		A					
V2207	Lens sphcy bifocal 4.25-7d/.		A					
V2208	Lens sphcy bifocal 4.25-7/2.		A					
V2209	Lens sphcy bifocal 4.25-7/4.		A					
V2210	Lens sphcy bifocal 4.25-7/ov		A					
V2211	Lens sphcy bifo 7.25-12/.25-		A					
V2212	Lens sphcyl bifo 7.25-12/2.2		A					
V2213	Lens sphcyl bifo 7.25-12/4.2		A					
V2214	Lens sphcyl bifocal over 12.		A					
V2215	Lens lenticular bifocal		A					
V2218	Lens aniseikonic bifocal		A					
V2219	Lens bifocal seg width over		A					
V2220	Lens bifocal add over 3.25d		A					
V2221	Lenticular lens, bifocal		A					
V2299	Lens bifocal speciality		A					
V2300	Lens sphere trifocal 4.00d		A					
V2301	Lens sphere trifocal 4.12-7.		A					
V2302	Lens sphere trifocal 7.12-20		A					
V2303	Lens sphcy trifocal 4.0/.12-		A					
V2304	Lens sphcy trifocal 4.0/2.25		A					
V2305	Lens sphcy trifocal 4.0/4.25		A					
V2306	Lens sphcyl trifocal 4.00/>6		A					
V2307	Lens sphcy trifocal 4.25-7/.		A					
V2308	Lens sphc trifocal 4.25-7/2.		A					
V2309	Lens sphc trifocal 4.25-7/4.		A					
V2310	Lens sphc trifocal 4.25-7/>6		A					
V2311	Lens sphc trifo 7.25-12/.25-		A					
V2312	Lens sphc trifo 7.25-12/2.25		A					
V2313	Lens sphc trifo 7.25-12/4.25		A					
V2314	Lens sphcyl trifocal over 12		A					
V2315	Lens lenticular trifocal		A					
V2318	Lens aniseikonic trifocal		A					
V2319	Lens trifocal seg width > 28		A					
V2320	Lens trifocal add over 3.25d		A					
V2321	Lenticular lens, trifocal		A					
V2399	Lens trifocal speciality		A					
V2410	Lens variab asphericity sing		A					
V2430	Lens variable asphericity bi		A					
V2499	Variable asphericity lens		A					
V2500	Contact lens pmma spherical		A					
V2501	Cntct lens pmma-toric/prism		A					
V2502	Contact lens pmma bifocal		A					
V2503	Cntct lens pmma color vision		A					
V2510	Cntct gas permeable sphericl		A					
V2511	Cntct toric prism ballast		A					
V2512	Cntct lens gas permbl bifocl		A					
V2513	Contact lens extended wear		A					
V2520	Contact lens hydrophilic		A					
V2521	Cntct lens hydrophilic toric		A					
V2522	Cntct lens hydrophil bifocl		A					
V2523	Cntct lens hydrophil extend		A					
V2530	Contact lens gas impermeable		A					
V2531	Contact lens gas permeable		A					
V2599	Contact lens/es other type		A					
V2600	Hand held low vision aids		A					
V2610	Single lens spectacle mount		A					
V2615	Telescop/othr compound lens		A					
V2623	Plastic eye prosth custom		A					
V2624	Polishing artifical eye		A					
V2625	Enlargemnt of eye prosthesis		A					
V2626	Reduction of eye prosthesis		A					
V2627	Scleral cover shell		A					
V2628	Fabrication & fitting		A					
V2629	Prosthetic eye other type		A					
V2630	Anter chamber intraocul lens		N					
V2631	Iris support intraoclr lens		N					
V2632	Post chmbr intraocular lens		N					
V2700	Balance lens		A					
V2702	Deluxe lens feature		E					
V2710	Glass/plastic slab off prism		A					
V2715	Prism lens/es		A					
V2718	Fresnell prism press-on lens		A					
V2730	Special base curve		A					
V2744	Tint photochromatic lens/es		A					
V2745	Tint, any color/solid/grad		A					
V2750	Anti-reflective coating		A					
V2755	UV lens/es		A					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
V2756	Eye glass case		E					
V2760	Scratch resistant coating		A					
V2761	Mirror coating		B					
V2762	Polarization, any lens		A					
V2770	Occluder lens/es		A					
V2780	Oversize lens/es		A					
V2781	Progressive lens per lens		B					
V2782	Lens, 1.54-1.65 p/1.60-1.79g		A					
V2783	Lens, ≧ 1.66 p/≧1.80 g		A					
V2784	Lens polycarb or equal		A					
V2785	Corneal tissue processing		F					
V2786	Occupational multifocal lens		A					
V2788	Presbyopia-correct function		E					
V2790	Amniotic membrane		N					
V2797	Vis item/svc in other code		A					
V2799	Miscellaneous vision service		A					
V5008	Hearing screening		E					
V5010	Assessment for hearing aid		E					
V5011	Hearing aid fitting/checking		E					
V5014	Hearing aid repair/modifying		E					
V5020	Conformity evaluation		E					
V5030	Body-worn hearing aid air		E					
V5040	Body-worn hearing aid bone		E					
V5050	Hearing aid monaural in ear		E					
V5060	Behind ear hearing aid		E					
V5070	Glasses air conduction		E					
V5080	Glasses bone conduction		E					
V5090	Hearing aid dispensing fee		E					
V5095	Implant mid ear hearing pros		E					
V5100	Body-worn bilat hearing aid		E					
V5110	Hearing aid dispensing fee		E					
V5120	Body-worn binaur hearing aid		E					
V5130	In ear binaural hearing aid		E					
V5140	Behind ear binaur hearing ai		E					
V5150	Glasses binaural hearing aid		E					
V5160	Dispensing fee binaural		E					
V5170	Within ear cros hearing aid		E					
V5180	Behind ear cros hearing aid		E					
V5190	Glasses cros hearing aid		E					
V5200	Cros hearing aid dispens fee		E					
V5210	In ear bicros hearing aid		E					
V5220	Behind ear bicros hearing ai		E					
V5230	Glasses bicros hearing aid		E					
V5240	Dispensing fee bicros		E					
V5241	Dispensing fee, monaural		E					
V5242	Hearing aid, monaural, cic		E					
V5243	Hearing aid, monaural, itc		E					
V5244	Hearing aid, prog, mon, cic		E					
V5245	Hearing aid, prog, mon, itc		E					
V5246	Hearing aid, prog, mon, ite		E					
V5247	Hearing aid, prog, mon, bte		E					
V5248	Hearing aid, binaural, cic		E					
V5249	Hearing aid, binaural, itc		E					
V5250	Hearing aid, prog, bin, cic		E					
V5251	Hearing aid, prog, bin, itc		E					
V5252	Hearing aid, prog, bin, ite		E					
V5253	Hearing aid, prog, bin, bte		E					
V5254	Hearing id, digit, mon, cic		E					
V5255	Hearing aid, digit, mon, itc		E					
V5256	Hearing aid, digit, mon, ite		E					
V5257	Hearing aid, digit, mon, bte		E					
V5258	Hearing aid, digit, bin, cic		E					
V5259	Hearing aid, digit, bin, itc		E					
V5260	Hearing aid, digit, bin, ite		E					
V5261	Hearing aid, digit, bin, bte		E					
V5262	Hearing aid, disp, monaural		E					
V5263	Hearing aid, disp, binaural		E					
V5264	Ear mold/insert		E					
V5265	Ear mold/insert, disp		E					
V5266	Battery for hearing device		E					
V5267	Hearing aid supply/accessory		E					
V5268	ALD Telephone Amplifier		E					
V5269	Alerting device, any type		E					
V5270	ALD, TV amplifier, any type		E					
V5271	ALD, TV caption decoder		E					
V5272	Tdd		E					
V5273	ALD for cochlear implant		E					
V5274	ALD unspecified		E					

ADDENDUM B.—PROPOSED OPPS PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
V5275	Ear impression		E					
V5298	Hearing aid noc		E					
V5299	Hearing service		B					
V5336	Repair communication device		E					
V5362	Speech screening		E					
V5363	Language screening		E					
V5364	Dysphagia screening		E					

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
0028T	Dexa body composition study		N1		
0042T	Ct perfusion w/contrast, cbf		N1		
054T	Bone surgery using computer	CH	N1		
0055T	Bone surgery using computer	CH	N1		
0056T	Bone surgery using computer	CH	N1		
0067T	Ct colonography;dx		Z2	3.1487	$130.36
0071T	U/s leiomyomata ablate <200		Z2	61.5205	$2,546.95
0072T	U/s leiomyomata ablate >200		Z2	61.5205	$2,546.95
0073T	Delivery, comp imrt		Z2	5.7275	$237.12
0126T	Chd risk imt study		N1		
0144T	CT heart wo dye; qual calc		Z2	1.6768	$69.42
0145T	CT heart w/wo dye funct		Z2	4.9887	$206.53
0146T	CCTA w/wo dye		Z2	4.9887	$206.53
0147T	CCTA w/wo, quan calcium		Z2	4.9887	$206.53
0148T	CCTA w/wo, strxr		Z2	4.9887	$206.53
0149T	CCTA w/wo, strxr quan calc		Z2	4.9887	$206.53
0150T	CCTA w/wo, disease strxr		Z2	4.9887	$206.53
0151T	CT heart funct add-on		Z2	1.6768	$69.42
0159T	Cad breast mri		N1		
0174T	Cad cxr with interp		N1		
0175T	Cad cxr remote		N1		
70010	Contrast x-ray of brain	CH	N1		
70015	Contrast x-ray of brain	CH	N1		
70030	X-ray eye for foreign body		Z3	0.3957	$16.38
70100	X-ray exam of jaw		Z3	0.4534	$18.77
70110	X-ray exam of jaw		Z3	0.5442	$22.53
70120	X-ray exam of mastoids		Z3	0.5111	$21.16
70130	X-ray exam of mastoids		Z2	0.7259	$30.05
70134	X-ray exam of middle ear		Z3	0.6266	$25.94
70140	X-ray exam of facial bones		Z3	0.4534	$18.77
70150	X-ray exam of facial bones		Z3	0.6348	$26.28
70160	X-ray exam of nasal bones		Z3	0.4700	$19.46
70170	X-ray exam of tear duct	CH	N1		
70190	X-ray exam of eye sockets		Z3	0.5196	$21.51
70200	X-ray exam of eye sockets		Z3	0.6348	$26.28
70210	X-ray exam of sinuses		Z3	0.4700	$19.46
70220	X-ray exam of sinuses		Z3	0.5855	$24.24
70240	X-ray exam, pituitary saddle		Z3	0.3957	$16.38
70250	X-ray exam of skull		Z3	0.5111	$21.16
70260	X-ray exam of skull		Z3	0.6761	$27.99
70300	X-ray exam of teeth		Z3	0.1978	$8.19
70310	X-ray exam of teeth		Z3	0.4865	$20.14
70320	Full mouth x-ray of teeth		Z2	0.5739	$23.76
70328	X-ray exam of jaw joint		Z3	0.4287	$17.75
70330	X-ray exam of jaw joints		Z3	0.7174	$29.70
70332	X-ray exam of jaw joint	CH	N1		
70336	Magnetic image, jaw joint		Z2	5.0067	$207.28
70350	X-ray head for orthodontia		Z3	0.2638	$10.92
70355	Panoramic x-ray of jaws		Z3	0.3297	$13.65
70360	X-ray exam of neck		Z3	0.3792	$15.70
70370	Throat x-ray & fluoroscopy		Z3	1.1708	$48.47
70371	Speech evaluation, complex		Z2	1.3270	$54.94
70373	Contrast x-ray of larynx	CH	N1		
70380	X-ray exam of salivary gland		Z3	0.5855	$24.24
70390	X-ray exam of salivary duct	CH	N1		
70450	Ct head/brain w/o dye		Z2	3.1487	$130.36
70460	Ct head/brain w/dye		Z2	4.5485	$188.31
70470	Ct head/brain w/o & w/dye		Z2	5.3374	$220.97
70480	Ct orbit/ear/fossa w/o dye		Z2	3.1487	$130.36
70481	Ct orbit/ear/fossa w/dye		Z2	4.5485	$188.31
70482	Ct orbit/ear/fossa w/o&w/dye		Z2	5.3374	$220.97
70486	Ct maxillofacial w/o dye		Z2	3.1487	$130.36
70487	Ct maxillofacial w/dye		Z2	4.5485	$188.31
70488	Ct maxillofacial w/o & w/dye		Z2	5.3374	$220.97
70490	Ct soft tissue neck w/o dye		Z2	3.1487	$130.36
70491	Ct soft tissue neck w/dye		Z2	4.5485	$188.31
70492	Ct sft tsue nck w/o & w/dye		Z2	5.3374	$220.97
70496	Ct angiography, head		Z2	5.2818	$218.67

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
70498	Ct angiography, neck		Z2	5.2818	$218.67
70540	Mri orbit/face/neck w/o dye		Z2	5.7101	$236.40
70542	Mri orbit/face/neck w/dye		Z2	6.7963	$281.37
70543	Mri orbt/fac/nck w/o & w/dye		Z2	8.6689	$358.89
70544	Mr angiography head w/o dye		Z2	5.7101	$236.40
70545	Mr angiography head w/dye		Z2	6.7963	$281.37
70546	Mr angiograph head w/o&w/dye		Z2	8.6689	$358.89
70547	Mr angiography neck w/o dye		Z2	5.7101	$236.40
70548	Mr angiography neck w/dye		Z2	6.7963	$281.37
70549	Mr angiograph neck w/o&w/dye		Z2	8.6689	$358.89
70551	Mri brain w/o dye		Z2	5.7101	$236.40
70552	Mri brain w/dye		Z2	6.7963	$281.37
70553	Mri brain w/o & w/dye		Z2	8.6689	$358.89
70554	Fmri brain by tech		Z2	5.7101	$236.40
70555	Fmri brain by phys/psych		Z2	5.7101	$236.40
70557	Mri brain w/o dye		Z2	5.7101	$236.40
70558	Mri brain w/dye		Z2	6.7963	$281.37
70559	Mri brain w/o & w/dye		Z2	8.6689	$358.89
71010	Chest x-ray		Z3	0.3464	$14.34
71015	Chest x-ray		Z3	0.4205	$17.41
71020	Chest x-ray		Z3	0.4618	$19.12
71021	Chest x-ray		Z3	0.5524	$22.87
71022	Chest x-ray		Z3	0.6266	$25.94
71023	Chest x-ray and fluoroscopy		Z3	0.8906	$36.87
71030	Chest x-ray		Z3	0.6514	$26.97
71034	Chest x-ray and fluoroscopy		Z2	1.3270	$54.94
71035	Chest x-ray		Z3	0.5029	$20.82
71040	Contrast x-ray of bronchi	CH	N1		
71060	Contrast x-ray of bronchi	CH	N1		
71090	X-ray & pacemaker insertion	CH	N1		
71100	X-ray exam of ribs		Z3	0.4534	$18.77
71101	X-ray exam of ribs/chest		Z3	0.5442	$22.53
71110	X-ray exam of ribs		Z3	0.6019	$24.92
71111	X-ray exam of ribs/chest		Z3	0.7585	$31.40
71120	X-ray exam of breastbone		Z3	0.4947	$20.48
71130	X-ray exam of breastbone		Z3	0.5688	$23.55
71250	Ct thorax w/o dye		Z2	3.1487	$130.36
71260	Ct thorax w/dye		Z2	4.5485	$188.31
71270	Ct thorax w/o & w/dye		Z2	5.3374	$220.97
71275	Ct angiography, chest		Z2	5.2818	$218.67
71550	Mri chest w/o dye		Z2	5.7101	$236.40
71551	Mri chest w/dye		Z2	6.7963	$281.37
71552	Mri chest w/o & w/dye		Z2	8.6689	$358.89
72010	X-ray exam of spine		Z2	0.7259	$30.05
72020	X-ray exam of spine		Z3	0.3382	$14.00
72040	X-ray exam of neck spine		Z3	0.5278	$21.85
72050	X-ray exam of neck spine		Z3	0.7585	$31.40
72052	X-ray exam of neck spine		Z3	0.9812	$40.62
72069	X-ray exam of trunk spine		Z3	0.4783	$19.80
72070	X-ray exam of thoracic spine		Z3	0.4947	$20.48
72072	X-ray exam of thoracic spine		Z3	0.5771	$23.89
72074	X-ray exam of thoracic spine		Z3	0.7256	$30.04
72080	X-ray exam of trunk spine		Z3	0.5278	$21.85
72090	X-ray exam of trunk spine		Z3	0.6432	$26.63
72100	X-ray exam of lower spine		Z3	0.5771	$23.89
72110	X-ray exam of lower spine		Z3	0.7915	$32.77
72114	X-ray exam of lower spine		Z3	1.0720	$44.38
72120	X-ray exam of lower spine		Z3	0.7751	$32.09
72125	Ct neck spine w/o dye		Z2	3.1487	$130.36
72126	Ct neck spine w/dye	CH	Z3	5.9614	$246.80
72127	Ct neck spine w/o & w/dye		Z2	5.3374	$220.97
72128	Ct chest spine w/o dye		Z2	3.1487	$130.36
72129	Ct chest spine w/dye		Z2	4.5485	$188.31
72130	Ct chest spine w/o & w/dye		Z2	5.3374	$220.97
72131	Ct lumbar spine w/o dye		Z2	3.1487	$130.36
72132	Ct lumbar spine w/dye	CH	Z3	5.9529	$246.45
72133	Ct lumbar spine w/o & w/dye		Z2	5.3374	$220.97
72141	Mri neck spine w/o dye		Z2	5.7101	$236.40

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
72142	Mri neck spine w/dye		Z2	6.7963	$281.37
72146	Mri chest spine w/o dye		Z2	5.7101	$236.40
72147	Mri chest spine w/dye		Z2	6.7963	$281.37
72148	Mri lumbar spine w/o dye		Z2	5.7101	$236.40
72149	Mri lumbar spine w/dye		Z2	6.7963	$281.37
72156	Mri neck spine w/o & w/dye		Z2	8.6689	$358.89
72157	Mri chest spine w/o & w/dye		Z2	8.6689	$358.89
72158	Mri lumbar spine w/o & w/dye		Z2	8.6689	$358.89
72170	X-ray exam of pelvis		Z3	0.3957	$16.38
72190	X-ray exam of pelvis		Z3	0.5937	$24.58
72191	Ct angiograph pelv w/o&w/dye		Z2	5.2818	$218.67
72192	Ct pelvis w/o dye		Z2	3.1487	$130.36
72193	Ct pelvis w/dye		Z2	4.5485	$188.31
72194	Ct pelvis w/o & w/dye		Z2	5.3374	$220.97
72195	Mri pelvis w/o dye		Z2	5.7101	$236.40
72196	Mri pelvis w/dye		Z2	6.7963	$281.37
72197	Mri pelvis w/o & w/dye		Z2	8.6689	$358.89
72200	X-ray exam sacroiliac joints		Z3	0.4370	$18.09
72202	X-ray exam sacroiliac joints		Z3	0.5278	$21.85
72220	X-ray exam of tailbone		Z3	0.4452	$18.43
72240	Contrast x-ray of neck spine	CH	N1		
72255	Contrast x-ray, thorax spine	CH	N1		
72265	Contrast x-ray, lower spine	CH	N1		
72270	Contrast x-ray, spine	CH	N1		
72275	Epidurography	CH	N1		
72285	X-ray c/t spine disk	CH	N1		
72291	Perq vertebroplasty, fluor	CH	N1		
72292	Perq vertebroplasty, ct	CH	N1		
72295	X-ray of lower spine disk	CH	N1		
73000	X-ray exam of collar bone		Z3	0.4205	$17.41
73010	X-ray exam of shoulder blade		Z3	0.4287	$17.75
73020	X-ray exam of shoulder		Z3	0.3546	$14.68
73030	X-ray exam of shoulder		Z3	0.4370	$18.09
73040	Contrast x-ray of shoulder	CH	N1		
73050	X-ray exam of shoulders		Z3	0.5442	$22.53
73060	X-ray exam of humerus		Z3	0.4452	$18.43
73070	X-ray exam of elbow		Z3	0.4205	$17.41
73080	X-ray exam of elbow		Z3	0.5196	$21.51
73085	Contrast x-ray of elbow	CH	N1		
73090	X-ray exam of forearm		Z3	0.4205	$17.41
73092	X-ray exam of arm, infant		Z3	0.4205	$17.41
73100	X-ray exam of wrist		Z3	0.4205	$17.41
73110	X-ray exam of wrist		Z3	0.5111	$21.16
73115	Contrast x-ray of wrist	CH	N1		
73120	X-ray exam of hand		Z3	0.4041	$16.73
73130	X-ray exam of hand		Z3	0.4618	$19.12
73140	X-ray exam of finger(s)		Z3	0.4287	$17.75
73200	Ct upper extremity w/o dye		Z2	3.1487	$130.36
73201	Ct upper extremity w/dye		Z2	4.5485	$188.31
73202	Ct uppr extremity w/o&w/dye		Z2	5.3374	$220.97
73206	Ct angio upr extrm w/o&w/dye		Z2	5.2818	$218.67
73218	Mri upper extremity w/o dye		Z2	5.7101	$236.40
73219	Mri upper extremity w/dye		Z2	6.7963	$281.37
73220	Mri uppr extremity w/o&w/dye		Z2	8.6689	$358.89
73221	Mri joint upr extrem w/o dye		Z2	5.7101	$236.40
73222	Mri joint upr extrem w/dye		Z2	6.7963	$281.37
73223	Mri joint upr extr w/o&w/dye		Z2	8.6689	$358.89
73500	X-ray exam of hip		Z3	0.3710	$15.36
73510	X-ray exam of hip		Z3	0.5196	$21.51
73520	X-ray exam of hips		Z3	0.5606	$23.21
73525	Contrast x-ray of hip	CH	N1		
73530	X-ray exam of hip	CH	N1		
73540	X-ray exam of pelvis & hips		Z3	0.5360	$22.19
73542	X-ray exam, sacroiliac joint	CH	N1		
73550	X-ray exam of thigh		Z3	0.4370	$18.09
73560	X-ray exam of knee, 1 or 2		Z3	0.4287	$17.75
73562	X-ray exam of knee, 3		Z3	0.5029	$20.82
73564	X-ray exam, knee, 4 or more		Z3	0.5771	$23.89

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
73565	X-ray exam of knees		Z3	0.4370	$18.09
73580	Contrast x-ray of knee joint	CH	N1		
73590	X-ray exam of lower leg		Z3	0.4123	$17.07
73592	X-ray exam of leg, infant		Z3	0.4205	$17.41
73600	X-ray exam of ankle		Z3	0.4041	$16.73
73610	X-ray exam of ankle		Z3	0.4700	$19.46
73615	Contrast x-ray of ankle	CH	N1		
73620	X-ray exam of foot		Z3	0.3957	$16.38
73630	X-ray exam of foot		Z3	0.4618	$19.12
73650	X-ray exam of heel		Z3	0.3957	$16.38
73660	X-ray exam of toe(s)		Z3	0.4123	$17.07
73700	Ct lower extremity w/o dye		Z2	3.1487	$130.36
73701	Ct lower extremity w/dye		Z2	4.5485	$188.31
73702	Ct lwr extremity w/o&w/dye		Z2	5.3374	$220.97
73706	Ct angio lwr extr w/o&w/dye		Z2	5.2818	$218.67
73718	Mri lower extremity w/o dye		Z2	5.7101	$236.40
73719	Mri lower extremity w/dye		Z2	6.7963	$281.37
73720	Mri lwr extremity w/o&w/dye		Z2	8.6689	$358.89
73721	Mri jnt of lwr extre w/o dye		Z2	5.7101	$236.40
73722	Mri joint of lwr extr w/dye		Z2	6.7963	$281.37
73723	Mri joint lwr extr w/o&w/dye		Z2	8.6689	$358.89
74000	X-ray exam of abdomen		Z3	0.3792	$15.70
74010	X-ray exam of abdomen		Z3	0.5278	$21.85
74020	X-ray exam of abdomen		Z3	0.5442	$22.53
74022	X-ray exam series, abdomen		Z3	0.6514	$26.97
74150	Ct abdomen w/o dye		Z2	3.1487	$130.36
74160	Ct abdomen w/dye		Z2	4.5485	$188.31
74170	Ct abdomen w/o & w/dye		Z2	5.3374	$220.97
74175	Ct angio abdom w/o & w/dye		Z2	5.2818	$218.67
74181	Mri abdomen w/o dye		Z2	5.7101	$236.40
74182	Mri abdomen w/dye		Z2	6.7963	$281.37
74183	Mri abdomen w/o & w/dye		Z2	8.6689	$358.89
74190	X-ray exam of peritoneum	CH	N1		
74210	Contrst x-ray exam of throat		Z3	1.1543	$47.79
74220	Contrast x-ray, esophagus		Z3	1.2367	$51.20
74230	Cine/vid x-ray, throat/esoph		Z3	1.2534	$51.89
74235	Remove esophagus obstruction	CH	N1		
74240	X-ray exam, upper gi tract		Z3	1.4263	$59.05
74241	X-ray exam, upper gi tract		Z2	1.4387	$59.56
74245	X-ray exam, upper gi tract		Z2	2.2875	$94.70
74246	Contrst x-ray uppr gi tract		Z2	1.4387	$59.56
74247	Contrst x-ray uppr gi tract		Z2	1.4387	$59.56
74249	Contrst x-ray uppr gi tract		Z2	2.2875	$94.70
74250	X-ray exam of small bowel	CH	Z2	1.4387	$59.56
74251	X-ray exam of small bowel		Z2	2.2875	$94.70
74260	X-ray exam of small bowel		Z2	1.4387	$59.56
74270	Contrast x-ray exam of colon		Z2	1.4387	$59.56
74280	Contrast x-ray exam of colon		Z2	2.2875	$94.70
74283	Contrast x-ray exam of colon		Z2	1.4387	$59.56
74290	Contrast x-ray, gallbladder		Z3	0.8906	$36.87
74291	Contrast x-rays, gallbladder		Z3	0.7833	$32.43
74300	X-ray bile ducts/pancreas	CH	N1		
74301	X-rays at surgery add-on	CH	N1		
74305	X-ray bile ducts/pancreas	CH	N1		
74320	Contrast x-ray of bile ducts	CH	N1		
74327	X-ray bile stone removal	CH	N1		
74328	X-ray bile duct endoscopy		N1		
74329	X-ray for pancreas endoscopy		N1		
74330	X-ray bile/panc endoscopy		N1		
74340	X-ray guide for GI tube	CH	N1		
74350	X-ray guide, stomach tube	CH	N1		
74355	X-ray guide, intestinal tube	CH	N1		
74360	X-ray guide, GI dilation	CH	N1		
74363	X-ray, bile duct dilation	CH	N1		
74400	Contrst x-ray, urinary tract		Z3	1.6737	$69.29
74410	Contrst x-ray, urinary tract		Z3	1.8222	$75.44
74415	Contrst x-ray, urinary tract		Z3	2.1273	$88.07
74420	Contrst x-ray, urinary tract		Z2	2.6114	$108.11

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
74425	Contrst x-ray, urinary tract	CH	N1		
74430	Contrast x-ray, bladder	CH	N1		
74440	X-ray, male genital tract	CH	N1		
74445	X-ray exam of penis	CH	N1		
74450	X-ray, urethra/bladder	CH	N1		
74455	X-ray, urethra/bladder	CH	N1		
74470	X-ray exam of kidney lesion	CH	N1		
74475	X-ray control, cath insert	CH	N1		
74480	X-ray control, cath insert	CH	N1		
74485	X-ray guide, GU dilation	CH	N1		
74710	X-ray measurement of pelvis		Z3	0.6514	$26.97
74740	X-ray, female genital tract	CH	N1		
74742	X-ray, fallopian tube	CH	N1		
74775	X-ray exam of perineum	CH	Z3	0.7998	$33.11
75552	Heart mri for morph w/o dye		Z2	5.7101	$236.40
75553	Heart mri for morph w/dye		Z2	6.7963	$281.37
75554	Cardiac MRI/function		Z2	5.7101	$236.40
75555	Cardiac MRI/limited study		Z2	5.7101	$236.40
75600	Contrast x-ray exam of aorta	CH	N1		
75605	Contrast x-ray exam of aorta	CH	N1		
75625	Contrast x-ray exam of aorta	CH	N1		
75630	X-ray aorta, leg arteries	CH	N1		
75635	Ct angio abdominal arteries	CH	N1		
75650	Artery x-rays, head & neck	CH	N1		
75658	Artery x-rays, arm	CH	N1		
75660	Artery x-rays, head & neck	CH	N1		
75662	Artery x-rays, head & neck	CH	N1		
75665	Artery x-rays, head & neck	CH	N1		
75671	Artery x-rays, head & neck	CH	N1		
75676	Artery x-rays, neck	CH	N1		
75680	Artery x-rays, neck	CH	N1		
75685	Artery x-rays, spine	CH	N1		
75705	Artery x-rays, spine	CH	N1		
75710	Artery x-rays, arm/leg	CH	N1		
75716	Artery x-rays, arms/legs	CH	N1		
75722	Artery x-rays, kidney	CH	N1		
75724	Artery x-rays, kidneys	CH	N1		
75726	Artery x-rays, abdomen	CH	N1		
75731	Artery x-rays, adrenal gland	CH	N1		
75733	Artery x-rays, adrenals	CH	N1		
75736	Artery x-rays, pelvis	CH	N1		
75741	Artery x-rays, lung	CH	N1		
75743	Artery x-rays, lungs	CH	N1		
75746	Artery x-rays, lung	CH	N1		
75756	Artery x-rays, chest	CH	N1		
75774	Artery x-ray, each vessel	CH	N1		
75790	Visualize A-V shunt	CH	N1		
75801	Lymph vessel x-ray, arm/leg	CH	N1		
75803	Lymph vessel x-ray,arms/legs	CH	N1		
75805	Lymph vessel x-ray, trunk	CH	N1		
75807	Lymph vessel x-ray, trunk	CH	N1		
75809	Nonvascular shunt, x-ray	CH	N1		
75810	Vein x-ray, spleen/liver	CH	N1		
75820	Vein x-ray, arm/leg	CH	N1		
75822	Vein x-ray, arms/legs	CH	N1		
75825	Vein x-ray, trunk	CH	N1		
75827	Vein x-ray, chest	CH	N1		
75831	Vein x-ray, kidney	CH	N1		
75833	Vein x-ray, kidneys	CH	N1		
75840	Vein x-ray, adrenal gland	CH	N1		
75842	Vein x-ray, adrenal glands	CH	N1		
75860	Vein x-ray, neck	CH	N1		
75870	Vein x-ray, skull	CH	N1		
75872	Vein x-ray, skull	CH	N1		
75880	Vein x-ray, eye socket	CH	N1		
75885	Vein x-ray, liver	CH	N1		
75887	Vein x-ray, liver	CH	N1		
75889	Vein x-ray, liver	CH	N1		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
75891	Vein x-ray, liver	CH	N1		
75893	Venous sampling by catheter		N1		
75894	X-rays, transcath therapy	CH	N1		
75896	X-rays, transcath therapy	CH	N1		
75898	Follow-up angiography	CH	N1		
75901	Remove cva device obstruct	CH	N1		
75902	Remove cva lumen obstruct	CH	N1		
75940	X-ray placement, vein filter	CH	N1		
75945	Intravascular us	CH	N1		
75946	Intravascular us add-on	CH	N1		
75960	Transcath iv stent rs&i	CH	N1		
75961	Retrieval, broken catheter	CH	N1		
75962	Repair arterial blockage	CH	N1		
75964	Repair artery blockage, each	CH	N1		
75966	Repair arterial blockage	CH	N1		
75968	Repair artery blockage, each	CH	N1		
75970	Vascular biopsy	CH	N1		
75978	Repair venous blockage	CH	N1		
75980	Contrast xray exam bile duct	CH	N1		
75982	Contrast xray exam bile duct	CH	N1		
75984	Xray control catheter change	CH	N1		
75989	Abscess drainage under x-ray		N1		
75992	Atherectomy, x-ray exam	CH	N1		
75993	Atherectomy, x-ray exam	CH	N1		
75994	Atherectomy, x-ray exam	CH	N1		
75995	Atherectomy, x-ray exam	CH	N1		
75996	Atherectomy, x-ray exam	CH	N1		
76000	Fluoroscope examination	CH	N1		
76001	Fluoroscope exam, extensive		N1		
76010	X-ray, nose to rectum		Z3	0.4123	$17.07
76080	X-ray exam of fistula	CH	N1		
76098	X-ray exam, breast specimen		Z3	0.2804	$11.61
76100	X-ray exam of body section		Z2	1.2024	$49.78
76101	Complex body section x-ray		Z2	1.4802	$61.28
76102	Complex body section x-rays		Z2	1.4802	$61.28
76120	Cine/video x-rays		Z3	1.1379	$47.11
76125	Cine/video x-rays add-on	CH	N1		
76150	X-ray exam, dry process		Z3	0.4452	$18.43
76350	Special x-ray contrast study		N1		
76376	3d render w/o postprocess	CH	N1		
76377	3d rendering w/postprocess	CH	N1		
76380	CAT scan follow-up study		Z2	1.6768	$69.42
76496	Fluoroscopic procedure		Z2	1.3270	$54.94
76497	Ct procedure		Z2	1.6768	$69.42
76498	Mri procedure		Z2	5.0067	$207.28
76499	Radiographic procedure		Z2	0.7259	$30.05
76506	Echo exam of head		Z2	0.9925	$41.09
76510	Ophth us, b & quant a	CH	Z3	1.5995	$66.22
76511	Ophth us, quant a only		Z3	1.2534	$51.89
76512	Ophth us, b w/non-quant a		Z3	1.0884	$45.06
76513	Echo exam of eye, water bath		Z3	1.1626	$48.13
76514	Echo exam of eye, thickness		Z3	0.0659	$2.73
76516	Echo exam of eye		Z3	0.9070	$37.55
76519	Echo exam of eye		Z3	0.9894	$40.96
76529	Echo exam of eye		Z3	0.8575	$35.50
76536	Us exam of head and neck	CH	Z2	1.5657	$64.82
76604	Us exam, chest		Z2	0.9925	$41.09
76645	Us exam, breast(s)		Z2	0.9925	$41.09
76700	Us exam, abdom, complete		Z2	1.5657	$64.82
76705	Echo exam of abdomen		Z3	1.4512	$60.08
76770	Us exam abdo back wall, comp		Z2	1.5657	$64.82
76775	Us exam abdo back wall, lim		Z3	1.4676	$60.76
76776	Us exam k transpl w/doppler		Z2	1.5657	$64.82
76800	Us exam, spinal canal		Z3	1.4099	$58.37
76801	Ob us < 14 wks, single fetus		Z2	1.5657	$64.82
76802	Ob us < 14 wks, add l fetus		Z3	0.7174	$29.70
76805	Ob us >/= 14 wks, sngl fetus		Z2	1.5657	$64.82
76810	Ob us >/= 14 wks, addl fetus		Z3	0.9812	$40.62

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
76811	Ob us, detailed, sngl fetus		Z3	2.4737	$102.41
76812	Ob us, detailed, addl fetus		Z2	0.9925	$41.09
76813	Ob us nuchal meas, 1 gest		Z3	1.4430	$59.74
76814	Ob us nuchal meas, add-on		Z3	0.6925	$28.67
76815	Ob us, limited, fetus(s)		Z2	0.9925	$41.09
76816	Ob us, follow-up, per fetus		Z2	0.9925	$41.09
76817	Transvaginal us, obstetric		Z2	0.9925	$41.09
76818	Fetal biophys profile w/nst		Z3	1.4430	$59.74
76819	Fetal biophys profil w/o nst		Z3	1.2367	$51.20
76820	Umbilical artery echo		Z3	0.8329	$34.48
76821	Middle cerebral artery echo		Z3	1.3440	$55.64
76825	Echo exam of fetal heart		Z2	1.5657	$64.82
76826	Echo exam of fetal heart	CH	Z2	0.9925	$41.09
76827	Echo exam of fetal heart	CH	Z2	0.9925	$41.09
76828	Echo exam of fetal heart		Z3	0.6514	$26.97
76830	Transvaginal us, non-ob		Z2	1.5657	$64.82
76831	Echo exam, uterus		Z3	1.6572	$68.61
76856	Us exam, pelvic, complete		Z2	1.5657	$64.82
76857	Us exam, pelvic, limited		Z2	0.9925	$41.09
76870	Us exam, scrotum		Z2	1.5657	$64.82
76872	Us, transrectal		Z2	1.5657	$64.82
76873	Echograp trans r, pros study		Z2	1.5657	$64.82
76880	Us exam, extremity		Z2	1.5657	$64.82
76885	Us exam infant hips, dynamic		Z2	0.9925	$41.09
76886	Us exam infant hips, static		Z2	0.9925	$41.09
76930	Echo guide, cardiocentesis	CH	N1		
76932	Echo guide for heart biopsy	CH	N1		
76936	Echo guide for artery repair	CH	N1		
76937	Us guide, vascular access		N1		
76940	Us guide, tissue ablation	CH	N1		
76941	Echo guide for transfusion	CH	N1		
76942	Echo guide for biopsy	CH	N1		
76945	Echo guide, villus sampling	CH	N1		
76946	Echo guide for amniocentesis	CH	N1		
76948	Echo guide, ova aspiration	CH	N1		
76950	Echo guidance radiotherapy	CH	N1		
76965	Echo guidance radiotherapy	CH	N1		
76970	Ultrasound exam follow-up		Z2	0.9925	$41.09
76975	GI endoscopic ultrasound	CH	N1		
76977	Us bone density measure		Z3	0.3792	$15.70
76998	Us guide, intraop	CH	N1		
76999	Echo examination procedure		Z2	0.9925	$41.09
77001	Fluoroguide for vein device		N1		
77002	Needle localization by xray		N1		
77003	Fluoroguide for spine inject		N1		
77011	Ct scan for localization	CH	N1		
77012	Ct scan for needle biopsy	CH	N1		
77013	Ct guide for tissue ablation	CH	N1		
77014	Ct scan for therapy guide	CH	N1		
77021	Mr guidance for needle place	CH	N1		
77022	Mri for tissue ablation	CH	N1		
77031	Stereotact guide for brst bx	CH	N1		
77032	Guidance for needle, breast	CH	N1		
77053	X-ray of mammary duct	CH	N1		
77054	X-ray of mammary ducts	CH	N1		
77071	X-ray stress view		Z3	0.3051	$12.63
77072	X-rays for bone age		Z3	0.2886	$11.95
77073	X-rays, bone length studies		Z3	0.5855	$24.24
77074	X-rays, bone survey, limited		Z3	0.8988	$37.21
77075	X-rays, bone survey complete		Z2	1.2024	$49.78
77076	X-rays, bone survey, infant		Z2	0.7259	$30.05
77077	Joint survey, single view	CH	Z2	0.7259	$30.05
77078	Ct bone density, axial		Z2	1.1920	$49.35
77079	Ct bone density, peripheral	CH	Z2	1.6768	$69.42
77080	Dxa bone density, axial		Z2	1.1920	$49.35
77081	Dxa bone density/peripheral	CH	Z3	0.5196	$21.51
77082	Dxa bone density, vert fx		Z3	0.5442	$22.53
77083	Radiographic absorptiometry		Z3	0.4947	$20.48

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
77084	Magnetic image, bone marrow		Z2	5.0067	$207.28
77280	Sbrt management		Z2	1.6409	$67.93
77285	Set radiation therapy field		Z2	4.1775	$172.95
77290	Set radiation therapy field		Z2	4.1775	$172.95
77295	Set radiation therapy field		Z3	13.9592	$577.91
77299	Radiation therapy planning		Z2	1.6409	$67.93
77300	Radiation therapy dose plan		Z3	0.9565	$39.60
77301	Radiotherapy dose plan, imrt		Z2	14.0797	$582.90
77305	Teletx isodose plan simple		Z3	1.0389	$43.01
77310	Teletx isodose plan intermed		Z3	1.3357	$55.30
77315	Teletx isodose plan complex		Z3	1.7396	$72.02
77321	Special teletx port plan		Z3	2.1601	$89.43
77326	Brachytx isodose calc simp		Z2	1.6409	$67.93
77327	Brachytx isodose calc interm		Z3	2.9271	$121.18
77328	Brachytx isodose plan compl		Z3	3.9164	$162.14
77331	Special radiation dosimetry		Z3	0.4205	$17.41
77332	Radiation treatment aid(s)		Z3	1.1130	$46.08
77333	Radiation treatment aid(s)		Z3	0.8821	$36.52
77334	Radiation treatment aid(s)		Z3	2.2923	$94.90
77336	Radiation physics consult		Z2	1.6409	$67.93
77370	Radiation physics consult		Z2	1.6409	$67.93
77371	Srs, multisource		Z3	24.8261	$1,027.80
77399	External radiation dosimetry		Z2	1.6409	$67.93
77401	Radiation treatment delivery		Z3	0.9234	$38.23
77402	Radiation treatment delivery		Z2	1.5000	$62.10
77403	Radiation treatment delivery		Z2	1.5000	$62.10
77404	Radiation treatment delivery		Z2	1.5000	$62.10
77406	Radiation treatment delivery		Z2	1.5000	$62.10
77407	Radiation treatment delivery		Z2	1.5000	$62.10
77408	Radiation treatment delivery		Z2	1.5000	$62.10
77409	Radiation treatment delivery		Z2	1.5000	$62.10
77411	Radiation treatment delivery		Z2	2.2933	$94.94
77412	Radiation treatment delivery		Z2	2.2933	$94.94
77413	Radiation treatment delivery		Z2	2.2933	$94.94
77414	Radiation treatment delivery		Z2	2.2933	$94.94
77416	Radiation treatment delivery		Z2	2.2933	$94.94
77417	Radiology port film(s)	CH	N1		
77418	Radiation tx delivery, imrt		Z2	5.7275	$237.12
77421	Stereoscopic x-ray guidance	CH	N1		
77422	Neutron beam tx, simple		Z2	2.2933	$94.94
77423	Neutron beam tx, complex		Z2	2.2933	$94.94
77435	Sbrt management		N1		
77470	Special radiation treatment		Z3	5.1039	$211.30
77520	Proton trmt, simple w/o comp		Z2	13.2746	$549.57
77522	Proton trmt, simple w/comp		Z2	13.2746	$549.57
77523	Proton trmt, intermediate		Z2	15.8841	$657.60
77525	Proton treatment, complex		Z2	15.8841	$657.60
77600	Hyperthermia treatment	CH	Z3	5.1862	$214.71
77605	Hyperthermia treatment		Z2	6.0275	$249.54
77610	Hyperthermia treatment		Z2	6.0275	$249.54
77615	Hyperthermia treatment		Z2	6.0275	$249.54
77620	Hyperthermia treatment	CH	Z3	5.2440	$217.10
77750	Infuse radioactive materials		Z3	1.7481	$72.37
77761	Apply intrcav radiat simple		Z3	3.1167	$129.03
77762	Apply intrcav radiat interm		Z3	3.8505	$159.41
77763	Apply intrcav radiat compl		Z3	4.9389	$204.47
77776	Apply interstit radiat simpl		Z3	3.2816	$135.86
77777	Apply interstit radiat inter		Z3	3.9742	$164.53
77778	Apply interstit radiat compl		Z3	5.2440	$217.10
77781	High intensity brachytherapy		Z3	10.0097	$414.40
77782	High intensity brachytherapy		Z2	11.6098	$480.65
77783	High intensity brachytherapy		Z2	11.6098	$480.65
77784	High intensity brachytherapy		Z2	11.6098	$480.65
77789	Apply surface radiation		Z3	0.8657	$35.84
77790	Radiation handling		N1		
77799	Radium/radioisotope therapy		Z2	8.3915	$347.41
78000	Thyroid, single uptake		Z3	1.1213	$46.42
78001	Thyroid, multiple uptakes		Z3	1.4263	$59.05

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
78003	Thyroid suppress/stimul		Z3	1.1295	$46.76
78006	Thyroid imaging with uptake		Z2	2.8272	$117.05
78007	Thyroid image, mult uptakes		Z3	2.2179	$91.82
78010	Thyroid imaging		Z3	2.3746	$98.31
78011	Thyroid imaging with flow	CH	Z3	2.7457	$113.67
78015	Thyroid met imaging		Z3	3.1249	$129.37
78016	Thyroid met imaging/studies		Z2	4.4988	$186.25
78018	Thyroid met imaging, body		Z2	4.4988	$186.25
78020	Thyroid met uptake	CH	N1		
78070	Parathyroid nuclear imaging	CH	Z3	3.0343	$125.62
78075	Adrenal nuclear imaging		Z2	3.6540	$151.28
78099	Endocrine nuclear procedure		Z2	2.8272	$117.05
78102	Bone marrow imaging, ltd		Z3	2.4406	$101.04
78103	Bone marrow imaging, mult		Z3	3.3804	$139.95
78104	Bone marrow imaging, body	CH	Z3	4.0732	$168.63
78110	Plasma volume, single		Z3	1.2285	$50.86
78111	Plasma volume, multiple		Z3	1.8882	$78.17
78120	Red cell mass, single		Z3	1.5171	$62.81
78121	Red cell mass, multiple		Z3	2.0447	$84.65
78122	Blood volume		Z3	2.7374	$113.33
78130	Red cell survival study		Z3	2.4983	$103.43
78135	Red cell survival kinetics	CH	Z3	5.3923	$223.24
78140	Red cell sequestration		Z3	2.7126	$112.30
78185	Spleen imaging		Z3	3.0012	$124.25
78190	Platelet survival, kinetics		Z2	3.2810	$135.83
78191	Platelet survival		Z2	3.2810	$135.83
78195	Lymph system imaging		Z2	4.1916	$173.53
78199	Blood/lymph nuclear exam		Z2	4.1916	$173.53
78201	Liver imaging		Z3	2.7870	$115.38
78202	Liver imaging with flow		Z3	3.2650	$135.17
78205	Liver imaging (3D)		Z3	4.4524	$184.33
78206	Liver image (3d) with flow		Z2	4.5297	$187.53
78215	Liver and spleen imaging		Z3	3.0754	$127.32
78216	Liver & spleen image/flow		Z3	2.4983	$103.43
78220	Liver function study		Z3	2.6961	$111.62
78223	Hepatobiliary imaging		Z2	4.5297	$187.53
78230	Salivary gland imaging		Z3	2.5065	$103.77
78231	Serial salivary imaging		Z3	2.3582	$97.63
78232	Salivary gland function exam		Z3	2.5065	$103.77
78258	Esophageal motility study		Z3	3.3476	$138.59
78261	Gastric mucosa imaging		Z2	3.8546	$159.58
78262	Gastroesophageal reflux exam		Z2	3.8546	$159.58
78264	Gastric emptying study		Z2	3.8546	$159.58
78270	Vit B-12 absorption exam		Z3	1.3853	$57.35
78271	Vit b-12 absrp exam, int fac		Z3	1.4181	$58.71
78272	Vit B-12 absorp, combined		Z3	1.7563	$72.71
78278	Acute GI blood loss imaging		Z2	3.8546	$159.58
78282	GI protein loss exam		Z2	3.8546	$159.58
78290	Meckel's divert exam		Z2	3.8546	$159.58
78291	Leveen/shunt patency exam		Z3	3.6196	$149.85
78299	GI nuclear procedure		Z2	3.8546	$159.58
78300	Bone imaging, limited area		Z3	2.6302	$108.89
78305	Bone imaging, multiple areas		Z3	3.5949	$148.83
78306	Bone imaging, whole body	CH	Z2	3.9566	$163.80
78315	Bone imaging, 3 phase		Z2	3.9566	$163.80
78320	Bone imaging (3D)		Z2	3.9566	$163.80
78399	Musculoskeletal nuclear exam		Z2	3.9566	$163.80
78414	Non-imaging heart function		Z2	5.4404	$225.23
78428	Cardiac shunt imaging		Z3	2.9106	$120.50
78445	Vascular flow imaging	CH	Z3	2.5065	$103.77
78456	Acute venous thrombus image		Z2	3.0424	$125.96
78457	Venous thrombosis imaging	CH	Z3	2.8857	$119.47
78458	Ven thrombosis images, bilat		Z2	3.0424	$125.96
78459	Heart muscle imaging (PET)		Z2	42.5674	$1,762.29
78460	Heart muscle blood, single		Z3	2.7210	$112.65
78461	Heart muscle blood, multiple		Z3	3.3886	$140.29
78464	Heart image (3d), single	CH	Z3	5.0708	$209.93
78465	Heart image (3d), multiple	CH	Z3	9.1935	$380.61

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
78466	Heart infarct image		Z3	2.7952	$115.72
78468	Heart infarct image (ef)		Z3	3.7350	$154.63
78469	Heart infarct image (3D)	CH	Z3	4.5019	$186.38
78472	Gated heart, planar, single	CH	Z3	4.5430	$188.08
78473	Gated heart, multiple		Z2	5.4404	$225.23
78478	Heart wall motion add-on	CH	N1		
78480	Heart function add-on	CH	N1		
78481	Heart first pass, single		Z3	3.9988	$165.55
78483	Heart first pass, multiple		Z2	5.4404	$225.23
78491	Heart image (pet), single		Z2	42.5674	$1,762.29
78492	Heart image (pet), multiple		Z2	42.5674	$1,762.29
78494	Heart image, spect	CH	Z3	5.2109	$215.73
78496	Heart first pass add-on	CH	N1		
78499	Cardiovascular nuclear exam		Z2	5.4404	$225.23
78580	Lung perfusion imaging		Z2	3.2976	$136.52
78584	Lung V/Q image single breath		Z3	2.3911	$98.99
78585	Lung V/Q imaging		Z2	5.1617	$213.69
78586	Aerosol lung image, single		Z3	2.6879	$111.28
78587	Aerosol lung image, multiple		Z3	3.2734	$135.52
78588	Perfusion lung image		Z3	4.6420	$192.18
78591	Vent image, 1 breath, 1 proj		Z3	2.7870	$115.38
78593	Vent image, 1 proj, gas		Z3	3.2899	$136.20
78594	Vent image, mult proj, gas		Z2	3.2976	$136.52
78596	Lung differential function		Z2	5.1617	$213.69
78599	Respiratory nuclear exam		Z2	3.2976	$136.52
78600	Brain imaging, ltd static		Z3	3.2568	$134.83
78601	Brain imaging, ltd w/flow	CH	Z2	3.3325	$137.97
78605	Brain imaging, complete		Z3	3.2568	$134.83
78606	Brain imaging, compl w/flow	CH	Z3	4.9389	$204.47
78607	Brain imaging (3D)	CH	Z3	6.8599	$284.00
78608	Brain imaging (PET)		Z2	17.3837	$719.69
78610	Brain flow imaging only		Z3	2.3829	$98.65
78615	Cerebral vascular flow image		Z3	3.7186	$153.95
78630	Cerebrospinal fluid scan	CH	Z3	5.4582	$225.97
78635	CSF ventriculography	CH	Z3	4.4688	$185.01
78645	CSF shunt evaluation		Z2	3.3325	$137.97
78647	Cerebrospinal fluid scan	CH	Z3	6.5056	$269.33
78650	CSF leakage imaging	CH	Z3	5.2853	$218.81
78660	Nuclear exam of tear flow		Z3	2.5147	$104.11
78699	Nervous system nuclear exam		Z2	3.3325	$137.97
78700	Kidney imaging, morphol		Z3	2.9766	$123.23
78701	Kidney imaging with flow		Z3	3.5618	$147.46
78707	Kflow/funct image w/o drug	CH	Z3	3.9082	$161.80
78708	Kflow/funct image w/drug		Z3	3.0589	$126.64
78709	Kflow/funct image, multiple		Z2	5.0935	$210.87
78710	Kidney imaging (3D)	CH	Z3	4.4771	$185.35
78725	Kidney function study		Z2	1.5806	$65.44
78730	Urinary bladder retention		Z2	0.6416	$26.56
78740	Ureteral reflux study		Z3	3.0507	$126.30
78761	Testicular imaging w/flow		Z3	3.2321	$133.81
78799	Genitourinary nuclear exam		Z2	5.0935	$210.87
78800	Tumor imaging, limited area		Z3	3.0589	$126.64
78801	Tumor imaging, mult areas		Z3	4.0732	$168.63
78802	Tumor imaging, whole body	CH	Z3	5.4336	$224.95
78803	Tumor imaging (3D)	CH	Z3	6.8188	$282.30
78804	Tumor imaging, whole body	CH	Z3	10.3807	$429.76
78805	Abscess imaging, ltd area		Z3	3.0012	$124.25
78806	Abscess imaging, whole body	CH	Z3	5.8870	$243.72
78807	Nuclear localization/abscess	CH	Z3	6.7116	$277.86
78811	Tumor imaging (pet), limited		Z2	17.3837	$719.69
78812	Tumor image (pet)/skul-thigh		Z2	17.3837	$719.69
78813	Tumor image (pet) full body		Z2	17.3837	$719.69
78814	Tumor image pet/ct, limited		Z2	17.3837	$719.69
78815	Tumorimage pet/ct skul-thigh		Z2	17.3837	$719.69
78816	Tumor image pet/ct full body		Z2	17.3837	$719.69
78890	Nuclear medicine data proc		N1		
78891	Nuclear med data proc		N1		
78999	Nuclear diagnostic exam		Z2	1.5806	$65.44

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
79005	Nuclear rx, oral admin		Z3	1.5913	$65.88
79101	Nuclear rx, iv admin		Z3	1.6572	$68.61
79200	Nuclear rx, intracav admin		Z3	1.7150	$71.00
79300	Nuclr rx, interstit colloid		Z2	3.4563	$143.09
79403	Hematopoietic nuclear tx		Z3	2.6384	$109.23
79440	Nuclear rx, intra-articular		Z3	1.5418	$63.83
79445	Nuclear rx, intra-arterial		Z2	3.4563	$143.09
79999	Nuclear medicine therapy		Z2	3.4563	$143.09
90371	Hep b ig, im		K2		$132.42
90375	Rabies ig, im/sc		K2		$64.82
90376	Rabies ig, heat treated		K2		$69.40
90396	Varicella-zoster ig, im		K2		$121.58
90585	Bcg vaccine, percut		K2		$112.56
90675	Rabies vaccine, im		K2		$145.53
90676	Rabies vaccine, id		K2		$124.09
90708	Measles-rubella vaccine, sc		K2		$61.10
90720	Dtp/hib vaccine, im	CH	N1		
90727	Plague vaccine, im	CH	N1		
90733	Meningococcal vaccine, sc		K2		$88.59
90734	Meningococcal vaccine, im		K2		$72.03
90735	Encephalitis vaccine, sc		K2		$98.17
A4218	Sterile saline or water		N1		
A4220	Infusion pump refill kit		N1		
A4248	Chlorhexidine antisept		N1		
A4262	Temporary tear duct plug		N1		
A4263	Permanent tear duct plug		N1		
A4270	Disposable endoscope sheath		N1		
A4300	Cath impl vasc access portal		N1		
A4301	Implantable access syst perc		N1		
A4305	Drug delivery system >=50 ML		N1		
A4306	Drug delivery system <=50 ml		N1		
A9527	Iodine I-125 sodium iodide	CH	H2		$28.62
A9698	Non-rad contrast materialNOC		N1		
C1713	Anchor/screw bn/bn,tis/bn		N1		
C1714	Cath, trans atherectomy, dir		N1		
C1715	Brachytherapy needle		N1		
C1716	Brachytx source, Gold 198	CH	H2		$31.95
C1717	Brachytx source, HDR Ir-192	CH	H2		$173.40
C1719	Brachytx sour,Non-HDR Ir-192	CH	H2		$57.40
C1721	AICD, dual chamber		N1		
C1722	AICD, single chamber		N1		
C1724	Cath, trans atherec,rotation		N1		
C1725	Cath, translumin non-laser		N1		
C1726	Cath, bal dil, non-vascular		N1		
C1727	Cath, bal tis dis, non-vas		N1		
C1728	Cath, brachytx seed adm		N1		
C1729	Cath, drainage		N1		
C1730	Cath, EP, 19 or few elect		N1		
C1731	Cath, EP, 20 or more elec		N1		
C1732	Cath, EP, diag/abl, 3D/vect		N1		
C1733	Cath, EP, othr than cool-tip		N1		
C1750	Cath, hemodialysis,long-term		N1		
C1751	Cath, inf, per/cent/midline		N1		
C1752	Cath,hemodialysis,short-term		N1		
C1753	Cath, intravas ultrasound		N1		
C1754	Catheter, intradiscal		N1		
C1755	Catheter, intraspinal		N1		
C1756	Cath, pacing, transesoph		N1		
C1757	Cath, thrombectomy/embolect		N1		
C1758	Catheter, ureteral		N1		
C1759	Cath, intra echocardiography		N1		
C1760	Closure dev, vasc		N1		
C1762	Conn tiss, human(inc fascia)		N1		
C1763	Conn tiss, non-human		N1		
C1764	Event recorder, cardiac		N1		
C1765	Adhesion barrier		N1		
C1766	Intro/sheath,strble,non-peel		N1		
C1767	Generator, neuro non-recharg		N1		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
C1768	Graft, vascular		N1		
C1769	Guide wire		N1		
C1770	Imaging coil, MR, insertable		N1		
C1771	Rep dev, urinary, w/sling		N1		
C1772	Infusion pump, programmable		N1		
C1773	Ret dev, insertable		N1		
C1776	Joint device (implantable)		N1		
C1777	Lead, AICD, endo single coil		N1		
C1778	Lead, neurostimulator		N1		
C1779	Lead, pmkr, transvenous VDD		N1		
C1780	Lens, intraocular (new tech)		N1		
C1781	Mesh (implantable)		N1		
C1782	Morcellator		N1		
C1783	Ocular imp, aqueous drain de		N1		
C1784	Ocular dev, intraop, det ret		N1		
C1785	Pmkr, dual, rate-resp		N1		
C1786	Pmkr, single, rate-resp		N1		
C1787	Patient progr, neurostim		N1		
C1788	Port, indwelling, imp		N1		
C1789	Prosthesis, breast, imp		N1		
C1813	Prosthesis, penile, inflatab		N1		
C1814	Retinal tamp, silicone oil		N1		
C1815	Pros, urinary sph, imp		N1		
C1816	Receiver/transmitter, neuro		N1		
C1817	Septal defect imp sys		N1		
C1818	Integrated keratoprosthesis		N1		
C1819	Tissue localization-excision		N1		
C1820	Generator neuro rechg bat sy	CH	N1		
C1821	Interspinous implant		J7		
C1874	Stent, coated/cov w/del sys		N1		
C1875	Stent, coated/cov w/o del sy		N1		
C1876	Stent, non-coa/non-cov w/del		N1		
C1877	Stent, non-coat/cov w/o del		N1		
C1878	Matrl for vocal cord		N1		
C1879	Tissue marker, implantable		N1		
C1880	Vena cava filter		N1		
C1881	Dialysis access system		N1		
C1882	AICD, other than sing/dual		N1		
C1883	Adapt/ext, pacing/neuro lead		N1		
C1884	Embolization Protect syst		N1		
C1885	Cath, translumin angio laser		N1		
C1887	Catheter, guiding		N1		
C1888	Endovas non-cardiac abl cath		N1		
C1891	Infusion pump,non-prog, perm		N1		
C1892	Intro/sheath,fixed,peel-away		N1		
C1893	Intro/sheath, fixed,non-peel		N1		
C1894	Intro/sheath, non-laser		N1		
C1895	Lead, AICD, endo dual coil		N1		
C1896	Lead, AICD, non sing/dual		N1		
C1897	Lead, neurostim test kit		N1		
C1898	Lead, pmkr, other than trans		N1		
C1899	Lead, pmkr/AICD combination		N1		
C1900	Lead, coronary venous		N1		
C2614	Probe, perc lumb disc		N1		
C2615	Sealant, pulmonary, liquid		N1		
C2616	Brachytx source, Yttrium-90	CH	H2		$11,943.79
C2617	Stent, non-cor, tem w/o del		N1		
C2618	Probe, cryoablation		N1		
C2619	Pmkr, dual, non rate-resp		N1		
C2620	Pmkr, single, non rate-resp		N1		
C2621	Pmkr, other than sing/dual		N1		
C2622	Prosthesis, penile, non-inf		N1		
C2625	Stent, non-cor, tem w/del sy		N1		
C2626	Infusion pump, non-prog,temp		N1		
C2627	Cath, suprapubic/cystoscopic		N1		
C2628	Catheter, occlusion		N1		
C2629	Intro/sheath, laser		N1		
C2630	Cath, EP, cool-tip		N1		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
C2631	Rep dev, urinary, w/o sling		N1		
C2634	Brachytx source, HA, I-125	CH	H2		$29.93
C2635	Brachytx source, HA, P-103	CH	H2		$47.06
C2636	Brachytx linear source,P-103	CH	H2		$37.09
C8900	MRA w/cont, abd		Z2	6.7963	$281.37
C8901	MRA w/o cont, abd		Z2	5.7101	$236.40
C8902	MRA w/o fol w/cont, abd		Z2	8.6689	$358.89
C8903	MRI w/cont, breast, uni		Z2	6.7963	$281.37
C8904	MRI w/o cont, breast, uni		Z2	5.7101	$236.40
C8905	MRI w/o fol w/cont, brst, un		Z2	8.6689	$358.89
C8906	MRI w/cont, breast, bi		Z2	6.7963	$281.37
C8907	MRI w/o cont, breast, bi		Z2	5.7101	$236.40
C8908	MRI w/o fol w/cont, breast,		Z2	8.6689	$358.89
C8909	MRA w/cont, chest		Z2	6.7963	$281.37
C8910	MRA w/o cont, chest		Z2	5.7101	$236.40
C8911	MRA w/o fol w/cont, chest		Z2	8.6689	$358.89
C8912	MRA w/cont, lwr ext		Z2	6.7963	$281.37
C8913	MRA w/o cont, lwr ext		Z2	5.7101	$236.40
C8914	MRA w/o fol w/cont, lwr ext		Z2	8.6689	$358.89
C8918	MRA w/cont, pelvis		Z2	6.7963	$281.37
C8919	MRA w/o cont, pelvis		Z2	5.7101	$236.40
C8920	MRA w/o fol w/cont, pelvis		Z2	8.6689	$358.89
C9003	Palivizumab, per 50 mg		K2		$677.97
C9113	Inj pantoprazole sodium, via		N1		
C9121	Injection, argatroban		K2		$17.87
C9232	Injection, idursulfase		K2		$455.03
C9233	Injection, ranibizumab		K2		$2,030.92
C9234	Inj, alglucosidase alfa		K2		$1.26
C9235	Injection, panitumumab		K2		$84.80
C9350	Porous collagen tube per cm		K2		$485.91
C9351	Acellular derm tissue percm2		K2		$41.59
C9399	Unclassified drugs or biolog		K7		
E0616	Cardiac event recorder		N1		
E0749	Elec osteogen stim implanted		N1		
E0782	Non-programble infusion pump		N1		
E0783	Programmable infusion pump		N1		
E0785	Replacement impl pump cathet		N1		
E0786	Implantable pump replacement		N1		
G0130	Single energy x-ray study		Z3	0.5278	$21.85
G0173	Linear acc stereo radsur com		Z2	61.5205	$2,546.95
G0251	Linear acc based stero radio		Z2	17.1992	$712.05
G0259	Inject for sacroiliac joint		N1		
G0269	Occlusive device in vein art		N1		
G0288	Recon, CTA for surg plan	CH	N1		
G0289	Arthro, loose body + chondro		N1		
G0339	Robot lin-radsurg com, first		Z2	61.5205	$2,546.95
G0340	Robt lin-radsurg fractx 2-5		Z2	47.3767	$1,961.40
J0120	Tetracyclin injection		N1		
J0128	Abarelix injection		K2		$67.97
J0129	Abatacept injection		K2		$18.69
J0130	Abciximab injection		K2		$409.26
J0132	Acetylcysteine injection	CH	N1		
J0133	Acyclovir injection		N1		
J0135	Adalimumab injection		K2		$316.02
J0150	Injection adenosine 6 MG		K2		$22.65
J0152	Adenosine injection		K2		$68.50
J0170	Adrenalin epinephrin inject		N1		
J0180	Agalsidase beta injection		K2		$1.26
J0190	Inj biperiden lactate/5 mg	CH	N1		
J0200	Alatrofloxacin mesylate		N1		
J0205	Alglucerase injection		K2		$38.85
J0207	Amifostine		K2		$476.10
J0210	Methyldopate hcl injection		K2		$10.01
J0215	Alefacept		K2		$25.82
J0256	Alpha 1 proteinase inhibitor		K2		$3.24
J0278	Amikacin sulfate injection		N1		
J0280	Aminophyllin 250 MG inj		N1		
J0282	Amiodarone HCl		N1		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
J0285	Amphotericin B		N1		
J0287	Amphotericin b lipid complex		K2		$10.28
J0288	Ampho b cholesteryl sulfate		K2		$11.89
J0289	Amphotericin b liposome inj		K2		$17.07
J0290	Ampicillin 500 MG inj		N1		
J0295	Ampicillin sodium per 1.5 gm		N1		
J0300	Amobarbital 125 MG inj		N1		
J0330	Succinycholine chloride inj		N1		
J0348	Anadulafungin injection		K2		$1.91
J0350	Injection anistreplase 30 u		K2		$2,693.80
J0360	Hydralazine hcl injection		N1		
J0364	Apomorphine hydrochloride	CH	N1		
J0365	Aprotonin, 10,000 kiu		K2		$2.50
J0380	Inj metaraminol bitartrate	CH	N1		
J0390	Chloroquine injection		N1		
J0395	Arbutamine HCl injection	CH	N1		
J0456	Azithromycin		N1		
J0460	Atropine sulfate injection		N1		
J0470	Dimecaprol injection		N1		
J0475	Baclofen 10 MG injection		K2		$195.18
J0476	Baclofen intrathecal trial		K2		$70.92
J0480	Basiliximab		K2		$1,347.14
J0500	Dicyclomine injection		N1		
J0515	Inj benztropine mesylate		N1		
J0520	Bethanechol chloride inject	CH	K2		$32.66
J0530	Penicillin g benzathine inj		N1		
J0540	Penicillin g benzathine inj		N1		
J0550	Penicillin g benzathine inj		N1		
J0560	Penicillin g benzathine inj		N1		
J0570	Penicillin g benzathine inj		N1		
J0580	Penicillin g benzathine inj		N1		
J0583	Bivalirudin		K2		$1.72
J0585	Botulinum toxin a per unit		K2		$5.05
J0587	Botulinum toxin type B		K2		$8.30
J0592	Buprenorphine hydrochloride		N1		
J0594	Busulfan injection		K2		$8.80
J0595	Butorphanol tartrate 1 mg		N1		
J0600	Edetate calcium disodium inj	CH	N1		
J0610	Calcium gluconate injection		N1		
J0620	Calcium glycer & lact/10 ML		N1		
J0630	Calcitonin salmon injection		N1		
J0636	Inj calcitriol per 0.1 mcg		N1		
J0637	Caspofungin acetate		K2		$30.07
J0640	Leucovorin calcium injection		N1		
J0670	Inj mepivacaine HCL/10 ml		N1		
J0690	Cefazolin sodium injection		N1		
J0692	Cefepime HCl for injection		N1		
J0694	Cefoxitin sodium injection		N1		
J0696	Ceftriaxone sodium injection		N1		
J0697	Sterile cefuroxime injection		N1		
J0698	Cefotaxime sodium injection		N1		
J0702	Betamethasone acet&sod phosp		N1		
J0704	Betamethasone sod phosp/4 MG		N1		
J0706	Caffeine citrate injection	CH	N1		
J0710	Cephapirin sodium injection		N1		
J0713	Inj ceftazidime per 500 mg		N1		
J0715	Ceftizoxime sodium / 500 MG		N1		
J0720	Chloramphenicol sodium injec		N1		
J0725	Chorionic gonadotropin/1000u		N1		
J0735	Clonidine hydrochloride		K2		$62.86
J0740	Cidofovir injection		K2		$754.62
J0743	Cilastatin sodium injection		N1		
J0744	Ciprofloxacin iv		N1		
J0745	Inj codeine phosphate /30 MG		N1		
J0760	Colchicine injection		N1		
J0770	Colistimethate sodium inj		N1		
J0780	Prochlorperazine injection		N1		
J0795	Corticorelin ovine triflutal		K2		$4.26

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
J0800	Corticotropin injection		K2		$126.52
J0835	Inj cosyntropin per 0.25 MG		K2		$63.25
J0850	Cytomegalovirus imm IV /vial		K2		$859.86
J0878	Daptomycin injection		K2		$0.33
J0881	Darbepoetin alfa, non-esrd		K2		$3.11
J0885	Epoetin alfa, non-esrd		K2		$9.36
J0894	Decitabine injection		K2		$26.48
J0895	Deferoxamine mesylate inj	CH	N1		
J0900	Testosterone enanthate inj		N1		
J0945	Brompheniramine maleate inj		N1		
J0970	Estradiol valerate injection		N1		
J1000	Depo-estradiol cypionate inj		N1		
J1020	Methylprednisolone 20 MG inj		N1		
J1030	Methylprednisolone 40 MG inj		N1		
J1040	Methylprednisolone 80 MG inj		N1		
J1051	Medroxyprogesterone inj		N1		
J1060	Testosterone cypionate 1 ML		N1		
J1070	Testosterone cypionat 100 MG		N1		
J1080	Testosterone cypionat 200 MG		N1		
J1094	Inj dexamethasone acetate		N1		
J1100	Dexamethasone sodium phos		N1		
J1110	Inj dihydroergotamine mesylt		N1		
J1120	Acetazolamid sodium injectio		N1		
J1160	Digoxin injection		N1		
J1162	Digoxin immune fab (ovine)		K2		$511.48
J1165	Phenytoin sodium injection		N1		
J1170	Hydromorphone injection		N1		
J1180	Dyphylline injection		N1		
J1190	Dexrazoxane HCl injection		K2		$172.43
J1200	Diphenhydramine hcl injectio		N1		
J1205	Chlorothiazide sodium inj		K2		$122.67
J1212	Dimethyl sulfoxide 50% 50 ML		N1		
J1230	Methadone injection		N1		
J1240	Dimenhydrinate injection		N1		
J1245	Dipyridamole injection		N1		
J1250	Inj dobutamine HCL/250 mg		N1		
J1260	Dolasetron mesylate		K2		$6.05
J1265	Dopamine injection		N1		
J1270	Injection, doxercalciferol		N1		
J1320	Amitriptyline injection		N1		
J1324	Enfuvirtide injection		K2		$22.69
J1325	Epoprostenol injection		N1		
J1327	Eptifibatide injection		K2		$15.90
J1330	Ergonovine maleate injection	CH	N1		
J1335	Ertapenem injection		N1		
J1364	Erythro lactobionate /500 MG		N1		
J1380	Estradiol valerate 10 MG inj		N1		
J1390	Estradiol valerate 20 MG inj		N1		
J1410	Inj estrogen conjugate 25 MG		K2		$60.32
J1430	Ethanolamine oleate 100 mg		K2		$78.26
J1435	Injection estrone per 1 MG		N1		
J1436	Etidronate disodium inj		K2		$70.73
J1438	Etanercept injection		K2		$160.03
J1440	Filgrastim 300 mcg injection		K2		$187.68
J1441	Filgrastim 480 mcg injection		K2		$297.75
J1450	Fluconazole		N1		
J1451	Fomepizole, 15 mg		K2		$12.28
J1452	Intraocular Fomivirsen na	CH	N1		
J1455	Foscarnet sodium injection	CH	N1		
J1457	Gallium nitrate injection	CH	K2		$1.47
J1458	Galsulfase injection		K2		$297.09
J1460	Gamma globulin 1 CC inj		K2		$11.31
J1470	Gamma globulin 2 CC inj	CH	K2		$22.63
J1480	Gamma globulin 3 CC inj	CH	K2		$33.93
J1490	Gamma globulin 4 CC inj	CH	K2		$45.25
J1500	Gamma globulin 5 CC inj	CH	K2		$56.56
J1510	Gamma globulin 6 CC inj	CH	K2		$67.91
J1520	Gamma globulin 7 CC inj	CH	K2		$79.14

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
J1530	Gamma globulin 8 CC inj	CH	K2		$90.50
J1540	Gamma globulin 9 CC inj	CH	K2		$101.88
J1550	Gamma globulin 10 CC inj	CH	K2		$113.13
J1560	Gamma globulin > 10 CC inj	CH	K2		$113.13
J1562	Immune globulin subcutaneous		K2		$12.60
J1565	RSV-ivig		K2		$16.02
J1566	Immune globulin, powder		K2		$25.48
J1567	Immune globulin, liquid		K2		$30.28
J1570	Ganciclovir sodium injection		N1		
J1580	Garamycin gentamicin inj		N1		
J1590	Gatifloxacin injection		N1		
J1595	Injection glatiramer acetate		N1		
J1600	Gold sodium thiomaleate inj		N1		
J1610	Glucagon hydrochloride/1 MG		K2		$65.64
J1620	Gonadorelin hydroch/ 100 mcg		K2		$178.59
J1626	Granisetron HCl injection		K2		$7.43
J1630	Haloperidol injection		N1		
J1631	Haloperidol decanoate inj		N1		
J1640	Hemin, 1 mg		K2		$6.74
J1642	Inj heparin sodium per 10 u		N1		
J1644	Inj heparin sodium per 1000u		N1		
J1645	Dalteparin sodium		N1		
J1650	Inj enoxaparin sodium		N1		
J1652	Fondaparinux sodium	CH	K2		$5.82
J1655	Tinzaparin sodium injection	CH	N1		
J1670	Tetanus immune globulin inj		K2		$96.35
J1700	Hydrocortisone acetate inj		N1		
J1710	Hydrocortisone sodium ph inj		N1		
J1720	Hydrocortisone sodium succ i		N1		
J1730	Diazoxide injection		K2		$113.24
J1740	Ibandronate sodium injection		K2		$138.71
J1742	Ibutilide fumarate injection		K2		$264.40
J1745	Infliximab injection		K2		$53.25
J1751	Iron dextran 165 injection		K2		$11.61
J1752	Iron dextran 267 injection		K2		$10.32
J1756	Iron sucrose injection		K2		$0.37
J1785	Injection imiglucerase /unit		K2		$3.89
J1790	Droperidol injection		N1		
J1800	Propranolol injection		N1		
J1815	Insulin injection		N1		
J1817	Insulin for insulin pump use		N1		
J1830	Interferon beta-1b / .25 MG		K2		$84.12
J1835	Itraconazole injection		K2		$38.05
J1840	Kanamycin sulfate 500 MG inj		N1		
J1850	Kanamycin sulfate 75 MG inj		N1		
J1885	Ketorolac tromethamine inj		N1		
J1890	Cephalothin sodium injection		N1		
J1931	Laronidase injection		K2		$23.64
J1940	Furosemide injection		N1		
J1945	Lepirudin		K2		$153.42
J1950	Leuprolide acetate /3.75 MG		K2		$429.83
J1956	Levofloxacin injection		N1		
J1960	Levorphanol tartrate inj		N1		
J1980	Hyoscyamine sulfate inj		N1		
J1990	Chlordiazepoxide injection		N1		
J2001	Lidocaine injection		N1		
J2010	Lincomycin injection		N1		
J2020	Linezolid injection		K2		$24.93
J2060	Lorazepam injection		N1		
J2150	Mannitol injection		N1		
J2170	Mecasermin injection		K2		$11.81
J2175	Meperidine hydrochl /100 MG		N1		
J2180	Meperidine/promethazine inj		N1		
J2185	Meropenem	CH	N1		
J2210	Methylergonovin maleate inj		N1		
J2248	Micafungin sodium injection		K2		$1.71
J2250	Inj midazolam hydrochloride		N1		
J2260	Inj milrinone lactate / 5 MG		N1		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
J2270	Morphine sulfate injection		N1		
J2271	Morphine so4 injection 100mg		N1		
J2275	Morphine sulfate injection		N1		
J2278	Ziconotide injection		K2		$6.46
J2280	Inj, moxifloxacin 100 mg		N1		
J2300	Inj nalbuphine hydrochloride		N1		
J2310	Inj naloxone hydrochloride		N1		
J2315	Naltrexone, depot form		K2		$1.88
J2320	Nandrolone decanoate 50 MG		N1		
J2321	Nandrolone decanoate 100 MG		N1		
J2322	Nandrolone decanoate 200 MG		N1		
J2325	Nesiritide injection		K2		$31.36
J2353	Octreotide injection, depot		K2		$95.86
J2354	Octreotide inj, non-depot		N1		
J2355	Oprelvekin injection		K2		$244.98
J2357	Omalizumab injection		K2		$16.79
J2360	Orphenadrine injection		N1		
J2370	Phenylephrine hcl injection		N1		
J2400	Chloroprocaine hcl injection		N1		
J2405	Ondansetron hcl injection		K2		$3.37
J2410	Oxymorphone hcl injection		N1		
J2425	Palifermin injection		K2		$11.32
J2430	Pamidronate disodium /30 MG		K2		$30.49
J2440	Papaverin hcl injection		N1		
J2460	Oxytetracycline injection		N1		
J2469	Palonosetron HCl		K2		$15.85
J2501	Paricalcitol		N1		
J2503	Pegaptanib sodium injection		K2		$1,054.70
J2504	Pegademase bovine, 25 iu		K2		$176.16
J2505	Injection, pegfilgrastim 6mg		K2		$2,142.92
J2510	Penicillin g procaine inj		N1		
J2513	Pentastarch 10% solution	CH	K2		$23.61
J2515	Pentobarbital sodium inj		N1		
J2540	Penicillin g potassium inj		N1		
J2543	Piperacillin/tazobactam		N1		
J2550	Promethazine hcl injection		N1		
J2560	Phenobarbital sodium inj		N1		
J2590	Oxytocin injection		N1		
J2597	Inj desmopressin acetate		N1		
J2650	Prednisolone acetate inj		N1		
J2670	Totazoline hcl injection		N1		
J2675	Inj progesterone per 50 MG		N1		
J2680	Fluphenazine decanoate 25 MG		N1		
J2690	Procainamide hcl injection		N1		
J2700	Oxacillin sodium injeciton		N1		
J2710	Neostigmine methylslfte inj		N1		
J2720	Inj protamine sulfate/10 MG		N1		
J2725	Inj protirelin per 250 mcg		N1		
J2730	Pralidoxime chloride inj		N1		
J2760	Phentolaine mesylate inj		N1		
J2765	Metoclopramide hcl injection		N1		
J2770	Quinupristin/dalfopristin		K2		$116.70
J2780	Ranitidine hydrochloride inj		N1		
J2783	Rasburicase		K2		$131.28
J2788	Rho d immune globulin 50 mcg		K2		$26.41
J2790	Rho d immune globulin inj		K2		$80.71
J2792	Rho(D) immune globulin h, sd		K2		$15.76
J2794	Risperidone, long acting		K2		$4.80
J2795	Ropivacaine HCl injection		N1		
J2800	Methocarbamol injection		N1		
J2805	Sincalide injection		N1		
J2810	Inj theophylline per 40 MG		N1		
J2820	Sargramostim injection		K2		$25.08
J2850	Inj secretin synthetic human		K2		$20.12
J2910	Aurothioglucose injeciton		N1		
J2916	Na ferric gluconate complex		N1		
J2920	Methylprednisolone injection		N1		
J2930	Methylprednisolone injection		N1		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
J2940	Somatrem injection		K2		$69.53
J2941	Somatropin injection		K2		$46.75
J2950	Promazine hcl injection		N1		
J2993	Reteplase injection		K2		$891.03
J2995	Inj streptokinase /250000 IU		K2		$75.48
J2997	Alteplase recombinant		K2		$32.48
J3000	Streptomycin injection		N1		
J3010	Fentanyl citrate injeciton		N1		
J3030	Sumatriptan succinate / 6 MG		K2		$58.82
J3070	Pentazocine injection		N1		
J3100	Tenecteplase injection		K2		$2,024.13
J3105	Terbutaline sulfate inj		N1		
J3120	Testosterone enanthate inj		N1		
J3130	Testosterone enanthate inj		N1		
J3140	Testosterone suspension inj		N1		
J3150	Testosteron propionate inj		N1		
J3230	Chlorpromazine hcl injection		N1		
J3240	Thyrotropin injection		K2		$758.16
J3243	Tigecycline injection		K2		$0.91
J3246	Tirofiban HCl		K2		$7.66
J3250	Trimethobenzamide hcl inj		N1		
J3260	Tobramycin sulfate injection		N1		
J3265	Injection torsemide 10 mg/ml		N1		
J3280	Thiethylperazine maleate inj		N1		
J3285	Treprostinil injection		K2		$55.36
J3301	Triamcinolone acetonide inj		N1		
J3302	Triamcinolone diacetate inj		N1		
J3303	Triamcinolone hexacetonl inj		N1		
J3305	Inj trimetrexate glucoronate		K2		$143.89
J3310	Perphenazine injeciton		N1		
J3315	Triptorelin pamoate		K2		$153.97
J3320	Spectinomycn di-hcl inj	CH	N1		
J3350	Urea injection		K2		$73.46
J3355	Urofollitropin, 75 iu		K2		$50.22
J3360	Diazepam injection		N1		
J3364	Urokinase 5000 IU injection	CH	K2		$9.07
J3365	Urokinase 250,000 IU inj		K2		$453.41
J3370	Vancomycin hcl injection		N1		
J3396	Verteporfin injection		K2		$8.84
J3400	Triflupromazine hcl inj		N1		
J3410	Hydroxyzine hcl injection		N1		
J3411	Thiamine hcl 100 mg		N1		
J3415	Pyridoxine hcl 100 mg		N1		
J3420	Vitamin b12 injection		N1		
J3430	Vitamin k phytonadione inj		N1		
J3465	Injection, voriconazole		K2		$4.94
J3470	Hyaluronidase injection		N1		
J3471	Ovine, up to 999 USP units		N1		
J3472	Ovine, 1000 USP units		K2		$133.77
J3473	Hyaluronidase recombinant		K2		$0.40
J3475	Inj magnesium sulfate		N1		
J3480	Inj potassium chloride		N1		
J3485	Zidovudine		N1		
J3486	Ziprasidone mesylate		N1		
J3487	Zoledronic acid		K2		$204.09
J3490	Drugs unclassified injection		N1		
J3530	Nasal vaccine inhalation		N1		
J3590	Unclassified biologics		N1		
J7030	Normal saline solution infus		N1		
J7040	Normal saline solution infus		N1		
J7042	5% dextrose/normal saline		N1		
J7050	Normal saline solution infus		N1		
J7060	5% dextrose/water		N1		
J7070	D5w infusion		N1		
J7100	Dextran 40 infusion		N1		
J7110	Dextran 75 infusion		N1		
J7120	Ringers lactate infusion		N1		
J7130	Hypertonic saline solution		N1		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
J7187	Inj Vonwillebrand factor IU		K2		$0.88
J7189	Factor viia		K2		$1.11
J7190	Factor viii		K2		$0.70
J7191	Factor VIII (porcine)	CH	N1		
J7192	Factor viii recombinant		K2		$1.07
J7193	Factor IX non-recombinant		K2		$0.89
J7194	Factor ix complex		K2		$0.75
J7195	Factor IX recombinant		K2		$0.99
J7197	Antithrombin iii injection		K2		$1.62
J7198	Anti-inhibitor		K2		$1.35
J7308	Aminolevulinic acid hcl top		K2		$104.43
J7310	Ganciclovir long act implant		K2		$4,707.42
J7311	Fluocinolone acetonide implt		K2		$19,162.50
J7340	Metabolic active D/E tissue		K2		$28.51
J7341	Non-human, metabolic tissue	CH	N1		
J7342	Metabolically active tissue		K2		$31.36
J7343	Nonmetabolic act d/e tissue		K2		$18.13
J7344	Nonmetabolic active tissue		K2		$88.37
J7345	Non-human, non-metab tissue		K2		$35.76
J7346	Injectable human tissue		K2		$728.44
J7500	Azathioprine oral 50mg		N1		
J7501	Azathioprine parenteral		K2		$47.99
J7502	Cyclosporine oral 100 mg		K2		$3.57
J7504	Lymphocyte immune globulin		K2		$314.19
J7505	Monoclonal antibodies		K2		$886.70
J7506	Prednisone oral		N1		
J7507	Tacrolimus oral per 1 MG		K2		$3.63
J7509	Methylprednisolone oral		N1		
J7510	Prednisolone oral per 5 mg		N1		
J7511	Antithymocyte globuln rabbit		K2		$324.66
J7513	Daclizumab, parenteral		K2		$297.03
J7515	Cyclosporine oral 25 mg		N1		
J7516	Cyclosporin parenteral 250mg		N1		
J7517	Mycophenolate mofetil oral		K2		$2.60
J7518	Mycophenolic acid		K2		$2.25
J7520	Sirolimus, oral		K2		$7.15
J7525	Tacrolimus injection		K2		$139.11
J7599	Immunosuppressive drug noc		N1		
J7674	Methacholine chloride, neb		N1		
J7799	Non-inhalation drug for DME		N1		
J8501	Oral aprepitant		K2		$5.02
J8510	Oral busulfan		K2		$2.12
J8520	Capecitabine, oral, 150 mg		K2		$3.94
J8521	Capecitabine, oral, 500 mg	CH	K2		$13.12
J8530	Cyclophosphamide oral 25 MG		N1		
J8540	Oral dexamethasone		N1		
J8560	Etoposide oral 50 MG		K2		$29.32
J8597	Antiemetic drug oral NOS		N1		
J8600	Melphalan oral 2 MG	CH	K2		$4.34
J8610	Methotrexate oral 2.5 MG		N1		
J8650	Nabilone oral		K2		$16.80
J8700	Temozolomide		K2		$7.34
J9000	Doxorubic hcl 10 MG vl chemo	CH	N1		
J9001	Doxorubicin hcl liposome inj		K2		$385.81
J9010	Alemtuzumab injection		K2		$536.10
J9015	Aldesleukin/single use vial		K2		$755.78
J9017	Arsenic trioxide		K2		$33.84
J9020	Asparaginase injection		K2		$54.20
J9025	Azacitidine injection		K2		$4.26
J9027	Clofarabine injection		K2		$115.64
J9031	Bcg live intravesical vac		K2		$109.63
J9035	Bevacizumab injection		K2		$56.98
J9040	Bleomycin sulfate injection		K2		$35.52
J9041	Bortezomib injection		K2		$32.37
J9045	Carboplatin injection		K2		$8.38
J9050	Carmus bischl nitro inj		K2		$138.52
J9055	Cetuximab injection		K2		$49.34
J9060	Cisplatin 10 MG injection		N1		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
J9062	Cisplatin 50 MG injection	CH	N1		
J9065	Inj cladribine per 1 MG		K2		$35.78
J9070	Cyclophosphamide 100 MG inj		N1		
J9080	Cyclophosphamide 200 MG inj	CH	N1		
J9090	Cyclophosphamide 500 MG inj	CH	N1		
J9091	Cyclophosphamide 1.0 grm inj	CH	N1		
J9092	Cyclophosphamide 2.0 grm inj	CH	N1		
J9093	Cyclophosphamide lyophilized	CH	N1		
J9094	Cyclophosphamide lyophilized	CH	N1		
J9095	Cyclophosphamide lyophilized	CH	N1		
J9096	Cyclophosphamide lyophilized	CH	N1		
J9097	Cyclophosphamide lyophilized	CH	N1		
J9098	Cytarabine liposome		K2		$391.31
J9100	Cytarabine hcl 100 MG inj		N1		
J9110	Cytarabine hcl 500 MG inj	CH	N1		
J9120	Dactinomycin actinomycin d		K2		$488.78
J9130	Dacarbazine 100 mg inj	CH	N1		
J9140	Dacarbazine 200 MG inj	CH	N1		
J9150	Daunorubicin		K2		$20.28
J9151	Daunorubicin citrate liposom		K2		$55.40
J9160	Denileukin diftitox, 300 mcg		K2		$1,393.32
J9165	Diethylstilbestrol injection		N1		
J9170	Docetaxel		K2		$303.92
J9175	Elliotts b solution per ml		N1		
J9178	Inj, epirubicin hcl, 2 mg		K2		$21.01
J9181	Etoposide 10 MG inj		N1		
J9182	Etoposide 100 MG inj	CH	N1		
J9185	Fludarabine phosphate inj		K2		$234.21
J9190	Fluorouracil injection		N1		
J9200	Floxuridine injection		K2		$50.82
J9201	Gemcitabine HCl		K2		$123.98
J9202	Goserelin acetate implant		K2		$196.81
J9206	Irinotecan injection		K2		$124.81
J9208	Ifosfomide injection		K2		$46.15
J9209	Mesna injection		K2		$8.89
J9211	Idarubicin hcl injection		K2		$301.74
J9212	Interferon alfacon-1		K2		$4.60
J9213	Interferon alfa-2a inj		K2		$37.53
J9214	Interferon alfa-2b inj		K2		$13.75
J9215	Interferon alfa-n3 inj		K2		$9.03
J9216	Interferon gamma 1-b inj		K2		$287.13
J9217	Leuprolide acetate suspnsion		K2		$227.34
J9218	Leuprolide acetate injeciton		K2		$8.79
J9219	Leuprolide acetate implant		K2		$1,696.96
J9225	Histrelin implant		K2		$1,446.98
J9230	Mechlorethamine hcl inj		K2		$140.27
J9245	Inj melphalan hydrochl 50 MG		K2		$12.72
J9250	Methotrexate sodium inj		N1		
J9260	Methotrexate sodium inj	CH	N1		
J9261	Nelarabine injection		K2		$82.54
J9263	Oxaliplatin		K2		$8.89
J9264	Paclitaxel protein bound		K2		$7.03
J9265	Paclitaxel injection		K2		$12.47
J9266	Pegaspargase/singl dose vial		K2		$1,667.61
J9268	Pentostatin injection		K2		$1,916.66
J9270	Plicamycin (mithramycin) inj	CH	N1		
J9280	Mitomycin 5 MG inj		K2		$15.98
J9290	Mitomycin 20 MG inj	CH	K2		$63.93
J9291	Mitomycin 40 MG inj	CH	K2		$127.85
J9293	Mitoxantrone hydrochl / 5 MG		K2		$166.64
J9300	Gemtuzumab ozogamicin		K2		$2,334.75
J9305	Pemetrexed injection		K2		$43.38
J9310	Rituximab cancer treatment		K2		$491.54
J9320	Streptozocin injection		K2		$152.28
J9340	Thiotepa injection		K2		$40.32
J9350	Topotecan		K2		$822.90
J9355	Trastuzumab		K2		$57.33
J9357	Valrubicin, 200 mg		K2		$219.39

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
J9360	Vinblastine sulfate inj		N1		
J9370	Vincristine sulfate 1 MG inj		N1		
J9375	Vincristine sulfate 2 MG inj	CH	N1		
J9380	Vincristine sulfate 5 MG inj	CH	N1		
J9390	Vinorelbine tartrate/10 mg		K2		$19.88
J9395	Injection, Fulvestrant		K2		$79.80
J9600	Porfimer sodium		K2		$2,539.13
J9999	Chemotherapy drug		N1		
L8600	Implant breast silicone/eq		N1		
L8603	Collagen imp urinary 2.5 ml		N1		
L8606	Synthetic implnt urinary 1ml		N1		
L8609	Artificial cornea		N1		
L8610	Ocular implant		N1		
L8612	Aqueous shunt prosthesis		N1		
L8613	Ossicular implant		N1		
L8614	Cochlear device		N1		
L8630	Metacarpophalangeal implant		N1		
L8631	MCP joint repl 2 pc or more		N1		
L8641	Metatarsal joint implant		N1		
L8642	Hallux implant		N1		
L8658	Interphalangeal joint spacer		N1		
L8659	Interphalangeal joint repl		N1		
L8670	Vascular graft, synthetic		N1		
L8682	Implt neurostim radiofq rec		N1		
L8690	Aud osseo dev, int/ext comp		J7		
L8699	Prosthetic implant NOS		N1		
Q0163	Diphenhydramine HCl 50mg		N1		
Q0164	Prochlorperazine maleate 5mg		N1		
Q0166	Granisetron HCl 1 mg oral		K2		$44.44
Q0167	Dronabinol 2.5mg oral		N1		
Q0169	Promethazine HCl 12.5mg oral		N1		
Q0171	Chlorpromazine HCl 10mg oral		N1		
Q0173	Trimethobenzamide HCl 250mg		N1		
Q0174	Thiethylperazine maleate10mg		N1		
Q0175	Perphenazine 4mg oral		N1		
Q0177	Hydroxyzine pamoate 25mg		N1		
Q0179	Ondansetron HCl 8mg oral		K2		$36.21
Q0180	Dolasetron mesylate oral		K2		$47.07
Q0515	Sermorelin acetate injection		K2		$1.74
Q1003	NTIOL category 3		L6		$50.00
Q2004	Bladder calculi irrig sol		N1		
Q2009	Fosphenytoin, 50 mg		K2		$5.50
Q2017	Teniposide, 50 mg		K2		$261.93
Q3025	IM inj interferon beta 1-a		K2		$113.49
Q4079	Natalizumab injection		K2		$7.45
Q4083	Hyalgan/supartz inj per dose		K2		$103.86
Q4084	Synvisc inj per dose		K2		$184.89
Q4085	Euflexxa inj per dose		K2		$115.19
Q4086	Orthovisc inj per dose		K2		$196.47
Q9945	LOCM <=149 mg/ml iodine, 1ml	CH	N1		
Q9946	LOCM 150-199mg/ml iodine,1ml	CH	N1		
Q9947	LOCM 200-249mg/ml iodine,1ml	CH	N1		
Q9948	LOCM 250-299mg/ml iodine,1ml	CH	N1		
Q9949	LOCM 300-349mg/ml iodine,1ml	CH	N1		
Q9950	LOCM 350-399mg/ml iodine,1ml	CH	N1		
Q9951	LOCM >= 400 mg/ml iodine,1ml	CH	N1		
Q9952	Inj Gad-base MR contrast,1ml	CH	N1		
Q9953	Inj Fe-based MR contrast,1ml	CH	N1		
Q9954	Oral MR contrast, 100 ml	CH	N1		
Q9955	Inj perflexane lip micros,ml	CH	N1		
Q9956	Inj octafluoropropane mic,ml	CH	N1		
Q9957	Inj perflutren lip micros,ml	CH	N1		
Q9958	HOCM <=149 mg/ml iodine, 1ml		N1		
Q9959	HOCM 150-199mg/ml iodine,1ml		N1		
Q9960	HOCM 200-249mg/ml iodine,1ml		N1		
Q9961	HOCM 250-299mg/ml iodine,1ml		N1		
Q9962	HOCM 300-349mg/ml iodine,1ml		N1		
Q9963	HOCM 350-399mg/ml iodine,1ml		N1		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Comment indicator	Payment indicator	Proposed CY 2008 payment weight	Proposed CY 2008 payment
Q9964	HOCM>= 400mg/ml iodine, 1ml		N1		
V2630	Anter chamber intraocul lens		N1		
V2631	Iris support intraoclr lens		N1		
V2632	Post chmbr intraocular lens		N1		
V2785	Corneal tissue processing		F4		
V2790	Amniotic membrane		N1		

ADDENDUM D1.—PROPOSED OPPS PAYMENT STATUS INDICATORS

Indicator	Item/Code/Service	OPPS payment status
A	• Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS, for example: • Ambulance Services. • Clinical Diagnostic Laboratory Services. • Non-Implantable Prosthetic and Orthotic Devices. • EPO for ESRD Patients. • Physical, Occupational, and Speech Therapy. • Routine Dialysis Services for ESRD Patients Provided in a Certified Dialysis Unit of a Hospital. • Diagnostic Mammography. • Screening Mammography.	Not paid under OPPS. Paid by fiscal intermediaries under a fee schedule or payment system other than OPPS.
B	Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x).	Not paid under OPPS. • May be paid by intermediaries when submitted on a different bill type, for example, 75x (CORF), but not paid under OPPS. • An alternate code that is recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x) may be available.
C	Inpatient Procedures	Not paid under OPPS. Admit patient. Bill as inpatient.
D	Discontinued Codes	Not paid under OPPS or any other Medicare payment system.
E	Items, Codes, and Services: • That are not covered by Medicare based on statutory exclusion. • That are not covered by Medicare for reasons other than statutory exclusion. • That are not recognized by Medicare but for which an alternate code for the same item or service may be available. • For which separate payment is not provided by Medicare.	Not paid under OPPS or any other Medicare payment system.
F	Corneal Tissue Acquisition; Certain CRNA Services and Hepatitis B Vaccines.	Not paid under OPPS. Paid at reasonable cost.
G	Pass-Through Drugs and Biologicals	Paid under OPPS; Separate APC payment includes pass through amount.
H	Pass-Through Device Categories	Separate cost-based pass-through payment; Not subject to coinsurance.
K	(1) Non-Pass-Through Drugs and Biologicals (2) Therapeutic Radiopharmaceuticals (3) Brachytherapy Sources (4) Blood and Blood Products	(1) Paid under OPPS; Separate APC payment. (2) Paid under OPPS; Separate APC payment. (3) Paid under OPPS; Separate APC payment. (4) Paid under OPPS; Separate APC payment.
L	Influenza Vaccine; Pneumococcal Pneumonia Vaccine	Not paid under OPPS. Paid at reasonable cost; Not subject to deductible or coinsurance.
M	Items and Services Not Billable to the Fiscal Intermediary	Not paid under OPPS.
N	Items and Services Packaged into APC Rates	Paid under OPPS; Payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.
P	Partial Hospitalization	Paid under OPPS; Per diem APC payment.
Q	Packaged Services Subject to Separate Payment Under OPPS Payment Criteria.	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Separate APC payment based on OPPS payment criteria. (2) If criteria are not met, payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.
S	Significant Procedure, Not Discounted when Multiple	Paid under OPPS; Separate APC payment.

ADDENDUM D1.—PROPOSED OPPS PAYMENT STATUS INDICATORS—Continued

Indicator	Item/Code/Service	OPPS payment status
T	Significant Procedure, Multiple Reduction Applies	Paid under OPPS; Separate APC payment.
V	Clinic or Emergency Department Visit	Paid under OPPS; Separate APC payment.
Y	Non-Implantable Durable Medical Equipment	Not paid under OPPS. All institutional providers other than home health agencies bill to DMERC.
X	Ancillary Services	Paid under OPPS; Separate APC payment.

ADDENDUM D2.—PROPOSED OPPS COMMENT INDICATORS

Comment indicator	Descriptor
NI	New code, interim APC assignment; comments will be accepted on the interim APC assignment for the new code.
CH	Active HCPCS code in current year and next calendar year, status indicator and/or APC assignment has changed; or active HCPCS code that is discontinued at the end of the current calendar year.

ADDENDUM DD1.—PROPOSED ASC PAYMENT INDICATORS

Indicator	Payment indicator definition
A2	Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight.
D5	Deleted/discontinued code; no payment made.
F4	Corneal tissue acquisition; paid at reasonable cost.
G2	Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight.
H2	Brachytherapy source paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.
H8	Device-intensive procedure on ASC list in CY 2007; paid at adjusted rate.
J7	OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced.
J8	Device-intensive procedure added to ASC list in CY 2008 or later; paid at adjusted rate.
K2	Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.
K7	Unclassified drugs and biologicals; payment contractor-priced.
L6	New Technology Intraocular Lens (NTIOL); special payment.
N1	Packaged service/item; no separate payment made.
P2	Office-based surgical procedure added to ASC list in CY 2008 or later with Medicare Physician Fee Schedule (MPFS) nonfacility practice expense (PE) relative value units (RVUs); payment based on OPPS relative payment weight.
P3	Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs.
R2	Office-based surgical procedure added to ASC list in CY 2008 or later without MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight.
Z2	Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS relative payment weight.
Z3	Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on MPFS nonfacility PE RVUs.

ADDENDUM DD2.—PROPOSED ASC COMMENT INDICATORS

Indicator	Comment indicator definition
CH	Active HCPCS code in current year and next calendar year, payment indicator has changed; or active HCPCS code that is newly recognized as payable in an ASC; or active HCPCS code that is discontinued at the end of the current calendar year.
NI	New code, interim payment; comments will be accepted on the interim payment indicator for the new code.

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008

HCPCS code	Short descriptor	SI
00176	Anesth, pharyngeal surgery	C
00192	Anesth, facial bone surgery	C
00214	Anesth, skull drainage	C
00215	Anesth, skull repair/fract	C
00452	Anesth, surgery of shoulder	C
00474	Anesth, surgery of rib(s)	C
00524	Anesth, chest drainage	C
00540	Anesth, chest surgery	C
00542	Anesth, release of lung	C
00546	Anesth, lung,chest wall surg	C
00560	Anesth, heart surg w/o pump	C
00561	Anesth, heart surg < age 1	C
00562	Anesth, heart surg w/pump	C
00580	Anesth, heart/lung transplnt	C
00604	Anesth, sitting procedure	C
00622	Anesth, removal of nerves	C
00632	Anesth, removal of nerves	C
00670	Anesth, spine, cord surgery	C
00792	Anesth, hemorr/excise liver	C
00794	Anesth, pancreas removal	C
00796	Anesth, for liver transplant	C
00802	Anesth, fat layer removal	C
00844	Anesth, pelvis surgery	C
00846	Anesth, hysterectomy	C
00848	Anesth, pelvic organ surg	C
00864	Anesth, removal of bladder	C
00865	Anesth, removal of prostate	C
00866	Anesth, removal of adrenal	C
00868	Anesth, kidney transplant	C
00882	Anesth, major vein ligation	C
00904	Anesth, perineal surgery	C
00908	Anesth, removal of prostate	C
00932	Anesth, amputation of penis	C
00934	Anesth, penis, nodes removal	C
00936	Anesth, penis, nodes removal	C
00944	Anesth, vaginal hysterectomy	C
01140	Anesth, amputation at pelvis	C
01150	Anesth, pelvic tumor surgery	C
01212	Anesth, hip disarticulation	C
01214	Anesth, hip arthroplasty	C
01232	Anesth, amputation of femur	C
01234	Anesth, radical femur surg	C
01272	Anesth, femoral artery surg	C
01274	Anesth, femoral embolectomy	C
01402	Anesth, knee arthroplasty	C
01404	Anesth, amputation at knee	C
01442	Anesth, knee artery surg	C
01444	Anesth, knee artery repair	C
01486	Anesth, ankle replacement	C
01502	Anesth, lwr leg embolectomy	C
01632	Anesth, surgery of shoulder	C
01634	Anesth, shoulder joint amput	C
01636	Anesth, forequarter amput	C
01638	Anesth, shoulder replacement	C
01652	Anesth, shoulder vessel surg	C
01654	Anesth, shoulder vessel surg	C
01656	Anesth, arm-leg vessel surg	C
01756	Anesth, radical humerus surg	C
01990	Support for organ donor	C
11004	Debride genitalia & perineum	C
11005	Debride abdom wall	C
11006	Debride genit/per/abdom wall	C
11008	Remove mesh from abd wall	C
15756	Free myo/skin flap microvasc	C
15757	Free skin flap, microvasc	C
15758	Free fascial flap, microvasc	C
16036	Escharotomy; add'l incision	C
19271	Revision of chest wall	C
19272	Extensive chest wall surgery	C
19305	Mast, radical	C
19306	Mast, rad, urban type	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
19361	Breast reconstr w/lat flap	C
19364	Breast reconstruction	C
19367	Breast reconstruction	C
19368	Breast reconstruction	C
19369	Breast reconstruction	C
20660	Apply, rem fixation device	C
20661	Application of head brace	C
20664	Halo brace application	C
20802	Replantation, arm, complete	C
20805	Replant forearm, complete	C
20808	Replantation hand, complete	C
20816	Replantation digit, complete	C
20824	Replantation thumb, complete	C
20827	Replantation thumb, complete	C
20838	Replantation foot, complete	C
20930	Spinal bone allograft	C
20931	Spinal bone allograft	C
20936	Spinal bone autograft	C
20937	Spinal bone autograft	C
20938	Spinal bone autograft	C
20955	Fibula bone graft, microvasc	C
20956	Iliac bone graft, microvasc	C
20957	Mt bone graft, microvasc	C
20962	Other bone graft, microvasc	C
20969	Bone/skin graft, microvasc	C
20970	Bone/skin graft, iliac crest	C
21045	Extensive jaw surgery	C
21141	Reconstruct midface, lefort	C
21142	Reconstruct midface, lefort	C
21143	Reconstruct midface, lefort	C
21145	Reconstruct midface, lefort	C
21146	Reconstruct midface, lefort	C
21147	Reconstruct midface, lefort	C
21151	Reconstruct midface, lefort	C
21154	Reconstruct midface, lefort	C
21155	Reconstruct midface, lefort	C
21159	Reconstruct midface, lefort	C
21160	Reconstruct midface, lefort	C
21172	Reconstruct orbit/forehead	C
21179	Reconstruct entire forehead	C
21180	Reconstruct entire forehead	C
21182	Reconstruct cranial bone	C
21183	Reconstruct cranial bone	C
21184	Reconstruct cranial bone	C
21188	Reconstruction of midface	C
21193	Reconst lwr jaw w/o graft	C
21194	Reconst lwr jaw w/graft	C
21196	Reconst lwr jaw w/fixation	C
21247	Reconstruct lower jaw bone	C
21255	Reconstruct lower jaw bone	C
21256	Reconstruction of orbit	C
21268	Revise eye sockets	C
21343	Treatment of sinus fracture	C
21344	Treatment of sinus fracture	C
21346	Treat nose/jaw fracture	C
21347	Treat nose/jaw fracture	C
21348	Treat nose/jaw fracture	C
21366	Treat cheek bone fracture	C
21386	Treat eye socket fracture	C
21387	Treat eye socket fracture	C
21395	Treat eye socket fracture	C
21422	Treat mouth roof fracture	C
21423	Treat mouth roof fracture	C
21431	Treat craniofacial fracture	C
21432	Treat craniofacial fracture	C
21433	Treat craniofacial fracture	C
21435	Treat craniofacial fracture	C
21436	Treat craniofacial fracture	C
21510	Drainage of bone lesion	C
21615	Removal of rib	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
21616	Removal of rib and nerves	C
21620	Partial removal of sternum	C
21627	Sternal debridement	C
21630	Extensive sternum surgery	C
21632	Extensive sternum surgery	C
21705	Revision of neck muscle/rib	C
21740	Reconstruction of sternum	C
21750	Repair of sternum separation	C
21810	Treatment of rib fracture(s)	C
21825	Treat sternum fracture	C
22010	I&d, p-spine, c/t/cerv-thor	C
22015	I&d, p-spine, l/s/ls	C
22110	Remove part of neck vertebra	C
22112	Remove part, thorax vertebra	C
22114	Remove part, lumbar vertebra	C
22116	Remove extra spine segment	C
22210	Revision of neck spine	C
22212	Revision of thorax spine	C
22214	Revision of lumbar spine	C
22216	Revise, extra spine segment	C
22220	Revision of neck spine	C
22224	Revision of lumbar spine	C
22226	Revise, extra spine segment	C
22318	Treat odontoid fx w/o graft	C
22319	Treat odontoid fx w/graft	C
22325	Treat spine fracture	C
22326	Treat neck spine fracture	C
22327	Treat thorax spine fracture	C
22328	Treat each add spine fx	C
22532	Lat thorax spine fusion	C
22533	Lat lumbar spine fusion	C
22534	Lat thor/lumb, addl seg	C
22548	Neck spine fusion	C
22554	Neck spine fusion	C
22556	Thorax spine fusion	C
22558	Lumbar spine fusion	C
22585	Additional spinal fusion	C
22590	Spine & skull spinal fusion	C
22595	Neck spinal fusion	C
22600	Neck spine fusion	C
22610	Thorax spine fusion	C
22630	Lumbar spine fusion	C
22632	Spine fusion, extra segment	C
22800	Fusion of spine	C
22802	Fusion of spine	C
22804	Fusion of spine	C
22808	Fusion of spine	C
22810	Fusion of spine	C
22812	Fusion of spine	C
22818	Kyphectomy, 1-2 segments	C
22819	Kyphectomy, 3 or more	C
22830	Exploration of spinal fusion	C
22840	Insert spine fixation device	C
22841	Insert spine fixation device	C
22842	Insert spine fixation device	C
22843	Insert spine fixation device	C
22844	Insert spine fixation device	C
22845	Insert spine fixation device	C
22846	Insert spine fixation device	C
22847	Insert spine fixation device	C
22848	Insert pelv fixation device	C
22849	Reinsert spinal fixation	C
22850	Remove spine fixation device	C
22852	Remove spine fixation device	C
22855	Remove spine fixation device	C
22857	Lumbar artif diskectomy	C
22862	Revise lumbar artif disc	C
22865	Remove lumb artif disc	C
23200	Removal of collar bone	C
23210	Removal of shoulder blade	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
23220	Partial removal of humerus	C
23221	Partial removal of humerus	C
23222	Partial removal of humerus	C
23332	Remove shoulder foreign body	C
23472	Reconstruct shoulder joint	C
23900	Amputation of arm & girdle	C
23920	Amputation at shoulder joint	C
24900	Amputation of upper arm	C
24920	Amputation of upper arm	C
24930	Amputation follow-up surgery	C
24931	Amputate upper arm & implant	C
24940	Revision of upper arm	C
25900	Amputation of forearm	C
25905	Amputation of forearm	C
25909	Amputation follow-up surgery	C
25915	Amputation of forearm	C
25920	Amputate hand at wrist	C
25924	Amputation follow-up surgery	C
25927	Amputation of hand	C
26551	Great toe-hand transfer	C
26553	Single transfer, toe-hand	C
26554	Double transfer, toe-hand	C
26556	Toe joint transfer	C
26992	Drainage of bone lesion	C
27005	Incision of hip tendon	C
27025	Incision of hip/thigh fascia	C
27030	Drainage of hip joint	C
27036	Excision of hip joint/muscle	C
27054	Removal of hip joint lining	C
27070	Partial removal of hip bone	C
27071	Partial removal of hip bone	C
27075	Extensive hip surgery	C
27076	Extensive hip surgery	C
27077	Extensive hip surgery	C
27078	Extensive hip surgery	C
27079	Extensive hip surgery	C
27090	Removal of hip prosthesis	C
27091	Removal of hip prosthesis	C
27120	Reconstruction of hip socket	C
27122	Reconstruction of hip socket	C
27125	Partial hip replacement	C
27130	Total hip arthroplasty	C
27132	Total hip arthroplasty	C
27134	Revise hip joint replacement	C
27137	Revise hip joint replacement	C
27138	Revise hip joint replacement	C
27140	Transplant femur ridge	C
27146	Incision of hip bone	C
27147	Revision of hip bone	C
27151	Incision of hip bones	C
27156	Revision of hip bones	C
27158	Revision of pelvis	C
27161	Incision of neck of femur	C
27165	Incision/fixation of femur	C
27170	Repair/graft femur head/neck	C
27175	Treat slipped epiphysis	C
27176	Treat slipped epiphysis	C
27177	Treat slipped epiphysis	C
27178	Treat slipped epiphysis	C
27179	Revise head/neck of femur	C
27181	Treat slipped epiphysis	C
27185	Revision of femur epiphysis	C
27187	Reinforce hip bones	C
27215	Treat pelvic fracture(s)	C
27217	Treat pelvic ring fracture	C
27218	Treat pelvic ring fracture	C
27222	Treat hip socket fracture	C
27226	Treat hip wall fracture	C
27227	Treat hip fracture(s)	C
27228	Treat hip fracture(s)	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
27232	Treat thigh fracture	C
27236	Treat thigh fracture	C
27240	Treat thigh fracture	C
27244	Treat thigh fracture	C
27245	Treat thigh fracture	C
27248	Treat thigh fracture	C
27253	Treat hip dislocation	C
27254	Treat hip dislocation	C
27258	Treat hip dislocation	C
27259	Treat hip dislocation	C
27280	Fusion of sacroiliac joint	C
27282	Fusion of pubic bones	C
27284	Fusion of hip joint	C
27286	Fusion of hip joint	C
27290	Amputation of leg at hip	C
27295	Amputation of leg at hip	C
27303	Drainage of bone lesion	C
27365	Extensive leg surgery	C
27445	Revision of knee joint	C
27447	Total knee arthroplasty	C
27448	Incision of thigh	C
27450	Incision of thigh	C
27454	Realignment of thigh bone	C
27455	Realignment of knee	C
27457	Realignment of knee	C
27465	Shortening of thigh bone	C
27466	Lengthening of thigh bone	C
27468	Shorten/lengthen thighs	C
27470	Repair of thigh	C
27472	Repair/graft of thigh	C
27477	Surgery to stop leg growth	C
27479	Surgery to stop leg growth	C
27485	Surgery to stop leg growth	C
27486	Revise/replace knee joint	C
27487	Revise/replace knee joint	C
27488	Removal of knee prosthesis	C
27495	Reinforce thigh	C
27506	Treatment of thigh fracture	C
27507	Treatment of thigh fracture	C
27511	Treatment of thigh fracture	C
27513	Treatment of thigh fracture	C
27514	Treatment of thigh fracture	C
27519	Treat thigh fx growth plate	C
27535	Treat knee fracture	C
27536	Treat knee fracture	C
27540	Treat knee fracture	C
27556	Treat knee dislocation	C
27557	Treat knee dislocation	C
27558	Treat knee dislocation	C
27580	Fusion of knee	C
27590	Amputate leg at thigh	C
27591	Amputate leg at thigh	C
27592	Amputate leg at thigh	C
27596	Amputation follow-up surgery	C
27598	Amputate lower leg at knee	C
27645	Extensive lower leg surgery	C
27646	Extensive lower leg surgery	C
27702	Reconstruct ankle joint	C
27703	Reconstruction, ankle joint	C
27712	Realignment of lower leg	C
27715	Revision of lower leg	C
27724	Repair/graft of tibia	C
27725	Repair of lower leg	C
27727	Repair of lower leg	C
27880	Amputation of lower leg	C
27881	Amputation of lower leg	C
27882	Amputation of lower leg	C
27886	Amputation follow-up surgery	C
27888	Amputation of foot at ankle	C
28800	Amputation of midfoot	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
28805	Amputation thru metatarsal	C
31225	Removal of upper jaw	C
31230	Removal of upper jaw	C
31290	Nasal/sinus endoscopy, surg	C
31291	Nasal/sinus endoscopy, surg	C
31360	Removal of larynx	C
31365	Removal of larynx	C
31367	Partial removal of larynx	C
31368	Partial removal of larynx	C
31370	Partial removal of larynx	C
31375	Partial removal of larynx	C
31380	Partial removal of larynx	C
31382	Partial removal of larynx	C
31390	Removal of larynx & pharynx	C
31395	Reconstruct larynx & pharynx	C
31584	Treat larynx fracture	C
31587	Revision of larynx	C
31725	Clearance of airways	C
31760	Repair of windpipe	C
31766	Reconstruction of windpipe	C
31770	Repair/graft of bronchus	C
31775	Reconstruct bronchus	C
31780	Reconstruct windpipe	C
31781	Reconstruct windpipe	C
31786	Remove windpipe lesion	C
31800	Repair of windpipe injury	C
31805	Repair of windpipe injury	C
32035	Exploration of chest	C
32036	Exploration of chest	C
32095	Biopsy through chest wall	C
32100	Exploration/biopsy of chest	C
32110	Explore/repair chest	C
32120	Re-exploration of chest	C
32124	Explore chest free adhesions	C
32140	Removal of lung lesion(s)	C
32141	Remove/treat lung lesions	C
32150	Removal of lung lesion(s)	C
32151	Remove lung foreign body	C
32160	Open chest heart massage	C
32200	Drain, open, lung lesion	C
32215	Treat chest lining	C
32220	Release of lung	C
32225	Partial release of lung	C
32310	Removal of chest lining	C
32320	Free/remove chest lining	C
32402	Open biopsy chest lining	C
32440	Removal of lung	C
32442	Sleeve pneumonectomy	C
32445	Removal of lung	C
32480	Partial removal of lung	C
32482	Bilobectomy	C
32484	Segmentectomy	C
32486	Sleeve lobectomy	C
32488	Completion pneumonectomy	C
32491	Lung volume reduction	C
32500	Partial removal of lung	C
32501	Repair bronchus add-on	C
32503	Resect apical lung tumor	C
32504	Resect apical lung tum/chest	C
32540	Removal of lung lesion	C
32650	Thoracoscopy, surgical	C
32651	Thoracoscopy, surgical	C
32652	Thoracoscopy, surgical	C
32653	Thoracoscopy, surgical	C
32654	Thoracoscopy, surgical	C
32655	Thoracoscopy, surgical	C
32656	Thoracoscopy, surgical	C
32657	Thoracoscopy, surgical	C
32658	Thoracoscopy, surgical	C
32659	Thoracoscopy, surgical	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
32660	Thoracoscopy, surgical	C
32661	Thoracoscopy, surgical	C
32662	Thoracoscopy, surgical	C
32663	Thoracoscopy, surgical	C
32664	Thoracoscopy, surgical	C
32665	Thoracoscopy, surgical	C
32800	Repair lung hernia	C
32810	Close chest after drainage	C
32815	Close bronchial fistula	C
32820	Reconstruct injured chest	C
32850	Donor pneumonectomy	C
32851	Lung transplant, single	C
32852	Lung transplant with bypass	C
32853	Lung transplant, double	C
32854	Lung transplant with bypass	C
32855	Prepare donor lung, single	C
32856	Prepare donor lung, double	C
32900	Removal of rib(s)	C
32905	Revise & repair chest wall	C
32906	Revise & repair chest wall	C
32940	Revision of lung	C
32997	Total lung lavage	C
33015	Incision of heart sac	C
33020	Incision of heart sac	C
33025	Incision of heart sac	C
33030	Partial removal of heart sac	C
33031	Partial removal of heart sac	C
33050	Removal of heart sac lesion	C
33120	Removal of heart lesion	C
33130	Removal of heart lesion	C
33140	Heart revascularize (tmr)	C
33141	Heart tmr w/other procedure	C
33202	Insert epicard eltrd, open	C
33203	Insert epicard eltrd, endo	C
33236	Remove electrode/thoracotomy	C
33237	Remove electrode/thoracotomy	C
33238	Remove electrode/thoracotomy	C
33243	Remove eltrd/thoracotomy	C
33250	Ablate heart dysrhythm focus	C
33251	Ablate heart dysrhythm focus	C
33254	Ablate atria, lmtd	C
33255	Ablate atria w/o bypass, ext	C
33256	Ablate atria w/bypass, exten	C
33261	Ablate heart dysrhythm focus	C
33265	Ablate atria w/bypass, endo	C
33266	Ablate atria w/o bypass endo	C
33300	Repair of heart wound	C
33305	Repair of heart wound	C
33310	Exploratory heart surgery	C
33315	Exploratory heart surgery	C
33320	Repair major blood vessel(s)	C
33321	Repair major vessel	C
33322	Repair major blood vessel(s)	C
33330	Insert major vessel graft	C
33332	Insert major vessel graft	C
33335	Insert major vessel graft	C
33400	Repair of aortic valve	C
33401	Valvuloplasty, open	C
33403	Valvuloplasty, w/cp bypass	C
33404	Prepare heart-aorta conduit	C
33405	Replacement of aortic valve	C
33406	Replacement of aortic valve	C
33410	Replacement of aortic valve	C
33411	Replacement of aortic valve	C
33412	Replacement of aortic valve	C
33413	Replacement of aortic valve	C
33414	Repair of aortic valve	C
33415	Revision, subvalvular tissue	C
33416	Revise ventricle muscle	C
33417	Repair of aortic valve	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
33420	Revision of mitral valve	C
33422	Revision of mitral valve	C
33425	Repair of mitral valve	C
33426	Repair of mitral valve	C
33427	Repair of mitral valve	C
33430	Replacement of mitral valve	C
33460	Revision of tricuspid valve	C
33463	Valvuloplasty, tricuspid	C
33464	Valvuloplasty, tricuspid	C
33465	Replace tricuspid valve	C
33468	Revision of tricuspid valve	C
33470	Revision of pulmonary valve	C
33471	Valvotomy, pulmonary valve	C
33472	Revision of pulmonary valve	C
33474	Revision of pulmonary valve	C
33475	Replacement, pulmonary valve	C
33476	Revision of heart chamber	C
33478	Revision of heart chamber	C
33496	Repair, prosth valve clot	C
33500	Repair heart vessel fistula	C
33501	Repair heart vessel fistula	C
33502	Coronary artery correction	C
33503	Coronary artery graft	C
33504	Coronary artery graft	C
33505	Repair artery w/tunnel	C
33506	Repair artery, translocation	C
33507	Repair art, intramural	C
33510	CABG, vein, single	C
33511	CABG, vein, two	C
33512	CABG, vein, three	C
33513	CABG, vein, four	C
33514	CABG, vein, five	C
33516	Cabg, vein, six or more	C
33517	CABG, artery-vein, single	C
33518	CABG, artery-vein, two	C
33519	CABG, artery-vein, three	C
33521	CABG, artery-vein, four	C
33522	CABG, artery-vein, five	C
33523	Cabg, art-vein, six or more	C
33530	Coronary artery, bypass/reop	C
33533	CABG, arterial, single	C
33534	CABG, arterial, two	C
33535	CABG, arterial, three	C
33536	Cabg, arterial, four or more	C
33542	Removal of heart lesion	C
33545	Repair of heart damage	C
33548	Restore/remodel, ventricle	C
33572	Open coronary endarterectomy	C
33600	Closure of valve	C
33602	Closure of valve	C
33606	Anastomosis/artery-aorta	C
33608	Repair anomaly w/conduit	C
33610	Repair by enlargement	C
33611	Repair double ventricle	C
33612	Repair double ventricle	C
33615	Repair, modified fontan	C
33617	Repair single ventricle	C
33619	Repair single ventricle	C
33641	Repair heart septum defect	C
33645	Revision of heart veins	C
33647	Repair heart septum defects	C
33660	Repair of heart defects	C
33665	Repair of heart defects	C
33670	Repair of heart chambers	C
33675	Close mult vsd	C
33676	Close mult vsd w/resection	C
33677	Cl mult vsd w/rem pul band	C
33681	Repair heart septum defect	C
33684	Repair heart septum defect	C
33688	Repair heart septum defect	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
33690	Reinforce pulmonary artery	C
33692	Repair of heart defects	C
33694	Repair of heart defects	C
33697	Repair of heart defects	C
33702	Repair of heart defects	C
33710	Repair of heart defects	C
33720	Repair of heart defect	C
33722	Repair of heart defect	C
33724	Repair venous anomaly	C
33726	Repair pul venous stenosis	C
33730	Repair heart-vein defect(s)	C
33732	Repair heart-vein defect	C
33735	Revision of heart chamber	C
33736	Revision of heart chamber	C
33737	Revision of heart chamber	C
33750	Major vessel shunt	C
33755	Major vessel shunt	C
33762	Major vessel shunt	C
33764	Major vessel shunt & graft	C
33766	Major vessel shunt	C
33767	Major vessel shunt	C
33768	Cavopulmonary shunting	C
33770	Repair great vessels defect	C
33771	Repair great vessels defect	C
33774	Repair great vessels defect	C
33775	Repair great vessels defect	C
33776	Repair great vessels defect	C
33777	Repair great vessels defect	C
33778	Repair great vessels defect	C
33779	Repair great vessels defect	C
33780	Repair great vessels defect	C
33781	Repair great vessels defect	C
33786	Repair arterial trunk	C
33788	Revision of pulmonary artery	C
33800	Aortic suspension	C
33802	Repair vessel defect	C
33803	Repair vessel defect	C
33813	Repair septal defect	C
33814	Repair septal defect	C
33820	Revise major vessel	C
33822	Revise major vessel	C
33824	Revise major vessel	C
33840	Remove aorta constriction	C
33845	Remove aorta constriction	C
33851	Remove aorta constriction	C
33852	Repair septal defect	C
33853	Repair septal defect	C
33860	Ascending aortic graft	C
33861	Ascending aortic graft	C
33863	Ascending aortic graft	C
33870	Transverse aortic arch graft	C
33875	Thoracic aortic graft	C
33877	Thoracoabdominal graft	C
33880	Endovasc taa repr incl subcl	C
33881	Endovasc taa repr w/o subcl	C
33883	Insert endovasc prosth, taa	C
33884	Endovasc prosth, taa, add-on	C
33886	Endovasc prosth, delayed	C
33889	Artery transpose/endovas taa	C
33891	Car-car bp grft/endovas taa	C
33910	Remove lung artery emboli	C
33915	Remove lung artery emboli	C
33916	Surgery of great vessel	C
33917	Repair pulmonary artery	C
33920	Repair pulmonary atresia	C
33922	Transect pulmonary artery	C
33924	Remove pulmonary shunt	C
33925	Rpr pul art unifocal w/o cpb	C
33926	Repr pul art, unifocal w/cpb	C
33930	Removal of donor heart/lung	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
33933	Prepare donor heart/lung	C
33935	Transplantation, heart/lung	C
33940	Removal of donor heart	C
33944	Prepare donor heart	C
33945	Transplantation of heart	C
33960	External circulation assist	C
33961	External circulation assist	C
33967	Insert ia percut device	C
33968	Remove aortic assist device	C
33970	Aortic circulation assist	C
33971	Aortic circulation assist	C
33973	Insert balloon device	C
33974	Remove intra-aortic balloon	C
33975	Implant ventricular device	C
33976	Implant ventricular device	C
33977	Remove ventricular device	C
33978	Remove ventricular device	C
33979	Insert intracorporeal device	C
33980	Remove intracorporeal device	C
34001	Removal of artery clot	C
34051	Removal of artery clot	C
34151	Removal of artery clot	C
34401	Removal of vein clot	C
34451	Removal of vein clot	C
34502	Reconstruct vena cava	C
34800	Endovas aaa repr w/sm tube	C
34802	Endovas aaa repr w/2-p part	C
34803	Endovas aaa repr w/3-p part	C
34804	Endovas aaa repr w/1-p part	C
34805	Endovas aaa repr w/long tube	C
34808	Endovas iliac a device addon	C
34812	Xpose for endoprosth, femorl	C
34813	Femoral endovas graft add-on	C
34820	Xpose for endoprosth, iliac	C
34825	Endovasc extend prosth, init	C
34826	Endovasc exten prosth, add'l	C
34830	Open aortic tube prosth repr	C
34831	Open aortoiliac prosth repr	C
34832	Open aortofemor prosth repr	C
34833	Xpose for endoprosth, iliac	C
34834	Xpose, endoprosth, brachial	C
34900	Endovasc iliac repr w/graft	C
35001	Repair defect of artery	C
35002	Repair artery rupture, neck	C
35005	Repair defect of artery	C
35013	Repair artery rupture, arm	C
35021	Repair defect of artery	C
35022	Repair artery rupture, chest	C
35045	Repair defect of arm artery	C
35081	Repair defect of artery	C
35082	Repair artery rupture, aorta	C
35091	Repair defect of artery	C
35092	Repair artery rupture, aorta	C
35102	Repair defect of artery	C
35103	Repair artery rupture, groin	C
35111	Repair defect of artery	C
35112	Repair artery rupture,spleen	C
35121	Repair defect of artery	C
35122	Repair artery rupture, belly	C
35131	Repair defect of artery	C
35132	Repair artery rupture, groin	C
35141	Repair defect of artery	C
35142	Repair artery rupture, thigh	C
35151	Repair defect of artery	C
35152	Repair artery rupture, knee	C
35182	Repair blood vessel lesion	C
35189	Repair blood vessel lesion	C
35211	Repair blood vessel lesion	C
35216	Repair blood vessel lesion	C
35221	Repair blood vessel lesion	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
35241	Repair blood vessel lesion	C
35246	Repair blood vessel lesion	C
35251	Repair blood vessel lesion	C
35271	Repair blood vessel lesion	C
35276	Repair blood vessel lesion	C
35281	Repair blood vessel lesion	C
35301	Rechanneling of artery	C
35302	Rechanneling of artery	C
35303	Rechanneling of artery	C
35304	Rechanneling of artery	C
35305	Rechanneling of artery	C
35306	Rechanneling of artery	C
35311	Rechanneling of artery	C
35331	Rechanneling of artery	C
35341	Rechanneling of artery	C
35351	Rechanneling of artery	C
35355	Rechanneling of artery	C
35361	Rechanneling of artery	C
35363	Rechanneling of artery	C
35371	Rechanneling of artery	C
35372	Rechanneling of artery	C
35390	Reoperation, carotid add-on	C
35400	Angioscopy	C
35450	Repair arterial blockage	C
35452	Repair arterial blockage	C
35454	Repair arterial blockage	C
35456	Repair arterial blockage	C
35480	Atherectomy, open	C
35481	Atherectomy, open	C
35482	Atherectomy, open	C
35483	Atherectomy, open	C
35501	Artery bypass graft	C
35506	Artery bypass graft	C
35508	Artery bypass graft	C
35509	Artery bypass graft	C
35510	Artery bypass graft	C
35511	Artery bypass graft	C
35512	Artery bypass graft	C
35515	Artery bypass graft	C
35516	Artery bypass graft	C
35518	Artery bypass graft	C
35521	Artery bypass graft	C
35522	Artery bypass graft	C
35525	Artery bypass graft	C
35526	Artery bypass graft	C
35531	Artery bypass graft	C
35533	Artery bypass graft	C
35536	Artery bypass graft	C
35537	Artery bypass graft	C
35538	Artery bypass graft	C
35539	Artery bypass graft	C
35540	Artery bypass graft	C
35548	Artery bypass graft	C
35549	Artery bypass graft	C
35551	Artery bypass graft	C
35556	Artery bypass graft	C
35558	Artery bypass graft	C
35560	Artery bypass graft	C
35563	Artery bypass graft	C
35565	Artery bypass graft	C
35566	Artery bypass graft	C
35571	Artery bypass graft	C
35583	Vein bypass graft	C
35585	Vein bypass graft	C
35587	Vein bypass graft	C
35600	Harvest artery for cabg	C
35601	Artery bypass graft	C
35606	Artery bypass graft	C
35612	Artery bypass graft	C
35616	Artery bypass graft	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
35621	Artery bypass graft	C
35623	Bypass graft, not vein	C
35626	Artery bypass graft	C
35631	Artery bypass graft	C
35636	Artery bypass graft	C
35637	Artery bypass graft	C
35638	Artery bypass graft	C
35642	Artery bypass graft	C
35645	Artery bypass graft	C
35646	Artery bypass graft	C
35647	Artery bypass graft	C
35650	Artery bypass graft	C
35651	Artery bypass graft	C
35654	Artery bypass graft	C
35656	Artery bypass graft	C
35661	Artery bypass graft	C
35663	Artery bypass graft	C
35665	Artery bypass graft	C
35666	Artery bypass graft	C
35671	Artery bypass graft	C
35681	Composite bypass graft	C
35682	Composite bypass graft	C
35683	Composite bypass graft	C
35691	Arterial transposition	C
35693	Arterial transposition	C
35694	Arterial transposition	C
35695	Arterial transposition	C
35697	Reimplant artery each	C
35700	Reoperation, bypass graft	C
35701	Exploration, carotid artery	C
35721	Exploration, femoral artery	C
35741	Exploration popliteal artery	C
35800	Explore neck vessels	C
35820	Explore chest vessels	C
35840	Explore abdominal vessels	C
35870	Repair vessel graft defect	C
35901	Excision, graft, neck	C
35905	Excision, graft, thorax	C
35907	Excision, graft, abdomen	C
36660	Insertion catheter, artery	C
36822	Insertion of cannula(s)	C
36823	Insertion of cannula(s)	C
37140	Revision of circulation	C
37145	Revision of circulation	C
37160	Revision of circulation	C
37180	Revision of circulation	C
37181	Splice spleen/kidney veins	C
37182	Insert hepatic shunt (tips)	C
37215	Transcath stent, cca w/eps	C
37616	Ligation of chest artery	C
37617	Ligation of abdomen artery	C
37618	Ligation of extremity artery	C
37660	Revision of major vein	C
37788	Revascularization, penis	C
38100	Removal of spleen, total	C
38101	Removal of spleen, partial	C
38102	Removal of spleen, total	C
38115	Repair of ruptured spleen	C
38380	Thoracic duct procedure	C
38381	Thoracic duct procedure	C
38382	Thoracic duct procedure	C
38562	Removal, pelvic lymph nodes	C
38564	Removal, abdomen lymph nodes	C
38724	Removal of lymph nodes, neck	C
38746	Remove thoracic lymph nodes	C
38747	Remove abdominal lymph nodes	C
38765	Remove groin lymph nodes	C
38770	Remove pelvis lymph nodes	C
38780	Remove abdomen lymph nodes	C
39000	Exploration of chest	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
39010	Exploration of chest	C
39200	Removal chest lesion	C
39220	Removal chest lesion	C
39499	Chest procedure	C
39501	Repair diaphragm laceration	C
39502	Repair paraesophageal hernia	C
39503	Repair of diaphragm hernia	C
39520	Repair of diaphragm hernia	C
39530	Repair of diaphragm hernia	C
39531	Repair of diaphragm hernia	C
39540	Repair of diaphragm hernia	C
39541	Repair of diaphragm hernia	C
39545	Revision of diaphragm	C
39560	Resect diaphragm, simple	C
39561	Resect diaphragm, complex	C
39599	Diaphragm surgery procedure	C
41130	Partial removal of tongue	C
41135	Tongue and neck surgery	C
41140	Removal of tongue	C
41145	Tongue removal, neck surgery	C
41150	Tongue, mouth, jaw surgery	C
41153	Tongue, mouth, neck surgery	C
41155	Tongue, jaw, & neck surgery	C
42426	Excise parotid gland/lesion	C
42845	Extensive surgery of throat	C
42894	Revision of pharyngeal walls	C
42953	Repair throat, esophagus	C
42961	Control throat bleeding	C
42971	Control nose/throat bleeding	C
43045	Incision of esophagus	C
43100	Excision of esophagus lesion	C
43101	Excision of esophagus lesion	C
43107	Removal of esophagus	C
43108	Removal of esophagus	C
43112	Removal of esophagus	C
43113	Removal of esophagus	C
43116	Partial removal of esophagus	C
43117	Partial removal of esophagus	C
43118	Partial removal of esophagus	C
43121	Partial removal of esophagus	C
43122	Partial removal of esophagus	C
43123	Partial removal of esophagus	C
43124	Removal of esophagus	C
43135	Removal of esophagus pouch	C
43300	Repair of esophagus	C
43305	Repair esophagus and fistula	C
43310	Repair of esophagus	C
43312	Repair esophagus and fistula	C
43313	Esophagoplasty congenital	C
43314	Tracheo-esophagoplasty cong	C
43320	Fuse esophagus & stomach	C
43324	Revise esophagus & stomach	C
43325	Revise esophagus & stomach	C
43326	Revise esophagus & stomach	C
43330	Repair of esophagus	C
43331	Repair of esophagus	C
43340	Fuse esophagus & intestine	C
43341	Fuse esophagus & intestine	C
43350	Surgical opening, esophagus	C
43351	Surgical opening, esophagus	C
43352	Surgical opening, esophagus	C
43360	Gastrointestinal repair	C
43361	Gastrointestinal repair	C
43400	Ligate esophagus veins	C
43401	Esophagus surgery for veins	C
43405	Ligate/staple esophagus	C
43410	Repair esophagus wound	C
43415	Repair esophagus wound	C
43420	Repair esophagus opening	C
43425	Repair esophagus opening	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
43460	Pressure treatment esophagus	C
43496	Free jejunum flap, microvasc	C
43500	Surgical opening of stomach	C
43501	Surgical repair of stomach	C
43502	Surgical repair of stomach	C
43520	Incision of pyloric muscle	C
43605	Biopsy of stomach	C
43610	Excision of stomach lesion	C
43611	Excision of stomach lesion	C
43620	Removal of stomach	C
43621	Removal of stomach	C
43622	Removal of stomach	C
43631	Removal of stomach, partial	C
43632	Removal of stomach, partial	C
43633	Removal of stomach, partial	C
43634	Removal of stomach, partial	C
43635	Removal of stomach, partial	C
43640	Vagotomy & pylorus repair	C
43641	Vagotomy & pylorus repair	C
43644	Lap gastric bypass/roux-en-y	C
43645	Lap gastr bypass incl smll i	C
43770	Lap, place gastr adjust band	C
43771	Lap, revise adjust gast band	C
43772	Lap, remove adjust gast band	C
43773	Lap, change adjust gast band	C
43774	Lap remov adj gast band/port	C
43800	Reconstruction of pylorus	C
43810	Fusion of stomach and bowel	C
43820	Fusion of stomach and bowel	C
43825	Fusion of stomach and bowel	C
43832	Place gastrostomy tube	C
43840	Repair of stomach lesion	C
43843	Gastroplasty w/o v-band	C
43845	Gastroplasty duodenal switch	C
43846	Gastric bypass for obesity	C
43847	Gastric bypass incl small i	C
43848	Revision gastroplasty	C
43850	Revise stomach-bowel fusion	C
43855	Revise stomach-bowel fusion	C
43860	Revise stomach-bowel fusion	C
43865	Revise stomach-bowel fusion	C
43880	Repair stomach-bowel fistula	C
43881	Impl/redo electrd, antrum	C
43882	Revise/remove electrd antrum	C
44005	Freeing of bowel adhesion	C
44010	Incision of small bowel	C
44015	Insert needle cath bowel	C
44020	Explore small intestine	C
44021	Decompress small bowel	C
44025	Incision of large bowel	C
44050	Reduce bowel obstruction	C
44055	Correct malrotation of bowel	C
44110	Excise intestine lesion(s)	C
44111	Excision of bowel lesion(s)	C
44120	Removal of small intestine	C
44121	Removal of small intestine	C
44125	Removal of small intestine	C
44126	Enterectomy w/o taper, cong	C
44127	Enterectomy w/taper, cong	C
44128	Enterectomy cong, add-on	C
44130	Bowel to bowel fusion	C
44132	Enterectomy, cadaver donor	C
44133	Enterectomy, live donor	C
44135	Intestine transplnt, cadaver	C
44136	Intestine transplant, live	C
44137	Remove intestinal allograft	C
44139	Mobilization of colon	C
44140	Partial removal of colon	C
44141	Partial removal of colon	C
44143	Partial removal of colon	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
44144	Partial removal of colon	C
44145	Partial removal of colon	C
44146	Partial removal of colon	C
44147	Partial removal of colon	C
44150	Removal of colon	C
44151	Removal of colon/ileostomy	C
44155	Removal of colon/ileostomy	C
44156	Removal of colon/ileostomy	C
44157	Colectomy w/ileoanal anast	C
44158	Colectomy w/neo-rectum pouch	C
44160	Removal of colon	C
44187	Lap, ileo/jejuno-stomy	C
44188	Lap, colostomy	C
44202	Lap, enterectomy	C
44203	Lap resect s/intestine, addl	C
44204	Laparo partial colectomy	C
44205	Lap colectomy part w/ileum	C
44210	Laparo total proctocolectomy	C
44211	Lap colectomy w/proctectomy	C
44212	Laparo total proctocolectomy	C
44227	Lap, close enterostomy	C
44300	Open bowel to skin	C
44310	Ileostomy/jejunostomy	C
44314	Revision of ileostomy	C
44316	Devise bowel pouch	C
44320	Colostomy	C
44322	Colostomy with biopsies	C
44345	Revision of colostomy	C
44346	Revision of colostomy	C
44602	Suture, small intestine	C
44603	Suture, small intestine	C
44604	Suture, large intestine	C
44605	Repair of bowel lesion	C
44615	Intestinal stricturoplasty	C
44620	Repair bowel opening	C
44625	Repair bowel opening	C
44626	Repair bowel opening	C
44640	Repair bowel-skin fistula	C
44650	Repair bowel fistula	C
44660	Repair bowel-bladder fistula	C
44661	Repair bowel-bladder fistula	C
44680	Surgical revision, intestine	C
44700	Suspend bowel w/prosthesis	C
44715	Prepare donor intestine	C
44720	Prep donor intestine/venous	C
44721	Prep donor intestine/artery	C
44800	Excision of bowel pouch	C
44820	Excision of mesentery lesion	C
44850	Repair of mesentery	C
44899	Bowel surgery procedure	C
44900	Drain app abscess, open	C
44950	Appendectomy	C
44955	Appendectomy add-on	C
44960	Appendectomy	C
45110	Removal of rectum	C
45111	Partial removal of rectum	C
45112	Removal of rectum	C
45113	Partial proctectomy	C
45114	Partial removal of rectum	C
45116	Partial removal of rectum	C
45119	Remove rectum w/reservoir	C
45120	Removal of rectum	C
45121	Removal of rectum and colon	C
45123	Partial proctectomy	C
45126	Pelvic exenteration	C
45130	Excision of rectal prolapse	C
45135	Excision of rectal prolapse	C
45136	Excise ileoanal reservior	C
45395	Lap, removal of rectum	C
45397	Lap, remove rectum w/pouch	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
45400	Laparoscopic proc	C
45402	Lap proctopexy w/sig resect	C
45540	Correct rectal prolapse	C
45550	Repair rectum/remove sigmoid	C
45562	Exploration/repair of rectum	C
45563	Exploration/repair of rectum	C
45800	Repair rect/bladder fistula	C
45805	Repair fistula w/colostomy	C
45820	Repair rectourethral fistula	C
45825	Repair fistula w/colostomy	C
46705	Repair of anal stricture	C
46710	Repr per/vag pouch sngl proc	C
46712	Repr per/vag pouch dbl proc	C
46715	Rep perf anoper fistu	C
46716	Rep perf anoper/vestib fistu	C
46730	Construction of absent anus	C
46735	Construction of absent anus	C
46740	Construction of absent anus	C
46742	Repair of imperforated anus	C
46744	Repair of cloacal anomaly	C
46746	Repair of cloacal anomaly	C
46748	Repair of cloacal anomaly	C
46751	Repair of anal sphincter	C
47010	Open drainage, liver lesion	C
47015	Inject/aspirate liver cyst	C
47100	Wedge biopsy of liver	C
47120	Partial removal of liver	C
47122	Extensive removal of liver	C
47125	Partial removal of liver	C
47130	Partial removal of liver	C
47133	Removal of donor liver	C
47135	Transplantation of liver	C
47136	Transplantation of liver	C
47140	Partial removal, donor liver	C
47141	Partial removal, donor liver	C
47142	Partial removal, donor liver	C
47143	Prep donor liver, whole	C
47144	Prep donor liver, 3-segment	C
47145	Prep donor liver, lobe split	C
47146	Prep donor liver/venous	C
47147	Prep donor liver/arterial	C
47300	Surgery for liver lesion	C
47350	Repair liver wound	C
47360	Repair liver wound	C
47361	Repair liver wound	C
47362	Repair liver wound	C
47380	Open ablate liver tumor rf	C
47381	Open ablate liver tumor cryo	C
47400	Incision of liver duct	C
47420	Incision of bile duct	C
47425	Incision of bile duct	C
47460	Incise bile duct sphincter	C
47480	Incision of gallbladder	C
47550	Bile duct endoscopy add-on	C
47570	Laparo cholecystoenterostomy	C
47600	Removal of gallbladder	C
47605	Removal of gallbladder	C
47610	Removal of gallbladder	C
47612	Removal of gallbladder	C
47620	Removal of gallbladder	C
47700	Exploration of bile ducts	C
47701	Bile duct revision	C
47711	Excision of bile duct tumor	C
47712	Excision of bile duct tumor	C
47715	Excision of bile duct cyst	C
47719	Fusion of bile duct cyst	C
47720	Fuse gallbladder & bowel	C
47721	Fuse upper gi structures	C
47740	Fuse gallbladder & bowel	C
47741	Fuse gallbladder & bowel	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
47760	Fuse bile ducts and bowel	C
47765	Fuse liver ducts & bowel	C
47780	Fuse bile ducts and bowel	C
47785	Fuse bile ducts and bowel	C
47800	Reconstruction of bile ducts	C
47801	Placement, bile duct support	C
47802	Fuse liver duct & intestine	C
47900	Suture bile duct injury	C
48000	Drainage of abdomen	C
48001	Placement of drain, pancreas	C
48020	Removal of pancreatic stone	C
48100	Biopsy of pancreas, open	C
48105	Resect/debride pancreas	C
48120	Removal of pancreas lesion	C
48140	Partial removal of pancreas	C
48145	Partial removal of pancreas	C
48146	Pancreatectomy	C
48148	Removal of pancreatic duct	C
48150	Partial removal of pancreas	C
48152	Pancreatectomy	C
48153	Pancreatectomy	C
48154	Pancreatectomy	C
48155	Removal of pancreas	C
48400	Injection, intraop add-on	C
48500	Surgery of pancreatic cyst	C
48510	Drain pancreatic pseudocyst	C
48520	Fuse pancreas cyst and bowel	C
48540	Fuse pancreas cyst and bowel	C
48545	Pancreatorrhaphy	C
48547	Duodenal exclusion	C
48548	Fuse pancreas and bowel	C
48551	Prep donor pancreas	C
48552	Prep donor pancreas/venous	C
48554	Transpl allograft pancreas	C
48556	Removal, allograft pancreas	C
49000	Exploration of abdomen	C
49002	Reopening of abdomen	C
49010	Exploration behind abdomen	C
49020	Drain abdominal abscess	C
49040	Drain, open, abdom abscess	C
49060	Drain, open, retrop abscess	C
49062	Drain to peritoneal cavity	C
49201	Remove abdom lesion, complex	C
49215	Excise sacral spine tumor	C
49220	Multiple surgery, abdomen	C
49255	Removal of omentum	C
49425	Insert abdomen-venous drain	C
49428	Ligation of shunt	C
49605	Repair umbilical lesion	C
49606	Repair umbilical lesion	C
49610	Repair umbilical lesion	C
49611	Repair umbilical lesion	C
49900	Repair of abdominal wall	C
49904	Omental flap, extra-abdom	C
49905	Omental flap, intra-abdom	C
49906	Free omental flap, microvasc	C
50010	Exploration of kidney	C
50040	Drainage of kidney	C
50045	Exploration of kidney	C
50060	Removal of kidney stone	C
50065	Incision of kidney	C
50070	Incision of kidney	C
50075	Removal of kidney stone	C
50100	Revise kidney blood vessels	C
50120	Exploration of kidney	C
50125	Explore and drain kidney	C
50130	Removal of kidney stone	C
50135	Exploration of kidney	C
50205	Biopsy of kidney	C
50220	Remove kidney, open	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
50225	Removal kidney open, complex	C
50230	Removal kidney open, radical	C
50234	Removal of kidney & ureter	C
50236	Removal of kidney & ureter	C
50240	Partial removal of kidney	C
50250	Cryoablate renal mass open	C
50280	Removal of kidney lesion	C
50290	Removal of kidney lesion	C
50300	Remove cadaver donor kidney	C
50320	Remove kidney, living donor	C
50323	Prep cadaver renal allograft	C
50325	Prep donor renal graft	C
50327	Prep renal graft/venous	C
50328	Prep renal graft/arterial	C
50329	Prep renal graft/ureteral	C
50340	Removal of kidney	C
50360	Transplantation of kidney	C
50365	Transplantation of kidney	C
50370	Remove transplanted kidney	C
50380	Reimplantation of kidney	C
50400	Revision of kidney/ureter	C
50405	Revision of kidney/ureter	C
50500	Repair of kidney wound	C
50520	Close kidney-skin fistula	C
50525	Repair renal-abdomen fistula	C
50526	Repair renal-abdomen fistula	C
50540	Revision of horseshoe kidney	C
50545	Laparo radical nephrectomy	C
50546	Laparoscopic nephrectomy	C
50547	Laparo removal donor kidney	C
50548	Laparo remove w/ureter	C
50600	Exploration of ureter	C
50605	Insert ureteral support	C
50610	Removal of ureter stone	C
50620	Removal of ureter stone	C
50630	Removal of ureter stone	C
50650	Removal of ureter	C
50660	Removal of ureter	C
50700	Revision of ureter	C
50715	Release of ureter	C
50722	Release of ureter	C
50725	Release/revise ureter	C
50727	Revise ureter	C
50728	Revise ureter	C
50740	Fusion of ureter & kidney	C
50750	Fusion of ureter & kidney	C
50760	Fusion of ureters	C
50770	Splicing of ureters	C
50780	Reimplant ureter in bladder	C
50782	Reimplant ureter in bladder	C
50783	Reimplant ureter in bladder	C
50785	Reimplant ureter in bladder	C
50800	Implant ureter in bowel	C
50810	Fusion of ureter & bowel	C
50815	Urine shunt to intestine	C
50820	Construct bowel bladder	C
50825	Construct bowel bladder	C
50830	Revise urine flow	C
50840	Replace ureter by bowel	C
50845	Appendico-vesicostomy	C
50860	Transplant ureter to skin	C
50900	Repair of ureter	C
50920	Closure ureter/skin fistula	C
50930	Closure ureter/bowel fistula	C
50940	Release of ureter	C
51060	Removal of ureter stone	C
51525	Removal of bladder lesion	C
51530	Removal of bladder lesion	C
51550	Partial removal of bladder	C
51555	Partial removal of bladder	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
51565	Revise bladder & ureter(s)	C
51570	Removal of bladder	C
51575	Removal of bladder & nodes	C
51580	Remove bladder/revise tract	C
51585	Removal of bladder & nodes	C
51590	Remove bladder/revise tract	C
51595	Remove bladder/revise tract	C
51596	Remove bladder/create pouch	C
51597	Removal of pelvic structures	C
51800	Revision of bladder/urethra	C
51820	Revision of urinary tract	C
51840	Attach bladder/urethra	C
51841	Attach bladder/urethra	C
51845	Repair bladder neck	C
51860	Repair of bladder wound	C
51865	Repair of bladder wound	C
51900	Repair bladder/vagina lesion	C
51920	Close bladder-uterus fistula	C
51925	Hysterectomy/bladder repair	C
51940	Correction of bladder defect	C
51960	Revision of bladder & bowel	C
51980	Construct bladder opening	C
53415	Reconstruction of urethra	C
53448	Remov/replc ur sphinctr comp	C
54125	Removal of penis	C
54130	Remove penis & nodes	C
54135	Remove penis & nodes	C
54332	Revise penis/urethra	C
54336	Revise penis/urethra	C
54390	Repair penis and bladder	C
54411	Remov/replc penis pros, comp	C
54417	Remv/replc penis pros, compl	C
54430	Revision of penis	C
54535	Extensive testis surgery	C
54650	Orchiopexy (Fowler-Stephens)	C
55605	Incise sperm duct pouch	C
55650	Remove sperm duct pouch	C
55801	Removal of prostate	C
55810	Extensive prostate surgery	C
55812	Extensive prostate surgery	C
55815	Extensive prostate surgery	C
55821	Removal of prostate	C
55831	Removal of prostate	C
55840	Extensive prostate surgery	C
55842	Extensive prostate surgery	C
55845	Extensive prostate surgery	C
55862	Extensive prostate surgery	C
55865	Extensive prostate surgery	C
55866	Laparo radical prostatectomy	C
56630	Extensive vulva surgery	C
56631	Extensive vulva surgery	C
56632	Extensive vulva surgery	C
56633	Extensive vulva surgery	C
56634	Extensive vulva surgery	C
56637	Extensive vulva surgery	C
56640	Extensive vulva surgery	C
57110	Remove vagina wall, complete	C
57111	Remove vagina tissue, compl	C
57112	Vaginectomy w/nodes, compl	C
57270	Repair of bowel pouch	C
57280	Suspension of vagina	C
57296	Revise vag graft, open abd	C
57305	Repair rectum-vagina fistula	C
57307	Fistula repair & colostomy	C
57308	Fistula repair, transperine	C
57311	Repair urethrovaginal lesion	C
57531	Removal of cervix, radical	C
57540	Removal of residual cervix	C
57545	Remove cervix/repair pelvis	C
58140	Myomectomy abdom method	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
58146	Myomectomy abdom complex	C
58150	Total hysterectomy	C
58152	Total hysterectomy	C
58180	Partial hysterectomy	C
58200	Extensive hysterectomy	C
58210	Extensive hysterectomy	C
58240	Removal of pelvis contents	C
58267	Vag hyst w/urinary repair	C
58275	Hysterectomy/revise vagina	C
58280	Hysterectomy/revise vagina	C
58285	Extensive hysterectomy	C
58293	Vag hyst w/uro repair, compl	C
58400	Suspension of uterus	C
58410	Suspension of uterus	C
58520	Repair of ruptured uterus	C
58540	Revision of uterus	C
58548	Lap radical hyst	C
58605	Division of fallopian tube	C
58611	Ligate oviduct(s) add-on	C
58700	Removal of fallopian tube	C
58720	Removal of ovary/tube(s)	C
58740	Revise fallopian tube(s)	C
58750	Repair oviduct	C
58752	Revise ovarian tube(s)	C
58760	Remove tubal obstruction	C
58822	Drain ovary abscess, percut	C
58825	Transposition, ovary(s)	C
58940	Removal of ovary(s)	C
58943	Removal of ovary(s)	C
58950	Resect ovarian malignancy	C
58951	Resect ovarian malignancy	C
58952	Resect ovarian malignancy	C
58953	Tah, rad dissect for debulk	C
58954	Tah rad debulk/lymph remove	C
58956	Bso, omentectomy w/tah	C
58957	Resect recurrent gyn mal	C
58958	Resect recur gyn mal w/lym	C
58960	Exploration of abdomen	C
59120	Treat ectopic pregnancy	C
59121	Treat ectopic pregnancy	C
59130	Treat ectopic pregnancy	C
59135	Treat ectopic pregnancy	C
59136	Treat ectopic pregnancy	C
59140	Treat ectopic pregnancy	C
59325	Revision of cervix	C
59350	Repair of uterus	C
59514	Cesarean delivery only	C
59525	Remove uterus after cesarean	C
59620	Attempted vbac delivery only	C
59830	Treat uterus infection	C
59850	Abortion	C
59851	Abortion	C
59852	Abortion	C
59855	Abortion	C
59856	Abortion	C
59857	Abortion	C
60254	Extensive thyroid surgery	C
60270	Removal of thyroid	C
60505	Explore parathyroid glands	C
60521	Removal of thymus gland	C
60522	Removal of thymus gland	C
60540	Explore adrenal gland	C
60545	Explore adrenal gland	C
60600	Remove carotid body lesion	C
60605	Remove carotid body lesion	C
60650	Laparoscopy adrenalectomy	C
61105	Twist drill hole	C
61107	Drill skull for implantation	C
61108	Drill skull for drainage	C
61120	Burr hole for puncture	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
61140	Pierce skull for biopsy	C
61150	Pierce skull for drainage	C
61151	Pierce skull for drainage	C
61154	Pierce skull & remove clot	C
61156	Pierce skull for drainage	C
61210	Pierce skull, implant device	C
61250	Pierce skull & explore	C
61253	Pierce skull & explore	C
61304	Open skull for exploration	C
61305	Open skull for exploration	C
61312	Open skull for drainage	C
61313	Open skull for drainage	C
61314	Open skull for drainage	C
61315	Open skull for drainage	C
61316	Implt cran bone flap to abdo	C
61320	Open skull for drainage	C
61321	Open skull for drainage	C
61322	Decompressive craniotomy	C
61323	Decompressive lobectomy	C
61332	Explore/biopsy eye socket	C
61333	Explore orbit/remove lesion	C
61340	Subtemporal decompression	C
61343	Incise skull (press relief)	C
61345	Relieve cranial pressure	C
61440	Incise skull for surgery	C
61450	Incise skull for surgery	C
61458	Incise skull for brain wound	C
61460	Incise skull for surgery	C
61470	Incise skull for surgery	C
61480	Incise skull for surgery	C
61490	Incise skull for surgery	C
61500	Removal of skull lesion	C
61501	Remove infected skull bone	C
61510	Removal of brain lesion	C
61512	Remove brain lining lesion	C
61514	Removal of brain abscess	C
61516	Removal of brain lesion	C
61517	Implt brain chemotx add-on	C
61518	Removal of brain lesion	C
61519	Remove brain lining lesion	C
61520	Removal of brain lesion	C
61521	Removal of brain lesion	C
61522	Removal of brain abscess	C
61524	Removal of brain lesion	C
61526	Removal of brain lesion	C
61530	Removal of brain lesion	C
61531	Implant brain electrodes	C
61533	Implant brain electrodes	C
61534	Removal of brain lesion	C
61535	Remove brain electrodes	C
61536	Removal of brain lesion	C
61537	Removal of brain tissue	C
61538	Removal of brain tissue	C
61539	Removal of brain tissue	C
61540	Removal of brain tissue	C
61541	Incision of brain tissue	C
61542	Removal of brain tissue	C
61543	Removal of brain tissue	C
61544	Remove & treat brain lesion	C
61545	Excision of brain tumor	C
61546	Removal of pituitary gland	C
61548	Removal of pituitary gland	C
61550	Release of skull seams	C
61552	Release of skull seams	C
61556	Incise skull/sutures	C
61557	Incise skull/sutures	C
61558	Excision of skull/sutures	C
61559	Excision of skull/sutures	C
61563	Excision of skull tumor	C
61564	Excision of skull tumor	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
61566	Removal of brain tissue	C
61567	Incision of brain tissue	C
61570	Remove foreign body, brain	C
61571	Incise skull for brain wound	C
61575	Skull base/brainstem surgery	C
61576	Skull base/brainstem surgery	C
61580	Craniofacial approach, skull	C
61581	Craniofacial approach, skull	C
61582	Craniofacial approach, skull	C
61583	Craniofacial approach, skull	C
61584	Orbitocranial approach/skull	C
61585	Orbitocranial approach/skull	C
61586	Resect nasopharynx, skull	C
61590	Infratemporal approach/skull	C
61591	Infratemporal approach/skull	C
61592	Orbitocranial approach/skull	C
61595	Transtemporal approach/skull	C
61596	Transcochlear approach/skull	C
61597	Transcondylar approach/skull	C
61598	Transpetrosal approach/skull	C
61600	Resect/excise cranial lesion	C
61601	Resect/excise cranial lesion	C
61605	Resect/excise cranial lesion	C
61606	Resect/excise cranial lesion	C
61607	Resect/excise cranial lesion	C
61608	Resect/excise cranial lesion	C
61609	Transect artery, sinus	C
61610	Transect artery, sinus	C
61611	Transect artery, sinus	C
61612	Transect artery, sinus	C
61613	Remove aneurysm, sinus	C
61615	Resect/excise lesion, skull	C
61616	Resect/excise lesion, skull	C
61618	Repair dura	C
61619	Repair dura	C
61624	Transcath occlusion, cns	C
61680	Intracranial vessel surgery	C
61682	Intracranial vessel surgery	C
61684	Intracranial vessel surgery	C
61686	Intracranial vessel surgery	C
61690	Intracranial vessel surgery	C
61692	Intracranial vessel surgery	C
61697	Brain aneurysm repr, complx	C
61698	Brain aneurysm repr, complx	C
61700	Brain aneurysm repr, simple	C
61702	Inner skull vessel surgery	C
61703	Clamp neck artery	C
61705	Revise circulation to head	C
61708	Revise circulation to head	C
61710	Revise circulation to head	C
61711	Fusion of skull arteries	C
61735	Incise skull/brain surgery	C
61750	Incise skull/brain biopsy	C
61751	Brain biopsy w/ct/mr guide	C
61760	Implant brain electrodes	C
61850	Implant neuroelectrodes	C
61860	Implant neuroelectrodes	C
61863	Implant neuroelectrode	C
61864	Implant neuroelectrde, addl	C
61867	Implant neuroelectrode	C
61868	Implant neuroelectrde, add'l	C
61870	Implant neuroelectrodes	C
61875	Implant neuroelectrodes	C
62005	Treat skull fracture	C
62010	Treatment of head injury	C
62100	Repair brain fluid leakage	C
62115	Reduction of skull defect	C
62116	Reduction of skull defect	C
62117	Reduction of skull defect	C
62120	Repair skull cavity lesion	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
62121	Incise skull repair	C
62140	Repair of skull defect	C
62141	Repair of skull defect	C
62142	Remove skull plate/flap	C
62143	Replace skull plate/flap	C
62145	Repair of skull & brain	C
62146	Repair of skull with graft	C
62147	Repair of skull with graft	C
62148	Retr bone flap to fix skull	C
62161	Dissect brain w/scope	C
62162	Remove colloid cyst w/scope	C
62163	Neuroendoscopy w/fb removal	C
62164	Remove brain tumor w/scope	C
62165	Remove pituit tumor w/scope	C
62180	Establish brain cavity shunt	C
62190	Establish brain cavity shunt	C
62192	Establish brain cavity shunt	C
62200	Establish brain cavity shunt	C
62201	Brain cavity shunt w/scope	C
62220	Establish brain cavity shunt	C
62223	Establish brain cavity shunt	C
62256	Remove brain cavity shunt	C
62258	Replace brain cavity shunt	C
63043	Laminotomy, add'l cervical	C
63044	Laminotomy, add'l lumbar	C
63050	Cervical laminoplasty	C
63051	C-laminoplasty w/graft/plate	C
63076	Neck spine disk surgery	C
63077	Spine disk surgery, thorax	C
63078	Spine disk surgery, thorax	C
63081	Removal of vertebral body	C
63082	Remove vertebral body add-on	C
63085	Removal of vertebral body	C
63086	Remove vertebral body add-on	C
63087	Removal of vertebral body	C
63088	Remove vertebral body add-on	C
63090	Removal of vertebral body	C
63091	Remove vertebral body add-on	C
63101	Removal of vertebral body	C
63102	Removal of vertebral body	C
63103	Remove vertebral body add-on	C
63170	Incise spinal cord tract(s)	C
63172	Drainage of spinal cyst	C
63173	Drainage of spinal cyst	C
63180	Revise spinal cord ligaments	C
63182	Revise spinal cord ligaments	C
63185	Incise spinal column/nerves	C
63190	Incise spinal column/nerves	C
63191	Incise spinal column/nerves	C
63194	Incise spinal column & cord	C
63195	Incise spinal column & cord	C
63196	Incise spinal column & cord	C
63197	Incise spinal column & cord	C
63198	Incise spinal column & cord	C
63199	Incise spinal column & cord	C
63200	Release of spinal cord	C
63250	Revise spinal cord vessels	C
63251	Revise spinal cord vessels	C
63252	Revise spinal cord vessels	C
63265	Excise intraspinal lesion	C
63266	Excise intraspinal lesion	C
63267	Excise intraspinal lesion	C
63268	Excise intraspinal lesion	C
63270	Excise intraspinal lesion	C
63271	Excise intraspinal lesion	C
63272	Excise intraspinal lesion	C
63273	Excise intraspinal lesion	C
63275	Biopsy/excise spinal tumor	C
63276	Biopsy/excise spinal tumor	C
63277	Biopsy/excise spinal tumor	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
63278	Biopsy/excise spinal tumor	C
63280	Biopsy/excise spinal tumor	C
63281	Biopsy/excise spinal tumor	C
63282	Biopsy/excise spinal tumor	C
63283	Biopsy/excise spinal tumor	C
63285	Biopsy/excise spinal tumor	C
63286	Biopsy/excise spinal tumor	C
63287	Biopsy/excise spinal tumor	C
63290	Biopsy/excise spinal tumor	C
63295	Repair of laminectomy defect	C
63300	Removal of vertebral body	C
63301	Removal of vertebral body	C
63302	Removal of vertebral body	C
63303	Removal of vertebral body	C
63304	Removal of vertebral body	C
63305	Removal of vertebral body	C
63306	Removal of vertebral body	C
63307	Removal of vertebral body	C
63308	Remove vertebral body add-on	C
63700	Repair of spinal herniation	C
63702	Repair of spinal herniation	C
63704	Repair of spinal herniation	C
63706	Repair of spinal herniation	C
63707	Repair spinal fluid leakage	C
63709	Repair spinal fluid leakage	C
63710	Graft repair of spine defect	C
63740	Install spinal shunt	C
64752	Incision of vagus nerve	C
64755	Incision of stomach nerves	C
64760	Incision of vagus nerve	C
64809	Remove sympathetic nerves	C
64818	Remove sympathetic nerves	C
64866	Fusion of facial/other nerve	C
64868	Fusion of facial/other nerve	C
65273	Repair of eye wound	C
69155	Extensive ear/neck surgery	C
69535	Remove part of temporal bone	C
69554	Remove ear lesion	C
69950	Incise inner ear nerve	C
75900	Intravascular cath exchange	C
75952	Endovasc repair abdom aorta	C
75953	Abdom aneurysm endovas rpr	C
75954	Iliac aneurysm endovas rpr	C
75956	Xray, endovasc thor ao repr	C
75957	Xray, endovasc thor ao repr	C
75958	Xray, place prox ext thor ao	C
75959	Xray, place dist ext thor ao	C
92970	Cardioassist, internal	C
92971	Cardioassist, external	C
92975	Dissolve clot, heart vessel	C
92992	Revision of heart chamber	C
92993	Revision of heart chamber	C
99190	Special pump services	C
99191	Special pump services	C
99192	Special pump services	C
99251	Inpatient consultation	C
99252	Inpatient consultation	C
99253	Inpatient consultation	C
99254	Inpatient consultation	C
99255	Inpatient consultation	C
99293	Ped critical care, initial	C
99294	Ped critical care, subseq	C
99295	Neonate crit care, initial	C
99296	Neonate critical care subseq	C
99298	Ic for lbw infant < 1500 gm	C
99299	Ic, lbw infant 1500-2500 gm	C
99356	Prolonged service, inpatient	C
99357	Prolonged service, inpatient	C
99433	Normal newborn care/hospital	C
0024T	Transcath cardiac reduction	C

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLYAS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI
0048T	Implant ventricular device	C
0049T	External circulation assist	C
0050T	Removal circulation assist	C
0051T	Implant total heart system	C
0052T	Replace component heart syst	C
0053T	Replace component heart syst	C
0075T	Perq stent/chest vert art	C
0076T	S&i stent/chest vert art	C
0077T	Cereb therm perfusion probe	C
0078T	Endovasc aort repr w/device	C
0079T	Endovasc visc extnsn repr	C
0080T	Endovasc aort repr rad s&i	C
0081T	Endovasc visc extnsn s&i	C
0090T	Cervical artific disc	C
0092T	Artific disc addl	C
0093T	Cervical artific diskectomy	C
0095T	Artific diskectomy addl	C
0096T	Rev cervical artific disc	C
0098T	Rev artific disc addl	C
0153T	Tcath sensor aneurysm sac	C
0157T	Open impl gast curve electrd	C
0158T	Open remv gast curve electrd	C
0163T	Lumb artif diskectomy addl	C
0164T	Remove lumb artif disc addl	C
0165T	Revise lumb artif disc addl	C
0166T	Tcath vsd close w/o bypass	C
0167T	Tcath vsd close w bypass	C
0169T	Place stereo cath brain	C
G0341	Percutaneous islet celltrans	C
G0342	Laparoscopy islet cell trans	C
G0343	Laparotomy islet cell transp	C

ADDENDUM L.—PROPOSED OUT-MIGRATION ADJUSTMENT

Provider No.	Out-Migration adjustment	Qualifying county name
010005	0.0322	MARSHALL
010008	0.0245	CRENSHAW
010009	0.0092	MORGAN
010010	0.0322	MARSHALL
010012	0.0182	DE KALB
010015	0.0043	CLARKE
010022	0.1106	CHEROKEE
010025	0.0235	CHAMBERS
010029	0.0281	LEE
010032	0.0320	RANDOLPH
010035	0.0263	CULLMAN
010038	0.0039	CALHOUN
010045	0.0216	FAYETTE
010047	0.0178	BUTLER
010052	0.0103	TALLAPOOSA
010054	0.0092	MORGAN
010061	0.0566	JACKSON
010065	0.0103	TALLAPOOSA
010078	0.0039	CALHOUN
010083	0.0125	BALDWIN
010085	0.0092	MORGAN
010091	0.0043	CLARKE
010100	0.0125	BALDWIN
010101	0.0209	TALLADEGA
010109	0.0451	PICKENS
010110	0.0302	BULLOCK
010125	0.0471	WINSTON
010128	0.0043	CLARKE
010129	0.0125	BALDWIN
010138	0.0113	SUMTER
010143	0.0263	CULLMAN
010146	0.0039	CALHOUN
010150	0.0178	BUTLER
010158	0.0067	FRANKLIN
010164	0.0209	TALLADEGA
013027	0.0125	BALDWIN
030040	0.0012	SANTA CRUZ
030067	0.0230	LAPAZ
040014	0.0163	WHITE
040019	0.0254	ST. FRANCIS
040039	0.0172	GREENE
040047	0.0117	RANDOLPH
040067	0.0008	COLUMBIA
040071	0.0149	JEFFERSON
040076	0.1001	HOT SPRING
040081	0.0358	PIKE
040100	0.0163	WHITE
050002	0.0009	ALAMEDA
050007	0.0141	SAN MATEO
050008	0.0026	SAN FRANCISCO
050009	0.0196	NAPA
050013	0.0196	NAPA
050014	0.0147	AMADOR
050016	0.0103	SAN LUIS OBISPO
050042	0.0184	TEHAMA
050043	0.0009	ALAMEDA
050047	0.0026	SAN FRANCISCO
050055	0.0026	SAN FRANCISCO
050069	0.0006	ORANGE
050070	0.0141	SAN MATEO
050073	0.0169	SOLANO
050075	0.0009	ALAMEDA
050076	0.0026	SAN FRANCISCO
050084	0.0135	SAN JOAQUIN
050089	0.0005	SAN BERNARDINO
050090	0.0085	SONOMA
050099	0.0005	SAN BERNARDINO
050101	0.0169	SOLANO
050113	0.0141	SAN MATEO
050118	0.0135	SAN JOAQUIN
050122	0.0135	SAN JOAQUIN

ADDENDUM L.—PROPOSED OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Out-Migration adjustment	Qualifying county name
050129	0.0005	SAN BERNARDINO
050133	0.0186	YUBA
050136	0.0085	SONOMA
050140	0.0005	SAN BERNARDINO
050150	0.0357	NEVADA
050152	0.0026	SAN FRANCISCO
050167	0.0135	SAN JOAQUIN
050168	0.0006	ORANGE
050173	0.0006	ORANGE
050174	0.0085	SONOMA
050193	0.0006	ORANGE
050194	0.0052	SANTA CRUZ
050195	0.0009	ALAMEDA
050197	0.0141	SAN MATEO
050211	0.0009	ALAMEDA
050224	0.0006	ORANGE
050226	0.0006	ORANGE
050228	0.0026	SAN FRANCISCO
050230	0.0006	ORANGE
050232	0.0103	SAN LUIS OBISPO
050242	0.0052	SANTA CRUZ
050245	0.0005	SAN BERNARDINO
050264	0.0009	ALAMEDA
050272	0.0005	SAN BERNARDINO
050279	0.0005	SAN BERNARDINO
050283	0.0009	ALAMEDA
050289	0.0141	SAN MATEO
050291	0.0085	SONOMA
050298	0.0005	SAN BERNARDINO
050300	0.0005	SAN BERNARDINO
050305	0.0009	ALAMEDA
050313	0.0135	SAN JOAQUIN
050320	0.0009	ALAMEDA
050325	0.0046	TUOLUMNE
050327	0.0005	SAN BERNARDINO
050335	0.0046	TUOLUMNE
050336	0.0135	SAN JOAQUIN
050348	0.0006	ORANGE
050366	0.0025	CALAVERAS
050367	0.0169	SOLANO
050385	0.0085	SONOMA
050407	0.0026	SAN FRANCISCO
050426	0.0006	ORANGE
050444	0.0229	MERCED
050454	0.0026	SAN FRANCISCO
050457	0.0026	SAN FRANCISCO
050476	0.0275	LAKE
050488	0.0009	ALAMEDA
050494	0.0357	NEVADA
050506	0.0103	SAN LUIS OBISPO
050512	0.0009	ALAMEDA
050517	0.0005	SAN BERNARDINO
050526	0.0006	ORANGE
050528	0.0229	MERCED
050541	0.0141	SAN MATEO
050543	0.0006	ORANGE
050547	0.0085	SONOMA
050548	0.0006	ORANGE
050551	0.0006	ORANGE
050567	0.0006	ORANGE
050570	0.0006	ORANGE
050580	0.0006	ORANGE
050584	0.0005	SAN BERNARDINO
050586	0.0005	SAN BERNARDINO
050589	0.0006	ORANGE
050603	0.0006	ORANGE
050609	0.0006	ORANGE
050618	0.0005	SAN BERNARDINO
050633	0.0103	SAN LUIS OBISPO
050667	0.0196	NAPA
050668	0.0026	SAN FRANCISCO

ADDENDUM L.—PROPOSED OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Out-Migration adjustment	Qualifying county name
050678	0.0006	ORANGE
050680	0.0169	SOLANO
050690	0.0085	SONOMA
050693	0.0006	ORANGE
050707	0.0141	SAN MATEO
050714	0.0052	SANTA CRUZ
050720	0.0006	ORANGE
050744	0.0006	ORANGE
050745	0.0006	ORANGE
050746	0.0006	ORANGE
050747	0.0006	ORANGE
050748	0.0135	SAN JOAQUIN
050754	0.0141	SAN MATEO
050756	0.0005	SAN BERNARDINO
052034	0.0009	ALAMEDA
052035	0.0006	ORANGE
052037	0.0005	SAN BERNARDINO
052039	0.0006	ORANGE
053034	0.0006	ORANGE
053037	0.0005	SAN BERNARDINO
053301	0.0009	ALAMEDA
053304	0.0006	ORANGE
054074	0.0169	SOLANO
054093	0.0005	SAN BERNARDINO
054110	0.0009	ALAMEDA
054111	0.0005	SAN BERNARDINO
054122	0.0196	NAPA
054123	0.0135	SAN JOAQUIN
060001	0.0045	WELD
060003	0.0075	BOULDER
060010	0.0153	LARIMER
060027	0.0075	BOULDER
060030	0.0153	LARIMER
060103	0.0075	BOULDER
060116	0.0075	BOULDER
064007	0.0075	BOULDER
080001	0.0063	NEW CASTLE
080003	0.0063	NEW CASTLE
083300	0.0063	NEW CASTLE
084002	0.0063	NEW CASTLE
100014	0.0059	VOLUSIA
100017	0.0059	VOLUSIA
100045	0.0059	VOLUSIA
100047	0.0026	CHARLOTTE
100068	0.0059	VOLUSIA
100072	0.0059	VOLUSIA
100077	0.0026	CHARLOTTE
100102	0.0125	COLUMBIA
100118	0.0179	FLAGLER
100156	0.0125	COLUMBIA
100232	0.0057	PUTNAM
100236	0.0026	CHARLOTTE
100252	0.0146	OKEECHOBEE
100290	0.0582	SUMTER
110023	0.0416	GORDON
110029	0.0056	HALL
110040	0.1727	JACKSON
110041	0.0624	HABERSHAM
110100	0.0789	JEFFERSON
110101	0.0067	COOK
110142	0.0202	EVANS
110146	0.0805	CAMDEN
110150	0.0227	BALDWIN
110187	0.0643	LUMPKIN
110190	0.0242	MACON
110205	0.0514	GILMER
130024	0.0422	BONNER
130049	0.0320	KOOTENAI
130066	0.0320	KOOTENAI
130067	0.0696	BINGHAM
130068	0.0320	KOOTENAI

ADDENDUM L.—PROPOSED OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Out-Migration adjustment	Qualifying county name
140001	0.0362	FULTON
140026	0.0288	LA SALLE
140043	0.0055	WHITESIDE
140058	0.0125	MORGAN
140110	0.0288	LA SALLE
140160	0.0302	STEPHENSON
140161	0.0193	LIVINGSTON
140167	0.1055	IROQUOIS
140234	0.0288	LA SALLE
150006	0.0113	LA PORTE
150015	0.0113	LA PORTE
150022	0.0151	MONTGOMERY
150030	0.0186	HENRY
150072	0.0101	CASS
150076	0.0210	MARSHALL
150088	0.0111	MADISON
150091	0.0047	HUNTINGTON
150102	0.0103	STARKE
150113	0.0111	MADISON
150133	0.0167	KOSCIUSKO
150146	0.0319	NOBLE
154014	0.0167	KOSCIUSKO
160013	0.0179	MUSCATINE
160030	0.0040	STORY
160032	0.0235	JASPER
160080	0.0066	CLINTON
170137	0.0336	DOUGLAS
170150	0.0176	COWLEY
180012	0.0081	HARDIN
180017	0.0035	BARREN
180049	0.0497	MADISON
180064	0.0319	MONTGOMERY
180066	0.0449	LOGAN
180070	0.0240	GRAYSON
180079	0.0263	HARRISON
183028	0.0081	HARDIN
190003	0.0085	IBERIA
190015	0.0231	TANGIPAHOA
190017	0.0184	ST. LANDRY
190034	0.0188	VERMILION
190044	0.0258	ACADIA
190050	0.0044	BEAUREGARD
190053	0.0100	JEFFRSON DAVIS
190054	0.0085	IBERIA
190078	0.0184	ST. LANDRY
190086	0.0050	LINCOLN
190088	0.0410	WEBSTER
190099	0.0188	AVOYELLES
190106	0.0101	ALLEN
190116	0.0084	MOREHOUSE
190133	0.0101	ALLEN
190140	0.0034	FRANKLIN
190144	0.0410	WEBSTER
190145	0.0090	LA SALLE
190184	0.0161	CALDWELL
190190	0.0161	CALDWELL
190191	0.0184	ST. LANDRY
190246	0.0161	CALDWELL
190257	0.0050	LINCOLN
192022	0.005	LINCOLN
193044	0.0231	TANGIPAHOA
193047	0.0188	VERMILION
193069	0.0084	MOREHOUSE
200024	0.0092	ANDROSCOGGIN
200032	0.0466	OXFORD
200034	0.0092	ANDROSCOGGIN
200050	0.0223	HANCOCK
210001	0.0184	WASHINGTON
210023	0.0070	ANNE ARUNDEL
210028	0.0512	ST. MARYS
210043	0.0070	ANNE ARUNDEL

ADDENDUM L.—PROPOSED OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Out-Migration adjustment	Qualifying county name
220002	0.0235	MIDDLESEX
220010	0.0461	ESSEX
220011	0.0235	MIDDLESEX
220029	0.0461	ESSEX
220033	0.0461	ESSEX
220035	0.0461	ESSEX
220049	0.0235	MIDDLESEX
220063	0.0235	MIDDLESEX
220070	0.0235	MIDDLESEX
220080	0.0461	ESSEX
220082	0.0235	MIDDLESEX
220084	0.0235	MIDDLESEX
220098	0.0235	MIDDLESEX
220101	0.0235	MIDDLESEX
220105	0.0235	MIDDLESEX
220171	0.0235	MIDDLESEX
220174	0.0461	ESSEX
222000	0.0235	MIDDLESEX
222026	0.0461	ESSEX
222044	0.0461	ESSEX
223026	0.0235	MIDDLESEX
224007	0.0235	MIDDLESEX
224022	0.0235	MIDDLESEX
224038	0.0235	MIDDLESEX
230003	0.0217	OTTAWA
230005	0.0473	LENAWEE
230013	0.0023	OAKLAND
230015	0.0297	ST. JOSEPH
230019	0.0023	OAKLAND
230021	0.0099	BERRIEN
230022	0.0212	BRANCH
230029	0.0023	OAKLAND
230035	0.0096	MONTCALM
230037	0.0211	HILLSDALE
230047	0.0018	MACOMB
230069	0.0209	LIVINGSTON
230071	0.0023	OAKLAND
230072	0.0217	OTTAWA
230075	0.0048	CALHOUN
230078	0.0099	BERRIEN
230092	0.0221	JACKSON
230093	0.0060	MECOSTA
230096	0.0297	ST. JOSEPH
230099	0.0230	MONROE
230121	0.0695	SHIAWASSEE
230130	0.0023	OAKLAND
230151	0.0023	OAKLAND
230174	0.0217	OTTAWA
230195	0.0018	MACOMB
230204	0.0018	MACOMB
230207	0.0023	OAKLAND
230208	0.0096	MONTCALM
230217	0.0048	CALHOUN
230222	0.0037	MIDLAND
230223	0.0023	OAKLAND
230227	0.0018	MACOMB
230254	0.0023	OAKLAND
230257	0.0018	MACOMB
230264	0.0018	MACOMB
230269	0.0023	OAKLAND
230277	0.0023	OAKLAND
230279	0.0209	LIVINGSTON
232023	0.0018	MACOMB
232025	0.0099	BERRIEN
232030	0.0023	OAKLAND
233025	0.0048	CALHOUN
234011	0.0023	OAKLAND
234021	0.0018	MACOMB
234023	0.0023	OAKLAND
240018	0.0872	GOODHUE
240044	0.0671	WINONA

ADDENDUM L.—PROPOSED OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Out-Migration adjustment	Qualifying county name
240064	0.0130	ITASCA
240069	0.0301	STEELE
240071	0.0377	RICE
240117	0.0593	MOWER
240211	0.0386	PINE
250023	0.0430	PEARL RIVER
250040	0.0022	JACKSON
250117	0.0430	PEARL RIVER
250128	0.0393	PANOLA
250160	0.0393	PANOLA
260059	0.0127	LACLEDE
260064	0.0092	AUDRAIN
260097	0.0295	JOHNSON
270081	0.0237	MUSSELSHELL
280077	0.0057	DODGE
280123	0.0118	GAGE
290002	0.0280	LYON
300011	0.0069	HILLSBOROUGH
300012	0.0069	HILLSBOROUGH
300020	0.0069	HILLSBOROUGH
300034	0.0069	HILLSBOROUGH
310002	0.0264	ESSEX
310009	0.0264	ESSEX
310010	0.0092	MERCER
310011	0.0115	CAPE MAY
310013	0.0264	ESSEX
310018	0.0264	ESSEX
310021	0.0092	MERCER
310031	0.0130	BURLINGTON
310032	0.0027	CUMBERLAND
310038	0.0368	MIDDLESEX
310039	0.0368	MIDDLESEX
310044	0.0092	MERCER
310054	0.0264	ESSEX
310057	0.0130	BURLINGTON
310061	0.0130	BURLINGTON
310070	0.0368	MIDDLESEX
310076	0.0264	ESSEX
310083	0.0264	ESSEX
310092	0.0092	MERCER
310093	0.0264	ESSEX
310096	0.0264	ESSEX
310108	0.0368	MIDDLESEX
310110	0.0092	MERCER
310119	0.0264	ESSEX
310127	0.0130	BURLINGTON
313025	0.0264	ESSEX
313027	0.0092	MERCER
313032	0.013B	URLINGTON
313036	0.0027	CUMBERLAND
314011	0.0368	MIDDLESEX
314021	0.013B	URLINGTON
320003	0.0629	SAN MIGUEL
320011	0.0442	RIO ARRIBA
320018	0.0025	DONA ANA
320085	0.0025	DONA ANA
330004	0.0615	ULSTER
330008	0.0102	WYOMING
330010	0.0042	MONTGOMERY
330027	0.0149	NASSAU
330033	0.0205	CHENANGO
330047	0.0042	MONTGOMERY
330073	0.0122	GENESEE
330094	0.0463	COLUMBIA
330103	0.0121	CATTARAUGUS
330106	0.0149	NASSAU
330126	0.0675	ORANGE
330132	0.0121	CATTARAUGUS
330135	0.0675	ORANGE
330167	0.0149	NASSAU
330175	0.0241	CORTLAND

ADDENDUM L.—PROPOSED OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Out-Migration adjustment	Qualifying county name
330181	0.0149	NASSAU
330182	0.0149	NASSAU
330191	0.0017	WARREN
330198	0.0149	NASSAU
330205	0.0675	ORANGE
330224	0.0615	ULSTER
330225	0.0149	NASSAU
330235	0.0281	CAYUGA
330259	0.0149	NASSAU
330264	0.0675	ORANGE
330331	0.0149	NASSAU
330332	0.0149	NASSAU
330372	0.0149	NASSAU
330386	0.0687	SULLIVAN
340020	0.0143	LEE
340021	0.0162	CLEVELAND
340024	0.0171	SAMPSON
340027	0.0125	LENOIR
340037	0.0162	CLEVELAND
340038	0.0253	BEAUFORT
340039	0.0101	IREDELL
340068	0.0094	COLUMBUS
340069	0.0083	WAKE
340070	0.0417	ALAMANCE
340071	0.0168	HARNETT
340073	0.0083	WAKE
340085	0.0250	DAVIDSON
340096	0.0250	DAVIDSON
340104	0.0162	CLEVELAND
340114	0.0083	WAKE
340124	0.0168	HARNETT
340126	0.0084	WILSON
340129	0.0101	IREDELL
340133	0.0242	MARTIN
340138	0.0083	WAKE
340144	0.0101	IREDELL
340145	0.0337	LINCOLN
340151	0.0053	HALIFAX
340173	0.0083	WAKE
344014	0.0083	WAKE
360002	0.0142	ASHLAND
360010	0.0076	TUSCARAWAS
360013	0.0136	SHELBY
360025	0.0072	ERIE
360036	0.0168	WAYNE
360040	0.0392	KNOX
360044	0.0124	DARKE
360065	0.0077	HURON
360071	0.0035	VAN WERT
360086	0.0187	CLARK
360096	0.0072	COLUMBIANA
360107	0.0095	SANDUSKY
360125	0.0137	ASHTABULA
360156	0.0095	SANDUSKY
360175	0.0176	CLINTON
360185	0.0072	COLUMBIANA
360187	0.0187	CLARK
360245	0.0137	ASHTABULA
362007	0.0095	SANDUSKY
370014	0.0363	BRYAN
370015	0.0369	MAYES
370023	0.0090	STEPHENS
370065	0.0097	CRAIG
370072	0.0260	LATIMER
370083	0.0051	PUSHMATAHA
370100	0.0101	CHOCTAW
370149	0.0292	POTTAWATOMIE
370156	0.0122	GARVIN
370169	0.0164	MCINTOSH
370172	0.0260	LATIMER
370214	0.0122	GARVIN

ADDENDUM L.—PROPOSED OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Out-Migration adjustment	Qualifying county name
380022	0.0068	LINN
380029	0.0075	MARION
380051	0.0075	MARION
380056	0.0075	MARION
390008	0.0055	LAWRENCE
390016	0.0055	LAWRENCE
390030	0.0284	SCHUYLKILL
390031	0.0284	SCHUYLKILL
390044	0.0191	BERKS
390052	0.0044	CLEARFIELD
390065	0.0490	ADAMS
390066	0.0364	LEBANON
390086	0.0044	CLEARFIELD
390096	0.0191	BERKS
390113	0.0049	CRAWFORD
390122	0.0049	CRAWFORD
390138	0.0213	FRANKLIN
390146	0.0019	WARREN
390150	0.0019	GREENE
390151	0.0213	FRANKLIN
390162	0.0200	NORTHAMPTON
390181	0.0284	SCHUYLKILL
390183	0.0284	SCHUYLKILL
390201	0.1091	MONROE
390313	0.0284	SCHUYLKILL
393026	0.0191	BERKS
394020	0.0364	LEBANON
420007	0.0037	SPARTANBURG
420009	0.0113	OCONEE
420019	0.0142	CHESTER
420027	0.0145	ANDERSON
420030	0.0051	COLLETON
420039	0.0153	UNION
420043	0.0132	CHEROKEE
420062	0.0109	CHESTERFIELD
420069	0.0023	CLARENDON
420083	0.0037	SPARTANBURG
422004	0.0142	CHESTER
423029	0.0145	ANDERSON
430008	0.0537	BROOKINGS
430048	0.0055	LAWRENCE
430094	0.0055	LAWRENCE
440007	0.0226	COFFEE
440008	0.0449	HENDERSON
440016	0.0144	CARROLL
440024	0.0230	BRADLEY
440030	0.0056	HAMBLEN
440031	0.0025	ROANE
440033	0.0036	CAMPBELL
440035	0.0309	MONTGOMERY
440047	0.0338	GIBSON
440051	0.0071	MC NAIRY
440057	0.0028	CLAIBORNE
440060	0.0338	GIBSON
440067	0.0056	HAMBLEN
440070	0.0109	DECATUR
440081	0.0069	SEVIER
440084	0.0033	MONROE
440109	0.0070	HARDIN
440115	0.0338	GIBSON
440137	0.0763	BEDFORD
440144	0.0226	COFFEE
440148	0.0306	DE KALB
440153	0.0007	COCKE
440174	0.0310	HAYWOOD
440180	0.0036	CAMPBELL
440181	0.0361	HARDEMAN
440182	0.0144	CARROLL
440185	0.0230	BRADLEY
450032	0.0253	HARRISON
450039	0.0024	TARRANT

ADDENDUM L.—PROPOSED OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Out-Migration adjustment	Qualifying county name
450052	0.0276	BOSQUE
450059	0.0074	COMAL
450064	0.0024	TARRANT
450087	0.0024	TARRANT
450090	0.0651	COOKE
450099	0.0143	GRAY
450135	0.0024	TARRANT
450137	0.0024	TARRANT
450144	0.0558	ANDREWS
450163	0.0053	KLEBERG
450192	0.0271	HILL
450194	0.0213	CHEROKEE
450210	0.0150	PANOLA
450224	0.0195	WOOD
450236	0.0389	HOPKINS
450270	0.0271	HILL
450283	0.0655	VAN ZANDT
450324	0.0132	GRAYSON
450347	0.0379	WALKER
450348	0.0058	FALLS
450370	0.0240	COLORADO
450389	0.0619	HENDERSON
450393	0.0132	GRAYSON
450395	0.0451	POLK
450419	0.0024	TARRANT
450438	0.0241	COLORADO
450451	0.0537	SOMERVELL
450460	0.0048	TYLER
450469	0.0132	GRAYSON
450497	0.0395	MONTAGUE
450539	0.0071	HALE
450547	0.0195	WOOD
450563	0.0024	TARRANT
450565	0.0486	PALO PINTO
450573	0.0115	JASPER
450596	0.0744	HOOD
450639	0.0024	TARRANT
450641	0.0395	MONTAGUE
450672	0.0024	TARRANT
450675	0.0024	TARRANT
450677	0.0024	TARRANT
450698	0.0135	LAMB
450747	0.0127	ANDERSON
450755	0.0294	HOCKLEY
450770	0.0182	MILAM
450779	0.0024	TARRANT
450813	0.0127	ANDERSON
450838	0.0115	JASPER
450872	0.0024	TARRANT
450880	0.0024	TARRANT
450884	0.0050	UPSHUR
450886	0.0024	TARRANT
450888	0.0024	TARRANT
452019	0.0024	TARRANT
452028	0.0024	TARRANT
452041	0.0132	GRAYSON
452088	0.0024	TARRANT
453040	0.0024	TARRANT
453041	0.0024	TARRANT
453042	0.0024	TARRANT
453089	0.0127	ANDERSON
453300	0.0024	TARRANT
454012	0.0024	TARRANT
460017	0.0364	BOX ELDER
460039	0.0364	BOX ELDER
490019	0.1081	CULPEPER
490084	0.0145	ESSEX
490110	0.0327	MONTGOMERY
500003	0.0164	SKAGIT
500007	0.0164	SKAGIT
500019	0.0140	LEWIS

ADDENDUM L.—PROPOSED OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Out-Migration adjustment	Qualifying county name
500039	0.0101	KITSAP
500041	0.0020	COWLITZ
510018	0.0187	JACKSON
510047	0.0270	MARION
510077	0.0021	MINGO
520028	0.0297	GREEN
520035	0.0083	SHEBOYGAN
520044	0.0083	SHEBOYGAN
520057	0.0184	SAUK
520059	0.0189	RACINE
520060	0.0048	GREEN LAKE
520071	0.0174	JEFFERSON
520076	0.0159	DODGE
520095	0.0184	SAUK
520096	0.0189	RACINE
520102	0.0242	WALWORTH
520116	0.0174	JEFFERSON
522005	0.0189	RACINE

ADDENDUM M.—PROPOSED HCPCS CODES FOR ASSIGNMENT TO COMPOSITE APCS FOR CY 2008

HCPCS code	Short descriptor	CI	SI	Single code APC assignment	Composite APC assignment
90801	Psy dx interview	CH	Q	0323	0034
90802	Intac psy dx interview	CH	Q	0323	0034
90804	Psytx, office, 20–30 min	CH	Q	0322	0034
90805	Psytx, off, 20–30 min w/e&m	CH	Q	0322	0034
90806	Psytx, off, 45–50 min	CH	Q	0323	0034
90807	Psytx, off, 45–50 min w/e&m	CH	Q	0323	0034
90808	Psytx, office, 75–80 min	CH	Q	0323	0034
90809	Psytx, off, 75–80, w/e&m	CH	Q	0323	0034
90810	Intac psytx, off, 20–30 min	CH	Q	0322	0034
90811	Intac psytx, 20–30, w/e&m	CH	Q	0322	0034
90812	Intac psytx, off, 45–50 minv	CH	Q	0323	0034
90813	Intac psytx, 45–50 min w/e&m	CH	Q	0323	0034
90814	Intac psytx, off, 75–80 min	CH	Q	0323	0034
90815	Intac psytx, 75–80 w/e&m	CH	Q	0323	0034
90816	Psytx, hosp, 20–30 min	CH	Q	0322	0034
90817	Psytx, hosp, 20–30 min w/e&m	CH	Q	0322	0034
90818	Psytx, hosp, 45–50 min	CH	Q	0323	0034
90819	Psytx, hosp, 45–50 min w/e&m	CH	Q	0323	0034
90821	sytx, hosp, 75–80 min	CH	Q	0323	0034
90822	Psytx, hosp, 75–80 min w/e&m	CH	Q	0323	0034
90823	Intac psytx, hosp, 20–30 min	CH	Q	0322	0034
90824	Intac psytx, hsp 20–30 w/e&m	CH	Q	0322	0034
90826	Intac psytx, hosp, 45–50 min	CH	Q	0323	0034
90827	Intac psytx, hsp 45–50 w/e&m	CH	Q	0323	0034
90828	Intac psytx, hosp, 75–80 min	CH	Q	0323	0034
90829	Intac psytx, hsp 75–80 w/e&m	CH	Q	0323	0034
90845	Psychoanalysis	CH	Q	0323	0034
90846	Family psytx w/o patient	CH	Q	0324	0034
90847	Family psytx w/patient	CH	Q	0324	0034
90849	Multiple family group psytx	CH	Q	0325	0034
90853	Group psychotherapy	CH	Q	0325	0034
90857	Intac group psytx	CH	Q	0325	0034
90862	Medication management	CH	Q	0605	0034
90865	Narcosynthesis	CH	Q	0323	0034
90880	Hypnotherapy	CH	Q	0323	0034
90899	Psychiatric service/therapy	CH	Q	0322	0034
96101	Psycho testing by pscy/phys	CH	Q	0382	0034
96102	Psycho testing by technician	CH	Q	0373	0034
96103	Psycho testing admin by comp	CH	Q	0373	0034
96110	Developmental test, lim	CH	Q	0373	0034
96111	Developmental test, exten	CH	Q	0382	0034
96116	Neurobehavioral status exam	CH	Q	0382	0034
96118	Neuropsych test by pscyh/phys	CH	Q	0382	0034
96119	Neuropscyh testing by tec	CH	Q	0382	0034
96120	Neuropsych tst admin w/comp	CH	Q	0373	0034
96150	Assess hlth/behave, initi	CH	Q	0432	0034
96151	Assess hlth/behave, subseq	CH	Q	0432	0034
96152	Intervene hlth/behave,indiv	CH	Q	0432	0034
96153	Intervene hlth/bhave, group	CH	Q	0432	0034
96154	Intevene hlth/behave, fam w/pt	CH	Q	0432	0034
M0064	Visit for drug monitoring	CH	Q	0605	0034
93619	Electrophysiology evaluation	CH	Q	0085	8000
93620	Electrophysiology evaluation	CH	Q	0085	8000
93650	Ablate heart dysrhythm focus	CH	Q	0085	8000
93651	Ablate heart dysrhythm focus	CH	Q	0086	8000
93652	Ablate heart dysrhythm focus	CH	Q	0086	8000
55875	Transperi needle place, pros	CH	Q	0163	8001
77778	Apply interstit radiat compl	CH	Q	0651	8001

[FR Doc. 07–3509 Filed 7–16–07; 4:00 pm]

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Vol. 72, No. 148

Thursday, August 2, 2007

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FEDERAL REGISTER PAGES AND DATE, AUGUST

CFR PARTS AFFECTED DURING AUGUST

At the end of each month, the Office of the Federal Register publishes separately a List of CFR Sections Affected (LSA), which lists parts and sections affected by documents published since the revision date of each title.

7 CFR

51 41885
Proposed Rules:
989 41948

8 CFR

103 41888

9 CFR

Proposed Rules:
93 42318
201 41952

12 CFR

748 42271
749 42271
Proposed Rules:
703 41956
704 41956

14 CFR

23 42274
Proposed Rules:
39 ..... 41958, 41963, 41968, 42326, 42328

17 CFR

171 42276
240 42222

18 CFR

33 42277
Proposed Rules:
385 42330

21 CFR

522 42290
524 42291

26 CFR

1 ..... 41890, 41891, 42291
26 42291
602 42291
Proposed Rules:
1 42335
26 42340

32 CFR

229 42298

33 CFR

117 42306
165 42307

37 CFR

2 42242

40 CFR

52 ..... 41891, 41894, 41896, 41900, 41903, 41906
81 ..... 41903, 41906
180 ..... 41909, 41913, 41931
Proposed Rules:
52 ..... 41970, 41975, 42344, 42349, 42354
81 42354
300 41976

42 CFR

410 42470
416 42470
Proposed Rules:
410 42628
411 42628
414 42628
416 42628
419 42628
424 42001
482 42628
485 42628

45 CFR

Proposed Rules:
1626 42363

46 CFR

67 42310

47 CFR

1 41935
2 41937
15 41937
22 ..... 41939, 41940
27 ..... 41939, 41940
73 41946
101 41940
Proposed Rules:
2 42011
15 42011
73 ..... 42015, 42016

48 CFR

202 42313
204 42313
205 42315
210 42313
213 42313
215 42313
219 42313
225 42315
252 42315
Proposed Rules:
216 42366
232 42366
252 ..... 42366, 42367

49 CFR

Proposed Rules:
238.....42016

50 CFR

922.....42318

Proposed Rules:
679.....42369

REMINDERS

The items in this list were editorially compiled as an aid to Federal Register users. Inclusion or exclusion from this list has no legal significance.

RULES GOING INTO EFFECT AUGUST 2, 2007

AGRICULTURE DEPARTMENT

Agricultural Marketing Service

Dairy Product mandatory Reporting Program; establishment; published 7-3-07

COMMODITY FUTURES TRADING COMMISSION

National Futures Association decisions in disciplinary, membership, registration, and member responsibility actions:

Service by facsimile (fax) or electronic means (email); published 8-2-07

DEFENSE DEPARTMENT

Defense Acquisition Regulations System

Acquisition regulations:

Berry Amendment notification requirement; published 8-2-07

Berry Amendment restrictions; clothing materials and components covered; published 8-2-07

Limitations on tiered evaluation of offers; published 8-2-07

Technical amendments; published 8-2-07

DEFENSE DEPARTMENT

Protection of archaeological resources; uniform regulations; published 8-2-07

HEALTH AND HUMAN SERVICES DEPARTMENT

Food and Drug Administration

Animal drugs, feeds, and related products:

Emodepside and Praziquantel; published 8-2-07

Oxytetracycline hydrochloride injection; published 8-2-07

Medical devices:

General hospital and personal use devices—

Filtering facepiece respirator for use by general public in public health medical emergencies; classification; published 7-3-07

TREASURY DEPARTMENT

Internal Revenue Service

Estate and gift taxes:

Generation-skipping transfer tax purposes; qualified severance of trust; published 8-2-07

COMMENTS DUE NEXT WEEK

AGRICULTURE DEPARTMENT

Agricultural Marketing Service

Almonds grown in California; comments due by 8-7-07; published 6-8-07 [FR 07-02837]

Cotton research and promotion program:

Procedures for conduct of sign-up period; comments due by 8-9-07; published 7-30-07 [FR E7-14608]

AGRICULTURE DEPARTMENT

Animal and Plant Health Inspection Service

Plant-related quarantine, domestic:

Citrus canker; comments due by 8-7-07; published 7-27-07 [FR E7-14530]

AGRICULTURE DEPARTMENT

Federal Crop Insurance Corporation

Crop insurance regulations:

Coverage enhancement option insurance provisions; comments due by 8-6-07; published 6-6-07 [FR E7-10825]

Cultivated wild rice crop insurance provisons; comments due by 8-6-07; published 6-6-07 [FR E7-10824]

COMMERCE DEPARTMENT

Industry and Security Bureau

Export administration regulations:

Entity list—

Entities acting contrary to national security and foreign policy interests of U.S.; export and reexport license requirements; comments due by 8-6-07; published 6-5-07 [FR E7-10788]

COMMERCE DEPARTMENT

National Oceanic and Atmospheric Administration

Fishery conservation and management:

Atlantic coastal fisheries—

American lobster; comments due by 8-6-07; published 6-20-07 [FR E7-11964]

West Coast States and Western Pacific fisheries—

Pacific Coast groundfish; comments due by 8-6-07; published 7-5-07 [FR 07-03262]

ENVIRONMENTAL PROTECTION AGENCY

Air pollution; standards of performance for new stationary sources:

Synthetic organic chemicals manufacturing industry and petroleum refineries; VOC equipment leaks; comments due by 8-8-07; published 7-9-07 [FR E7-13203]

Air programs:

Volatile organic compound emissions control—

Paper, film, foil, metal furniture, and large appliance coatings; control techniques guidelines; comments due by 8-9-07; published 7-10-07 [FR E7-13104]

Air quality implementation plans:

Preparation, adoption, and submittal—

Electric generating units emission increases; prevention of significant deterioration and nonattainment new source review; comments due by 8-8-07; published 7-9-07 [FR E7-13297]

Increment modeling procedures refinement; prevention of significant deterioration new source review; comments due by 8-6-07; published 6-6-07 [FR E7-10459]

Pesticides; tolerances in food, animal feeds, and raw agricultural commodities:

Captan, etc.; comments due by 8-6-07; published 6-6-07 [FR E7-10863]

Superfund program:

National oil and hazardous substances contingency plan priorities list; comments due by 8-6-07; published 7-5-07 [FR E7-13056]

Water programs:

Water quality standards—

Washington; Federal marine aquatic life water quality criteria for toxic pollutants; withdrawn; comments due by 8-8-07; published 7-9-07 [FR E7-13206]

Washington; Federal marine aquatic life water quality criteria for toxic pollutants; withdrawn; comments due by 8-8-07; published 7-9-07 [FR E7-13207]

FEDERAL COMMUNICATIONS COMMISSION

Common carrier services:

Customer propriety network information; comments due by 8-7-07; published 6-8-07 [FR E7-10732]

Price cap local exchange carriers; interstate special access services; regulatory framework; comments due by 8-8-07; published 7-25-07 [FR E7-14272]

Television broadcasting—

Digital television—

Conversion; transition issues; comments due by 8-8-07; published 7-9-07 [FR E7-12905]

HEALTH AND HUMAN SERVICES DEPARTMENT

Food and Drug Administration

Administrative rulings and decisions:

Ozone-depleting substances use; essential-use designations—

Oral pressurized metered-dose inhalers containing flunisolide, triamcinolone, metaproterenol, pirbuterol, albuterol, etc.; removed; comments due by 8-10-07; published 6-11-07 [FR 07-02883]

Oral pressurized metered-dose inhalers containing flunisolide, triamcinolone, metaproterenol, pirbuterol, albuterol, etc.; removed; meeting; comments due by 8-10-07; published 7-9-07 [FR E7-13300]

HOMELAND SECURITY DEPARTMENT

Articles conditionally free, subject to reduced rates, etc.:

U.S.-Singapore Free Trade Agreement; preferential

LIST OF PUBLIC LAWS

This is a continuing list of public bills from the current session of Congress which have become Federal laws. It may be used in conjunction with "P L U S" (Public Laws Update Service) on 202–741–6043. This list is also available online at *http://www.archives.gov/federal-register/laws.html*.

The text of laws is not published in the **Federal Register** but may be ordered in "slip law" (individual pamphlet) form from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402 (phone, 202–512–1808). The text will also be made available on the Internet from GPO Access at *http://www.gpoaccess.gov/plaws/index.html*. Some laws may not yet be available.

S. 1868 / Public Law 110-51

Second Higher Education Extension Act of 2007 (July 31, 2007; 121 Stat. 263; 1 page)

Last List August 1, 2007

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