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Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 410, 411, 412, et al.
Medicare and Medicaid Programs; Interim and Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 410, 411, 412, 413, 414, 416, 419, 482, and 485

[CMS–1392–FC], [CMS–1533–F2], and [CMS–1531–IFC2]

RIN 0938–AO71, RIN 0938–AO70, and RIN 0938–AO35

Medicare Program: Changes to the Hospital Outpatient Prospective Payment System and CY 2008 Payment Rates, the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates, the Hospital Inpatient Prospective Payment System and FY 2008 Payment Rates; and Payments for Graduate Medical Education for Affiliated Teaching Hospitals in Certain Emergency Situations Medicare and Medicaid Programs: Hospital Conditions of Participation; Necessary Provider Designations of Critical Access Hospitals

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Interim and final rule with comment period.

SUMMARY: This final rule with comment period revises the Medicare hospital outpatient prospective payment system to implement applicable statutory requirements and changes arising from our continuing experience with this system. We describe the 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 are applicable to services furnished on or after January 1, 2008. In addition, the rule sets forth 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 apply, and other pertinent rate setting information for the CY 2008 ASC payment system. Furthermore, this final rule with comment period will make changes to the policies relating to the necessary provider designations of critical access hospitals and changes to several of the current conditions of participation requirements.

The attached document also incorporates the changes to the FY 2008 hospital inpatient prospective payment system (IPPS) payment rates made as a result of the enactment of the TMA, Abstinence Education, and QI Programs Extension Act of 2007, Public Law 110–90. In addition, we are changing the provisions in our previously issued FY 2008 IPPS final rule and are establishing a new policy, retroactive to October 1, 2007, of not applying the documentation and coding adjustment to the FY 2008 hospital-specific rates for Medicare-dependent, small rural hospitals (MDHs) and sole community hospitals (SCHs). In the interim final rule with comment period in this document, we are modifying our regulations relating to graduate medical education (GME) payments made to teaching hospitals that have Medicare affiliation agreements for certain emergency situations.

DATES: *Effective Date:* The provisions of this rule are effective on January 1, 2008.

IPPS Payment Rates: The FY 2008 IPPS payment rates, provided in section XIX of the preamble of this document, became effective October 1, 2007.

Comment Period: We will consider comments on the payment classifications assigned to HCPCS codes identified in Addenda B, AA, and BB to this final rule with the ''NI'' comment indicator, and other areas specified throughout this rule, at the appropriate address, as provided below, no later than 5 p.m. EST on January 28, 2008. We will also consider comments relating to the Medicare GME teaching hospital affiliated agreement provisions, as provided below, no later than 5 p.m. EST on January 28, 2008.

Application Deadline—New Class of New Technology Intraocular Lens: Requests for review of applications for a new class of new technology intraocular lenses must be received by 5 p.m. EST on April 1, 2008.

Deadline for Submission of Written Medicare GME Affiliation Agreements: Written Medicare GME affiliation agreements must be received by 5 p.m. EST on January 1, 2008.

ADDRESSES: In commenting, please refer to file codes CMS–1392–FC (for OPPS and ASC matters) or CMS–1531–IFC (for Medicare GME matters), as appropriate. 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–FC (for OPPS and ASC matters), Attention: CMS–1531–IFC (for Medicare GME matters), P.O. Box 8013, 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–FC (for OPPS and ASC matters), Attention: CMS–1531–IFC (for Medicare GME matters), 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 who wish to retain proof of filing by stamping in and retain 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.

Applications for a new class of new technology intraocular lenses: Requests for review of applications for a new class of new technology intraocular lenses must be sent by regular mail to:ASC/NTIOL, Division of Outpatient Care, Mailstop C4–05–17, Centers for Medicare and Medicaid Services,7500 Security Boulevard,Baltimore, MD 21244–1850.

Submissions of written Medicare GME affiliation agreements: Written

Medicare GME affiliation agreements must be sent by regular mail to:Centers for Medicare and Medicaid Services, Division of Acute Care, Attention: Elizabeth Troung or Renate Rockwell,Mailstop C4–08–06,7500 Security Boulevard, Baltimore, MD 21244–1850.

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 center 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.

Miechal Lefkowitz, (410) 786–5316, Hospital inpatient prospective payment system issues.

Tzvi Hefter, (410) 786–4487, Graduate medical education program issues.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on the OPPS APC assignments and/or status indicators assigned to HCPCS codes identified in Addendum B to this final rule with comment period with comment indicator ''NI'' and on the ASC payment indicators assigned to HCPCS codes identified in Addenda AA and BB to this final rule with comment period with comment indicator ''NI'' in order to assist us in fully considering issues and developing OPPS and ASC payment policies for those services. You can assist us by referencing file code CMS–1392–FC.

We also welcome comments from the public on all issues set forth regarding the revised regulations regarding the Medicare GME affiliation agreements to assist us in fully considering issues and developing policies. You can assist us by referencing the file code CMS–1531–IFC2 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 This Final Rule With Comment Period

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
GME Graduate medical education
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
IME Indirect medical education
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 vaccine
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 several payment systems under the Medicare program: The hospital outpatient prospective payment system (OPPS); the revised ambulatory surgical center (ASC) payment system; the hospital inpatient prospective payment system (IPPS); and payments for direct and indirect graduate medical education (GME). The provisions relating to the OPPS are included in sections I. through XV., XVII., XXI. through XXIV. of this final rule with comment period and in Addenda A, B, C (Addendum C is available on the Internet only; see section XXI. of this final rule with comment period), D1, D2, E, L, and M to this final rule with comment period. The provisions related to the revised ASC payment system are included in sections XVI., XVII., and XXI. through XXIV. of this final rule with comment period and in Addenda AA, BB, DD1, DD2, and EE (Addendum EE is available on the Internet only; see section XXI. of this final rule with comment period) to this final rule with comment period.

The provisions relating to the IPPS payment rates are included in section XIX., XXIV., and XXV. of this document. The provisions relating to policy changes to the Medicare GME affiliation provisions for teaching hospitals in certain emergency situations are included in sections XX., XXIV., and XXV. of this document.

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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.

The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999 (Pub. L. 106–113) made major changes in the hospital outpatient prospective payment system (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, also 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 changes is included in sections I.E., VII., and XVII. of this final rule with comment period.

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 final rule with comment period. 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 generally use the median cost of the item or service assigned to an APC group.

For new technology items and services, special payments under the OPPS may be made 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 payment for screening and diagnostic mammography services from the OPPS. The Secretary exercised the authority granted under the statute to also 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, not 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).

On August 2, 2007, we issued in the **Federal Register** (72 FR 42628) a proposed rule for the CY 2008 OPPS/ASC to implement statutory requirements and changes arising from our continuing experience with both systems. We received approximately 2,180 pieces of timely correspondence in response to the proposed rule. A summary of the public comments we received and our responses to those comments are included in the specific sections of this final rule with comment period.

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 final rule with comment period, 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 payment 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, membership, 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 12 subsequent meetings, with the last meeting taking place on September 5 and 6, 2007. Prior to each meeting, we publish a notice in the **Federal Register** to announce the meeting, and when necessary, to solicit nominations for APC Panel membership, and to announce new members.

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 last approved at the September 2007 APC Panel meetings. 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 and September 2007 meetings are included in the sections of this final rule with comment period that are specific to each recommendation. For discussions of earlier APC Panel meetings and recommendations, we refer readers to previously published 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 the CY 2008 OPPS/ASC Proposed Rule

On August 2, 2007, we published a proposed rule in the **Federal Register** (72 FR 42628) that set forth proposed changes to the Medicare hospital OPPS for CY 2008 to implement statutory requirements and changes arising from our continuing experience with the system and to implement certain statutory provisions. In addition, we proposed changes to the revised Medicare ASC payment system for CY 2008 such as adding procedures to the list of covered surgical procedures and adjusting the ASC rates so that the revised ASC payment system is budget neutral. We also proposed to make changes to the policies relating to the necessary provider designations of 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 proposed 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. Finally, we set forth proposed quality measures for a Hospital Outpatient Quality Data Reporting (HOP QDRP) program for reporting quality data for annual payment rate updates for CY 2009 and subsequent calendar years. We also briefly discussed the legislative provisions of the MIEA–TRHCA that give the Secretary authority to develop quality measures for reporting data by ASCs. The following is a summary of the major changes included in the CY 2008 OPPS/ASC proposed rule:

1. Updates Affecting OPPS Payments

In section II. of the 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. OPPS Ambulatory Payment Classification (APC) Group Policies

In section III. of the proposed rule, we discussed 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 discussed 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. OPPS Payment for Devices

In section IV. of the proposed rule, we discussed proposed payment for device dependent APCs and pass-through payment for specific categories of devices.

4. OPPS Payment for Drugs, Biologicals, and Radiopharmaceuticals

In section V. of the proposed rule, we discussed 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. Estimate of OPPS Transitional Pass-Through Spending for Drugs, Biologicals, and Devices

In section VI. of the proposed rule, we discussed the estimate of CY 2008 OPPS transitional pass-through spending for drugs, biologicals, and devices.

6. OPPS Payment for Brachytherapy Sources

In section VII. of the proposed rule, we discussed our proposal concerning coding and payment for brachytherapy sources.

7. OPPS Coding and Payment for Drug Administration Services

In section VIII. of the proposed rule, we set forth our proposed policy concerning coding and payment for drug administration services.

8. OPPS Hospital Coding and Payments for Visits

In section IX. of the proposed rule, we set forth our proposed policies for the coding and reporting of clinic and emergency department visits and

critical care services on claims paid under the OPPS.

9. OPPS Payment for Blood and Blood Products

In section X. of the proposed rule, we discussed our proposed payment for blood and blood products.

10. Proposed OPPS Payment for Observation Services

In section XI. of the proposed rule, we discussed the proposed payment policies for observation services furnished to patients on an outpatient basis.

11. Procedures That Will Be Paid Only as Inpatient Services

In section XII. of the proposed rule, we discussed the procedures that we proposed to remove from the inpatient list and assign to APCs.

12. Nonrecurring Technical and Policy Changes

In section XIII. of the proposed rule, we set forth our proposals for nonrecurring technical and policy changes and clarifications relating to outpatient services and supplies incident to physicians' services; 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. OPPS Payment Status and Comment Indicators

In section XIV. of the proposed rule, we discussed proposed changes to the definitions of status indicators assigned to APCs and presented our proposed comment indicators for the OPPS/ASC final rule with comment period.

14. OPPS Policy and Payment Recommendations

In section XV. of the proposed rule, we addressed recommendations made by the Medicare Payment Advisory Commission (MedPAC) in its March and June 2007 Reports to Congress and by the APC Panel regarding the OPPS for CY 2008.

15. Update of the Revised ASC Payment System

In section XVI. of the proposed rule, we discussed the proposed update of the revised ASC payment system payment rates for CY 2008. We also discussed our proposed changes to our regulations at §§ 414.22(b)(5)(i)(A) and (B) regarding physician payment for performing excluded surgical procedures in ASCs. In addition, we set forth our proposal 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 the proposed rule, we discussed 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 discussed the legislative provisions of the MIEA–TRHCA that give the Secretary authority to develop quality measures for reporting by ASCs. (We note that, as discussed in section XVII.J. of this final rule with comment period, we are also finalizing a proposal from the FY 2008 IPPS proposed rule relating to the FY 2009 RHQDAPU quality measures. Specifically, we are finalizing the inclusion of SCIP Infection 4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose and SCIP Infection 6: Surgery Patients with Appropriate Hair Removal in the FY 2009 RHQDAPU measure set, bringing the total number of measures in that measure set to 30.)

17. Changes Affecting Necessary Provider Critical Access Hospitals (CAHs) and Hospital Conditions of Participation (CoPs)

In section XVIII. of the proposed rule, we discussed our proposed changes affecting CAHs both when the CAH enters into a new co-location arrangement with another hospital or CAH and when the CAH creates or acquires a provider-based off campus location. We also discussed 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 after surgery or a procedure requiring anesthesia services but before discharge or transfer from the postanesthesia recovery area.

18. Regulatory Impact Analysis

In section XXII. of the proposed rule, we set forth an analysis of the impact the proposed changes would have on affected entities and beneficiaries. (We note that this regulatory impact analysis section is redesignated as section XXIV. of this final rule with comment period.)

G. Public Comments Received in Response to the CY 2008 OPPS/ASC Proposed Rule

We received approximately 2,180 timely pieces of correspondence containing multiple comments on the CY 2008 OPPS/ASC proposed rule. We note that we received some comments that were outside the scope of the CY 2008 OPS/ASC proposed rule. These comments are not addressed in this CY 2008 OPPS/ASC final rule with comment period. Summaries of the public comments that are within the scope of the proposals and our responses to those comments are set forth in the various sections of this final rule with comment period under the appropriate headings.

H. Public Comments Received on the November 24, 2006 OPPS/ASC Final Rule with Comment Period

We received approximately 21 timely items of correspondence on the CY 2007 OPPS/ASC final rule with comment period, some of which contained multiple comments on the interim final APC assignments and/or status indicators of HCPCS codes identified with comment indicator ''NI'' in Addendum B to that final rule with comment period. Summaries of those public comments and our responses to them are set forth in the various sections of this final rule with comment period under the appropriate headings.

II. Updates Affecting OPPS Payments

A. Recalibration of APC Relative Weights

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).

In the CY 2008 OPPS/ASC proposed rule, we proposed 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 proposed to recalibrate the relative payment weights for each APC based on claims and cost report data for outpatient services. We proposed 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 outpatient department (HOPD) 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 the proposed rule on the CMS Web site at: *http://www.cms.hhs.gov/HospitalOutpatientPPS/HORD/).*

Of the 141 million final action claims for services provided in hospital outpatient settings used to calculate the CY 2008 OPPS payment rates for this final rule with comment period, approximately 103 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 103 million claims, approximately 45 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 54 million whole claims of the approximately 58 million claims that remained to set the OPPS APC relative weights for the CY 2008 OPPS. From the 54 million whole claims, we created approximately 97 million single records, of which approximately 65 million were ''pseudo'' single claims (created from multiple procedure claims using the process we discuss in this section). Approximately 926,000 claims trimmed out on cost or units in excess of +/−3 standard deviations from the geometric mean, yielding approximately 96 million single bills used for median setting. Ultimately, we were able to use for CY 2008 ratesetting some portion of 93 ercent of the CY 2006 claims containing services payable under the OPPS. This is approximately the same percentage of CY 2005 claims where some portion could be used for CY 2007 ratesetting as described in the CY 2007 OPPS/ASC final rule with comment period (71 FR 67970).

As proposed, the final APC relative weights and payments for CY 2008 in Addenda A and B to this final rule with comment period were calculated using claims from this period that were processed before June 30, 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 proposed to convert to relative payment weights for purposes of calculating the CY 2008 payment rates.

We did not receive any comments on our proposal to base the CY 2008 APC relative weights on the most currently available cost reports and on claims for services furnished in CY 2006. Therefore, we are finalizing our data source for the recalibration of the CY 2008 APC relative payment weights as proposed, without modification, as described in this section of this final rule with comment period.

b. Use of Single and Multiple Procedure Claims

For CY 2008, in general, we proposed 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 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 continued 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 packaging approach that we proposed for the CY 2008 OPPS also allows 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 the proposed rule for a full discussion of the packaging approach for CY 2008.

We received several public comments on our proposed use of single bills to calculate the APC median costs for ratesetting under the CY 2008 OPPS. A summary of the public comments and our responses follow.

Comment: Some commenters supported the ''natural'' and ''pseudo'' single methodology but asked that CMS continue to refine the approach in order to improve the accuracy of the estimates because the medians are used to develop payment rates for services on both single and multiple procedure claims. Other commenters asserted that continued reliance on single procedure bills to establish the medians from which the rates were calculated failed to produce a statistically valid sample of services for ratesetting, in particular for brachytherapy services that are often provided in combination with one another in a single encounter. Other commenters requested that CMS explore additional revisions to the current methodology to ensure that OPPS payment would be based on a substantial number of accurate hospital claims.

Response: We generally base median costs for services on single procedure claims to ensure that the median cost captures the full cost of a service when it is the only service furnished. We recognize that this approach has limitations and, in some cases, prevents us from using many of the claims for services that are most commonly furnished at the same time as other services. For this reason, we have developed a number of different strategies, such as date of service stratification and the use of the bypass list, that enable us to break multiple procedure claims into ''pseudo'' single procedure claims where we have confidence that the ''pseudo'' single claim contains the full cost of the service, including related packaged costs. In recent years, however, we have increasingly used multiple procedure claims to develop median costs for individual services or groups of services. We have developed these methodologies so that we can use more naturally occurring claims data in cases in which care is most commonly reported with multiple major procedure

codes on the same date, such as observation services, hyperbaric oxygen therapy (HBOT), and single allergy tests.

Similarly, for CY 2008, we developed and proposed composite APCs for low dose rate prostate brachytherapy (APC 8001 (LDR Prostate Brachytherapy Composite)) and cardiac electrophysiology services (APC 8000 (Cardiac Electrophysiologic Evaluation and Ablation Composite)). These APCs are designed to use multiple procedure claims to establish a median cost and APC payment for multiple major procedures when they are furnished together. As we discuss in section II.A.4.d. of this final rule with comment period, we intend to explore the creation of additional composite APCs for services that frequently are provided in the same HOPD encounter. We also plan to continue to develop and refine methods to increase the amount of claims data that we can use for setting OPPS payment rates in a manner that gives us the most confidence that the costs derived from these approaches are valid reflections of the costs of the services described by HCPCS codes or, in the case of composite APCs, described by the APCs. We anticipate that the Data Subcommittee of the APC Panel will continue to provide us with valuable advice regarding possible methodologies for increasing the OPPS use of multiple procedure claims for ratesetting.

After consideration of the public comments received, we are finalizing our proposal, without modification, to calculate median costs for APCs using single and ''pseudo'' single procedure claims, except where otherwise specified.

(1) Use of Date of Service Stratification and a Bypass List To Increase the Amount of Data Used To Determine Medians

Through 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 numerous separately paid procedures reported on the same date on one 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 (sorting the lines by date of service and treating all lines with the same date of service as a separate claim) and bypass list process we used for the CY 2007 OPPS (combined with the packaging changes we proposed in section II.A.4. of the proposed rule) resulted in our being able to use some part of approximately 92 percent of the total claims that were eligible for use in the OPPS ratesetting and modeling for the proposed rule. This process enabled us to create, for the CY 2008 proposed rule, approximately 58 million ''pseudo'' singles and approximately 30 million ''natural'' single bills. For the proposed rule, ''pseudo'' single procedure bills represented 66 percent of all single bills used to calculate median costs. This compared 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 believed that the reduction in the percent of ''pseudo'' single bills and the corresponding increase in the proportion of ''natural'' single bills observed for the CY 2008 proposed rule occurred largely because of our proposal to increase packaging as discussed in section II.A.4. of the 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 proposed to bypass 425 HCPCS codes that are identified in Table 1 of the proposed rule. We proposed to continue the use of the codes on the CY 2007 OPPS bypass list but to remove codes we proposed to package for CY 2008. We also proposed 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 the 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 the 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. In addition, we note that many of the codes we proposed to newly package for CY 2008 were on the bypass list used for setting the OPPS payment rates for CY 2007 and were not proposed for bypass because we also proposed to package them. We proposed to add to the bypass list HCPCS codes that, using the proposed rule data, met the same previously established empirical criteria for the bypass list that are reviewed below or which our clinicians believed would have little associated packaging if the services were coded correctly.

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 the 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. Similarly, for this final rule with comment period,

66 percent of single bills were ''pseudo'' singles. Moreover, the numbers of ''natural'' single bills and ''pseudo'' single bills were reduced by the volume of services that we proposed 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 proposed to package.

As in prior years, we proposed 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 assumed that the representation of packaging in the single claims for any given code was 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 separately 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 proposed to add to the bypass list codes that our clinicians believe have minimal associated packaging based on their clinical assessment of the complete CY 2008 OPPS proposal. As proposed, this list contained bypass codes that were appropriate to claims for services in CY 2006 and, therefore, included codes that were deleted for CY 2007. Moreover, there were codes on the proposed bypass list that were new for CY 2007 and which were appropriate additions to the bypass list in preparation for use of the CY 2007 claims for creation of the CY 2009 OPPS.

We received a number of public comments on the use of the bypass list for creation of ''pseudo'' single procedure claims. A summary of the comments and our responses follow.

Comment: Some commenters objected to the removal of HCPCS codes from the bypass list because the codes ceased to meet the criteria for the bypass list as a result of increased packaging in the ''natural'' single claims due to the proposed packaging approach. The commenters objected to the removal of codes from the bypass list for this reason because they asserted that it caused claims that would otherwise have become ''pseudo'' single claims to not be used and, thereby, reduced the number of single bills that were available for ratesetting for certain services.

Response: We agree with the commenters, so we have reevaluated the bypass list for this final rule with comment period and restored a number of codes on the bypass list prior to the CY 2008 proposal to maximize the creation of single and ''pseudo'' single procedure bills. As we discuss later in this section and in section II.A.4. of this final rule with comment period, we have made changes to the data process to ensure that we capture as much data as possible for services assigned status indicator ''Q.'' Although we revised the process to apply the specific ''Q'' status indicator policies before assessment of the bypass list so that additional HCPCS codes could be considered for the bypass list without risk of losing their data regarding packaging, we determined that no codes with status indicator ''Q'' were appropriate for addition to the final CY 2008 bypass list because of their significant associated packaging.

Comment: Several commenters asked that CMS add certain HCPCS codes to the bypass list so that more single bills would be available for median setting. Some commenters specifically objected to the removal of the following radiation oncology services that they indicated should seldom have any associated packaging: CPT codes 77280 (Therapeutic radiology simulation-aided field setting; simple); 77285 (Therapeutic radiology simulation-aided field setting; intermediate); 77290 (Therapeutic radiology simulation-aided field setting; complex); 77295 (Therapeutic radiology simulation-aided field setting; 3-dimensional); 77332 (Treatment devices, design and construction; simple (simple block, simple bolus)); 77333 (Treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus)); 77334 (Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)); and 77417 (Therapeutic radiology port film(s)). One commenter explained that there was an interaction with the packaging of image guided radiation therapy codes that reduced the percentage of single bills for high dose rate (HDR) brachytherapy from 62 percent to 48 percent of the total frequency. The commenter believed that the payment for APC 0313 (Brachytherapy) dropped from $789.70 in CY 2007 to $739.46 in the CY 2008 proposed rule because there were packaged costs on claims that could no longer be used because the multiple procedure claims included codes that were removed from the bypass list. The commenter asked that these codes be restored to the bypass list so that these claims could be used. Other commenters asked that CMS place CPT code 93017 (Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; tracing only, without interpretation and report) on the bypass list because it is typically performed with single photon emission computed tomography (SPECT) procedures (CPT code 78465 (Myocardial perfusion imaging; tomographic (SPECT), multiple studies (including attenuation correction when performed), at rest and/or stress (exercise and/or pharmacologic) and redistribution and/or rest injection, without or without quantification)). These commenters believed that significant data from multiple procedure claims were lost because CPT code 93017 was not bypassed. Other commenters asked that CMS add the following drug administration CPT codes to the bypass list because doing so would enable use of more multiple procedure claims data to establish median costs for drug administration services: CPT codes 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)); 90768 (Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure); 90775 (Therapeutic, prophylactic or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)); 96411 (Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)); and 96417 (Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour (List

separately in addition to code for primary procedure)). A commenter asked that we add HCPCS code 88307 (Level V Surgical pathology, gross and microscopic examination) because it is so similar to HCPCS codes 88305 (Level III Surgical pathology, gross and microscopic examination) and 88306 (Level IV Surgical pathology, gross and microscopic examination) that were already included on the bypass list.

Response: We have reviewed the requests to add these codes to the bypass list and we have made the following decisions for CY 2008 for the reasons stated below:

We have added the radiation oncology services listed above, with the exception of CPT code 77417, to the bypass list because we agree that they are of the type that should not have packaging associated with them. We recognize that including them on the bypass list may yield significantly more single procedure bills and may also increase the number of claims that we can use for calculation of the low dose rate prostate brachytherapy composite APC (APC8001). We have not added CPT code 77417 to the CY 2008 bypass list because, based on its final CY 2008 unconditionally packaged status, the code would not be a candidate for the bypass list. Unconditionally packaged codes are not included on the bypass list because their presence on a claim does not make that claim a multiple procedure bill.

We have added CPT code 93017 to the bypass list because we agree that it should not have significant associated packaging, and we recognize that including it on the bypass list may yield significantly more single procedure bills for median setting.

We have not added the drug administration services listed above to the bypass list. Four of these five codes are for sequential drug infusion services or injections of additional drugs and, therefore, by definition, new drugs and medical supplies that are associated with these codes should be reported in all cases in which the services are furnished. We note that, beginning in CY 2007, we placed the CPT codes for additional hours of infusion on the bypass list, recognizing that all packaging related to these hours would be associated with the initial services on the claim. We proposed and finalized this approach for CY 2007, because we were unable to accurately assign representative portions of packaged costs to multiple different drug administration services. We expected that the packaging related to additional hours of infusion of drugs that spanned several hours would be appropriately assigned to the code for the first hour of infusion on the same claim. If we had not placed the codes for additional hours of infusion on the bypass list, we would have had a substantial set of drug administration multiple procedure claims that were unusable for ratesetting purposes. However, adding the sequential drug administration services to the bypass list too would force all of the costs of the associated additional drugs and supplies to be packaged into the payment for the initial drug administration service for another drug, which we do not believe is an appropriate allocation of packaging. While we understand the concerns of the commenters regarding the challenges associated with setting appropriate payment rates for these sequential services reported on multiple procedure claims, we have very little CY 2006 claims data for the four codes because they were not recognized for payment under the CY 2006 OPPS. We will reconsider the treatment of these CPT codes for the CY 2009 OPPS update when CY 2007 data, where these codes were separately paid under the OPPS, are available. We have not added CPT code 90768 to the bypass list because our final CY 2008 policy unconditionally packages payment for this service and, therefore, it is not a candidate for the bypass list.

We agree that HCPCS code 88307 (which was on the proposed bypass list for the CY 2008 OPPS) is appropriate and we have added it to the final CY 2008 bypass list.

In addition to these responses to comments, we have added six other HCPCS codes to the final CY 2008 bypass list that met the empirical criteria for inclusion using the final rule data, and we have also added three HCPCS codes for clinical consistency with codes that are already on the bypass list. New bypass codes for this final rule with comment period are identified in Table 1 with an asterisk.

Comment: One commenter objected to the use of the bypass list to create ''pseudo'' single claims for median setting on the basis that it artificially lowers the median cost of the services on the bypass list by sending all packaging on the claim to the other major separately paid service on the claim. Specifically, the commenter believed that inclusion of CPT code 93880 (Duplex scan of extracranial arteries; complete bilateral study) on the bypass list resulted in the use of the cost data for the lowest cost services and, thereby, lowered the cost of this service. The commenter stated that CMS should work with stakeholders on use of the bypass list, its impact on median costs, and ways that CMS could use data that were more reflective of the real costs for these procedures. The commenter believed that the median cost of CPT code 93880 should be based on the cost of the typical patient and not the least expensive patient because the OPPS payment caps payment in the physician's office for the service. The commenter explained that using the bypass list to generate more ''pseudo'' single claims without any packaging resulted in stagnation in payment that encouraged hospitals to pressure physicians to order more expensive tests and threatened access to care for beneficiaries who would be served well by simpler tests that were being underpaid as a result of inclusion of CPT code 93880 on the bypass list.

One commenter asked that CMS provide a code-specific analysis of the impact of bypassing each code on the bypass list because the commenter believed that removing and using the line item costs for the bypass codes to set the median costs for the APCs to which the bypass codes are assigned results in understatement of the median costs for those APCs.

Response: The bypass list has been very effective in enabling us to use claims data that would not otherwise be available for median calculation. Since its origin for the CY 2004 OPPS, we have been very careful in determining the codes to be placed on the bypass list. As described above, we use a standard set of criteria to select claims that seldom have packaging (that is, fewer than 5 percent of ''natural'' single bills); that have little packaging (that is, less than $50); for which we have at least 100 ''natural'' single bills; and that are not unlisted codes (for which there is no specified service). In addition to codes that pass these criteria, we also have added HCPCS codes to the bypass list that have been recommended to us by members of the public, including the specialty societies that are most familiar with them, as services with which packaging should be seldom, if ever, associated. Therefore, we believe that we have been very prudent with regard to our selection of the codes to be added to the bypass list and with our use of the list. Moreover, we open the criteria and the list to public comment each year and we respond to comments in the final rule for the update year.

We also make available the claims data used to calculate the median costs on which the relative weights are based, and we provide an extensive narrative description of our data process. Hence, we provide commenters with the tools to conduct any further analyses they chose with regard to the codes on the

bypass list or otherwise. In the case of CPT code 93880, the median packaged cost on ''natural'' single procedure claims (of which there were 403,106) was $0 and the percent of natural single procedure claims on which there was any packaging was 0.47 percent (1,899 claims out of 403,106). Therefore, the code meets the criteria for inclusion on the bypass list and will remain on it for CY 2008. We have no evidence that physicians or hospitals are billing more expensive tests as a result of the OPPS payment rate for CPT code 93880, and our data show there is very little packaging associated with the service in the typical case.

In order to keep the established empirical criteria for the bypass list constant, we specifically solicited 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. We believed that adding an inflation adjustment factor would ensure that the same amount of packaging associated with candidate codes for the bypass list was reviewed each year relative to nominal costs.

We received one public comment on the appropriateness of updating the $50 packaging cost criteria for inclusion of a code on the bypass list to account for annual inflation. A summary of the comment and our response follow.

Comment: One commenter stated that CMS should update the $50 maximum ''natural'' single bill median packaging cost criterion for including HCPCS codes on the bypass list on the basis of empirical criteria. The commenter did not suggest a methodology we might use for the update.

Response: We have not changed the $50 maximum ''natural'' bill median packaging cost criterion for this final rule with comment period. However, we will consider whether to update the criterion and, if so, what methodology would be used, as part of the development of the proposals for the CY 2009 OPPS.

After consideration of the public comments received, we are adopting, as final, the proposed ''pseudo'' single claims process and the CY 2008 bypass codes listed in Table 1 below. This list has been modified from the CY 2008 proposed list, with the addition of HCPCS codes that meet the empirical criteria based on updated claims data and certain HCPCS codes recommended by commenters, as discussed above. As stated earlier, the new bypass codes for this final rule with comment period are identified in Table 1 with an asterisk.

TABLE 1.—CY 2008 FINAL BYPASS CODES FOR CREATING ''PSEUDO'' SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS

HCPCS code	Short description	Added for this final rule
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.	
53661	Dilation of urethra	*
54240	Penis study.	
56820	Exam of vulva w/ scope.	
57150	Treat vagina infection.	*
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.	
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.	

TABLE 1.—CY 2008 FINAL BYPASS CODES FOR CREATING ''PSEUDO'' SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS—Continued

HCPCS code	Short description	Added for this final rule
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.	

TABLE 1.—CY 2008 FINAL BYPASS CODES FOR CREATING "PSEUDO" SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS—Continued

HCPCS code	Short description	Added for this final rule
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.	
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.	

TABLE 1.—CY 2008 FINAL BYPASS CODES FOR CREATING "PSEUDO" SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS—Continued

HCPCS code	Short description	Added for this final rule
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	Contrast x-ray exam of throat.	
74220	Contrast x-ray, esophagus.	
74230	Cine/vid x-ray, throat/esoph.	
74246	Contrast 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.	

TABLE 1.—CY 2008 FINAL BYPASS CODES FOR CREATING "PSEUDO" SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS—Continued

HCPCS code	Short description	Added for this final rule
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.	
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.	
77280	Set radiation therapy field.	*
77285	Set radiation therapy field.	*
77290	Set radiation therapy field.	*
77295	Set radiation therapy field.	*
77300	Radiation therapy dose plan.	

TABLE 1.—CY 2008 FINAL BYPASS CODES FOR CREATING "PSEUDO" SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS—Continued

HCPCS code	Short description	Added for this final rule
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.	
77332	Radiation treatment aid(s).	*
77333	Radiation treatment aid(s).	*
77334	Radiation treatment aid(s).	*
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.	

TABLE 1.—CY 2008 FINAL BYPASS CODES FOR CREATING "PSEUDO" SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS—Continued

HCPCS code	Short description	Added for this final rule
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.	
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.	

TABLE 1.—CY 2008 FINAL BYPASS CODES FOR CREATING "PSEUDO" SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS—Continued

HCPCS code	Short description	Added for this final rule
88331	Path consult intraop, 1 bloc.	
88342	Immunohistochemistry.	
88346	Immunofluorescent study.	
88347	Immunofluorescent study.	
88348	Electron microscopy.	
88358	Analysis, tumor.	
88360	Tumor immunohistochem/manual.	
88361	Tumor immunohistochem/comput.	*
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.	
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.	

TABLE 1.—CY 2008 FINAL BYPASS CODES FOR CREATING "PSEUDO" SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS—Continued

HCPCS code	Short description	Added for this final rule
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	Ophth dx imaging post seg.	
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.	
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.	

TABLE 1.—CY 2008 FINAL BYPASS CODES FOR CREATING "PSEUDO" SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS—Continued

HCPCS code	Short description	Added for this final rule
93005	Electrocardiogram, tracing.	
93017	Cardiovascular stress test.	*
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.	

TABLE 1.—CY 2008 FINAL BYPASS CODES FOR CREATING "PSEUDO" SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS—Continued

HCPCS code	Short description	Added for this final rule
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.	
95250	Glucose monitoring, cont.	*
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.	
95872	Muscle test, one fiber.	*
95900	Motor nerve conduction test.	
95921	Autonomic nerv function test.	
95925	Somatosensory testing.	
95926	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.	

TABLE 1.—CY 2008 FINAL BYPASS CODES FOR CREATING ''PSEUDO'' SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS—Continued

HCPCS code	Short description	Added for this final rule
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 the CY 2008 OPPS/ASC proposed rule. However, we did not expect the services newly proposed for packaged payment to commonly appear with a drug administration service. Therefore, we believed that the analysis conducted on the CY 2007 final rule with comment period data was sufficient to inform our development of the CY 2008 OPPS/ASC proposed rule.

In general, we did not believe that the proportionate amount of packaged costs in the multiple bills relative to the number of primary services would be greater than that in the single bills. Our findings supported our hypothesis. The costs in uncoded revenue codes and HCPCS codes with a packaged status indicator accounted 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 accounted 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 were 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 were attributable to packaged services, and 29 percent of observed costs across all claims were attributable to packaged services. Therefore, we concluded that, in general, the extent of packaging in all bills was similar to the amount of packaging in the single procedure bills we used to set median costs for most APCs.

In the CY 2008 proposed rule (72 FR 42640), we recognized that aggregate numbers do not address the packaging associated with single and multiple procedure claims for specific services. In past years, we received comments stating that the amount of packaging in the single bills for drug administration services was not representative of the typical packaged costs of these drug administration services, which were usually performed in combination with one another, because the single bills represented 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 and also published the results in the CY 2008 OPPS/ASC proposed rule (72 FR 42640 through 42641).

As discussed in the proposed rule, we found that drug administration services demonstrated reasonable single bill representation in comparison with other OPPS services. Single bills for drug administration constituted, roughly, 30 percent of all observed occurrences of drug administration services, varying by code from 7 to 55 percent. The study also demonstrated that packaged costs substantially contributed to median cost estimates for the majority of drug administration HCPCS codes (72 FR 42640 through 42641).

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 made 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) demonstrated limited packaging (median 0 percent and mean 17 percent), and the median cost for the code was derived from only 7 percent of all occurrences of the code. Across all drug administration codes, over half showed significant median packaged costs largely attributable to packaged drug and pharmacy costs.

By definition, we were 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 suggested the presence of moderate packaged costs, especially drug and pharmacy costs, associated with drug administration services in the multiple bills. We calculated measures of central tendency for packaging percentages in the multiple bills or portions of multiple bills remaining after ''pseudo'' singles were created. We referred 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 were the only separately paid procedure codes on the claim, we estimated that packaged costs were 22 percent of total costs (27 percent, on average), where total costs consisted of costs for all payable codes. Costs for packaged drug HCPCS codes and pharmacy revenue codes comprised 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 appeared with other payable codes (largely radiology services and visits), we estimated packaged costs were 13 percent of total cost at the median (19 percent, on average). Costs for packaged drugs and pharmacy revenue codes comprised 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 resembled 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 suggested that the multiple bill data probably would support current median estimates.

In the CY 2008 OPPS/ASC proposed rule (72 FR 42641), we noted that we had received several comments over the past few years offering algorithms for packaging the costs associated with specific revenue codes or packaging drugs with certain drug administration codes. Because of the complexity of even routine OPPS claims, prior research suggested that such algorithms have limited power to generate additional single bill claims and do little to change median cost estimates. In the proposed rule (72 FR 42641), we explained that 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 specifically solicited methodologies for creation of single bills that meet these criteria.

We received several public comments with regard to the use of data from single and multiple procedure claims for ratesetting. A summary of the public comments and our responses follow.

Comment: Several commenters expressed appreciation for CMS' analysis of packaged costs included on single and multiple procedure claims for drug administration services. One commenter encouraged CMS to further analyze the total amount and percentage of packaged costs associated with all packaged HCPCS codes, as well as other packaged services reported by hospitals, and examine this information on single versus multiple procedure claims in order to increase hospitals' understanding of the actual packaged costs used in the ratesetting process. Once again, several commenters encouraged CMS to consider specific packaging algorithms to allocate packaged costs on multiple procedures claims, in order to create additional ''pseudo'' single claims for ratesetting.

Response: The packaging of associated costs into payment for major procedures is a longstanding principle of the OPPS. The OPPS packages payment for the operating and capital-related costs that are directly related and integral to furnishing a service on an outpatient basis. These packaged costs have historically included costs related to use of an operating or treatment room, anesthesia, medical supplies, implantable devices, inexpensive drugs, etc. Our findings related to the packaged costs on single and multiple claims for drug administration services confirm that the packaging on the single bills used for ratesetting resembles the drug and pharmacy-related packaged costs on multiple procedure claims. The packaging associated with drug administration services on single and multiple claims has historically been of particular concern to the public, so we are reassured by this finding. We are not convinced that developing this information for all other HCPCS codes would provide further useful information to hospitals. Instead, we prefer to direct our analytic resources toward exploring additional approaches to using more cost data from multiple procedure claims for ratesetting. If we are eventually able to use all OPPS claims in developing median costs, then all packaged costs on claims would also be incorporated in ratesetting under the OPPS. We remind hospitals that they should continue to take into consideration all costs associated with providing HOPD services in establishing their charges for the services. In addition, hospitals should report packaged HCPCS codes and charges, consistent with all CPT, OPPS, and local

contractor instructions, whenever those services are provided to ensure that the associated costs are included in ratesetting for the major services.

As we have stated previously regarding our exploration of specific packaging algorithms, we have found that these approaches, while resource-intensive on our part, have limited power to generate additional single bill claims and do little to change median cost estimates. We received no other specific suggestions for other approaches to allocating packaged costs on ''hardcore'' multiple bills that would 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 will continue to explore these data challenges with the assistance of the Data Subcommittee of the APC Panel. We believe that further progression toward encounter-based or episode-based payment for commonly provided combinations of services could reduce the number of these multiple claims and incorporate additional claims data, as discussed in section II.A.4.d. of this final rule with comment period regarding low dose rate prostate brachytherapy and cardiac electrophysiologic evaluation and ablation procedures.

After consideration of the public comments received, we are finalizing our CY 2008 proposal for the use of single and multiple procedure claims for ratesetting. We will continue to pursue additional methodologies that would allow use of cost data from ''hardcore'' multiple claims for ratesetting.

c. Calculation of CCRs

We calculated hospital-specific overall CCRs and hospital-specific departmental CCRs for each hospital for which we had claims data in the period of claims being used to calculate the median costs that we converted to scaled relative weights for purposes of setting the OPPS payment rates. We applied 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.* We calculated CCRs for the standard and nonstandard cost centers accepted by the electronic cost report database. In general, the most detailed level at which we calculated CCRs was 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 because 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. This is commonly known as ''charge compression.''

In CY 2006, the device industry commissioned a study to interpolate a device specific CCR from the medical supply CCR, using publicly available hospital claims 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 expenditures 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 hospital outpatient 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 discussed each recommendation within the context of the OPPS and provided our assessment of its application to the OPPS in the CY 2008 OPPS/ASC proposed rule (72 FR 42642). Of the four short term recommendations, we believe that only the recommendation to establish regression based estimates as a

temporary or permanent method for disaggregating national average CCRs for medical supplies, drugs, and radiology services under the IPPS has specific application to the OPPS (RTI study, pages 11 and 86). Moreover, with regard to radiology services, the OPPS already has partially implemented RTI's recommendation to use lower CCRs to estimate costs for those OPPS services allocated to MRI or CT Scan cost centers through its use of hospital-specific CCRs for nonstandard cost centers.

For reasons discussed below and in more detail in the proposed rule (72 FR 42642 through 42643), we proposed 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 regression-based CCRs that could be applied to both inpatient and outpatient charges. We proposed to evaluate the results of that methodology for purposes of determining whether the resulting regression-based CCRs should be proposed for use in developing the CY 2009 OPPS payment rates. As noted in the proposed rule (72 FR 42642), the revised all charges model and resulting regression-based CCRs were not available in time for use in developing this final rule with comment period.

Since publication of the proposed rule, we have contracted with RTI to determine whether the statistical model that RTI recommended in its January 2007 report for adjusting CCRs in inpatient cost computations can be expanded to include cost computations for significant categories of outpatient services that are paid under the OPPS and to assess the impact of any such changes on payment under the OPPS (HHSM 500–2005–00029I Task Order 0008, ''Refining Cost-to-Charge Ratios for Calculating APC and DRG Relative Payment Weights''). Under this task order, RTI will assess the validity of the revenue code-to-cost center crosswalk used under the OPPS by comparing revenue code and cost center charges, make recommendations for changes to the crosswalk, and assess the OPPS use of nonstandard cost centers. RTI will estimate regression-based CCRs using charge data from both inpatient and outpatient claims for hospital ancillary departments. RTI will extend its recommended models to estimate regression-based CCRs for cost centers that are particularly relevant to APCs, working with CMS staff to analyze the sensitivity of APC weights to proposed adjustments. RTI also will convene a technical expert panel to review analyses, as it did for its first study.

There are several reasons why we did not propose to use the intradepartmental regression-based CCRs that RTI estimated using IPPS charges for the CY 2008 OPPS estimation of median costs. We agree with RTI that the intradepartmental CCRs 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 believed 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. Therefore, we believed that an all charges model examining an expanded subset of revenue codes would be the most appropriate, and that this model should be developed before we could apply the resulting regression based CCRs to the charges for supplies paid under the OPPS.

Moreover, we were concerned that implementing the regression-based IPPS related 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, and that a subsequent change to application of the regression-based 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 did not propose to adopt the RTI regression-based CCRs under the CY 2008 OPPS. As indicated in the proposed rule (72 FR 42643), we stated that we would consider whether it would be appropriate to adopt regression-based CCRs for the OPPS after we received RTI's comprehensive review of the OPPS cost estimation methodology and reviewed the results of the use of both inpatient and outpatient charges across all payers to reestimate regression-based CCRs.

We received many public comments on the issue of application of the disaggregated CCRs that RTI estimated using regression analysis to calculate payments for the CY 2008 OPPS. A summary of the public comments and our responses follow.

Comment: The commenters made a number of requests for the CY 2008 OPPS. Some commenters asked specifically that CMS use the RTI regression-based CCRs to calculate the costs of devices, implants, and drugs under the CY 2008 OPPS. Other commenters urged CMS not to apply this charge compression adjustment methodology to diagnostic radiology services because the application of the methodology to these capital intensive procedures has not been fully validated and would benefit from additional analysis. The commenters who supported the application of the adjustment methodology for CY 2008 asserted that CMS should disregard the fact that the estimated regression-based CCRs were calculated using only inpatient charge data because the commenters had found that using inpatient or outpatient charges yielded similar CCR estimates for implantable devices and all other supplies. These commenters believed that CMS should accept the RTI findings that were based on inpatient charges alone and apply them to the calculation of median costs for all OPPS weights. They explained that CMS could consider further refinements to the methodology in future years, such as estimating the regression-based CCRs using either outpatient or combined charges, but that CMS should not delay implementing this important change as it evaluates an all charges model.

Some commenters who supported the application of the adjustment for CY 2008 also stated that the most glaring cases of charge compression occur with high cost implantable devices that are reported by hospitals with low cost supplies in the same supply cost center. They asserted that the need for analysis of the extent of a problem in other cost centers should not stop CMS from applying the estimated regression-based CCRs for CY 2008 to charges for medical supplies, drugs, and radiology services. One commenter submitted a set of revised weights for all APCs reflecting regression-based CCRs for implantable devices and all other supplies, as well as its assumptions in developing the weights, and asked that CMS review the results. Some commenters stated that if CMS decides not to implement the RTI recommendations for regression-based CCRs for CY 2008, it should ensure that an all charges model is implemented in both the IPPS and the OPPS for CY 2009 through a joint IPPS/OPPS task force. Some commenters believed that CMS should either implement the regression-based adjustments in CY 2008 or begin a transition to them over a period of 2 to 3 years.

The MedPAC recommended that CMS use the RTI's estimated disaggregated, regression-based CCRs for medical supplies, drugs, and radiology as part of the OPPS ratesetting process for CY

2008. It stated that, although the application of the regression based CCR estimates is not a perfect solution to the problem of charge compression, the possibility of payment inaccuracies is sufficiently serious that CMS should implement this imperfect solution. The MedPAC also recommended that if CMS prefers to await the results of the all charges model and chooses not to correct for the effects of charge compression under the CY 2008 OPPS, CMS must do so for the CY 2009 OPPS.

Response: While the RTI recommendations for regression-based CCRs may have the potential to address issues of charge compression raised in the public comments about OPPS cost-based weights, we are not sufficiently convinced that we should adopt the regression-based CCR estimates for the CY 2008 OPPS from the January 2007 RTI short-term recommendations for several reasons. First, the focus of the RTI study on inpatient charges did more than just restrict the regression model dependent variables to inpatient percentages. The study also limited the cost centers addressed to those where the inpatient charges comprised a significant portion of the cost center charges and substantially contributed to the DRGs. The RTI analysis did not examine cost centers that have a much greater proportion of outpatient charges, and as such, are particularly important to APC weights, while also potentially having a residual import for DRG weight calculations as well.

Second, adoption of regression-based CCRs in this final rule with comment period would produce significant changes to the proposed APC payment rates beyond those already introduced with our CY 2008 packaging approach. The lengthy discussion of public comments to our proposed packaging approach in section II.A.4. of this final rule with comment period reflects the public concern raised by a modest change in the methodology for estimating APC relative weights. Disaggregating drug and supply cost centers clearly would redistribute hospitals' resource costs among relative weights for different APCs. Estimated APC median costs calculated using regression-based CCRs for implantable devices and all other supplies, which were furnished by one commenter, showed increases for some services of as high as 28 percent, such as APC 0418 (Insertion of Left Ventricular Lead). Others would decline by as much as 11 percent, including APC 0674 (Prostate Cryoablation) and APC 0086 (Level III Electrophysiologic Procedures). An adjusted ''all other supply'' CCR would reduce the median cost of any service with significant supply packaging. Adoption of regression-based CCRs could interact with other potential changes to the APC payment groups under the OPPS. Budget neutrality adjustments could further increase the magnitude of these observed differences. We believe that these significant redistributional effects would have to be confirmed through CMS analysis, modeled, and made available for public comment should CMS decide to adopt regression-based CCRs.

Third, we anticipate overall changes to our cost estimation methodology in the future, including changes to the revenue code-to-cost center crosswalk and use of nonstandard cost centers. We believe that a comprehensive review of cost estimation is an appropriate time to explore the potential use of disaggregated CCRs for the OPPS. For example, if we implemented only select regression-based CCRs or crosswalk refinements, we could inappropriately redistribute weight within the system.

Finally, as noted in the FY 2008 IPPS final rule (72 FR 47192 through 47200), despite commenters' support for the disaggregated CCRs developed from regression analysis, we remain concerned about the accuracy of using regression-based estimates to determine relative weights rather than the Medicare cost report. This is especially true for the OPPS, given the potential redistribution of resource costs among services. One commenter noted that poor capital allocation to MRI and CT Scan revenue code charges could explain the observed differences in CCRs for these services, and a regression-based adjustment based on incorrect capital allocation would be equally inaccurate. As discussed in the FY 2008 IPPS final rule (72 FR 47196), we fully support voluntary educational initiatives to improve uniformity in reporting costs and charges on the cost report. Participation in these educational initiatives by hospitals is voluntary. Hospitals are not required to change how they report costs and charges if their current cost reporting practices are consistent with rules and regulations and applicable instructions. However, both the IPPS and OPPS relative weight estimates will benefit from any steps taken to improve cost reporting. To the extent allowed under current regulations and cost report instructions, we encourage hospitals to report costs and charges consistently with how the data are used to determine relative weights. We believe this goal is of mutual benefit to both Medicare and hospitals.

In conclusion, we believe that it is important that the initial RTI estimation of regression-based CCRs be replicated with the inclusion of hospital outpatient charges, that the study examine the current OPPS revenue code-to-cost center crosswalk and the use of nonstandard cost centers, and that the analysis focus on the cost centers that have significant hospital outpatient charges. Regression-based CCRs may have potential to address issues of charge compression under the OPPS and possible mismatches between how costs and charges are reported in the cost reports and on OPPS claims. However, given the potential resulting change in APC weights and redistributional impact, we believe we would need to apply regression-based CCRs in all areas eligible for an adjustment, as well as implement appropriate crosswalk refinements, in order to not under-or overvalue relative weights within the system. We continue to have concerns about premature adoption of regression-based CCRs without the benefit of knowing how they would interact with other APC changes. We further believe that such methodological changes would need to be proposed, including presentation of our assessment of the possible impact of the methodology and solicitation of public comment. Once we have received the results of RTI's evaluation, we will analyze the findings and then consider whether it could be appropriate to propose to use regression-based CCRs under the OPPS. Once we have completed our analysis, we will then examine whether the educational activities being undertaken by the hospital community to improve cost reporting accuracy under the IPPS would help to mitigate charge compression under the OPPS, either as an adjunct to the application of regression-based CCRs or in lieu of such an adjustment. After the conclusion of our analysis of the RTI evaluation and our review of hospital educational activities, we will then determine whether any refinements should be proposed.

Comment: One commenter indicated that the standard hospital accounting methodology for treatment of high capital costs, including the costs of expensive nonmovable radiology equipment, results in CCRs for radiology services that understate the true costs of radiology services because the high capital costs are spread over all departments of the hospital on a square footage basis. The commenter argued that this understatement of the costs in the CCR for radiology-related

departments results in calculated costs for radiology services that are too low because flawed CCRs are applied to the charges for the services provided by the radiology department.

Response: We will consider the issue as part of our assessment of CCRs over the upcoming year, in the context of the RTI study as described earlier and the ongoing work that the hospital industry is undertaking with respect to cost reporting.

2. Calculation of Median Costs

In this section of this final rule with comment period, we discuss the use of claims to calculate the final OPPS payment rates for CY 2008. The hospital OPPS page on the CMS Web site on which this final rule with comment period is posted provides an accounting of claims used in the development of the final rates on the CMS Web site at: *http://www.cms.hhs.gov/HospitalOutpatientPPS.* The accounting of claims used in the development of this final rule with comment period is included on the Web site under supplemental materials for the CY 2008 final rule with comment period. 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.'' These files are available for both the claims that were used to calculate the proposed payment rates for the CY 2008 OPPS and also for the claims that were used to calculate the final payment rates for the CY 2008 OPPS.

As proposed, we used the following methodology to establish the relative weights used in calculating the OPPS payment rates for CY 2008 shown in Addenda A and B to this final rule with comment period. This methodology is as follows:

a. Claims Preparation

We used hospital outpatient claims for the full CY 2006, processed before June 30, 2007, to set the final 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 would 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 108 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. As proposed, for this final rule with comment period, we used the most recently submitted cost reports to calculate the CCRs to be used to calculate median costs for the 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 final overall CCR calculation discussed in section II.A.1.c. of this final rule with comment period for all purposes that required 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 the proposed rule contained a list of the revenue codes we proposed to package. Revenue codes not included in Table 4 were those not allowed under the OPPS because their services could not 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 final rule with comment period.

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 packaging all observation care for the CY 2008 OPPS.

We next copied line-item costs for drugs, blood, and brachytherapy sources (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 brachytherapy sources, as well as other information used to set payment rates, such as a unit-to-day ratio for drugs.

b. Splitting Claims and Creation of ''Pseudo'' Single Claims.

We then split the claims into five groups: single majors, multiple majors, single minors, multiple minors, and other claims. (Specific definitions of these groups follow below.) In years prior to the CY 2007 OPPS, we made a determination about 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 reporting separately paid procedure codes and, therefore, those 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 noted that such an edit would be broader than the device-to-procedure code edits we implemented for CY 2007 for selected devices, and we solicited comments on the impact of establishing such edits on hospital billing processes and related potential improvements to claims data. In the CY 2008 proposed rule (72 FR 42645), we explained that in view of the prior public comments and our desire to ensure that the public data files contained all appropriate data, for the CY 2008 OPPS, we proposed to define majors as HCPCS codes that have a status indicator of ''S,'' ''T,'' ''V,'' or ''X.'' We proposed to define minors as HCPCS codes that have a status indicator of ''F,'' ''G,'' ''H,'' ''K,'' ''L,'' or ''N'' but, as discussed above, to make single bills out of any claims for single procedures with a minor code that also has an APC assignment. This ensured that the claims that contained only HCPCS codes for drugs and biologicals or devices but that did not contain codes for procedures were included in the limited data set and the identifiable data set. It also ensured that conditionally packaged services proposed to receive separate payment only when they were billed without any other separately payable OPPS services would be treated appropriately for purposes of median cost calculations. We proposed to define ''other'' services as HCPCS codes that had a status indicator other than those defined as majors or minors.

We received several public comments regarding our proposal to continue to process OPPS claims for a separately paid drug or device that did not also report a procedural HCPCS code with a status indicator of ''S,'' ''T,'' ''V,'' or ''X.'' A summary of the public comments and our responses follow.

Comment: Several commenters requested that we adopt the recommendation of the APC Panel that CMS edit and return for correction claims that contained a HCPCS code for a separately paid drug or device but that did not also report a HCPCS code with a status indicator of ''S,'' ''T,'' ''V,'' or ''X.'' These commenters believed that this process would generally improve hospitals' coding and charging practices. One commenter indicated that, under some circumstances, a hospital may bill for a diagnostic radiopharmaceutical that is administered on one day but may not report the associated nuclear medicine procedure on the same claim because the procedure would be provided several days later. In this case, the bill for the diagnostic radiopharmaceutical would include no other services with a status indicator of ''S,'' ''T,'' ''V,'' or ''X'' because the administration of the radiopharmaceutical would be considered to be a part of the nuclear medicine study.

Response: We have accepted this recommendation in selective situations. We currently edit claims in the Outpatient Code Editor (OCE) for selected devices for which our data show that hospitals have a history of reporting the HCPCS device code but not reporting the HCPCS procedure code that is necessary for the device to have therapeutic benefit. See the device-to-procedure edits on the OPPS Web page at *http://www.cms.hhs.gov/HospitalOutpatientPPS/*. Moreover, as discussed in more detail in section II.A.4.c.(5) of this final rule with comment period, effective for dates of service on or after January 1, 2008, we will implement OCE edits for diagnostic nuclear medicine services that will require that a HCPCS code for a diagnostic radiopharmaceutical must be on the claim for the claim to be processed to payment. Claims will be returned to the provider for correction if they contain a nuclear medicine service but the hospital does not also report a radiopharmaceutical on the same claim. We will continue to assess the need for OCE edits based upon the unique

circumstances of individual services or categories of services.

In the CY 2008 proposed rule (72 FR 42645), we explained our continued belief that using status indicators, with the proposed changes, was an appropriate way to sort the claims into these groups and also to make our process more transparent to the public. We further believed that this proposed method of sorting claims would enhance the public's ability to derive useful information for analysis and public comment on the proposed rule.

We used status indicator ''Q'' in Addendum B to the proposed rule to identify services that would receive separate HCPCS code-specific payment when specific criteria are met, and payment for the individual service would be packaged in all other circumstances. We proposed several different sets of criteria to determine whether separate payment would be made for specific services. For example, we proposed that HCPCS code G0379 (Direct admission of patient for hospital observation care) be assigned status indicator ''Q'' in Addendum B to the proposed rule because we proposed 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). We also proposed to assign the specific services in the proposed composite APCs discussed in section II.A.4.d. of the proposed rule status indicator ''Q'' in Addendum B to the proposed rule because we proposed that their payment would be bundled into a single composite payment for a combination of major procedures under certain circumstances. As proposed, these services would only receive separate code-specific payment if certain criteria were met. The same is true for those less intensive outpatient mental health treatment services for which payment would be limited to the partial hospitalization per diem rate and which also were assigned status indicator ''Q'' in Addendum B to the 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 those 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 the proposed rule were those codes that we identified as ''special'' packaged codes, where we proposed that a hospital would receive separate payment for providing one unit of a service when the ''special'' packaged code appears on the same day on a claim without another service that was assigned status indicator ''S,'' ''T,'' ''V,'' or ''X.'' We proposed to package payment for these HCPCS codes when the code appears on the same date of service on a claim with any other service that was assigned status indicator ''S,'' ''T,'' ''V,'' or ''X.''

In response to public comments as discussed in detail in section II.A.4. of this final rule with comment period, we refined the proposed methodology for paying claims that contain ''special'' packaged codes with status indicator ''Q'' when there is a major separately paid procedure on the claim for the same date and when there are multiple ''special'' packaged codes with status indicator ''Q'' but no major procedure on the claim. This last and largest subset of conditionally packaged services, referred to as ''special'' packaged codes in the proposed rule, had to be integrated into the identification of single and multiple bills for ratesetting to ensure that the costs for these services were appropriately packaged when they appeared with any other separately paid service or paid separately when appearing by themselves.

We handled these ''special'' packaged ''Q'' status codes in the data for this final rule with comment period by assigning the HCPCS code an APC and a data status indicator of ''N.'' This gives all special packaged codes an initial status of ''minor'' that is changed, when appropriate, through the split process. We identified two subsets of the ''special'' packaged codes for the purpose of payment and ratesetting. Imaging supervision and interpretation ''special'' packaged codes are now named ''T-packaged'' codes. All other ''special'' packaged codes are referred to as ''STVX-packaged'' codes. When an ''STVX-packaged'' code appeared with a HCPCS code with a status indicator of ''S,'' ''T,'' ''V,'' or ''X'' on the same date of service, it retained its minor status and was treated as a packaged code and received a status indicator of ''N.'' The costs that appeared on the lines with these codes were packaged into the cost of the HCPCS code with a status indicator of ''S,'' ''T,'' ''V,'' or ''X'' in the single bills and contributed to the median cost for the primary service with which they appeared. When the ''STVX packaged'' code appeared by itself, without other special packaged codes on the same claim, and had a unit of one, we changed the status indicator on the line to the status indicator of the APC to which the code was assigned, converting the service from a single minor to a single major. This created ''natural'' single bills for the ''STVX-packaged'' codes. In the case of multiple ''STVX-packaged'' codes reported on a claim on the same date of service but without a major separately paid procedure (that is, ''S,'' ''T,'' ''V,'' or ''X''), we first identified the ''STVX-packaged'' code with the highest CY 2007 OPPS payment weight. We then changed the status indicator on the line to the status indicator of the APC to which this particular code was assigned, converting the service from a single minor to a single major, and we forced the units to be one to conform with our policy of paying only one unit of a ''Q'' status service. We extracted these claims from the multiple minors to create ''pseudo'' single bills. We summed all costs on the claim and associated the resulting cost with the payable ''STVX-packaged'' code that had the highest CY 2007 OPPS payment weight. We used natural and ''pseudo'' single procedure claims for ''STVX-packaged'' codes to set the median costs for the APCs to which the codes were assigned when they would be separately paid.

We modified this methodology for the ''T-packaged'' codes (imaging supervision and interpretation services in CY 2008) because our final CY 2008 payment policy for these services differs from the policy for ''STVX-packaged'' codes. Although we treated all ''special'' packaged codes as ''STVX-packaged'' codes in the proposed rule, in this final rule with comment period, ''T-packaged'' services are packaged only when they appear with a service with a status indicator of ''T'' on the same date; otherwise, ''T packaged'' services are paid separately. We assessed all claims for the presence of ''T packaged'' services and determined their final payment disposition, packaged or separately paid, prior to splitting the claims into single and multiple majors and minors. When a ''T-packaged'' code appeared with a HCPCS code with a status indicator of ''T'' on the same date of service, the ''T-packaged'' code was treated as a packaged code and retained its minor status and a status indicator of ''N.'' Otherwise, we designated a ''T-packaged'' service that would be separately paid by identifying the ''T-packaged'' code on the date of service with the highest CY 2007 payment weight. We changed the status indicator on the line of the ''T-packaged'' code with the highest CY 2007 payment weight to the status indicator of the APC

to which the code was assigned, converting it from a single minor to a single major. We forced the units to be one to conform with our policy of paying only one unit of a service with a status indicator of ''Q.'' Any remaining ''T-packaged'' codes appearing on the same date of service retained their minor status and a status indicator of ''N.'' In the single and ''pseudo'' single bills, the costs that appeared on the lines with these codes were packaged into the cost of the HCPCS code with a status indicator of ''T.'' The remaining claims, ''T-packaged'' services on claims with another service with a status indicator of ''S,'' ''V,'' or ''X'' on the same date, became multiple majors. The bypass process for breaking multiple major claims created additional ''pseudo'' single bills for the ''T-packaged'' codes that had been converted to major status. When the ''T-packaged'' code appeared by itself with packaged services and one unit, we changed the status indicator on the line to the status indicator of the APC to which the code was assigned, converting the service to a single major procedure. In the case of multiple ''T-packaged'' codes reported on a claim on the same date of service but without a major separately paid procedure (''S,'' ''T,'' ''V,'' or ''X''), we summed all costs on the claim, associated the resulting cost with the ''T-packaged'' or ''STVX-packaged'' code that had the highest 2007 OPPS payment weight, and forced the units to one. We extracted these claims from the multiple minors to created new single bills. These processes created ''natural'' and ''pseudo'' single bills for the ''T-packaged'' codes that were then used to set the median cost for each specific code and for the APCs to which the codes would be assigned when they were separately paid.

We added the logic necessary to deal with these codes as part of the split of the claims into the five groups defined below and in our review of the multiple minor claims. We evaluated the ''T-packaged'' codes that had been on the bypass list to see if they might be eligible for continuation on the list, as these codes would appear with their final payment disposition in the multiple majors. However, we determined that none of these codes should be returned to the bypass list because their associated packaging under their CY 2008 ''Q'' payment status exceeded the empirical criteria designed to limit error in the allocation of packaged costs through the bypass process.

Specifically, we 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''). Claims with one unit of a status indicator ''Q'' code that was an ''STVX-packaged'' code or ''T-packaged'' code where there was no code on the claim with status indicator ''S,'' ''T,'' '' V,'' or ''X,'' or ''T,'' respectively.

2. *Multiple Major Claims:* Claims with more than one separately payable procedure (that is, status indicator ''S,'' ''T,'' ''V,'' or ''X''), or multiple units of one payable procedure. As discussed below, some of these were used in median setting. These claims included those with a status indicator ''Q'' code that was a ''T-packaged'' code and no procedure with a status indicator ''T'' on the same date of service. We also included in this set claims that contained one unit of one code when the bilateral modifier was appended to the code and the code was conditionally or independently bilateral. In these cases, the claims represented more than one unit of the service described by the code, notwithstanding that only one unit was billed.

3. *Single Minor Claims:* Claims with a single HCPCS code that was assigned status indicator ''F,'' ''G,'' ''H,'' ''K,'' ''L,'' or ''N'' and was not an ''STVX-packaged'' or ''T packaged code.''

4. *Multiple Minor Claims:* Claims with multiple HCPCS codes that were assigned status indicator ''F,'' ''G,'' ''H,'' ''K,'' ''L,'' or ''N.'' This set included ''STVX packaged'' and ''T-packaged'' codes with more than one unit of the code or more than one line of these codes on the same date of service. As noted above, we created ''pseudo'' singles from some of these claims when we broke the claim by date, packaged the costs into the code with the highest CY 2007 payment weight, and forced the units to one to match our payment policy of paying one unit.

5. *Non-OPPS Claims:* Claims that contained no services payable under the OPPS (that is, all status indicators other than those listed for major or minor status). These claims were 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.

The claims listed in numbers 1, 2, 3, and 4 above were included in the data files that can be purchased as described above. ''STVX-packaged'' and ''T-packaged'' codes appear in the single major file, the multiple major file, and the multiple minor file.

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 used the bypass codes listed earlier in Table 1 and discussed in section II.A.1.b. of this final rule with comment period to remove separately payable procedures that we determined contained limited or no packaged costs or that 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 claim 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 then examined the multiple major claims for dates of service to determine if we could break them into ''pseudo'' 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 dates 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 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 contained codes that were viewed as independently or conditionally bilateral and that contained the bilateral modifier (Modifier 50 (Bilateral procedure)) because the line-item cost for the code represented the cost of two units of the procedure, notwithstanding that the code appeared with a unit of one. Therefore, the charge on the line

represented the charge for two services rather than a single service and using the line as reported would have overstated the cost of a single procedure.

c. Completion of Claim Records and Median Cost Calculations

We then packaged the costs of packaged HCPCS codes (codes with status indicator ''N'' listed in Addendum B to the proposed rule and the costs of those lines for ''Q'' status services that retained status indicator ''N'' through the split process as described above) and packaged revenue codes into the cost of the single major procedure remaining on the claim.

The final list of packaged revenue codes is shown in Table 2 below. 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 final 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 stated in the CY 2008 OPPS/ASC proposed rule (72 RF 42646) that we accepted the APC Panel's recommendation and we proposed to change the list of packaged revenue codes for the CY 2008 OPPS in the following manner. First, we proposed 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 specifically proposed to add revenue code 0273 (Take Home Supplies) to the list of packaged revenue codes because we believed that the charges under this revenue code were for the incidental supplies that hospitals sometimes provided for patients who were discharged at a time when it was not possible to secure the supplies needed for a brief time at home. We proposed to conform the list of packaged revenue codes in the OCE to the OPPS for CY 2008. We made these changes in the calculation of the CY 2008 OPPS payment rates. The final CY 2008 packaged revenue codes are displayed in Table 2 below.

We packaged the costs of the HCPCS codes that were shown with status indicator ''N'' into the cost of the independent service to which the packaged service was ancillary or supportive. We refer readers to section II.A.4. of this final rule with comment period for a more complete discussion of the final packaging changes for CY 2008.

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 assigned packaging flag number 3 to claims on which hospitals submitted token charges for a service with status indicator ''S'' or ''T'' (a major separately paid service under the OPPS) for which the fiscal intermediary was required to allocate the sum of charges for services with a status indicator equaling ''S'' or ''T'' based on the weight of the APC to which each code was assigned. We did not believe that these charges, which were token charges as submitted by the hospital, were valid reflections of hospital resources. Therefore, we deleted these claims. We also deleted claims for which the charges equaled the revenue center payment (that is, the Medicare payment) on the assumption that where the charge equaled 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 used the pre reclassified wage indices for standardization because we believed that they better reflected the true costs of items and services in the area in which the hospital was 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).

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 58 million claims were left for this final rule comment period. Of these 58 million claims, we were able to use some portion of approximately 54 million whole claims (93 percent of approximately 58 million potentially usable claims) to create approximately 97 million single and ''pseudo'' single claims, of which we used 96 million single bills (after trimming out just over 900,000 claims as discussed below) in the CY 2008 median development and ratesetting.

We used the remaining claims to calculate the CY 2008 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 final rule with comment period includes a discussion of certain 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 the CY 2008 proposed rule (72 FR 42646), we explained that in our review of median costs for HCPCS codes and their assigned APCs, we had frequently noticed that some services were consistently rarely performed in the hospital outpatient setting for the Medicare population. In particular, there were a number of services, such as several procedures related to the care of pregnant women, that had annual Medicare claims volume of 100 or fewer occurrences. By definition, these services also had a small number of single bills from which to estimate median costs. In addition, in some cases, these codes had been historically assigned to clinical APCs where all the services were low volume. Therefore, the median costs for these services and APCs often fluctuated 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 would be moderated by the increased number of observations for similar services on

which the APC median cost was 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 believed that it would be more appropriate to reconfigure clinical APCs to eliminate most of the low total volume APCs. We observed that these low volume services differed from other OPPS services only because they were not often furnished to the Medicare population. Therefore, we proposed 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 believed that these proposed reconfigurations maintained APC clinical and resource homogeneity. We proposed these changes as an alternative to developing specific quantitative approaches to treating low total volume APCs differently for purposes of median calculation. Specifically, we proposed that 3 APCs (all of which are New Technology APCs) would have a total volume of services less than 100, and only 17 APCs would 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. In this final rule with comment period, 3 APCs (all New Technology APCs) have a total volume of less than 100 and 15 APCs have a total volume of less than 1,000.

We received a number of public comments on our proposed process for calculating the median costs on which our payment rates are based. A summary of the pubic comments and our responses follow.

Comment: Some commenters objected to the volatility of the OPPS rates from year to year. The commenters asserted that the absence of stability in the OPPS rates creates budgeting, planning, and operating problems for hospitals, and that as more care is provided on an outpatient, rather than inpatient basis, the need for stable payment rates from one year to the next becomes more important to hospitals. Some commenters asked that CMS permit no payment rate to change by more than 5 percent from one year to the next.

Response: There are a number of factors pertinent to the OPPS that cause median costs to change from one year to the next. Some of these are a reflection of hospital behavior, and some of them are a reflection of fundamental characteristics of the OPPS as defined in statute. For example, the OPPS payment rates are based on hospital cost report and claims data. However, hospital costs and charges change each year and this results in both changes to the CCRs taken from the most currently available cost reports and also differences in the charges on the claims that are the basis of the calculation of the median costs on which OPPS rates are based. Similarly, hospitals adjust their mix of services from year to year by offering new services and ceasing to furnish services or changing the proportion of the various services they furnish, which has impact on the CCRs that we derive from their cost reports. CMS cannot stabilize these hospital-driven fundamental inputs to the calculation of OPPS payment rates. Moreover, there are other essential elements of the OPPS which contribute to the changes in relative weights each year. These include, but are not limited to, reassignments of HCPCS codes to APCs to rectify 2 times violations as required by the law, to address the costs of new services, and to respond to public comments. Moreover, for some services, we cannot avoid using small numbers of claims, either because the volume of services is naturally low or because the claims data do not facilitate the calculation of a median cost for a single service. Where there are small numbers of claims to be used in median calculation, there is more volatility in the median cost from one year to the next. Lastly, changes to OPPS payment policy (for example, changes to packaging) also contribute to some extent to the fluctuations in the OPPS payment rates for the same service from year to year.

We cannot avoid the naturally occurring volatility in the cost report and claims data that hospitals submit and on which the payment rates are based. Moreover (with limited exceptions), we are required by law to reassign HCPCS codes to APCs where it is necessary to avoid 2 times violations. However, we have made other changes to resolve some of the other potential reasons for instability from year to year. Specifically, we continue to seek ways to use more claims data so that we have fewer APCs for which there are small numbers of single bills used to set the APC median costs. Moreover, we have tried to eliminate APCs with very small numbers of single bills where we could do so. We received no public comments that objected to our proposal to eliminate a number of very low volume APCs; therefore, we are adopting these reconfigurations for CY 2008. We recognize that changes to payment policies, such as the packaging of payment for ancillary and supportive services and the implementation of composite APCs, may contribute to volatility in payment rates in the short term, but we believe that larger payment packages and bundles will help to stabilize payments in future years by enabling us to use more claims data and by establishing payments for larger groups of services.

Comment: A commenter stated that CMS should crosswalk revenue code 0278 (Other implants, under the Medical/Surgical Supplies category) to cost center 3540 (Prosthetic Devices), which generally represents higher cost technology, instead of crosswalking it to cost center 5500 (Medical Supplies Charge to Patient), which often represents lower cost items. The commenter indicated that this change to the revenue code-to-cost center crosswalk would result in improved estimates of the costs of the devices billed under revenue code 0278 and, therefore, would result in more accurate payments.

Response: We will carefully examine the implications of making this change in the future. However, for CY 2008 this change would have a negligible effect on the median costs for services with charges reported under revenue code 0278. Only 20 providers out of 4,201 in the file of the 2005–2006 cost reports used cost center 3540.

Comment: Some commenters asked that CMS provide an adjustment for medical education costs under the OPPS because so much of the costs of teaching services are being incurred in the HOPD as many of the services previously furnished only in the inpatient setting are now being furnished in the HOPD. The commenters stated that CMS indicated that it would study the costs and payment differential among different classes of providers in the April 7, 2000 OPPS final rule with comment period but has not done so. The commenters also asserted that section 4523 of the BBA requires the Secretary to establish adjustments ''as determined to be necessary to ensure equitable payments * * * for certain classes of hospitals'' and, therefore, CMS should study whether the hospital outpatient costs of teaching hospitals are higher than the costs of other hospitals for purposes of determining whether there should be a teaching

hospital adjustment. The commenters explained that their internal analysis of 2004 Medicare cost reports showed that the average outpatient margins were −20.2 percent for major teaching hospitals, −10.1 percent for other teaching hospitals, and −11.8 percent for non-teaching hospitals. They believed these findings demonstrated that the hospital outpatient costs of major teaching hospitals are significantly greater than the costs of other hospitals. The commenters requested that CMS conduct its own analysis, and added that if that analysis shows such a difference, CMS should add a teaching adjustment to the OPPS.

Response: Unlike payment under the IPPS, the law does not provide for payment for indirect medical education costs to be made through the OPPS. Section 1833(t)(2)(E) of the Act, as added by section 4523 of the BBA, states that the Secretary shall establish, in a budget neutral manner '' * * * other adjustments as determined to be necessary to ensure equitable payments, such as adjustments for certain classes of hospitals.'' We have not found such an adjustment to be necessary to ensure equitable payments to teaching hospitals and, therefore, have not developed such an adjustment. We do not believe an indirect medical education add-on payment is appropriate in a budget neutral payment system where such changes would result in reduced payments to all other hospitals. Furthermore, in this final rule with comment period, we have developed payment weights that we believe provide appropriate and adequate payment for the complex medical services, such as visits requiring prolonged observation, new technology services and device-dependent procedures, which we understand are furnished largely by teaching hospitals. Teaching hospitals benefit from the recalibration of the APCs and the changes to packaging that are implemented in this final rule with comment period. The final CY 2008 impacts by class of hospital are displayed in Table 61 in section XXIV.B. of this final rule with comment period. Therefore, we do not believe that there is sufficient reason to develop an adjustment to the OPPS payment to teaching hospitals for the CY 2008 OPPS.

Comment: The MedPAC commented that while CMS proposed to apply a multiple procedure reduction to imaging services for CY 2006, CMS did not adopt this proposal as final but stated that it would continue to study whether such a reduction was appropriate. The MedPAC asked that CMS continue to examine ways to improve payment accuracy for imaging services, including considering applying a multiple procedure reduction to these services.

Response: The question of whether it would be appropriate to apply a multiple procedure reduction pertains only to those imaging services for which we make separate payment. It is not an issue for packaged imaging services, including the numerous imaging services that we are packaging for CY 2008 as part of our expanded payment bundles under the OPPS. The concern, therefore, is partially mitigated by our final CY 2008 packaging policies. Commenters responding to the CY 2006 proposal OPPS indicated that, in contrast to the MPFS payment rates, the hospital cost data used by CMS to set payment rates for imaging services already reflects savings due to the efficiencies of performing multiple procedures during the same session and that the proposal to discount second and subsequent procedures would be tantamount to discounting those procedures twice (70 FR 68707). As we indicated in our response to that comment, we were unable to disprove commenters' contentions that there are already efficiencies included in hospitals' costs and, therefore, in their CCRs and in the median costs on which the OPPS payments are based (70 FR 68708). However, we believe it is possible that there may be a relationship between the extent to which efficiencies are incorporated into the median costs and the degree to which charge compression affects the median costs for imaging services. RTI's study of charge compression using inpatient charges found that use of regression adjusted CCRs would reduce the costs of magnetic resonance imaging and computed tomography services. This is one of the categories of hospital services that has high outpatient utilization. Over the coming year, as discussed earlier in this section of this final rule with comment period, we will explore through the RTI contract the results of including hospital outpatient charges to determine regression-adjusted CCRs for calculation of the median costs for imaging services. We believe that this information could be useful in the reassessment of whether it would be appropriate to apply a multiple procedure reduction to separately paid imaging services.

A detailed discussion of the development of median costs for blood and blood products is included in section X. of this final rule with comment period. A discussion of the calculation of medians for APCs that require one or more implantable devices when the service is performed is provided in section IV.A. of this final rule with comment period. The methodology for developing the median costs for composite APCs is included below in section II.A.4.d. of this final rule with comment period. A description of the methodology for calculating the median cost for partial hospitalization services is presented below in section II.B. of this final rule with comment period.

After consideration of the public comments received, we are finalizing our proposed CY 2008 methodology for calculating the median costs upon which the CY 2008 OPPS payment rates are based, with the modifications described earlier regarding the treatment of services which are assigned status indicator ''Q.''

TABLE 2.—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.

TABLE 2.—CY 2008 PACKAGED REVENUE CODES—Continued

Revenue code	Description
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.
0721	LABOR.
0732	TELEMETRY.
0762	OBSERVATION ROOM.
0801	HEMODIALYSIS.
0802	PERITONEAL DIALYSIS.
0803	CAPD.
0804	CCPD.
0809	OTHER INPATIENT DIALYSIS.
0810	ORGAN ACQUISITION.
0819	OTHER ORGAN ACQUISITION.
0821	HEMODIALYSIS COMP OR OTHER RATE.
0824	MAINTENANCE 100%.
0825	SUPPORT SERVICES.
0829	OTHER HEMO OUTPATIENT.
0942	EDUCATION/TRAINING.

3. Calculation of OPPS Scaled Payment Weights

Using the median APC costs discussed previously, we calculated the final relative payment weights for each APC for CY 2008 shown in Addenda A and B to this final rule with comment period. In years prior to CY 2007, we standardized all the relative payment weights to APC 0601 (Mid Level Clinic Visit) because it was 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 APC 0606 was the middle level clinic visit APC (that is, Level 3 of five levels). We had 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 were among the most frequently performed services in the hospital outpatient setting. As proposed for CY 2008, to maintain consistency in using a median for calculating unscaled weights representing the median cost of some of the most frequently provided services, we continued 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 2008 median for APC 0606, for CY 2008 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.

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 final 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 final unscaled relative payment weights were adjusted by a weight scaler of 1.3226 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 decline in the weight scaler compared to the proposed weight scaler of 1.3665 results largely from the refinement for this final rule with comment period of the proposed packaging policy to package imaging supervision and interpretation services only if they are reported on the same date of service as a HCPCS code that has a status indicator of ''T.'' This change both increased the median costs for these imaging supervision and interpretation services and added a significant number of units for these services that would be separately paid under the final CY 2008 policy. The other factors that contributed to the decline of the scaler from the proposed rule to this final rule with comment period include the creation of the observation composite APCs and the increase in the final CY 2008 payment rate for partial hospitalization services compared to the proposed payment rate.

The final relative payment weights listed in Addenda A and B to this final rule with comment period incorporate the recalibration adjustments discussed in sections II.A.1. and 2. of this final rule with comment period.

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 final rule with comment period) is included in the budget neutrality calculations for the CY 2008 OPPS. We did not receive any public comments on the methodology for calculating scaled weights from the median costs for the CY 2008 OPPS. Therefore, we are finalizing our proposed methodology, without modification, including updating of the budget neutrality scaler for the final rule as proposed.

4. Changes to Packaged Services

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 or multiple units of the same procedure 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, 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 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 create 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 and bundling 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 3 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 3.–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	29.741	32.714	36.072
Percent Increase	.....	10.5	8.2	12.8	11.3	11.9	10.1	10.26

Based on the Midsession Review of the President's FY 2008 Budget.

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 4 below illustrates the increases in the volume and intensity of hospital outpatient services over the past several years.

TABLE 4.–PERCENTAGE 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	10.1	9.4	5.8

Based on the Midsession Review of the President's FY 2008 Budget.

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 10.1 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. 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. 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. 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 budget-neutral 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 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(a) of the MIEA–TRHCA, which added section 1833(t)(19) to the Act, 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 final rule with comment period.

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 payment system and the OPPS 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 the Web site 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. 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 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 final rule with comment period for a more detailed discussion of the treatment of multiple procedure claims in the ratesetting process.) In the CY 2008 OPPS/ASC proposed rule, we proposed two new composite APCs for CY 2008 payment of combinations of services in two clinical care areas, as discussed in section II.A.4.d. of this final rule with comment period. In that section, we summarize and respond to the public comments we received 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.

c. Packaging Approach

With the exception of the two composite APCs that we proposed for CY 2008 and discuss in detail in section II.A.4.d. of this final rule with comment period, we indicated in the CY 2008 OPPS/ASC proposed rule that we were not 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 for the proposed rule, we examined services currently provided under the OPPS, looking for categories of ancillary items and services for which we believed 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, in development of the proposed rule, we examined whether there were 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, in the CY 2008 OPPS/ASC proposed rule (72 FR 42652), we proposed 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 proposed 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 proposed 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 proposed 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 final rule with comment period.

Specifically, we proposed 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
- Observation services

In the proposed rule, we identified the HCPCS codes we proposed to package for CY 2008, explained our rationale for proposing to package the codes in these categories, provided examples of how HCPCS and APC median costs and payments would change under these proposals, and discussed the impact of these changes under each category, as follows:

The median costs of services at the HCPCS level for many separately paid procedures changed as a result of our proposal because we proposed 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 proposed 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 proposed APC median costs changed 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 the proposed rule on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/HORD/list.asp#TopOfPage*.

Review of the HCPCS median costs for the proposed rule indicated 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, 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 examined the aggregate impact of making these proposed changes on payment for CY 2008 in the proposed rule. 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 proposed resulted in changes to scaled weights and, therefore, to the proposed payment rates for all separately paid procedures. These changes resulted from both shifts in median costs as a result of increased packaging, changes in multiple procedure discounting patterns, and a higher weight scaler that was applied to all unscaled APC weights. (We refer readers to section II.A.3. of this final rule with comment period for an explanation of the weight scaler.) In a budget neutral system, the monies previously paid for services that were 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 did not completely reflect the full incremental cost of the packaged services. The impact of the cumulative changes for the CY 2008 OPPS payments is discussed in section XXIV.B. of this final rule with comment period.

We estimated that our CY 2008 packaging proposal would redistribute approximately 1.2 percent of the estimated CY 2007 base year expenditures under the OPPS. The monies associated with this redistribution were in addition to any increases that would otherwise occur due to a higher median cost for the APC as a result of the expanded payment package. If the relative weight for a particular APC decreased 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 proposed would have more effect on payment for some services than on payment for others because the dependent items and services that we proposed 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 our 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.

We received many, often widely diverging, public comments on the CY 2008 proposed packaging approach. In many cases the comments were generally applicable to the totality of the packaging proposal and, in other cases, the same general comments were made but only with regard to a specific category or set of services of interest to the commenter. We have addressed all similar public comments in the discussion of general comments, whether they were made in general or for specific categories of services, because the same response applies

whether the comment was on packaging in general or on a specific service. We have limited the summary of public comments and our responses in the individual category discussions to issues that pertain only to the category or specific services within the category.

During the September 2007 APC Panel meeting, the APC Panel supported packaging for contrast agents, image processing services, guidance (except for radiation oncology guidance procedures), diagnostic radiopharmaceuticals with a median per day cost of less than $200, and intraoperative testing other than possibly for CPT code 96020 (Neurofunctional testing selection and administration during noninvasive imaging functional brain mapping, with test administered entirely by a physician or psychologist, with review of test results and report). The Panel recommended a delay in packaging for imaging supervision and interpretation services because of excessive payment reductions that the Panel believed would occur under the CMS proposal, particularly with regard to packaging payment for those supervision and interpretation services that already include packaged injection services. The Panel did not support packaging of observation services, although it suggested that if CMS were to package observation, it should instead create a composite APC (or a group of composite APCs) for observation and the related visit services, without restriction to specific clinical conditions. The APC Panel also recommended that CMS provide additional information in the CY 2008 final rule with comment period about packaging, including crosswalks and information clarifying how newly packaged services map back to primary procedures.

Comment: MedPAC generally supported the proposed packaging because the services proposed for packaging are typically furnished on the same day as a separately paid service and there is little potential for them to be furnished on another date to avoid the effects of packaging. MedPAC explained that packaging of observation services is logical because currently 70 percent of observation care is packaged. MedPAC's principal concern about the proposed packaging of observation was that this approach could result in hospitals' costs being higher than OPPS payments in some cases, and thereby create an incentive for inpatient admissions. It encouraged CMS to carefully monitoring whether hospitals change their behavior with regard to inpatient admissions.

Some commenters supported encounter-based or episode-based payment, but asked that this approach be based on single encounter only and not span a period of time, because they believed that it would be very difficult to set rates for periods of recurring services. The commenters supported use of multiple procedure claims and payment for combinations of services but encouraged CMS to carefully evaluate the overall impact of packaging on all hospitals. Other commenters suggested that CMS package only services that are low cost and furnished at a high frequency with the independent service. Several commenters stated that CMS should not finalize the proposed packaging approach because it would lead to inappropriate payment, including both overpayments and underpayments.

Several commenters asked that CMS delay the packaging approach for at least a year because they believed the proposed rule did not furnish sufficient data analysis in support of the proposal. They asserted that the aggregate impact analysis provided no information that commenters could use to evaluate the individual codes proposed to be packaged, making it impossible for the public to determine how payment for services would be affected. Some commenters requested that CMS furnish the same level of impact discussion for each of the services in each of the categories as it did for the composite APCs. Other commenters asked CMS to identify the percent of charges for dependent services that were packaged into each independent procedure, identify all independent procedures into which cost was packaged from each packaged procedure, and identify the cost of each procedure code with and without the proposed packaging. They recommended that, before implementing the proposed packaging, CMS publish all HCPCS and revenue codes and the costs for each that enter into the consideration of packaging for every code proposed to be packaged. The commenters believed that the lack of transparency, together with late availability of a correct OPPS proposed rule claims data set, made it difficult to determine whether packaged costs were retained or lost in the median setting process.

Other commenters suggested that CMS explicitly crosswalk packaged services to identified independent services, rather than packaging payment into the independent service with which the packaged services is billed on each claim. They asserted that no service should be packaged unless it is furnished the majority of the time with the specified independent service. The commenters stated that items and services should be packaged only where there are substitutable services that could be chosen by the hospital, and that no packaging should occur where there is only one dependent service that would be provided with the independent service.

Some commenters contended that CMS should not implement the proposed packaging changes until after it implements an adjustment for charge compression because errors in the proposed rates as a result of charge compression would result in too little payment being packaged into the independent service and would create disincentives for hospital to furnish the packaged services, thus harming beneficiary access to advanced technologies.

Some commenters requested that CMS develop and propose a set of criteria for packaging services that would be open to public comment and that would control whether and, if so, when CMS could package payment for a service. The commenters stated that the criteria in the proposed rule were too vague, undefined, and subjective to identify which codes should be packaged. The commenters provided criteria that they believe should govern whether a service should be packaged. The suggested criteria included, but were not limited to, requiring that packaging should only be adopted for high volume, low cost, minor and ancillary services that are very frequently performed with the specified independent service; no packaging of services that require specialized equipment or devices; no packaging of services that are only furnished in a small number of hospitals; no packaging of add-on services unless the service is furnished with its base code at least 50 percent or 75 percent of the time; packaging only when a service is being packaged into a specified service and, therefore, no general packaging of services into the service with which it is performed; no packaging unless CMS has provided the public with a full data assessment of the effects of packaging each service; and no packaging if the median cost for the code exceeds an established amount.

Other commenters suggested CMS not implement the proposed packaging because the 60-day comment period provided insufficient time for analysis and because the APC Panel recommendations and report were not posted on the Web site immediately after the meeting.

Response: We have reviewed all of the public comments we received on the

proposed packaging approach, and we have decided to finalize our proposal with significant modifications and refinements to address some of the concerns raised by commenters on our proposal to package payment for diagnostic radiopharmaceuticals, imaging supervision and interpretation services, contrast agents, and observation services. We refer readers to sections II.A.4.c.(4), (5), (6), and (7) of this final rule with comment period for detailed discussion of these modifications and section II.A.2 of this final rule with comment period for discussion of the changes we made to the data process in this regard. We are finalizing our proposal for guidance, image processing, and intraoperative services without substantial modification. Table 10, which appears in section II.A.4., contains a comprehensive list of all codes in the final seven categories for which we will package payment either unconditionally (to which we assign status indicator ''N'') or conditionally, providing separate payment if certain criteria are met (to which we assign status indicator ''Q''). There is a category of conditionally packaged codes assigned status indicator ''Q,'' which we previously referred to as ''special'' packaged codes because their payment was packaged when provided on the same date as a service that was assigned status indicator ''S,'' ''T,'' ''V,'' or ''X.'' These ''special'' packaged codes will now be referred to as ''STVX-packaged codes.'' We have identified a new category of conditionally packaged codes that are called ''T-packaged codes,'' whose payment is packaged when provided on the same date as another service that is assigned status indicator ''T.'' The rationale for these changes are discussed in detail below in section II.A.4.c.(4) of this final rule with comment period.

We believe that it is appropriate and fully consistent with the principles of a prospective payment system to package payment for ancillary and supportive services into the payment for the independent service with which they are furnished as a means of making payment for a more comprehensive service package. Although separate payment will no longer be made for the packaged services, the payments for the independent services with which they are furnished will reflect the costs of the packaged services to the extent that the packaged services are provided with the independent service. We recognize that, in some cases, certain supportive and ancillary dependent services are furnished with only one independent service, and in other cases they are furnished with many independent services. Similarly, in some cases they are furnished frequently with independent services, and in some cases they are uncommonly furnished with independent services.

We believe that packaging should reflect the reality of how the services are furnished and reported on claims by hospitals. We believe that nonspecific packaging (as opposed to selected code packaging) based on combinations of services observed on hospital claims is fully appropriate because of the myriad combinations of services that can be appropriately provided together. This approach to packaging payment has long existed in prospective payment systems, including the OPPS. For example, in the IPPS, Medicare's oldest prospective payment system, payment for all services furnished is packaged into a single payment for an entire hospital inpatient stay that is based on the diagnosis-related group (DRG) into which the stay is categorized. The DRG payment packages together all payment for routine care, drugs, biologicals, medical supplies, diagnostic tests, and all other covered services that were provided to the patient, regardless of the extent to which different patients in the same DRG received somewhat different services during their stay. We believe that a similar approach to nonspecific packaging under the OPPS is likewise fully appropriate. We have used this packaging approach for ratesetting throughout the history of the OPPS, and note that payment for APC groups currently reflects significant nonspecific packaging in many cases. Similarly, we believe that it is appropriate to establish under the OPPS a single payment for multiple independent procedures that are frequently furnished together. For that reason, we are adopting five composite APCs for CY 2008 and intend to explore developing others.

We do not agree with the commenters that we should not package a service unless it is a low cost ancillary and supportive service that appears frequently with an independent service. To establish that policy would negate the concept of averaging that is an underlying premise of a prospective payment system by packaging only services that will increase the payment for the independent service. To do that would also create incentives for hospitals to provide ancillary and dependent services that are higher cost or historically were infrequently furnished with an independent service and would remain separately paid. Similarly, we do not agree that we should not finalize the proposed packaging approach because it will ''overpay'' some services and ''underpay'' others. Payment based on a measure of central tendency is also a principle of any prospective payment system. In some cases, payment in an individual case exceeds the average cost and in other cases payment is less than the average cost, but on balance, payment should approximate the relative cost of the average case, recognizing that the OPPS, as created in the statute, was not intended to pay the full cost of HOPD services.

We also do not agree that it would be beneficial to delay the implementation of the proposed packaging approach for a year because that would delay the implementation of incentives under the OPPS for hospitals to look carefully at ways that they could provide care more efficiently. We recognize that, as with any payment policy, there will be affected parties that will ask for changes to the policy, and we are always willing to hear their concerns and to make changes if the changes are appropriate. Moreover, both APC and status indicator assignments are open to public comment each year in the proposed rule, and hence affected parties may provide their arguments for separate payment as part of that process in the future.

We further disagree that we should delay or not finalize the proposed packaging approach pending provision of the extensive data that the commenters requested. We make available a considerable amount of data for public analysis each year and while we are not developing and providing the extensively detailed information that the commenters request, we provide the public use files of claims and a detailed narrative description of our data process that the public can use to perform any desired analyses. While we acknowledge that we needed to issue a second corrected file of claims data, the second file differed from the first only in that it deleted a relatively small number of duplicate claims for observation that would have been used to calculate an APC rate for separately payable observation, had we proposed to pay separately for observation, and hence we believe that the accidental inclusion of these duplicate claims for observation care should have had little or no effect on the majority of studies of the HCPCS codes we proposed to package.

With regard to the request for extensive data on all HCPCS codes we proposed to package, it would not be possible for us to anticipate the specific combinations of services of interest to the public. In addition, we believe that

the commenters must examine the data themselves to develop the specific arguments to support their requests for changes to payments under the OPPS. We note that we pay hospitals under the OPPS, and we showed the impact of the CY 2008 packaging proposal on payment to different classes of hospitals in Table 67 of the proposed rule (72 FR 42822 through 42824). We believe our estimate of the impact of these changes provided valuable information to the hospitals that would receive packaged payment for services that had been previously paid separately under the OPPS.

With regard to the public comments that we should explicitly crosswalk packaged codes to the independent codes into which the costs would be packaged, we do not believe that this is feasible, given the myriad combinations of services that are furnished in the HOPD, nor is it consistent with the principles of a prospective payment system, which bases payment on real occurrences of services that are furnished by hospitals and reported on claims. Moreover, creation of such a crosswalk would undoubtedly result in omissions of appropriate packaging of services and would create a maintenance task that would not be sustainable, given the number of changes to HCPCS codes each year and the ever changing way in which services are furnished. Similarly, it is not consistent with the concept of packaging within a prospective payment system to package only those services for which there are substitutes that could be furnished. In contrast, it is fully consistent with the principles of a prospective payment system for groups of services to package items and services that are always furnished with an independent service and for which there are no substitutes.

We also do not agree that we should delay creation of larger payment bundles through packaging until after there is adjustment for charge compression under the OPPS. As we discuss in section II.A.1.c. of this final rule with comment period, we will consider whether to use regression-adjusted CCRs to adjust for charge compression under the OPPS after RTI reviews the OPPS cost estimation process, including an assessment of the revenue code-to-cost center crosswalk and estimating regression-adjusted CCRs from a model that includes outpatient charges. There is no reason to delay the creation of incentives for encouraging cost-effective utilization and efficiency in the provision of HOPD services until a decision is made regarding the appropriateness of using regression-adjusted CCRs to estimate OPPS costs.

We do not agree that we should develop and establish criteria with stakeholder input before we finalize the packaging proposal. Nor do we believe that the specific criteria the commenters recommended are appropriate for determining when services should be packaged. The criteria that the commenters provided are focused almost exclusively on preventing packaging, rather than on determining when packaging would be appropriate. We believe that packaging is appropriate when the nature of a service is such that it is supportive and ancillary to another service, whether the dependent service is frequently furnished with the independent service or not and regardless of the cost of the supportive ancillary service. This is largely a clinical decision based on the nature of the service being considered for packaging.

Lastly, we do not agree that we should not implement the proposed changes because the commenters believed that the 60 day comment period was insufficient or because the APC Panel recommendations and report were not posted to the Web site immediately after the public meeting. The 60 day comment period is generally the standard comment period for the proposed rule process. The availability of updated claims and cost report data necessary to develop the proposed rule and issue the final rule for the OPPS precludes a longer period for comment. Moreover, we do not believe that the Web site posting of the APC Panel recommendations and report is necessary for the public to provide meaningful comments, in light of the fact that the APC Panel meeting is open to the public.

We are not accepting the recommendation of the APC Panel to provide information in this final rule with comment period clarifying how newly packaged services map back to primary procedures because we would be unable to display in a meaningful way all of the many combinations of services that may be of interest to the public. Moreover, given the numerous new, refined, and interrelated payment policies finalized for CY 2008 involving APC reconfiguration, HCPCS migration, reduction in the numbers of low volume APCs, and others, to adopt the APC Panel's example of simulating median costs holding all other CY 2008 policies constant for HCPCS codes with and without the additional packaging of those services newly packaged for CY 2008 would not provide meaningful comparative information. Almost certainly, if we were not to adopt packaging of the additional services for CY 2008, the APC configurations, bypass list, single claims available for ratesetting, and other important features upon which the final median costs depend would differ in significant ways from those aspects under our final CY 2008 policies.

Comment: A number of commenters disagreed with the CMS estimate of the amount of payment that would be redistributed under the proposed rule. The commenters indicated that the services proposed to be newly packaged constitute 6 percent of the OPPS costs, although CMS estimated that the packaging proposal would redistribute 1.2 percent of the CY 2008 expenditures under the OPPS. They attributed the difference in cost estimates to the methodology for applying status indicator ''Q.'' The commenters believed that the resulting impact analysis would be quite different from CMS' estimated impact displayed in the proposed rule and, therefore, the implications of the policy are not fully understood. They objected to packaging of observation services in particular, but recommended that CMS reevaluate the entire packaging proposal in light of methodological and data concerns.

Response: In the proposed rule, we estimated that the proposed packaging approach would redistribute 1.2 percent of the CY 2007 base expenditures under the OPPS to other OPPS services as part of our budget neutrality adjustments for the proposed CY 2008 payment system. This 1.2 percent is the aggregate payment weight reduction from the packaging proposal, where the medians are marginally less than the costs for the individual services prior to packaging. This is not inconsistent with a finding that the total cost of services proposed to be packaged constitutes 6 percent of HOPD costs. These percentages measure different things. The first provides an estimate of money redistributed to other services and the second an estimate of the proportion of OPPS spending on services addressed by the policy. We understand, and intended, that the packaging proposal affect services responsible for significant OPPS spending, in order to provide hospitals with meaningful incentives to examine their patterns of care delivery and improve efficiency. The 1.2 percent reflects the difference in total weight with and without the packaging proposal relative to the CY 2007 total base weight. Whether or not the 1.2 percent of redistributed dollars was entirely attributable to the proposed policy for estimating the median cost for ''Q'' status indicator services cannot be

determined. For this final rule with comment period, we made modifications to the policy governing the handling of many services assigned status indicator ''Q,'' as discussed in section II.A.4.c.(4) of this final rule with comment period, that resulted in use of more claims data and significant changes to the median costs for some services. We also accepted the public comments that recommended that we create a composite APC for observation services, as discussed in section II.A.4.c.(7) of this final rule with comment period.

Comment: Some commenters stated that CMS must undertake provider education and claims monitoring because providers will cease to bill HCPCS codes and charges for packaged services, which will result in lower payment rates than would otherwise be made if they reported all codes and charges and thus the costs of packaged services would be lost to the payment system in future years. They indicated that this presents huge operational challenges to hospitals to ensure that they bill and charge for the packaged codes. Other commenters believed that the implementation of increased packaging will be particularly difficult in CY 2008 because CMS is simultaneously implementing Medicare-Severity DRGs (MS–DRGs) for IPPS payment, which also poses operational challenges for hospitals.

Response: We do not believe that there will be a significant change in what hospitals charge and report for the services they furnish to Medicare beneficiaries and to others as a result of the increased packaging for the CY 2008 OPPS. Medicare cost reporting standards specify that hospitals must impose the same charges for Medicare patients as for other patients. We are often told by hospitals that many private payers pay based on a percentage of charges and that hospital chargemasters do not differentiate between the charges to Medicare patients and others. Therefore, we have no reason to believe that hospitals will cease to report charges and HCPCS codes for packaged services they provide to Medicare beneficiaries. We expect that hospitals, as other prudent businesses, will have a quality review process that ensures that they accurately and completely report the services they furnish, with the appropriate charges for those services to Medicare and all other payers. Therefore, we do not see either the need or the responsibility to undertake a special effort to educate providers to report and charge Medicare for the services they furnish, whether separately paid or packaged. According to our longstanding policy, we will continue to encourage hospitals to report the HCPCS codes and associated charges for all services they provide, taking into consideration all CPT, OPPS, and local contracture instructions, regardless of whether payment for those HCPCS codes is packaged or separately provided. Similarly, we do not believe that the implementation of MS–DRGs will create operational issues for hospitals that would be complicated by increased packaging under the OPPS.

Comment: Some commenters asserted that increased packaging will create disincentives to provide certain services and that providers may stop furnishing these services to Medicare beneficiaries. The commenters stated that increased packaging would reduce expenditures, but the ultimate result would be reduced access to necessary care as the payment incentives to provide care are reduced. Other commenters believed that increased packaging will result in services being furnished on multiple days in order to maximize payment, which will increase, rather than decrease, volumes of services and provide a significant inconvenience to beneficiaries.

Response: We also do not agree that beneficiary access to care will be harmed by increased packaging. We believe that packaging will create incentives for hospitals and their physician partners to work together to establish appropriate protocols that will eliminate unnecessary services where they exist and will institutionalize approaches to providing necessary services more efficiently. Where this review results in reductions in services that are only marginally beneficial, we believe that this could improve rather than harm the quality of care for beneficiaries because every service furnished in a hospital carries some level of risk to the patient. Similarly, where this review results in the concentration of some services in a reduced number of hospitals in the community, we believe that the quality of care and hospital efficiency may both be enhanced as a result. The medical literature shows that concentration of services in certain hospitals often results in both greater efficiency and higher quality of care for patients.

Moreover, we do not believe that packaging will result in Medicare beneficiaries being treated differently from other patients with regard to the care they receive in the hospital. A hospital may have its provider agreement terminated by Medicare under 42 CFR 489.53(a)(2) if it places restrictions on the persons it accepts for treatment and either fails to exempt Medicare beneficiaries from those restrictions or apply them to Medicare beneficiaries the same as to all other persons seeking care. We do not believe that a hospital would risk termination of its provider agreement by Medicare by refusing to furnish a medically necessary service to a Medicare beneficiary, although it provides the same service to other patients for the same clinical indications.

As we indicated in the proposed rule, we will examine our claims data for patterns of fragmented care and if we find a pattern in which a hospital appears to be fragmenting care across multiple days, we will refer it for investigation to the QIO or to the program safeguard contractor, as appropriate to the circumstances we find. However, we do not believe that, in general, hospitals would routinely, and for purposes of financial gain, require patients to return on multiple days to receive services that could have been furnished on the same day.

Comment: One commenter objected to the implication in the proposed rule that hospitals provide whatever services they wish at whatever cost, with their only concern being payment for the services, and that payment rates could motivate hospitals to report services on separate claims or split the service among different hospitals in order to be paid more. The commenter stated that 42 CFR 411.15(m) requires that hospitals must furnish and bill for services necessary to complete an outpatient encounter and that, therefore, it would be a violation of CMS regulations for a hospital to deliver part of the service at one hospital and the rest at another hospital.

Response: We believe that hospitals strive to provide the best care they can to the patients they serve. However, we are aware that there are financial pressures on hospitals that might motivate some of them to split services in such a way as to maximize payments. While we do not expect that hospitals would routinely change the way they furnish services or the way they bill in order to maximize payment, we do believe that it would be possible, and hence we offered the cautionary note in the proposed rule that we will consider that possibility as we review our claims data. Other commenters, as described in the preceding comment, stated that volumes of services and expenditures would increase because hospitals would provide services on multiple days to maximize payment.

We note that 42 CFR 411.15(m) specifies exclusions from Medicare coverage in cases in which the hospital does not furnish a service directly or

under arrangements as defined in 42 CFR 409.3 and, therefore, would not prohibit a hospital from discharging a patient and sending that patient to another hospital for a service that would otherwise be packaged if furnished during the same encounter. However, as noted above, a hospital that does not make available the same services to Medicare beneficiaries as to its other hospital patients can be terminated from Medicare under 42 CFR 489.53(a)(2). Additionally, we remind hospitals that any business models or arrangements they make for the provision of services intended to be billed by that hospital must comply with all applicable laws and regulations, including, but not limited to, the Stark law and other anti-kickback laws, the provider-based rules at 42 CFR 413.65, the ''incident-to'' rules at 42 CFR 410.27, and the conditions for outpatient diagnostic services at 42 CFR 410.28. In regard to hospital services provided under arrangements, as defined in 42 CFR 409.3, we have specified in the Eligibility and Entitlement Manual that, ''In permitting providers to furnish services under arrangements, it was not intended that the provider merely serve as a billing mechanism for the other party. Accordingly, for services provided under arrangements to be covered, the provider must exercise professional responsibility over the arranged for services'' (Pub. 100–1, Chapter 5, section 10.3). Therefore, we would not expect hospitals to send patients to a separate entity merely to avoid packaged payment, but, as stated above, we will consider that possibility as we review our claims data.

Comment: Some commenters suggested that CMS work with and through the AMA process in making any packaging decisions and not make any arbitrary and single-sided bundling decisions that have not been fully reviewed and analyzed for impact by the stakeholders. They suggested that CMS discuss with the AMA CPT Editorial Panel the potential for unintended consequences of proposed packaging or bundling on the establishment of CPT codes. For example, one commenter believed that packaging add-on codes, which the commenter viewed as integral to maintaining flexibility of CPT coding, would likely discourage future consideration of creating add-on codes as a means to describe code-specific procedures and resources. Other commenters objected to what they view as a ''codebook'' approach to determining what should be packaged. The commenters stated that CMS not rely on CPT and HCPCS code descriptors because the descriptors are complex and many do not accurately describe the services furnished. Some commenters argued that CMS should pay across settings in the same way and, therefore, should not package under the OPPS services that are paid separately under the MPFS.

Response: Our general process for developing the OPPS, including making major payment policy decisions, is prescribed by the Administrative Procedure Act (APA) and the Federal Advisory Committee Act (FACA). As such, proposed payment rates and the attendant policies are open to public comment both through the **Federal Register** notice and comment rulemaking process and through the public meetings of the APC Panel, which is a Federal Advisory Committee chartered by the Secretary of Health and Human Services. Therefore, our proposed packaging for the CY 2008 OPPS and the decisions we are announcing in this final rule with comment period are neither arbitrary nor single-sided, as all stakeholders have had the opportunity to comment. In this final rule with comment period, we are responding to their comments. We note that the AMA, as a member of the public, has the same opportunity to comment on the packaging proposal in the proposed rule as any other member of the public.

We believe that it is entirely appropriate to rely on the HCPCS descriptors, including the AMA's CPT descriptors, for the definition of the services furnished for purposes of the proposed packaging approach and other payment policies. The OPPS is based on the definitions of services reported with HCPCS codes, of which the CPT code set is a fundamental part. The HCPCS codes are the only means by which hospitals report the services they furnish and the charges for those services and, therefore, they are basis of the OPPS. For that reason, we look to the HCPCS definition of the service to determine whether a particular service is ancillary and supportive of another service. To the extent that there are changes to the HCPCS codes and, by extension, to the CPT code descriptors, we will reevaluate the decisions we make with regard to packaging payment. However, we do not believe that the AMA's CPT Editorial Board is influenced by OPPS payment policy in its deliberations, nor should it be influenced by OPPS payment policy in its creation of CPT codes.

Moreover, we disagree that we should not package payment for ancillary and supportive services because the MPFS pays separately for them. The OPPS is not a fee schedule, but a prospective payment system based on relative weights derived from costs and charges. Packaging of payments into appropriate groups is a fundamental principle that distinguishes a prospective payment system from a fee schedule and we do not believe that we should refrain from packaging payment for ancillary and supportive services into payment for the independent services with which they are furnished because they may be treated differently in the MPFS or because of the unlikely possibility that this policy may have some influence on the AMA CPT Editorial Panel's decisions regarding creation of codes.

Comment: One commenter stated that the concept of creating incentives for hospitals to negotiate better prices on goods and services through packaging is not applicable to small rural hospitals and, therefore, it should not apply to them. The commenter argued that smaller rural hospitals cannot negotiate for better prices on goods and services because they buy smaller amounts of products and lack the ability that large urban hospitals have to negotiate for better prices on goods and services.

Response: We believe that the creation of incentives for hospitals to seek more efficient ways of furnishing services is applicable to all hospitals, including small rural hospitals. Small rural hospitals and their physician partners have the same capacity and capability as other hospitals to evaluate the appropriateness and efficiency of the packaged services they furnish. Moreover, small rural hospitals can join in cooperatives and group purchasing organizations that can achieve purchasing efficiencies that they could not achieve by themselves. We recognize that some costs are higher for certain categories of rural hospitals, therefore we have provided the 7.1 percent rural adjustment for rural SCHs. Moreover, the law holds harmless rural hospitals with 100 or fewer beds. However, we also expect that small rural hospitals will be motivated by the packaging approach to seek ways of furnishing services as efficiently as possible and to eliminate services that are essential to the appropriate treatment of the patient in any clinical case.

Comment: Some commenters contended that the proposed packaging approach has the potential for systemwide net savings and redistribution of payments away from hospitals that invested in high-cost equipment and toward hospitals that do not have such costs. They believed that charge compression contributes to this

problem because hospitals are limited in what they can charge, and the allocation of radiology equipment capital costs exacerbates the problem. The commenters suggested that CMS not finalize the packaging proposal because packaging creates incentives for hospitals to divest themselves of important but expensive technologies because those technologies have ceased to be profitable.

Response: We agree that there is the potential for systemwide redistribution of payments away from hospitals that invested in costly equipment for services for which payment will be packaged and toward hospitals that do not have such costs. However, to the extent that packaging payment for ancillary and supportive services reduces the amount of payment weight in the system for separately paid services, that amount will be redistributed to all hospitals across all services paid under the OPPS through the budget neutral weight scaler. Any reduction in the growth of OPPS expenditures will result from slower growth in hospital costs in future years as a result of hospitals reducing the volume of certain services or finding more efficient ways to provide care. That potential future savings is one of the purposes of this packaging initiative and the exploration of episode-based or encounter-based payments under the OPPS. Similarly, if increased packaging causes hospitals to be more cautious in their decision making regarding investing in new equipment or incurring other large capital expenditures, we view that as a positive result of the policy. Hospitals make decisions regarding the equipment they buy for general business reasons, of which payment under the OPPS is only one factor among many, including, but not limited to, utilization and payments from other payers and payments from Medicare for IPPS services, which is the dominant source of Medicare payment for hospital care.

Comment: One commenter asserted that linking growth in volume to reduced payments is premature, inappropriate, and not supported by statutory authority. The commenter was particularly concerned about any methodology that would establish different update factors for different OPPS service categories, where the update factor is determined in a manner that takes into account utilization trends. Many commenters stated that HOPD utilization of services is only marginally within the control of hospitals. They explained that hospitals provide services ordered by their medical staff and community physicians, and it would be inappropriate to penalize hospitals for performing services whose utilization is not within their control. The commenters believed that innovation and best practices have increased utilization, not the provision of excessive services.

Response: Section 1833(t)(2)(F) of the Act requires us to develop a method of controlling unnecessary increases in the volume of covered OPS 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 our proposed rule, we prefer not to take the approach of creating an SGR-type mechanism that could result in a reduced conversion factor under the OPPS and that could inadvertently result in actually increasing the volume of services. We prefer to establish larger packages of services on which to base OPPS payment in order to create incentives for hospitals and their physician partners to make thoughtful decisions regarding what services are medically necessary for their patients and to continuously reassess how they might be able to provide care more efficiently. We recognize that decisions regarding the care provided in HOPDs are not made unilaterally by the hospital, nor are they made unilaterally by the physician who is ordering the care. While physicians, rather than hospital staff, may order specific services for patients, hospitals decide what HOPD services they will and will not furnish, what drugs and supplies they will or will not buy and from whom they will buy them, what investments in equipment they will or will not make, and what programs they will open or close. Certainly, they make these decisions with significant input from their medical staff, but it is the hospital administration that makes the final decisions in this regard. Moreover, hospitals control, to some extent, the physicians on their medical staff and increasingly employ physicians to provide services to patients and to supervise the provision of hospital services. Hence, we do not agree with the argument that hospitals have no control over the services they furnish or that they have no influence over the physicians who order the specific services furnished to their patients.

Comment: Some commenters asked CMS to impose a payment floor to limit the amount of decline in any APC payment in at least the first year of implementation as a means of mitigating the effects of no longer paying separately for the packaged services.

Response: We do not agree that we should impose a payment floor to limit the amount of decline in any APC payment as a means of mitigating the effects of no longer paying separately for the packaged services. The purpose of creating larger payment packages is to create incentives for hospitals to assess the services they are furnishing to ensure that they are furnishing only medically necessary services as efficiently as possible. To establish a payment floor that would artificially inflate payments for APCs that are declining would reduce what would otherwise be appropriate increases in payments for other APCs. We believe that this would be contrary to the stated goal of paying appropriately for all services through larger payment bundles that are intended to create incentives for efficiency.

Comment: Several commenters objected to the proposed packaging approach because they believed that it would be more difficult for new services to be approved for payment under New Technology APCs. One commenter believed that it would be difficult for new guidance services, in particular, to be approved for assignment to a New Technology APC if CMS considers guidance to be a supportive and ancillary service rather than a separately paid complete service. Therefore, the commenter concluded that the proposed packaging not only packages existing services but creates the potential for new technologies to not be approved for New Technology APC payment.

Response: We assess applications for New Technology APC placement on a case-by-case basis. The commenter is correct that, to qualify for New Technology APC placement, the service must be a complete service, by which we mean a comprehensive service that stands alone as a meaningful diagnostic or therapeutic service. To the extent that a service for which New Technology APC status is being requested is ancillary and supportive of another service, for example, a new intraoperative service or a new guidance service, we might not consider it to be a complete service because its value is as part of an independent service. However, if the entire, complete service, including the guidance component of the service, for example, is ''truly new,'' as we explained that term at length in the November 30, 2001 final rule (66 FR 59898) which set forth the criteria for eligibility for assignment of services to New Technology APCs, we would consider the new complete procedure for New Technology APC assignment.

As stated in the November 30, 2001 final rule, by way of examples provided, ''The use of a new expensive instrument for tissue debridement or a new, expensive wound dressing does not in and of itself warrant creation of a new HCPCS code to describe the instrument or dressing; rather, the existing wound repair code appropriately describes the service that is being furnished * * * '' (66 FR 59898). This example may hold for some new guidance technologies as well.

The following discussions separately address each of the seven categories of items and services for which we proposed to package payment under the CY 2008 OPPS as part of our packaging proposal and which we are adopting in this final rule with comment period, with the modifications discussed under the applicable topic. Many codes that we proposed 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 proposed and final policy, 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 image 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.

Each HCPCS code we discuss in this section has a status indicator of either ''N'' or ''Q.'' The payment for a HCPCS code with a status indicator of ''N'' is unconditionally packaged so that its payment is always incorporated into the payments for the separately paid services with which it is reported. Payment for a HCPCS code with a status indicator of ''Q'' is either packaged or separately paid, depending on the services with which it is reported. Payment for a HCPCS code with a status indicator of ''Q'' that is ''STVX-packaged'' is packaged unless the HCPCS code is not reported on the same day with a service that has a status indicator of ''S,'' ''T,'' ''V,'' or ''X,'' in which case it would be paid separately. Payment for a HCPCS code with a status indicator of ''Q'' that is ''T-packaged'' is packaged unless the HCPCS code is not reported on the same day with a service that has a status indicator of ''T,'' in which case it would be paid separately. Payment for a HCPCS code with a status indicator of ''Q'' that is assigned to a composite APC is packaged into the payment for the composite APC when the criteria for payment of the composite APC are met.

(1) Guidance Services

We proposed 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 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 proposed 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 proposed 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 in the CPT coding scheme 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 that have code descriptors that 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 believed 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 believed 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 proposed 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, as we noted in the CY 2008 proposed rule, the historical hospital claims data demonstrated 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 recognized that hospitals have several options regarding the performance and types of guidance services they use. However, we believed

that hospitals utilize the most appropriate form of guidance for the specific procedure that is performed. We did 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 specifically encouraged 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 proposed 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 proposed 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 proposed 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 proposed to identify as guidance codes for CY 2008 that would receive packaged payment were listed in Table 8 of the CY 2008 proposed rule (72 FR 42657). (Table 10 in this final rule with comment period contains a comprehensive list of all codes in the final seven categories for services that are packaged for CY 2008.)

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 real time ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)), were already unconditionally (that is, always) packaged under the CY 2007 OPPS, where they have been assigned 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 did not propose status indicator changes for the five guidance procedures that were unconditionally packaged for CY 2007.

We proposed to change the status indicators for 31 guidance procedures from separately paid to unconditionally packaged (status indicator ''N'') for the CY 2008 OPPS. We believed 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 proposed to change the status indicator for one guidance procedure from separately paid to conditionally packaged (status indicator ''Q''), and to 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 will 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 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 status indicator ''S,'' ''T,'' ''V,'' or ''X,'' we proposed to package payment for it as a dependent service. In all cases, we proposed that hospitals that furnish independent services on the same date as dependent guidance services must bill them all on the same claim. We believed 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 that supports the independent service.

The estimated overall impact of these changes presented in section XXII.B. of the proposed rule (section XXIV.B. in this final rule with comment period) was 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 will change in the immediate future.

As we indicated earlier, in all cases, we proposed that hospitals that furnish the guidance service on the same date as the independent service must bill both services on the same claim. We indicated that we expected 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.

During the September 2007 APC Panel meeting, the Panel recommended that CMS finalize the proposal to package guidance services, with the exception of radiation oncology guidance procedures.

We received many public comments on our proposal to package guidance services for CY 2008. A summary of the public comments and our responses follow.

Comment: Many commenters requested that, if CMS elected to finalize the packaging status of the guidance codes proposed for packaging, CMS exclude radiation oncology guidance procedures, in accordance with the APC Panel recommendation. Specifically, many commenters requested that CMS pay separately for CPT codes 76950 (Ultrasonic guidance for placement of radiation therapy fields); 76965 (Ultrasonic guidance for interstitial radioelement application); 77014 (Computed tomography guidance for placement of radiation therapy fields); 77417 (Therapeutic radiology port film(s)); and 77421 (Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy). The commenters were concerned that packaging radiation oncology guidance procedures would encourage hospitals to decrease utilization of advanced technologies for localization used in radiation oncology treatment delivery. The commenters noted that packaging payment for radiation oncology guidance services offers a financial incentive to those hospitals that use little or no daily localization when providing radiation therapy. One commenter believed that packaging payment for these guidance services encourages hospitals to use older, less effective technologies, thereby discouraging development of new, more effective technologies. Another commenter noted that if hospitals are discouraged from using new technologies due to low payment rates, it will take many years to gather robust cost data that reflect these new technologies, likely even longer than New Technology APC and pass-through payments are available for new technologies.

Response: After reviewing these public comments, considering the recommendation of the APC Panel, and ensuring that CMS clinical staff analyzed the content of these comments, we have decided to finalize our proposal to package these guidance services, as proposed. These services are ancillary and dependent in relation to the radiation therapy services with which they are most commonly furnished. Moreover, there are no unique clinical aspects to these radiation oncology guidance services that would differentiate them from other guidance services. Consistent with the principles of a prospective payment system, in some cases, payment in an individual case exceeds the average costs, and in other cases payment is less than the average cost, but on balance, payment should approximate the relative cost of the average case. We do not believe that beneficiary access to care will be harmed by increased packaging. We believe that packaging will create incentives for hospitals and their physician partners to work together to establish appropriate protocols that will eliminate unnecessary services where they exist and institutionalize approaches to providing necessary services more efficiently. Therefore, we see no basis for treating radiation oncology services differently from other guidance services that are ancillary and dependent to the procedure that they facilitate.

Comment: Many commenters were concerned with the proposal to package payment for electrodiagnostic guidance for chemodenervation procedures, specifically, CPT codes 95873 (Electrical stimulation for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)), and 95874 (Needle electromyography for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)). The commenters indicated that chemodenervation involves the injection of chemodenervation agents, such as botulinum toxin, to control the symptoms associated with dystonia and other disorders. According to the commenters, physicians often, but not always, use electromyography or electrical stimulation guidance to guide the needle to the most appropriate location. The commenters were concerned that the proposal to package payment for these guidance services may discourage utilization of this particular form of guidance, even when medically appropriate. Several commenters noted that the CY 2008 proposed payment rate for the injection and the associated guidance is a 15 percent decrease from the CY 2007 payment rate. Most commenters requested that CMS pay separately for electrodiagnostic guidance, several of whom specified that CMS assign the

three chemodenervation procedures to their own APC. The commenters noted that even if the median cost for the chemodenervation procedures increased, the payment rate would not increase because chemodenervation procedures are only a small proportion of all claims in their proposed APC 0204 (Level I Nervous System Injections). Several other commenters stated that the median costs for the chemodenervation procedures do not reflect the full cost of the guidance because the guidance is performed with the procedure infrequently.

Response: We note that the cost of the chemodenervation guidance services will be reflected in the median cost for the independent HCPCS code as a function of the frequency that chemodenervation services are reported with that particular HCPCS code. As noted above, we recognize that, in some cases, supportive and ancillary dependent services are furnished at high frequency with independent services, and in other cases, they are furnished with independent services at a low frequency. We believe that packaging should reflect the reality of how services are furnished. While the commenters are correct that the chemodenervation procedures reflect only approximately 10 percent of the services that comprise APC 0204, we note that they appropriately map to this APC both clinically and in terms of resource use. If the median costs for the individual chemodenervation procedures were to change dramatically, based on resource cost data, we would review these services as part of our annual review process to determine if a different APC were more appropriate. We also note that if these three chemodenervation procedures were mapped to their own APC, the estimated median cost of the APC would be in the same general cost range as the current median cost for APC 0204. Therefore, it is unnecessary to map these three services to their own APC for CY 2008.

Comment: Several commenters requested that CMS clarify how the DRA imaging cap for services paid under the MPFS would be applied to services that are packaged under the OPPS.

Response: If an imaging service is packaged under the OPPS, the DRA cap on the technical component payment for that service under the MPFS is not applicable.

Comment: Many commenters supported the proposal to package each of the guidance services that we identified in the proposed rule. The commenters also gave specific comments related to almost every guidance code that we proposed to package. In general, each commenter requested that we pay separately for several of the guidance codes that we proposed to package. The commenters expressed concern in several areas, specifically, that insufficient payment rates would discourage new technologies; that guidance services used infrequently with specific services contribute very little to the payment rates for those services; that the expected decrease in utilization for guidance services could ultimately lead to increased costs, as a result of worse patient outcomes; that packaged payment under the OPPS and separate payment under the MPFS leads to payment disparity; and, in general, that the lack of published crosswalks makes it difficult to analyze the specific effects of this policy.

Response: We note that we did not receive any unique arguments specific to any particular code. We received many similar public comments regarding all the categories of codes that we proposed for packaged payment. Therefore, we have responded to these general comments above in section II.A.4.c. of this final rule with comment period. In light of the public comments we received, our clinical advisors reassessed every guidance code on the list to ensure that it was still appropriate for packaged payment.

For CY 2008, we are finalizing the CY 2008 proposal, without modification, to package payment for all guidance services for CY 2008. We are partially accepting the APC Panel recommendation. Specifically, we are packaging all guidance services for CY 2008, including radiation oncology services. The guidance codes that are packaged for CY 2008 are identified and displayed in Table 10 of this final rule with comment period. These services are assigned status indicator ''N'' to indicate their unconditional packaging, with the exception of CPT code 76000, which is an ''STVX-packaged'' code assigned status indicator ''Q.''

(2) Image Processing Services

We proposed 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 proposed 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 proposed 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 believed it was 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 listed the image processing services that we proposed to be packaged for CY 2008 in Table 10 in the

CY 2008 proposed rule (72 FR 42659). 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 post-processing 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 proposed to package vary in their hospital resource costs. Resource cost was not a factor we considered when we proposed to package supportive image processing services. Notably, the majority of image processing services that we proposed 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 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 status indicator ''N.'' We did not propose status indicator changes for the four image processing services that were unconditionally packaged for CY 2007.

We proposed 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.

The estimated overall impact of these changes presented in section XXII.B. of the proposed rule (section XXIV.B. of this final rule with comment period) was based on the assumption that hospital behavior would not change with regard to when these dependent image processing 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 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 provided that hospitals that furnish the image processing procedure in association with the independent service must bill both services on the same claim. We indicated that we expected 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.

The APC Panel recommended that all image processing services be packaged as proposed in the proposed rule.

We received a number of public comments on our proposal to package image processing service for CY 2008. A summary of the public comments and our responses follow.

Comment: Many commenters were concerned with the proposal to package payment for CPT code 93325 (Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)). The commenters noted that this service is often critical to decisionmaking and consumes significantly greater resources than the general echocardiography study process. Several commenters noted that the AMA is planning to revise this CPT code for CY 2009, and that changing the payment status of this code may confuse hospital coding staff. Some commenters requested that CMS make no changes to the payment status of this code until this code's descriptor has been revised by the AMA, while others requested that CMS instruct hospitals not to use the new CPT code that will be created by the AMA.

Response: We acknowledge that this service may be an important clinical tool that is critical to decisionmaking. However, we continue to believe that packaged payment is appropriate for this dependent service that must, per the CY 2007 CPT book, be provided in conjunction with echocardiography. In fact, packaging the status of this code may make it easier to crosswalk the data from this code to the new CPT code that the AMA may create for CY 2009. We see no compelling reason to postpone packaging this service until CY 2009.

Comment: One commenter requested that CMS pay separately for HCPCS code G0288 (Reconstruction, computed tomographic angiography of aorta for surgical planning for vascular surgery) because it is different than the other image processing codes proposed for packaged payment. The commenter stated that the service is often an out-sourced service purchased by the hospital. The commenter was particularly concerned that hospitals would no longer continue to purchase this service if insufficient payment was provided. Another commenter requested separate payment for CPT code 95957 (Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)). The commenter stated that this service is often performed on a different day than the EEG and by a technologist other than the one who performed the EEG.

Response: As noted above, we believe it is important to package payment for supportive dependent services that may not need to be provided face-to-face with the patient in the same encounter as the independent service. Packaging payment for supportive services that utilize data that were collected during the preceding independent services encourages the most efficient use of hospital resources. In fact, as part of our proposed CY 2008 packaging approach, we also proposed to unconditionally package payment in CY 2008 for several other image processing services that are not always performed face-to-face, including 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); 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); 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).

We also believe it is likely that a hospital that performed the computed tomographic angiography diagnostic procedure but does not have the technology necessary to provide the preoperative image reconstruction would send the results to another hospital for performance of the reconstruction. In this situation, the second hospital would be providing the reconstruction under arrangement and, therefore, at least one service provided by the first hospital would be separately paid. We believe that packaged payment for image reconstruction under a prospective payment methodology for hospital outpatient services is most appropriate. The same situation occurs when hospitals provide the service described by CPT code 95957. We proposed to unconditionally package payment for HCPCS code G0288 and CPT code 95957 for CY 2008, fully consistent with the packaging approach for the CY 2008 OPPS. Because HCPCS code G0288 and CPT code 95957 are supportive ancillary services that fit into the image processing category, and we proposed to package payment for all image processing services for CY 2008, we believe it is appropriate to unconditionally package payment associated with these codes. Specifically, we determined that these services are dependent services that are integral to independent services, in this case, the computed tomographic angiography and the EEG that we would expect to be provided. Even if the imaging process services were provided on another day than the independent services, our packaging methodology packages costs across dates of service on ''natural'' single claims, so that the costs of image process services would be captured.

For CY 2008, we are finalizing the packaged status of HCPCS code G0288 and CPT code 95957, as listed in Table 10 of the proposed rule. We note an inadvertent error in Addendum B to the proposed rule. However, Table 10 of the proposed rule listed the accurate proposed payment status of HCPCS code G0288.

Comment: Many commenters supported the proposal to package each of the image processing services that was identified in the proposed rule. Numerous other commenters requested that CMS postpone packaging all the packaged codes included in all categories of the proposal until additional data were provided to the public. These commenters also submitted specific comments related to almost every image processing code that CMS proposed to package. The commenters expressed concern in several areas, specifically, that what they considered to be insufficient payment rates would discourage new technologies; that image processing services used infrequently with specific services contribute very little to the payment rates for those services; that the expected decrease in utilization for image processing services could ultimately lead to increased costs, as a result of worse patient outcomes; and in general, that the lack of published crosswalks makes it difficult to analyze the specific effects of this policy.

Several commenters requested a crosswalk that specified how the packaged costs were allocated from each dependent code to each independent code. Other commenters requested that CMS create edits to ensure that costs are appropriately mapped to independent codes. Several commenters requested that CMS consider resource cost when determining which codes to package. The commenters were concerned that what they considered to be insufficient payment would create a disincentive for hospitals to adopt new technology.

Response: We note that we did not receive any unique arguments specific to any particular code. These comments are similar to those received for all the categories of codes that we proposed for packaged payment. Therefore, we have responded to these general comments above in section II.A.4.c. of this final rule with comment period. In light of the public comments we received, our clinical advisors reassessed every image processing code on the list to ensure that it was still appropriate for packaged payment.

We received one comment related to CPT codes 0174T and 0175T. The comment summary and response related to those codes are located in section II.A.4.e. of this final rule with comment period.

For CY 2008, we are finalizing our proposal, without modification, to unconditionally package the payment for all imaging processing codes listed in Table 10 of this final rule with comment period. We are accepting the APC Panel recommendation to package all image processing services. These services are assigned status indicator ''N'' to indicate their unconditional packaging.

(3) Intraoperative Services

We proposed 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 proposed 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 proposed 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 believed it would be appropriate to package their payment into the OPPS payment for the independent procedure performed. Therefore, we did not propose 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 proposed 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 proposed 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 proposed to identify as intraoperative services for CY 2008 that would receive packaged payment under the OPPS were listed in Table 12 of the proposed rule (72 FR 42661 through 42662).

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 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 status indicator ''N.'' We did not propose status indicator changes for the five diagnostic intraoperative services that were unconditionally packaged for CY 2007.

We proposed to change the status indicator for 34 intraoperative services from separately paid to unconditionally packaged (status indicator ''N'') for the CY 2008 OPPS. As stated in the CY 2008 proposed rule, 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 also proposed 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 believed 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 status indicator ''S,'' ''T,'' ''V,'' or ''X'' reported on the same date of service, under our proposal we proposed not to 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 status indicator ''S,'' ''T,'' ''V,'' or ''X,'' we proposed to package payment for it as a dependent service. In all cases, we proposed that hospitals that furnish independent services on the same date as this IMT procedure must bill them all on the same claim. We believed 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.

The estimated overall impact of these changes presented in section XXII.B. of the proposed rule (section XXIV.B. of this final rule with comment period) was based on the assumption that hospital behavior would not change with regard to when these intraoperative 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 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 believed 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 provided 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.

During the September 2007 APC Panel meeting, the Panel recommended that CMS finalize the proposal to package intraoperative services and that CMS consider assigning status indicator ''Q'' to CPT code 96020 (Neurofunctional testing selection and administration during noninvasive imaging functional brain mapping, with test administered entirely by a physician or psychologist, with review of test results and report).

We received many public comments on our proposal to package

intraoperative services for CY 2008. A summary of the public comments and our responses follow.

Comment: Several commenters requested that CMS change the status of CPT code 96020 to conditionally packaged or separately payable instead of finalizing the proposal to unconditionally package this code. According to the commenters, functional brain mapping is often performed prior to epilepsy surgery. The commenters noted that functional brain mapping is performed by staff other than the neurologist or neuropsychologist who performs the accompanying functional MRI, reported with CPT code 70555 (Magnetic resonance imaging, brain, functional MRI; requiring physician or psychologist administration of entire neurofunctional testing). One commenter clarified that functional MRI is more commonly performed without functional brain mapping. If CPT code 96020 were conditionally packaged, the commenter believed that separate payment should be made for CPT code 96020 when it was provided with the functional MRI. Another commenter stated that functional brain mapping is a separate service from the functional MRI, and therefore should not be packaged.

Response: The AMA 2007 CPT book specifically states that CPT code 70555 can only be reported if CPT code 96020 is also performed. CPT code 70555 is separately payable under the CY 2008 OPPS. Therefore, whenever CPT code 70555, the independent procedure, is billed with CPT code 96020, the dependent procedure, the payment associated with CPT code 96020 is appropriately packaged into the payment for CPT code 70555. Even if CPT code 96020 were conditionally packaged, separate payment would not be made when it was billed with CPT code 70555. In addition, we believe that functional brain mapping is never provided to a patient as a sole service. Instead, it is always provided in conjunction with a functional MRI. Therefore, we continue to believe that unconditional packaging is appropriate for CPT code 96020.

Comment: Many commenters requested that CMS continue to pay separately for intravascular ultrasound (IVUS), fractional flow reserve (FFR), and intracardiac echocardiography (ICE) reported with CPT codes 37250 (Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel (List separately in addition to code for primary procedure)); 37251 (Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; each additional vessel (List separately in addition to code for primary procedure)); 75946 (Intravascular ultrasound (non coronary vessel), radiological supervision and interpretation; each additional non-coronary vessel (List separately in addition to code for primary procedure)); 92978 (Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel (List separately in addition to code for primary procedure)); 92979 (Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; each additional vessel (List separately in addition to code for primary procedure)); 93571 (Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel (List separately in addition to code for primary procedure)); 93572 (Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; each additional vessel (List separately in addition to code for primary procedure)); and 93662 (Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)).

The commenters noted that, while use of these procedures often results in better patient outcomes and reduced need for subsequent procedures, they are only provided to a small proportion of patients who undergo stenting, angioplasty, and other related services. A number of commenters specified that IVUS is performed on 1 to 20 percent of patients who undergo a related diagnostic or therapeutic intervention, using Medicare claims and internal hospital assessments. Therefore, the commenters stated that the costs for IVUS, FFR, and ICE do not affect the payment rates for the independent procedures in a significant way, if at all. In addition, the commenters noted that IVUS, in particular, involves high resource costs because of expensive capital equipment, significant labor cost, and disposable supplies. Several commenters noted that the CY 2005 OPPS data included a median cost of $2,000 for IVUS, with approximately $800 of those costs related solely to the device component. One commenter stated that IVUS may be performed in conjunction with a diagnostic procedure that maps to an APC such as 0080 (Diagnostic Cardiac Catheterization); 0267 (Level III Diagnostic and Screening Ultrasound); or 0280 (Level III Angiography and Venography), rather than a major therapeutic procedure such as stenting or angioplasty, resulting in a total payment of $150 to $2,500, which would not cover the hospital's costs. Other commenters elaborated on the costs associated with ICE, which is reported with the corresponding independent services described by CPT codes 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)); 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); and 93652 (Intracardiac catheter ablation of arrhythmogenic focus; for treatment of ventricular tachycardia), in only 5 percent of the claims involving the above procedures. The commenters also noted that only 14 percent of hospitals billed ICE with the CPT codes listed above, indicating that the impact of packaged payment will affect a subset of hospitals who invested in this capital equipment. One commenter noted that IVUS and ICE are clearly not integral to any independent procedure because they are used infrequently. Other commenters noted that costs will be improperly allocated to hospitals that perform the independent procedure, regardless of whether they purchased the equipment for the dependent procedure. One commenter disputed describing FFR services as ''ancillary'' and stated that they are ''decisional'' and therefore should not be packaged. The commenters expressed concern that packaged payment will create a

significant financial disincentive to provide these services. The commenters also noted that these procedures should not be described as ''intraoperative'' because they precede the independent procedure, and may even result in canceling the independent procedure. One commenter requested that CMS assign status indicator ''Q'' to CPT codes 93571 and 93572. On the other hand, several commenters specified that these services are not stand alone procedures. One commenter stated that it is illegal under section 1833(t)(2)(G) of the Act to package payment for IVUS and FFR, which do not use contrast agents, into payment for coronary or peripheral angiography, which require contrast agents. Specifically, the commenter summarized the Act which states that CMS must create payment groups under the OPPS that ''classify separately those procedures that utilize contrast agents from those that do not.''

Response: We appreciate the many thoughtful comments related to the packaged status of IVUS, FFR, and ICE services. We acknowledge that the costs associated with packaged services may contribute more or less to the median cost of the independent service, depending on how often the dependent service is billed with the independent service. It is our goal to adhere to the principles inherent in a prospective payment system and to encourage hospitals to utilize resources in a cost-effective manner. In this case, hospitals must choose whether to utilize IVUS, FFR, and ICE, balancing the needs of the patient with the costs associated with the services.

We continue to believe that IVUS, FFR, and ICE are dependent services that are always provided in association with independent services. This is different than stating that every angioplasty or other related independent procedure utilizes IVUS, FFR, or ICE. In fact, all of the codes about which we received comment are listed as add-on codes in the CY 2007 CPT book. While we agree that some of these services may contribute to decisionmaking, we still believe that these services are never provided without another independent service on the same day. Therefore, we do not believe it is appropriate to assign status indicator ''Q'' to CPT codes 93571 and 93572, or any of the other IVUS, FFR, or ICE services.

While the statute requires us to establish separate APCs for those services that require contrast and those that do not require contrast, the statute does not state a similar requirement for the packaged services that are ancillary and supportive to the main independent procedure. In this case, IVUS, FFR, and ICE are not the services themselves that must be mapped to contrast or noncontrast APCs for payment. Instead, independent services must map to contrast or noncontrast APCs, as we have done. IVUS, FFR, and ICE are similar to other supportive packaged services, including drugs and anesthesia. Packaged codes never map to an APC, and, therefore, it is unnecessary to distinguish whether they require contrast agents or not. Instead, the independent procedure must map to a contrast or noncontrast APC.

For the reasons stated above, we are finalizing our proposal to unconditionally package payment for IVUS, FFR, and ICE services for CY 2008.

Comment: One commenter requested that CMS conditionally package payment for CPT code 75898 (Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion), instead of finalizing the proposal to unconditionally package payment for this service. The commenter clarified that this is often the only service performed when a patient has lengthy thrombolytic therapy.

Response: We agree with the commenter that this code should be conditionally packaged rather than unconditionally packaged, so that separate payment is made when this service is provided without any other separately payable services on the same date of service. We are changing the status indicator for CPT code 75898 to ''Q'' for CY 2008 and including it as an ''STVX-packaged'' code. When provided on the same date of service as other separately payable services, payment for CPT code 75898 will be packaged into payment for the other services.

Comment: One commenter requested that CMS continue to pay separately for CPT codes 67299 (Unlisted procedure, posterior segment) and 95999 (Unlisted neurological or neuromuscular diagnostic procedure). These codes describe unlisted procedures, and the commenter explained that it would be impossible to know whether the services they describe should be appropriately packaged or separately paid.

Response: We agree with the commenter that CPT codes 67299 and 95999 should not be packaged under the OPPS for CY 2008 because they are unlisted procedures. Therefore, we are finalizing a separately payable status indicator and APC assignment for them in Addendum B to this final rule with comment period.

Comment: Many commenters supported the proposal to package payment for all intraoperative services and recommended that CMS finalize the proposal without modification. Several commenters requested that CMS pay separately for other intraoperative services that it proposed to package for CY 2008, but did not present unique arguments specific to any code.

Response: We agree with commenters that packaging payment for intraoperative services is consistent with the principles of the OPPS and will help contain costs while creating an incentive for hospitals to utilize resources in a cost efficient manner. We understand that hospitals would prefer if certain intraoperative services were paid separately. In light of the public comments we received, our clinical advisors reassessed each intraoperative code on the list to ensure that it was still appropriate for packaged payment. However, we did not see any compelling reason to pay separately for any of the intraoperative services that were not already discussed and revised above.

For CY 2008, we are finalizing our CY 2008 proposal, with modification, to package the payment for all intraoperative HCPCS codes with three exceptions. Specifically, we are finalizing all of the packaging changes we proposed, with the exception of conditionally packaging CPT code 75898 as an ''STVX-packaged'' code and paying separately for CPT codes 67299 and 95999. Except as otherwise specified above, we are fully adopting the APC Panel recommendation to package all intraoperative services and to review the status indicator of CPT code 96020. Table 10 of this final rule with comment period includes the final comprehensive list of all codes in the seven categories that are packaged for CY 2008.

(4) Imaging Supervision and Interpretation Services

We proposed 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 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 proposed 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 is 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 proposed 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 the 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 proposed to identify as imaging supervision and interpretation codes for CY 2008 that would receive packaged payment were listed in Table 14 of the proposed rule (72 FR 42665–42667).

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 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 did not propose status indicator changes for the six imaging supervision and interpretation services that were unconditionally packaged for CY 2007.

We proposed 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 believed 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 proposed 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 status indicator ''S,'' ''T,'' ''V,'' or ''X,'' we proposed to package payment for them as dependent services. In all cases, we proposed 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 proposed conditional packaging, we indicated that 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.

The estimated overall impact of these changes presented in section XXII.B. of the proposed rule (section XXIV.B. of this final rule with comment period) was 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 believed 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 providing 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.

During the September 2007 APC Panel meeting, the APC Panel recommended that CMS delay packaging the imaging supervision and interpretation services because of the reductions in payment that would occur for services that would only be paid separately if they occurred with other minor procedures that are already packaged. The Panel was concerned about the proposed reductions in payment for typical combinations of expensive imaging services. The Panel asked that CMS develop an alternative model for these services and present it at the next APC Panel meeting.

We received many public comments on our proposal to package imaging supervision and interpretation services for CY 2008. A summary of the public comments and our response follows.

Comment: Many commenters objected to the packaging of imaging supervision and interpretation services. They asserted that the proposal would, in many cases, excessively reduce payments because the proposal packaged the cost of the service into one or more services that are already packaged or would inappropriately package the cost of expensive imaging supervision and interpretation services into more minor services, like visits or minor diagnostic tests. The commenters believed that this would result in little or no payment being made for the more expensive services provided in an encounter. Other commenters suggested that CMS package only the 33 codes for which the associated surgical service is separately paid but not package the 93 codes proposed to be conditionally packaged because payments would be excessively reduced. As an alternative, one commenter suggested that CMS review claims data for the 93 imaging supervision and interpretation codes proposed to be assigned status indicator ''Q'' to identify high volume combinations of services and evaluate the combinations for creation of composite APCs. For example, the commenter suggested that CMS could create a composite APC for CPT codes 72265 (Myelography, lumbosacral, radiological supervision and interpretation) and 72132 (Computed tomography lumbar spine, with contrast material) that would ensure that the full payment for CPT code 72265 would always be made when furnished with CPT code 72132. The commenter was concerned that CMS could ''overpay'' lumbar CT when no myelography was furnished but could ''underpay'' when myelography is performed without lumbar computed tomography (CT) but in addition to another minor services such as an emergency department visit or other radiological service. Like others, the commenter was concerned that, as proposed, if an expensive imaging supervision and interpretation service is billed on the same date as a visit, the visit would be paid and the expensive service would not be paid.

Some commenters believed that the absence of consideration of how payment would be made when unrelated services or packaged services were the only other services on the claim demonstrated that the CMS proposal was not carefully or sufficiently analyzed prior to being proposed and should not be made final. The commenters cited several examples of packaging with minor services or packaged services that they view as common, which they believe illuminate the problems with packaging imaging supervision and interpretation services. The commenters asserted that CMS should ensure that no service is packaged into a service that is already packaged. Some commenters believed that the proposed policy would reduce payment for important interventional imaging services by 25 percent in the aggregate, would cause CMS to use fewer claims for ratesetting, and would result in access problems for patients. Some commenters stated that the methodology reduces the number of records that could be used to value these imaging codes for separate payment, thereby resulting in costs that would be much lower than would be the case if the medians were calculated with a higher number of claims.

The commenters explained that some of the most common scenarios for the services that are assigned to APC 0280 (Level III Angiography and Venography) and are proposed for packaging are comparable to cardiac catheterization (APC 0080 (Diagnostic Cardiac Catheterization)) in time, equipment, supply, and labor but under the CMS proposal, the payment made under APC 0280 would be significantly less than the payment for APC 0080. Therefore, the commenters asked that the proposal to package services in APCs 0279 (Level II Angiography and Venography), 280, and 668 (Level I Angiography and Venography) not be adopted in CY 2008 because the packaging would result in payments that are much less than the cost of furnishing the services. One commenter added that it is methodologically circular and unreasonable to package payment for services that already include other packaged services.

Response: We have carefully considered the comments of the APC Panel and the many thoughtful public comments we received on the proposal to package imaging supervision and interpretation services for the CY 2008 OPPS. We spent considerable time and effort in analysis of the data as we developed our proposed rule, and we appreciate the helpful comments we received on this issue. We have decided to finalize our proposal to package these services after refining our methodology for estimating the median cost of conditionally packaged codes assigned status indicator ''Q'' to address concerns that packaging significant services into services that either are already packaged

or are minor services leads to underpayment and concerns that the proposal reduced the number of claims available for setting APC medians for these services. We agree that we should not pay for a more minor service, such as a visit or minor diagnostic procedure, when the conditionally packaged imaging supervision and interpretation services require more resources. We have modified the conditionally packaged status of these services to be specific to surgical procedures and called them ''T-packaged services.'' The payment for these imaging supervision and interpretation codes will be packaged into the payment for services with a status indicator ''T'' when they appear on the same date as the surgical procedure. When these imaging supervision and interpretation services appear with other codes that have any other payable status indicator (''S,'' ''V,'' or ''X'') or with other services that have a status indicator ''Q'' on the same date, we would pay one unit of the ''T-packaged'' service with the highest relative payment weight. We discuss how we split the claims to acquire ''T-packaged'' single bills that represent all of the resource costs associated with the conditionally packaged service in greater detail in section II.A.2. of this final rule with comment period. The ratesetting methodology specifically includes single bill claims for T-packed services that represent the costs of multiple services with status indicator ''Q'' and other packaged services. We believe that this resolves many of the payment concerns with regard to our proposal to treat the majority of supervision and interpretation codes as conditionally packaged codes. These refinements to our methodology significantly raised the median costs for a number of these services compared to the proposed rule median costs. Furthermore, the refinements, especially those creating single bills from multiple minor claims, allowed us to use many more claims to estimate a median cost for these conditionally packaged codes and, therefore, to develop an APC median cost estimate that better reflects the resources consumed by these services that are commonly performed in combination with one another.

We believe that our changes have resulted in resolution of many of the concerns raised by the commenters and the APC Panel. There were a number of specific examples cited by the commenters to illustrate their concerns on this issue. We include the commenters' examples below, expanded to add the CY 2008 final rule payment. In the examples below, ''pkg'' means payment is packaged; ''na'' means not applicable.

EXAMPLE 1.—MYLEOGRAPHY AND LUMBOSACRAL CT WITH CONTRAST

HCPCS Code	Descriptor	CY 2007 APC	CY 2007 SI	CY 2007 Payment	CY 2008 Proposed payment	CY 2008 APC	CY 2008 SI	CY 2008 Final payment
72265	Contrast X-ray lower spine	0274	S	$157.01	pkg	0274	Q	$481.46
72132	CT lumbar spine w/dye	0283	S	$250.94	$751.09	0283	S	$277.48
Sum				$407.95	$751.09			$758.94

EXAMPLE 2.—ANGIOGRAPHY, CAROTID, CERVICAL, VERTEBRAL AND/OR INTRACRANIAL

HCPCS Code	Descriptor	CY 2007 APC	CY 2007 SI	CY 2007 Payment	CY 2008 Proposed payment	CY 2008 APC	CY 2008 SI	CY 2008 Final payment
36216	Place catheter in artery		N	pkg	pkg	na	N	pkg
36215	Place catheter in artery		N	pkg	pkg	na	N	pkg
36217	Place catheter in artery		N	pkg	pkg	na	N	pkg
36216–59	Place catheter in artery		N	pkg	pkg	na	N	pkg
75671	Artery Xrays head and neck	0280	S	$1,279.92	pkg	0280	Q	$2,847.85
75680	Artery Xrays, neck	0280	S	$1,279.92	pkg	0279	Q	pkg
75685X2	Artery Xrays, spine	0280	S	$2,559.84	$1,442.28	0279	Q	pkg
Sum				$5,119.68	$1,442.28			$2,847.85

Note: Several commenters submitted this example or this example with minor variation. The final payment for this service in its entirety is similar to the payment for cardiac catheterization (APC 0080), to which the commenters compared this service.

EXAMPLE 3.—EVALUATION AND PERCUTANEOUS REVASCULARIZATION OF GRAFT

HCPCS Code	Descriptor	CY 2007 APC	CY 2007 SI	CY 2007 Payment	CY 2008 Proposed payment	CY 2008 APC	CY 2008 SI	CY 2008 Final payment
36145X2	Place catheter in artery	na	N	pkg	pkg	na	N	pkg
75790	Visualize A–V shunt	0279	S	$584.32	pkg	0668	Q	pkg
G0393	A–V fistula or graft venous	0081	T	$2,639.19	$2,934.24	0083	T	$2,890.72
75978X2	Repair venous blockage	0668	S	$767.90	pkg	0083	Q	pkg
35476	Repair venous blockage	0081	T	$1,319.60	$1,467.37	0083	T	$1,445.36
Sum				$5,311.01	$4,401.61			$4,336.08

EXAMPLE 4.—DIAGNOSTIC ANGIOGRAPHY WITH BALLOON ANGIOPLASTY OF SUPERFICIAL FEMORAL ARTERY

HCPCS Code	Descriptor	CY 2007 APC	CY 2007 SI	CY 2007 Payment	CY 2008 Proposed payment	CY 2008 APC	CY 2008 SI	CY 2008 Final payment
75625	Contrast Xray exam of aorta	0280	S	$1,279.92	pkg	0279	Q	pkg
75716	Artery Xrays, arms/legs	0280	S	$1,279.92	pkg	0279	Q	pkg
75774	Artery Xray, each vessel	0279	S	$584.32	pkg	na	N	pkg
75774	Artery Xray, each vessel	0279	S	$584.32	pkg	na	N	pkg
36247	Place catheter in artery		N	pkg	pkg	na	N	pkg
35474	Repair arterial blockage	0081	T	$2,639.19	$2,934.24	0083	T	$2,890.72
35474	Repair arterial blockage	0081	T	$1,319.60	$1,467.37	0083	T	$1,445.36
75962	Repair atrial blockage	0668	S	$383.95	pkg	0083	Q	pkg
75964	Repair artery blockage, each	0668	S	$383.95	pkg	na	N	pkg
Sum				$8,455.17	$4,401.61			$4336.08

Comment: Some commenters believed that CMS should not package imaging supervision and interpretation services because CMS did not conduct a sufficiently thorough analysis of the many ways that CPT codes can be reported for services where there could be more than one surgical CPT code associated with a single imaging supervision and interpretation service. The commenters stated that these codes are created on a ''component'' basis to deal effectively with the huge variation in the combinations of services that could occur.

Response: We disagree with the commenters. We acknowledge that the APC Panel and the commenters raised concerns about the packaging of these services that we did not fully anticipate in development of the proposed rule. However, the purpose of the APC Panel and the exposure of the proposal to public comment are to raise issues for our consideration as we develop final policies for the final rule. We appreciate the assistance of the APC Panel and the many thoughtful public comments we received on the proposal to package these codes. We recognize that the codes are created as they exist, in order to describe many different treatment scenarios through the use of multiple and varied combinations of codes. As we discuss above, we have developed a methodology that addresses the concerns raised by the commenters and, as such, continue to believe that it is appropriate to package these services for CY 2008.

Comment: Some commenters believed that the revenue code to CCR mapping for these services is problematic because most are billed with revenue code 0361 and revenue code 0361 is mapped to the surgery cost center. However, as the commenters pointed out, most of these procedures are performed in the imaging department or the heart catheterization laboratory and, therefore, their median cost calculation is highly suspect.

Response: We do not view the unknown amount of error that occurs as a result of a theoretical conflict between the revenue code reported for a service and the CCR used to reduce that charge to an estimated cost as justification to not package these services. The costs we calculate for purposes of establishing median costs for ratesetting are estimated costs and as such, in general, there is error in them to the extent that the charges are reported under a revenue code that maps to a cost center in which the costs for the services are not found. Hospitals select the revenue codes with which they report services to Medicare and other payers for a wide range of reasons over which CMS generally exercises no control. The CMS crosswalk of revenue codes to cost centers is available for inspection and comment at the CMS Web site at: *http://www.cms.hhs.gov/HospitalOutpatientPPS/*. Hospitals that want to ensure that the correct CCR is applied to a service could, if they chose, use this crosswalk to select either the revenue codes to report or the cost center to use for costs reported with a particular revenue code.

Comment: Some commenters believed that implementation of the imaging and supervision packaging would present huge operational challenges for hospitals to ensure that codes and charges continue to be billed so that the data in future years will be acceptable as the basis for setting relative weights for the OPPS. The commenters stated that hospitals will cease to report the codes and charges for the services that are no longer separately paid and that the costs of the services will then be lost to the payment system and the median costs for the services that should carry the packaging will be inappropriately low.

Response: The commenters did not articulate how implementation of the imaging supervision and interpretation packaging proposal would present huge operational challenges for hospitals to ensure that the codes and charges continue to be billed so that future claims will contain the necessary costs for setting relative weights for the OPPS. Hospitals need only continue to report the codes and charges for all of the services they furnish. There are no new billing requirements associated with this change in payment policy. Moreover, hospitals are required to charge the same amount to all payers for the same services. We understand that many private payers continue to pay a percent of charges, creating incentives for hospitals to report and charge for all services furnished to all patients.

Comment: Some commenters suggested that CMS update the OPPS packaging policies to address newly added or deleted codes.

Response: We routinely review all new or revised HCPCS codes each year to determine what status indicator to assign and whether other changes to our files are needed. We also indicate new codes with a change indicator in Addendum B to this final rule with comment period, and we solicit public comments on the interim APC placement and status indicator we assign to them for those HCPCS codes designated with comment indicator ''NI'' in the final rule with comment period. We do not review deleted codes because they naturally fall out of the system, beginning in the claims for the period in which they are deleted, although we continue to assign their claims data for ratesetting purposes.

Comment: Some commenters expressed concerns with the treatment of the claims data for imaging supervision and interpretation codes with status indicator ''Q'' with regard to the impact on the number of multiple procedure claims. Some commenters stated that reporting packaged services

will create more multiple procedure bills that will not be used to set rates.

Response: The reporting of packaged services will not result in more multiple procedure claims because the packaged service, which has a status indicator of ''N'' for data purposes, unless it is changed to be separately paid, will not by itself cause a claim to be viewed as a multiple major procedure claim. Moreover, if packaged services and their charges are not reported, the payment for the services into which their cost is packaged may be understated. Therefore, it is important that hospitals report all services furnished and the associated charges.

Comment: Some commenters indicated that where there are multiple codes with status indicator ''Q'' on a claim and no separately paid services, they are assigned status indicator ''N'' and sent to multiple minors because the assignment of the status indicator ''N'' happens before the split. They suggested that if the assignment happened after the split and after the ''pseudo'' single creation, they could be used in the median calculation for the APC.

Response: The commenter correctly describes how codes with status indicator ''Q'' were treated in this circumstance for the proposed rule data. We agree that claims with multiple occurrences of codes with status indicator ''Q'' should be used to estimate the APC median cost through which they will be separately paid. In response to the public comments we received, we have revised the data process in several places to address the estimation of costs for services with a status indicator of ''Q.'' (See section II.A.2.b. of this final rule with comment period for further discussion of the changes to the data process.) With regard to this particular comment, we continue to assign claims with multiple ''Q'' procedure or packaged services to the multiple minor file. We then create additional single bills from the multiple minor file by identifying which conditionally packaged code will be the prime code that will carry the packaging by selecting the conditionally packaged code with the highest payment for CY 2007 and packaging all costs of the other codes into the cost for that code. We also set the units to one for the prime code to reflect our policy of only paying one unit of a service for codes with a status indicator of ''Q.'' That claim then becomes a single procedure claim assigned to the APC to which the prime code is assigned. These modifications have resulted in the use of many more claims than were used for the proposed rule to set APC medians where conditionally packaged codes are assigned.

Comment: One commenter believed that the data for many single bills for the services with status indicator ''Q'' will be lost because CMS assesses the status of the status indicator ''Q'' code before applying the bypass list. The commenters stated that where there are three services on the claim, two of which are on the bypass list, the status indicator ''Q'' service will be changed to packaged before the bypass list is applied and the two bypass codes will leave the claim without packaging. The commenter added that there will then be no code to which to package the cost of the status indicator ''Q'' code and the data will neither be used nor packaged into anything (because nothing is left for it to be packaged with). The commenter believed that if CMS had made the assignment of the ''Q'' after the bypass codes were removed, the data could be used to set the APC median for the ''Q'' service and more claims could have been used.

Response: The commenter accurately described the treatment of a code with status indicator ''Q'' if it is on the same claim with two codes that are on the bypass list. However, we disagree with the commenter's recommendation. First, by definition, codes on the bypass list do not have significant packaging. We specifically reassessed the codes included on the bypass list in light of this packaging proposal to ensure removal of any services with significant packaging. The circumstances where ''Q'' service data would remain on a claim as ''packaging'' after removing the other two codes as bypass codes should be very limited. Second, we would not want to use that data to set the median cost for the ''Q'' status service because the final payment disposition of the code with status indicator ''Q'' on the claim would be packaged. Under this commenter's recommendation, we would be sending the data for the status indicator ''Q'' codes to the APC to which it is assigned even though, when the claim was processed, no separate payment would be made for the status indicator ''Q'' code.

Comment: One commenter found that its calculation of median costs using proposed rule data for the imaging supervision and interpretation services to which CMS proposed to assign status indicator ''Q'' resulted in median costs for these codes and the APCs to which they were assigned that were significantly higher than the median costs calculated by CMS for these codes and their APCs. The commenter was concerned that CMS may have inadvertently failed to include the packaged costs in the calculation of the medians for these costs codes.

Response: The commenter is correct in that we inadvertently erred and did not include the packaged costs of ''Q'' status procedures in the calculation of the medians for these codes and their related APCs in the proposed rule. We have packaged these costs with the ''Q'' procedures for this final rule with comment period, in addition to making the other modifications to the calculation of the median costs for these codes as discussed in detail above and in section II.A.2. of this final rule with comment period.

For CY 2008, we are finalizing our proposal, with modification as discussed above, to unconditionally or conditionally packaged imaging supervision and interpretation services. These codes, with their assigned status indicator ''N'' as unconditionally packaged or ''Q'' as ''T-packaged'' codes, are listed in Table 10 of this final rule with comment period. We are not accepting the APC Panel recommendation to delay packaging of these services and provide an alternative model at the next Panel meeting, because we are finalizing a modified model. We will review the final CY 2008 policy, including the ratesetting methodology, with the APC Panel at its 2008 winter meeting.

(5) Diagnostic Radiopharmaceuticals

For CY 2008, we proposed 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, as we indicated in the CY 2008 OPPS/ASC proposed rule, 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. As we indicated in the proposed rule, 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 proposed to package payment for all diagnostic radiopharmaceuticals that are not otherwise packaged according to the CY 2008 packaging threshold for drugs, biologicals, and radiopharmaceuticals that we proposed. We proposed this packaging approach for diagnostic radiopharmaceuticals, while we proposed 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.a.(c) of this final rule with comment period. 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 in the proposed rule (72 FR 42668) presented 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 included a HCPCS code for a diagnostic radiopharmaceutical at least 84 percent of the time for 19 of the top 20 procedures. More specifically, 84 to 86 percent of the single bills for 4 diagnostic nuclear medicine procedures included a diagnostic radiopharmaceutical, 87 to 89 percent of the single bills for 8 diagnostic nuclear medicine procedures included a diagnostic radiopharmaceutical, and 90 percent or more of the single bills for 7 diagnostic nuclear medicine procedures included a diagnostic radiopharmaceutical.

Among the lower volume diagnostic nuclear medicine procedures (which were outside the top 20 in terms of volume), there was 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 had at least 80 percent of the single bills for that diagnostic procedure that included a diagnostic radiopharmaceutical HCPCS code; about 37 percent of the low volume diagnostic procedures had between 50 to 79 percent of the single bills that included a diagnostic radiopharmaceutical HCPCS code; and about 23 percent of the low volume diagnostic procedures

had 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 included a diagnostic radiopharmaceutical HCPCS code, we believed there could be several reasons why the percentage of single bills for the diagnostic nuclear medicine procedure with a diagnostic radiopharmaceutical HCPCS code was low.

As noted earlier, it is possible that hospitals may have included 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 used 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 costs were less than $50 in CY 2006. We stated in the proposed rule that 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. In the proposed rule, we noted that we planned to accept the APC Panel's recommendation, and we specifically welcomed public comment on the hospitals' burden involved should we require such precise reporting. We also sought public 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.

As we indicated in the proposed rule, we are aware 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 indicated in the proposed rule that we believe that our standard OPPS ratesetting methodology of using median costs calculated from claims data would adequately capture the costs of diagnostic radiopharmaceuticals associated with diagnostic nuclear medicine procedures that are not provided on the same date of service.

The packaging proposal we presented would have reduced the overall frequency of single bills for diagnostic nuclear medicine procedures, but the percent of single bills out of total claims remained 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 reduced 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 the proposed rule, and this final rule with comment period. Generally, we found that changing the status of diagnostic radiopharmaceuticals to packaged increased the packaging on each claim. This would 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

continued to have good representation in the single bills. On average, single bills as a percent of total occurrences remained 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 final rule with comment period.

We indicated in the proposed rule that we believe our CY 2006 claims data supported our CY 2008 proposal to package payment for all diagnostic radiopharmaceuticals and would lead to 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 were even higher than the percentages indicated. 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 included a diagnostic radiopharmaceutical HCPCS code, the fact that the percentage was somewhat less than 100 percent was likely to have minimal impact on the median cost of the procedure in most cases. Even in those few instances where we had a low total number of single bills, largely because of low overall volume, we had ample representation of diagnostic radiopharmaceutical HCPCS codes on the single bills for the majority of lower volume nuclear medicine procedures. We also continued 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 were already packaged, the proposal to package additional diagnostic radiopharmaceuticals would have had little impact on the payment for these procedures.

The estimated overall impact of these changes presented in section XXII.B. of the proposed rule (section XXIV.B. of this final rule with comment period) was based on the assumption that hospital behavior would not change with regard to whether the dependent diagnostic radiopharmaceuticals services are provided by the same hospital that performs the independent services. In order to provide diagnostic nuclear medicine procedures under this policy, 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 expect that hospitals would always bill the diagnostic radiopharmaceutical on the same claim as the other independent services for which the radiopharmaceutical was administered.

The APC Panel recommended that CMS package radiopharmaceuticals with a median per day cost of less than $200 but pay separately for radiopharmaceuticals with a per day cost of $200 or more. The APC Panel also recommended that CMS should identify nuclear medicine procedure claims with and without radiopharmaceuticals and should present its findings to the Panel at the next meeting for consideration of whether an edit is needed to ensure that the cost of the radiopharmaceutical is packaged into the payment for the nuclear medicine service.

We received many public comments on our proposal to package payment for diagnostic radiopharmaceuticals for CY 2008. A summary of the public comments and our responses follow.

Comment: Some commenters recommended that CMS package radiopharmaceuticals with a per day cost less than $200 but pay separately for radiopharmaceuticals with a per day cost of $200 or more. Other commenters objected to packaging diagnostic radiopharmaceuticals and asked that CMS continue to pay separately for radiopharmaceuticals with per day costs that exceed the packaging threshold for drugs. These commenters explained that FDA views radiopharmaceuticals to be drugs, they are defined as drugs for purposes of pass-through payment under OPPS in sections 1833(t)(6)(A)(iii) of the Act, and for purposes of payment as specified covered outpatient drugs (SCODs) and biologicals in section 1833(t)(14)(B)(i)(l) of the Act. The commenters argued that CMS should, therefore, pay separately for radiopharmaceuticals with a per day cost in excess of $60, as it does for other drugs.

The commenters believed that section 1833(t)(14)(B)(i)(l) of the Act requires CMS to treat radiopharmaceuticals no differently from other SCODs and, therefore, CMS must pay radiopharmaceuticals actual acquisition costs or, failing that, charges adjusted to costs. Some commenters believed that there is no authority for CMS to package drugs that are incidental or ancillary to a procedure and that by doing so, CMS is relying on a form of ''functional equivalence'' which is expressly limited by statute under section 1833(t)(6)(F) of the Act. The commenters argued that the proposal will create an incentive for hospitals to not use advanced technologies and will harm patient care. Some commenters believed that packaging diagnostic radiopharmaceuticals could discourage hospitals from using the most appropriate drug for each patient and encourage them to use less clinically effective radiopharmaceuticals when there is a choice of radiopharmaceutical. Some commenters added that the proposal ignores medical indications and focuses solely on cost reduction, which could result in constraints on medical decisionmaking and would compromise medical care.

Response: After review of the public comments we received on this issue, we have decided to finalize our proposal to package payment for diagnostic

radiopharmaceuticals into the payment for the nuclear medicine services which cannot be performed without the administration of a radiopharmaceutical. We refer readers to section V.B.4.b. of this final rule with comment period for a discussion of the rationale to package payment for diagnostic radiopharmaceuticals as SCODs and our belief that the packaged payment provides payment at average acquisition cost for the products.

We find the argument that we are creating functional equivalence by packaging the payment for diagnostic radiopharmaceuticals into the payment for the nuclear medicine services without which they cannot be performed to be unconvincing. We are not establishing an equivalent payment for different products based on their function. We are instead packaging the cost of radiopharmaceuticals, however differential those costs may be, into the payment for nuclear medicine services to create an appropriate payment for the nuclear medicine services that use these products, whether there is one product or multiple products that could be used to furnish the service. This is analogous to our longstanding practice of packaging of medical devices into the payment for the procedure in which they are used, notwithstanding that there may be different devices that could be used to furnish the service.

Moreover, we do not agree with the argument that paying for radiopharmaceuticals as part of the payment for the nuclear medicine service to which they are essential will harm patient care. We believe that providing packaged payment for radiopharmaceuticals as part of the nuclear medicine service will cause hospitals and their physician partners to give even more careful consideration to the selection of the radiopharmaceutical that is the most appropriate for the patient whom they are treating.

We are not accepting the APC Panel recommendation to pay separately for radiopharmaceuticals with a per day cost in excess of $200 because we could not determine an empirical basis for paying separately for radiopharmaceuticals with a per day cost in excess of $200.

Comment: Many commenters stated that a diagnostic radiopharmaceutical is always needed to provide a nuclear medicine service and, therefore, CMS should use only claims in which both services were present to compute the median cost for the nuclear medicine procedure if CMS decides to package diagnostic radiopharmaceuticals. Some commenters suggested that CMS establish OCE edits that would require a charge be reported under the diagnostic radiopharmaceutical revenue code 0343 when there was a charge in revenue codes 0340 or 0341 for a nuclear medicine procedure. Other commenters recommended that CMS establish OCE edits that would require a HCPCS code for a diagnostic radiopharmaceutical be reported on a claim for a diagnostic nuclear medicine procedure. Some commenters were concerned that the actual cost of radiopharmaceuticals would be lost because hospitals would not report the charges on the claim unless CMS mandates and enforces their reporting.

Response: We agree that it is important that the costs of radiopharmaceuticals be reported on the same claim with the nuclear medicine service so that we can have confidence that the payment for the nuclear medicine procedure reflects the cost of the radiopharmaceutical as well as the nuclear medicine service. Therefore, we have used only claims that contain a HCPCS code and charge for a diagnostic radiopharmaceutical to calculate the median costs of the nuclear medicine procedures for CY 2008. Moreover, effective for services furnished on and after January 1, 2008, the OCE will return for correction any claim for a nuclear medicine procedure that does not contain a HCPCS code and charge for a diagnostic radiopharmaceutical. These edits are similar to the edits we have had in place in the OCE since CY 2005 for medical devices. The significant difference, however, is that we recognize that, for some nuclear medicine procedures, there is a choice of radiopharmaceuticals that could be used and, therefore, the edits will not specify which radiopharmaceutical must be billed with any given nuclear medicine procedure. We also recognize that, in some cases, the radiopharmaceutical is administered several days before the nuclear medicine service is furnished. In these cases, the hospital will need to hold the claim until after the service is furnished so that the radiopharmaceutical can appear on the bill with the nuclear medicine procedure or the bill for the procedure will be returned for correction. We did not accept the comment that we should establish the edits using combinations of revenue codes because to do so would not provide specific information on the particular radiopharmaceutical being furnished and we could not be certain that the charges were for radiopharmaceuticals.

Comment: Some commenters asserted that, based on survey data they gathered, claims data fail to capture hospital average acquisition costs for radiopharmaceuticals. The commenters, therefore, concluded that the costs of low volume, high cost radiopharmaceuticals are not captured in the claims data that is used to set the median costs on which the nuclear medicine services payment rates are based and the packaged payment for radiopharmaceuticals will be inadequate to pay for the cost of the drug. The commenters believed that these incorrectly priced products are unlikely to continue to be manufactured and thus will cease to be available. The commenters also stated that it is unlikely that the industry will develop new products for the market if they find that hospitals will not use them because of inadequate payment. The commenters believed that beneficiary care would suffer as hospitals ceased to furnish the service because payment would be inadequate to cover the cost. Some commenters explained that, while CMS implemented revenue codes for diagnostic and therapeutic radiopharmaceuticals in CY 2004, hospitals have not yet fully reflected these revenue codes in their billing practices and, therefore, the claims data are not correct or reliable and CMS should continue to pay separately for radiopharmaceuticals at charges adjusted to cost. Other commenters believed that the proposed changes would overestimate payments for some diagnostic radiopharmaceuticals, underestimate others, and create improper financial incentives for hospitals and physicians to select certain radiopharmaceuticals rather than others, potentially reducing the quality of care.

Response: We believe that we have appropriately calculated the radiopharmaceutical costs that we are packaging into the nuclear medicine services by using only claims for nuclear medicine services that contain a radiopharmaceutical, as noted above. This is analogous to our process for ensuring that the costs of devices are packaged into the payment for the APC in which they are used, and we believe that using only these claims will negate any existing problems with the use or lack of use of the radiopharmaceutical revenue codes.

With regard to the concern that packaging radiopharmaceuticals will result in overpayment in some cases and underpayment in others, we note that the most fundamental characteristic of a prospective payment system is that payment is to be set at an average for the service, which, by definition, means that some services are paid more or less than the average. However, the average

should provide adequate payment for the service, while creating incentives for hospitals to control costs and utilization of high cost services where it is appropriate to do so. We do not believe that either beneficiary access to care or the quality of care will be adversely affected because we pay for diagnostic radiopharmaceuticals as part of the payment for the procedure to which they are an integral part. With regard to the influence this may have on the development and production of radiopharmaceuticals, there are many aspects of the health care economy that influence what is developed and produced, of which Medicare payment under the OPPS is merely one.

Comment: Some commenters stated that CMS has not provided adequate information for specialty societies and others to adequately review the matching of the drugs with the services to determine whether an appropriate radiopharmaceutical is packaged into the nuclear medicine services. The commenters indicated that CMS should provide data on the percent of nuclear medicine claims that were reported with and without a corresponding radiopharmaceutical so that the public can determine whether an edit is indicated for reporting these services either through OCE or backend rate setting and, if so, what edit would be appropriate.

Response: We provided considerable information and data in support of our proposal. Moreover, we make available our claims data both for the proposed rule and the final rule so that the public can perform any analysis they choose. There are limits to our ability to provide specialized studies of interest. Therefore, we provide a narrative claims accounting that is intended to illuminate our data process for those who would like to use the claims data to explore alternatives.

Comment: Some commenters believed that packaging diagnostic radiopharmaceuticals would undermine the clinical and resource homogeneity of the nuclear medicine APCs, especially the cardiac imaging APCs, resulting in 2 times violations. The commenters stated that the APC revision that is proposed as a result of the proposed packaging results in a lack of resource and clinical homogeneity within the APCs. Specifically, the commenters believed that, by packaging diagnostic radiopharmaceuticals, CMS created a 2 times violation in APC 0408 because the median costs for the services assigned to the APC vary widely for the procedure code based on the radiopharmaceutical used.

Response: We agree that packaging costs into the median for a service to which they are an integral part can change the median cost for that service and result in 2 times violations. As we noted in the proposed rule, there were a significant number of APC reassignments to eliminate 2 times violations that would otherwise have resulted from the proposed packaging approach. However, we disagree that we should refrain from packaging payment for necessary items into the payment for the service in which they are required in order to prevent 2 times violations from occurring. Instead, we believe that we should make the necessary reassignments to different APCs where necessary to resolve 2 times violations where they occur. For example, to resolve 2 times violations that would otherwise have occurred when we used only those claims for nuclear medicine procedures reporting HCPCS code for diagnostic radiopharmaceuticals, we made the following APC reassignments for this final rule with comment period. We reassigned CPT code 78730 (Urinary bladder residual study (List separately in addition to code for primary procedure)) from APC 0340 (Minor Ancillary Procedures) to APC 0389 (Level I Non-Imaging Nuclear Medicine). We reassigned CPT code 78725 (Kidney function study, non-imaging radioisotopic study) from APC 0389 to APC 0392 (Level II Non-Imaging Nuclear Medicine). We reassigned CPT code 78006 (Thyroid imaging, with uptake; single determination) from APC 0390 (Level I Endocrine Imaging) to APC 0391 (Level II Endocrine Imaging). With regard to APC 0408 (Level III Tumor/Infection Imaging), that APC contained only one code for the proposed rule, CPT code 78804 (Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring two or more days imaging), and it had a proposed median of approximately $1,010. For this final rule with comment period, APC 0408 contains 3 CPT codes: 78804 (Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring two or more days imaging); 78075 (Adrenal Imaging, cortex and/or medulla); and 78803 (Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(t); tomographic (SPECT)). For this final rule with comment period, APC 408 has a median cost of approximately $969.

Because we have traditionally paid for a service package under the OPPS as represented by a HCPCS code for the major procedure that is assigned to an APC group for payment, we assess the applicability of the 2 times rule to services at the HCPCS code level, not at a more specific level based on the individual diagnostic radiopharmaceuticals that may be utilized in a service reported with a single HCPCS code. If the use of a very expensive diagnostic radiopharmaceutical in a clinical scenario causes a specific procedure to be much more expensive for the hospital than the APC payment, we consider such a case to be the natural consequence of a prospective payment system that anticipates that some cases will be more costly and other less costly than the procedure payment. In addition, very high cost cases could be eligible for outlier payment. As we note elsewhere in this final rule with comment period, 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 the case of diagnostic radiopharmaceuticals, these products will be part of the OPPS payment package for the procedures in which they are used beginning in CY 2008.

Comment: One commenter objected to packaging of diagnostic radiopharmaceuticals because the commenter believed that including the payment for the item in the payment for the procedure would improperly subject the portion of the payment that is attributable to the diagnostic radiopharmaceutical to wage adjustment. The commenter indicated that there should be no wage adjustment applied to the cost of a diagnostic radiopharmaceutical.

Response: We disagree that we should not package the payment for a radiopharmaceutical into the payment for the procedure in which it is an integral part because part of the procedure payment will be wage adjusted. Since the inception of the OPPS, we have determined that, approximately 60 percent of the cost of an OPPS service is attributable to wage costs. That figure is an overall average percent that takes into account the extent to which there are costs in the OPPS payments that are not attributable to wages. We have a longstanding policy of wage adjusting 60 percent of the cost of the APC, regardless of whether it is an office visit (which is mostly wage costs) or an ICD replacement (in which most of the cost is a device), because our analysis shows that, overall, OPPS

services approximately 60 percent of the cost is attributable to wages.

Comment: Some commenters stated that diagnostic radiopharmaceuticals are not interchangeable and carry high costs because, if the patient for whom the hospital secures a radiopharmaceutical cannot use the product, the hospital cannot bill for it and must absorb the loss. The commenters stated that hospitals have little or no flexibility in determining the diagnostic radiopharmaceutical that they purchase and have little ability to achieve efficiency.

Response: We recognize that radiopharmaceuticals are specialized products that have unique costs associated with them. However, we believe that the costs should be reflected in the charges that hospitals set for them and in the cost report where the full costs of the services are carried. Therefore, the costs will be calculated like any other OPPS cost and packaged into the total cost of the nuclear medicine service to which they are an integral part and will be the basis for the payment rate for the nuclear medicine service in the same way that other packaged costs contribute to the payment rate for the services to which they are an integral part.

Comment: Several commenters stated that HCPCS codes A9542 (Indium IN–111 ibritumomab tiuxetan, diagnostic, per study dose, up to 5 millicuires) and A9544 (Iodine I–131 tositumomab, diagnostic, per study dose) are not diagnostic radiopharmaceuticals and should not be packaged. The commenters reported that they are not used to diagnose the patient's disease but instead are used to assess the biodistribution of radioimmunotherapy agents or to calculate the therapeutic dose of those agents. The commenters contended that, although packaging is intended to create incentives for using the most cost-effective product, in these cases there are no other products that are available, and hence these products should always be paid separately. The commenters concluded that the proposed payments for these services are so low that hospitals will not offer the treatments to Medicare beneficiaries.

Response: We continue to believe that HCPCS codes A9542 and A9544 are diagnostic radiopharmaceuticals. While they are not used to diagnose disease, they are used to determine whether future therapeutic services would be beneficial to the patient and to determine how to proceed with therapy. This is analogous to the use of positron emission tomography (PET) scanning for staging purposes when there has already been a diagnosis of disease but the physician is seeking information to use in planning a course of therapy. The scan is a diagnostic service, notwithstanding that the disease has previously been diagnosed and the diagnostic service is essential to planning therapy. While we recognize that these radiopharmaceuticals are sole source products, we do not believe that is sufficient to justify treating them differently from other diagnostic radiopharmaceuticals. Moreover, given that the Medicare population is such a dominant portion of the population to which these services are targeted, we do not believe that hospitals will cease to provide the service because the payment is packaged into the payment for the service to which the radiopharmaceutical is an integral part. We also note that, under 42 CFR 489.53(a)(2), CMS may terminate the provider agreement of any hospital that furnishes this or any other service to its patients but fails to also furnish it to Medicare patients who need it.

Comment: Some commenters asked that CMS pay hospitals separately for diagnostic radiopharmaceuticals based on acquisition costs. The commenters had a variety of recommendations regarding how CMS should acquire acquisition cost data on which CMS could base separate payment for radiopharmaceuticals. Some commenters recommended that CMS conduct surveys of radiopharmaceutical costs or rely on the external data from surveys conducted by outside entities to obtain cost data. Some commenters recommended that CMS work with stakeholders to develop a standardized radiopharmaceutical reporting format and base separate payment for radiopharmaceuticals on a radiopharmaceutical average selling nuclear pharmacy price (ASNPP), average acquisition cost (ACC), or another voluntarily reported amount if furnished by manufacturers and nuclear pharmacies, instead of claims data charges adjusted to cost by departmental CCRs. Other commenters suggested that CMS require hospitals to report acquisition costs for radiopharmaceuticals, instruct contractors to collect periodic reports from hospitals of diagnostic radiopharmaceutical costs, and gather and summarize nuclear pharmacy invoice data through CY 2008 that would be used to set CY 2009 rates. The commenters stated that separate payment of diagnostic radiopharmaceuticals for CY 2008 is critical to enable hospitals to account for the complex combinations of radiopharmaceuticals used to provide nuclear medicine procedures. Some commenters indicated that continuation of the current payment at charges reduced to cost by the overall CCR, while not ideal, is a reasonable temporary solution until CMS can implement a long term solution to pay acquisition costs for radiopharmaceuticals as required by law. Some commenters supported CMS' use of its claims data alone to set the CY 2008 payment rates, but only if no external data source is available to pay actual acquisition costs for radiopharmaceuticals.

Response: As we previously stated, we have decided to package payment for diagnostic radiopharmaceuticals into the payment for nuclear medicine services. Therefore, proposals for gathering data on which separate payment could be based are not relevant. However, we note that when we proposed to acquire ASP data for radiopharmaceuticals for purposes of paying separately for them under the CY 2006 OPPS, commenters were virtually unanimous that the industry could not report valid sales price data on radiopharmaceuticals.

After consideration of the public comments received, we are finalizing our CY 2008 proposal to provide packaged payment for diagnostic radiopharmaceuticals, with modification to calculate the median costs for the APCs for nuclear medicine studies that require a diagnostic radiopharmaceutical using only claims on which at least one diagnostic radiopharmaceutical is present. We will implement edits in the OCE for services furnished on and after January 1, 2008, that will return to providers any claim for a nuclear medicine study that does not also report a HCPCS code and charge for a diagnostic radiopharmaceutical. We are not accepting the APC Panel's recommendation to set a packaging threshold for diagnostic radiopharmaceuticals at a median cost of $200 per day. We are accepting the APC Panel's recommendation to provide information regarding claims for diagnostic radiopharmaceuticals reported with nuclear medicine procedures, and we will discuss that information with the Panel at the 2008 winter meeting. Diagnostic radiopharmaceuticals assigned status indicator ''N'' that will be unconditionally packaged are listed in Table 10 of this final rule with comment period.

(6) Contrast Agents

For CY 2008, we proposed 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 (72 FR 42672 through 42674). As noted in section II.A.4.c. of the proposed rule and this final rule with comment period, 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 stated in the proposed rule (72 FR 42672), 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 indicated that 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 final rule with comment period.) 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 proposed rule claims data.

At the time of the proposed rule, contrast agents were described by those Level II HCPCS codes in the range from Q9945 through Q9964. There were currently 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 of the proposed rule, 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 proposed 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 the proposed rule. In fact, of the 20 contrast agent HCPCS codes we included 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, using proposed rule data. As stated in the proposed rule (72 FR 42672), 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 stated in the proposed rule (72 FR 42672) that 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 noted in the proposed rule (72 FR 42672) that the significant costs associated with these 15 contrast agents would already be reflected in the 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.

The estimated overall impact of these changes presented in section XXII.B. of the proposed rule (and section XXIV.B. of this final rule with comment period) was based on the assumption that hospital behavior would not change with regard to when these contrast agents are provided by the same hospital that performs the imaging procedure. Under this policy, in order to provide imaging procedures requiring contrast agents, hospitals will 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 expected 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 providing 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. As noted in the proposed rule (72 FR 42673), 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.

During its September 2007 APC Panel meeting, the Panel recommended that contrast agents be packaged as proposed.

We received many public comments on the proposal to package payment for all contrast agents. A summary of the public comments and our responses follow.

Comment: Many commenters supported our proposal to package all contrast agents, while others requested that we pay separately for all contrast agents in accordance with the Average

Sales Price (ASP) payment methodology. Many commenters requested that we treat contrast agents in the same manner as we treat other drugs under the OPPS, thereby continuing to apply the proposed $60 threshold to determine packaging status. One commenter expressed concern with the accuracy of CMS' cost data, and estimated that if contrast agents were packaged, hospitals would not receive any payment in addition to the payment for the procedure without contrast. Several commenters requested that CMS create edits to ensure that the costs for contrast agents are only packaged with appropriate procedures, rather than with any code that may appear on the claim. Other commenters requested that CMS implement edits to ensure that contrast agents are always billed with procedures that require contrast agents. Some commenters were concerned that CMS may not be accounting for the full cost of the contrast agent, because of the methodology used to determine the acquisition costs of the agents. One commenter noted that it is difficult for hospitals operationally to treat contrast agents as packaged, then separately payable the following year, and then packaged again. In addition, commenters were concerned that packaged status would encourage less coding accuracy, which would hinder the development of accurate future payment rates. One commenter expressed concern that patient access to more expensive contrast agents, such as gadolinium-based contrast agents, may be limited, if the proposal to package all contrast agents were finalized.

Response: We have considered all of the comments on this issue and have concluded that it is appropriate to package all contrast agents into payment for the procedure in which they are used. Many contrast agents are packaged currently under the OPPS and have been packaged since the inception of the OPPS. We have no reason to believe that the cost data that we developed for contrast agents are insufficient to result in an appropriate median cost for the services in which the contrast agent is used. Moreover, we are not convinced that there are benefits to making separate payment that would outweigh the incentives for appropriate utilization and efficiency that are created by packaging the payment for the contrast agent into the payment for the service in which it is used.

In addition, we do not believe it is necessary to create edits to ensure that contrast agents are billed in conjunction with services that require contrast agents. For example, we believe that the payment rates for CT with and without contrast are accurate, further bolstering our perspective that hospitals are correctly billing the charges for contrast agents for those services that require them. There is currently a significant cost differential that appears to be appropriate between CT scans with and without contrast, and we have no reason to believe that this cost differential is inaccurate. For example, the CY 2008 median cost for CPT code 72192 (Computer tomographic angiography, pelvis, without contrast material) is approximately $190. The CY 2008 median cost for CPT code 72193 (Computer tomographic angiography, pelvis, with contrast material) the same procedure, with contrast, is approximately $249. The CY 2008 median costs for the services in APC 0332 (Computed Tomography Without Contrast) range from approximately $164 to $227. The CY 2008 proposed median costs for the services in APC 0283 (Computed Tomography with Contrast) range from approximately $247 to $333, significantly higher than the median costs for the procedures that do not involve contrast media.

Providers have several ways to report contrast agents, including uncoded charges on revenue code lines, including the charge for the contrast agent in the charge for the procedure, or reporting the appropriate HCPCS code for the contrast agent that was used. Prior to proposing to package payment for all contrast agents, we note that there were no concerns or complaints about the payment rates for imaging studies with and without contrast, when a number of the commonly used contrast agents were packaged. In addition, if we were to subset claims for procedures that require a contrast agent to use only those claims that included a coded contrast agent, we would be able to use many fewer claims, which would cause our median costs to be less accurate and representative.

Most of the contrast media would have been packaged in the absence of this packaging proposal, because 75 percent of all contrast agents fall below the $60 threshold for CY 2008. However, we are interested to know whether the public thinks it would be beneficial from a ratesetting perspective to require hospitals to report contrast media by including HCPCS codes for contrast on all claims for procedures that use contrast. We are particularly concerned with unnecessarily burdening hospitals, and are seeking comments in this final rule with comment period related to how administratively burdensome this requirement would be for hospitals.

In response to the commenter who found it difficult operationally to manage changes in the packaged status of contrast media, we note that we do not anticipate regular changes to the packaged status of contrast media, now that we are finalizing our proposal to package payment for all contrast media.

In response to the commenter's concern about payment for expensive contrast agents like gadolinium-based contrast media, we note that the gadolinium-based contrast agents would be packaged under the $60 packaging threshold, regardless of whether this proposal to package payment for all contrast media was finalized. Packaging payment for these products provides hospitals with an incentive to choose the most cost-effective contrast agent that meets the needs of the patient.

Comment: Several commenters questioned whether we have the authority under the Social Security Act to package all contrast agents.

Response: See section V.B.4.b. of this final rule with comment period for a discussion of the rationale to package payment for contrast agents as SCODs and our belief that the packaged payment provides payment at average acquisition cost for the products.

Comment: Several commenters requested that contrast agents used for echocardiography imaging procedures remain separately paid in CY 2008. These commenters were concerned that echocardiography procedure codes do not distinguish between services provided with contrast and those provided without contrast, although section 1833(t)(2)(G) of the Act requires that contrast and noncontrast procedures be paid through separate APC groups. As echocardiography procedures are not usually performed with contrast, the commenters asserted that the packaged payment for contrast and echocardiography would be insufficient to cover both costs, and that physicians would therefore be limited in their ability to use contrast when necessary.

Response: The commenters are correct; section 1833(t)(2)(G) of the Act requires us to create additional groups of services for procedures that use contrast agents. As contrast agents were eligible for separate payment in CY 2007 but subject to the OPPS drug packaging threshold, a distinction was made in payment between those procedures performed with contrast from those without contrast. However, as noted above, we are finalizing our proposal to package all contrast agents in CY 2008 regardless of if they meet the OPPS drug packaging threshold.

Because current CPT codes do not distinguish between echocardiography procedures performed without contrast from those performed with contrast, we calculated HCPCS–specific median costs for echocardiography procedures that were performed with contrast by isolating single and ''pseudo'' single claims with CPT codes 93303 through 93350 where there was also a contrast agent on the claim. Our analysis indicated that median costs for echocardiography procedures performed with contrast are similar both clinically and in terms of resource use, as evidenced by similar HCPCS median costs. Therefore, pursuant to the statute, we have created APC 0128 (Echocardiogram With Contrast) to provide payment for echocardiography procedures that are performed with a contrast agent in CY 2008.

In order for hospitals to report echocardiography procedures performed with contrast, as all contrast will be packaged in CY 2008, we have also created the eight new HCPCS codes shown in Table 3 below. We have assigned HCPCS codes C8921 through C8928 to the newly created APC 0128. Hospitals performing echocardiography procedures without contrast will continue to use the CPT codes indicated in Table 5, while echocardiography procedures performed with contrast will be reported with the newly developed C-codes also identified in Table 5. We will provide further instruction about reporting echocardiography procedures with and without contrast in the January 2007 OPPS update.

TABLE 5.—CY 2008 ECHOCARDIOGRAPHY HCPCS CODES FOR PROCEDURES WITH AND WITHOUT CONTRAST

Echocardiography without contrast				Echocardiography with contrast			
HCPCS	Descriptor	SI	APC	HCPCS	Descriptor	SI	APC
93303	Transthoracic echocardiography for congenital cardiac anomalies; complete.	S	0269	C8921	Transthoracic echocardiography with contrast for congenital cardiac anomalies; complete.	S	0128
93304	Transthoracic echocardiography for congenital cardiac anomalies; follow-up or limited study.	S	0697	C8922	Transthoracic echocardiography with contrast for congenital cardiac anomalies; follow-up or limited study.	S	0128
93307	Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete.	S	0269	C8923	Transthoracic echocardiography with contrast, real-time with image documentation (2D) with or without M-mode recording; complete.	S	0128
93308	Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; follow-up or limited study.	S	0697	C8924	Transthoracic echocardiography with contrast, real-time with image documentation (2D) with or without M-mode recording; follow-up or limited study.	S	0128
93312	Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report.	S	0270	C8925	Transesophageal echocardiography (TEE) with contrast, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report.	S	0128
93313	Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); placement of transesophageal probe only.	S	0270				
93314	Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); image acquisition, interpretation and report only.	N					
93315	Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report.	S	0270	C8926	Transesophageal echocardiography (TEE) with contrast for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report.	S	0128
93316	Transesophageal echocardiography for congenital cardiac anomalies; placement of transesophageal probe only.	S	0270				
93317	Transesophageal echocardiography for congenital cardiac anomalies; image acquisition, interpretation and report only.	N					
93318	Echocardiography, transesophageal (TEE) for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis.	S	0270	C8927	Transesophageal echocardiography (TEE) with contrast for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis.	S	0128

TABLE 5.—CY 2008 ECHOCARDIOGRAPHY HCPCS CODES FOR PROCEDURES WITH AND WITHOUT CONTRAST—Continued

Echocardiography without contrast				Echocardiography with contrast			
HCPCS	Descriptor	SI	APC	HCPCS	Descriptor	SI	APC
93320	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete.	N					
93321	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); follow-up or limited study (List separately in addition to codes for echocardiographic imaging).	N					
93325	Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography).	N					
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.	S	0697	C8928	Transthoracic echocardiography with contrast, 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.	S	0128

In order to determine a payment rate for APC 0128 for CY 2008, we isolated single and ''pseudo'' single claims in our database that included those CPT codes in the range of 93303 through 93350 that correspond to the contrast studies described by the new C-codes. We created new C-codes for contrast studies only to parallel those CPT codes for procedures where we expected that the procedures could be provided with or without contrast. For claims where an echocardiography procedure was billed with a contrast agent, we packaged the payment for the contrast agent into the echocardiography procedure and then calculated the median cost for this subset of claims. This became the median for APC 0128. In addition, we recalculated the medians for APCs 0269 (Level II Echocardiogram Without Contrast Except Transesophageal); 0270 (Transesophageal Echocardiogram Without Contrast); and 0697 (Level I Echocardiogram Without Contrast Except Transesophageal), as we needed to remove the claims from the ratesetting process that included contrast because they were used to set the median cost for APC 0128. The resulting CY 2008 APC medians are shown in Table 6.

TABLE 6.–CY 2008 FINAL RULE ECHOCARDIOGRAM APC MEDIANS

APC	Title	HCPCS Codes	Median
0269	Level II Echocardiogram Without Contrast Except Transesophageal	93303 93307	$401
0270	Transesophageal Without Contrast Echocardiogram	93312 93313 93315 93316 93318	$517
0697	Level I Echocardiogram Without Contrast Except Transesophageal	93304 93308 93350	$210
0128	Echocardiogram With Contrast	C8921 C8922 C8923 C8924 C8925 C8926 C8927 C8928	$534

We believe that these medians accurately reflect hospital costs when performing echocardiography procedures, both with and without contrast. This final coding and payment methodology allows us to both adhere to the statutory requirement to create additional groups of services for procedures that use contrast agents and to package payment contrast agents in CY 2008. Therefore, we are finalizing our policy to assign HCPCS codes C8921

through C8928 to APC 0128 and will instruct hospitals to use these contrast-specific HCPCS codes when submitting an OPPS claim for echocardiography procedures performed with contrast.

For CY 2008, we are finalizing our proposal to unconditionally packaged payment for all contrast agents, with modification as discussed above. We are fully adopting the APC Panel recommendation to package all contrast media for CY 2008. Consistent with the statute, we are also finalizing the creation of APC 0128, as well as eight Level II HCPCS codes that describe echocardiography procedures performed with contrast. Contrast agents that are packaged are assigned status indicator ''N'' and are listed in Table 10 of this final rule with comment period.

(7) Observation Services

We proposed to package payment for all observation care, reported under HCPCS code G0378 (Hospital observation services, per hour) for CY 2008. We proposed that payment for observation care 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 the proposed rule and in this final rule with comment period, 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 final rule with comment period (section XI.), we proposed 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. As noted in the proposed rule (72 FR 42674), this requirement would no longer be applicable under our proposal to package all observation services reported under HCPCS code G0378.

For CY 2007, 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 follow-up 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, we indicated that we believed that it was 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 (ED) 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 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 (section II.A.4.b. of this final rule with comment period), 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 CYs 2003 and 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 CYs 2005 to 2008 (that is, claims data reflecting services furnished from CYs 2003 to 2006), we saw substantial growth in separately payable observation care billed under the OPPS over that time. In CY 2003, the first full year that 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. By CY 2005, that number had increased to approximately 124,300 claims, representing an increase of approximately 61 percent over the previous calendar year. Based on the CY 2006 data available for issuance of the proposed rule, the frequency of claims for separately payable observation services increased to more than 271,200 claims which represents an increase of approximately 118 percent over CY 2005 and more than triple the number of claims for CY 2004. 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.

In the proposed rule (72 FR 42675), we indicated that we were also concerned that the current criteria for separate payment for observation services may provide disincentives for efficiency. For CY 2007, 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 final rule with comment period, 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.

We indicated in the proposed rule (72 FR 42676) that, 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 believed it was 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. We noted in the proposed rule (72 FR 42676) that 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 expansion 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.

The estimated overall impact of these changes, presented in section XXII.B. of the proposed rule (and in section XXIV.B. of this final rule with comment period), was 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 indicated that 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 indicated that we believe it is unlikely that hospitals will 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 stated in the proposed rule (72 FR 42677) that we expect that hospitals would always bill the supportive observation services on the same claim as the other independent services provided in the single hospital encounter.

As we indicated earlier, in all cases we proposed 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 services can be appropriately packaged into payment for the independent services. We stated in the proposed rule (72 FR 42677) that we expected 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.

During its September 2007 APC Panel meeting, the APC Panel recommended that CMS not package observation services as proposed, thereby maintaining the CY 2007 payment policy. However, the APC Panel indicated that if CMS were to package observation, CMS should create a composite emergency department/clinic and observation APC (or group of composite APCs) that would be paid only when both services were furnished; if the composite APC were paid, neither the emergency department nor the clinic visit would be paid separately. The APC Panel recommended that coding and service requirements currently applicable to separately paid observation would remain the same, with the exception that there would be no clinical condition (that is, diagnosis) restrictions on payment for the composte APC. The APC Panel noted that payment rates for this (these) composite APC(s) would need to be adjusted based on readily available historical visit and observation data.

We received many public comments on our proposal to package payment for observation services into the payment for the services with which it is furnished. A summary of public comments and our responses follow.

Comment: Several commenters, including MedPAC, requested that CMS finalize its policy to package payment for all observation care. MedPAC specifically stated that packaging of observation care is logical because currently 70 percent of observation care is packaged. However, most commenters addressing observation packaging requested that CMS finalize its proposal to package all of the categories of codes that it identified in the proposed rule, with the exception of observation care. Many of these commenters stated that observation care is often a significant service and is not supportive and integral to an independent service. These commenters recommended that CMS implement various policies, such as paying separately for all observation care regardless of diagnosis, expanding the diagnoses that would enable separate payment, postponing packaging observation services, or creating a composite APC to allow separate payment for observation care in certain circumstances.

Response: Based on our review of the comments received, we continue to believe that observation services are usually ancillary and supportive to the other independent services that are provided to the patient on the same day. However, we accept the commenters' and the APC Panel's statements that observation care may sometimes rise to the level of a major component service, specifically, when it is provided for 8 hours or more in association with a high level clinic or ED visit, direct admission to observation, or critical care services and it is not provided in conjunction with a surgical procedure. In addition, based on our review of the clinical circumstances provided by many commenters, we recognize that observation care can be a major component service when provided to patients with clinical conditions other than congestive heart pain, chest pain, and asthma for which separate observation payment may currently by provided under the OPPS.

Consistent with our statutory flexibility to define what constitutes a service under the OPPS, we proposed to view a service, in some cases, as the totality of care provided in a hospital outpatient encounter that would be reported with two or more HCPCS codes for component services with the proposal of composite APCs for low dose rate prostate brachytherapy and cardiac electrophysiological evaluation and ablation services. In general, we intend to request public comment on possible composite APCs in the annual OPPS proposed rulemaking cycle. This also includes creating composite APCs, as appropriate, in response to those public comments received during rulemaking.

Therefore, we have decided to create two composite APCs that will provide payment to hospitals in certain circumstances when extended assessment and management of a patient occur. These composite APCs describe an extended encounter for care provided to a patient. Specifically, we are creating two new composite APCs for CY 2008, APCs 8002 (Level I Extended Assessment and Management Composite) and 8003 (Level II Extended Assessment and Management Composite). APC 8002 describes an encounter for care provided to a patient that includes a high level (Level 5) clinic visit or direct admission to observation in conjunction with observation services of substantial duration. APC 8003 describes an encounter for care provided to a patient that includes a high level (Level 4 or 5) emergency department visit or critical care services in conjunction with observation services of substantial duration. As with the other composite APCs that we proposed, we anticipate that assignment to and payment through one of these two new composite APCs will be transparent from a billing perspective. The OCE will evaluate every claim received to determine if payment through a composite APC is appropriate. If payment through a composite APC is inappropriate, the OCE in conjunction with the PRICER, will determine the appropriate status

indicator, APC, and payment for every code on a claim. The specific logic associated with the two Extended Assessment and Management Composite APCs is detailed below.

APC 8002 will be assigned when 8 or more units of HCPCS code G0378 (Hospital observation service, per hour) are billed—

• On the same day as HCPCS code G0379 (Direct admission of patient for hospital observation care); or

• On the same day or the day after—

++ CPT code 99205 (Office or other outpatient visit for the evaluation and management of a new patient (Level 5)); or

++ CPT code 99215 (Office or other outpatient visit for the evaluation and management of an established patient (Level 5)).

If a hospital provides a service with status indicator ''T'' on the same date of service, or 1 day earlier than the date of service associated with HCPCS code G0378, the hospital will not be eligible for payment under APC 8002. There is no diagnosis requirement for purposes of this composite APC. Rather, patients with any diagnosis may trigger payment of APC 8002. If any of the criteria listed above are not met, payment would not be made through APC 8002. Instead, payment for any separately payable services, including the clinic visit, would be made through the usual associated APCs. Payment for a direct admission to observation would be made according to the usual HCPCS code G0379 payment criteria and payment for HCPCS code G0378 would remain packaged because we consider the observation care to be supportive and ancillary to whichever service(s) it accompanies.

APC 8003 will be assigned when eight or more units of HCPCS code G0378 (Hospital observation service, per hour) are billed on the same day or the day after CPT code 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)); or 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30–74 minutes). The remaining criteria are identical to the criteria associated with composite APC 8002. If a hospital provides a service with status indicator ''T'' on the same date of service, or one day earlier than the date of service associated with HCPCS code G0378, the composite APC 8003 would not apply. Instead, payment for the ED visit or critical care and any other separately payable services will be made through the usual associated APCs, and payment for HCPCS code G0378 for observation services will remain packaged because we consider the observation care to be supportive and ancillary to whichever service(s) it accompanies. There is no diagnosis requirement for purposes of this composite APC either. Instead, patients with any diagnosis may trigger payment of APC 8003.

We note that HCPCS code G0378 will continue to be assigned status indicator ''N,'' signifying that its payment is always packaged. As stated above, in most circumstances, observation services are supportive and ancillary to the other services provided to a patient. In the circumstances when observation care is elevated to a major component service in conjunction with a high level visit or direct admission that is an integral part of a patient's extended encounter for care, payment is made for the entire care encounter through APC 8002 or 8003, as appropriate.

We are retaining as general reporting requirements for all observation services those criteria related to physician order and evaluation, documentation, and observation beginning and ending time as listed in section XI. of this final rule with comment period. 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.

The CY 2008 median cost for APC 8002 (Level I Extended Assessment and Management Composite) is approximately $347. The payment associated with APC 8002 is intended to pay the hospital for the costs associated with a single episode of extended assessment and management that includes a high level clinic visit or direct admission to the hospital for observation care, 8 hours or more of observation services, and any associated packaged services. We calculated this median cost using all CY 2006 single bill claims that met the criteria for APC 8002, as specified above. The CY 2008 median cost for APC 8003 (Level II Extended Assessment and Management Composite) is approximately $631. The payment associated with APC 8003 is intended to pay the hospital for the costs associated with a single episode of more intense extended assessment and management that includes a high level emergency department visit or critical care services, 8 hours or more of observation services, and any associated packaged services. We calculated this median cost using all CY 2006 single bill claims that met the criteria for APC 8003, as specified above.

While analyzing CY 2006 claims data, the most current full year claims data available, we observed that applying CY 2008 criteria for composite APCs resulted in payment for 55 percent more instances of observation care through a composite APC than if we had applied the CY 2007 criteria to those same claims. In addition, our CY 2006 claims data indicate that close to 30 percent of all observation care was paid separately. We estimate that roughly 90 percent of those instances of separately payable observation care reported in CY 2006 would be eligible for payment through composite APCs 8002 and 8003, using CY 2008 criteria. Those separately payable observation services that would not be eligible for payment through a composite APC involve observation services that were associated with low level clinic or emergency department visits. In addition, some of the packaged observation care that was provided in CY 2006 would be eligible for payment through composite APCs 8002 and 8003 because we are eliminating the diagnosis requirement for CY 2008.

As noted in detail in section IX.C of this final rule with comment period, we see a normal and stable distribution of clinic and ED visit levels. We do not expect this distribution to change due to the increase in claims for high level visits that may result from the new composite APCs. Depending on our CY 2008 claims data (which would be used for the CY 2010 OPPS), we may choose to modify the composite APCs that we are creating for CY 2008 or move to packaging observation care as we originally proposed to create further incentives for hospitals to operate in an efficient way.

In summary, for CY 2008, payment for observation services will remain packaged with status indicator ''N.'' We are creating two composite APCs for extended assessment and management, of which observation care is a component major service. When criteria for payment of the composite APCs are met, separate payment will be made to the hospital through the composite APC. This composite APC payment methodology will 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.

d. Development of Composite APCs

(1) Background

As we discuss above in regard to our reasons for our 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 the packaging approach for services that we proposed for 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 proposed 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 final rule with comment period, 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, in the CY2008 OPPS/ASC proposed rule (72 FR 42678 through 42679), we proposed 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 proposed 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 also proposed 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 proposed 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, we indicated that 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

noted 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 would be exploring in the future how we could potentially 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 did not propose to implement multiday episode-of-care APCs in CY 2008, we welcomed 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 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 proposed 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 did not propose to change this mental health services payment policy for CY 2008. However, we proposed 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 final rule with comment period entitled ''Mental Health Composite,'' consistent with our naming taxonomy and publication of the two other composite APCs. We are also including the mental health composite APC 0034 and its member HCPCS codes in Addendum M to this final rule with comment period 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.

We solicited 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 expressed our hope of involving the public and the APC Panel in the creation of additional composite APCs. As stated in the proposed rule (72 FR 42679), our goal is 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 for individual services.

We received many comments on the concept of composite APCs in general and on the proposal to create the LDR Prostate Brachytherapy Composite and the Electrophysiologic Evaluation and Ablation Composite APC in particular. A summary of the comments and our responses follow.

Comment: In general, most commenters supported the creation of the two composite APCs that were proposed for CY 2008: Cardiac Electrophysiologic Evaluation and Ablation Composite (APC 8000) and Low Dose Rate Prostate Brachytherapy Composite (APC 8001). Commenters, including MedPAC and the APC Panel, supported the implementation of the proposed composite APCs. Commenters stated that creation of these composites will enable use of more multiple claims data and enable the payment system to better reflect the reality of how services are commonly furnished. In particular, MedPAC indicated that it supports the proposed composite APCs because they will increase incentives for efficiency and can serve as a starting point for payment bundles that reflect encounters or episodes of care. MedPAC indicated that it will be exploring both packaging and bundling under the OPPS in its future work. Other commenters objected to the creation of composite APCs because they believed that they are dependent on proposed packaging changes that the commenters do not support. Other commenters supported the concept of composite APCS as long as a composite is limited to related services furnished on the same date of service. These commenters believed that the creation of composite APCs for discontinuous services that span multiple dates of service would present too many problems to be viable.

Response: We appreciate the commenters' support for the creation of the two proposed composite APCs and we will implement the proposed new composite APCs 8000 and 8001 for services furnished on and after January 1, 2008. We also acknowledge that the viability of the composite APCs is dependent on packaging of the supportive and ancillary services. However, as discussed above, we are finalizing the proposed packaging approach, with modifications, and therefore, we believe that it is appropriate to finalize the creation of these two composite APCs for the CY 2008 OPPS. We will take the commenters' concerns with regard to the possible creation of composite APCs for discontinuous services that span multiple dates of service into account in development of future proposals for composite APCs.

Comment: Some commenters asked that CMS provide a clear and transparent process for identifying and calculating payments for future composite APCs and asked that CMS evaluate closely the impact of the proposed composites on payment adequacy and access to care before expanding to other services. They asserted that any development of further composite APCs should include the views of all stakeholders.

Response: We expect that in the future, we would identify possible

composite APCs using the same process that we used to identify the codes in composite APCs 8000 and 8001. As we described in the proposed rule, we examined the multiple procedure claims that we could not convert to single procedure claims to identify common combinations of services for which we had relatively few single procedure claims. We then performed a clinical assessment of the combinations that we identified to determine whether our findings were consistent with our understanding of the services furnished. After we defined the minimal combination of services for which we would pay under the composite APC, we then identified claims for which the only separately paid codes were members of the composite, and we calculated the median cost for the package of services, including the costs of the packaged services. We intend to proceed carefully in examining the potential for creation of more composite APCs. In general, we intend to follow this process for creation of composite APCs and to request public comment in the rulemaking cycle, which is our standard process for securing the views of stakeholders. See section II.A.4.c.(7). for our discussion of the composite APCs we created for this final rule with comment period, specifically APC 8002 (Level I Extended Assessment and Management Composite) and APC 8003 (Level II Extended Assessment and Management Composite).

Comment: Some commenters asked that CMS ensure that all packaged costs are captured in the payment rate for the composite APC. Other commenters stated that there are many intraoperative services that we proposed to package that may or may not be done at the same time and whose costs, when packaged may not be fully accommodated in the composite payment and should therefore be paid separately in addition to the payment for the composite APCs. Some commenters identified services that CMS proposed to package for which they believed separate payment should be made outside of the composite APC payment. For example, one commenter asked that CPT code 93662 (Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)) continue to be paid separately and not as part of composite APC 8000 because its cost is high but the frequency of its use with the main procedures in APC 8000 is low.

Response: We capture the packaged costs in the creation of the composite APC medians to the extent that the packaged services are reported on the claims that meet the criteria for composite payment. The effectiveness of the composite APCs is highly dependent upon the packaging of the ancillary and supportive services that are furnished at the same encounter with the services in the composite APC. By packaging guidance, imaging post processing, intraoperative, and imaging supervision and interpretation services we are able to identify many more services that contain only the separately paid procedures that are assigned to the composite APC that we can then use to calculate a median cost for the composite APC. Separate payment for guidance, imaging post processing, intraoperative, and imaging supervision and interpretation services would greatly reduce the number of claims that would be available for use in composite APCs because the HCPCS codes assigned to the composite APC would no longer be the only separately paid procedure codes on the claims and one of the benefits of using a composite APC (enabling use of more claims) would be lost. As with packaging of the costs of OPPS services in general, we package costs into the cost of the major separately paid service being furnished. In the case of the composite APCs, the costs of ancillary and dependent services are packaged into the payment for the composite APC to the extent that they are furnished with the services that are assigned to the composite APC. In general, the premise of the OPPS, like that of other claims-based prospective payment systems, is that hospitals report HCPCS codes and charges to reflect the reality of how they furnish services. In general, we believe we can rely on the claims data to be an accurate reflection of the services that were furnished to Medicare beneficiaries.

Comment: A commenter stated that the composite APCs differ significantly in concept from the conditionally packaged services to which CMS also proposed to assign status indicator ''Q'' and urged CMS to assign a status indicator other than ''Q'' to composites so that they would be more easily distinguishable from a conditionally packaged service. Other commenters stated that the definition of the status indicator Q was ill defined and confusing.

Response: For CY 2008, we will assign the status indicator ''Q'' to composite APCs, to codes that are packaged when billed on the same claim with a procedure that has status indicator ''S,'' ''T,'' ''V,'' or ''X,'' and to codes that are packaged only when billed on the same claim with a procedure that has a status indicator ''T.'' We will consider for CY 2009 whether it would be more appropriate to assign status indicators based on the particular packaging policy that applies to the code.

We appreciate the comments on composite APCs. With respect to our treatment of mental health services, we are not making 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 changing 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.

(2) 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) is used to report 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 the CY 2008 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) is used to report 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 7.

TABLE 7.—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 at its March 2006 meeting, and in response to the CY 2006 OPPS proposed rule and CY 2007 OPPS/ASC proposed rule, 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 CYs 2006 and 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 CYs 2006 and CY 2007 OPPS, we based payment for CPT codes 55859 and 77778 on single procedure claims.

(b) Payment for LDR Prostate Brachytherapy

For the CY 2008 OPPS, we proposed 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 final rule with comment period as APC 8001 (LDR Prostate Brachytherapy Composite). As discussed in detail in section VII. of this final rule with comment period, as we proposed, we are continuing to pay sources of brachytherapy separately in accordance with 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, was approximately $2,329. 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 was approximately $2,322. 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 was approximately $970.

In examining the claims data used to calculate the median costs for the 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 policy is provided in section II.A. of this final rule with comment period.

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 approximately $3,127 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, the sum of the CPT median costs we calculated using the single procedure bills for CPT codes 55859 and 77778 (($2,329 plus $969). As stated in the proposed rule (72 FR 42680), 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.

In the proposed rule (72 FR 42681), we indicated our belief 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 frequently reduced under the multiple procedure reduction policy because we believe that it is unlikely that a higher paid procedure would be performed on the same date.

We proposed 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 proposed 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 proposed 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.

Comment: One commenter supported the creation of the composite APC for LDR Prostate Brachytherapy (APC 8001) but was concerned about the assignment of status indicator ''T'' to APC 8001. The commenter asked which codes would be reduced when furnished with the composite as a result of the assignment of the status indicator ''T.''

Response: We assigned status indicator ''T'' to APC 8001 because CPT code 55875 is a surgical service that has a status indicator ''T'' in APC 163. The multiple surgical reduction will apply only when other surgical procedures that have the status indicator of ''T'' are performed on the same date of service. Payment for the APC with the highest payment rate with status indicator ''T'' will not be reduced but payments for other codes on the same claim that also have a status indicator of ''T'' will be reduced by 50 percent under our standard multiple procedure reduction policy. Currently, when CPT code 55875 is reported with another procedure that has a status indicator of ''T,'' payment for the service with the lower payment rate would be reduced by 50 percent. Similarly, when CPT code 55875 is paid as part of composite APC 8001 and another procedure that has a status indicator of ''T'' is also reported on the claim, payment for the composite APC or the other procedure would be reduced by 50 percent, depending on which payment rate was lower. This is the standard OPPS multiple surgical procedure payment reduction policy.

As proposed, we are establishing 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 status indicator ''Q'' in Addendum B to this final rule with comment period to signify their conditionally packaged status, and their composite APC assignments are noted in Addendum M. This policy will 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 will also include payment for the commonly associated imaging guidance services, which will be newly packaged under our CY 2008 packaging approach. Most importantly, this composite APC payment methodology will 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. In our final calculation of the median cost for this composite APC for CY 2008, we were able to use 7,870 claims that contained both CPT code 77778 and 55859 (the code in effect in 2006) and the median cost on which payment is based is approximately $3,391. This compares favorably to the proposed rule in which we were able to us only 1,343 claims containing both codes and calculated a proposed median cost of approximately $3,127. We believe that the number of usable claims increased so greatly as the result of the addition of related procedure codes to the bypass list as a result of public comments. The CY 2008 composite median is slightly less than $3,410, the sum of the medians for APCs 163 and 651 ($2,270 + $1,140), which commenters have told us are unreliable because they are calculated from single bills although there should never be single bills for this procedure. Hence, we believe that the median cost for the composite APC of approximately $3,391, which is calculated from bills we believe to be correctly coded will result in a reasonable and appropriate payment rate for this service.

(3) 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 8 shows the 10 most common unique occurrences from CY 2006 proposed rule claims data available at that time.

TABLE 8.—TEN MOST FREQUENTLY OCCURRING UNIQUE OCCURRENCES OF CARDIAC ELECTROPHYSIOLOGIC EVALUATIONS, MAPPING, AND ABLATION PROCEDURES AND OTHER SEPARATELY PAYABLE SERVICES

Combination No.	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 9 below.

TABLE 9.—GROUPS OF CARDIAC ELECTROPHYSIOLOGIC EVALUATION AND ABLATION PROCEDURES ON WHICH WE BASE THE COMPOSITE APC

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 proposed rule 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 proposed rule 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 proposed 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, in section II.A.4.c.(3) above.

However, packaging these supportive ancillary services that are so often reported with the cardiac electrophysiologic evaluation and ablation services did not, by itself, 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 was the pair of CPT codes 93620 and 93651, there are numerous other combinations of services from APCs 0085 and 0086 that were performed and, while not as frequent, these combinations were 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 was approximately $8,529. 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) and CPT code 93651 (which is $5,644) is approximately $8,756. 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 $7,200 ($5,644 + $1,556). 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 in Table 24 of the proposed rule (72 FR 42684) represented 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.

Moreover, by packaging CPT codes 93609, 93613, 93621, 93622, and 93623, we were able to 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 could 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) 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 proposed to establish one composite APC, shown in Addendum A of the proposed rule 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 the proposed rule to identify their conditionally packaged status, and their composite APC assignments were identified in Addendum M of the proposed rule. We proposed to use the composite median cost of approximately $8,529 as the basis for establishing the relative weight for this newly created APC for the composite electrophysiology evaluation and ablation service. Under this composite APC, unlike most other APCs, we proposed to make a single payment for all services reported in groups A and B. We proposed 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 proposed 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 proposed 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 also proposed 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 proposed 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 approximately $603; Level II Electrophysiologic Procedures (APC 0085) at approximately $2,976; and Level III Electrophysiologic Procedures (APC 0086) at approximately $5,842, respectively. We refer readers to section IV.A.2. of this his final rule with comment period rule for a discussion of calculation of median costs for device-dependent APCs. We believe this reconfiguration improved 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 electrophysiology 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 the 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.

We did not receive any public comments specific to the creation of the composite APC for cardiac electrophysiology evaluation and ablation other than those included in the general discussion of composite APCs above. Therefore, we are finalizing the creation of this APC as proposed. For this final rule with comment period, we recalculated the median cost of the APC as proposed. We were able to use 5,596 claims that met the criteria of having at least one code in group A and one code in group B, which had correct device codes, no token charges for devices and no FB modifiers on the claims. Using these 5,596 correctly coded claims from the final rule data, we calculated a median cost from the final rule data of approximately $8,438. We note that while the number of usable claims for the final rule date increased to 5,596 from the 5,118 claims used in the proposed rule, the median cost declined slightly (approximately 1 percent) to approximately $8,438 from the $8,529 median cost calculated from proposed rule data. However, we believe that the median cost for this composite APC is a valid reflection of the estimated relative cost of these services when furnished in combination with one another.

After consideration of the public comments we received on the proposed composite APCs for LDR Prostate Brachytherapy and Cardiac Electrophysiology Evaluation and Ablation, we are finalizing our proposed policy regarding these composite APCs without modification.

In conclusion, we are finalizing our proposed packaging approach with the modifications discussed above for the CY 2008 OPPS. Table 10 in this final rule with comment period displays the list of packaged services in the categories of guidance, image processing, intraoperative services, radiopharmaceuticals, contrast media, imaging supervision and interpretation,

and observation services. Codes in composite APCs, including the two extended assessment and management APCs, are displayed in Addendum M. In Table 10, HCPCS codes with status indicator ''N'' are always packaged. HCPCS codes with status indicator ''Q'' are conditionally packaged. Codes with status indicator ''Q'' that are for imaging supervision and interpretation are packaged only when reported on the same claim on the same day as a procedure with status indicator ''T'' and are identified as ''T-packaged'' in the sixth column. Codes that are packaged when they are reported on the same claim with a code with status indicator ''S,'' ''T,'' ''V,'' or ''X'' on the same day are identified as ''STVX-packaged'' in the sixth column.

TABLE 10.—CY 2008 PACKAGED HCPCS CODES INCLUDED IN SEVEN PACKAGING CATEGORIES

2008 HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	Final CY 2008 SI	''STVX-packaged'' or ''T-packaged''	Final CY 2008 APC	Category
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
19295	Place breast clip, percut	S	0657	N	n/a	n/a	Guidance
20975	Electrical bone stimulation	X	0340	N	n/a	n/a	Intraoperative.
20985	Cptr-asst dir ms px	n/a	n/a	N	n/a	n/a	Guidance.
20986	Cptr-asst dir ms px io img	n/a	n/a	N	n/a	n/a	Guidance.
20987	Cptr-asst dir ms px pre img	n/a	n/a	N	n/a	n/a	Guidance.
31620	Endobronchial us add-on	S	0670	N	n/a	n/a	Intraoperative.
37250	Iv us first vessel add-on	S	0416	N	n/a	n/a	Intraoperative.
37251	Iv us each add vessel add-on	S	0416	N	n/a	n/a	Intraoperative.
58110	Bx done w/colposcopy add-on	T	0188	N	n/a	n/a	Intraoperative.
61795	Brain surgery using computer	S	0302	N	n/a	n/a	Guidance.
62160	Neuroendoscopy add-on	T	0122	N	n/a	n/a	Guidance.
70010	Contrast x-ray of brain	S	0274	Q	T	0274	Imaging S&I.
70015	Contrast x-ray of brain	S	0274	Q	T	0274	Imaging S&I.
70170	X-ray exam of tear duct	X	0264	Q	T	0317	Imaging S&I.
70332	X-ray exam of jaw joint	S	0275	Q	T	0275	Imaging S&I.
70373	Contrast x-ray of larynx	X	0263	Q	T	0263	Imaging S&I.
70390	X-ray exam of salivary duct	X	0263	Q	T	0263	Imaging S&I.
71040	Contrast x-ray of bronchi	X	0263	Q	T	0263	Imaging S&I.
71060	Contrast x-ray of bronchi	X	0263	Q	T	0317	Imaging S&I.
71090	X-ray & pacemaker insertion	X	0272	N	n/a	n/a	Imaging S&I.
72240	Contrast x-ray of neck spine	S	0274	Q	T	0274	Imaging S&I.
72255	Contrast x-ray, thorax spine	S	0274	Q	T	0274	Imaging S&I.
72265	Contrast x-ray, lower spine	S	0274	Q	T	0274	Imaging S&I.
72270	Contrast x-ray, spine	S	0274	Q	T	0274	Imaging S&I.
72275	Epidurography	S	0274	N	n/a	n/a	Imaging S&I.
72285	X-ray c/t spine disk	S	0388	Q	T	0388	Imaging S&I.
72291	Perq vertebroplasty, fluor	S	0274	N	n/a	n/a	Imaging S&I.
72292	Perq vertebroplasty, ct	S	0274	N	n/a	n/a	Imaging S&I.
72295	X-ray of lower spine disk	S	0388	Q	T	0388	Imaging S&I.
73040	Contrast x-ray of shoulder	S	0275	Q	T	0275	Imaging S&I.
73085	Contrast x-ray of elbow	S	0275	Q	T	0275	Imaging S&I.
73115	Contrast x-ray of wrist	S	0275	Q	T	0275	Imaging S&I.
73525	Contrast x-ray of hip	S	0275	Q	T	0275	Imaging S&I.
73530	X-ray exam of hip	X	0261	N	n/a	n/a	Intraoperative.
73542	X-ray exam, sacroiliac joint	S	0275	Q	T	0275	Imaging S&I.
73580	Contrast x-ray of knee joint	S	0275	Q	T	0275	Imaging S&I.
73615	Contrast x-ray of ankle	S	0275	Q	T	0275	Imaging S&I.
74190	X-ray exam of peritoneum	S	0264	Q	T	0317	Imaging S&I.
74235	Remove esophagus obstruction	S	0257	N	n/a	n/a	Imaging S&I.
74300	X-ray bile ducts/pancreas	X	0263	N	n/a	n/a	Intraoperative.
74301	X-rays at surgery add-on	X	0263	N	n/a	n/a	Intraoperative.
74305	X-ray bile ducts/pancreas	X	0263	N	n/a	n/a	Imaging S&I.
74320	Contrast x-ray of bile ducts	X	0264	Q	T	0317	Imaging S&I.
74327	X-ray bile stone removal	S	0296	N	n/a	n/a	Imaging S&I.
74328	X-ray bile duct endoscopy	N	n/a	N	n/a	n/a	Imaging S&I.
74329	X-ray for pancreas endoscopy	N	n/a	N	n/a	n/a	Imaging S&I.
74330	X-ray bile/panc endoscopy	N	n/a	N	n/a	n/a	Imaging S&I.
74340	X-ray guide for GI tube	X	0272	N	n/a	n/a	Imaging S&I.
74355	X-ray guide, intestinal tube	X	0263	N	n/a	n/a	Imaging S&I.
74360	X-ray guide, GI dilation	S	0257	N	n/a	n/a	Imaging S&I.
74363	X-ray, bile duct dilation	S	0297	N	n/a	n/a	Imaging S&I.
74425	Contrst x-ray, urinary tract	S	0278	Q	T	0278	Imaging S&I.
74430	Contrast x-ray, bladder	S	0278	Q	T	0278	Imaging S&I.
74440	X-ray, male genital tract	S	0278	Q	T	0278	Imaging S&I.
74445	X-ray exam of penis	S	0278	Q	T	0278	Imaging S&I.
74450	X-ray, urethra/bladder	S	0278	Q	T	0278	Imaging S&I.
74455	X-ray, urethra/bladder	S	0278	Q	T	0278	Imaging S&I.
74470	X-ray exam of kidney lesion	X	0263	Q	T	0263	Imaging S&I.
74475	X-ray control, cath insert	S	0297	Q	T	0317	Imaging S&I.

TABLE 10.—CY 2008 PACKAGED HCPCS CODES INCLUDED IN SEVEN PACKAGING CATEGORIES—Continued

2008 HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	Final CY 2008 SI	"STVX-packaged" or "T-packaged"	Final CY 2008 APC	Category
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
74480	X-ray control, cath insert	S	0296	Q	T	0317	Imaging S&I.
74485	X-ray guide, GU dilation	S	0296	Q	T	0317	Imaging S&I.
74740	X-ray, female genital tract	X	0264	Q	T	0263	Imaging S&I.
74742	X-ray, fallopian tube	X	0264	N	n/a	n/a	Imaging S&I.
75600	Contrast x-ray exam of aorta	S	0280	Q	T	0279	Imaging S&I.
75605	Contrast x-ray exam of aorta	S	0280	Q	T	0279	Imaging S&I.
75625	Contrast x-ray exam of aorta	S	0280	Q	T	0279	Imaging S&I.
75630	X-ray aorta, leg arteries	S	0280	Q	T	0279	Imaging S&I.
75635	Ct angio abdominal arteries	S	0662	Q	T	0662	Imaging S&I.
75650	Artery x-rays, head & neck	S	0280	Q	T	0280	Imaging S&I.
75658	Artery x-rays, arm	S	0279	Q	T	0279	Imaging S&I.
75660	Artery x-rays, head & neck	S	0668	Q	T	0280	Imaging S&I.
75662	Artery x-rays, head & neck	S	0280	Q	T	0280	Imaging S&I.
75665	Artery x-rays, head & neck	S	0280	Q	T	0279	Imaging S&I.
75671	Artery x-rays, head & neck	S	0280	Q	T	0280	Imaging S&I.
75676	Artery x-rays, neck	S	0280	Q	T	0279	Imaging S&I.
75680	Artery x-rays, neck	S	0280	Q	T	0279	Imaging S&I.
75685	Artery x-rays, spine	S	0280	Q	T	0279	Imaging S&I.
75705	Artery x-rays, spine	S	0668	Q	T	0279	Imaging S&I.
75710	Artery x-rays, arm/leg	S	0280	Q	T	0279	Imaging S&I.
75716	Artery x-rays, arms/legs	S	0280	Q	T	0279	Imaging S&I.
75722	Artery x-rays, kidney	S	0280	Q	T	0279	Imaging S&I.
75724	Artery x-rays, kidneys	S	0280	Q	T	0279	Imaging S&I.
75726	Artery x-rays, abdomen	S	0280	Q	T	0279	Imaging S&I.
75731	Artery x-rays, adrenal gland	S	0280	Q	T	0279	Imaging S&I.
75733	Artery x-rays, adrenals	S	0668	Q	T	0279	Imaging S&I.
75736	Artery x-rays, pelvis	S	0280	Q	T	0279	Imaging S&I.
75741	Artery x-rays, lung	S	0279	Q	T	0279	Imaging S&I.
75743	Artery x-rays, lungs	S	0280	Q	T	0279	Imaging S&I.
75746	Artery x-rays, lung	S	0279	Q	T	0668	Imaging S&I.
75756	Artery x-rays, chest	S	0279	Q	T	0668	Imaging S&I.
75774	Artery x-ray, each vessel	S	0279	N	n/a	n/a	Imaging S&I.
75790	Visualize A–V shunt	S	0279	Q	T	0668	Imaging S&I.
75801	Lymph vessel x-ray, arm/leg	X	0264	Q	T	0317	Imaging S&I.
75803	Lymph vessel x-ray, arms/legs	X	0264	Q	T	0317	Imaging S&I.
75805	Lymph vessel x-ray, trunk	X	0264	Q	T	0317	Imaging S&I.
75807	Lymph vessel x-ray, trunk	X	0264	Q	T	0317	Imaging S&I.
75809	Nonvascular shunt, x-ray	X	0263	Q	T	0263	Imaging S&I.
75810	Vein x-ray, spleen/liver	S	0279	Q	T	0279	Imaging S&I.
75820	Vein x-ray, arm/leg	S	0668	Q	T	0668	Imaging S&I.
75822	Vein x-ray, arms/legs	S	0668	Q	T	0668	Imaging S&I.
75825	Vein x-ray, trunk	S	0279	Q	T	0279	Imaging S&I.
75827	Vein x-ray, chest	S	0279	Q	T	0668	Imaging S&I.
75831	Vein x-ray, kidney	S	0279	Q	T	0279	Imaging S&I.
75833	Vein x-ray, kidneys	S	0279	Q	T	0279	Imaging S&I.
75840	Vein x-ray, adrenal gland	S	0280	Q	T	0279	Imaging S&I.
75842	Vein x-ray, adrenal glands	S	0280	Q	T	0279	Imaging S&I.
75860	Vein x-ray, neck	S	0668	Q	T	0668	Imaging S&I.
75870	Vein x-ray, skull	S	0668	Q	T	0668	Imaging S&I.
75872	Vein x-ray, skull	S	0279	Q	T	0668	Imaging S&I.
75880	Vein x-ray, eye socket	S	0668	Q	T	0668	Imaging S&I.
75885	Vein x-ray, liver	S	0280	Q	T	0279	Imaging S&I.
75887	Vein x-ray, liver	S	0279	Q	T	0668	Imaging S&I.
75889	Vein x-ray, liver	S	0280	Q	T	0279	Imaging S&I.
75891	Vein x-ray, liver	S	0279	Q	T	0279	Imaging S&I.
75893	Venous sampling by catheter	Q	0668	Q	T	0279	Imaging S&I.
75894	X-rays, transcath therapy	S	0298	N	n/a	n/a	Imaging S&I.
75896	X-rays, transcath therapy	S	0263	N	n/a	n/a	Imaging S&I.
75898	Follow-up angiography	X	0263	Q	STVX	0263	Intraoperative.
75901	Remove cva device obstruct	X	0263	N	n/a	n/a	Imaging S&I.
75902	Remove cva lumen obstruct	X	0263	N	n/a	n/a	Imaging S&I.
75940	X-ray placement, vein filter	S	0298	N	n/a	n/a	Imaging S&I.
75945	Intravascular us	S	0267	Q	T	0267	Imaging S&I.
75946	Intravascular us add-on	S	0266	N	n/a	n/a	Imaging S&I.
75960	Transcath iv stent rs&i	S	0668	N	n/a	n/a	Imaging S&I.
75961	Retrieval, broken catheter	S	0668	N	n/a	n/a	Imaging S&I.
75962	Repair arterial blockage	S	0668	Q	T	0083	Imaging S&I.

TABLE 10.—CY 2008 PACKAGED HCPCS CODES INCLUDED IN SEVEN PACKAGING CATEGORIES—Continued

2008 HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	Final CY 2008 SI	"STVX-packaged" or "T-packaged"	Final CY 2008 APC	Category
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
75964	Repair artery blockage, each	S	0668	N	n/a	n/a	Imaging S&I.
75966	Repair arterial blockage	S	0668	Q	T	0083	Imaging S&I.
75968	Repair artery blockage, each	S	0668	N	n/a	n/a	Imaging S&I.
75970	Vascular biopsy	S	0668	N	n/a	n/a	Imaging S&I.
75978	Repair venous blockage	S	0668	Q	T	0083	Imaging S&I.
75980	Contrast xray exam bile duct	S	0297	N	n/a	n/a	Imaging S&I.
75982	Contrast xray exam bile duct	S	0297	N	n/a	n/a	Imaging S&I.
75984	Xray control catheter change	X	0263	N	n/a	n/a	Imaging S&I.
75989	Abscess drainage under x-ray	N	.....	N	n/a	n/a	Imaging S&I.
75992	Atherectomy, x-ray exam	S	0668	N	n/a	n/a	Imaging S&I.
75993	Atherectomy, x-ray exam	S	0668	N	n/a	n/a	Imaging S&I.
75994	Atherectomy, x-ray exam	S	0668	N	n/a	n/a	Imaging S&I.
75995	Atherectomy, x-ray exam	S	0668	N	n/a	n/a	Imaging S&I.
75996	Atherectomy, x-ray exam	S	0668	N	n/a	n/a	Imaging S&I.
76000	Fluoroscope examination	X	0272	Q	STVX	0272	Guidance.
76001	Fluoroscope exam, extensive	N	n/a	N	n/a	n/a	Guidance.
76080	X-ray exam of fistula	X	0263	Q	T	0263	Imaging S&I.
76125	Cine/video x-rays add-on	X	0260	N	n/a	n/a	Image Processing.
76350	Special x-ray contrast study	N	n/a	N	n/a	n/a	Image Processing.
76376	3d render w/o postprocess	X	0340	N	n/a	n/a	Image Processing.
76377	3d rendering w/postprocess	S	0282	N	n/a	n/a	Image Processing.
76930	Echo guide, cardiocentesis	S	0268	N	n/a	n/a	Guidance.
76932	Echo guide for heart biopsy	S	0309	N	n/a	n/a	Guidance.
76936	Echo guide for artery repair	S	0309	N	n/a	n/a	Guidance.
76937	Us guide, vascular access	N	n/a	N	n/a	n/a	Guidance.
76940	Us guide, tissue ablation	S	0268	N	n/a	n/a	Guidance.
76941	Echo guide for transfusion	S	0268	N	n/a	n/a	Guidance.
76942	Echo guide for biopsy	S	0268	N	n/a	n/a	Guidance.
76945	Echo guide, villus sampling	S	0268	N	n/a	n/a	Guidance.
76946	Echo guide for amniocentesis	S	0268	N	n/a	n/a	Guidance.
76948	Echo guide, ova aspiration	S	0309	N	n/a	n/a	Guidance.
76950	Echo guidance radiotherapy	S	0268	N	n/a	n/a	Guidance.
76965	Echo guidance radiotherapy	S	0308	N	n/a	n/a	Guidance.
76975	GI endoscopic ultrasound	S	0266	Q	T	0267	Imaging S&I.
76998	Us guide, intraop	S	0266	N	n/a	n/a	Guidance.
77001	Fluoro guide for vein device	N	n/a	N	n/a	n/a	Guidance.
77002	Needle localization by xray	N	n/a	N	n/a	n/a	Guidance.
77003	Fluoroguide for spine inject	N	n/a	N	n/a	n/a	Guidance.
77011	Ct scan for localization	S	0283	N	n/a	n/a	Guidance.
77012	Ct scan for needle biopsy	S	0283	N	n/a	n/a	Guidance.
77013	Ct guide for tissue ablation	S	0333	N	n/a	n/a	Guidance.
77014	Ct scan for therapy guide	S	0282	N	n/a	n/a	Guidance.
77021	Mr guidance for needle place	S	0335	N	n/a	n/a	Guidance.
77022	Mri for tissue ablation	S	0335	N	n/a	n/a	Guidance.
77031	Stereotact guide for brst bx	X	0264	N	n/a	n/a	Guidance.
77032	Guidance for needle, breast	X	0283	N	n/a	n/a	Guidance.
77053	X-ray of mammary duct	X	0263	Q	T	0263	Imaging S&I.
77054	X-ray of mammary ducts	X	0263	Q	T	0263	Imaging S&I.
77417	Radiology port film(s)	X	0260	N	n/a	n/a	Guidance.
77421	Stereoscopic x-ray guidance	S	0257	N	n/a	n/a	Guidance.
78020	Thyroid met uptake	S	0399	N	n/a	n/a	Intraoperative.
78478	Heart wall motion add-on	S	0399	N	n/a	n/a	Intraoperative.
78480	Heart function add-on	S	0399	N	n/a	n/a	Intraoperative.
78496	Heart first pass add-on1	S	0399	N	n/a	n/a	Intraoperative.
92547	Supplemental electrical test	X	0363	N	n/a	n/a	Intraoperative.
92978	Intravasc us, heart add-on	S	0670	N	n/a	n/a	Intraoperative.
92979	Intravasc us, heart add-on	S	0416	N	n/a	n/a	Intraoperative.
93320	Doppler echo exam, heart	S	0697	N	n/a	n/a	Intraoperative.
93321	Doppler echo exam, heart	S	0697	N	n/a	n/a	Intraoperative.
93325	Doppler color flow add-on	S	0697	N	.....	n/a	Image Processing.
93555	Imaging, cardiac cath	N	n/a	N	n/a	n/a	Imaging S&I.
93556	Imaging, cardiac cath	N	n/a	N	n/a	n/a	Imaging S&I.
93571	Heart flow reserve measure	S	0670	N	n/a	n/a	Intraoperative.
93572	Heart flow reserve measure	S	0416	N	n/a	n/a	Intraoperative.
93609	Map tachycardia, add-on	T	0087	N	n/a	n/a	Intraoperative.
93613	Electrophys map 3d, add-on	T	0087	N	n/a	n/a	Image Processing.
93621	Electrophysiology evaluation	T	0085	N	n/a	n/a	Intraoperative.

TABLE 10.—CY 2008 PACKAGED HCPCS CODES INCLUDED IN SEVEN PACKAGING CATEGORIES—Continued

2008 HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	Final CY 2008 SI	"STVX-packaged" or "T-packaged"	Final CY 2008 APC	Category
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
93622	Electrophysiology evaluation	T	0085	N	n/a	n/a	Intraoperative.
93623	Stimulation, pacing heart	T	0087	N	n/a	n/a	Intraoperative.
93631	Heart pacing, mapping	T	0087	N	n/a	n/a	Intraoperative.
93640	Evaluation heart device	N	n/a	N	n/a	n/a	Intraoperative.
93641	Electrophysiology evaluation	N	n/a	N	n/a	n/a	Intraoperative.
93662	Intracardiac ecg (ice)	S	0670	N	n/a	n/a	Intraoperative.
95829	Surgery electrocorticogram	S	0214	N	n/a	n/a	Intraoperative.
95873	Guide nerv destr, elec stim	S	0215	N	n/a	n/a	Guidance.
95874	Guide nerv destr, needle emg	S	0215	N	n/a	n/a	Guidance.
95920	Intraop nerve test add-on	S	0216	N	n/a	n/a	Intraoperative.
95955	EEG during surgery	S	0213	N	n/a	n/a	Intraoperative.
95957	EEG digital analysis	S	0214	N	n/a	n/a	Image Processing.
95980	Io anal gast n-stim init	n/a	n/a	N	n/a	n/a	Intraoperative.
96020	Functional brain mapping	X	0373	N	n/a	n/a	Intraoperative.
0126T	Chd risk imt study	N	n/a	Q	STVX	0340	Intraoperative.
0159T	Cad breast MRI	N	n/a	N	n/a	n/a	Image Processing.
0173T	Iop monit io pressure	N	n/a	N	n/a	n/a	Intraoperative.
0174T	Cad cxr remote	N	n/a	N	n/a	n/a	Image Processing.
0175T	Cad cxr with interp	N	n/a	N	n/a	n/a	Image Processing.
A4641	Radiopharm dx agent noc	N	n/a	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A4642	In111 satumomab	H	0704	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9500	Tc99m sestamibi	H	1600	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9501	Technetium TC–99m teboroxime	n/a	n/a	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9502	Tc99m tetrofosmin	H	0705	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9503	Tc99m medronate	N	n/a	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9504	Tc99m apcitide	N	n/a	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9505	TL201 thallium	H	1603	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9507	In111 capromab	H	1604	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9508	I131 iodobenguate, dx	H	1045	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9509	Iodine I–123 sod iodide mil	n/a	n/a	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9510	Tc99m disofenin	N	n/a	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9512	Tc99m pertechnetate	N	n/a	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9516	I123 iodide cap, dx	H	9148	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9521	Tc99m exametazime	H	1096	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9524	I131 serum albumin, dx	H	9100	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9526	Nitrogen N–13 ammonia	H	0737	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9528	Iodine I–131 iodide cap, dx	H	1088	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9529	I131 iodide sol, dx	N	n/a	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9531	I131 max 100uCi	N	n/a	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9532	I125 serum albumin, dx	N	n/a	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9536	Tc99m depreotide	H	0739	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9537	Tc99m mebrofenin	N	n/a	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9538	Tc99m pyrophosphate	N	n/a	N	n/a	n/a	Diagnostic Radiopharmaceutical.

TABLE 10.—CY 2008 PACKAGED HCPCS CODES INCLUDED IN SEVEN PACKAGING CATEGORIES—Continued

2008 HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	Final CY 2008 SI	"STVX-packaged" or "T-packaged"	Final CY 2008 APC	Category
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
A9539	Tc99m pentetate	H	0722	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9540	Tc99m MAA	N	n/a	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9541	Tc99m sulfur colloid	N	n/a	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9542	In111 ibritumomab, dx	H	1642	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9544	I131 tositumomab, dx	H	1644	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9546	Co57/58	H	0723	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9547	In111 oxyquinoline	H	1646	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9548	In111 pentetate	H	1647	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9550	Tc99m gluceptate	H	0740	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9551	Tc99m succimer	H	1650	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9552	F18 fdg	H	1651	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9553	Cr51 chromate	H	0741	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9554	I125 iothalamate, dx	N	n/a	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9555	Rb82 rubidium	H	1654	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9556	Ga67 gallium	H	1671	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9557	Tc99m bicisate	H	1672	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9558	Xe133 xenon 10mci	N	n/a	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9559	Co57 cyano	H	0724	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9560	Tc99m labeled rbc	H	0742	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9561	Tc99m oxidronate	N	n/a	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9562	Tc99m mertiatide	H	0743	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9566	Tc99m fanolesomab	H	1678	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9567	Technetium TC–99m aerosol	H	0829	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9568	Tc99m arcitumomab	H	1648	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9569	Technetium TC–99m auto WBC	n/a	n/a	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9570	Indium In-111 auto WBC	n/a	n/a	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9571	Indium In-111 auto platelet	n/a	n/a	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9572	Indium In-111 pentetreotide	n/a	n/a	N	n/a	n/a	Diagnostic Radiopharmaceutical.
A9576	Inj prohance multipack	n/a	n/a	N	n/a	n/a	Contrast Agent.
A9577	Inj multihance	n/a	n/a	N	n/a	n/a	Contrast Agent.
A9578	Inj multihance multipack	n/a	n/a	N	n/a	n/a	Contrast Agent.
A9579	Gad-base MR contrast NOS, 1ml	n/a	n/a	N	n/a	n/a	Contrast Agent.
G0268	Removal of impacted wax md	X	0340	N	n/a	n/a	Intraoperative.
G0275	Renal angio, cardiac cath	N	n/a	N	n/a	n/a	Intraoperative.
G0278	Iliac art angio,cardiac cath	N	n/a	N	n/a	n/a	Intraoperative.
G0288	Recon, CTA for surg plan	S	0417	N	n/a	n/a	Image Processing.
G0378	Hospital observation per hr	Q	339	N	n/a	n/a	Observation.
Q9951	LOCM >= 400 mg/ml iodine, 1ml	K	9163	N	n/a	n/a	Contrast Agent.
Q9953	Inj Fe-based MR contrast, 1ml	K	1713	N	n/a	n/a	Contrast Agent.

TABLE 10.—CY 2008 PACKAGED HCPCS CODES INCLUDED IN SEVEN PACKAGING CATEGORIES—Continued

2008 HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	Final CY 2008 SI	''STVX-packaged'' or ''T-packaged''	Final CY 2008 APC	Category
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Q9954	Oral MR contrast, 100 ml	K	9165	N	n/a	n/a	Contrast Agent.
Q9955	Inj perflexane lip micros, ml	K	9203	N	n/a	n/a	Contrast Agent.
Q9956	Inj octafluoropropane mic, ml	K	9202	N	n/a	n/a	Contrast Agent.
Q9957	Inj perflutren lip micros, ml	K	9112	N	n/a	n/a	Contrast Agent.
Q9958	HOCM <= 149 mg/ml iodine, 1ml	N	n/a	N	n/a	n/a	Contrast Agent.
Q9959	HOCM 150–199mg/ml iodine, 1ml	N	n/a	N	n/a	n/a	Contrast Agent.
Q9960	HOCM 200–249mg/ml iodine, 1ml	N	n/a	N	n/a	n/a	Contrast Agent.
Q9961	HOCM 250–299mg/ml iodine, 1ml	N	n/a	N	n/a	n/a	Contrast Agent.
Q9962	HOCM 300–349mg/ml iodine, 1ml	N	n/a	N	n/a	n/a	Contrast Agent.
Q9963	HOCM 350–399mg/ml iodine, 1ml	N	n/a	N	n/a	n/a	Contrast Agent.
Q9964	HOCM >= 400mg/ml iodine, 1ml	N	n/a	N	n/a	n/a	Contrast Agent.
Q9965	LOCM 100–199mg/ml iodine, 1ml	n/a	n/a	N	n/a	n/a	Contrast Agent.
Q9966	LOCM 200–299mg/ml iodine, 1ml	n/a	n/a	N	n/a	n/a	Contrast Agent.
Q9967	LOCM 300–399mg/ml iodine, 1ml	n/a	n/a	N	n/a	n/a	Contrast Agent.

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 packaging approach for CY 2008, we have modified the historical considerations outlined above in developing our policy for the CY 2008 OPPS. The Packaging Subcommittee discussed many HCPCS codes during the March 2007 APC Panel meeting, prior to development of the 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 exploring the possibility of 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 proposed 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 real-time 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)

In addition, the Packaging Subcommittee reported its findings to the APC Panel at its September 2007 meeting. The APC Panel accepted the report of the Packaging Subcommittee, heard presentations on certain packaged services, discussed the deliberations of the Packaging Subcommittee, and recommended that—

9. CMS provide more data at the next APC Panel meeting on HCPCS code A4306 (Disposable drug delivery system, flow rate of less than 50 mL per hour). (Recommendation 9)

10. The Packaging Subcommittee remains active until the next APC Panel meeting. (Recommendation 10)

We address each of these recommendations in turn in the discussion that follows.

Recommendation 1

For CY 2008, we proposed 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 proposed 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 proposed to package payment for all guidance procedures for CY 2008, we believe it is still appropriate to maintain the unconditionally packaged status of this code, which is a CPT designated add-on procedure that we expected 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 was a supportive ancillary service that was 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 demonstrated that guidance services were used frequently for the insertion of vascular access devices, and we had no evidence that patients lacked 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 was most commonly performed. We further believe that hospital staff chose 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 the 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 proposed to continue to unconditionally package CPT code 76937 for CY 2008.

We received several comments that referenced CPT code 76937 in discussions related to the packaged status of guidance services in general. Those comments are summarized and responded to in section II.4.c.1 of this final rule with comment period. As noted in that section, we are finalizing our proposal, without modification, to unconditionally package CPT code 76937 for CY 2008.

Recommendation 2

For CY 2008, we proposed 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, we are exploring the possibility of expanding 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 budget-neutral 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 proposed 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 explore the possibility of developing 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 the OPPS, 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 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 proposed to maintain the packaged status of revenue code 068x, except when revenue code 068x is billed in association with critical care services.

We did not receive any comments on this proposal. Therefore, we are finalizing our proposal, without modification, to maintain the packaged status of revenue code 068x, trauma response, when the trauma response is provided without critical care services.

We note that we do not anticipate that the new composite Extended Assessment and Management APCs, 8002 and 8003, will affect this policy in any way.

Recommendation 3

For CY 2008, we proposed 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 believed and continue to believe that packaged payment for diagnostic chest x-ray CAD under a prospective payment methodology for outpatient hospital services is most appropriate. We proposed to maintain CPT codes 0174T and 0175T as unconditionally packaged services for CY 2008, fully consistent with the 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 proposed to package payment for all image processing services for CY 2008, we believe it is appropriate to maintain the packaged status of these code. 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 x-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 approach 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 also proposed 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). As noted in section II.A.4.c.(2) of this final rule with comment period, we are finalizing our proposal for those codes and they will be unconditionally packaged for CY 2008.

The proposed unconditionally packaged treatment of the two CPT codes for chest x-ray CAD is fully consistent with the 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 proposed to continue to unconditionally package payment for CPT codes 0174T and 0175T for CY 2008.

Comment: One commenter requested that CPT codes 0174T and 0175T, which were provided interim assignments in CY 2007 be assigned to status indicator ''S'' and be paid separately with a payment rate of $15. That commenter then requested conditional payment for both of these CPT codes, status indicator ''Q'' assignment, and a payment rate of $15. The commenter indicated that this technology is an important diagnostic test for lung cancer patients, and that insufficient payment will limit access to this cost-effective diagnostic tool.

Response: As discussed extensively above, after thorough discussion with the APC Panel and repeated review by our clinical advisors, we continue to believe that these codes are appropriately unconditionally packaged.

For CY 2008, we are finalizing our proposal without modification to unconditionally package CPT codes

0174T and 0175T for CY 2008. We note that these codes fall into the category of the image processing codes that are packaged for the CY 2008 OPPS.

Recommendation 4

For CY 2008, we adopted the APC Panel's recommendation and proposed 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 adopted the APC Panel recommendation and proposed 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 packaging approach for the CY 2008 OPPS, as discussed above. Because CPT code 0126T is almost always performed during another procedure, and we proposed 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.

We did not receive any comments related to this proposal. Therefore, we are finalizing our proposal without modification to designate CPT code 0126T as a ''special'' packaged code for CY 2008. This code is an ''STVX-packaged'' code.

Recommendation 5

For CY 2008, we proposed 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 approximately $5, 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 proposed to continue to package payment for CPT code 0069T for CY 2008.

We did not receive any comments related to this proposal. Therefore, we are finalizing our proposal, without modification, to continue to package payment for CPT code 0069T for CY 2008.

Recommendation 6

For CY 2008, we proposed to adopt the APC Panel's recommendation and maintain the packaged status of HCPCS code A4306. We note that at its

September 2007 APC Panel meeting, the Panel recommended specifically that CMS provide more data at the next meeting on this code.

HCPCS code A4306 describes a disposable drug delivery system with a flow rate of less than 50 ml per hour. As discussed during 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 proposed to maintain the packaged status of HCPCS code A4306 for CY 2008.

Comment: A commenter supported CMS' proposal to maintain the packaged status of HCPCS code A4306 for CY 2008. The commenter suspected that this code is misreported by hospitals and estimated that the true cost of the supply is between $20 and $60. The commenter requested that CMS provide instructions to hospitals on the appropriate revenue center for this supply and contact the AHA coding clinic regarding the need for better HCPCS code instructions for this supply.

Response: In general, we give hospitals the flexibility to report charges under whichever revenue code the hospital believes is most appropriate. In addition, it is not our usual practice to refer codes to the AHA coding clinic for review. Instead, we encourage the commenter to submit any questions or requests for clarification to the AHA coding clinic, if appropriate.

We are finalizing without modification our proposal to continue to package payment for HCPCS code A4306 for CY 2008. In addition, with respect to APC Panel Recommendation 9, we will provide the APC Panel with more cost data related to this code at its next meeting.

Recommendation 7

For CY 2008, we proposed 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 was approximately $35, with individual costs ranging from approximately $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 showed that this service was provided most frequently with high level emergency department visits and critical care services.

As we noted in the CY 2008 proposed rule, we believed that the circumstances in which total body hypothermia would be provided to a Medicare beneficiary and billed under the OPPS were extremely rare, as patients requiring this therapy would almost always be admitted as inpatients if they survive. Moreover, 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.

This code was discussed by the APC Panel members during the September 2007 APC Panel meeting, but they made no official recommendation.

We did not receive any comments related to our proposal. Therefore, we are finalizing our proposal to maintain the packaged status of CPT code 99186 for CY 2008.

Recommendation 8

We note that the Packaging Subcommittee remains active. See Recommendation 10 below.

Recommendation 9

As noted in Recommendation 6, in accordance with the APC Panel's recommendation, we will provide more cost data related to HCPCS code A4306 (Disposable drug delivery system, flow

rate of less than 50 mL per hour) for the APC Panel's review at its next meeting.

Recommendation 10

In response to the APC Panel's recommendation for the Packaging Subcommittee to remain active until the next APC Panel 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. Payment for Partial Hospitalization

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 § 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, which includes a discussion of the decision to base relative payment rates on median cost, we refer readers to the April 7, 2000 OPPS final rule with comment period (65 FR 18482).

Historically, the median per diem cost for CMHCs greatly exceeded the median per diem cost for hospital-based PHPs and fluctuated significantly from year to year, while the median per diem cost for hospital-based PHPs 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 final rule with comment period 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.

Due to concern 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 2006 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 could be calculated based on better empirical data (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, and 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. 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. 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. PHP APC Update for CY 2008

As noted in the CY 2008 OPPS/ASC proposed rule (72 FR 42691), 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 the data reflects the level of cost for the type of services that are 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.

As stated in the CY 2008 proposed rule (72 FR 42691), the CY 2006 and CY 2007 OPPS updates data have produced median costs that we believed 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 continued to reflect a low PHP per diem cost in CY 2008, we expected 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*.

As noted in the proposed rule (72 FR 42691), 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.

As indicated in the proposed rule (72 FR 42691), 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 believed 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, the majority of Occupational Therapy services are not furnished to PHP patients and, therefore, these services 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.

For this final rule with comment period, we have updated this analysis using updated claims and CCR data for PHP claims. Again, we remapped the 10 revenue center codes described earlier in this section 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 723,749 line items in the CY 2006 hospital-based PHP claims. Prior to remapping, there were 320,504 line items where a default CCR was used to estimate costs. After the remapping, there were 160,351 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, again 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 (from $172 to $177). We note that, unlike the proposed rule, this final rule analysis was done using the revised methodology for computing per diem costs described below. We received no public comments in opposition to the proposed change in remapping revenue codes to alternate cost centers. Therefore, we are adopting this proposed change beginning in CY 2008.

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 final rule with comment period, 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.

As indicated in the proposed rule (72 FR 42692), 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 proposed to adopt this alternative method of computing PHP per diem median cost because we believe it produces a more accurate estimate because each day gets an equal weight towards computing the median. In light of the stabilizing trend in the data, and the robustness of recent data analysis, we believe it is now appropriate to adopt 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. We received no public comments in opposition to the revised method for computing per diem cost, although we did receive a few public comments critical of our current method of computing per diem costs. (These public comments and our response are addressed below.) Therefore, we are adopting this proposed change beginning in CY 2008.

As noted previously, for the past 2 years, the data have produced median costs that we believed 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 five or six 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 fewer than 4 units of service were provided.

Using updated data from the CY 2008 proposed rule, specifically, 64 percent of the days that CMHCs were paid were for days where 3 or less units of services were provided, and 31 percent of the days that hospital-based PHPs were paid were for days where 3 or less units of service were provided. We continue to believe these findings are significant because they may explain a lower per diem cost. Based on these updated 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 updated median per diem costs were computed separately for CMHCs and hospital based PHPs and are shown in the table below:

	CMHCs	Hospital-based PHPs	Combined
All Days	$172	$177	$172
Days with 4 units or more	192	189	192

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 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 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 (or a patient who is transitioning at the beginning of their PHP stay). 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 (or admission). We intended that the PHP benefit is for a full day, with shorter days only occurring while a patient transitions into or 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.

We believed 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 proposed a CY 2008 APC PHP per diem cost of $178.

We received a large number of public comments on our proposal. A summary of the public comments received and our responses follow.

Comment: A number of commenters expressed concern about the magnitude of the PHP per diem rate reduction, particularly in light of the reductions over the past few years. Many commenters believe that such a reduction would reduce the financial viability and possibly lead to the closure of many PHPs, thus affecting access to this crucial service that serves vulnerable populations. Many commenters stated that PHPs are an

integral part of the continuum of care, and if programs were forced to close, there would be an increase in the length and number of more costly inpatient hospital stays. In addition, because hospital outpatient mental health services paid under the OPPS are capped at the PHP per diem rate, many commenters were concerned about overall access to outpatient mental health treatment. The majority of commenters requested that CMS freeze the PHP per diem rate at the CY 2007 level, and some suggested inflating this rate each year by the consumer price index or market basket update. In addition, several patients were concerned that the proposed 24-percent reduction in payment would negatively impact their ability to continue therapy. One commenter requested that CMS limit the annual reduction to 5 percent, phasing in the reduction over several years if necessary.

Response: For this CY 2008 final rule with comment period, we analyzed 12 months of more current data for hospital and CMHC PHP claims for PHP services furnished between January 1, 2006 and December 31, 2006. These claims data are more current than the CY 2008 proposed rule claims data because the data include claims paid through June 30, 2007. We also used the most currently available CCRs to estimate costs. Using these updated data, we recreated the analysis performed for the 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 decreased $6 to $172, while the median per diem cost for hospital based PHPs decreased $9 to $177. The combined median per diem cost, which is computed from both hospital-based and CMHC PHP data, decreased $6 to $172. The CY 2006 average charge per day for CMHCs was $615, similar to the figure noted in the CY 2007 proposed rule ($613) and slightly lower than the average charge per day for hospital-based PHPs ($631).

The data in this area have been volatile in the past and CMS must establish a payment amount that reflects the intensity of the PHP, and that also considers that costs for providing PHP services are declining. We proposed two refinements to the methodology for computing the PHP median, however, these refinements did not appreciably impact the median per diem cost. We received no public comments in opposition to these refinements and, therefore, we are adopting them in this final rule with comment period. Thus, for CY 2008, we remapped the revenue codes to the most appropriate cost centers and computed the median using a per day methodology (as described earlier in this section).

In addition, based on our data analysis, we have determined that CMHCs (and hospital-based PHPs to a lesser extent) are furnishing a substantial number of low unit days. Although these are all covered days in the context of existing Medicare guidelines, PHPs are furnished in lieu of psychiatric hospitalization and are intended to be more intensive than a half-day program. While the guidelines have allowed a minimum of three services per day, this was intended to be a floor, not the norm.

We conducted extensive data analysis, which included unit analysis, revenue code and HCPCS/CPT frequency analysis, and we have learned that PHPs often use the least costly staff and may not offer the full range of PHP services contemplated in section 1861(ff) of the Act. However, we believe the data accurately represent the level of service provided.

Because partial hospitalization is provided in lieu of inpatient care, it should be a highly structured and clinically-intensive program, usually lasting most of the day. Our goal is to improve the level of service furnished in a PHP day. We are concerned that the proposed decrease in PHP payment may not reflect the mix and quantity of services that should be provided under such an intensive program. In an effort to ensure access to this needed service to vulnerable populations, we are mitigating the reduction to 50 percent of the difference between the current APC amount ($233) and the computed amount based on the PHP data ($172), resulting in an APC median cost of $203. We believe this payment amount will give the providers an opportunity to increase the intensity of their programs and maintain partial hospitalization as part of the continuum of mental health care.

We reiterate our expectation that hospitals and CMHCs will provide a comprehensive program consistent with the statutory intent. We intend to explore the changes to our regulations and claims processing systems in order to deny payment for low intensity days and we specifically invite public comment on the most appropriate threshold.

Comment: A few commenters disagreed with the CMS approach to establishing the median per diem cost by summarizing the line-item costs on each bill and dividing by the number of days on the bills. The commenters indicated that this calculation can severely dilute the rate and penalize providers. The commenters stated that all programs are strongly encouraged by the fiscal intermediaries to submit all PHP service days on claims, even when the patient receives less than three services. They further stated that programs must report these days to be able to meet the 57 percent attendance threshold and avoid potential delays in the claim payment. The commenters were concerned that programs are only paid their per diem when three or more qualified services are presented for a day of service. The commenters stated that if only one or two services are assigned a cost and the day is divided into the aggregate data, the cost per day is significantly compromised and diluted. They claimed that even days that are paid but only have three services dilute the cost factors on the calculations.

Response: As discussed earlier in this section, we have refined our methodology for computing per diem costs. 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. We only assign costs for line items on days when a payment is made. 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 adopted this alternative method of computing PHP per diem median cost because we believe it produces a more accurate estimate because each day gets an equal weight towards computing the median. This method for computing a PHP per diem median cost more accurately reflects the costs of a PHP and uses all available PHP data. Additionally, if a provider has charges on a bill for which the provider does not receive payment, this will be reflected in that provider's CCRs. This lower CCR will be applied to the larger charges and will result in the appropriate cost per diem.

To gauge the effect that days with one or two services had on the per diem cost, we trimmed all days with less than three services, and the recalculated median per diem cost only changed by $2.00. As such, we do not believe the calculations are adversely affected by the inclusion of these days.

Comment: One commenter suggested that CMS set the PHP median per diem cost based on days when four or more services are provided and then pay a low-utilization payment adjustment amount for days when three or fewer

services are provided. The commenter also suggested that CMS establish frequency constraints for billing three or fewer services to prevent the bulk of days furnished by a provider from becoming low utilization days. The commenter urged CMS to further research this suggestion as a possible payment restructuring for CY 2009. Several commenters urged CMS to reevaluate the PHP payment methodology and to either refine the APC structure for PHP to reflect different service levels or to exclude the low-volume days from the calculation of the PHP rate and develop an alternate payment policy for low-volume days.

Response: The structure of partial hospitalization is a full day of treatment. We are concerned about providing an incentive for providers to structure their PHPs on a half-day basis. As discussed earlier in this section, in an effort to ensure access to this needed service to vulnerable populations, we are mitigating the reduction to the PHP rate for CY 2008. We think establishing a half-day rate is inconsistent with this policy. Therefore, we are not prepared to establish a half day rate at this time. However, we are willing to explore how we could utilize frequency controls to maintain the overall intensity of the partial hospitalization benefit.

Comment: One commenter noted that CMS did not respond to previous statements from commenters that the industry would welcome accreditation rules and/or stricter policies for PHPs.

Response: For the CY 2009 OPPS update, we are exploring proposing conditions of participation for CMHCs to establish minimum standards for patient rights, physical environment, staffing, and documentation requirements. In addition, we are considering changes that are necessary to our regulations and claims processing systems to deny payment for low intensity days. We specifically invite public comment on the most appropriate threshold.

Comment: Many commenters requested that the CMHC cost report data be included in the HCRIS so that the industry can review and analyze CMHC cost data.

Response: We understand the commenters' need to have CMHC data available through the HCRIS system and are working to accomplish this task.

Comment: With respect to the methodology used to establish the PHP APC amount, commenters were concerned that data from settled cost reports do not include costs reversed on appeal. The commenters stated that there are inherent problems in using claims data from a time period that is different from that for the CCRs from settled cost reports. The commenters indicated this methodology would artificially lower the computed median costs, and that the data used to calculate the PHP rate should be revised to include costs that were subsequently allowed. The commenters also stated that CMS uses costs that are at least 1 to 3 years old to project rates 2 years forward and that this approach does not accurately reflect the true costs of the providers.

Response: We use the best available data in computing the APCs. On January 17, 2003, we issued Program Memorandum No. A–03–004 that directed fiscal intermediaries to update the CCRs on an on going basis whenever a more recent full year settled or tentatively settled cost report is available. In this way, we minimize the time lag between the CCRs and claims data and continue to use the best available data for ratesetting purposes.

Comment: Several commenters summed the payment rate for four Group Therapy sessions (APC 0325) and requested that amount as the minimum for a day of PHP (that is, 4 x $64.45=$257.80). Another commenter presented two different typical days using proposed CY 2008 rates. Typical Day 1 included three Group Therapy sessions (CPT code 90853, APC 0325, 3 x $64.45) and one Individual Psychotherapy session (CPT code 90818, APC 0323, $106.49). The commenter priced Typical Day 1 at $299.84. Typical Day 2 included one Group Therapy session (CPT code 90853, APC 0325, $64.45), one Individual Psychotherapy session (CPT code 90818, APC 0323, $106.49), and one Family Therapy session (CPT code 90847, APC 0324, $141.61). The commenter priced Typical Day 2 at $312.55. Based on the commenter's presented material, the commenter stated that the typical days yield an average componentized rate of $306. The commenter questioned how CMS can set rates for APCs 0322 through 0325, but is unable to determine a payment rate for a day that is comprised of a minimum of three to four of those services. Other commenters stated that while CMS requires a minimum of four treatments per day to qualify for a day of PHP, the proposed per diem rate of $179.88 for PHP is less than what CMS would pay for four Group Therapy sessions.

Response: We do not believe this is an appropriate comparison. The commenter does not use the payment rate for the PHP APC, that is, APC 0033, in the calculations. The payment rates for APC services cited by the commenter (APC 0323, APC 0324 and APC 0325) are not computed from PHP bills. As stated earlier, we used data from PHP programs (both hospitals and CMHCs) to determine the median cost of a day of PHP. PHP is a program of services where savings can be realized by hospitals and CMHCs over delivering individual psychotherapy services.

We structured the PHP APC (APC 0033) as a per diem methodology in which the day of care is the unit that reflects the structure and scheduling of PHPs and the composition of the PHP APC consists of the cost of all services provided each day. Although we require that each PHP day include a psychotherapy service, we do not specify the specific mix of other services provided and our payment methodology reflects the cost per day rather than the cost of each service furnished within the day.

CMS examined both CMHC and hospital-based PHP program data to determine what services these programs are providing to their patients. An important finding was that the days cited by the commenter are not typical days for most CMHCs. For CMHCs, 60 percent of services are Group Psychotherapy (CPTs 90853 and 90857), 26 percent of services are Training and Education (HCPCS G0177), 12 percent are Activity Therapy (HCPCS G0176), and only 1 percent of PHP days included Individual Therapy (Brief or Extended, CPTs 90816 or 90818)).

The days cited by the commenter are not typical days for hospital-based PHPs either. For hospital-based PHPs, 47 percent of services are Group Psychotherapy (CPT codes 90853 and 90857), 27 percent of services are Training and Education (HCPCS code G0177), 16 percent are Activity Therapy (HCPCS code G0176), 3 percent are Occupational Therapy (HCPCS code G0129), 2 percent of PHP days include Brief Individual Psychotherapy (CPT code 90816), and only 1 percent of PHP days include Extended Individual Therapy (CPT code 90818).

We note that the APCs for Training and Education (HCPCS code G0177), Activity Therapy (HCPCS code G0176), and Occupational Therapy (HCPCS code G0129) are not separately payable under the OPPS. They are packaged services and only payable as part of a PHP day of care. In CMHCs, Training and Education (HCPCS code G0177) and Activity Therapy (HCPCS code G0176), account for 38 percent of PHP services. In hospital-based PHPs, Training and Education and Activity Therapy account for 43 percent of PHP services. In addition to not being separately payable, these services may be provided to

patients by less costly staff than staff that provide Psychotherapy and Occupational Therapy. Based on the mix of services provided on the majority of PHP days, we believe the data used for setting the PHP payment appropriately reflect the typical PHP day.

Comment: One commenter asked CMS to consider implementing a reimbursement level for intensive outpatient program (IOP) services because the commenter's State requires 3 hours of service for such programs.

Response: While some private insurers and some State Medicaid programs recognize IOP as a distinct benefit (like PHP), Medicare does not. However, hospitals that provide IOP services may bill Medicare under the OPPS for individual mental health services that are otherwise covered and billable under the OPPS.

Comment: Several commenters claimed that the costs of CMHCs are higher because ''hospitals can share and spread their costs to other departments.'' The commenters believed that the CMHC patient acuity level is more intense than that for hospital patients because hospital outpatient departments need only provide one or two therapies, yet still receive the full PHP per diem.

Response: CMHCs are required to furnish an array of outpatient services including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of its service area who have been discharged from inpatient treatment. Accordingly, CMHCs have the same ability as hospitals to share costs among its programs as needed. Further, we believe hospital costs in some areas, for example, capital and 24-hour maintenance costs, greatly exceed comparable CMHC costs. Notably, we believe patient acuity across hospital-based and CMHC PHPs should be the same, that is, the patients would otherwise require inpatient psychiatric care regardless of setting (see sections 1861(ff) and 1835(a)(2)(F) of the Act).

Comment: A few commenters expressed concern that the current methodology used to calculate the daily rate does not capture all relevant data nor does it reflect the actual cost to providers to deliver these services. The commenters asked that CMS analyze the mapping of revenue-codes-to-cost centers for CMHCs similar to the analysis CMS completed for hospital-based programs and discussed in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68000). The commenters indicated that CMHC PHP services have higher cost-to-charge ratios than the overall CMHC cost-to-charge ratios.

Response: We are unable to conduct a revenue code mapping analysis for CMHCs because PHP is the CMHCs' only Medicare cost and CMHCs do not have the same cost centers as hospitals. Therefore, for CMHCs, we use the overall facility CCR from the outpatient provider-specific file.

Comment: Several commenters expressed concern that cost report data frequently do not reflect bad debt expense for the entire year. The commenters are concerned that these costs are not being considered in the CMS data and severely short change the rate calculations.

Response: While, the bad debt policy is outside the scope of this rule, we refer the commenter to § 413.89 and the Provider Reimbursement Manual Part I (PRM), Chapter 3, concerning our bad debt requirements.

Comment: One commenter stated that administrative costs for CMHCs continue to be a major impediment to operating PHPs for Medicare beneficiaries. The commenter was concerned that Medicare does not cover the cost of meals and transportation to and from programs. The commenter stated that almost all programs offer transportation because in most cases Medicare beneficiaries with serious mental illnesses would not be able to access these programs without the transportation.

Response: The services that are covered as part of a PHP are specified in section 1861(ff) of the Act. Meals and transportation are specifically excluded under section 1861(ff)(2)(I) of the Act.

Comment: One commenter requested that the same provisions given to rural HOPDs also be given to rural CMHCs. Several commenters urged CMS to reconsider the changes in funding for these programs, especially the programs in rural areas.

Response: We believe the commenter may be referring to the statutory hold harmless provisions. Section 1833(t)(7)(D) of the Act authorizes such payments, on a permanent basis, for children's hospitals and cancer hospitals and, through CY 2005, for rural hospitals having 100 or fewer beds and SCHs in rural areas. Section 1866(t)(7)(D) of the Act does not authorize hold harmless payments to CMHCs. In addition, although section 411 of Pub. L. 108–173 required CMS to determine the appropriateness of additional payments for certain rural hospitals, that authority also does not extend to CMHCs.

Comment: A few commenters stated that hospitals that offer partial hospitalization services should not be penalized for the instability in data reporting of CMHCs. Many commenters requested that CMS require that CMHCs improve their reporting or have that provider group face economic consequences.

Response: As described earlier in this section, after extensive analysis, we now believe we have determined the appropriate level of cost for the type of services that are being provided by PHPs. 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. We note that for CY 2006, the hospital-based PHPs per diem median cost is $177 and for CMHCs, the per diem median cost is $172. We have observed a stabilizing trend in CMHC data and similar per diem costs between hospital-based and CMHC PHPs.

Comment: Two national behavioral health care organizations expressed concern that contrary to congressional intent, the most intensive provider settings are being penalized. The commenters pointed out that CMS data show that PHP programs providing four or more units of service per day (programs that are highly intensive) have a substantially higher median cost for those days than the overall median cost per day. The commenters pointed out that hospital-based programs (66 percent of their days have 4 or more units of service) have a median cost of $218 versus a median cost of $186 for all days regardless of the number of units of service. They noted that CMS' use of the overall median cost per day understates the degree to which hospital-based programs are structured around four or more units of services, but acknowledge that on some days a patient may only get three services (due to leaving early for illness, transitioning out of the program, or other reasons). Similarly, according to one commenter, CMHCs have a median cost of $191 for those days with 4 or more units of service provided versus a median cost of $178 for all days. The commenter stated that CMHCs have 36 percent of their days with 4 or more units of service provided. The commenter indicated that its State's Medicaid program requires a minimum of four hours to qualify for a day of PHP and believed the CMS payment methodology is in conflict with its State's laws.

Several commenters stated that the CMS data, when it combines those programs that offer 3 units with those that offer 4 or more units, clearly

penalizes the programs that routinely offer 4 or more units.

Response: We refer the commenter to the table presented earlier in this section that provides updated figures to the ones cited by the commenter. We recognize that by definition, 50 percent of PHP days will have per diem costs higher than the median per diem cost, while 50 percent will have costs lower than the median per diem cost. It is likely that the programs providing 4 units of service are on the high side of the median per diem cost. In addition, we note that the final rate of $203 is well above the combined median per diem cost for days with 4 units of service of more ($192). Days where four services are provided are certainly within this amount.

Comment: One commenter asked that CMS change the Medicare lifetime maximum of 190 mental health days of stay in a psychiatric hospital, to unlimited. The commenter asserted that if a person is diagnosed with a mental health illness of various kinds the individual will need ''maintenance'' throughout his or her entire life.

Response: The 190-day lifetime limit on inpatient psychiatric care is statutory, and established in section 1812(b)(3) of the Act.

Comment: Many commenters, including a national behavioral health association, recommended that PHP be removed from the APC codes and created under an independent status using home health and hospice as examples. The commenters are concerned that the current methodology is not conducive to this APC code and asserted that there is precedent in other CMS OPPS service industries to exclude the service from the APC code listing and treat it independently.

Response: 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 and thus, PHP is paid under the OPPS. However, it would require a statutory change to establish an independent payment system for partial hospitalization programs outside the OPPS. The statute provides specific separate and distinct payment systems for both home health and hospice services, which are also separate and distinct benefit categories.

Comment: One commenter asked why there are no CMHCs shown in the impact statements in the annual OPPS updating documents published in the **Federal Register**. The commenter asked if this is required by regulation.

Response: CMHCs do not share the same characteristics as hospitals and do not fit into the traditional impact categories (like bed size). Therefore, we have not included them in the impact chart. As PHP is the only Medicare service CMHCs provide, the impact is the percentage change in the APC amount from year to year. Assuming that the number of PHP days provided by CMHCs stays the same as it was in CY 2006, the estimated impact on CMHCs as a result of the CY 2008 PHP payment rate compared to the CY 2007 PHP payment rate is a 13-percent decrease. In this year's impact table we have included CMHCs in the total count of providers, but they are not shown separately. (For additional information, see section XXIV, ''Regulatory Impact Analysis'' of this final rule with comment period.)

Comment: Several commenters suggested establishing a PHP rate calculation task force to develop a new rate methodology that captures all relevant data and reflects the actual costs to providers to deliver PHP services. The commenter recommended that the ratesetting task force be composed of CMS staff and a diverse group of stakeholder that include front-line providers of PHP services and representatives from national industry organizations. Other commenters requested that CMS further study the possibility of differentiating payment based on the intensity of services provided during a day of PHP services for CY 2009. These commenters also recommended that CMS establish quality criteria to judge performance and that would influence future rate reimbursement.

Response: We agree that the payment rate for PHP needs to be accurate and appropriate to sustain access to care. While we believe we provide an accurate and appropriate approach to payment for PHP, as changes to the current methodology are considered, input from the industry is an important part of that process. Therefore, we welcome any input and information that the industry can provide about the costs of their programs and encourage providers to submit information on their costs. We would also find information about the status of quality criteria useful and would encourage providers to submit that information as well.

Comment: A few commenters stated that the wage index adjustment does not accurately reflect the cost of labor in areas affected by Hurricanes Katrina and Rita. The commenters also pointed out that the proposed wage index in Louisiana has decreased post-hurricane instead of increasing, which has resulted in a much lower payment rate in Louisiana. The commenters further stated that the time lag for wage indexing is a huge factor for Hurricane Zone providers and that the wage index decrease makes the assumption that the cost of labor has actually decreased since the hurricanes. Some commenters noted that the lack of facilities, trained professionals and inadequate reimbursement will make Louisiana worse off now than prior to Hurricanes Katrina and Rita. A few commenters asked that CMS freeze the 2005 level rates to maintain the Hurricane Zones at status quo until a realistic impact study can be commissioned.

Response: The hospital wage data used to compute the IPPS FY 2008 hospital wage index is from the FY 2004 hospital cost reports for all hospitals. This is the standard lag timeframe in determining the hospital wage index. It will be another year before FY 2005 data will be reflected in the IPPS FY 2009 hospital wage index. However, we note that the wage index is a relative measure of differences in area hourly wage levels. It compares a labor market's average hourly wage to the national average hourly wage. To the extent that post-hurricane hospital labor costs are higher relative to the national average, the wage index will reflect the higher relative labor cost beginning when the FY 2005 data will be used in the FY 2009 IPPS hospital wage index (which will be applied to the CY 2009 OPPS rate year). In addition, the statutory authority for the OPPS wage index policy in section 1833(t)(2)(D) of the Act requires that the wage adjustments be made in a budget neutral manner. Therefore, we cannot raise one wage area and still maintain budget neutrality. Finally, it should be noted that CMHCs located in Federal Emergency Management Agency (FEMA) designated disaster areas were provided with relief funds by the Department of Health and Human Services in 2007.

3. 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 final rule with comment period, for CY 2008, we proposed to continue our policy of setting aside 1.0 percent of the aggregate total payments under the OPPS for outlier payments. We proposed 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 final rule with comment period, we again proposed 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 did not propose to set a dollar threshold for CMHC outliers. As noted above, we proposed 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.

We received no public comments on our proposal. As discussed in section II.G. of this final rule with comment period, using more recent data for this final rule with comment period, we set the target for hospital outpatient outlier payments at 1.0 percent of total OPPS payments. We allocate a portion of that 1.0 percent, an amount equal to 0.02 percent of outlier payments and 0.0002 percent of total OPPS payments to CMHCs for PHP service outliers. For CY 2008, we set the outlier threshold for CMHCs for CY 2008 at 3.40 times the APC payment amount and the CY 2008 outlier percentage applicable to costs in excess of the threshold at 50 percent.

C. Conversion Factor Update

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 final hospital market basket increase for FY 2008 published in the IPPS final rule with comment period on August 22, 2007 is 3.3 percent (72 FR 48173), the same as the forecast published in the FY 2008 IPPS proposed rule on May 3, 2007 (72 FR 24787). To set the OPPS 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 we are making 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 1.0019 for wage index changes by comparing total payments from our simulation model using the FY 2008 IPPS final wage index values as finalized to those payments using the current (FY 2007) IPPS wage index values. This adjustment reflected an adjustment of 1.0001 for changes to the wage index and an additional 1.0018 to accommodate the IPPS budget neutrality adjustment for inclusion of the rural floor. As discussed further in section II.D. of this final rule with comment period, for the first time, the final FY 2008 IPPS wage indices included 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 policy in its entirety, we refer readers to the FY 2008 IPPS proposed rule (72 FR 24787 through 24792) and the FY 2008 IPPS final rule with comment period (72 FR 47325 through 47330). This adjustment is specific to the IPPS. For the OPPS, we are increasing the conversion factor by the proportional amount of the rural floor budget neutrality adjustment to accommodate this change.

For this final rule with comment period, we estimated the rural adjustment for CY 2008 to reflect the extension of the adjustment to payment for brachytherapy sources as discussed in section II.F.2. of this final rule with comment period, but as the impact of the extension was negligible, we did not change the rural adjustment. Therefore, we calculated a budget neutrality factor of 1.000 for the rural adjustment. For CY 2008, in this final rule with comment period, we estimated that allowed pass through spending for both drugs and devices would equal approximately $32 million, which represents 0.09 percent of total OPPS projected spending for CY 2008. The conversion factor was also adjusted by the difference between the 0.21 percent pass through dollars set aside in CY 2007 and the 0.09 percent estimate for CY 2008 pass through spending. Finally, estimated payments for outliers remain at 1.0 percent of total payments for CY 2008.

The market basket increase update factor of 3.3 percent for CY 2008, the required wage index and rural budget neutrality adjustment of approximately 1.0019, and the adjustment of 0.12 percent for the difference in the pass-through set aside resulted in a final standard OPPS conversion factor for CY 2008 of $63.694.

We received one public comment on our proposed conversion factor update for CY 2008. A summary of the public comment and our response follow.

Comment: A commenter objected to the proposed market basket increase of 3.3 percent. The commenter stated that the average outpatient cost of service is projected to increase by at least 5 percent for CY 2008 due to increases in salaries and medical supply costs for services to Medicare beneficiaries. The

commenter recommended that the average payment to hospitals for outpatient services be increased by 5 percent, the actual amount by which the commenter believed costs would increase for CY 2008.

Response: Section 1833(t)(3)(C)(iv) of the Act requires that CMS update the conversion factor annually using an OPD fee schedule increase factor specific to the PPS year. However, the statute gives CMS the discretion to use the hospital inpatient update factor, the hospital inpatient operating market basket, as an appropriate substitute for the OPD fee schedule increase for purposes of the annual percentage increase specific to covered OPD services. The statute permits, and we continue to believe, that the hospital inpatient operating market basket is an appropriate measure of change in hospital input prices for goods and services required to provide hospital care, including that in the outpatient setting. Hospitals use similar resources in their hospital inpatient and outpatient departments. The hospital market basket is carefully estimated for each PPS year, and periodically rebased and revised. For these reasons, we have specified in the regulations governing the annual OPPS update at § 419.32 (b)(iv) that, for years beginning after CY 2003, the update factor for the OPPS equals the update factor for the IPPS. We disagree that the update factor for the CY 2008 OPPS should be 5 percent. For FY 2008, the IPPS update factor is the hospital market basket of 3.3 percent and, therefore, we have used this update factor in the establishment of the conversion factor for the CY 2008 OPPS.

After consideration of the public comment received, we are finalizing our CY 2008 proposal, without modification, to update the conversion factor by the FY 2008 IPPS market basket increase update factor of 3.3 percent, resulting in a final conversion factor of $63.694.

D. Wage Index Changes

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, which includes the copayment standardized amount, that is 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). Therefore, we did not propose to revise this policy for the CY 2008 OPPS. We refer readers to section II.H. of this final rule with comment period 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 proposed 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 final rule with comment period, we standardize 60 percent of estimated costs as 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), the 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 the OPPS is reasonable and logical, given the inseparable, subordinate status of the hospital outpatient department 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 proposed 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 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 FY 2008 IPPS wage indices and any adjustments that we are applying to the OPPS for CY 2008. We refer the reader to the FY 2008 IPPS final rule with comment period (72 FR 47308 through 47345) for a detailed discussion of the changes to the wage indices. In this final rule with comment period, we are not reprinting the final FY 2008 IPPS wage indices referenced in the discussion below, with the exception of the out migration wage adjustment table (Addendum L to this final rule with comment period), which includes non-IPPS providers paid under the OPPS. We also refer readers to the CMS Web site for the OPPS at: *http://www.cms.hhs.gov/providers/hopps*. At this link, the reader will find a link to the final FY 2008 IPPS wage indices tables.

1. *The 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 final rule with comment period, 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 expired after FY 2007. We adopted the same policy for the 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 finalized in the FY 2008 IPPS final rule with comment period, 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 final rule with comment period, we have used the wage indices identified in the FY 2008 IPPS final rule with comment period (and as corrected in the September 28, 2007 second FY 2008 IPPS correction notice that was printed in the October 10, 2007 **Federal Register** (72 FR 57634) 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 proposed 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 expired 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 final rule with comment period (72 FR 473398 through 47341), 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 final rule with comment period, we finalized our proposal to use the post-reclassified, rather than the pre-reclassified, wage indices in calculating the out-migration adjustment. (See the FY 2008 IPPS final rule with comment period and the second FY 2008 IPPS correction notice for further information on the out migration adjustment.) For OPPS purposes, we proposed 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 final rule with comment period (and corrected in the second FY 2008 IPPS correction notice) identifies counties eligible for the out-migration adjustment and providers receiving the adjustment. As stated earlier, we are reprinting the final version of Table 4J, as corrected, in this final rule with comment period as Addendum L.

4. *Wage Index for Multicampus Hospitals.* As indicated in the CY 2008 OPPS/ASC proposed rule (72 FR 42695), we also wish to clarify that the IPPS policy for multicampus wage index payments also applies to the 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 CMS certification number (CCN) 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 final rule with comment period (72 FR 47317).

In the FY 2008 IPPS final rule with comment period, we finalized our proposal to apportion wages and hours across multiple campuses using full-time equivalent (FTE) staff data or Medicare discharge data in order to include wage data for the individual campuses of a multicampus hospital in its local wage index calculation. We indicated our intent to collect campus locations and numbers of FTE staff by location by adding lines to Worksheet S–2 of the Medicare cost report submitted by hospitals. We stated that we would continue to use either Medicare discharge data or self-reported FTE data to apportion wage data by campus until revisions are made to Worksheet S–2 of the Medicare cost report to require reporting of FTE data by campus and until such data in the cost report can be used to calculate the wage index, at which time the wage data of a multicampus hospital will be allocated among its campuses based only on FTE counts by campus reported in the Medicare cost report. We stated that the effective date of the revised cost report is not expected until FY 2009. Therefore the FTE data reported by multicampus hospitals in the revised Medicare cost report could not be used to allocate wages and hours to each labor market by FTEs until at least the FY 2013 wage index. As part of this policy, we would fully expect that an HOPD 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 final multicampus hospital policy in its entirety, we refer readers to the FY 2008 IPPS final rule with comment period (72 FR 47317 through 47319).

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 final rule with comment period (72 FR 47503) (and as corrected in the September 28, 2007 second correction notice for the FY 2008 IPPS final rule, which appeared in the October 10, 2007 issue of the **Federal Register**) 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 proposed 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 final 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 final policy in its entirety, we refer readers to the FY 2008 IPPS final rule with comment period (72 FR 47325 through 47330) and the second FY 2008 IPPS correction notice (72 FR 57634).

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 final rule with comment period, 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 adopted in the FY 2008 IPPS final rule with comment period. For the CY 2008 OPPS, we proposed 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 OPPS conversion factor would compensate for the inclusion of this budget neutrality adjustment in the wage indices in section II.C. of this final rule with comment period relating to the conversion factor update.

Comment: Commenters supported the CMS proposal for CY 2008 to extend the IPPS wage indices to the OPPS as we had done in previous years. One commenter agreed with the proposal to adopt the IPPS wage index but suggested that it would be logical to adopt the same labor component percentage as applied under the IPPS. The commenter argued that the labor component is derived from hospital cost report information that does not separate inpatient from outpatient services for labor-related and nonlabor-related costs, and thus the labor component utilized in the IPPS is based on a combination of inpatient and outpatient costs. The commenter also suggested that the 60 percent labor-related share used in the OPPS was derived nearly 10 years ago and has never been supported by analysis. The commenter recommended that CMS revise the labor-related share from 60 percent to 69.731 percent to be consistent with the IPPS.

Response: We appreciate the support expressed by commenters concerning our proposed wage index policies for CY 2008. In response to the comment concerning the OPPS labor-related share, we do not believe that such a change to adopt the IPPS labor related share is appropriate. The current IPPS labor-related share of 69.731 percent was calculated by summing the relative weights for labor components in the IPPS operating market basket (70 FR 2339). The IPPS estimates a labor-related share that is specific to inpatient services; the OPPS estimates a labor-related share that is specific to outpatient services. The OPPS labor-related share was determined through regression analyses conducted for the initial OPPS proposed rule (63 FR 47581). Those analyses examined the extent of variability in hospital outpatient cost per unit explained by variability in the wage index, holding outpatient service mix under the proposed system, geographic location, volume, and other variables constant. The unit cost dependent variable in these analyses was derived by applying the CCRs for ancillary cost centers to charges, and those ancillary CCRs should reflect the proportional labor costs for ancillary services. The wage index provides a measure of the wage level faced by a hospital relative to the national average, which should be roughly the same for the institution across inpatient and outpatient settings. Those initial analyses identified 60 percent as the appropriate labor-related share for outpatient services. We confirmed that this labor-related share is still appropriate during our regression analysis for the payment adjustment for rural hospitals, as discussed in the CY 2006 OPPS final rule with comment period (70 FR 68556). Further, we would expect services delivered in the HOPD to require proportionately less labor than more acute inpatient services that require greater nursing care and an extended stay. We believe that the 60 percent labor-related share for the OPPS compares favorably to the hospital inpatient labor-related share of 69.731 percent.

We are finalizing our proposal, without modification, to use the final IPPS FY 2008 wage indices to adjust the OPPS standard payment amounts for labor market differences under the CY 2008 OPPS.

E. Statewide Average Default CCRs

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). As we proposed, in this final rule with comment period we have updated 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 published in the CY 2008 OPPS/ASC proposed rule listed the proposed CY 2008 default urban and rural CCRs by State and compared 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 ratios from submitted cost reports to reflect final settled status by applying the differential between settled to submitted costs and charges from the most recent pair of final settled and submitted cost reports.

For the proposed rule, approximately 78 percent of the submitted cost reports represented data for CY 2005. We have since updated the cost report data we use to calculate CCRs with additional submitted cost reports for CY 2006. For this final rule with comment period, 47 percent of the submitted cost reports utilized in the default ratio calculation were for CY 2005 and 49 percent were for CY 2006. 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 Medicare 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.

Prior to CY 2007, OPPS policy required hospitals that experienced a change of ownership, but that did not accept assignment of the previous hospital's provider agreement, to use the

previous provider's CCR. However, in CY 2007 we revised this policy and finalized our proposal to use default statewide CCRs for entities that had not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18 and that had not yet submitted its first Medicare cost report. For CY 2008, we proposed 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 believed 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 believed that the hospital that has chosen not to accept assignment may have different costs and charges than the existing hospital. Furthermore, we believed that the hospital should be provided time to establish its own costs and charges. Therefore, we proposed to use the default statewide CCR to determine cost-based payments until the hospital has submitted its first Medicare cost report.

We did not receive any public comments concerning this issue. Therefore, we are finalizing the statewide average default CCRs as shown in Table 11 below for OPPS services furnished on or after January 1, 2008, without modification.

TABLE 11.—CY 2008 STATEWIDE AVERAGE CCRS

State	Rural/urban	CY 2008 default CCR	Previous default CCR (CY 2007 OPPS final rule)
ALASKA	RURAL	0.537	0.534
ALASKA	URBAN	0.351	0.383
ALABAMA	RURAL	0.228	0.232
ALABAMA	URBAN	0.213	0.223
ARKANSAS	RURAL	0.266	0.264
ARKANSAS	URBAN	0.270	0.275
ARIZONA	RURAL	0.264	0.282
ARIZONA	URBAN	0.232	0.232
CALIFORNIA	RURAL	0.232	0.246
CALIFORNIA	URBAN	0.218	0.232
COLORADO	RURAL	0.355	0.370
COLORADO	URBAN	0.254	0.267
CONNECTICUT	RURAL	0.391	0.389
CONNECTICUT	URBAN	0.339	0.349
DISTRICT OF COLUMBIA	URBAN	0.346	0.339
DELAWARE	RURAL	0.302	0.323
DELAWARE	URBAN	0.400	0.395
FLORIDA	RURAL	0.219	0.219
FLORIDA	URBAN	0.198	0.199
GEORGIA	RURAL	0.279	0.285
GEORGIA	URBAN	0.269	0.289
HAWAII	RURAL	0.373	0.357
HAWAII	URBAN	0.317	0.320
IOWA	RURAL	0.349	0.349
IOWA	URBAN	0.325	0.343
IDAHO	RURAL	0.445	0.436
IDAHO	URBAN	0.414	0.416
ILLINOIS	RURAL	0.286	0.308
ILLINOIS	URBAN	0.271	0.288
INDIANA	RURAL	0.313	0.316
INDIANA	URBAN	0.301	0.320
KANSAS	RURAL	0.318	0.320
KANSAS	URBAN	0.240	0.252
KENTUCKY	RURAL	0.244	0.251
KENTUCKY	URBAN	0.262	0.270
LOUISIANA	RURAL	0.271	0.281
LOUISIANA	URBAN	0.277	0.273
MARYLAND	RURAL	0.308	0.318
MARYLAND	URBAN	0.284	0.298
MASSACHUSETTS	URBAN	0.338	0.349
MAINE	RURAL	0.433	0.457
MAINE	URBAN	0.424	0.429
MICHIGAN	RURAL	0.331	0.346
MICHIGAN	URBAN	0.318	0.329
MINNESOTA	RURAL	0.499	0.508
MINNESOTA	URBAN	0.342	0.338
MISSOURI	RURAL	0.289	0.294
MISSOURI	URBAN	0.292	0.303
MISSISSIPPI	RURAL	0.267	0.284
MISSISSIPPI	URBAN	0.217	0.231
MONTANA	RURAL	0.453	0.439

TABLE 11.—CY 2008 STATEWIDE AVERAGE CCRS—Continued

State	Rural/urban	CY 2008 default CCR	Previous default CCR (CY 2007 OPPS final rule)
MONTANA	URBAN	0.450	0.463
NORTH CAROLINA	RURAL	0.286	0.305
NORTH CAROLINA	URBAN	0.321	0.370
NORTH DAKOTA	RURAL	0.379	0.367
NORTH DAKOTA	URBAN	0.378	0.395
NEBRASKA	RURAL	0.347	0.376
NEBRASKA	URBAN	0.290	0.290
NEW HAMPSHIRE	RURAL	0.375	0.370
NEW HAMPSHIRE	URBAN	0.337	0.325
NEW JERSEY	URBAN	0.276	0.297
NEW MEXICO	RURAL	0.275	0.274
NEW MEXICO	URBAN	0.353	0.398
NEVADA	RURAL	0.329	0.335
NEVADA	URBAN	0.200	0.214
NEW YORK	RURAL	0.417	0.445
NEW YORK	URBAN	0.402	0.427
OHIO	RURAL	0.354	0.369
OHIO	URBAN	0.268	0.283
OKLAHOMA	RURAL	0.288	0.295
OKLAHOMA	URBAN	0.245	0.261
OREGON	RURAL	0.321	0.344
OREGON	URBAN	0.366	0.405
PENNSYLVANIA	RURAL	0.298	0.305
PENNSYLVANIA	URBAN	0.241	0.252
PUERTO RICO	URBAN	0.474	0.469
RHODE ISLAND	URBAN	0.308	0.309
SOUTH CAROLINA	RURAL	0.258	0.255
SOUTH CAROLINA	URBAN	0.244	0.248
SOUTH DAKOTA	RURAL	0.334	0.348
SOUTH DAKOTA	URBAN	0.289	0.304
TENNESSEE	RURAL	0.256	0.265
TENNESSEE	URBAN	0.241	0.249
TEXAS	RURAL	0.271	0.289
TEXAS	URBAN	0.242	0.258
UTAH	RURAL	0.416	0.441
UTAH	URBAN	0.406	0.416
VIRGINIA	RURAL	0.268	0.282
VIRGINIA	URBAN	0.275	0.280
VERMONT	RURAL	0.416	0.432
VERMONT	URBAN	0.340	0.338
WASHINGTON	RURAL	0.358	0.374
WASHINGTON	URBAN	0.368	0.372
WISCONSIN	RURAL	0.384	0.367
WISCONSIN	URBAN	0.362	0.364
WEST VIRGINIA	RURAL	0.298	0.316
WEST VIRGINIA	URBAN	0.360	0.369
WYOMING	RURAL	0.449	0.471
WYOMING	URBAN	0.351	0.352

F. OPPS Payments to Certain Rural Hospitals

1. Hold Harmless Transitional Payment Changes Made by Pub. L. 109–171 (DRA)

When the OPPS was implemented, every provider was eligible to receive an additional payment adjustment (called either transitional corridor payment or transitional outpatient payment) if the payments it received for covered outpatient department (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 to ease their transition from the prior reasonable cost-based payment system to the OPPS system. There are two exceptions, cancer hospitals and children's hospitals, to this provision and those 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 ended 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, for rural hospitals having 100 or fewer beds and SCHs located in rural areas expired 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 the 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 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 believed and continue to believe that EACHs are not currently eligible for TOPs under Pub. L. 109–171. However, they are eligible for the adjustment for rural SCHs. 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. Adjustment for Rural SCHs Implemented in CY 2006 Related to Pub. L. 108–173 (MMA)

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 for rural SCHs. Therefore, we implemented a payment adjustment for only 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. 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). Currently, fewer than 10 hospitals are classified as EACHs and as of CY 1998, under section 4201(c) of Pub. L. 105–33, a hospital can no longer become newly classified as an EACH.

This adjustment for rural SCHs is budget neutral and applied before calculating outliers and copayment. 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 note that we may review the adjustment in the future and, if appropriate, would revise the adjustment.

For CY 2008, we proposed 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. This adjustment is in accordance with section 411 of the MMA, which gave the Secretary the authority to make an adjustment to OPPS payments for rural hospitals, 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. For CY 2008, we also proposed to include brachytherapy sources in the group of services eligible for the 7.1 percent payment increase because we proposed to pay them at prospective rates based on their median costs as calculated from historical claims data. Consequently, we proposed to revise § 419.43 to reflect our proposal to make brachytherapy sources eligible for the 7.1 percent payment increase for rural SCHs. As indicated in our proposed rule (72 FR 42698), we intend 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.

Comment: Several commenters supported our proposals 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, and to make brachytherapy sources eligible for the 7.1 percent payment increase for rural SCHs.

Response: We appreciate the commenters' support of the policy.

After consideration of the public comments received, we are finalizing, without modification, our policy to continue a payment adjustment for rural SCHs, including EACHs, of 7.1 percent for CY 2008. We also are finalizing our proposed revision of § 419.43 to make brachytherapy sources eligible for the 7.1 percent payment increase for rural SCHs, including EACHs, without modification.

G. Hospital Outpatient Outlier Payments

1. Background

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. In the CY 2008 OPPS/ASC

proposed rule (72 FR 42698), we estimated, using available CY 2006 claims, that the outlier payments for CY 2006 would be approximately 1.1 percent of total CY 2006 OPPS payment. In the final CY 2006 claims, aggregated outlier payments were 1.1 percent of aggregated total OPPS payments. For CY 2006, the estimated outlier payments were set at 1.0 percent of the total aggregated OPPS payments. Therefore, for CY 2006 we paid 0.1 percent in excess of the CY 2006 outlier target of 1.0 percent of total aggregated OPPS payments. Using the final CY 2006 claims and CY 2007 payment rates, we currently estimate that outlier payments for CY 2007 would be approximately 0.7 percent of total CY 2007 OPPS payments and the difference between 1.0 percent and 0.7 percent is reflected in the regulatory impact analysis in section XXIV.B. of this final rule with comment period. We will not know the final amount of outlier payments as a percent of total payments until we have final CY 2007 claims. 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/*.

2. Proposed Outlier Calculation

For CY 2008, we proposed to continue our policy of setting aside 1.0 percent of aggregate total payments under the OPPS for outlier payments. We proposed 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 this final rule, we estimate that 0.02 percent of total outlier payments would be allocated to CMHC's for partial hospitalization program service outliers. For further discussion of CMHC outliers, we refer readers to section II.B.3. of this final rule with comment period.

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 proposed 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 reflected minor changes to the methodology discussed below as well as APC recalibration, including changes due in part to the CY 2008 packaging approach discussed in section II.A.4.c. of this final rule with comment period.

We calculated the fixed-dollar threshold for the CY 2008 proposed rule using largely the same methodology as we did in CY 2007, except that we proposed 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. As noted in the CY 2008 OPPS/ASC proposed rule (72 FR 42699), 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, MACs) 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 OPPS/ASC proposed rule and final rule with comment period, 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, MACs) would use to determine outlier payments in CY 2008. For the 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 the proposed rule, we used CY 2006 claims to model the CY 2008 OPPS. In order to estimate CY 2008 outlier payments for the 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) and in the FY 2008 IPPS final rule with comment period (72 FR 47417). 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 believed that the costs and charges reported under the applicable cost centers largely are commingled inpatient and outpatient costs and charges. We did not want to systematically overestimate the OPPS outlier threshold as could occur if we did not apply a CCR inflation adjustment factor. Therefore, we proposed to apply the CCR adjustment factor that was proposed to be applied for IPPS outlier calculation to the CCRs used to simulate the CY 2008 OPPS outlier payments that determined the fixed-dollar threshold. Specifically, for CY 2008, we proposed 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) and the FY 2008 IPPS final rule with comment period (72 FR 47417).

Therefore, for the 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 estimated 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 proposed 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.

We received several public comments related to this proposal. A summary of the public comments and our responses follow.

Comment: Several commenters requested that CMS publish annual outlier payments as a percentage of total OPPS payment.

Response: We currently publish the total outlier payments as a percent of total payment for past years in the annual OPPS/ASC proposed and final rules. We have projected outlier payments to be 1.1 percent of total OPPS payments for CY 2006, the most complete set of full year claims data that currently exists. We plan to continue to publish these numbers for future years, after we have full year cost data. For CY 2008, we estimate that outlier payments will be 1.0 percent of total payment.

Comment: One commenter agreed with our proposal to raise the fixed dollar outlier threshold accordingly so that the 1.0 percent target for outlier payments is met. Other commenters requested that CMS lower the fixed dollar threshold so that a greater number of services would be eligible for outlier payments. One commenter noted that the proposed increased fixed dollar threshold significantly reduced the number of services that would be eligible for outlier payments. Another commenter expressed concern that increased OPPS packaging would cause CMS to pay less in outlier payments than in the past. Other commenters were concerned that the fixed dollar outlier threshold that CMS proposed was set too high and would result in CMS spending less money than allocated for the projected 1.0 percent outlier target. These commenters argued that the estimated outlier target amount has historically been greater than the actual need, and they asked that CMS either reduce the set-aside amount and retain that money in the base OPPS rates or reduce the threshold for qualification so that the outlier expenditures would be at a zero balance at the end of each year. Several commenters asked that CMS limit the increase in the outlier threshold to the amount of the market basket update each year, which would mean, for CY 2008, that the CY 2008 threshold would be increased by only 3.3 percent. Other commenters suggested that the outlier payment be increased from 50 percent to 80 percent of the difference between the APC payment and the cost of the service. They believed that this would more appropriately account for the additional cost of the service and make the outlier payment policy consistent with IPPS policy.

Response: Consistent with the views of most commenters, we are reducing the proposed fixed dollar outlier threshold based on our updated analysis for this final rule with comment period, where we use the most current claims and cost report data and final payment policies to estimate the threshold that would allow us to pay CY 2008 outlier payments of 1.0 percent of total CY 2008 OPPS payment.

In CY 2008, the OPPS outlier outlay is projected to be 1.0 percent of total payments. We note that our projections for CY 2008 outlier payments take into account the final packaging policies, as well as all other final payment policies, of the OPPS. We acknowledge that outlier payments are an integral component of the OPPS and could be particularly important as the APC payment bundles grow larger and hospitals potentially experience financially greater risk associated with individual patient encounters. In a movement toward encounter-based or episode-based payment, multiple service payments for a claim could become less common, and OPPS outlier payments could come to be increasingly targeted toward clinical cases rather than individual services, consistent with the customary role of outlier payment in a prospective payment system. We prospectively set the outlier thresholds so that we will pay 1.0 percent of projected payment based on our best inflation assumptions and model of final payment policies. The final policy to increase packaging for the CY 2008 OPPS should not result in less aggregate outlier payment in CY 2008 than other years, although the distribution of payment across APCs will change.

We believe that the estimated total CY 2008 outlier payments will meet the target of 1.0 percent of total OPPS payments. In CY 2006, aggregated outlier payments were 1.1 percent of aggregated total spending, while the target was set at 1.0. As we indicated in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68010), in the final set of CY 2005 OPPS claims, aggregated outlier payments were 2.39 percent of aggregated total OPPS payments, while the target was set at 2.0 percent. Similarly, using the final set of CY 2004 OPPS claims, aggregated outlier payments were 2.5 percent of total OPPS payments, while the target was set at 2 percent. Hence, our historic estimation of outlier payments has resulted in outlier payments that exceeded our target. As noted above, we currently estimate that we will pay 0.7 percent of total payments in outlier payments in CY 2007. We believe that our proposed methodology that applies charge and CCR inflation factors to updated CY 2006 claims and overall CCRs from the most recent OPSF file to approximate CY 2008 values yields an outlier threshold that will result in more accurate aggregate program outlier payments.

We did not increase the CY 2008 outlier threshold by the market basket update of 3.3 percent because our calculations are intended to best approximate the outlier target of 1.0 percent of CY 2008 OPPS expenditures. We continue to believe that an outlier target of 1.0 percent of total OPPS payment is appropriate for the OPPS. However, we will monitor outlier payments distributed during CY 2008 to determine whether a different outlier target would be more appropriate.

Similarly, we do not believe it is appropriate to increase the payment percentage to 80 percent of the difference between the APC payment and the cost of the service in order to align it with the IPPS outlier policy. In a budget neutral system with a specified payment target, the payment percentage

and fixed-dollar threshold have an inverse relationship. Raising the payment percentage would require us to significantly increase the fixed dollar threshold to ensure that the outlier target is not exceeded. We agree with most commenters that a relatively lower fixed-dollar threshold is more desirable for the OPPS than a higher fixed-dollar threshold, given the current size of the OPPS payment bundles.

After consideration of the public comments received, we are finalizing our CY 2008 proposal, without modification, for the outlier calculation as outlined below.

3. Final Outlier Calculation

For CY 2008, we are applying the overall CCRs from the July 2007 OPSF file with a CCR adjustment factor of 1.0027 to approximate CY 2008 CCRs to charges on the final CY 2006 claims that were adjusted to approximate CY 2008 charges (using the final charge inflation factor of 1.1278). These are the same CCR adjustment and charge inflation factors that we used to set the IPPS fixed-dollar threshold for FY 2008 (72 FR 47418). 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 fixed-dollar threshold of $1,575, combined with the multiple threshold of 1.75 times the APC payment rate, will allocate 1.0 percent of aggregated total OPPS payments to outlier payments.

In summary, for CY 2008 we will 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 $1,575 threshold are met. As discussed in section VII.B. of this final rule with comment period, brachytherapy sources will be eligible for outlier payment beginning in CY 2008. In addition, the costs of diagnostic radiopharmaceuticals and contrast media for which CY 2008 payment is packaged into the APC payments for nuclear medicine and other imaging procedures under the final packaging approach will contribute to a claim's eligibility for outlier payment in CY 2008. 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 an Adjusted Medicare Payment From the National Unadjusted Medicare Payment

(We note that the title of this section has been changed from that used in the CY 2008 OPPS/ASC proposed rule. In that rule this section was entitled, ''Proposed Calculation of the National Unadjusted Medicare Payment.'')

The basic methodology for determining prospective payment rates for HOPD services under the OPPS is set forth in existing regulations at § 419.31 and § 419.32, and § 419.43 and § 419.44. 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 final rule with comment period and the relative weight determined under section II.A. of this final rule with comment period. Therefore, the national unadjusted payment rate for each APC contained in Addendum A to this final rule with comment period and for HCPCS codes to which separate payment under the OPPS has been assigned in Addendum B to this final rule with comment period (Addendum B is provided as a convenience for readers) was calculated by multiplying the final CY 2008 scaled weight for the APC by the final 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 any of the status indicator assignments ''S,'' ''T,'' ''V,'' or ''X,'' as defined in Addendum D1 of this final rule with comment period, in a circumstance in which the multiple procedure discount does not apply and the procedure is not bilateral or discontinued, 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).

Individual providers interested in calculating the final payment amount that they will receive for a specific service from the national payment rates presented in Addenda A and B to this final rule with comment period should follow the formulas presented in the following steps. The formula below is a mathematical representation of step 1 discussed above and identifies the labor-related portion of a specific payment rate for the specific service.

x—Labor-related portion of the national unadjusted payment rate

$x = .60 * (\text{national unadjusted payment rate})$

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 expired on September 30, 2007, and is no longer applicable in this determination of appropriate wage values for the CY 2008 OPPS. The wage index values include the occupational mix adjustment described in section II.D. of this final rule with comment period that was developed for the final FY 2008 IPPS payment rates published in the **Federal Register** on August 22, 2007 (72 FR 47309 through 47315) and corrected in the correction notice to the FY 2008 IPPS final rule with comment period published in the **Federal Register** on October 10, 2007 (72 FR 57634 through 57738).

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 final rule with comment period contains the qualifying counties and the final wage index increase developed for the FY 2008 IPPS published in the FY 2008 IPPS final rule with comment period (72 FR 47339) and corrected in the correction notice to the FY 2008 IPPS final rule with comment period published in the **Federal Register** on October 10, 2007 (72 FR 57634 through 57738). 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.

The formula below is a mathematical representation of step 4 discussed above and adjusts the labor-related portion of the national payment rate for the specific service by the wage index.

x_a—Labor-related portion of the national unadjusted payment rate (wage adjusted

x_a = 60 * (national unadjusted payment rate) * applicable wage index.

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.The formula below is a mathematical representation of step 5 discussed above and calculates the remaining portion of the national payment rate, the amount not attributable to labor, and the adjusted payment for the specific service.

y—Nonlabor-related portion of the national unadjusted payment rate

y = .40 * (national unadjusted payment rate)

Adjusted Medicare Payment = $y + x_a$

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 § 412.64(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.

The formula below is a mathematical representation of step 6 discussed above and applies the rural adjustment for rural SCHs.

Adjusted Medicare Payment (SCH or EACH) = Adjusted Medicare Payment * 1.071

We did not receive any public comments on our proposed methodology for calculating an adjusted payment from the national unadjusted Medicare payment amount for CY 2008. Therefore, we are finalizing our methodology as proposed for CY 2008, without modification.

I. Beneficiary Copayments

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 a specified percentage. 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 copayment 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 require that the copayment for screening flexible sigmoidoscopies and screening colonoscopies be equal to 25 percent of the payment amount. We have applied the 25-percent copayment to screening flexible sigmoidoscopies and screening colonoscopies since the beginning of the OPPS.

2. Copayment

For CY 2008, we proposed 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 unadjusted copayment amounts for services payable under the OPPS that will be effective January 1, 2008, are shown in Addendum A and Addendum B to this final rule with comment period.

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) were $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 proposed to round 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) had 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. As proposed, we continue to 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 proposed 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 proposed 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.

We did not receive any public comments on this proposal, and, therefore, we are adopting it as final, without modification.

3. Calculation of an 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 23 percent of $30.61.

Individuals interested in calculating the their final copayment liability for a given service from the national copayment rates presented in Addenda A and B should follow the formulas presented in the following steps. The formula below is a mathematical representation of step 1 discussed above and calculates national copayment as a percentage of national payment for a given service.

b—Beneficiary payment percentage

b = national unadjusted copayment for APC / national unadjusted payment rate for APC

Step 2. Calculate the wage adjusted payment rate for the APC, for the provider in question, as indicated in section II.H. of this final rule with comment period. Calculate the rural adjustment for eligible providers as indicated in section II.H. of this final rule with comment period.

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 formula below is a mathematical representation of step 3 discussed above and applies the beneficiary percentage to the adjusted payment rate for a service calculated under II.H. above, with and without the rural adjustment, to calculate the final adjusted beneficiary copayment for a given service.

Wage-adjusted copayment amount for the APC = Adjusted Medicare Payment * *b*

Wage-adjusted copayment amount for the APC (SCH or EACH) = (Adjusted Medicare Payment * 1.071)* *b*

The unadjusted copayments for services payable under the OPPS that will be effective January 1, 2008, are shown in Addenda A and B to this final rule with comment period.

We did not receive any public comments concerning the proposed methodology for calculating the unadjusted copayment amount for CY 2008. Therefore, we are finalizing our proposal without modification.

III. OPPS Ambulatory Payment Classification (APC) Group Policies

A. Treatment of New HCPCS and CPT Codes

1. Treatment of New HCPCS Codes Included in the April and July Quarterly OPPS Updates for CY 2007

a. Background

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 the CY 2008 OPPS/ASC proposed rule, we also solicited public comment on the status indicators, APC assignments, and payment rates of these codes, which were listed in Table 26A and Table 26B of that proposed rule, and now appear in Tables 10 and 11, respectively, of this final rule with comment period. Because of the timing of the proposed rule, the codes implemented through the July 2007 OPPS update were not included in Addendum B to that rule. In the CY 2008 OPPS/ASC proposed rule, we proposed to assign the new HCPCS codes for CY 2008 to APCs with the proposed rates as displayed in Tables 26A and 26B and incorporate them into Addendum B of this final rule with comment period for CY 2008, which is consistent with our annual APC updating policy. As noted in Table 13 of this final rule with comment period, HCPCS codes Q4087, Q4088, Q4089, Q4090, Q4091, Q4092, and Q4095 will be deleted on December 31, 2007 and replaced with HCPCS J-codes effective January 1, 2008. Readers should refer to Table 13 for their replacement codes.

b. Implantation of Interstitial Devices (APC 0156)

Effective January 1, 2007, 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) was implemented. We assigned this code to APC 0156 (Level III Urinary and Anal Procedures) for CY 2007 on an interim final basis. We then created a new Level II HCPCS code for a similar interstitial device implantation service for non-prostate sites, C9728 (Placement of interstitial device(s) for radiation therapy/surgery guidance (e.g., fiducial markers, dosimeter), other than prostate (any approach), single or multiple). We implemented HCPCS code C9728 effective July 1, 2007 via Program Transmittal 1259 dated June 1, 2007, as a result of information we received during our evaluation of an application for assignment of the implantation of a radiation dose verification system to a New Technology APC. We assigned HCPCS code C9728 to APC 0156 because we believed it was similar to CPT code 55876 from both clinical and resource perspectives. We proposed to maintain both CPT code 55876 and HCPCS code C9728 in APC 0156 for CY 2008, with a proposed payment rate of approximately $195.

We received a number of comments on the APC assignments of these codes, both on the CY 2007 OPPS/ASC final rule with comment period and on the CY 2008 proposed rule. A summary of the comments and our response follow.

Comment: A few commenters expressed concern about CMS' interim final placement of CPT code 55876 in APC 0156 for CY 2007 as shown in Addendum B to the CY 2007 final rule with comment period. Several commenters expressed similar concern regarding the proposed CY 2008 APC assignment for this code. The commenters recommended that the payment rate for implanting the interstitial devices not incorporate the cost of the devices, because such items have a range of costs. Several commenters claimed that the costs of these devices range widely, from approximately $200 for gold markers, to $900 for implantable dosimeters, to $1200 for electromagnetic transponders, which they believed justified separate payment for the various types of interstitial devices.

Some commenters also expressed concern about the proposed CY 2008 APC placement of a new code that CMS created for non-prostate applications, specifically HCPCS code C9728 which was assigned to APC 0156, effective July 1, 2007, because it is similar to CPT code 55876. Several commenters asserted that the payment for HCPCS code C9728 should include the costs of dosimeter sensors, which they believed are currently excluded. These commenters also noted that payment for CPT code 55876 excludes the cost of dosimeter sensors. They recommended that CMS develop Level II HCPCS codes that permit hospitals to report the specific technologies associated with HCPCS code C9728 and CPT code 55876 in each clinical case and receive appropriate payment for the specific interstitial device implanted.

Several commenters pointed out that the CPT coding instructions for CPT code 55876 instruct coders to report the supply of devices for the implantation procedure separately from CPT code 55876. These commenters claimed that when the CPT Editorial Panel established the code, it did not include the implantable interstitial device and the imaging guidance for the implantation procedure in the code, and, therefore, both device costs and imaging guidance costs were excluded from the proposed CY 2008 APC payment for CPT code 55876. Because a dosimeter sensor could be implanted with CPT code 55876 for prostate applications, the commenters asserted that its costs are not reflected in that service. The commenters claimed that, unlike the instructions for CPT code 55876, the descriptor for HCPCS code C9728 does not direct coders to report the device separately. These commenters recommended that CMS assign the DVS® Dosimeter device for any body site to New Technology APC 1514 (New Technology—Level XIV ($1200–$1300)), with a payment rate of $1250 for the device for CY 2008. Alternatively, they suggested that CMS package payment for all of the items and services needed to implant the dosimeter into payment for a single code which they recommended be assigned to New Technology APC 1522 (New Technology—Level XXII ($2000–$2500)). One commenter further claimed that CMS was required to set the APC assignment for the DVS® device based on the cost estimate

included in its New Technology APC application.

Response: Many procedures paid under the OPPS include payment for various implantable devices, where the procedure cost in an individual case would vary by the type of device. Our long-standing policy is to package the costs of implantable devices into payment for the procedures in which they are used, unless those devices are paid separately for a limited period of 2 to 3 years based on their transitional pass-through status. Payment for OPPS services includes payment for all costs that are directly related and integral to performing a procedure or furnishing a service on an outpatient basis, as set forth in § 419.2.

According to our usual practice, when we originally evaluated CPT code 55876 for APC assignment for CY 2007, we took into consideration all information available to us about the particular service, as well as other OPPS services for which we have claims-based cost data. In particular, we considered the probable utilization of the various devices, including fiducial markers and dosimeters, whose implantation could be reported with the CPT code, as well as possible implantation approaches, recognizing that a prospective payment system is based on principles of averaging. For established services paid under the OPPS, payment is generally based on the median cost of the service from claims data. Although CPT instructions state that the supply of the implantable device is to be reported separately, we considered the device costs associated with CPT code 55876, which would be packaged into payment for the implantation procedure under the OPPS even if the device were separately reported, when we assigned the CPT code to APC 0156. A previous pass-through device category, C1879 (Tissue marker (implantable)) for a device that we believe could be reported with CPT code 55876, was active from August 2000 through December 2002. After its expiration, the cost of tissue markers has been packaged into the OPPS payment for the procedures in which they are used. We note that the line-item CY 2006 median cost for HCPCS code C1879 for an implantable tissue marker was $88 based on approximately 18,600 units of this device. Although there was no specific HCPCS device code for a dosimeter in CY 2007, we would consider payment for the dosimeter packaged under the OPPS into the implantation procedure and would have no need to establish a specific HCPCS code for the dosimeter for OPPS payment purposes. There may be other devices whose implantation would also be reported with CPT code 55876 and, similarly, we would package their payment under the OPPS. We note that the CMS HCPCS Workgroup has created two related supply codes for CY 2008, specifically A4648 (Tissue marker, implantable, any type, each) and A4650 (Implantable radiation dosimeter, each), which will be packaged under the OPPS for CY 2008 and which could also be reported in association with CPT code 55876. Therefore, any of these HCPCS codes for devices or supplies, A4648, A4650 or C1879, are reportable with service codes 55876 or C9728.

In response to public comments on the CY 2007 OPPS/ASC final rule with comment period and on the CY 2008 proposed rule on the proposed assignment of CPT code 55876 for CY 2008, we once again examined information available to us regarding procedures that could be reported with the CPT code, along with updated claims data for other OPPS services. We continue to believe that APC 0156 is the most appropriate APC assignment for CPT code 55876, based on the expected median cost and utilization of all of the services that would be reported with the code under the OPPS. We will first have claims data for CPT code 55876 for the CY 2009 OPPS update, which we will review in the context of our CY 2009 update proposals.

We note that during CY 2007, we evaluated a New Technology APC application submitted by the manufacturer of the DVS® System for a service the applicant entitled ''Implantation of the DVS® Dosimeter.'' We did not approve an item or service for payment specifically for the DVS® Dosimeter. However, we approved creation of a new code for a *service* for non-prostate placement of interstitial device(s) for radiation therapy or surgical guidance, using such devices as fiducial markers or dosimeters. As explained by the commenters, and similar to CPT code 55876, this procedure could implant devices with a wide range of costs, including dosimeters that commenters claimed ranged from $900 to $1200. Our general policy in creating a new service code under the OPPS, whether we assign it to a clinical or New Technology APC, is to develop a general service code so that it may be reported for a range of technologies, rather than only for a single proprietary service. This reduces potential barriers to payment under the OPPS for related new services and is consistent with the general coding practices of the CPT Editorial Panel and the CMS HCPCS Workgroup. When we approve a new service for assignment to a New Technology APC, we are not required to set the payment rate based on the cost data presented in the New Technology APC application alone, as we have stated in our final rule published in the **Federal Register** on November 30, 2001. In that rule, we specifically explained that we do not limit our determination of the cost of a service to information submitted by the applicant. We obtain information on costs from other appropriate sources before making a determination of the cost of the procedure to hospitals (66 FR 59900). In addition, we note that only complete services are currently assigned to New Technology APCs, not items, such as drugs or devices.

In response to comments to the CY 2008 proposed rule on the proposed assignment of HCPCS code C9728, we examined all information available to us on procedures that could be reported with the code, as well as updated cost data from claims regarding other OPPS services. We continue to believe that the resources and utilization associated with HCPCS code C9728, including the cost of the various possible implantable devices that may be implanted in the service and the different approaches to the implantation, resemble those associated with CPT code 55876. Therefore, we will maintain HCPCS code C9728 in APC 0156 for CY 2008. We will first have data for HCPCS code C9728 for the CY 2009 OPPS update, which we will review in the context of our CY 2009 update proposals. We expect that these data will reflect the costs of the implantable devices utilized and, the extent that more costly devices, such as implantable dosimeters and electromagnetic transponders, are increasingly reported with this procedure, the cost of these devices will gradually be reflected in the median cost of HCPCS code C9728.

c. Other New HCPCS Codes Implemented in April or July 2007

While we received public comments on the proposed CY 2008 OPPS treatment of HCPCS code C9728 as discussed above and HCPCS codes C2638, C2639, C2640, C2641, C2642, C2643, C2698, and C2699 as discussed in section VII. of this final rule with comment period, we did not receive any public comments on the proposed APC assignments and status indicators for HCPCS codes Q4087, Q4088, Q4089, Q4090, Q4091, Q4092, and Q4095 that were implemented in July 2007. However, for CY 2008, the CMS HCPCS Workgroup decided to delete the drug codes described by Q-codes on December 31, 2007 and replace them with permanent J-codes effective

January 1, 2008. Consistent with our general policy of using permanent HCPCS codes for the reporting of drugs under the OPPS in order to streamline coding, we are displaying the J-codes in Table 13 that will replace the seven Q-codes, effective January 1, 2008. We note that Q codes are temporary national HCPCS codes. To avoid duplication, temporary national HCPCS codes, such as ''C-,'' ''G-,'' ''K-,'' and ''Q-codes,'' are generally deleted once permanent national HCPCS codes are created that describe the same item, service, or procedure. The J-codes describe the same drugs and the same dosages as the Q-codes that will be deleted December 31, 2007. Because we did not receive any public comments on the proposed CY 2008 APC and status indicator assignments for the new HCPCS codes, with the exception of HCPCS code C9728, that were implemented in July 2007, we are adopting our proposal as final, without modification, and are assigning the replacement HCPCS J codes to the same status indicators and APCs that were proposed for the predecessor Q-codes, as shown in Addendum B to this final rule with comment period.

TABLE 12.—NEW NON-DRUG HCPCS CODES IMPLEMENTED IN JULY 2007

HCPCS code	Long descriptor	Final CY 2008 status indicator	Final CY 2008 APC	Final CY 2008 median cost
C2638	Brachytherapy source, stranded, iodine-125, per source	K	2638	$45
C2639	Brachytherapy source, non-stranded, iodine-125, per source	K	2639	32
C2640	Brachytherapy source, stranded, palladium-103, per source	K	2640	65
C2641	Brachytherapy source, non-stranded, palladium-103, per source	K	2641	51
C2642	Brachytherapy source, stranded, cesium-131, per source	K	2642	97
C2643	Brachytherapy source, non stranded, cesium-131, per source	K	2643	63
C2698	Brachytherapy source, stranded, not otherwise specified, per source	K	2698	45
C2699	Brachytherapy source, non-stranded, not otherwise specified, per source	K	2699	31
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	192

TABLE 13.—NEW DRUG HCPCS CODES IMPLEMENTED IN JULY 2007

New HCPCS J-code effective January 1, 2008	HCPCS Q-code	Long descriptor	Final CY 2008 status indicator	Final CY 2008 APC
J1568	Q4087	Injection, immune globulin, (Octogam), intravenous, non-lyophilized, (e.g. liquid), 500 mg.	K	0943
J1569	Q4088	Injection, immune globulin, (Gammagard), intravenous, non-lyophilized, (e.g. liquid), 500 mg.	K	0944
J2791	Q4089	Injection, rho(d) immune globulin (human), (Rhophylac), intravenous, 100 iu	K	0945
J1571	Q4090	Injection, hepatitis b immune globulin (Hepagam B), intramuscular, 0.5 ml	K	0946
J1572	Q4091	Injection, immune globulin, (Flebogamma), intravenous, non-lyophilized, (e.g. liquid), 500 mg.	K	0947
J1561	Q4092	Injection, immune globulin, (Gamunex), intravenous, non-lyophilized, (e.g. liquid), 500 mg.	K	0948
J3488	Q4095	Injection, zoledronic acid (Reclast), 1 mg	K	0951

2. Treatment of New Category I and III CPT Codes and Level II HCPCS Codes

a. Establishment and Assignment of New Codes

As has been our practice in the past, we implement new Category I and III CPT codes and new Level II HCPCS codes through program transmittals, 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.) In the CY 2008 OPPS/ASC proposed rule, we proposed to continue this recognition and process for CY 2008. Therefore, new Category I and III CPT codes and new Level II HCPCS codes, effective January 1, 2008, are listed in Addendum B to this 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'' is open to public comment in this final rule with comment period. As indicated in the CY 2008 OPPS/ASC proposed rule, we will respond to all comments received concerning these codes in a subsequent final rule for the next calendar year's OPPS/ASC update.

We did not receive any public comments on our proposal to assign a comment indicator of ''NI'' in Addendum B of the OPPS final rule with comment period to the new codes that are open to public comment. Therefore, we are finalizing our proposed treatment of new CY 2008 Category I and III CPT codes, as well as the Level II HCPCS codes, without modification.

We received some comments to the CY 2008 proposed rule regarding individual new HCPCS codes that commenters expected to be implemented for the first time in the CY 2008 OPPS. We could not discuss the CY 2008 codes, including their APC

and/or status indicator assignments, because the codes were not available when we developed and issued the proposed rule. For those new Category I CPT codes whose descriptors were not officially available during the comment period and development of the CY 2008 final rule with comment period, we do not specifically respond to those comments in this final rule with comment period. For those new Category III CPT codes that were released on July 1, 2007, for implementation January 1, 2008, we respond to those comments in this final rule with comment period because those codes were publicly available during the comment period to the proposed rule and the development of this final rule with comment period. Both of these groups of codes are flagged with comment indicator ''NI'' in this final rule with comment period, as discussed above, to signal that they are open to public comment.

Effective for January 1, 2008, we have created eight HCPCS C-codes that describe transthoracic echocardiography with contrast and transesophageal echocardiography with contrast to enable facilities to appropriately report contrast-enhanced echocardiography services. (See section II.A.4.c(6) of this final rule with comment period for further discussion of these codes). Effective January 1, 2008, these C-codes will be used by HOPDs to report contrast echocardiography services. These codes are assigned comment indicator ''NI'' in Addendum B to this final rule with comment period.

In the CY 2008 OPPS/ASC proposed rule, we also proposed 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 proposed 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, as proposed, only those new Category III CPT codes implemented effective January 1, 2008, are flagged with comment indicator ''NI'' in Addendum B to this 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 appeared in Table 27 of the proposed rule and are displayed in Table 14 of this final rule with comment period, were subject to comment in the proposed rule, and we proposed to finalize their status in this final rule with comment period.

b. Electronic Brachytherapy Services (New Technology APC 1519)

The AMA's CPT Editorial Panel created a new Category III code, 0182T (High dose rate (HDR) electronic brachytherapy, per fraction), as of July 1, 2007. We assigned CPT code 0182T to New Technology APC 1519 (New Technology—Level IXX ($1700–$1800)), with a payment rate of $1750, as of July 1, 2007 (via Program Transmittal 1259, Change Request 5623).

We received a wide variety of comments regarding the proposed assignment of CPT code 0182T to New Technology APC 1519. A summary of the comments and our response follows.

Comment: Some commenters thought the proposed assignment provided a payment that was too high, some believed the proposed payment was too low, while others agreed with the proposed APC assignment. A number of commenters believed that placement of CPT code 0182T into APC 1519 resulted in a payment amount much higher relative to existing APCs for application of brachytherapy sources, specifically, APCs 0312 (Radioelement Applications), 0313 (Brachytherapy), and 0651 (Complex Interstitial Radiation Source Application), with proposed CY 2008 payment rates of $534.48, $739.46, and $981.88, respectively. One commenter indicated that only a very small number of patients would be treated using electronic brachytherapy. Another commenter expressed appreciation of CMS's prompt assignment of new technologies to APCs, while some commenters were concerned that the proposed payment for CPT code 0182T as a new technology service was between two and three times the payment rate for the other conventional brachytherapy service APCs cited above. These commenters believed that the proposed payment for electronic brachytherapy was excessive and, given that the risks of the treatment have yet to be clearly established, such conditions would encourage the early and possibly inappropriate adoption of this service. Some commenters recommended that CMS consult with specialty organizations regarding the pricing of new technology services prior to assigning them to APCs. Other commenters supported the proposed assignment of CPT code 0182T and recommended that the service reside in that New Technology APC for at least 2 years.

Another commenter expressed concern that the payment level was too low for a single fraction treatment of electronic brachytherapy. The commenter pointed out that two applications for New Technology APCs were submitted to CMS for electronic brachytherapy with the following descriptions: (a) HDR electronic brachytherapy, complete course as a single fraction, and (b) HDR electronic brachytherapy, per fraction. The commenter claimed that the two forms of HDR electronic brachytherapy are each unique and should not be classified into the same APC. The commenter requested that a new HCPCS code for HDR electronic brachytherapy, complete course as a single fraction, be developed and assigned to APC 1529 (New Technology—Level XXIX ($5,500–$6,000)) for CY 2008.

Response: The CY 2008 proposed APC assignment of CPT code 0182T maintained our initial placement of HDR electronic brachytherapy. Consistent with our recent OPPS practice for Category III CPT codes that are implemented mid-year by the AMA, we recognized CPT code 0182T under the OPPS in July 2007. This recognition ensures timely collection of data pertinent to the service described by the code, ensures patient access to the service, and eliminates potential redundancy between Category III CPT codes and Level II HCPCS codes that are created by us in response to applications for new technology services.

Commenters did not provide analyses regarding the costs of the service; however, we received cost estimates from two manufacturers in their respective New Technology APC applications over the course of an extensive evaluation period. As is our customary practice, we also used claims data for related services and other sources of information to supplement information included in the New Technology APC applications in order to provide an APC assignment we believed to be appropriate at this time. Regarding the comments on potential complications or risks of the new service that has a higher payment rate than conventional brachytherapy procedures, we note that the APC assignment of a service based on its estimated cost is our usual practice for new services under the OPPS, which generally pays for services based on estimated hospital resources. In the absence of cost data from hospital claims, we believe that comparisons of OPPS payment for electronic

brachytherapy to payment for conventional brachytherapy services that are assigned to APCs 0312, 0313, and 0651 and that implant radioactive sources are not appropriate. The law specifically requires separate payment for the brachytherapy sources, and, therefore, these costs are not included in the procedure payment for conventional brachytherapy services that are reported for implanting the sources. We define brachytherapy sources as containing a radioactive isotope so, by definition, in the case of electronic brachytherapy treatment the New Technology APC payment for the procedure would include payment for the costs of the radiation actually delivered to the patient. Thus, it is not appropriate to compare the costs of conventional and electronic brachytherapy treatments based on a comparison of the treatment procedure costs alone.

In light of the commenters' concerns regarding safety of the new procedures, we reiterate that even though a service is assigned a HCPCS code and a payment rate under the OPPS, it does not imply coverage by the Medicare program but indicates only how the service may be paid if covered by the program. Unless CMS has issued a national coverage determination (NCD), local contractors determine whether a service meets all program requirements for coverage. While we do not specifically consult with specialty organizations during the New Technology APC application evaluation process that may result in an initial APC assignment for a service, the APC assignments of new technology services, like all other OPPS services, are open to comment in the annual OPPS update, and we welcome public comments.

We will not create a new Level II HCPCS code for HDR electronic brachytherapy, complete course as a single fraction, and assign it to a different New Technology APC. We evaluated both New Technology APC applications at length and received input from both applicants. We believe that the two forms of HDR electronic brachytherapy, whether provided in a single fraction or multiple fractions depending on the technology, are both described by CPT code 0182T that is appropriately assigned to a single APC. We note that the payment is per fraction, and that would include a single fraction treatment as well.

After reviewing the public comments received and all current information available to us regarding HDR electronic brachytherapy and other hospital outpatient services, we continue to believe that New Technology APC 1519, with a payment rate of $1750, is the most appropriate assignment for CPT code 0182T. Therefore, we are finalizing our proposal, without modification, to maintain the assignment of CPT code 0182T to New Technology APC 1519, with a payment rate of $1750 for CY 2008.

c. Other Mid-Year CPT Codes

We did not receive any comments on the proposed CY 2008 APC and status indicator assignments of Category III CPT codes first implemented in July 2007 for services other than CPT code 0182T. After considering the public comments received on CPT code 0182T, we are finalizing our general proposal for the treatment of new mid-year CPT codes, including our proposed APC assignments for CPT code 0182T and other Category III CPT codes as displayed Table 14.

TABLE 14.—CATEGORY III CPT CODES IMPLEMENTED IN JULY 2007

CPT code	Long descriptor	Final CY 2008 status indicator	Final 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. Variations Within APCs

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 final rule with comment period); and (7) incidental services such as venipuncture. Our final packaging methodology for ancillary and supportive services is discussed in section II.A.4.c. of this final rule with comment period.

Under the OPPS, we pay for hospital outpatient services on a rate-per-service basis, where the service may be reported with one or more HCPCS codes. Payment 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 final rule with comment period).

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 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 final rule with comment period.

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 proposed changes to their HCPCS codes' APC assignments in Addendum B to the proposed rule. In these cases, to eliminate a 2 times violation or to improve clinical and resource homogeneity, we proposed to reassign the codes to APCs that contained services that were similar with regard to both their clinical and resource characteristics. We also proposed 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 the proposed rule were related to changes in median costs of services and APCs resulting from our proposed bundling approach for CY 2008, as discussed in section II.A.4.c. of the proposed rule. We also proposed changes to the status indicators for some codes that were not specifically and separately discussed in the proposed rule. In these cases, we proposed to change the status indicators for some codes because we believed that another status indicator more accurately described their payment status from an OPPS perspective based on the policies that we proposed for CY 2008.

Addendum B to the proposed rule identified with a comment indicator ''CH'' those HCPCS codes for which we proposed a change to the APC assignment or status indicator as assigned in the April 2007 Addendum B update (via Change Request 5544, Transmittal 1209, dated March 21, 2007). Addendum B to this final rule with comment period identifies with the ''CH'' comment indicator the final CY 2008 changes compared to the codes' status as reflected in the October 2007 Addendum B update (via Change Request 5718, Transmittal 1336, dated September 14, 2007).

We received many public comments regarding the proposed APC and status indicator assignments for CY 2008 for specific HCPCS codes. These are discussed mainly in sections III.C. and III.D. of this final rule with comment period, and the final action for CY 2008 related to each HCPCS code is noted in those sections. We also received a number of specific comments about some of the procedures assigned to APCs that may have violated the 2 times rule. These comments are addressed elsewhere in the final rule with comment period, primarily in sections related to the types of procedures that were the subject of the comments.

3. 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 proposed for CY 2008 based on the APC Panel recommendations discussed mainly in sections III.C. and III.D. of this final rule with comment period, the proposed changes to status indicators and APC assignments as identified in Addendum B to the 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 of the proposed rule listed the APCs that we proposed 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 proposed for CY 2008. The median costs for hospital outpatient services for these and all other APCs that were used in the development of the proposed rule can

be found on the CMS Web site at: *http://www.cms.hhs.gov.*

We did not receive any general public comments related to the list of proposed exceptions to the 2 times rule, specifically those listed in Table 28 of the proposed rule. For the proposed rule, the list of APCs excepted from the 2 times rule were based on data from January 1, 2006, through September 30, 2006. For this final rule with comment period, we used data from January 1, 2006 through December 1, 2006. Thus, after responding to all of the comments on the proposed rule and making changes to APC assignments based on the comments received, we analyzed the full CY 2006 data to identify APCs with 2 times rule violations. In contrast to previous years, for CY 2008 we have calculated a significant number of APC medians through customized methodologies, such as device-dependent APC, APCs to which nuclear medicine procedures are assigned, and Visit APCs, that are impacted by the Extended Assessment and Management Composite APCs. Therefore, for this final rule with comment period we assessed the HCPCS code-specific median costs for HCPCS codes that are part of these customized APC median cost calculations to accurately identify 2 times violations. We also have some APCs where the concept of a 2 times violation is not relevant, typically those set based on multiple claims, such as APC 0381 for single allergy tests and APC 0375 for ancillary services when a hospital outpatient dies. Table 15 below has been revised relative to prior years to remove APCs where a 2 times violation is not a relevant concept and to identify final APCs, including those with customized median cost methodologies, with 2 times violations.

Based on our final data, we found that there were 21 APCs with 2 times rule violations. We applied the criteria as described earlier to finalize the APCs that are exceptions to the 2 times rule for CY 2008. After consideration of all public comments received on the proposed rule and the careful review of the CY 2006 claims data for the full year, we are finalizing the list of APCs exempted from the 2 times rule. The final list of APCs that are exceptions to the 2 times rule for CY 2008 is displayed in Table 15 below.

TABLE 15.—FINAL APC EXCEPTIONS TO THE 2 TIMES RULE FOR CY 2008

APC	APC title
0043	Closed Treatment Fracture Finger/Toe/Trunk.
0058	Level I Strapping and Cast Application.
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.
0141	Level I Upper GI Procedures.
0235	Level I Posterior Segment Eye Procedures.
0251	Level I ENT Procedures.
0256	Level V ENT Procedures.
0260	Level I Plain Film Except Teeth.
0303	Treatment Device Construction.
0323	Extended Individual Psychotherapy.
0330	Dental Procedures.
0409	Red Blood Cell Tests.
0432	Health and Behavior Services.
0437	Level II Drug Administration.
0438	Level III Drug Administration.
0604	Level 1 Hospital Clinic Visits.
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver.

C. New Technology APCs

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. 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 did not accept the APC Panel's recommendation for CY 2008 because we believed 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 proposed 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.

We received a number of public comments on our OPPS treatment of New Technology services. A summary of the public comments and our responses follow.

Comment: Several commenters requested that CMS reconsider maintaining a new service in a New Technology APC for a minimum of at least 2 years, to ensure sufficient claims data, before assigning it to a clinical APC. These commenters were concerned that reassigning a new service from a New Technology APC to a clinical APC in less than 2 years may result in the collection of inaccurate claims data because integration of new technologies can be slow and hospitals need time to update their chargemasters to appropriately include charges that are related to the actual costs of the new service. Other commenters reported that while a new technology service may increase hospital outpatient costs, it could ultimately replace more invasive inpatient procedures that are more costly for the Medicare program.

In addition, several commenters recommended that CMS place all new HCPCS codes for new services in New Technology APCs, rather than assigning them directly to clinical APCs, until claims data are available in order to ensure access to these services. Some commenters also recommended that CMS consider alternatives to moving procedures from New Technology APCs to clinical APCs that would prevent excessive reductions in payment, including moving procedures to different APCs, utilizing external data for ratesetting, or maintaining procedures in their current New Technology APCs.

Response: As we have stated previously, we generally keep a procedure in the New Technology APC to which it is initially assigned until we have collected sufficient claims data 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 bands, reassign the procedure or service to a different New Technology APC that most appropriately reflects its cost. This policy would allow 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, and also allows us to move a service from a New Technology APC in less than 2 years if sufficient claims data are available. To retain a new service under a New Technology APC for a minimum of at least two years, especially for a service for which we have significant claims data, may result in inappropriate payment of the service. We want to ensure appropriate allocation of Medicare expenditures, and for a service that has been placed in a New Technology APC with significant claims data, we believe it is in the best interest of both the Medicare program and the beneficiary to reassign the service to an appropriate clinical APC based on clinical coherence and resource similarity.

In response to the different suggestions for transitioning new technology services from New Technology APCs to clinical APCs to prevent excessive reductions in payment, because we generally move new services from New Technology APCs to clinical APCs only when we have adequate data upon which to base a decision, we do not believe a transition would commonly be necessary in order to provide appropriate payment for the services based on their hospital costs. We have no need to utilize external data in these cases where we believe our claims data, developed according to the standard OPPS ratesetting methodology, are adequate to reassign the new services to clinical APCs. In a few past situations, we have moved services from one New Technology APC to another New Technology APC with a lower payment rate if we believed that our data were not fully developed to support a final clinical APC assignment, but we expect these cases to continue to be rare. In addition, all reassignments of services out of New Technology APCs are proposed during the annual rulemaking cycle, allowing the opportunity for public comment prior to their movement.

When evaluating new services for payment under the OPPS, we use all information available to us regarding the clinical characteristics of the procedures and the expected hospital resource costs. We reserve New Technology APC assignments for those services where we do not believe there is an appropriate clinical APC for the new service. In many cases, new HCPCS codes describe services that are similar to existing services that are paid under the OPPS and for which we have robust cost data from hospital claims. We continue to believe that it is appropriate to assign similar new and existing services to the same clinical APC in such cases. We follow the claims data closely and carefully review the New Technology and clinical APC assignments of relatively new OPPS services for each update year when new claims data become available. In addition, the OPPS treatment of all new services is open to public comment in the annual OPPS/ASC rule (either proposed or final with comment period) that follows the service's implementation under the OPPS.

After consideration of all public comments received, we are finalizing our CY 2008 proposal, without modification, to maintain a new service in a New Technology APC until we gather sufficient claims data to assign the service to a clinically appropriate APC. Thus, a service can be assigned to a New Technology APC for more than 3 years if we have insufficient claims data to reassign the service to a clinical APC, or it could be reassigned to a clinical APC in less than 2 years if we have adequate claims data. We will continue to assess new services for potential assignment to clinical APCs before assigning them to New Technology APCs.

The procedures presented below in sections III.C.2.a., III.C.2.b., and III.C.2.c. represent services assigned to New Technology APCs for CY 2007 for which we stated in the CY 2008 proposed rule that we believed we had sufficient data to propose their reassignment to clinically appropriate APCs for CY 2008.

a. Positron Emission Tomography (PET)/Computed Tomography (CT) Scans (APC 0308)

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 were 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 approximately $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 proposed the reassignment of concurrent PET/CT scans, specifically CPT codes 78814, 78815, and 78816, to a clinical APC because we believed we had adequate claims data from CY 2006 upon which to determine the median cost of performing these procedures. Based on our proposed rule analysis of approximately 117,000 CY 2006 single claims, the median cost of PET/CT scans was approximately $1,094. We then examined approximately 34,000 single claims from CY 2006 for nonmyocardial PET scans, as described by CPT codes 78608, 78811, 78812, and 78813, and found that the median cost was also approximately $1,094. In the proposed rule, we noted 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, demonstrated that these costs were almost the same, thereby reflecting significant hospital resource equivalency between the two types of services. This result was 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 were 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.c.(5) of this final rule with comment period that would package payment for the costs of the radiopharmaceuticals utilized similarly into the payment for both PET and PET/CT scans. As stated in the proposed rule (72 FR 42705), we believe that our claims data accurately reflected the comparable hospital resources required to provide nonmyocardial PET and PET/CT procedures, and that the scans had obvious clinical similarity as well. Therefore, for CY 2008 we proposed to reassign the CPT codes for PET/CT scans to the clinical APC where nonmyocardial PET scans were also assigned, specifically APC 0308, with a proposed median cost of approximately $1,094.

We noted in the proposed rule (72 FR 42705) that we had 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 the proposed packaging approach as discussed in section II.A.4.c.(5) of the proposed rule, we proposed to package payment for the diagnostic radiopharmaceutical FDG into payment for the associated PET and PET/CT procedures. Because FDG was the most commonly used radiopharmaceutical for both PET and PET/CT scans and our single claims for these procedures included FDG more than 80 percent of the time, the packaging of this radiopharmaceutical fully maintained the clinical and resource homogeneity of the reconfigured APC 0308 that we proposed.

We received a number of public comments concerning our proposed reassignment of concurrent PET/CT scans for CY 2008. A summary of the public comments and our response follow.

Comment: Several commenters thanked CMS for proposing to increase the payment rate for concurrent PET/CT scans from the CY 2007 payment of approximately $950 to approximately $1,107 for CY 2008 and ensuring that these scans are assigned to a clinical APC with other services with similar median costs. However, these commenters were concerned that the proposed payment rate for the PET/CT scans for CY 2008 would be inadequate if the payment for the diagnostic radiopharmaceutical used in these procedures, specifically FDG, was packaged into the payment for the scans. Other commenters questioned the validity of the claims used to set the proposed payment rate for the concurrent PET/CT scan procedures. They indicated that the proposal to assign concurrent PET/CT scans from a New Technology APC to clinical APC 0308 was inappropriate and unsupported by reliable data. They believed that CMS did not have sufficient or accurate claims data to justify movement of the concurrent PET/CT services from New Technology APC 1514 to clinical APC 0308. Several

commenters suspected that the claims used to set the proposed payment rate were flawed because they believed that many hospitals had not yet updated their chargemasters to distinguish charges for the conventional nonmyocardial PET scans from charges for concurrent PET/CT scans. One commenter indicated that if CMS were to blend its own external data from the refined direct cost inputs used to establish the practice expense relative value units under the MPFS with OPPS claims data to establish a payment rate for PET/CT, the payment rate would be significantly higher than the proposed payment. Several commenters claimed that that proposed payment rate for the concurrent PET/CT procedures failed to recognize the differences in technology between the conventional nonmyocardial PET procedures and the concurrent PET/CT scans. They indicated that concurrent PET/CT scans used more advanced technology, resulting in greater capital equipment costs. Many commenters recommended that CMS continue to assign these PET/CT scans to a New Technology APC for one more year while CMS collects additional data on the cost of these procedures. Conversely, several commenters strongly urged CMS to assign the concurrent PET/CT scans to a separate clinical APC, distinct from the APC for conventional PET scans, to better reflect the incremental cost differences associated with this technology.

Response: As stated above, CPT codes 78814, 78815, and 78816 were new codes in CY 2005 and were assigned to New Technology APC 1514 with a payment rate of $1,250. We continued with this same APC assignment in CY 2006. In CY 2007, we assigned these services to a different New Technology APC, specifically New Technology APC 1511, with a payment rate of $950 in order to maintain the historical payment differential of about $100 between the conventional PET and concurrent PET/CT procedures. For CY 2007 ratesetting, we had only 9 months of claims data and public commenters were concerned that these data did not yet reflect updated and appropriate hospital charges specifically for PET/CT scans. Therefore, concurrent PET/CT scan procedures have been assigned to a New Technology APC under the OPPS since CY 2005, a period of almost 3 years.

As we have stated in other sections of this final rule with comment period, such as in section III.D., comparisons between the MPFS and OPPS payments for services are not appropriate because the MPFS applies a very different methodology for establishing the payment for the physician's office practice expenses associated with a procedure, based on direct cost inputs. Consequently, the application of the different methodologies results in different payment amounts in the two settings.

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. We disagree with the commenters' argument that we have insufficient claims data to justify movement of concurrent PET/CT scans from New Technology APC 1511 to clinical APC 0308. For this final rule with comment period, our updated claims data for concurrent PET/CT scans showed a total of over 149,000 services performed, with about 126,000 single claims available for ratesetting. The median cost for PET/CT scans alone was approximately $1,076. Similarly, we had over 40,000 total claims for conventional PET scans, with approximately 35,000 single claims available for ratesetting. The median cost for conventional PET scans alone was approximately $1,029, very close to the median cost of PET/CT scans. Based on their common clinical characteristics and the hospital resource similarity observed in our claims data for conventional PET and concurrent PET/CT scans, we believe that our claims data are sufficiently robust to support reassignment of PET/CT scans to the same clinical APC as conventional PET scans. The final median cost of APC 0308 of approximately $1,044 appropriately reflects the similar costs of both conventional PET and concurrent PET/CT scans.

After consideration of the public comments received, we are finalizing our CY 2008 proposal, without modification, to assign concurrent PET/CT scan procedures described by CPT codes 78814, 78815, and 78816 to clinical APC 0308, with a CY 2008 median cost of approximately $1,044, which includes packaged costs for diagnostic radiopharmaceuticals used in the scans. For further discussion of our final CY 2008 payment policy for diagnostic radiopharmaceuticals, refer to section II.A.4.c.(5) of this final rule with comment period.

b. IVIG Preadministration-Related Services (APC 0430)

In CY 2006, we created the temporary HCPCS 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/ASC 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 proposed 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 noted we had 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. For the CY 2008 OPPS/ASC proposed rule, our claims data for this high volume service showed a total of over 49,000 services performed, with about 48,000 single claims available for ratesetting. Therefore, we proposed to reassign HCPCS code G0332 to new clinical APC 0430 (Drug Preadministration—Related Services) for CY 2008, with a proposed median cost of approximately $39, where it would be the only service assigned to the APC at this time.

As noted in the proposed rule (72 FR 42705), 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 we did not make a determination about the appropriateness of continuing separate OPPS payment for HCPCS code G0332 after CY 2008, we stated in the proposed rule (72 FR

42705) that we would consider packaging payment for HCPCS code G0332 in future years if we determined that separate payment was no longer warranted. We intend to reevaluate the appropriateness of separate payment for IVIG 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.

We received a number of public comments on our CY 2008 proposed payment for IVIG preadministration-related services. A summary of the public comments and our response follow.

Comment: Many commenters questioned the accuracy and reliability of the CY 2006 hospital outpatient claims data that were used to set the proposed payment rate for HCPCS code G0332. Some commenters indicated that because HCPCS code G0332 was a new code for CY 2006, it was clearly not well understood by many hospitals, and as a result, it took some time for hospitals to appropriately determine the cost and the reported charge for the service. Many commenters stated that the proposed payment rate of $39 was likely based on flawed data, and as such, the data should not be used as a basis for reassigning HCPCS code G0332 from New Technology APC 1502 to APC 0430. These commenters believed that the low payment rate was due to underreporting of this service because their findings revealed that hospitals reported HCPCS code G0332 on only 49 percent of the claims for IVIG administration. One commenter believed that, based on an analysis of its hospital system's claims data for HCPCS code G0332, that claims data were distorted due to a number of factors, including revenue code selections by hospitals, differences in the CCRs mapped to those revenue codes, and the actual dollar charges reported by hospitals for this service. Several commenters explained that hospitals set widely varying charges for HCPCS code G0332, and some of these commenters believed that it would be appropriate to exclude from the ratesetting process claims where the reported charge is equal to or less than the $75 payment rate.

Many commenters believed that reducing this add-on payment would have a negative impact on patient access to care, considering the short supply and high costs of acquiring IVIG. Several commenters suggested that CMS should maintain the $75 add-on payment for HCPCS code G0332 to maintain parity with the proposed $71 MPFS payment rate for this service. These commenters asserted that establishing a difference in payment for HCPCS code G0332 across systems could drive patients from one site of service to another. They further believed that maintaining payment parity for the service at comparable levels across these sites of service would mitigate potential disruptions to the sites of service where patients are now receiving care and would also allow the choice of site of care to be dictated by particular patient circumstances. Several commenters commended CMS for continued support in extending the add-on payment for HCPCS code G0332; however, they recommended that the $75 separate payment under New Technology APC 1502 be continued for another year. Alternatively, several commenters requested that CMS reassign HCPCS code G0332 to a clinical APC whose payment rate is equivalent to $75 to ensure that hospitals would continue to be paid appropriately for the full range of costs incurred in furnishing IVIG to their patients and to help mitigate the possible adverse financial impact on hospitals acquiring IVIG that could result from a lower payment for preadministration-related services.

Response: Just as our payment rates are updated annually, so too are billing codes (that is, ICD–9–CM, Level II HCPCS, and CPT). Annual updates to the HCPCS coding system (whether through addition of a new code, revision of a code descriptor, or deletion of a code), are a well–established and predictable process that has been in place for some time. Hospitals are well aware of this practice because they have successfully implemented these changes each year.

The MPFS applies a distinct methodology for establishing the payment for the physician's office practice expenses associated with a procedure that differs significantly from the OPPS methodology which generally pays based on relative payment weights calculated from hospitals' costs as determined from claims data. The application of the different methodologies results in different payment amounts in the two settings. Therefore, comparisons between OPPS and MPFS payments are not appropriate.

In determining the CY 2008 final rule median cost of approximately $37 for HCPCS code G0332, we used the most recent claims data available under the OPPS, specifically CY 2006 claims. According to our standard OPPS methodology as described in section II.A.2. of this final rule with comment period, we excluded claims for HCPCS code G0332 where the line-item charge was exactly equal to the CY 2006 payment rate, a process we followed for all OPPS services. We did not remove claims whose charges were less than $75 because hospitals are free to set their own charges for individual services based on their own judgment.

Under the OPPS, the current payment methodology for IVIG treatments consists of three components, which include payment for the drug itself (described by a HCPCS J code), administration of the IVIG product (described by one or more CPT codes), and the preadministration-related services (HCPCS code G0332). As stated previously, this service has been assigned to New Technology APC 1502 under the OPPS for 2 full years. 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. We do not agree with the commenters' argument that underreporting of this service in CY 2006 is a compelling rationale for delaying reassignment to a clinical APC. Our CY 2006 claims data include approximately 59,000 total claims for HCPCPS code G0332, and we have no reason to believe those claims do not accurately represent the costs to hospitals of providing the service in CY 2006. We believe that the approximately 57,000 single claims used to set the CY 2008 median cost of IVIG preadministration-related services at approximately $37 accurately reflect hospitals' costs for the service and that the final CY 2008 payment rate for HCPCS code G0332 is adequate to ensure access to IVIG therapy.

After consideration of the public comments received, we are finalizing our CY 2008 proposal, without modification, to assign HCPCS code G0332 to APC 0430, with a median cost of approximately $37. As we stated previously, we will 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 IVIG 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

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 final rule with comment period, there are five procedures currently assigned to New Technology APCs for CY 2007 for which we believed we also had data that were adequate to support their reassignment to clinical APCs. For CY 2008, we proposed 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 were displayed in Table 29 of the proposed rule. This table has been reproduced as Table 16 at the end of this section and updated with the final status indicators, APC assignments, and median costs of these services.

(1) Breast Brachytherapy Catheter Implantation (APC 0648)

For CY 2008, we proposed to reassign CPT code 19298 (Placement of radiotherapy afterloading 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) from New Technology APC 1524 (New Technology—Level XXIV ($3,000–$3,500)) to APC 0648 (Level IV Breast Surgery), with a proposed median cost of approximately $3,417.

We received several public comments concerning the proposed reassignment of CPT code 19298. A summary of the public comments and our response follow.

Comment: Several commenters agreed with CMS's proposal to reassign CPT code 19298 to APC 0648. They acknowledged that this proposed reassignment of CPT code 19298 would place the three surgical codes for the placement of catheters for breast brachytherapy in the same APC, that is, CPT codes 19296 (Placement of radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy); 19297 (Placement of radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; concurrent with partial mastectomy (List separately in addition to code for primary procedure)); and 19298.

Response: We thank the commenters for their input and support. Because of its clinical and resource characteristics similar to those other procedures also assigned to APC 0648, we are finalizing our CY 2008 proposal, without modification, to reassign CPT code 19298 to APC 0648, with a median cost of approximately $3,560.

(2) Preoperative Services for Lung Volume Reduction Surgery (LVRS) (APCs 0209 and 0213)

As illustrated in Table 16 below, CY 2008, we proposed to reassign HCPCS codes G0302 (Pre operative pulmonary surgery services for preparation for LVRS, complete course of services, to include a minimum of 16 days of services) and G0303 (Pre-operative pulmonary surgery services for preparation for LVRS, 10 to 15 days of services) to APC 0209 (Level II Extended EEG and Sleep Studies). For CY 2008, we also proposed to reassign HCPCS codes G0304 (Pre-operative pulmonary surgery services for preparation for LVRS, 1 to 9 days of services) and G0305 (Post-discharge pulmonary surgery services after LVRS, minimum of 6 days of services) to APC 0213 (Level I Extended EEG and Sleep Studies).

We did not receive any public comments on these two proposals and, therefore, we are finalizing our CY 2008 proposals for HCPCS codes G0302, G0303, G0304, and G0305 without modification. Specifically, HCPCS codes G0302 and G0303 are assigned to APC 0209, with a CY 2008 median cost of approximately $710. HCPCS codes G0304 and G0305 are assigned to APC 0213, with a CY 2008 median cost of approximately $145.

TABLE 16.—FINAL 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	Final CY 2008 SI	Final CY 2008 APC	Final CY 2008 APC median cost
19298	Place breast rad tube/caths	S	1524	$3,250	T	0648	$3,560
G0302	Pre-op service LVRS complete	S	1509	750	S	0209	710
G0303	Pre-op service LVRS 10–15 dos	S	1507	550	S	0209	710
G0304	Pre-op service LVRS 1–9 dos	S	1504	250	S	0213	145
G0305	Post op service LVRS min 6	S	1504	250	S	0213	145

D. APC–Specific Policies

1. Cardiac Procedures

a. Cardiac Computed Tomography and Computed Tomographic Angiography(APCs 0282 and 0383)

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 were shown in Table 31 of the proposed rule, 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. In CY 2006, the CCT and CCTA procedure codes were 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). We did not receive any public comments on the interim APC assignments.

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 public 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. In the CY 2008 OPPS/ASC proposed rule (72 FR 42711), we reiterated that we would 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 explained that 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.

During the development of the CY 2008 proposed rule, we noted that analysis of our hospital data for claims submitted for CY 2006 indicated that CCT and CCTA procedures were performed relatively frequently on Medicare patients. Our claims data showed 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 at that time, we believed we had 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 saw no rationale for reassigning these procedures to New Technology APCs in CY 2008, when we had claims-based cost information regarding these procedures, and they were clinically similar to other procedures paid under the OPPS.

We acknowledged the concerns that had been expressed to us regarding the clinical homogeneity of APCs 0376, 0377, and 0398, where some of the CCT and CCTA were assigned for CY 2007 along with nuclear medicine cardiac imaging procedures. Because we proposed 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.c.(5) of this final rule with comment period, we believed 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 proposed 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 17 below. The proposed median cost of approximately $314 for APC 0383 was based entirely on claims data for CPT codes 0145T, 0146T, 0147T, 0148T, 0149T, and 0150T that described CCT and CCTA services, a clinically homogeneous grouping of services. In addition, the individual median costs of these services ranged from a low of approximately $277 to a high of $437, reflecting their hospital resource similarity as well. We proposed 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 resulted in a CY 2008 proposed APC median cost of about $105.

We received a number of public comments concerning our CY 2008 proposals for CCT and CCTA procedures. A summary of the public comments and our responses follow.

Comment: While several commenters expressed appreciation for the proposed reassignment of CCT and CCTA procedures into their own clinically homogenous APC groups, many commenters disagreed with the proposal to reassign these services from APCs 0282, 0376, 0377, and 0398 to APCs 0282 and 0383 for CY 2008. These commenters were especially concerned with the proposed payment rates for these procedures and asserted that the proposed median costs of $105 for APC 0282 and $314 for APC 0383 were inadequate because they were based on limited data, thereby undervaluing these new technology services. The commenters further believed that the CY 2008 proposed payment rates of $107 for APC 0282 and $318 for APC 0383 were unreasonably low based on only 16,000 total procedures, with about 11,000 single claims used for ratesetting. Some commenters pointed out that the

first year in which the new procedures were specifically reported by hospitals was CY 2006. They argued that because it takes time for hospitals to completely capture and report the full costs associated with new procedures in their charges, hospitals could not have reported these services accurately in CY 2006. One commenter believed that because most hospitals do not specifically allocate capital costs to the cost centers involved, the CCRs used to convert charges to costs for CCT and CCTA procedures were likely understated.

Many commenters expressed concern that there had not been sufficient time to develop accurate and reliable claims data for these new procedures and that additional measures were necessary to ensure appropriate payments. Some commenters recommended that CMS delay the implementation of the CY 2008 median costs until a full year of claims data were available from both multiple and single claims and suggested that CMS continue with the CY 2007 APC assignments for CCT and CCTA procedures. They argued that inadequate payment rates would unintentionally encourage the use of more expensive and invasive diagnostic procedures for Medicare beneficiaries. Some commenters further requested that CMS consult with stakeholders and utilize external data to determine the degree to which OPPS claims data accurately reflected the relative resource costs of these procedures and to make appropriate adjustments to the payment rates, especially for APC 0383. Other commenters requested that CMS reassign the CCT and CCTA procedures to appropriate New Technology APCs for CY 2008.

Some commenters requested that CMS reconsider the reassignment of CPT codes 0144T and 0151T whose median costs varied significantly, from $86 and $144, respectively, because these services did not appear to be clinically appropriate when compared to the other procedures assigned to APC 0282.

Response: While we acknowledge that the CPT codes for CCT and CCTA procedures were new for January 2006, we disagree with the commenters' argument that our claims data are inadequate to support the reassignment of CCT and CCTA procedures to clinical APCs for CY 2008 based on hospital costs derived from claims. We used the approximately 12,000 single bills available for this final rule with comment period in determining the median costs for the CCT and CCTA procedures because the single bills provide us with the most accurate costs that are the foundation of our standard OPPS ratesetting methodology. As we discuss in section II.A.1.b. of this final rule with comment period, we are unable to appropriately allocate packaged costs on multiple procedure claims so we generally are not able to use them in setting payment rates. As we also discuss in that section, we are continuing to work on additional methodologies that would allow us to use claims data from more OPPS claims. While we recognize that reliance on single procedure claims may result in the use of fewer claims for some services than for others, in the case of CCT and CCTA procedures, in particular, we were able to use about two-thirds of all approximately 18,000 claims for ratesetting. These services were reported by many hospitals in CY 2006, and we have no reason to believe that costs based upon this large percentage of all claims do not accurately reflect the resource costs of these services to hospitals. Our standard OPPS methodology determines the relative costs of services from claims, with a specific focus on relative costs and not absolute costs, and we do not believe there is any need for us to utilize external data to determine the costs of these services. Additionally, we do not agree with the commenters' suggestion to place the CCT and CCTA procedures in New Technology APCs. We believe that, based on the clinical characteristics and resource use calculated from CY 2006 claims for CCT and CCTA procedures, our proposal would assign them to appropriate clinical APCs for CY 2008. In fact, several commenters acknowledged that the proposed APC assignments of these procedures were appropriate based on explicit consideration of clinical homogeneity.

Further, in the case of CPT codes 0144T and 0151T, the commenters mistakenly believed that the CY 2008 OPPS median costs for these procedures were $86 and $144, respectively. The CY 2008 proposed rule median cost for CPT code 0144T was approximately $68 and approximately $43 for CPT code 0151T, and their final rule median costs are approximately $68 and $54, respectively. The $86 and $144 figures reported by some commenters were based on the procedures' mean costs, not the median costs which are used for ratesetting under the OPPS. We believe that CPT codes 0144T and 0151T are appropriately assigned to APC 0282 as their median costs fall within the range of costs of other procedures also assigned to the APC, which has a final median cost of approximately $100.

Comment: Some commenters were uncertain as to whether the costs of the contrast agents used in conjunction with CCT and CCTA procedures were included in the proposed payment rate calculations for APCs 0282 and 0383. They requested that CMS address this issue in this final rule with comment period. The commenters requested that CMS increase the payment rates for APCs 0282 and 0383 if the costs of the contrast agents were not included in the proposed payment rates.

Response: The proposed payment rates for APCs 0282 and 0383 included the costs of the contrast agents, because, as discussed further in section II.A.4.c.(6) of this final rule with comment period, we proposed to package payment for all contrast agents for CY 2008. Our final CY 2008 policy packages payment for all contrast agents and, therefore, the final payment rates for CCT and CCTA procedures include these costs.

After consideration of the public comments received, we are finalizing our CY 2008 proposal, without modification, to assign CCT and CCTA procedures to APCs 0282 and 0383, with CY 2008 median costs of approximately $100 and approximately $296, respectively. The final CY 2008 APC assignments and APC median costs for the specific CCT and CCTA procedures are displayed in Table 17.

TABLE 17.—FINAL CY 2008 APC ASSIGNMENTS OF CCT AND CCTA PROCEDURES

HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	CY 2007 APC median cost	Final CY 2008 SI	Final CY 2008 APC	Final CY 2008 APC median cost
0144T	CT heart wo dye; qual calc	S	0398	$252	S	0282	$100
0145T	CT heart w/wo dye funct	S	0376	305	S	0383	296
0146T	CCTA w/wo dye	S	0376	305	S	0383	296
0147T	CCTA w/wo, quan calcium	S	0376	305	S	0383	296
0148T	CCTA w/wo, strxr	S	0377	397	S	0383	296

TABLE 17.—FINAL CY 2008 APC ASSIGNMENTS OF CCT AND CCTA PROCEDURES—Continued

HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	CY 2007 APC median cost	Final CY 2008 SI	Final CY 2008 APC	Final CY 2008 APC median cost
0149T	CCTA w/wo, strxr quan calc	S	0377	397	S	0383	296
0150T	CCTA w/wo, disease strxr	S	0398	252	S	0383	296
0151T	CT heart funct add-on	S	0282	94	S	0282	100

b. Coronary and Non-Coronary Angioplasty (PTCA/PTA) (APCs 0082, 0083, and 0103)

For CY 2008, we proposed to delete APC 0081 (Noncoronary Angioplasty or Atherectomy) as a result of the effects of the proposed CY 2008 packaging approach on median costs (see section II.A.4.c. of this final rule with comment period for more discussion of our packaging approach). We proposed to reassign the procedures that mapped to this APC in CY 2007 to APCs that would be homogeneous with respect to clinical characteristics and resource use in CY 2008, specifically APCs 0082 (Coronary or Non-Coronary Atherectomy), 0083 (Coronary or Non-Coronary Angioplasty and Percutaneous Valvuloplasty), and 0103 (Miscellaneous Vascular Procedures). The CY 2008 proposed payment rates for these APCs were approximately $5,654, $2,934, and $972, respectively. The CY 2007 payment rate for APC 0081 was approximately $2,639.

We received one public comment on our CY 2008 proposal to delete APC 0081 and reassign the procedures that mapped to this APC to APCs 0082 and 0083. A summary of the public comment and our response follow.

Comment: One commenter stated that the proposed reassignment of some of the angioplasty procedures assigned to APC 0081 in CY 2007 to APC 0083 in CY 2008 fails to recognize the differences in median costs associated with the use of specialty balloons in certain coronary and non-coronary angioplasty (PTCA/PTA) procedures. According to the commenter, specialty balloons are defined as balloons that can be used for purposes other than inflation and deflation (eg, cutting balloons and cold therapy balloons). The commenter estimated from an analysis of the CY 2006 Medicare claims data that the median costs for PTCA/PTA procedures involving specialty balloons are approximately 55 percent higher than the median costs of all PTCA/PTA procedures in APC 0083, and represent approximately 4 percent of the cases. The commenter expressed concern that inadequate payment for PTCA/PTA procedures involving specialty balloons could reduce beneficiary access to this technology.

The commenter urged CMS to reconsider its proposal to reassign all PTCA/PTA procedures to APC 0083. Specifically, the commenter requested that CMS establish a HCPCS Level II G-code to differentiate coronary and noncoronary PTCA/PTA procedures using specialty balloons from those PTCA/PTA procedures using standard, nonspecialty balloons, defining specialty balloons as those which have a median reported cost of more than $800 based on CY 2006 hospital claims containing the Level II HCPCS C-code for PTCA/PTA balloons, C1725 (Catheter, transluminal angioplasty, non-laser). The commenter stated that nonspecialty balloons cost approximately $200 to $400. According to the commenter's suggestion, the new G-code would map to a new APC for coronary and noncoronary angioplasty procedures using specialty balloons, the payment for which would be based upon the median cost of procedures performed using specialty balloons, as indicated on CY 2006 claims by the reporting of C1725 where the reported catheter cost is more than $800.

Response: We believe that the proposed reassignment of the procedures assigned to APC 0081 in CY 2007 to APC 0083 in CY 2008 is appropriate, both in terms of the clinical similarities and resource costs of the procedures involved. The HCPCS-specific median costs of significant procedures assigned to APC 0083 range from approximately $2,621 to $4,339. Even considering the information provided by the commenter about the expected differential cost between specialty and non-specialty balloons of $400 to $600, we would not expect Medicare beneficiaries to have problems with access to procedures with specialty balloons, when the APC 0083 CY 2008 median cost is approximately $2,855. Packaging payment for the variety of implantable devices that are used in specific procedures is a well-established principle of the OPPS, and we expect that hospitals will carefully consider the clinical benefits and costs of all technologies when performing procedures on patients. Therefore, we also believe that a policy to provide different payments for PTCA/PTA procedures involving specialty balloons would not be consistent with our overall strategy to encourage hospitals to use resources more efficiently by increasing the size of the payment bundles. If the use of a very expensive device in a clinical scenario, such as a specialty balloon, caused a specific procedure to be much more expensive for the hospital than the APC payment, we consider such a case to be the natural consequence of a prospective payment system that anticipates that some cases will be more costly and others less costly than the procedure payment. We will continue to monitor the costs of PTCA/PTA procedures over time based on the evolution of clinical practice and will consider proposing future modifications to the configuration of APC 0083 as necessary.

After consideration of the public comment received, we are finalizing our CY 2008 proposal, without modification, to reassign angioplasty procedures assigned to APC 0081 in CY 2007 to APC 0083 in CY 2008. The median cost of APC 0083 is approximately $2,855.

c. Implantation of Cardioverter-Defibrillators (APCs 0107 and 0108)

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) for CY 2008 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 was 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. Table 34 included in the CY 2008 OPPS/ASC proposed rule presented a historical summary of all single claim median costs. (For purposes of this analysis, we displayed the median costs for all single claims without regard to adjustment or to whether the claims met various selection criteria; these were not the median costs on which proposed payments were based.)

Hospitals have consistently indicated that they would prefer to report services furnished using the CPT codes that describe them, rather than the Level II HCPCS 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.

In the CY 2008 OPPS/ASC proposed rule (72 FR 42715), we stated our belief 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 proposed 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.

We received a number of public comments on our CY 2008 proposal for reporting ICD implantation procedures under the OPPS. A summary of the public comments and our responses follow.

Comment: Several commenters supported implementing the policy as proposed. One commenter favored the elimination of the Level II HCPCS codes for ICD implantation, citing the administrative burden these pose for hospitals, but remained concerned about the potential negative impact to hospitals when the more expensive dual chamber device is used for Medicare beneficiaries. The commenter suggested that CMS should consider creation of composite APCs for device-dependent procedures, such as ICD implantation, where the device costs can vary significantly based on the type of device used. The commenter suggested that payment for these composite APCs would be based on the combination of the device implantation CPT code and the existing Level II HCPCS code for the particular device. According to the commenter, this would minimize the administrative burden for providers, allow coding to remain consistent across payers, and enable more appropriate payment for procedures with varying device costs.

Response: Composite APCs provide a single payment for two or more major procedures that are commonly performed together, in order to promote efficiency by increasing the size of the payment bundle. We do not agree that the payment methodology outlined by one commenter, to base payment for ICDs on the combination of the ICD implantation CPT code and the existing device code, is consistent with the concept of composite APCs as described in the proposed rule and as finalized in section II.A.4.d. of this final rule with comment period. The scenario described by the commenter largely describes the current packaging of device payment into the payment for the procedure, except that we generally base payment on all of the devices associated with a procedure as a mechanism to promote the efficient utilization of resources. The recommended approach could actually reduce packaging under the OPPS by creating small and more specific payment bundles, rather than increasing the size of the payment bundles to provide hospitals with the flexibility to manage their resources as they control costs. To establish a separate APC for each combination of a procedure and a particular device used, as described by the commenter, would create incentives for the use of the most expensive device rather than creating incentives for efficiency and therefore is contrary to the principles of a prospective payment system. As described above, we believe that the payment for the procedures and associated devices included in APCs 0107 and 0108 is appropriate, as the differences between the median costs for the two Level II HCPCS codes currently assigned to each APC do not currently support differential APC assignments for single and dual chamber ICD insertion procedures.

After consideration of the public comments received, we are adopting the March 2007 APC Panel recommendation and finalizing our CY 2008 proposal, without modification, to delete the Level II HCPCS codes (G0297, G0298, G0299, and G0300) for ICD insertion procedures and require hospitals to bill the appropriate CPT codes for ICD insertion, specifically CPT code 33240 or CPT code 33249, as appropriate, along with the applicable device C-codes, for payment under the OPPS in CY 2008.

d. Removal of Patient-Activated Cardiac Event Recorder (APC 0109)

In the CY 2008 OPPS/ASC proposed rule, we proposed to continue our CY 2007 assignment of CPT code 33284 (Removal of an implantable, patient-activated cardiac event recorder) to APC 0109 (Removal/Repair of Implanted Devices), with a proposed CY 2008 payment rate of approximately $389. The CY 2007 payment rate for this service is approximately $676.

We received one public comment on the CY 2008 proposed reconfiguration of APC 0109. A summary of the public comment and our response follow.

Comment: One commenter requested that CMS reexamine its proposed assignment of CPT code 33284 to APC 0109 in light of the proposed reassignment of CPT codes 36575 (Repair of tunneled or non-tunneled central venous access catheter, without subcutaneous port or pump, central or peripheral insertion site) and 36589 (Removal of tunneled central venous catheter, without subcutaneous port or pump) from APC 0621 (Level I Vascular Access Procedures) to APC 0109 for CY 2008. The commenter asserted that the proposed inclusion of CPT codes 36575 and 36589 in APC 0109 significantly altered the proposed median cost of APC 0109, to the extent that it was no longer representative of the resource requirements of CPT code 33284. The commenter requested that CMS create a separate APC for CPT code 33284 if CMS finalizes its proposal to reassign CPT codes 36575 and 36589 to APC 0109.

Response: We agree with the commenter that the change in composition of APC 0109 may no longer most accurately reflect the resource characteristics of CPT code 33284. CPT codes 36575 and 36589 have median costs of approximately $319 and $357, respectively, while CPT code 33284 has a median cost of approximately $682. While we appreciate the commenter's suggestion for a new APC for CPT code 33284, we believe that an existing clinical APC may sufficiently account for the clinical and resource characteristics of the procedure described by CPT code 33284. The clinical characteristics of CPT code 33284 are similar to those procedures in APC 0020 (Level II Excision/Biopsy). CPT code 33284 and the other procedures assigned to APC 0020 generally require surgical incisions, local anesthesia, and suturing. In addition, we believe that APC 0020, with an APC median cost of approximately $546, more closely aligns with the resources of CPT code 33284, rather than its proposed assignment to APC 0109, with an APC median cost of approximately $356.

After consideration of the public comment received, we are not finalizing our CY 2008 proposal to assign CPT code 33284 to APC 0109. Instead, we are reassigning CPT code 33284 to APC 0020 for CY 2008, with a median cost of approximately $546.

e. Stress Echocardiography (APC 0697)

In the CY 2008 OPPS/ASC proposed rule, we proposed to assign 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) to APC 0697 (Level I Echocardiogram, Except Transesophageal), with a proposed payment rate of approximately $306. Currently, this service is assigned to APC 0269 (Level II Echocardiogram Except Transesophageal), with a payment rate of approximately $198 for CY 2007. The proposed packaging approach for CY 2008, as described further in section II.A.4.c. of this final rule with comment period, proposed to package significant additional costs for ancillary and supportive services into the CY 2008 payment for CPT code 93350.

We received a few public comments concerning our CY 2008 proposed reassignment of CPT code 93350 to APC 0697. A summary of the public comments and our response follow.

Comment: A few commenters requested that we continue to assign CPT code 93350 to APC 0269, instead of reassigning this procedure to APC 0697 as proposed. The commenters stated that the Level II APC is a more appropriate placement, as the procedure is comparable in clinical and resource characteristics to CPT code 93307 (Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recoding; complete) that CMS proposed to retain in APC 0269.

Response: We have a significantly greater number of single and ''pseudo'' single claims available for CPT code 93350 for this final rule with comment period than we had for the proposed rule because, in response to the request of commenters, we added CPT code 93017 (Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; tracing only, without interpretation or report) to the final CY 2008 bypass list, as described in section II.A.1.b. of this final rule with comment period. By adding CPT code 93017 to the CY 2008 bypass list, we did not attribute any packaged services that may be on the claim to this procedure, and we were therefore able to create single and ''pseudo'' single claims from claims that would have otherwise been considered multiple procedure claims. The availability of additional claims for ratesetting and our final policy for paying for contrast and nonconstrast echocardiography through different APCs also contribute to the differences between the final rule median costs and the proposed rule median costs for echocardiography CPT codes.

For CY 2008, we are establishing a new APC for echocardiograms with contrast as described in section II.A.4.c.(6) of this final rule with comment period, specifically APC 0128 (Echocardiogram with Contrast). The median cost of CPT code 93350 for contrast studies is approximately $527, while the median cost of CPT code 93307 for contrast studies is approximately $545. When these studies are performed with contrast in CY 2008, they will be reported with HCPCS codes C8928 (Transthoracic echocardiography with contrast, 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); and C8923 (Transthoracic echocardiography with contrast, real-time with image documentation (2D) with or without M-mode recording; complete), respectively. Both of these C-codes are assigned to new APC 0128 based on their clinical and resource comparability, with a CY 2008 median cost of approximately $534.

For this final rule with comment period, we have over 88,000 single bills for noncontrast studies reported with CPT code 93350 that have an updated median cost of approximately $374. This median cost is quite close to the final rule median cost of CPT code 93307 for noncontrast studies of approximately $404. We agree with the commenters that CPT code 93350 for noncontrast studies is more appropriately placed in the Level II noncontrast APC that has a median cost of approximately $401, and where CPT code 93307 is also assigned. The two procedures are clinically similar, both representing comprehensive transthoracic echocardiography services.

Therefore, after consideration of the public comments received, we are not

finalizing our proposal to assign noncontrast studies reported with CPT code 93350 to APC 0697, which has the new APC title of ''Level I Echocardiogram Without Contrast Except Esophageal''. Instead, we are retaining the assignment of CPT code 93350 for noncontrast studies to APC 0269, which has the new APC title of ''Level II Echocardiogram Without Contrast Except Transesophageal,'' because we believe this procedure is clinically similar to other procedures in the Level II APC and the median costs indicate that the noncontrast studies in this APC require similar hospital resources as well. Contrast studies reported with the corresponding C-code to CPT code 93350, specifically C8928, are assigned to APC 0128, with a CY 2008 median cost of approximately $534.

f. Coronary or Non-Coronary Atherectomy (APC 0082)

Currently, APC 0082 is titled ''Coronary Atherectomy'' and contains only two CPT codes: 92995 (Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; single vessel) and 92996 (Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)). We proposed to reconfigure APC 0082 for the CY 2008 OPPS by adding 11 CPT codes, most of which were for percutaneous atherectomy procedures, and to change its title to ''Coronary or Non-Coronary Atherectomy'', as shown in Addendum A to the proposed rule (72 FR 42838), to better reflect the composition of procedures that we proposed to assign to this APC. The CY 2008 proposed payment rate for APC 0082 was approximately $5,654, while its CY 2007 payment rate is approximately $4,438.

We received one public comment on the CY 2008 proposed reconfiguration of APC 0082. A summary of the public comment and our response follow.

Comment: A commenter objected to the proposed composition of APC 0082 on the basis that it includes both coronary and noncoronary atherectomy procedures, as a result of the proposed packaging of imaging supervision and interpretation CPT codes. The commenter stated that, as proposed, APC 0082 no longer contains services that are comparable clinically and with respect to resource use and, therefore, believed that the coronary and noncoronary services should not be assigned to the same APC. The commenter indicated that treatment of peripheral vascular disease is more diffuse, requires a different approach, and utilizes different resources than treatment of coronary disease. The commenter noted that it could not determine if the proposed payment rate for APC 0082 is appropriate, due to the proposed packaging of imaging supervision and interpretation codes for the noncoronary atherectomy procedures, and questioned whether the claims data could accurately reflect the costs associated with these different procedures.

Response: We believe that there is sufficient clinical homogeneity among all the services that we proposed to assign to APC 0082 for the CY 2008 OPPS and that the resources that those services require are sufficiently similar to justify assigning coronary and noncoronary atherectomy procedures to the same clinical APC. The CY 2006 claims data show that CPT codes 92995 and 92996 are very uncommon services in the HOPD, as they have a total combined frequency of 159 services for CY 2006. Moreover, the median costs for these codes (approximately $5,696 for CPT code 92995 and $3,924 for CPT code 92996) are very comparable to the median costs for the two highest volume noncoronary atherectomy codes in APC 0082: CPT code 35493 (Transluminal peripheral atherectomy, percutaneous; femoral-popliteal), which has a total frequency of 8,473 and a median cost of approximately $5,956; and CPT code 37204 (Transcatheter occlusion or embolization (e.g., for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck), which has a total frequency of 5,789 and a median cost of approximately $4,867. The CY 2008 OPPS median cost for APC 0082 (with correct devices, no token claims, and no claims with the ''FB'' modifier) is approximately $5,506 and the total frequency of services in the APC is 18,357.

There are no HCPCS codes in APC 0082, as proposed, that would cause the APC to violate the 2 times rule. We believe that it is appropriate to reassign the noncoronary atherectomy procedures to APC 0082 because we believe that the clinical characteristics and resource costs are sufficiently similar to warrant their placement in the same APC with coronary atherectomy procedures. We recognize that the similar resource costs may result, to some extent, from the packaging of guidance and imaging supervision and interpretation services under the CY 2008 OPPS. However, even absent our proposal to increase packaging for the CY 2008 OPPS, the median cost of virtually all codes for procedural services contains some costs for packaged services. Moreover, the movement of codes from one APC to another occurs for a variety of reasons, including changes in packaging from one year to another. In addition, as discussed further in section II.A.2. of this final rule with comment period, we proposed 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 APCs, with a particular focus on APCs with total frequencies of less than 1,000. APC 0082, as configured for CY 2007, includes only 232 services. Therefore, the reconfiguration of APC 0082 for CY 2008, as a result of increased costs that occur with more packaging and our effort to minimize the number of low volume APCs, among other reasons, is a normal occurrence in the course of updating the OPPS from one year to another.

After consideration of the public comment received, we are finalizing our CY 2008 proposal, without modification, to reconfigure APC 0082 as proposed, with a median cost of approximately $5,506.

2. Gastrointestinal Procedures

a. Computed Tomographic Colonography (APC 0332)

For CY 2008, we proposed to reassign diagnostic computed tomographic colonography, specifically described by CPT code 0067T (Computed tomographic (CT) colonography (i.e., virtual colonoscopy); diagnostic), from APC 0333 (Computed Tomography without Contrast followed by Contrast) to APC 0332 (Computed Tomography without Contrast), with a proposed payment rate of approximately $201.

We received several public comments concerning this proposal. A summary of the public comments and our response follow.

Comment: Several commenters requested that CMS continue the CY 2007 APC assignment for CPT code 0067T, specifically APC 0333, rather than reassign it to APC 0332 for CY 2008 as proposed.

Response: CPT code 0067T was implemented on January 1, 2005, and initially assigned to APC 0332. As part of our annual APC review process, we subsequently reassigned CPT code 0067T to APC 0333 in CY 2006 and continued this APC assignment in CY 2007. Based on analysis of the CY 2006

hospital outpatient claims data, we proposed to reassign CPT code 0067T to APC 0332 for CY 2008 based on clinical homogeneity and resource considerations. Specifically, our hospital outpatient claims data from CY 2006 showed a median cost of approximately $164 for CPT code 0067T based on 1,421 single claims (of 1,904 total claims). Based on the median costs of the significant procedures assigned to APC 0332 for CY 2008, which range from $164 to $227, we believe that CPT code 0067T most closely resembles other noncontrast CT procedures also assigned to APC 0332. We do not agree with the commenters' recommendation that APC 0333 is the most appropriate APC assignment for CPT code 0067T because the median cost of approximately $322 for APC 0333, which contains significant procedures with HCPCS-specific median costs ranging from about $272 to $359, is much higher than the median cost of CPT code 0067T. In addition, as discussed in section II.A.4.c. of this final rule with comment period, we are finalizing our proposal to package payment for all contrasts agents in CY 2008. Because the CT scans assigned to APC 0333 for CY 2008 all include the administration of contrast and CT colonography is a noncontrast study, we believe 0067T is most appropriately assigned to APC 0332, where other noncontrast CT scans reside.

After consideration of the public comments received, we are finalizing, without modification, the proposed assignment of CPT code 0067T to APC 0332, with a median cost of about $189 for CY 2008.

b. Laparoscopic Neurostimulator Electrode Implantation (APC 0130)

In the CY 2008 OPPS/ASC proposed rule, we proposed to continue our CY 2007 assignment of CPT code 43647 (Laparoscopy, surgical; implantation or replacement of gastric neurostimulators electrodes, antrum) to APC 0130 (Level I Laparoscopy), with a proposed payment rate of approximately $2,217. CPT code 43647 was a new code for CY 2007, so it received an interim final CY 2007 assignment to APC 0130, with a payment rate of approximately $1,975. In addition, during the September 2007 meeting of the APC Panel, the Panel recommended that CMS reevaluate its decision to assign the device-dependent procedure described by CPT code 43647 to APC 0130 because the procedure requires a device and APC 0130 is not a device-dependent APC. We accepted the APC Panel recommendation and reassessed the proposed CY 2008 APC assignment of CPT code 43647 for this final rule with comment period. We respond to this recommendation below.

We received a number of public comments on our interim final CY 2007 and proposed CY 2008 assignments of CPT code 43647 to APC 0130, both on the CY 2007 OPPS/ASC final rule with comment period and on the CY 2008 OPPS/ASC proposed rule. A summary of the public comments and our response follow.

Comment: A few commenters objected to our assignment of CPT code 43647 to APC 0130, stating that APC 0130 does not accurately reflect the clinical and cost characteristics of CPT code 43647. The commenters noted that APC 0130 includes procedures for implanting minor devices that have modest costs, while the laparoscopic implantation of gastric neurostimulator electrodes is an invasive procedure that is comparable to the surgical implantation of neurostimulator electrodes via incision or laminectomy procedures that are assigned to APC 0061 (Laminectomy or Incision for Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve). The commenters requested that we assign CPT code 43647 to APC 0061, which they believed more accurately reflects the clinical and resource aspects of this procedure. In addition, the commenters noted that if CPT code 43647 is reassigned to APC 0061, then all peripheral neurostimulator lead implantations would be assigned to the same APC.

Response: We have no hospital claims data for CPT code 43647 because the code was new for CY 2007. However, we agree with the commenters that CPT code 43647 would be expected to have device costs that are similar to other procedures assigned to APC 0061 for CY 2007 because all of these procedures implant neurostimulator electrodes. In particular, the device percentage of device-dependent APC 0061 is about 60 percent, so that assignment of CPT code 43647 to an APC in the laparoscopic APC series as proposed may not provide the most appropriate payment for the procedure. While CPT code 43647 involves a different surgical approach to neurostimulator electrode implantation, in comparison with the potentially more invasive procedures currently assigned to APC 0061, we still believe the procedure's clinical characteristics more closely resemble the other procedures assigned to APC 0061 than the minimally invasive percutaneous neurostimulator electrode implantation procedures assigned to APC 0040 (Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve). Therefore, we agree with commenters that APC 0061 would be an appropriate APC assignment for CPT code 43647 for CY 2008, taking into account the procedure's clinical characteristics and expected hospital resource costs. We will reassign CPT code 43647 to APC 0061 for CY 2008, while we await the opportunity to review its CY 2007 claims data in preparation for the CY 2009 rulemaking cycle.

After consideration of the public comments received, we are not finalizing our CY 2008 proposal to assign CPT code 43647 to APC 0130. Instead, we will reassign CPT code 43647 to APC 0061, with a median cost of approximately $5,213. In addition, we are changing the title of APC 0061 to ''Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve'' to better reflect all of the procedures assigned to the APC for CY 2008.

c. Screening Colonoscopies and Screening Flexible Sigmoidoscopies (APCs 0158 and 0159)

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 policy for the revised ASC payment system as described in the August 2007 final rule for the revised ASC payment system (72 FR 42493), 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 (72 FR 42511). 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, for CY 2008, we proposed 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.C. of this final rule with comment period, 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 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 believed and continue to 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 proposed to adjust the payment rates under the OPPS to pay for the procedures according to the standard OPPS payment rates. We believed 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 believed 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.

We received several public commenters concerning this proposal. A summary of the public comments and our response follow.

Comment: Several commenters agreed that it would be inequitable to pay for screening colonoscopies and screening flexible sigmoidoscopies services in the HOPD at their lower ASC payment rate. They supported CMS's use of the equitable adjustment authority to adjust the OPPS payment rates for these services.

Response: We appreciate commenters' support of our proposal. We acknowledge that sections 1834(d)(2) and (d)(3) of the Act would otherwise require that the CY 2008 OPPS payment rates for screening colonoscopies and screening flexible sigmoidoscopies be set equal to their significantly lower ASC payment rates. However, we continue to believe it is necessary to invoke the equitable adjustment authority provided by section 1833(t)(2)(E) of the Act to adjust the OPPS payment rates for these procedures in order to establish the most appropriate payment for these procedures in the context of the contemporary payment policies of the OPPS and the revised ASC payment system.

After consideration of the public comments received, we are finalizing our CY 2008 proposal, without modification, to pay for screening colonoscopies and screening flexible sigmoidoscopies under the OPPS at payment rates developed according to the standard OPPS ratesetting methodology.

3. Genitourinary Procedures

a. Cystoscopy With Stent (APC 0163)

For CY 2008, we proposed to continue assignment of CPT code 52282 (Cystourethroscopy, with insertion of urethral stent) to APC 0163 (Level IV Cystourethroscopy and other Genitourinary Procedures), with a proposed payment rate of approximately $2,351. Payment for APC 0163 in CY 2007 is approximately $2,147.

We received one public comment on our CY 2008 proposed assignment of CPT code 52282 to APC 0163. A summary of the public comment and our response follow.

Comment: One commenter indicated that the procedure described by CPT code 52282 is inappropriately assigned to APC 0163, and that it should be reassigned to a new device-dependent APC for CY 2008. According to the commenter, the procedure described by CPT code 52282 is dissimilar to the other procedures that map to APC 0163, both clinically and in terms of cost. The commenter stated that this procedure is the only procedure in APC 0163 that involves an implant. In addition, the commenter asserted that the APC's CY 2008 proposed payment of approximately $2,351 is inadequate to cover hospitals' costs for performing this procedure, and that as a result, hospitals may limit beneficiary access to this treatment. According to the commenter, the urethral stent that is placed during these procedures is approximately $4,200. The commenter also noted that other stent placement procedures have device-dependent

status so that adequate costs can be tracked. The commenter recommended that CMS create a new device-dependent APC for CPT code 52282 with a payment rate of at least $4,000.

Response: In response to the concerns raised by the commenter, we reviewed the clinical characteristics and hospital costs from CY 2006 claims data for all procedures proposed for CY 2008 assignment to APC 0163. The APC median cost is approximately $2,270, while CPT code 52282 has a median cost of approximately $2,016, based on 291 single claims out of a total of 900 claims for the procedure. Because of the commenter's concern about whether the stent costs were appropriately reflected in the procedure's median cost, we compared the median costs of CY 2006 claims that include both CPT code 52282 for cystoscopy with implant of a stent and a Level II HCPCS C code for a stent, to CY 2006 claims that include CPT code 52282 but do not include a device C-code for a stent. While a stent is always necessary for the procedure and we require that hospitals report device HCPCS codes whenever they implant a device that is described by an available device code, we found that hospitals did not always report a stent HCPCS code with CPT code 52282. This is similar to our findings in other cases of device-related procedures. We believe, however, that hospitals are usually otherwise accounting for the device cost in their charges on claims for CPT code 52282, either by incorporating the charge into the charge for the procedure or reporting a charge on an uncoded revenue code line. We found only a small difference in median costs of approximately $500 for procedures reported with and without a device C-code. This difference in costs is well within an appropriate range for the APC group. Furthermore, the median cost for the claims billed with CPT code 52282 and a stent C-code was approximately $2,369, very close to the CY 2008 median cost of APC 0163 of approximately $2,270. We also believe that CPT code 52282 clinically resembles the other cystourethroscopic procedures also assigned to APC 0163. Therefore, we do not believe that there are sufficient differences in clinical characteristics or resources required to perform the procedure described by CPT code 52282 relative to the other procedures assigned to APC 0163 to warrant reassignment of CPT code 52282 to a new, device-dependent APC as the commenter suggested.

After consideration of the public comment received, we are finalizing our proposal, without modification, to assign CPT code 52282 to APC 0163, with a CY 2008 median cost of approximately $2,270.

b. Percutaneous Renal Cryoablation (APC 0423)

For CY 2008, we proposed to assign CPT code 0135T (Ablation renal tumor(s), unilateral, percutaneous, cryotherapy) to APC 0423 (Level II Percutaneous Abdominal and Biliary Procedures), with a proposed payment rate of approximately $2,810. This code was new in CY 2006, when it was assigned to APC 0163 (Level IV Cystourethroscopy and other Genitourinary Procedures) on an interim final basis, with a payment rate of $1,999. In CY 2007, based on the APC Panel's recommendation made at the March 2006 APC Panel meeting, we reassigned CPT code 0135T from APC 0163 to APC 0423 with a payment rate of approximately $2,297. We expected hospitals, when billing CPT code 0135T, to also report the device HCPCS code, C2618 (Probe, cryoablation), associated with the procedure.

We received several public comments concerning this proposal. A summary of the public comments and our responses follow.

Comment: Several commenters disagreed with our proposed APC assignment for CPT code 0135T. They indicated that the proposed payment rate for APC 0423 does not cover the cost hospitals incur for the cryoprobes used in the procedure. One commenter reported that the average cost of one probe is about $1,000, while several commenters indicated that a single procedure, on the average, uses about 2.5 probes but may involve up to 4 probes depending on the size of the tumor and the probe needle selected. Other commenters argued that CPT code 0135T requires more resources than the other procedures currently assigned to APC 0423, specifically CPT codes 47382 (Ablation, one or more liver tumor(s), percutaneous, radiofrequency) and 50592 (Ablation, one or more renal tumor(s), percutaneous, unilateral, radiofrequency). Several commenters highlighted the variance in the use of probes used for the procedures assigned to APC 0423. Specifically, these commenters asserted that CPT code 0135T requires the use of multiple probes while the radiofrequency ablation procedures require only a single probe in a procedure. Further, the commenters highlighted the various median costs associated with the procedures assigned to APC 0423. That is, they pointed out that the proposed median cost of about $3,520 for CPT code 0135T was 30 to 32 percent more than the median cost for CPT code 47382, which had a proposed median cost of about $2,706, or CPT code 50592, which had a proposed median cost of about $2,658. The commenters urged CMS to reevaluate the proposed payment rate for APC 0423 and use acquisition cost data provided by manufacturers, as many of the claims used to set the payment rate do not contain the required device. Alternatively, some commenters requested that CMS consider creating a unique clinical APC for renal cryoablation that would be designated as device-dependent to appropriately distinguish the resource costs associated with renal cryoablation from radiofrequency ablation procedures.

Response: Based on our comprehensive review of the procedures assigned to APC 0423, public comments, and the CY 2006 recommendation of the APC Panel regarding renal cryoablation, we believe that we have appropriately assigned CPT code 0135T to APC 0423 for CY 2008 based on clinical and resource considerations. We disagree with the commenters' argument regarding the clinical dissimilarity of the renal cryoablation procedure from the radiofrequency ablation procedures in APC 0423. The commenters to the CY 2007 OPPS proposed rule (71 FR 68049) acknowledged that cryoablation and radiofrequency percutaneous ablation procedures for renal tumors are clinically similar. We continue to believe that CPT code 0135T is appropriately assigned to APC 0423 because it is placed with other procedures that share its clinical and resource characteristics. If hospitals use more than one probe in performing the renal cryoablation procedure, we expect hospitals to report this information on the claim and adjust their charges accordingly. Hospitals should report the number of cryoablation probes used to perform CPT code 0135T as the units of HCPCS code C2618 which describes these devices, with their charges for the probes. Since CY 2005, we have required hospitals to report device HCPCS codes for all devices used in procedures if there are appropriate HCPCS codes available. In this way, we can be confident that hospitals have included charges on their claims for costly devices used in procedures when they submit claims for those procedures.

Comment: Several commenters informed us that the hospital claims data that we used to set the proposed payment rate for CPT code 0135T do not accurately capture the full costs related to this procedure. They believed that the omission on the claims for the device C-code, specifically HCPCS code C2618,

for the cryoprobes leads to omission of cryoprobe cost information and undervaluation of the cost of the procedure. Some commenters reported the results of their study of our hospital outpatient claims data which revealed that of the 110 Medicare claims submitted for CPT code 0135T, only 44 single claims included the device HCPCS C-code (C2618) on the claims. Because the procedure cannot be performed without the cryoprobe device, these commenters strongly urged CMS to designate the renal cryoablation procedure as a ''device-dependent'' procedure and require hospitals to submit claims with the appropriate HCPCS C-code. One commenter who acknowledged its experience with hospital billing reported that hospitals are not motivated to report the cost of the devices on the claim form unless a HCPCS C-code is required by a code edit for claim submission. Several commenters requested that CMS designate CPT code 0135T as a ''device-dependent'' procedure to ensure that future claims data more accurately reflect the total cost of the procedure.

Response: We acknowledge the concerns raised by the commenters regarding the hospitals' failure to report the device HCPCS code C2618 with the procedure. We further examined our CY 2006 hospital outpatient claims data to determine the frequency of billing CPT code 0135T with and without HCPCS code C2618. Our analysis revealed that the final rule median cost of approximately $3,446 based on 48 single bills used for ratesetting falls within the range for those procedures billed with and without the device HCPCS code C2618. Specifically, our data showed a median cost of about $4,402 based on 17 single bills for procedures billed with the device HCPCS code C2618 and a median cost of about $2,834 based on 31 single bills for those procedures billed without the device C-code. Even considering only those claims for CPT code 0135T with the device HCPCS code and higher median cost, CPT code 0135T would be appropriately assigned to APC 0423 based on that cost.

Further, we do not believe that we should create a claims processing edit in this instance. We create device edits, when appropriate, for procedures assigned to device-dependent APCs, where those APCs have been historically identified under the OPPS as having very high device costs. Because APC 0423 is not a device-dependent APC and the costs of the procedure with and without HCPCS code C2618 are reasonably similar, we will not create edits. We remind hospitals that they must report all of the HCPCS codes that appropriately describe the items used to provide services, regardless of whether the HCPCS codes are packaged or paid separately.

After further analysis of our CY 2006 hospital outpatient claims data, the APC Panel recommendation from the March 2006 meeting, and consideration of the public comments received, we are finalizing our proposal, without modification, to assign CPT code 0135T to APC 0423 for CY 2008 with a median cost of approximately $2,705.

For CY 2008, the CPT Editorial Panel decided to delete CPT code 0135T on December 31, 2007, and replace it with CPT code 50593 (Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy). The replacement CPT code 50593 will be assigned to APC 0423 effective January 1, 2008. Similar to its predecessor code, we expect hospitals to report both the device HCPCS code C2618 and CPT code 50593 to appropriately report the renal cryoablation procedure.

c. Prostatic Thermotherapy (APC 0163)

For CY 2008, we proposed to reconfigure certain clinical APCs to eliminate most of the low total volume APCs as an alternative to developing specific quantitative approaches to treating low total volume APCs differently for purposes of median calculation. We further concluded that there were other clinical APCs with higher volumes of total claims to which these low total volume services could be reassigned, while maintaining the continued clinical and resource homogeneity of the clinical APCs to which they would be newly reassigned. As a result, we eliminated certain APCs and reassigned the procedures associated with these APCs to other clinical APCs with higher volumes of claims. Prostatic thermotherapy procedures were assigned to APC 0675 (Prostatic Thermotherapy) for CY 2007, with a payment rate of approximately $2,529. For CY 2008, we proposed to reassign CPT codes 53850 (Transurethral destruction of prostate tissue; by microwave thermotherapy) and 53852 (Transurethral destruction of prostate tissue; by radiofrequency thermotherapy) from APC 0675 to APC 0163 (Level IV Cystourethroscopy and other Genitourinary Procedures), with a proposed payment rate of approximately $2,351. We proposed to eliminate APC 0675, which would otherwise have included only approximately 550 total services based on CY 2006 claims.

We received some public comments on the proposed deletion of APC 0675 and the reassignment of the prostatic thermotherapy procedures in APC 0675 to APC 0163. A summary of the public comments and our response follow.

Comment: Specifically, some commenters requested clarification from CMS on the reassignment of CPT codes 53850 and 53852 from APC 0675 to APC 0163, as reflected in Addendum B of the CY 2008 OPPS proposed rule. One commenter urged CMS to investigate whether these procedures were correctly assigned to APC 0163 as the procedures described by CPT codes 53850 and 53852 seemed more appropriate, in terms of clinical characteristics and resource costs, for assignment to APC 0429 (Level V Cystourethroscopy and other Genitourinary Procedures). The commenter recommended that the APC Panel discuss this issue at its next meeting to further review the data before the proposed change is finalized.

Response: As part of our annual review, we examine the APC assignments for all items and services under the OPPS for appropriate placements in the context of our proposed policies for the update year. This review involves careful and extensive analysis of our hospital outpatient claims data, as well as input from our medical advisors and the APC Panel and recommendations from the public. Based on our analysis of the hospital outpatient claims from CY 2006, the final median cost for CPT code 53850 is approximately $2,482 based on 199 single claims (223 total), and the final median cost for CPT code 53852 is approximately $2,894 based on 195 single claims (315 total). We agree with the commenter who recommended reassignment of these CPT codes to APC 0429, which has a median cost of approximately $2,844 for CY 2008 and includes several other procedures to destroy prostate tissue. We believe that APC 0429 is the most appropriate assignment for both CPT codes based on clinical and resource considerations.

After consideration of the public comments received, we are modifying our proposal and finalizing the CY 2008 assignments of CPT codes 53850 and 53852 to APC 0429, with a median cost of approximately $2,844.

d. Radiofrequency Ablation of Prostate (APC 0163)

For CY 2008, we proposed to delete APC 0675 (Prostatic Thermotherapy) and reassign the two CPT codes that mapped to this APC in CY 2007, CPT code 53850 (Transurethral destruction of prostate tissue; by microwave thermotherapy) and CPT code 53852

(Transurethral destruction of prostate tissue; by radiofrequency thermotherapy) to APC 0163 (Level IV Cystourethroscopy and other Genitourinary Procedures). The CY 2007 payment rate for APC 0675 is approximately $2,529, and the CY 2008 proposed payment rate for APC 0163 was approximately $2,351.

Comment: One commenter asserted that the proposed reassignment of CPT code 53852 to APC 0163 is not clinically appropriate or consistent with the resource costs of other procedures assigned to APC 0163. The commenter suggested that CMS reassign CPT code 53852 to APC 0429 (Level V Cystourethroscopy and other Genitourinary Procedures), with a CY 2008 proposed payment rate of approximately $2,924. According to the commenter, CMS cost data showed that the median cost of CPT code 53852 is 26 percent higher than the median cost of the APC 0163 to which CMS proposed to reassign the procedure. The commenter stated that the clinical characteristics of the procedure described by CPT code 53852 are more similar to the procedure described by CPT code 52647 (Laser coagulation of the prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included if performed)), which maps to APC 0429, than the procedures that are included in APC 0163. Specifically, the commenter stated that both procedures can be done under direct visualization, placement of the energies are customized, and there is no incision or cutting of the tissues involved. The commenter also argued that CMS data on intraservice procedure times and the direct costs of clinical labor, supplies, and equipment indicate that CPT code 53852 should be reassigned to APC 0429 rather than to APC 0163.

Response: We examined the clinical characteristics and claims-based resource costs of all procedures proposed for assignment to APC 0163 and APC 0429 for CY 2008. We agree with the commenter that APC 0429 would be an appropriate assignment for CPT code 53852 for CY 2008. CPT code 53852 appears to be more closely related, both in terms of clinical characteristics and resource costs, to the laser surgery procedures assigned to APC 0429 than to many of the cystourethroscopy and transurethral resection procedures assigned to APC 0163. CPT code 53852, like some other procedures assigned to APC 0429, is a minimally invasive procedure for the destruction of prostate tissue, and we believe the procedure room time and recovery period for the services would be relatively comparable.

After consideration of the public comments received, we are modifying our CY 2008 proposal and will reassign CPT code 53852 to APC 0429, with a median cost of approximately $2,844.

e. Ultrasound Ablation of Uterine Fibroids With Magnetic Resonance Guidance (MRgFUS) (APC 0067)

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) guidance. 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 public 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 differed 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 HOPDs (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 approximately $8,461. 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 during the development of the proposed rule indicated that MRgFUS procedures were rarely performed on Medicare patients. As we stated in the CY 2006 OPPS final rule with comment period and the 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 did not expect that there ever would 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 showed that there

were only two claims submitted for CPT code 0071T in CY 2005 and one in CY 2006. We had 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 had a proposed APC median cost of approximately $3,870 for CY 2008. The APC Panel discussed its general belief that while the MRgFUS procedures might 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, following publication of the CY 2007 OPPS/ASC final rule with comment period, we 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 proposed 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. We agreed 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 believed 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 proposed to reassign CPT codes 0071T and 0072T to APC 0067, with a proposed APC median cost of approximately $3,870, which was reflected in Table 32 of the proposed rule (72 FR 42713).

We received several public comments on our CY 2008 proposal concerning MRgFUS procedures. A summary of the public comments and our responses follow.

Comment: Several commenters agreed with CMS's proposal to assign the MRgFUS procedures, specifically CPT codes 0071T and 0072T, to APC 0067 because the services share similarities, both clinically and with regard to resource costs, with other procedures also assigned to APC 0067. However, many commenters disagreed with the proposed payment rate of approximately $3,918 for APC 0067. They recommended that MRgFUS be placed in APC 0127 (Level IV Stereotactic Radiosurgery, MRgFUS, and MEG), which had a proposed payment rate of approximately $7,864, as they believed that this APC accurately reflected the hospital charges and costs for this procedure. The commenters believed that the proposed payment rate for APC 0067 was far below the costs incurred to provide MRgFUS procedures and did not accurately reflect the treatment planning component that is part of the MRgFUS procedure. Other commenters disagreed with the placement of MRgFUS services in an APC that historically had contained only SRS procedures. These same commenters argued that the MRgFUS procedure is not similar to SRS treatment delivery services based on clinical coherence and resource utilization. Some commenters suggested that CMS reassign these procedures, as previously done in CY 2007, to a female reproductive procedure APC.

Response: As we stated in the CY 2006 OPPS final rule with comment period and the 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 did not expect that there ever would be many Medicare claims for the MRgFUS procedures (70 FR 68600 and 71 FR 68050, respectively). Analysis of hospital outpatient data for claims submitted for CY 2006 indicates that MRgFUS procedures were rarely performed on Medicare patients. For OPPS claims submitted from CY 2005 through CY 2006, our claims data showed that there were only two claims submitted for CPT code 0071T in CY 2005 and one in CY 2006. We had no hospital claims for CPT code 0072T from either of those years. While we have no information from hospital claims regarding the costs of MRgFUS procedures, we continue to believe that the clinical and expected resource characteristics of MRgFUS procedures resemble the first or complete session LINAC-based SRS treatment delivery services that are also assigned to APC 0067. The APC Panel also recommended that MRgFUS procedures be assigned to that clinical APC, instead of a New Technology APC. While commenters pointed to specific differences in the technologies utilized for MRgFUS and SRS procedures, both services are noninvasive and utilize specialized equipment and image guidance in the targeted ablation of abnormal tissue during a lengthy treatment session. Therefore, we believe that the services are sufficiently similar to reside in the same clinical APC.

After consideration of the public comments received and the APC Panel recommendation at its March 2007 meeting, we are finalizing our proposal, without modification, to assign CPT codes 0071T and 0072T to APC 0067, with a CY 2008 median cost of approximately $3,882. Table 18 lists the final APC median costs for the MRgFUS CPT codes.

TABLE 18.—FINAL CY 2008 APC ASSIGNMENTS OF MRGFUS PROCEDURES

HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	CY 2007 APC median cost	Final CY 2008 SI	Final CY 2008 APC	Final CY 2008 APC median cost
0071T	U/s leiomyomata ablate <200	T	0195	$1,742	S	0067	$3,882
0072T	U/s leiomyomata ablate >200	T	0202	$2,534	S	0067	$3,882

f. Uterine Fibroid Embolization (APC 0202)

Prior to January 1, 2007, a specific CPT code did not exist to describe uterine fibroid embolization. CPT guidance suggests that hospitals previously reported this procedure using CPT codes 37204 (Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck) and 75894 (Transcatheter therapy, embolization, any method, radiological supervision and interpretation). In CY 2006, the combined APC payment for these two procedures was approximately $2,504. Effective January 1, 2007, the CPT Editorial Panel created CPT code 37210 (Uterine fibroid embolization (UFE, embolization of the uterine arteries to treat uterine fibroids, leiomyomata), percutaneous approach inclusive of vascular access, vessel selection, embolization, and all radiological supervision and interpretation, intraprocedural roadmapping, and image guidance necessary to complete the procedure) to describe this procedure. In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68317), we provided an interim final assignment of CPT code 37210 to APC 0202 (Level VII Female Reproductive Procedures), with a CY 2007 payment rate of approximately $2,642. For CY 2008, we proposed continued assignment of CPT code 37210 to APC 202 (72 FR 42936), with a proposed payment rate of approximately $2,753. Because this is a new code for CY 2007, the CY 2006 claims data, upon which we set CY 2008 payment rates, do not reflect use of this code.

At the September 2007 meeting of the APC Panel, the Panel recommended that CMS consider moving CPT code 37210 to another APC, such as APC 0067 (Level III Stereotactic Radiosurgery), with a CY 2008 proposed payment rate of approximately $3,918, or APC 0229 (Transcatheter Placement of Intravascular Shunts), with a CY 2008 proposed payment rate of approximately $5,713, to improve the clinical and resource homogeneity of the procedure within its assigned APC.

We received several public comments on the CY 2007 OPPS/ASC final rule with comment period and the CY 2008 OPPS/ASC proposed rule regarding the placement of CPT code 37210 in APC 0202. A summary of the public comments and our response follow.

Comment: Several commenters requested that CMS consider the APC Panel's recommendation to reassign CPT code 37210 to a different APC. The commenters argued that the uterine fibroid embolization procedure is clinically dissimilar to the other procedures assigned to APC 0202, which do not require the implantation of a device and do not utilize imaging resources. The commenters suggested that CMS create a new APC for CPT code 37210 or reassign it to APC 0229. The commenters stated that the uterine fibroid embolization procedure is similar to the other vascular procedures included in APC 0229, both clinically and in terms of resource utilization. Specifically, the commenters noted that the uterine fibroid embolization procedure is similar to the revision of transvenous intrahepatic portosystemic shunts, described by CPT code 37183 (Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanulization/dilatation, stent placement and all associated imaging guidance and documentation)), which maps to APC 0229. According to the commenters, both uterine fibroid embolization and the revision of transvenous intrahepatic portosystemic shunts involve device implantation, selective catheterization, and radiological supervision and interpretation. The commenters stated that the hospital resource consumption related to the devices used in uterine fibroid embolization are also similar to other procedures in APC 0229, including those described by CPT code 37205 (Transcatheter placement of an intravascular stent(s) (except coronary, carotid, and vertebral vessel), percutaneous; initial vessel) and CPT code 37206 (Transcatheter placement of an intravascular stent(s) (except coronary, carotid, and vertebral vessel), percutaneous; each additional vessel).

Response: We reviewed the clinical characteristics and claims-based costs of all procedures also proposed for assignment to APC 0202 for CY 2008, as well as the recommendation of the APC Panel from its September 2007 meeting. We do not believe that the procedure described by CPT code 37210 sufficiently resembles the services assigned to APC 0067, one of the possibilities recommended by the APC Panel, for that clinical APC to be an appropriate assignment. The stereotactic radiosurgery, magnetic resonance-guided focused ultrasound ablation, and magnetoencephalography services assigned to APC 0067 all are noninvasive procedures that do not require vascular catheterization or the use of implantable devices. We examined the clinical characteristics and resource costs of procedures assigned to APC 0229 and agree with some of the commenters that this APC would be an appropriate assignment for CPT code 37210 for CY 2008 while we await claims data that will be available for the CY 2009 OPPS update. CPT code 37210, like other procedures assigned to APC 0229, requires the targeted use of intravascular catheters, imaging guidance, and implantable devices, and we believe the procedure room time and recovery period for the services would be relatively comparable. CPT code 37210 appears to be more closely related, both in terms of clinical characteristics and resource costs, to the minimally invasive interventional procedures assigned to APC 0229 than to many of the open surgical repair procedures of the female reproductive system assigned to APC 0202. We are unable to assign CPT code 37210 to a new clinical APC for CY 2008 because we would have no claims data for the procedure upon which to base the payment rate for that APC. Therefore, we have adopted the recommendation of the APC Panel to consider moving CPT code 37210 to APC 0229 and will reassign the procedure to that APC for CY 2008.

After consideration of the public comments received, we are modifying our CY 2008 proposal and will reassign CPT code 37210 for uterine fibroid embolization to APC 0229, with a median cost of approximately $5,570.

4. Nervous System Procedures

a. Chemodenervation (APC 0206)

For CY 2008, we proposed to reassign two chemodenervation procedures, specifically those described by CPT codes 64650 (Chemodenervation of eccrine glands; both axillae) and 64653 (Chemodenervation of eccrine glands; other area(s) (eg, scalp, face, neck), per day) to APC 0206 (Level II Nerve Injections), with a proposed payment rate of approximately $265. These services are currently assigned to APC 0204 (Level I Nerve Injections) for CY 2007, with a payment rate of approximately $139.

We received one public comment on our CY 2008 proposed assignment of chemodenervation procedures to APC 0206. A summary of the public comment and our response follow.

Comment: One commenter was concerned that CMS proposed to reassign CPT codes 64650 and 64653 to APC 0206 for CY 2008, but retained other chemodenervation procedures in

APC 0204, specifically CPT codes 64612 (Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (eg, for blepharospasm, hemifacial spasm); 64613 (Chemodenervation of muscle(s); cervical spinal muscle(s) (eg, for spasmodic torticollis); and 64614 (Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis). The commenter believed that CPT codes 64650 and 64653 for chemodenervation of eccrine glands should be grouped with the other three cited chemodenervation codes based on clinical and resource considerations. Of note, many commenters stated that if CMS proceeded with the packaging of electrodiagnostic guidance for chemodenervation procedures, a new distinct APC should be established for CPT codes 64612, 64613, and 64614, but CPT codes 64650 and 64653 were not included in that request.

Response: CPT codes 64650 and 64653 were new codes in CY 2006, which were initially assigned to APC 0204 on an interim final basis, and subsequently retained in that APC for CY 2007. For CY 2008, we proposed to reassign them to APC 0206 based on analysis of our first limited claims data from CY 2006. The final rule median cost for APC 0204 is approximately $146 and for APC 0206 is approximately $258. Our claims data showed a median cost of approximately $221 for CPT code 64650 and a median cost of approximately $235 for CPT code 64653 based on only 7 claims (of 11 total claims) and 15 claims (of 22 total claims), respectively. We agree with the commenter that these two chemodenervation procedures are clinically similar to the three procedures reported for chemodenervation of the muscles. Given the final CY 2008 packaging policy as discussed section II.A.4.c.(1) of this final rule with comment period that will package payment for the electrodiagnostic guidance for chemodenervation services, we would expect that the hospital resources required for CPT codes 64612 through 64614, where this guidance is sometimes used, would be at least as great as those required for chemodenervation of eccrine glands. In view of the limited claims for CY 2006 for CPT codes 64650 and 64653, we agree with the commenters that these two CPT codes should be assigned to the same APC as the other three chemodenervation procedures, specifically CPT codes 64612 through 64614, whose median costs of approximately $125 through $187 are within the range of costs for other significant services also assigned to APC 0204, where these muscle chemodenervation procedures were proposed for assignment in CY 2008. We do not see any need to establish a new APC for CPT codes 64612 through 64614 for CY 2008 based on clinical and resource considerations. Therefore, we believe that CPT codes 64650 and 65653 should remain in APC 0204 for CY 2008. As we accumulate additional claims data for these procedures we will reassess their resource utilization and APC placement.

After consideration of the public comment received, we are modifying the CY 2008 proposed assignments of CPT codes 64650 and 64653 and retaining these two CPT codes in APC 0204, with a median cost of approximately $146, rather than reassigning them to APC 0206 as proposed.

b. Implantation of Intrathecal or Epidural Catheter (APC 0224)

For CY 2008, we proposed to delete APC 0223 (Implantation or Revision of Pain Management Catheter) and reassign CPT code 62350 (Implantation, revision, or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy) to APC 0224 (Implantation of catheter/reservoir/shunt). The procedure described by CPT code 62350 is the only procedure assigned to APC 0223 in CY 2007, with a payment rate of approximately $1,896. The CY 2008 proposed payment for APC 0224 was approximately $2,364.

We received one public comment on our CY 2008 proposal to reassign CPT code 62350 to APC 0224. A summary of the public comment and our response follow.

Comment: One commenter supported the proposal to delete APC 0223 and reassign CPT code 62350 to APC 0224. According to the commenter, this policy would increase resource homogeneity and clinical coherence.

Response: We appreciate the commenter's support and agree that the deletion of APC 0223 and the reassignment of CPT code 62350 to APC 0224 would increase resource homogeneity and clinical coherence of the resulting APC configuration by assigning multiple similar procedures for the implantation of nervous system shunts and catheters to the same clinical APC. We also believe this proposal is consistent with our overall strategy to encourage hospitals to use resources more efficiently by increasing the size of the payment bundles, and by eliminating, whenever possible, APCs comprised of few procedures.

Therefore, we are finalizing our proposal, without modification, to delete APC 0223 and reassign CPT code 62350 to APC 0224, with a median cost of approximately $2,282.

c. Implantation of Spinal Neurostimulators (APC 0222)

The CPT code for insertion of a spinal neurostimulator (63685, Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling), which is currently 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 the 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, in CY 2007 we 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 or gastric 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 final rule with comment period. 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 payment for APCs 0039 and 0222. 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.

Because we traditionally have paid for a service package under the OPPS as represented by a HCPCS code for the major procedure that is assigned to an APC group for payment, we assess the applicability of the 2 times rule to services at the HCPCS code level, not at a more specific level based on the individual devices that may be utilized in a service reported with a single HCPCS code. If the use of a very expensive device in a clinical scenario causes a specific procedure to be much more expensive for the hospital than the APC payment, we consider such a case to be the natural consequence of a prospective payment system that anticipates that some cases will be more costly and others less costly than the procedure payment. In addition, very high cost cases could be eligible for outlier payment. As we note in section II.A.4. of this final rule with comment period, 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 the case of implantable nonpass-through devices, these devices are part of the OPPS payment package for the procedures in which they are used.

Stakeholders encouraged us to deem as two distinct procedures neurostimulator implantation involving rechargeable and nonrechargeable devices, so in the CY 2008 proposed rule we conducted a review of our CY 2006 claims data for APC 0222. This examination showed that the median costs of the associated neurostimulator implantation procedures are higher for rechargeable neurostimulator implantation than for nonrechargeable neurostimulator implantation, as shown in Table 35 of the proposed rule (72 FR 42716). However, the difference in costs (approximately $6,500 based on proposed rule data) was not so great that retaining the procedures for the implantation of both types of devices for spinal or peripheral neurostimulation in APC 0222 would cause a 2 times violation, even if we were to consider them to be distinct procedures. The data did not 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 in which we proposed to increase packaging under the OPPS through expanded payment groups.

Therefore, for CY 2008 we proposed 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 was approximately $12,162. We thought this approach to be the most administratively simple, consistent with the OPPS packaging principles, and supportive of encouraging hospital efficiency, while also providing appropriate packaged payment for implantable neurostimulators. In the proposed rule (72 FR 42716), we specifically requested that commenters submit comments that address how this specific device implantation situation differed 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.

We received many public comments in response to this proposal. A summary of the public comments and our response follow.

Comment: The commenters urged CMS to pay differentially for rechargeable and nonrechargeable neurostimulators by creating separate APCs for the implantation procedures. They argued that the 2 times rule is a sufficient but not necessary condition for splitting APCs, and they identified other factors apart from the 2 times rule that should be taken into consideration in determining APC assignments. The commenters argued that the resources required to implant rechargeable versus nonrechargeable neurostimulators vary substantially, and that a combined APC for these procedures would result in a payment that is inequitable for both technologies and may lead to incentives for facilities to furnish only the less costly technology, even when the more expensive technology is clinically indicated for a particular patient. The commenters stated that the prospect of hospitals limiting patient access to rechargeable neurostimulators is particularly troubling because this technology represents a substantial clinical improvement for select patients and is more cost-effective compared to nonrechargeable neurostimulators. The commenters argued that paying more initially for rechargeable neurostimulators would save the Medicare program and beneficiaries money in the long term, and improve overall patient care and satisfaction. The commenters also pointed to provider concentration as an additional factor that should be considered in APC assignments. In the case of neurostimulators, commenters provided data that showed only 27 percent of the total number of hospitals that implant nonrechargeable neurostimulators also implant rechargeable neurostimulators, and stated that an APC payment that combines payment for rechargeable and nonrechargeable neurostimulator implantation procedures may bias the payment system against those hospitals.

The commenters disagreed with the assertion in the proposed rule that creating a new APC dedicated solely to rechargeable neurostimulator implantation procedures would be inconsistent with OPPS packaging principles. According to the commenters, distinct treatment of rechargeable and nonrechargeable neurostimulators is not an issue of packaging, because the technologies are not ancillary services or products. Instead, the commenters characterized them as alternative treatments depending on patient needs, and indicated that neither rechargeable nor nonrechargeable neurostimulators represent subordinate, supportive, or optional services relative to the other. The commenters also disagreed that as rechargeable neurostimulators become the dominant device implanted for neurostimulation, the median costs of APC 0222 would increase to reflect the costs of the technology. According to their analysis of claims data, approximately 60 percent of the CY 2006 single procedure claims for APC 0222 were for implantation of gastric, sacral, or other types of peripheral nerve neurostimulator devices, all of which utilize and are indicated for nonrechargeable technologies only. Therefore, the commenters claimed that the median costs for APC 0222 would continue to be dominated by nonrechargeable neurostimulator implantation procedures, even as the utilization of rechargeable neurostimulators grows.

The commenters responded to the proposed rule request to describe how this specific device implantation situation differed 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. The commenters stated that they were unaware of other APCs that include devices where the magnitude of the cost difference among packaged services is as substantial as proposed for neurostimulators. They also asserted that, unlike other OPPS services, rechargeable neurostimulators can reduce long-term costs. Rather than promoting efficiency, they argued, the CMS proposal to group payment for rechargeable neurostimulator implantation procedures with procedures involving nonrechargeable neurostimulators would discourage efficient resource utilization. They submitted economic models presented at special society meetings that concluded rechargeable spinal neurostimulators should reduce the number of reimplantation procedures due to battery depletion as well as reduce the number of complications associated with reimplantation procedures, and ultimately result in cost savings to payers and the health system.

The commenters offered various coding mechanisms that would enable the creation of unique APCs for rechargeable and nonrechargeable neurostimulator implantation procedures. Some commenters urged CMS to create new Level II HCPCS codes to differentiate between neurostimulator implantation procedures involving nonrechargeable and rechargeable devices, assign those HCPCS codes to separate APCs, and discontinue the use of CPT codes describing these procedures for OPPS payment purposes. These commenters stated that any administrative burden posed by new Level II HCPCS codes would be outweighed by the higher payment the hospital would receive for rechargeable neurostimulators, and that this methodology is consistent with previous CMS actions to identify and allow specific payment for services of importance to Medicare. Other commenters, however, supported the CMS proposal not to implement new Level II HCPCS codes, arguing that it is too much of an administrative burden for hospitals to follow coding rules for Medicare patients that are inconsistent with CPT coding guidelines. They suggested that neurostimulator implantation procedures that contain the existing C-code for the rechargeable device (C1820) map to a new APC with a higher payment rate, while claims for neurostimulator implantation procedures with the existing C-code for the nonrechargeable device (C1767) continue to map to APC 0222. Other commenters requested that CMS pursue new CPT codes through the AMA rather than create new Level II HCPCS codes.

Response: After consideration of the comments received on this issue, we have decided to reconfigure the APC assignments of procedures involving implantation of neurostimulators in order to improve the resource homogeneity of these APCs and ensure appropriate payment for both rechargeable and nonrechargeable neurostimulators. Effective January 1, 2008, CMS will implement a revised APC configuration for neurostimulator implantation procedures that groups payment for certain procedures mainly involving nonrechargeable neurostimulator technology (that is, cranial, sacral, gastric, or other peripheral neurostimulators) into two clinical APCs (APCs 0039 and 0315), while establishing a single APC for spinal neurostimulator implantation, which may commonly utilize either rechargeable or nonrechargeable technologies (APC 0222). Specifically, CMS will reassign CPT code 64590 for implantation of peripheral neurostimulators from APC 0222 to APC 0039, which already includes CPT code 61885 for implantation of single array cranial neurostimulators. CPT code 63685 for the implantation of spinal neurostimulators will be the only code remaining in APC 0222. By moving CPT code 64590 to APC 0039, all procedures that generally use nonrechargeable technologies only will be removed from ratesetting for spinal neurostimulator implantation, for which both rechargeable and nonrechargeable neurostimulators are indicated and commonly utilized. This APC reconfiguration will not affect CPT code assignment to APC 0315 (Level II Implantation of Neurostimulators), which will continue to include only CPT code 61886 (Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to two or more electrode arrays), although we will rename all three APCs to accommodate this new configuration. The revised APC configuration and naming convention for neurostimulator implantation APCs are summarized in Table 19 below. We note that this approach does not require hospitals to alter their coding practices in any way to conform to the new payment policy.

We agree with commenters that there are other important factors we consider when deciding on APC assignments besides the 2 times rule. In our CY 2001 final rule, we recognized that resource homogeneity is a fundamental criterion for evaluating changes to APC assignments. We wrote in the CY 2001 final rule that ''if the procedures within an APC require widely varying resources, it would be difficult to develop equitable payment rates. Aggregated payments to a facility that performed a disproportionate share of either the expensive or inexpensive procedures within an APC would be distorted. Further, the facility might be encouraged to furnish only the less costly procedures within the APC, resulting in a potential access problem for the more costly services'' (65 FR 18457). In the case of the neurostimulator implantation APC configuration that we are adopting for CY 2008, two of the APCs contain only one procedure and one APC contains only two CPT codes, with very close CPT code-specific median costs, so these three APCs reflect great resource homogeneity. We do not consider the implantation of rechargeable and nonrechargeable neurostimulators to be different procedures, so we see no need to adopt differential coding and/or payment for procedures that depend on the device implanted. We believe our final APC configuration will provide appropriate payment for neurostimulator implantation procedures that ensures access to the appropriate neurostimulator technologies under the OPPS for Medicare beneficiaries.

Just as we do not want to provide incentives for the underutilization of rechargeable neurostimulators, we also do not want to provide incentives for the overutilization of this expensive technology. According to information provided by the manufacturers of rechargeable neurostimulators, these devices are clinically indicated in only a subset of patients for whom spinal neurostimulation is a treatment option. They estimate that approximately 35 percent of these patients are candidates for rechargeable spinal neurostimulators, although this proportion may be higher. Our claims data from CY 2006, the first year of device pass-through for the rechargeable devices, already indicate that rechargeable neurostimulators are being implanted in about one-third of the spinal neurostimulator implantation cases. We received comments from many providers, however, who stated that they use or wish to use the rechargeable technology in all of their patients. We believe that creating a separate APC for rechargeable neurostimulator implantation, as was recommended by commenters, could

create incentives for hospitals to use the more expensive rechargeable technology, even when the more expensive technology is not clinically indicated. In contrast to the commenters' perspective, we believe that packaging payment for implantable devices into the related procedures is an important packaging principle that contributes to the size of the OPPS payment bundles. Although our CY 2008 proposal was to newly package payment for certain ancillary and supportive services, many other items and types of services that are fundamental to a procedure's therapeutic effect have been historically packaged under the payment system and will remain packaged for CY 2008. A policy to provide different payments for procedures according to the devices implanted would not be consistent with our overall strategy to encourage hospitals to use resources more efficiently by increasing the size of the payment bundles. However, we believe that the revised neurostimulator APC configuration that we are adopting for CY 2008 will allow us to calculate payment rates for procedures involving spinal neurostimulators that reflect changes in surgical practice based on clinical, rather than financial, considerations. To the extent that rechargeable neurostimulators may become the dominant device implanted for spinal neurostimulation over time based on the evolution of clinical practice, the median costs for the spinal neurostimulator implantation APC may increase to reflect contemporary utilization patterns.

In summary, for CY 2008, we are finalizing our proposal, with modification, for payment of neurostimulator implantation procedures. We will implement a revised APC configuration for neurostimulator implantation procedures that packages payment for procedures involving mainly nonrechargeable neurostimulator technology (*i.e.*, cranial, sacral, gastric, or other peripheral neurostimulators) into two APCs (APCs 0039 and 0315), while establishing a single APC for spinal neurostimulator implantation, which commonly utilizes either rechargeable or nonrechargeable technologies (APC 0222). We believe that this revised APC configuration best serves the principles of a prospective payment system by following our standard practice of retaining a single CPT code for neurostimulator implantation procedures that does not distinguish between the implantation of rechargeable and nonrechargeable neurostimulators, into which the costs of both types of devices are packaged in relationship to their OPPS utilization. We also believe the revised APC configuration is both consistent with our standard ratesetting practice for technologies coming off pass-through status, and reflective of the clinical and resource considerations presented by commenters. Because no new codes or coding practices will be required, hospitals will not experience any change in the administrative burden associated with reporting neurostimulator implantation procedures.

TABLE 19.—CY 2008 APC CONFIGURATION FOR PAYMENT OF RECHARGEABLE AND NONRECHARGEABLE NEUROSTIMULATOR IMPLANTATION PROCEDURES

APC	Revised title for CY 2008	Previous title	HCPCS codes included in CY 2008 median cost	HCPCS descriptor	CY 2008 CPT code median cost	CY 2008 APC median cost
0039	Level I Implantation of Neurostimulator.	Level I Implantation of Neurostimulator.	61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array.	$12,799	$11,732
			64590	Insertion or replacement of peripheral neurostimulator pulse generator or receiver, direct or inductive coupling.	$10,954	$11,732
0222	Level II Implantation of Neurostimulator.	Implantation of Neurological Device.	63685	Insertion or replacement of spinal neurostimulator pulse generation or receiver, direct or inductive coupling.	$15,150	$15,150
0315	Level III Implantation of Neurostimulator.	Level II Implantation of Neurostimulator.	61886	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to two or more electrode arrays.	$16,988	$16,988

5. Nuclear Medicine and Radiation Oncology Procedures

a. Adrenal Imaging (APC 0391)

For CY 2008, we proposed to assign CPT code 78075 (Adrenal imaging, cortex and/or medulla) to APC 0391 (Level II Endocrine Imaging), with a proposed payment rate of about $233. Currently, this procedure is assigned to the same clinical APC for CY 2007.

We received several public comments concerning this proposal. A summary of the public comments and our response follow.

Comment: Some commenters requested that CMS recognize this code as a high intensity multiday imaging procedure and reassign CPT code 78075 to APC 0408 (Level III Tumor/Infection Imaging), along with another multiday tumor imaging procedure code CPT code 78804 (Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring two or more days imaging).

Response: Based on our review of the costs and clinical characteristics of CPT code 78075, we agree with the commenters that this procedure is similar to CPT code 78804, in terms of clinical homogeneity and resource costs. Both procedures require nuclear medicine imaging several days following the injection of a diagnostic radiopharmaceutical. We note that these services are nuclear medicine procedures and, therefore, their final rule median costs are calculated according to the temporary special methodology that relies on the subset of claims reporting coded diagnostic radiopharmaceuticals, as described in section II.A.4.c. of this final rule with comment period. Our claims data from CY 2006 showed that the median cost for CPT code 78075 is approximately $954 based on 124 single claims for

ratesetting, which is relatively similar to the median cost of approximately $1,194 for the sole procedure code 78804 proposed for assignment to APC 0408. In contrast, the HCPCS-specific median costs for the individual significant procedures in APC 0391 range from approximately $201 to $243, resulting in an APC median cost of approximately $217. The median cost of APC 0391 is significantly lower than the APC 0408 median cost of approximately $969 and the CPT code 78075 median cost of approximately $954.

After considering the public comments received, we are modifying our proposal and are reassigning CPT code 78075 to APC 0408, with a CY 2008 median cost of approximately $969, rather than to APC 0391 as proposed.

b. Injection for Sentinel Node Identification (APC 0389)

For CY 2008, we proposed to assign the sentinel node identification procedure, specifically described by CPT code 38792 (Injection procedure; for identification of sentinel node), to APC 0389 (Level I Non-imaging Nuclear Medicine), with a proposed payment rate of approximately $101. Currently, this procedure is assigned to the same clinical APC for CY 2007.

We received several public comments on our CY 2008 proposed assignment of CPT code 38792 to APC 0389. A summary of the public comments and our responses follow.

Comment: Some commenters recommended that CPT code 38792 be reassigned from APC 0389 to APC 0392 (Level II Non-imaging Nuclear Medicine), which had a proposed payment rate of approximately $209. The commenters indicated that an injection for sentinel node identification is more resource intensive, as corroborated by the CMS hospital outpatient claims data, than other procedures also assigned to APC 0389. These commenters requested that CMS reassign CPT code 38792 to APC 0392 for CY 2008.

Response: Based on our review of the costs and clinical characteristics of CPT code 38792, we agree with the commenters that this procedure is most similar to those procedures assigned to APC 0392 for CY 2008. Our claims data from CY 2006 showed that the median cost for CPT code 38792 is approximately $174 based on 390 single claims available for ratesetting, which is significantly higher than the median cost of approximately $114 for APC 0389. The median cost of APC 0392 of $183, which contains nuclear medicine procedures and, therefore, is calculated according to the special methodology described in section II.A.4.c. of this final rule with comment period, is more consistent with the hospital resources required to perform CPT code 38792.

After consideration of the public comments received, we are modifying our proposal and reassigning CPT code 38792 to APC 0392, with a CY 2008 median cost of approximately $183, rather than to APC 0389 as proposed.

c. Myocardial Positron Emission Tomography (PET) Scans (APC 0307)

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 approximately $736. 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 approximately $801, 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 approximately $2,485, 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 approximately $727.

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, as indicated in the CY 2008 proposed rule (72 FR 42713), we did not accept the APC Panel's recommendation because, consistent with our observations from the CY 2005 claims data, our CY 2006 claims data available for the proposed rule did not support the creation of a clinical APC for CPT code 78492 alone. Analysis of the latest CY 2006 claims data continued to support a single level APC payment structure for the myocardial PET scan procedures because very few single scan studies were performed and we believed single and multiple scan procedures were clinically similar. Our claims data available for the proposed rule showed a total of 2,547 procedures reported with the multiple scan CPT code 78492. Alternatively, our claims data showed 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 was observed in the single bills available for ratesetting.

Similar to findings from the CY 2005 data, as we discussed in the proposed rule, our CY 2006 claims data revealed that more hospitals were not only providing multiple myocardial PET scan services, but most myocardial PET scans were multiple studies. Further, our most recent data analysis for this final rule with comment period revealed that multiple myocardial PET scan services were commonly performed in the same hospital encounter with a cardiovascular stress test, specifically CPT code 93017 (Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; tracing only, without interpretation and report).

In the CY 2008 OPPS/ASC proposed rule, we indicated our belief that the assignment of CPT codes 78459, 78491, and 78492 to a single clinical APC for CY 2008 was still appropriate because the CY 2006 claims data did 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 proposed to continue to assign both the single and multiple myocardial PET scan procedure codes to APC 0307, with a proposed APC median cost of approximately $2,678 for CY 2008. We noted that the proposed CY 2008 median cost of APC 0307 was 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.c.(5) of this final rule with comment period that would package payment for diagnostic radiopharmaceuticals into the payment for their related diagnostic nuclear medicine studies, such as myocardial PET scans. The myocardial PET scan CPT codes and their proposed CY 2008 APC assignments were displayed in Table 33 of the proposed rule, which has been reproduced as Table 20 below, and updated to show the final status indicators, APC assignments, and median costs for these services.

We received a number of public comments concerning our proposed payment for myocardial PET scans. A summary of the public comments and our response follow.

Comments: Some commenters disagreed with our proposal to assign CPT codes 78459, 78491, and 78492 to a single clinical APC even though the CY 2006 claims data did not support a resource differential. They requested that CMS separate single (rest or stress) from multiple (rest and stress) PET myocardial perfusion imaging studies. Specifically, these commenters requested that CMS assign the single myocardial PET codes, CPT codes 78459 and 78491, to APC 0307, and create a new clinical APC for CPT code 78492, which describes the multiple myocardial PET scan procedure. The commenters believed that maintaining the multiple myocardial PET scan in the same APC as the single myocardial PET scans significantly underpaid hospitals for providing multiple myocardial PET scan procedures. They reported that multiple myocardial PET procedures require greater hospital resources than single myocardial PET scans.

Response: Based on our review of the hospital outpatient claims data from CY 2005 and CY 2006, as well as the clinical characteristics of CPT code 78492, we do not agree that we should establish a new clinical APC solely for the multiple myocardial PET scans. Our claims data for this final rule with comment period showed a total of 2,808 procedures reported with the multiple scan CPT code 78492. Conversely, our claims data showed only a combined total of 286 procedures reported with the single scan CPT codes 78459 and 78491.

We note that our final median cost for this APC is approximately $1,384, which is significantly lower than the proposed rule median cost for the APC. According to our final ratesetting policies in which we included CPT code 93017 on the bypass list as discussed in section II.1.b of this final rule with comment period, we based APC 0307's final median cost on 1,832 single claims out of 3,094 CY 2006 claims for myocardial PET procedures. Due to our bypassing of CPT code 93017 for the cardiovascular stress test commonly reported with myocardial PET scans, we were able to use almost twice the number of claims to develop the final median cost based on claims from a large number of hospitals in comparison with the proposed rule, and almost all of those additional single claims were for multiple myocardial PET scan services. As discussed in section II.A.4.c.(5) of this final rule comment period, the final median cost for APC 0307 was also calculated only from those claims for myocardial PET scan procedures that also contained a HCPCS code for a diagnostic radiopharmaceutical. The median cost of approximately $1,384 compares favorably to our CY 2007 estimated average total payment of $1191 for these services, consisting of approximately $731 for the scan (APC 0307) and approximately $460 (average estimate of charges reduced to cost) for the commonly used diagnostic radiopharmaceutical A9555 (Rubidium Rb-82-diagnostic, per study dose, up to 60 millicuries). Therefore, we believe that the final median cost of APC 0307 for the scans and associated diagnostic radiopharmaceuticals appropriately reflects the hospital resources associated with providing myocardial PET scans to Medicare beneficiaries in cost-efficient settings and is adequate to ensure appropriate access to these services for Medicare beneficiaries.

The CY 2008 median cost for APC 0307 of approximately $1,384 is very similar to the median cost of CPT code 78492 of $1,467, so we do not believe that the assignment of the relatively small number of generally lesser cost single scan claims to APC 0307 significantly reduces the payment rate for multiple scan studies. In addition, as discussed in section II.A.2. of this final rule with comment period, we are attempting to reduce the number of low volume APCs under the OPPS to promote the stability of payment rates. If we were to create a new clinical APC for multiple myocardial PET scans, APC 0307 for single scan studies would become a very low volume APC. We continue to 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.

After consideration of the public comments received, we are finalizing our CY 2008 proposal, without modification, to provide payment for all myocardial PET scans through APC 0307, with a CY 2008 median cost of approximately $1,384, as shown in Table 20.

TABLE 20.—FINAL CY 2008 APC ASSIGNMENTS FOR MYOCARDIAL PET SCANS

HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	CY 2007 APC median cost	Final CY 2008 SI	Final CY 2008 APC	Final CY 2008 APC median cost
78459	Heart muscle imaging (PET)	S	0307	$727	S	0307	$ 1,384
78491	Heart image (pet), single	S	0307	$727	S	0307	$ 1,384
78492	Heart image (pet), multiple	S	0307	$727	S	0307	$ 1,384

d. Nonmyocardial Positron Emission Tomography (PET) Scans (APC 0308)

For CY 2008, we proposed to continue to assign the nonmyocardial PET scans to APC to 0308 (Non-Myocardial Positron Emission Tomography (PET) Imaging), with a proposed payment rate of approximately $1,107, specifically CPT codes 78811 (Tumor imaging, positron emission tomography (PET); limited area (eg, chest, head/neck)), 78812 (Tumor imaging, positron emission tomography (PET); skull base to mid-thigh)), 78813 (Tumor imaging, positron emission tomography (PET); whole body)), and 78608 (Brain imaging, positron emission tomography (PET); metabolic evaluation). We note that this proposed payment will include payment for the diagnostic radiopharmaceuticals used in the PET scans. APC 0308 will also include concurrent PET/CT procedures. Refer to section III.C.2.a. of this final rule with comment period for further discussion of the CY 2008 OPPS assignment of concurrent PET/CT procedures.

We received several public comments concerning this proposal. A summary of the public comments and our responses follow.

Comment: Several commenters agreed with the placement of CPT codes 78811, 78812, and 78813 in APC 0308; however, some commenters requested that CMS reassign CPT code 78608 to a new clinical APC for PET brain imaging.

Response: We disagree with the commenters' suggestion that we should create a separate clinical APC for CPT code 78608. Brain PET scan services have historically been assigned to the same APCs as other nonmyocardial PET services for a number of years, initially to the same New Technology APCs and for CY 2007 to the same clinical APC. Analysis of our hospital outpatient claims data from CY 2006 reveals that the median cost of approximately $1,046 for CPT code 78608 falls within the range of the HCPCS-specific median costs, approximately $1,004 to $1,240, for the other PET procedures also assigned to APC 0308. We are not convinced that separating nonmyocardial PET scans according to the body site being examined is necessary for clinical homogeneity, and the result of such a distinction would be a single CPT code in one APC. The OPPS is a prospective payment system that provides payment for groups of services that share clinical and resource characteristics. We believe that PET scans for tumor imaging and brain imaging are similar in both respects and are appropriately assigned to the same clinical APC.

After considering the public comments received, we are finalizing our proposal, without modification, including assignment of CPT code 78608 to APC 0308, with a CY 2008 median cost of approximately $1,044.

e. Proton Beam Therapy (APCs 0664 and 0667)

For CY 2008, we proposed to pay for the following four CPT codes for proton beam therapy: 77520 (Proton treatment delivery; simple, without compensation); 77522 (Proton treatment delivery; simple, with compensation); 77523 (Proton treatment delivery; intermediate); and CPT 77525 (Proton treatment delivery; complex). We proposed to continue to assign the simple proton beam therapy procedures to APC 0664 (Level I Proton Beam Radiation Therapy), with a proposed median cost of approximately $845, and the intermediate and complex proton beam therapy procedures to APC 0667 (Level II Proton Beam Radiation Therapy), with a proposed median cost of approximately $1,012. The CY 2007 payment rates for these APCs are approximately $1,161 and $1,389, respectively. We also proposed to make an exception to the 2 times rule for APC 0664, as we did in CYs 2006 and 2007.

We received several public comments concerning this proposal. A summary of the public comments and our responses follow.

Comment: One commenter expressed concern that the CY 2008 proposed payment rates for APCs 0664 and 0667 are approximately 27 percent lower than the CY 2007 payment rates for these same APCs. The commenter characterized proton beam therapy as an extremely complex and expensive technology that is currently offered in only two hospitals. The commenter asked CMS to reevaluate the claims data and its analysis of the median costs contained in those claims data for errors. The commenter asserted that if the data and rate calculations were verified as valid, CMS should take into consideration that for any service provided by only two hospitals, the payment rates for the service will be highly dependent on the idiosyncrasies of the billing and charging practices of those two facilities. The commenter stated that a 27 percent reduction in payment would discourage, if not eliminate, the adoption of this technology by other providers. In addition, the commenter offered support for the proposal to designate APC 0664 as an exception to the 2 times rule for CY 2008.

Another commenter reviewed its proton beam therapy claims, charges, and cost data, and determined that the CY 2008 proposed median costs for APCs 0664 and 0667 appropriately reflect the cost of this technology.

Response: In response to one commenter's concern about the validity of our data and our ratesetting analyses, we examined the claims and cost reports for proton beam therapy and verified our calculations. Consistent with the other commenter's examination of its own claims, charges, and costs, we found both the data and our calculation of the median costs to be accurate for APCs 0664 and 0667. We note that the median costs for relatively low volume APCs, such as APCs 0664 and 0667, often fluctuate from year to year, in part due to the variability created by a small number of claims. We agree with the commenter that because our standard ratesetting methodology is based on OPPS claims, the payment rates for those services provided by only a few hospitals to Medicare beneficiaries are dependent on the particular costs and charging practices of that small subset of hospitals paid for the services under the OPPS. Therefore, the small number of hospitals providing proton beam therapy also may contribute to additional variation in payment rates as those hospitals' charging and cost reporting practices evolve over time. As more hospitals adopt this technology, we expect that the fluctuation in payment for APCs 0664 and 0667 will be moderated by the increased number of observations for similar services and the incorporation of claims from a larger number of hospitals in the ratesetting process.

We note that neither of these APCs violate the 2 times rule based on the CY 2008 final rule data because the volume of CPT code 77520 is such a small percentage of claims for APC 0664. The law permits exceptions to the 2 times rule for services that are low volume, which we generally have considered as having a single bill frequency that is less than or equal to 1,000, or less than or equal to 99 if the service constitutes less than 2 percent of the single bill frequency for an APC. CPT code 77520 has a single bill frequency of 188 in the CY 2008 OPPS data and constitutes only 1 percent of the single claims in the APC. Therefore, there is no 2 times violation in APC 0664.

After consideration of the public comments received, we are finalizing our CY 2008 proposal, without modification, to assign CPT codes 77520 and 77522 to APC 0664, with a median cost of approximately $807, and to assign CPT codes 77523 and 77525 to APC 0667, with a median cost of approximately $965.

6. Ocular and Ear, Nose, and Throat Procedures

a. Amniotic Membrane for Ocular Surface Reconstruction (APC 0244)

We proposed to assign HCPCS code V2790 (Amniotic membrane for surgical reconstruction, per procedure) status indicator ''N'' (packaged) for CY 2008 and to assign its related CPT procedure codes to APC 0244 (Corneal Transplant). The proposed status indicators for the item and procedures and the proposed APC assignments for the procedures were the same as their CY 2007 OPPS treatment.

We received several comments on the proposed OPPS treatment of HCPCS code V2790 for CY 2008. A summary of the public comments and our response follow.

Comment: Several commenters requested that CMS consider assigning a status indicator of ''F'' (paid at reasonable cost) to HCPCS code V2790 and creating a separate APC for amniotic membrane transplantation procedures that includes the costs of amniotic membrane tissue. They compared V2785 (Processing, preserving and transporting corneal tissue) and V2790, noting a difference in payment policy and status indicator assignments for the two types of tissues used for ocular surface transplant. That is, HCPCS code V2785, which is assigned status indicator ''F'' and HCPCS code V2790, which is assigned status indicator ''N,'' are not treated similarly with regard to status indicator assignments and OPPS payment policy. Payment for items and services assigned status indicator ''N'' is packaged into payment for the associated procedures, while payment for items and services with status indicator ''F'' is made at reasonable cost, not under the OPPS. Another commenter requested that CMS reassign the CPT procedure codes associated with the amniotic tissue transplant from APC 0244 to a separate APC. This commenter indicated that the source tissue is not bundled into the payment for every CPT code in APC 0244, only the amniotic membrane tissue.

In addition, several commenters were concerned that paying separately for corneal tissue and not for amniotic membrane tissue could create a competitive disadvantage and a financial disincentive for hospitals to treat ocular surface diseases using amniotic membrane tissue and ultimately would impede beneficiary access to this ocular reconstructive procedure. Some commenters indicated that HCPCS code V2790 and its related procedure code, specifically CPT code 65780 (Ocular surface reconstruction; amniotic membrane transplantation), are not adequately represented in hospital claims data. Despite instructions from CMS that packaged items and services should be reported on claims, some commenters believed that hospitals often fail to report HCPCS code V2790 because payment for HCPCS code V2790 is packaged with its related procedure code. They argued that the underreporting of the use of amniotic membrane tissue, which includes the costs of procuring, processing, storing, and distributing the product, leads to inadequate payment for CPT code 65780. Some commenters recommended that CMS establish claims processing edits to ensure the presence of the tissue HCPCS code and a charge for the item on claims for the ocular reconstruction procedure. One commenter indicated that the costs for amniotic membrane tissue can vary widely, similar to corneal tissue, and that the procurement of the tissue adds to the highly variable costs because hospitals require different sized tissues to accommodate various treatment and patient requirements. These commenters requested that CMS reassign HCPCS code V2790 from status indicator ''N'' to ''F'' and also create a separate APC specifically for amniotic membrane transplantation procedures for CY 2008.

Response: The OPPS has provided separate payment for corneal tissue acquisition at reasonable cost since the beginning of the OPPS, due to the highly variable corneal tissue processing fees required for eye banks to provide safe corneal tissue from donors as needed for transplant, through special distribution channels. These costs may vary substantially and unpredictably, depending on philanthropic and in-kind service contributions to eye banks that vary from community-to-community and from year-to-year. Our understanding is that amniotic membrane retrieved from donated placental tissues is a processed, cryopreserved, and commercially marketed product used for ocular reconstruction that may be stocked and stored by hospitals. Unlike corneal tissue, we believe that amniotic tissue is a supply with stable and predictable costs. We do not consider the circumstances of amniotic tissue to be like those of corneal tissue, and consider it appropriate to continue to package the payment for amniotic tissue into payment for its related procedure code.

We examined CY 2008 proposed rule claims, derived from CY 2006, for CPT code 65780, with and without HCPCS code V2790. While most claims did not specifically include HCPCS code V2790, the median costs for claims with and without HCPCS code V2790 were reasonably close and consistent with the costs of other services assigned to APC 0244. Specifically, claims with HCPCS code V2790 had a median cost of approximately $2,553, while claims without HCPCS code V2790 had a median cost of approximately $2,063. The median line-item cost of HCPCS code V2790 was $506, relatively consistent with the difference in cost between the claims with and without HCPCS code V2790. Based on our analysis, the proposed rule median cost of approximately $2,409 for all procedures in APC 0244, which would not include the costs of corneal tissue but would incorporate the costs of amniotic membrane tissue, is very close to the median cost of the amniotic tissue transplant procedure claims that include the HCPCS code for amniotic membrane tissue. The CY 2008 APC 0244 final rule median cost of approximately $2,359 is consistent with the APC's proposed rule cost.

Based on our claims data from CY 2006, we believe that the current and proposed packaged status of HCPCS code V2790 is appropriate based on resource and clinical considerations. We also believe that the proposed composition of APC 0244, dominated by claims for corneal transplant procedures, reflects appropriate clinical and resource homogeneity. While some commenters were concerned with hospitals not reporting HCPCS code V2790 when reporting CPT code 65780, we do not believe that we should create a claims processing edit in this instance. We create device edits, when appropriate, for procedures assigned to device-dependent APCs, where those APCs have been historically identified under the OPPS as having very high device costs. Because APC 0244 is not a device-dependent APC and the costs of the procedure with and without HCPCS code V2790 are relatively close, we will not create edits. We remind hospitals that they must report all of the HCPCS codes that appropriately describe the items used to provide services, regardless of whether the HCPCS codes are packaged or paid separately.

After consideration of the public comments received, we are finalizing our proposed CY 2008 payment policies, without modification, for HCPCS codes V2785 and V2790 as reflected in their status indicators, as well as the proposed configuration of APC 0244. We are also changing the APC title for APC 0244 from ''Corneal

Transplant'' to ''Corneal and Amniotic Membrane Transplant,'' effective January 1, 2008, to ensure that the title better describes all procedures assigned to that APC.

b. Keratoprosthesis (APC 0293)

CPT code 65570 (Keratoprosthesis) describes the surgical procedure for implantation of an artificial cornea, also known as a keratoprosthesis. In the CY 2007 OPPS/ASC final rule with comment period, we indicated that we were implementing device edits in CY 2007 for CPT code 65770 to ensure that all claims for CPT code 65570 in CY 2007 and after include charges for a required device (71 FR 68053). For CY 2008, we proposed continued assignment of CPT code 65570 to APC 0293 (Level V Anterior Segment Eye Procedures), with a proposed payment rate of approximately $5,290. The CY 2007 payment rate for APC 0293 is approximately $3,196.

We received one public comment on our CY 2008 proposal for CPT code 65770. A summary of the public comment and our response follow.

Comment: One commenter expressed concern that the procedure described by CPT code 65570 required significant implantation of a costly device, but it was not assigned to a device-dependent APC. The commenter stated that assignment to a nondevice-dependent APC may result in inadequate payment rates in the ASC setting. The commenter noted that the revised ASC payment methodology, which will be implemented in CY 2008, includes an exception to the standard ratesetting methodology for device-intensive procedures that allows only the service portion of the procedure to be reduced by the ASC budget neutrality adjustment to reflect the relatively constant price of medical devices across hospital outpatient and ASC settings of care. Device-intensive procedures are defined as those procedures assigned to device-dependent APCs under the OPPS for payment purposes, where the APC device cost is greater than 50 percent of the APC median cost. The commenter pointed out that by assigning CPT code 65570 to a non-device-dependent APC under the OPPS, the procedure did not qualify as device intensive for ASC payment purposes. The commenter concluded that the entire payment rate for the procedure would be reduced by the ASC budget neutrality adjustment, rather than just the service portion, in contrast to other procedures assigned to APCs for which the device costs constitute a significant portion of the total procedure costs.

Response: We agree with the commenter that the procedure described by CPT code 65770 requires the implantation of a device, and that a significant portion of the total cost of keratoprosthesis implantation procedures is likely to be attributable to device costs. Currently CPT code 65570 is assigned to APC 0293 under the OPPS, where it is the only procedure in the APC. There also are two device codes for reporting keratoprostheses, HCPCS code C1818 (Integrated Keratoprosthesis) that describes the expired pass-through device category that was created in CY 2003 and HCPCS code L8609 (Artificial cornea) that was first available for reporting in CY 2007. It is not possible to calculate a device percentage for APC 0293 for CY 2008 that reflects the full costs of the devices implanted in CY 2006 because there was no device code that described all possible devices that could be implanted in the procedure at that time.

As we stated in the CY 2007 OPPS/ASC final rule with comment period, when there are device HCPCS codes for all possible devices that could be used to perform a procedure that always requires a device and the APC is designated a device-dependent APC, we commonly institute device edits that prevent payment of claims that do not include both the procedure and an acceptable device code (71 FR 68053). We implemented device edits in CY 2007 for APC 0293, the first year that device HCPCS codes that describe all possible devices that could be used to perform the procedure were available, and we agree with the commenter that it would be most consistent with our established device editing policy to designate APC 0293 as device-dependent. However, we are unable to consider only CY 2006 claims for CPT code 65570 that contain a device HCPCS code for CY 2008 ratesetting for the APC. If we were to follow our usual ratesetting methodology for device-dependent APCs, we could be systematically and incorrectly excluding claims for CPT code 65570 that may have been correctly coded at the time by hospitals implanting a two-part keratoprosthesis not described by the only available HCPCS code, specifically C1818.

After consideration of the public comments received, we are finalizing our CY 2008 proposal, with modification. We are assigning CPT code 65570 to APC 0293 as proposed. In addition, we are designating APC 0293 as a device-dependent APC, with a median cost of approximately $5,335.

c. Palatal Implant (APC 1510)

In Addendum B to the CY 2008 proposed rule (72 FR 43018), we proposed to pay $850 for HCPCS code C9727 (Insertion of implants into the soft palate; minimum of three implants) through its assignment to New Technology APC 1510 (New Technology—Level X ($800–$900)). This is the same APC assignment for the service as its CY 2007 placement.

We received one comment on our CY 2008 payment proposal for HCPCS code C9727. A summary of the comment and our response follow.

Comment: One commenter considered the proposed CY 2008 payment rate for HCPCS code C9727 to be inappropriate based on the costs of the clinical staff, supplies, equipment, and overhead required to perform the procedure. The commenter reported that, based on its estimate that used the MPFS Practice Expense Database as a reference, the appropriate median cost for this procedure should be between $1,100 and $1,200. The commenter submitted a categorized list of items involved in performing the procedure to CMS, along with approximate costs for each category. In addition, the commenter asked CMS to reassign HCPCS code C9727 to New Technology APC 1514 (New Technology—Level XV ($1200–$1300)) for CY 2008 because the commenter believed that the payment for this APC would appropriately reflect the complexity and resource costs associated with performing this procedure.

Response: We assign a new procedure to a New Technology APC when we do not have adequate claims data upon which to determine the median cost of performing a procedure and there is no appropriate clinical APC for its assignment based on clinical and resource homogeneity considerations. We perform our own cost analysis and cost estimate, in addition to taking the project costs that may be submitted in a New Technology APC application into consideration. As we stated in our November 30, 2001 final rule (66 FR 59900), concerning the placement of new services into New Technology APCs in response to an application, ''We will not limit our determination of the cost of the procedure to information submitted by the application. Our staff will obtain information on cost from other appropriate sources before making a determination of the cost of the procedure to hospitals.'' We received a New Technology APC application from the manufacturer of palatal implants required for the Pillar® Procedure. Consistent with our customary practice,

we compared the estimated hospital resources, including procedure room time, personnel, device costs, and other resources of the new procedure to various other OPPS procedures for which we have historical claims data. We believed that, based on this analysis, a payment rate of $850 was appropriate based on all cost and utilization information available to us regarding the palatal implant procedure and other services provided in the hospital outpatient setting. Consequently, we assigned HCPCS code C9727 to New Technology APC 1510, effective October 1, 2006.

Analysis of our hospital data for claims submitted for CY 2006 indicates that the palatal implant procedure was rarely performed on Medicare beneficiaries in the last quarter of that year when specific OPPS payment was first available. OPPS claims for services between October 1, 2006, and December 1, 2006, show that there were only two claims submitted for HCPCS code C9727. We reexamined the service's proposed CY 2008 assignment in light of all current information available to us for this final rule with comment period, and we conclude that its proposed assignment to New Technology APC 1510 remains appropriate. We will reexamine the claims data for this procedure next year when we review its APC placement in preparation for the annual CY 2009 OPPS update.

Furthermore, the MPFS applies a very different methodology for establishing the payment for the physician's office practice expenses associated with a procedure, specifically considering the individual costs of the inputs, whereas the OPPS generally pays based on relative payment weights calculated from hospitals' costs as determined from claims data. Thus, comparisons between the MPFS and OPPS payments for services are not appropriate. While the palatal implant procedure is a relatively new service under the OPPS, the procedure resembles other OPPS services for which cost data are currently available.

Therefore, after consideration of all the public comments received, we are finalizing our CY 2008 proposal, without modification, to assign HCPCS code C9727 to New Technology APC 1510 with a payment rate of $850.

7. Orthopedic Procedures

a. Arthroscopic Procedures (APCs 0041 and 0042)

For CY 2008, we proposed two primary APCs for arthroscopic procedures, APC 0041 (Level I Arthroscopy), comprised of 49 procedures with a CY 2008 proposed payment rate of approximately $1,876, and APC 0042 (Level II Arthroscopy), comprised of 17 procedures with a proposed payment rate of approximately $3,043. The CY 2007 payment rates for these APCs 0041 and 0042 are approximately $1,759 and $2,797, respectively. While we proposed to assign the majority of arthroscopic procedures to these APCs for CY 2008, we also proposed to continue the assignment of several arthroscopic procedures to APC 0053 (Level I Hand Musculoskeletal Procedures), with a proposed CY 2008 payment rate of approximately $1,071. The CY 2007 payment rate for APC 0053 is approximately $993.

We received one public comment on our CY 2008 proposed configuration of arthroscopy APCs. A summary of the public comment and our response follow.

Comment: A commenter stated that the current configuration of arthroscopic procedures assigned to APCs 0041, 0042, and 0053 fails to appropriately recognize the distinct clinical and resource features of the wide range of arthroscopic procedures now being provided to Medicare beneficiaries. The commenter requested that CMS create new arthroscopy APCs and reconfigure the current assignment of arthroscopic procedures to ensure that the arthroscopy APCs are clinically homogenous and contain only those procedure that are similar in resource utilization. Specifically, the commenter requested that CMS restructure the arthroscopy APCs to reflect the following clinical categories: diagnostic arthroscopies, lower extremity versus upper extremity arthroscopies, and arthroscopies with implants. The commenter suggested that each clinical distinction be divided further into three levels of resource utilization, for a total of 9 new APCs for arthroscopy procedures with recommended payment ranging from $1,530 to $4,100. According to the commenter, these clinical distinctions parallel the distinctions CMS has created for other classes of procedures, including other orthopedic procedures, and would more accurately and equitably reflect the clinical characteristics and resource utilization of the services rendered.

Response: In response to the concerns raised by the commenter, we reviewed the clinical characteristics and hospital costs from CY 2006 claims data for all procedures proposed for CY 2008 assignment to APCs 0041, 0042, and 0053. In considering the commenter's recommended APC configurations, we identified several procedures that were assigned to APCs 0041 and 0053 with median costs and clinical characteristics that were more similar to procedures assigned to other clinical APCs than the APCs to which we proposed their assignment. Therefore, for CY 2008, we will reassign 11 arthroscopic procedures that are currently in APC 0041 to APC 0042, and we will reassign 3 arthroscopic procedures that are currently in APC 0053 to 0041, as reflected in Table 21 below. While we appreciate the commenter's suggestion for nine new APCs for arthroscopic procedures, we believe that the existing clinical APCs, with the modifications included in Table 21 that assign procedures to the larger groups in a way that is generally consistent with the commenter's more specific recommended groupings, sufficiently account for the different clinical and resource characteristics of these procedures. Furthermore, to reduce the size of the APC payment groups and establish new clinical APC payment groups to pay more precisely would be inconsistent with our overall strategy to encourage hospitals to use resources more efficiently by increasing the size of the payment bundles.

After consideration of the public comment received, we are modifying our CY 2008 proposal and will reassign several arthroscopic procedures to APCs 0041 and 0042, as displayed in Table 21 below.

TABLE 21.—CY 2008 APC REASSIGNMENT OF ARTHROSCOPIC PROCEDURES

HCPCS code	Short descriptor	CY 2007 APC assignment	CY 2007 APC median cost	CY 2008 APC assignment	CY 2008 APC median cost
29819	Shoulder arthroscopy/surgery	0041	$1,749	0042	$2,876
29820	Shoulder arthroscopy/surgery	0041	1,749	0042	2,876
29821	Shoulder arthroscopy/surgery	0041	1,749	0042	2,876
29823	Shoulder arthroscopy/surgery	0041	1,749	0042	2,876

TABLE 21.—CY 2008 APC REASSIGNMENT OF ARTHROSCOPIC PROCEDURES—Continued

HCPCS code	Short descriptor	CY 2007 APC assignment	CY 2007 APC median cost	CY 2008 APC assignment	CY 2008 APC median cost
29825	Shoulder arthroscopy/surgery	0041	1,749	0042	2,876
29847	Wrist arthroscopy/surgery	0041	1,749	0042	2,876
29856	Tibial arthroscopy/surgery	0041	1,749	0042	2,876
29860	Hip arthroscopy, dx	0041	1,749	0042	2,876
29861	Hip arthroscopy/surgery	0041	1,749	0042	2,876
29891	Ankle arthroscopy/surgery	0041	1,749	0042	2,876
29892	Ankle arthroscopy/surgery	0041	1,749	0042	2,876
29900	Mcp joint arthroscopy, dx	0053	987	0041	1,811
29901	Mcp joint arthroscopy, surg	0053	987	0041	1,811
29902	Mcp joint arthroscopy, surg	0053	987	0041	1,811

b. Closed Fracture Treatment (APC 0043)

For CY 2008, we proposed to continue the assignment of various CPT codes that describe closed treatment of fractures of the fingers, toes, and trunk to APC 0043 (Closed Treatment Fracture Finger/Toe/Trunk), with a proposed payment rate of about $119. We did not propose any CPT code reassignment changes for APC 0043.

We received one public comment on our proposed CY 2008 configuration of APC 0043. A summary of the public comment and our response follow.

Comment: A commenter expressed concern about the wide variety of procedures assigned to APC 0043, which the commenter claimed ranged from $1 to $3,000 in cost. The commenter disapproved of CMS assigning one APC for various types of fracture treatments as the commenter asserted that the costs associated with finger treatments, hip dislocations, and spinal fractures vary significantly. The commenter indicated specifically that the costs associated with spinal fractures are significantly greater than the costs associated with finger or toe fractures. The commenter believed that grouping all of these procedures in one clinical APC violated the 2 times rule, and that continuing to except APC 0043 from the 2 times rule was not appropriate. To pay appropriately for these procedures under the current OPPS, the commenter recommended that CMS divide the procedures currently assigned to APC 0043 among several APCs, because of the existing large variations in resource costs for the procedures.

Response: We thank the commenter for bringing this concern to our attention. We agree with the commenter that grouping all of the closed fracture treatment procedures in one APC may not most accurately distinguish the more expensive from the less resource-intensive fracture treatment procedures. We note that while there are about 150 procedures assigned to APC 0043, only 13 procedures are significant procedures with the frequency necessary to assess the APC's alignment with the 2 times rule. The remainder of the procedures are low volume and, therefore, not significant procedures in the APC for purposes of evaluating the APC by applying the 2 times rule. The median costs of the significant procedures in APC 0043 for CY 2008 range from about $68 to $248. This particular APC has been excepted from the 2 times rule for the past 6 years under the OPPS, and we have not previously received public comments regarding the structure of this APC over the past several years. The commenter did not make a specific recommendation regarding alternative APC configurations. Because APC 0043 contains so many different fracture treatment procedures with low volume, we are concerned that any restructuring for CY 2008 without the benefit of public comment could lead to APCs that do not reflect improved clinical and resource homogeneity over the proposed configuration; therefore, we will not establish a different APC configuration for CY 2008. However, we are specifically inviting public comment on potential alternative APC configurations for the services currently assigned to APC 0043 for the CY 2009 APC review process. We also plan to bring this APC issue to the attention of the APC Panel at its winter 2008 meeting and will request its input as to how to appropriately categorize the procedures in APC 0043.

After consideration of the public comment received, we are finalizing, without modification, our proposed configuration of APC 0043, with a median cost of about $111 for CY 2008.

c. Insertion of Posterior Spinous Process Distraction Device (APC 0050)

We proposed to assign CPT codes 0171T (Insertion of posterior spinous process distraction device (including necessary removal of bone or ligament for insertion and imaging guidance), lumbar; single level); and 0172T (Insertion of posterior spinous process distraction device (including necessary removal of bone or ligament for insertion and imaging guidance), lumbar; each additional level) to APC 0050 (Level II Musculoskeletal Procedures Except Hand and Foot), with a proposed payment rate of approximately $1,868. These two codes were new in CY 2007, where they were assigned to APC 0050 on an interim final basis. We created a new device category, specifically, C1821 (Interspinous process distraction device (implantable)) for transitional pass-through payment, effective January 1, 2007, which we expected to be reported with CPT codes 0171T and 0172T. This pass-through device category will continue to be paid at hospital charges adjusted to cost for CY 2008, as discussed in section IV.A.1.b. of this final rule with comment period.

We received several public comments on our CY 2008 proposed APC assignments for CPT codes 0171T and 0172T. A summary of the public comments and our response follow.

Comment: Some commenters disagreed with our proposed APC assignments for CPT codes 0171T and 0172T, and indicated that these procedures should be reassigned from APC 0050 to APC 0208 (Laminotomies and Laminectomies), which had a proposed payment rate of approximately $3,036 for CY 2008. The commenter asserted that the spinous distraction device insertion is clinically different and involves greater hospital resources than the other procedures assigned to APC 0050. This commenter cited one procedure in APC 0050, specifically vertebroplasty, claiming that its costs are significantly lower than the spinous process distraction device procedure. The commenter claimed that the vertebroplasty procedure is one that involves an injection procedure that is

performed in 30 minutes and does not involve implanting a spinal device. Alternatively, the commenter explained that inserting a spinous process distraction device requires an hour in the operating room and involves implanting a device in the spine. Several commenters reported that the spinous process distraction device insertion is similar to a laminectomy procedure in that both procedures involve the spinal processes and take approximately 1 hour to perform. These commenters requested that CMS reassign CPT codes 0171T and 0172T to APC 0208 based on clinical and cost considerations.

Response: We carefully analyzed the CY 2006 claims data for other musculoskeletal procedures under the OPPS, and we believe that CPT codes 0171T and 0172T are appropriately assigned to APC 0050, based on both clinical and expected resource considerations. We do not agree with some commenters that these minimally invasive procedures to insert a spinal device are similar to the procedures that are currently assigned to APC 0208, which are generally significant open surgical procedures on the spine. We believe that the hospital's nondevice costs and the clinical characteristics of CPT codes 0171T and 0172T more closely align with the less invasive musculoskeletal procedures presently assigned to APC 0050.

We will continue pass-through payment status, initially implemented in January 2007, for the spinous process distraction device (C1821) reported with CPT codes 0171T and 0172T through CY 2008. Separate payment for HCPCS code C1821 will be made under the OPPS for at least 2 and not more than 3 years of pass-through payment. After that period, payment for the cost of the device will be packaged into the procedural payment for its implantation, specifically CPT codes 0171T and 0172T.

After consideration of the public comments received, we are finalizing our CY 2008 proposal, without modification, to assign CPT codes 0171T and 0172T to APC 0050, with a median cost of approximately $1,836.

d. Intradiscal Annuloplasty (APC 0050)

For CY 2008, we proposed to assign the intradiscal electrothermal (IDET) annuloplasty procedures, specifically those described by CPT codes 22526 (Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level) and 22527 (Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; one or more additional levels (List separately in addition to code for primary procedure)) to APC 0050 (Level II Musculoskeletal Procedures Except Hand and Foot), with a proposed payment rate of approximately $1,868 for CY 2008. These CPT codes were new for CY 2007, when they were first assigned to APC 0050 under the OPPS on an interim final basis.

We received several public comments on our CY 2008 proposed APC assignments for CPT codes 22526 and 22527. A summary of the public comments and our response follow.

Comment: Several commenters disagreed with the proposed assignment for CPT codes 22526 and 22527 and recommended that these procedures be reassigned to APC 0051 (Level III Musculoskeletal Procedures Except Hand and Foot), which had a proposed CY 2008 payment rate of approximately $2,777. These commenters believed that the hospital costs associated with IDET are relatively higher than the payment associated with APC 0050. One commenter who provided its price list reported that the cost of one disposable catheter used in the procedure is approximately $1,800. The commenter indicated that APC 0051 would more accurately pay hospitals for the IDET procedure. Another commenter indicated that the other procedures in APC 0051 are similar to the IDET procedure based on clinical homogeneity and resource costs.

Response: CPT codes 22526 and 22527 were created effective January 1, 2007. Prior to CY 2007, the IDET procedure was described by CPT code 0062T, which was implemented on January 1, 2005. The initial code long descriptor for CPT code 0062T in CY 2005 was ''Percutaneous intradiscal annuloplasty, any method, unilateral or bilateral including fluoroscopic guidance; single level.'' However, in CY 2007, the CPT Editorial Panel revised this descriptor to ''Percutaneous intradiscal annuloplasty, any method except electrothermal, unilateral or bilateral including fluoroscopic guidance; single level'' to appropriately differentiate between electrothermal and non-electrothermal methods. Following the descriptor revision, CPT codes 22526 and 22527 described the electrothermal methodology for percutaneous intradiscal annuloplasty, while CPT code 0062T described the non-electrothermal methodology.

Since the code descriptor change did not occur until CY 2007, hospital outpatient claims from CY 2006 for CPT code 0062T describe both electrothermal and non-electrothermal methods. Based on our review of the hospital outpatient claims from CY 2006 and CY 2005, percutaneous intradiscal annuloplasty is performed infrequently in the hospital outpatient setting for the Medicare population. Claims from CY 2006 show a median cost of approximately $1,019 for CPT code 0062T based on 44 single claims, and a median cost of approximately $2,034 based on only 28 single claims for CY 2005.

We believe, based on our review of the clinical characteristics and historical hospital costs for percutaneous intradiscal annuloplasty and other musculoskeletal procedures assigned to APCs 0050 and 0051, that the most appropriate APC assignment for percutaneous intradiscal annuloplasty procedures, whether electrothermal or non-electrothermal, is APC 0050.

After considering the public comments received, we are finalizing our CY 2008 proposal, without modification, to assign CPT codes 22526 and 22527 to APC 0050, with a median cost of approximately $1,836.

e. Kyphoplasty Procedures (APC 0052)

For CY 2008, we proposed to assign CPT codes 22523 (Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic), 22524 (Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); lumbar), and 22525 (Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)) to APC 0052 (Level IV Musculoskeletal Procedures Except Hand and Foot) with a proposed payment rate of approximately $5,010.

We received one public comment on our CY 2008 proposal for CPT codes 22523, 22524, and 22525. A summary of the public comment and our response follow.

Comment: Some commenters expressed concern about the accuracy of hospital charge data for these procedures. Because of charge compression, the commenters believed that the current data collected from hospital charges do not accurately

reflect the true costs of the kyphoplasty procedures. The commenters appreciated CMS'' attention in reviewing and placing these procedures in an appropriate APC for CY 2008; however, they believed that charge compression directly contributes to inaccurate and reduced payment rates for the services. One commenter explained that procedures that involve the use of expensive medical devices, whereby hospitals apply smaller mark-up rates to higher-cost medical devices than they do to lower-cost supplies used in procedures, results in charge compression. Because the current OPPS payment methodology is to calculate the payment weight for an APC based on hospital charges adjusted to cost, the commenters argued that charge compression results in the lowering of payment rates for procedures that involve the use of expensive medical devices. These commenters strongly urged CMS to continue to consider future refinements to the OPPS payment amounts for kyphoplasty procedures in light of the effects of charge compression.

Response: We thank the commenters for their suggestions and refer to section II.A.3. of this final rule with comment period for further discussion on charge compression. Consistent with our update process, we review hospital outpatient claims data and assign services and items to appropriate APCs on an annual basis.

After consideration of the public comments received, we are finalizing our CY 2008 proposal, without modification, to assign CPT codes 22523, 22524, and 22525 to APC 0052, with a median cost of approximately $4,997.

8. Vascular Procedures

a. Blood Transfusion (APC 0110)

We have a longstanding policy under the OPPS that blood 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 did not agree with the APC Panel's recommendation, and we proposed to not accept this recommendation for the CY 2008 OPPS. As stated in the CY 2008 OPPS/ASC proposed rule (72 FR 42718), 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 (72 FR 42717 through 42718).

Therefore, for CY 2008 we proposed 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.

We received several public comments on this proposal to maintain the current payment policy for blood transfusion services. A summary of the public comments and our response follow.

Comment: Several commenters requested that CMS reconsider the APC Panel's recommendation to provide separate payment for the transfusion of each unit of blood or blood products, as an alternative to CMS' current, encounter-based payment policy. They stated that the current policy does not pay OPPS providers adequately for the additional resources required for hospital outpatient visits involving multiple transfusions. They suggested that hospitals could report the ''59'' modifier (distinct procedural service) or another appropriate modifier to indicate that additional transfusions provided on the same day are distinct from the first transfusion. Some commenters argued that this would not conflict with the descriptor for CPT code 36430, as hospitals would only report multiple units of the code when they have performed more than one distinct transfusion. In contrast, another commenter noted that CPT guidelines indicate that CPT code 36430 should be reported once per transfusion regardless of the number of units administered, and supported CMS' proposal to continue provide one payment for blood transfusion services based on charges for all services provided in a hospital outpatient encounter.

One commenter also requested that CMS clarify that hospitals should charge for blood transfusion and administration services the same way for both hospital inpatients and outpatients. Another commenter indicated that hospitals should be able to base blood transfusion charges according to instructions published when Medicare was first created. According to the commenter, blood transfusion services were charged and paid on a per unit basis at that time.

Response: We believe that the current payment policy for blood transfusion services provides adequate and appropriate payment to OPPS providers for the additional resources required for hospital outpatient visits involving multiple transfusions. As described in

the proposed rule (72 FR 42718), we instruct hospitals to include charges for all of the hospital resource costs associated with the totality of transfusion services furnished on a date of service. While the CPT code descriptor would not preclude hospitals from reporting multiple units of the code when they have performed more than one distinct transfusion if they were to consider each unit of blood transfused to be a distinct transfusion, CPT coding guidelines indicate that CPT code 36430 should be reported only once per transfusion, regardless of the number of units administered. We believe that the median cost calculated from our claims data for blood transfusion services represents the full cost of an episode of transfusion, rather than the cost of the transfusion of a single unit of blood or blood product. We also 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. Therefore, for CY 2008, we are implementing our proposal 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.

Hospital inpatient departments and HOPDs have very different reporting structures that utilize different coding systems and vary in other significant ways. Inpatient charges for blood transfusion services are not relevant to the OPPS. Hospitals are free to set their charges for all items and services based on their own judgment. As is the case in other areas of CMS payment policy, reporting instructions for transfusion services reflect our current payment methodologies, which have evolved over time, and may not be the same as instructions published in the past.

In summary, for CY 2008, after consideration of the public comments received, we are finalizing our proposal, without modification, to continue to pay hospitals for only one unit of CPT code 36430 on a single date of service. We are not adopting the APC Panel's March 2007 recommendation to provide a separate payment for each unit of blood or blood product transfused. Because the payment for one unit of APC 0110, with a final CY 2008 median cost of approximately $214, is based on the costs of all transfusion services provided in a hospital outpatient encounter, 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.

b. Endovenous Ablation (APC 0092)

For CY 2008, we proposed to pay approximately $1,684 for CPT code 36478 (Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated) through its proposed assignment to APC 0092 (Level I Vascular Ligation). The proposed APC assignment for this service is the same as its CY 2007 APC assignment.

We received several public comments on the proposed CY 2008 payment for CPT code 36478. A summary of the public comments and our response follow.

Comment: Several commenters believed that the proposed payment rate for CPT code 36478 was considerably inadequate in view of the expense associated with the capital equipment required to perform this procedure. One commenter reported that, based on its estimate that used the MPFS Practice Expense Database as a reference, the appropriate placement for this procedure, in comparison with the practice expense of other endovenous procedures, would be APC 0091 (Level II Vascular Ligation), which had a CY 2008 proposed payment rate of approximately $2,781. Another commenter asserted that the other procedures assigned to APC 0092 bear little resemblance to the procedure described by CPT code 36478, and that in terms of clinical homogeneity and resource costs, endovenous ablation therapy of incompetent veins is very similar to those procedures assigned to APC 0091. The commenter requested that CMS reassign CPT code 36478 from APC 0092 to APC 0091 for CY 2008.

Response: We disagree with the commenters' argument that CPT code 36478 is less clinically related to procedures in APC 0091 than to procedures assigned to APC 0092. Procedures assigned to both APCs 0091 and 0092 include a variety of surgical procedures involving veins, and both APCs include endovenous ablation procedures using different technologies. Analysis of our CY 2006 hospital claims data results in a median cost of approximately $2,681 for APC 0091, which is considerably higher than the HCPCS-specific median cost of approximately $1,713 for CPT code 36478 based on 984 single claims. However, the median cost of CPT code 37478 is quite close to the CY 2008 median cost of approximately $1,626 for APC 0092. We believe that CPT code 36478 is most appropriately assigned to APC 0092 based on clinical and resource considerations.

We remind hospitals that in a budget neutral environment, Medicare does not make payments that fully cover hospitals' costs, including those for the purchase and maintenance of capital equipment. We rely on hospitals to make their business decisions regarding acquisition of expensive capital equipment taking into consideration their knowledge about their entire patient base (Medicare beneficiaries included) and an understanding of Medicare's and other payers' payment policies.

Furthermore, the MPFS applies a very different methodology for establishing the payment for the physician's office practice expenses associated with a procedure, specifically considering the individual costs of the inputs, whereas the OPPS generally pays based on relative payment weights calculated from hospitals' costs as determined from claims data. The application of the different methodologies results in different payment amounts in the two settings. Therefore, comparisons between the MPFS and OPPS payments for services are not appropriate.

After consideration of the public comments received, we are finalizing our CY 2008 proposal, without modification, to assign CPT code 36478 to APC 0092, with a median cost of about $1,626.

c. Insertion of Central Venous Access Device (APC 0625)

For the CY 2008 OPPS, we proposed to assign 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)) to APC 0625 (Level IV Vascular Access Procedures), as the only code in that APC. The procedure is for the purpose of implanting a vascular access device that is typically furnished to persons with end stage renal disease when there are no suitable access points for hemodialysis. The device that is implanted is reported under HCPCS code C1881 (Dialysis access system). For CY 2008, we proposed a national unadjusted payment of approximately $5,562 for the service, compared to the CY 2007 national unadjusted payment of approximately $5,130. As proposed, the payment for the device is packaged into the payment for APC 0625, a device-dependent APC.

We received several public comments on the proposed CY 2008 payment for APC 0625. A summary of the public comments and our responses follow.

Comment: Several commenters stated that the proposed CY 2008 payment for APC 0625 is excessive and recommended that the CY 2008 APC payment not exceed the CY 2007 payment. The commenters also recommended that CMS use external data to establish an appropriate benchmark cost for HCPCS code C1881. The commenters asked that CMS continue to require that hospitals must report HCPCS code C1881 on claims on which they report CPT code 36556. They also asked that CMS establish a payment for CPT code 36556 that is more stable from year to year. The commenters indicated that the low volume of these procedures may result in unstable payment rates over time and that use of external data to provide a benchmark for the cost of the device could help alleviate this problem. The commenters claimed that the cost of the device reported by HCPCS code C1881 is approximately $3,500.

Response: For this final rule with comment period, the median cost for APC 0625 is approximately $5,143, as compared with the proposed rule median cost of approximately $5,493. Both the proposed and final rule medians were calculated using only 8 claims of 479 total bills for the proposed rule and 535 total bills (of which 325 were potentially usable single bills) for this final rule with comment period. This is, in part, because we used only claims that contained the correct device code, no token charges for the device, and no ''FB'' modifier. Procedure-to-device edits that return to providers those claims for CPT code 36556 that do not also contain HCPCS code C1881 did not go into place until January 1, 2007 and, therefore, were not in place for CY 2006. We recognize that the small number of claims that contain the HCPCS C-code for the device without which the procedure cannot be performed may result in a median that is more volatile than is desirable. However, given that the commenter advises us that the cost of the device is approximately $3,500 and given that the median we calculated using final rule data is approximately $5,143, we believe that it is a reasonable estimate of the cost of the procedure, including the packaged cost of the device. We expect that the data available for future OPPS updates, beginning in CY 2009, will include more claims that report the device HCPCS code and, therefore, future median costs for APC 0625 may stabilize with additional claims available for ratesetting.

Comment: One commenter asked that CMS change the short descriptor for CPT code 36566 to read ''Ins tunneled cath w/subq port'' because the commenter believed that it is confusing to have multiple CPT codes with the same short descriptor. The commenter also asked that we revise the definition for HCPCS code C1881 to read ''Dialysis access system with subcutaneous port or valve.''

Response: The CPT codes, including the short descriptors, are owned by the AMA and any change to them is outside of the purview of CMS and should be addressed to the AMA CPT Editorial Board. HCPCS code C1881 describes the category of dialysis access devices, which is an existing pass-through device category that expired from pass through status as of the CY 2003 OPPS. As stated in the November 1, 2005 OPPS final rule with comment period (70 FR 68631), we revise a code that describes an existing category of devices (such as C1881) only if such revision is necessary to distinguish the existing category from a new category of pass-through devices in instances in which we must create a new category to describe a device that meets the criteria for pass-through payment. Therefore, there is no basis in policy to revise the definition of HCPCS code C1881.

After consideration of the public comments received, we are finalizing our CY 2008 proposal, without modification, to pay for CPT code 36566 through device-dependent APC 0625, with a median cost of approximately $5,143. We will not change the short descriptor for pass-through device category C1881.

d. Noninvasive Vascular Studies (APC 0267)

For the CY 2008 OPPS, we proposed to pay approximately $158 for procedures assigned to APC 0267 (Noninvasive Vascular Studies). We also proposed to pay approximately $420 for services assigned to APC 0269 (Level II Echocardiogram Except Transesophageal).

We received one public comment on our CY 2008 proposal. A summary of the public comment and our response follow.

Comment: A commenter stated that the vascular ultrasound procedures included in APC 0267 are grossly underpaid and that the CY 2008 payment for this APC should be similar to the payment for APC 0269, for which CMS proposed to pay approximately $417. The commenter indicated that the services in these two APCs require virtually the same resource costs. Specifically, the commenter explained that the equipment and software are equivalent and have similar costs, and in some facilities, the same equipment is used for the services in both APCs. According to the commenter, the technicians performing the studies in both APCs are of the same skill level and the associated cost is the same. The commenter claimed that the pay scale that CMS uses for purposes of establishing the MPFS RVUs for the procedures differs by only 2 cents per hour. The commenter asserted that the time scheduled for the procedures is virtually identical and that the supplies are essentially the same for the services assigned to both APCs. Hence, the commenter concluded that there is no basis for the differences in calculated costs for the services under the OPPS and recommended that CMS study this differential to provide insight into situations where the OPPS CCR methodology to calculate costs does not result in an accurate measure of relative resource utilization.

Response: We agree that it appears that the resources required to perform the vascular ultrasound and echocardiography services in these APCs appear, from a clinical perspective, to be very similar. We performed a limited initial examination of elements of the CY 2006 claims data for these APCs to determine if we could identify the reason for the difference in estimated median costs. We first looked at the charges for the services in these APCs, because one of the most fundamental elements of the calculation of estimated costs is hospitals'' charges for the services. The mean charge per service for the 17 HCPCS codes assigned to APC 0267 was approximately $786. In contrast, the mean charge per service for the three procedure codes assigned to APC 0269 was approximately $1,135. Clearly, on average hospitals charge much more for the services in APC 0269 than for the services in APC 0267. However, while the proposed payment for APC 0267 was 38 percent of the proposed payment for APC 0269, the mean charge for APC 0267 based upon the final rule data was 64 percent of the mean charge for APC 0269. Therefore, there is more of a disparity between the payments (and hence, between the median costs) than between the mean charges.

We next looked at the total frequency of services furnished in each APC and found that the total frequency of services was quite substantial in each APC. Therefore, it is unlikely that the disparity between the median costs for the two APCs is related to differences in

total volumes of services residing in those APCs. APC 0267 had a total frequency of approximately 1.2 million claims and APC 0269 had a total frequency of approximately 1 million claims in the final rule data from CY 2006 claims.

We then looked at single bills as a percentage of the total frequency and found that there is good representation in the single bills. For APC 0267, we were able to use approximately 99 percent of the total claims to set the median cost and for APC 0269, we were able to use approximately 75 percent of the total claims to set the median cost. Hence, the disparity is unlikely to be related to the variability associated with using a small percentage of total claims to calculate the median costs.

We also looked at the number of providers that furnish the highest volumes of services in each APC to see if there were significantly different counts of providers that might be a factor in the differences in estimated costs. CPT code 93880 (Duplex scan of intracranial arteries; complete bilateral study), assigned to APC 0267, was furnished by 3,119 hospitals and CPT code 93970 (Duplex scan of extremity veins including responses to compression and other maneuvers, complete bilateral study) was furnished by 3,160 hospitals in CY 2006. Similarly, CPT code 93307 (Echocardiography, transthoracic, real-time with imaging documentation (2D) with or without M-mode recording; complete), assigned to APC 0269, was furnished by 3,227 hospitals in CY 2006. These are a large number of the 4,089 hospitals whose claims were used for the final rule median cost calculations and, therefore, it is unlikely that idiosyncratic data from a few providers could be causing the disparity.

We note that the CY 2008 median cost of APC 0267 was about the same as its CY 2007 median cost, whereas the median cost of APC 0269 was almost double its CY 2007 median cost. We believe the increased cost of APC 0269 for CY 2008 may be a result of the CY 2008 packaging approach for ancillary and supportive services described in section II.A.4.c. of this final rule with comment period. In particular, the packaging of payment for doppler echocardiography and color flow velocity mapping, which are frequently reported with the CPT codes assigned to APC 0269 and which have been paid separately under the OPPS prior to CY 2008, may have contributed to the increased cost for APC 0269, whereas services assigned to APC 0267 had little new packaging due to our CY 2008 packaging approach.

We note we wish to investigate further the specific packaging associated with services assigned to both APCs, the revenue codes under which the services were charged, the revenue centers to which these revenue codes mapped, and the CCRs that applied to the charges for these services. We intend to undertake this further analysis and to discuss our findings with the APC Panel at its winter 2008 meeting.

However, for CY 2008 we are basing payment for APCs 0267 and 0269 on the median costs calculated from our claims data according to our standard median cost calculation process because our investigation of the data does not reveal a problem with the methodology or with the data. At this point, it appears that the median costs may be different because of dissimilar packaging and because hospitals charge significantly less for the services in APC 0267 than they charge for the services in APC 0269, where this significant difference in charges is not neutralized by the application of the CCRs applicable to these charges. Therefore, the median cost for APC 0267 is significantly lower than the median cost for APC 0269.

After consideration of the public comment received, we are finalizing our CY 2008 proposal, without modification, to provide payment for APCs 0267 and 0269 based on costs from claims, according to the standard OPPS methodology, with median costs of approximately $150 and $404, respectively. We note that for CY 2008, APC 0269 will be paid specifically for noncontrast echocardiography studies. We plan to analyze these APCs further and discuss our findings with the APC Panel at its winter 2008 meeting.

9. Other Procedures

a. Hyperbaric Oxygen Therapy (APC 0659)

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 proposed to continue using the same methodology to estimate a ''per unit'' median cost for HCPCS code C1300 of approximately $99 using 60,775 claims with multiple units or multiple occurrences for the proposed rule.

CY 2008 is the fourth year in which we will 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. As stated in the proposed rule (72 FR 42706), 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 proposed to continue to use the same methodology that we have used since CY 2005 to estimate payment for HBOT.

We received one public comment on our proposal. A summary of the public comment and our response follow.

Comment: One commenter commended CMS for applying a consistent methodology of utilizing an overall hospital CCR to yield a valid median cost for HBOT services. However, the commenter also encouraged CMS to consider an alternative methodology for calculating a median cost for HBOT. Specifically, the commenter stated that a contractor for a wound care association had established and reproduced an accurate CCR for HBOT and encouraged CMS to consider this methodology for the near future.

Response: We appreciate the commenter's support for our proposed methodology for estimating a ''per unit'' median cost for HBOT. In response to the comment urging us to utilize an alternate calculation to estimate a median cost for HBOT services, we note, as we did in our CY 2005 OPPS final rule with comment period (69 FR 65759), that we are not confident that the external research produces a definitive CCR for HBOT. That final rule with comment period provided an extensive discussion of our concerns about using survey findings to set, rather than validate, APC medians. These concerns included a lack of subscripted cost centers in the electronic cost report database, the wide variability in observed CCRs, and the possibility of nonresponse bias. As also noted in the CY 2005 final rule with comment period, we agree that the previous study definitively demonstrated great diversity among hospitals in the subscripted location of reported hyperbaric oxygen costs on the cost report, which prompted us to use the hospital's overall CCR, rather than a specific cost center CCR that would be used in our standard ratesetting methodology. We continue to believe that the median cost for APC 0659 developed according to our established ''per unit'' median cost calculation for HBOT is an appropriate relative cost to be used to set the payment weight upon which the HBOT payment is based.

After consideration of the public comment received, we are finalizing our CY 2008 proposal, without modification, for estimating a ''per unit'' median cost for HCPCS code C1300, assigned to APC 0659, with a median cost of approximately $98 based on 67,435 claims with multiple units or multiple occurrences.

b. Skin Repair Procedures (APCs 0133, 0134, 0135, 0136, and 0137)

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. Specifically, the section of the CPT book previously titled ''Free Skin Grafts'' and containing codes for skin repair 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, 37 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).

In the CY 2008 OPPS/ASC proposed rule, we observed that 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. The CY 2007 skin repair 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 the proposed rule, the median costs for the APCs as configured for CY 2007 were 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 had 2 times violations based on CY 2006 claims data. The HCPCS-specific median costs of significant procedures in APC 0024 ranged from approximately $83 to $255. We noted that a number of the procedures currently assigned to APC 0024 were very low volume, with few single claims available for ratesetting. Similarly, the median costs of the significant procedures in APC 0025 ranged from a low of about $119 to a high of about $399. This APC also contained a number of low volume procedures, as well as some new CY 2007 CPT codes without CY 2006 claims data. There was also some variation in the median costs of the HCPCS codes assigned to APCs 0686 and 0027, but there were 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 eliminated the 2 times violations that would have otherwise existed in APCs 0024 and 0025. It also more accurately attributed 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 the reorganization by CMS 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. In the proposed rule (72 FR 42707), we stated that we accepted the APC Panel's recommendation through this CY 2008 proposal to reconfigure the skin APCs into five levels, and we reexamined the placement of each of the add-on codes within the framework of the five APCs. We agreed with the APC Panel that, because these skin repair APCs were 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 warranted 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 APC Panel were changed for the CY 2008 proposal.

In summary, for CY 2008 we proposed to eliminate the four CY 2007 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 proposed 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 proposed 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 were approximately $84 (APC 0133); $133 (APC 0134); $295 (APC 0135); $971 (APC 0136); and $1,317 (APC 0137). The proposed configurations of these new APCs were listed in Table 30 of the proposed rule.

At the September 2007 meeting of the APC Panel, one presenter requested that CPT codes 15340 (Tissue cultured allogeneic skin substitute; first 25 sq cm or less) and 15341 (Tissue cultured allogeneic skin substitute; each additional 25 sq cm) be moved from the proposed APC 0134 (Level II Skin Repair) to APC 0135 (Level III Skin Repair). The presenter stated that the CY 2008 proposal to reassign the CPT codes for the application of certain skin products to different APCs is premature because hospitals have been confused by the CY 2006 code descriptor changes made by the CPT Editorial Panel. Current CPT instructions state that hospitals should not bill these two procedures in conjunction with the CPT codes for wound site preparation and debridement (CPT codes 15002–15005). The presenter stated that the CMS data used in the proposed rule do not reflect the true costs of performing CPT codes 15340 or 15341 because hospitals have been slow to adjust their charges based on the coding changes. The APC Panel made no recommendation at the September 2007 meeting related to the presenter's recommendations or to the overall skin repair APC proposal.

We received numerous public comments concerning our CY 2008 proposals for these skin repair procedures. A summary of the public comments and our responses follow.

Comment: Many commenters provided recommendations regarding the CY 2008 proposed treatment of specific skin repair CPT codes. One commenter suggested delaying the proposed reconfiguration from four skin repair APCs to five. Many commenters submitted similar letters requesting that CPT codes 15340 and 15341 be moved from the proposed APC 0134 to APC 0135, expressing concern that their placement in proposed APC 0134 did not reflect the actual clinical resource use for the application of the single skin repair biological product currently described by HCPCS code J7340 (Dermal and epidermal, (substitute) tissue of human origin, with or without bioengineered or processed elements, per square centimeter) because hospitals have been confused about appropriate billing for these surgical procedures. The commenters expressed concern that the proposed changes to the skin repair APCs would negatively impact patient access to skin repair procedures, such as CPT codes 15340 and 15341.

One commenter believed that the proposed payments for the proposed five level APC series would create an inappropriate incentive to use specific competing skin replacement and skin substitute products, because in many cases different biologicals used for skin repair are reported with different CPT codes that were, in turn, proposed for assignment to various APC levels. The commenter requested that CMS move CPT codes 15340 and 15341 from the proposed APC 0134 to APC 0135 in order to treat the application of J7340 similarly to other skin repair procedures and to recognize the facility costs associated with wound site preparation for J7340. Alternatively, the commenter recommended that CMS delay restructuring the four CY 2007 APCs and except APCs 0024 and 0025 (based on their CY 2007 structure) from the 2 times rule until another year of claims data are available for the CPT codes that were new in CY 2006. As a third alternative, the commenter suggested assigning all 16 skin repair CPT codes discussed by the APC Panel last year to a new and separate APC. (A complete listing and discussion of the codes and recommendations of the APC Panel for CY 2007 may be found in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68054 through 68057).) Finally, the commenter requested that CMS depart from CPT billing guidance and allow hospitals to report CPT codes for wound site preparation, such as CPT code 15002 (Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children), or create a new Level II HCPCS G-code, mapped APC 0135, to be used by hospitals to specifically report site preparation performed in conjunction with application of tissue cultured allogeneic skin substitutes described by HPCS code J7340.

A few commenters also requested that the CPT skin repair codes related to application of the single skin repair biological product currently described by HCPCS code J7342 (Dermal (substitute) tissue of human origin, with or without other bioengineered or processed elements, with metabolically active elements, per square centimeter), specifically CPT code 15365 (Tissue cultured allogeneic dermal substitute, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children) and CPT code 15366 (Tissue cultured allogeneic dermal substitute, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)) be moved from the proposed APC 0134 to APC 0135. The commenters stated that the storage and handling of the product applied with these CPT codes is more resource-intensive than other products whose application procedures were proposed for assignment to APC 0135. They also explained that the claims data that CMS used for APC placement do not accurately reflect the costs associated with these procedures because the product was not available on the market from CY 2006 through the beginning of CY 2007. In addition, they argued that

hospital confusion about skin repair CPT coding changes has led to inaccurate claims.

Response: We have examined CY 2006 claims data available for the CY 2008 final rule with comment period, as well as each of the comments and the public presentation from the September 2007 APC Panel meeting, and find that the five level APC configuration we proposed most appropriately allocates the large number of skin repair and replacement procedures based on the frequency, resource utilization, and clinical characteristics of each procedure. The proposed configuration eliminates the 2 times violations in APCs 0024 and 0025 that would otherwise exist and more accurately attributes higher cost procedure codes to the proposed Levels IV and V APCs.

As for the specific CPT code assignments raised by commenters (CPT codes 15340/15341 and 15365/15366), these codes were all placed in the Level II Skin Repair APC for CY 2007 and were proposed to remain in the Level II Skin Repair APC for CY 2008. In addition to these codes, the following skin repair codes that were new for CY 2006 and discussed by the APC Panel in CY 2006 were also proposed to be assigned to proposed new APC 0134: CPT codes 15170 (Acellular dermal replacement, truck, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children); CPT code 15171 (Acellular dermal replacement, truck, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)); CPT code 15360 (Tissue cultured allogeneic dermal substitute, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children): and CPT code 15361 (Tissue cultured allogeneic dermal substitute, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure). Therefore, we disagree with commenters who believe that we have not treated CPT codes 15340, 15341, 15365 and 15366 similarly to other skin repair procedures. The other 10 skin repair and replacement codes proposed for assignment to APC 0135 have significantly higher median costs than the CPT codes discussed by the commenters. We note, in particular, that payment for HCPCS code J7341 (dermal (substitute) tissue of non-human origin, with or without other bioengineered or processed with metabolically active elements, per square centimeter) whose is application is reported with CPT codes 15430 (Acellular xenograft implant; first 100 sq cm or less, or 1% of body area of infants and children) and 15431 (Acellular xenograft implant; first 100 sq cm or less, or 1% of body area of infants and children; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)), is packaged for CY 2008 because the mean per day cost of J7341 is less than the final $60 drug packaging threshold. Therefore, it is not surprising that these two CPT codes have higher median costs than CPT codes 15340, 15341, 15365 and 15366 and were proposed for assignment to the higher paying Level III APC 0135, rather than to APC 0134.

Further, we do not believe that it would be appropriate to maintain our CY 2007 structure for the skin repair APCs because we have significant claims data for the new CY 2006 CPT codes that capture the differential hospital costs associated with the procedures. We have no reason to except two of the four skin repair APCs from the 2 times rule based on their CY 2007 structure when the five level configuration that we proposed and that was supported by the APC Panel demonstrates clinical and resource homogeneity without 2 times violations. In particular, we have over 8,000 single claims for CPT code 15340, so we are confident that the procedure's final median cost of approximately $162 falls within the range of costs for other procedures also assigned to APC 0134, and the APC's median cost of approximately $132. Similarly, CPT code 15341 for the application of each additional area has a median cost of approximately $100, so it would be appropriately paid based on the 50 percent multiple procedure reduction applicable to APC 0134. Likewise, we have almost 200 claims for CPT code 15365 from CY 2006, with a median cost of approximately $147 that is consistent with the median costs of other procedures also assigned to APC 0134. We note one commenter requested that we provide higher payment for CPT codes 15365 and 15366 to apply J7342 because of the greater handling and storage costs of the particular biological. However, we pay for such pharmacy overhead through payment for the biological, not the associated procedures, because, as we describe in section V.B. of this final rule with comment period, we believe that hospitals include the costs of pharmacy overhead in their charges for drugs and biologicals. Despite the commenter's concern about the integrity of the data because it reported that there was limited availability of the biological described by HCPCS code J7342 in CY 2006, our CY 2006 claims data include over 25,000 units of the product provided on almost 1,200 days of service under the OPPS. In summary, we are confident that our CY 2006 claims data for the procedures reported with CPT codes 15340, 15341, 15365, and 15365 accurately reflect the hospital costs of those procedures and that their proposed APC assignments are appropriate. We note that HCPCS codes J7340 and J7342 for the associated biologicals will be separately paid under the CY 2008 OPPS at ASP+5 percent, as discussed in section V.B.3. of this final rule with comment period.

We do not move CPT codes to higher paying APCs in anticipation of future changes in hospital billing practices, so we believe that it would be premature to reassign any of the four procedures of particular interest to commenters to APC 0135 and unnecessary to create a sixth APC specifically for the 16 skin substitute and skin replacement codes mentioned by the commenter. We also believe that it would be inappropriate in this case to depart from CPT instructions by allowing hospitals to separately report wound site preparation and debridement when services described by CPT codes 15340 and 15341 are performed, whether using the associated CPT codes or by creating a G code. We generally advise hospitals to follow CPT billing guidance, and we disagree with the commenter that the CPT guidance does not adequately reflect the hospital facility component of these services. CPT coding instructions package the wound site preparation into the two codes for application of the biological, and hospitals have been reporting the services since CY 2006 based on those CPT instructions. Given our commitment to greater packaging under the OPPS, it would be inconsistent to adopt a policy for payment of these skin repair procedures that would move away from encounter-based payment by unpackaging wound site preparation.

After consideration of the public comments received, we are finalizing our CY 2008 proposed reconfiguration of the skin substitute and skin replacement APCs, without modification, as shown in Table 22 below.

TABLE 22.—CY 2008 SKIN REPAIR APC CONFIGURATION

HCPCS code	Short descriptor	CY 2008 APC	CY 2008 APC median cost
11950	Therapy for contour defects	0133	$80
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).		
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
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	285
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.		

TABLE 22.—CY 2008 SKIN REPAIR APC CONFIGURATION—Continued

HCPCS code	Short descriptor	CY 2008 APC	CY 2008 APC median cost
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.		
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	Aply 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	Aply 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	947
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	1,271
13160	Late closure of wound.		
14300	Skin tissue rearrangement.		

TABLE 22.—CY 2008 SKIN REPAIR APC CONFIGURATION—Continued

HCPCS code	Short descriptor	CY 2008 APC	CY 2008 APC median cost
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.		
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.		

c. Stereotactic Radiosurgery (SRS) Treatment Delivery Services (APCs 0065, 0066, and 0067)

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 (Level IV Stereostatic Radiosurgery) 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. In the CY 2008 OPPS/ASC proposed rule (72 FR 42716), we noted 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 indicated that we would specifically respond to those comments, according to our usual practice, in this 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 did not accurately and specifically describe the HCPCS G-codes that we used in prior years 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 were 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 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 were more specific in their descriptors than CPT code 77373 and were 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 status indicator ''B'' under the OPPS.

In the CY 2008 proposed rule (72 FR 42716 through 42717), we explained that while we had received 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 had also heard from others that continued use of the G-codes under the OPPS would be the most appropriate way to recognize the facility resource differences between different types of LINAC-based procedures. For the past several years, we had 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. As we discussed in the CY 2008 proposed rule (72 FR 42717), their hospital claims data continued 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 believed 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 proposed 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 note that we now have 3 years of hospital claims data reflecting the costs of each of these services. Based on the latest claims data from CY 2006 for the CY 2008 proposed rule, 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, was approximately $3,870 based on 1,946 single claims available for ratesetting. 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, was approximately $2,980 based on 5,209 single claims. The proposed CY 2008 APC median cost for each fractionated

session of LINAC-based SRS, as described by HCPCS code G0251 in APC 0065, was approximately $1,082 based on 1,938 single claims. Therefore, for CY 2008, we proposed 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 were displayed in Table 36 of the proposed rule (72 FR 42717).

We received several public comments concerning our treatment of new CPT codes for SRS treatment delivery discussed in the CY 2007 OPPS/ASC final rule with comment period and our CY 2008 proposal for these services. A summary of the public comments and our responses follow.

Comment: Several commenters agreed with CMS's proposed continued use of HCPCS codes G0173, G0251, G0339, and G0340 to report SRS services as these codes were more specific in their descriptors than either CPT code 77372 or 77373. However, these commenters requested that CMS further clarify the descriptors of these G-codes to more specifically differentiate image-guided robotic SRS from other LINAC systems. Other commenters to the CY 2008 proposed rule and the CY 2007 OPPS/ASC final rule with comment period disagreed with the use of the G-codes and requested that CMS recognize the CPT codes for ease of billing. Some commenters indicated that use of different codes for the same service for different payers is not consistent with government and industry goals for data uniformity and consistency, and is administratively burdensome for hospitals. One commenter explained that not all payers recognize Medicare's temporary HCPCS codes. This commenter recommended that APCs 0065, 0066 and 0067 be combined into a single APC containing the following codes: CPT codes 77372; 77373; 95966 (Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (e.g., epileptic cerebral cortex localization)); 95967 (Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, single modality (e.g., sensory, motor, language, or visual cortex localization)); 95965 (Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, each additional modality (e.g., sensory, motor, language, or visual cortex localization) (List separately in addition to code for primary procedure)); 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). Another commenter requested that HCPCS code G0251 be reassigned from its proposed APC 0065 to APC 0067.

Additionally, several commenters disagreed with CMS's proposal to assign both the MRgFUS and MEG procedures to APCs 0065, 0066, and 0067. These commenters believed that MRgFUS and MEG procedures did not share the same clinical or resource characteristics as SRS procedures. They urged CMS to reassign the MRgFUS and MEG procedures to other APCs that more accurately reflected their clinical characteristics and resource use. Some commenters recommended that the MEG procedures be placed in an APC that described nerve and muscle tests rather than assigning them to an SRS APC. Other commenters did not understand why CMS included the words ''MRgFUS'' and/or ''MEG'' in the APC titles for APCs 0065 and 0066 when the proposed APCs did not include one or both of these procedures.

Response: We appreciate the various differences of opinion offered by commenters on coding and payment for LINAC-based SRS treatment delivery services under the OPPS. We will not recognize CPT codes 77372 and 77373 for CY 2008 because we continue to believe that they do not accurately and specifically describe the HCPCS G-codes that we currently use for reporting LINAC-based SRS treatment delivery services under the OPPS. Hospital claims data from CY 2006 for the current G codes demonstrate significant resource differences for the four different services, ranging from approximately $994 to $3,620, and these G-codes cannot be mapped in a one-to-one relationship to the CPT codes. We remain unclear about how we could use our historical hospital claims data as the basis for establishing appropriate payment rates for CPT codes 77372 and 77373. We believe that our CY 2008 proposed APC assignments for the four G-codes to APCs 0065, 0066, and 0067, consistent with their CY 2007 assignments, will provide the most appropriate payment for the SRS services described by these codes in CY 2008.

We note that we intend to reevaluate the appropriateness of the use of the HCPCS G-codes for LINAC-based SRS services for the CY 2009 OPPS rulemaking cycle. With that planned reevaluation in mind, we will not modify the G-code descriptors for LINAC based SRS treatment services. These codes have been in effect for the past 4 years and, based on questions brought to our attention by hospitals, we have no reason to believe that hospitals are confused about the reporting of these codes. In addition, we see resource differences based on the median costs for the four codes that are reasonably consistent with our expectations based on the current code descriptors. We believe it would be confusing to hospitals if we were to modify these code descriptors at this point in time and could lead to instability in our median costs and inaccurate payments for some services. Therefore, we believe that modifying the G-code descriptors is not necessary for us to continue to provide appropriate payment for the services they describe.

We disagree with the recommendation of some commenters to combine all of the SRS, MEG, and MRgFUS procedures into one single clinical APC, when the median costs for these services vary from approximately $663 to $4,207. Such a single clinical APC would violate the 2 times rule based on the different hospital resources required for all of the services. With the respect to the proposed assignment of MEG and MRgFUS services to APCs 0065 and 0067, we note that the APC Panel recommended at its March 2007 meeting that we assign both CPT codes for MRgFUS procedures to APC 0067. Although we have no single claims available for CPT codes 0071T and 0072T for CY 2008 ratesetting, we continue to believe that these services share sufficient clinical and resource similarity to LINAC-based SRS procedures based on their use of image-guidance and focused energy for tissue ablation that they should be assigned to APC 0067 for CY 2008 as the APC Panel recommended and as we proposed . With respect to MEG procedures, we also believe that, based on the clinical characteristics of these services and the procedures' median costs from claims data, these three services should also be assigned to APCs 0065 and 0067 as proposed.

In the case of the APC titles for APCs 0065, 0066, and 0067, because the titles specify three separate levels of the same series, we will follow our usual practice of maintaining the same APC title for each level for purposes of clarity and consistency, even if not all specific services are assigned to every level.

After consideration of the public comments received, we are finalizing our CY 2008 proposal, without modification, to continue the use of the current HCPCS G-codes for LINAC-based SRS treatment delivery services, specifically, HCPCS G-codes G0173, G0251, G0339, and G0340, under the

OPPS. We will not recognize CPT codes 77372 and 77373 under the CY 2008 OPPS. The HCPCS G-codes will continue to be assigned to the same CY 2007 APCs for CY 2008, specifically, APCs 0065, 0066, and 0067, with final APC median costs of approximately $1,044, $2,835, and $3,882, respectively. Table 23 displays the final APC median costs for the SRS treatment delivery HCPCS G-codes.

TABLE 23.—FINAL 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	Final CY 2008 SI	Final CY 2008 APC final	Final CY 2008 APC median cost
G0173	Linear acc stereo radsur com	S	0067	$3,873	S	0067	$3,882
G0251	Linear acc based stero radio	S	0065	1,242	S	0065	1,044
G0339	Robot lin-radsurg com, first	S	0067	3,873	S	0067	3,882
G0340	Robt lin-radsurg fractx 2–5	S	0066	2,630	S	0066	2,835

10. Medical Services

a. Single Allergy Tests (APC 0381)

We proposed 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 the CY 2008 proposed rule for APC 0381 (Single Allergy Tests) did not reflect improved and more consistent hospital billing practices of ''per test'' for single allergy tests. The median cost of APC 0381 calculated for the proposed rule according to the standard single claims OPPS methodology was approximately $66, significantly higher than the CY 2007 median cost of APC 0381 calculated according to the ''per unit'' methodology of approximately $16, 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 provide 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 calculated a ''per unit'' median cost for APC 0381, based upon 276 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 approximately $19 for APC 0381 for CY 2008. We noted in the CY 2008 OPPS/ASC proposed rule (72 FR 42713) that 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.

We did not receive any public comments on this proposal. Therefore, we are finalizing our CY 2008 proposal, without modification, to calculate a ''per unit'' median cost for APC 0381 as described above. The CY 2008 median cost of APC 0381 is approximately $17.

b. Continuous Glucose Monitoring (APC 0097)

For CY 2008, we proposed to reassign CPT code 95250 (Ambulatory continuous glucose monitoring of interstitial fluid via a subcutaneous sensor for up to 72 hours; sensor placement, hook-up; calibration of monitor, patient training, removal of sensor, and printout of recording) to APC 0097 (Prolonged Physiologic and Ambulatory Monitoring), with a proposed payment rate of approximately $66. CPT code 95250 is assigned to APC 0421 (Prolonged Physiologic Monitoring) for CY 2007, with a payment rate of approximately $100. We also proposed to discontinue APC 0421 effective January 1, 2008. At the September 2007 APC Panel meeting, the APC Panel recommended that CMS retain APC 0421 with its CY 2007 composition, including maintaining CPT code 95250 in that APC for CY 2008.

We received one public comment on our CY 2008 proposed reassignment of CPT code 95250 to APC 0097. A summary of the public comment and our response follow.

Comment: One commenter considered the proposal to reassign CPT code 95250 to APC 0097 to be an apparent violation of the 2 times rule. The commenter further reported that placement of CPT code 95250 in APC 0097 was problematic with respect to ensuring resource comparability among all the procedures assigned to the APC for CY 2008, because continuous glucose monitoring involves significant patient training of 30 to 40 minutes, whereas there is minimal to no patient training associated with most of the other HCPCS codes in APC 0097. In addition, the commenter noted that the OPPS payment for CPT code 95250 should include payment for a sensor that costs approximately $35, which would consume 53 percent of the proposed payment for the service. The commenter recommended that CMS not discontinue APC 0421 and maintain CPT code 95250 in APC 0421 for CY 2008. Alternatively, the commenter believed that CMS could split APC 0097 into two APCs for Level I and Level II services, assigning CPT code 95250 to the higher paying Level II APC. Another commenter also recommended that CMS maintain APC 0421 on the basis that the lower payment rate of APC 0097 would potentially result in limiting patient access to this monitoring approach for patients with diabetes.

Response: As described in section II.A.2. of this final rule with comment period, for CY 2008 we proposed to eliminate many APCs with low total claims volume in order to stabilize OPPS payments for these low volume services. We generally proposed to reassign the services residing in these low volume APCs to other clinical APCs, along with services that share clinical and resource characteristics. We note that APC 0421, as configured for

CY 2007 and where CPT code 95250 is currently assigned, is a low volume APC, which would have included only about 750 CY 2006 claims. We proposed to discontinue APC 0421 and reassign CPT code 95250 to APC 0097. Proposed APC 0097 consisted of 17 services, with approximately 487,000 CY 2006 claims for those services. Low volume services, including CPT code 95250, are not significant services in APCs and, therefore, do not result in violations of the 2 times rule.

We agree with the commenters that CPT code 95250 should not be assigned to APC 0097, based on our review of its clinical and resource characteristics. However, we will not maintain APC 0421 for CY 2008, given our interest in eliminating low volume APCs, and, therefore, we are not adopting the recommendation of the APC Panel. In addition, we will not separate APC 0097 into two levels because we believe that an alternative assignment of CPT code 95250 to another existing clinical APC would be more appropriate. Taking into consideration the patient training required in association with CPT code 95250, we believe that it would be appropriate to assign this service to APC 0607 (Level 4 Hospital Clinic Visits), which has a CY 2008 final median cost of approximately $104. The median cost of CPT code 95250 of approximately $100 is well within the range of approximately $99 to $122 for other significant procedures also assigned to that APC for CY 2008. This final reassignment of CPT code 95250 to APC 0607 should resolve any concerns about violations of the 2 times rule and leads to appropriate grouping of the service with other similar services that share clinical and resource characteristics.

After consideration of the public comment received, we are finalizing our CY 2008 proposal with modification. We are discontinuing APC 0421 and reassigning CPT code 95250 to APC 0607, with a CY 2008 median cost of approximately $104, rather than to APC 0097 as proposed.

c. Home International Normalized Ratio (INR) Monitoring (APC 0097)

For CY 2008, we proposed to reassign the two following HCPCS codes to APC 0097 (Prolonged Physiologic and Ambulatory Monitoring), with a proposed payment rate of approximately $66: G0248 (Demonstration at initial use, of home INR monitoring for patient with mechanical heart valve(s) who meets Medicare coverage criteria, under the direction of a physician; includes: demonstrating use and care of the INR monitor, obtaining at least one blood sample, provision of instructions for reporting home INR test results, and documentation of patient ability to perform testing) and HCPCS code G0249 (Provision of test materials and equipment for home INR monitoring to patient with mechanical heart valve(s) who meets Medicare coverage criteria; includes provision of materials for use in the home and reporting of test results to physician; per 4 tests). Currently, HCPCS codes G0248 and G0249 are assigned to APC 0421 (Prolonged Physiologic Monitoring), with a payment rate of approximately $100 for CY 2007. As stated in section III.D.10.b. of this final rule with comment period, we also proposed to discontinue APC 0421 effective January 1, 2008. At the September 2007 APC Panel meeting, the APC Panel recommended that CMS retain APC 0421 with its CY 2007 composition, including maintaining HCPCS codes G0248 and G0249 in that APC for CY 2008.

We received one public comment on our CY 2008 proposed reassignment of HCPCS codes G0248 and G0249 to APC 0097. A summary of the public comment and our response follow.

Comment: One commenter was concerned that CMS's proposal to reassign HCPCS codes G0248 and G0249 from APC 0421 to APC 0097 would substantially reduce payments for these services and would make it financially impossible for hospitals to offer these services, thereby reducing patient access to home INR monitoring. The commenter urged CMS to maintain APC 0421 or, as an alternative, to create a new APC that would include HCPCS codes G0248 and G0249 and two other higher cost procedures also proposed for CY 2008 assignment to APC 0097, specifically CPT code 93271 (Patient demand single or multiple event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; monitoring, receipt of transmissions, and analysis) and CPT code 95250 (Ambulatory continuous glucose monitoring of interstitial fluid via a subcutaneous sensor for up to 72 hours; sensor placement, hook-up; calibration of monitor, patient training, removal of sensor, and printout of recording).

Response: As described in section II.A.2. of this final rule with comment period, for CY 2008 we proposed to eliminate many APCs with low total claims volume in order to stabilize OPPS payments for these low volume services. We generally proposed to reassign the services residing in these low volume APCs to other clinical APCs, along with services that share clinical and resource characteristics. We note that APC 0421, as configured for CY 2007 and where HCPCS codes G0248 and G0249 are currently assigned, is a low volume APC, which would have included only about 750 CY 2006 claims. We proposed to discontinue APC 0421 and reassign HCPCS codes G0248 and G0249 to proposed APC 0097. Proposed APC 0097 consisted of 17 services, with approximately 487,000 CY 2006 claims for those services.

We agree with the commenter that HCPCS codes G0248 and G0249 should not be assigned to APC 0097, based on our reexamination of their clinical and resource characteristics. However, we will not maintain APC 0421 for CY 2008, given our interest in eliminating low volume APCs, and, therefore, we are not adopting the recommendation of the APC Panel. In addition, we will not create another new clinical APC consisting of four of the higher cost services proposed for CY 2008 assignment to APC 0097 because we believe that alternative assignments of those codes to other existing clinical APCs are more appropriate. We discuss the final CY 2008 reassignment of CPT code 95250 to APC 0607 (Level 4 Hospital Clinic Visits) in section III.D.10.b. of this final rule with comment period. In addition, we are reassigning CPT code 93271, which has a median cost of approximately $93 to APC 0663 (Level I Electronic Analysis of Devices), with a CY 2008 median cost of approximately $96. Taking into consideration the patient training required in association with HCPCS code G0248 in particular, we believe that it would be appropriate to assign both HCPCS codes G0248 and G0249 to APC 0607 (Level 4 Hospital Clinic Visits), which has a CY 2008 final median cost of approximately $104. The median costs of HCPCS codes G0248 and G0249 are approximately $72 and $120, respectively, similar to the hospital costs for other services also assigned to that APC for CY 2008.

After consideration of the public comment received, we are finalizing our CY 2008 proposal, with modification. We are discontinuing APC 0421 and reassigning HCPCS codes G0248 and G0249 to APC 0607, with a CY 2008 median cost of approximately $104, rather than to APC 0097 as proposed.

d. Mental Health Services (APCs 0322, 0323, 0324, and 0325)

For CY 2008, we did not propose any policy changes to the range or composition of APCs that describe psychotherapy services provided in HOPDs. These APCs include 0322 (Brief Individual Psychotherapy), which has a CY 2008 median cost of approximately

$74; 0323 (Extended Individual Psychotherapy), which has a CY 2008 median cost of approximately $101; 0324 (Family Psychotherapy), which has a CY 2008 median cost of approximately $149; and 0325 (Group Psychotherapy), which has a CY 2008 median cost of approximately $62. Proposals related to partial hospitalization programs are discussed in section II.B. of this final rule with comment period.

We note that 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 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.

We received several public comments regarding our CY 2008 proposed payment for APCs 0332, 0323, 0324, and 0325. A summary of the public comments and our responses follow.

Comment: Several commenters noted that the payment rates associated with APCs 0322, 0323, 0324, and 0325 have decreased in recent years. Specifically, the commenters stated that payment associated with APC 0325 decreased by 17 percent between CY 2006 and CY 2007 and was proposed to decline by an additional 3 percent for CY 2008. These commenters expressed concern that the payment rates are insufficient to cover their costs for mental health services. One commenter noted that it is more cost-effective to treat Medicare beneficiaries in HOPDs, rather than costly partial hospitalization programs, and encouraged CMS to provide adequate payment rates to the less intensive programs.

Response: We carefully analyzed several years of resource cost data associated with APCs 0322 through 0325. We note that the median costs of APCs 0322, 0323, and 0324 have remained fairly constant in recent years. APC 0323 has a small 2 times rule violation for CY 2008, and also had a small violation in CY 2007, but it is not clear how to best resolve the violation, while ensuring the clinical and resource homogeneity of reconfigured APCs. For CY 2007 and CY 2008, APC 0323 is excepted from the 2 times rule. We will review APC 0323 at the next APC Panel meeting and seek its guidance in reconfiguring this APC for CY 2009. As the commenters noted, the median cost for APC 0325 declined significantly in CY 2007, and declined again for CY 2008, using full year CY 2006 claims data. We cannot speculate as to why this recent decline in the median cost of group psychotherapy services has occurred. We have robust claims data for the CPT codes that map to APC 0325. Specifically, we were able to use almost 80 percent of the 1.6 million claims submitted by hospitals to report group psychotherapy services. In general, we set payment rates using our standard OPPS methodology based on relative costs from hospital outpatient claims. In this case, we have no reason to discount our claims data, and it would appear that the relative cost of providing these mental health services in comparison with other HOPD services has decreased in recent years.

While reviewing the CY 2008 OPPS proposal for mental health services, we noted that CPT code 90862 (Pharmacologic management, including prescription, use, and review of medication with no more than minimal psychotherapy) and HCPCS code M0064 (Brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental psychoneurotic and personality disorders) were proposed to map to APC 0605 (Level 2 Hospital Clinic Visits) for CY 2008, with a proposed payment of approximately $64. These assignments were proposed changes from their CY 2007 assignments to APC 0374 (Monitoring Psychiatric Drugs), which has a payment rate of approximately $70. We proposed to discontinue APC 0374 for CY 2008. Based on our reexamination of the claims data for this final rule with comment period, particularly the hospitals costs associated with these visits, we are reassigning HCPCS codes 90862 and M0064 to APC 0606 (Level 3 Hospital Clinic Visits) for CY 2008, with a median cost of approximately $83.

Comment: Several commenters expressed concern that payment for mental health services provided on one date is capped at the partial hospitalization payment rate. One commenter noted that if an HOPD provides four particular mental health services in one day, that department would receive full payment for the first two services, partial payment for the third service, and no payment for the fourth service.

Response: We continue to believe that 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. We note that these commenters also submitted comments requesting that the partial hospitalization payment rate increase for CY 2008. The mental health payment limitation will rise and fall in the same manner as payment for partial hospitalization services.

After consideration of the public comments received, we will ask the APC Panel to provide advice at its next meeting regarding the possible reconfiguration of APC 0323 to resolve a small 2 times violation for CY 2009. For CY 2008, we are modifying our proposal for two medication management services and will reassign CPT code 90862 and HCPCS code M0064 from APC 0605 to APC 0606, with a median cost of approximately $83.

IV. OPPS Payment for Devices

A. Treatment of Device-Dependent APCs

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 we 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. Payment Under the CY 2008 OPPS

For CY 2008, we proposed to calculate the median costs for device-dependent APCs using three different sets of CY 2006 claims (72 FR 42719). 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 believed that the claims that met these three criteria (appropriate device codes, nontoken device charges, and no ''FB'' modifier) reflected the best estimated costs for these device-dependent APCs when the hospital pays the full cost of the device, and we proposed 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 the proposed rule on median costs, we proposed to make some changes to CY 2007 device-dependent APCs for CY 2008. Specifically, we proposed 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 believed that reconfiguration of the APCs was 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 proposed for deletion ceased to be appropriate as a result of the reassignment of the HCPCS codes that we proposed for continued separate payment in CY 2008.

As proposed, the following seven APCs remained device-dependent APCs for CY 2008, but we proposed 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 resulted from the proposed CY 2008 packaging approach, the HCPCS codes would be assigned to APCs that were 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 proposed to consider APC 0084 (Level I Electrophysiologic Procedures) to be a device-dependent APC for CY 2008 because we proposed 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, we noted that it was not appropriate to compare the proposed CY 2008 OPPS median costs for these eight APCs to the CY 2007 OPPS final rule median costs that were the basis for the CY 2007 OPPS payment rates. When we compared 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 increased, some of them by significant amounts, and the median costs for 5 APCs decreased. We believed that these median costs represented valid estimates of the relative costs of the services in these APCs, both with regard to the increases and the decreases that appeared when the proposed CY 2008 median costs were compared to the CY 2007 median costs on which the payment rates for these APCs were based.

Therefore, we proposed 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. We did not believe that any special payment policies were needed, as we believed that the claims data we proposed to use for ratesetting would ensure that the costs of the implantable devices were adequately and appropriately reflected in the median costs for these device-dependent APCs.

We received a number of public comments on our CY 2008 proposed payment methodology for device-dependent APCs. A summary of the public comments and our responses follow.

Comment: Commenters supported the proposal to set the median costs for device-dependent APCs using only claims that meet the three selection criteria described in the proposed rule (that is, pass the device edits, do not contain token charges, and do not have the without cost/full credit modifier ''FB''), and urged CMS to continue to use device edits to ensure that hospitals bill Level II HCPCS device codes in addition to CPT codes for device-dependent procedures. Commenters also suggested certain refinements to CMS' ratesetting methodology for device-dependent APCs. One commenter asked for implementation of the March 2007 APC Panel's recommendation to edit and return for correction all claims that contain an HCPCS code for a separately payable device but do not contain a CPT code assigned to a procedural APC. Another commenter requested that at least 2 full years of data be used to set rates for device-dependent APCs, as it may take hospitals several months before they bill new Level II HCPCS device codes correctly, and also asked that we implement a payment floor to prevent large decreases in payment and promote stability in payment rates from year to year. Another commenter asked CMS to redefine ''token charge'' for cochlear implants to mean any amount lower than the amount the commenter specified should be charged.

Response: We agree that it is appropriate to base the median costs for device-dependent APCs on claims that contain the correct devices, do not contain token charges, and do not contain the ''FB'' modifier. However, we do not believe that it would be appropriate to define ''token charge'' at particular amounts for particular devices based on external data or otherwise because hospitals are free to set their charges for all items and services based on their own judgment. We encourage hospitals to develop their charges, revenue centers, and internal processes as they find appropriate. We have no reason to believe, in any given case other than a token charge reported according to CMS' instructions, that the charge on a claim is not an appropriate charge by a hospital established for that specific service.

We agree that claims processing edits for services and items integral to the performance of certain OPPS procedures paid under the OPPS are an important element of our ratesetting methodology and, therefore, we will continue to require that correct devices be billed with certain HCPCS procedure codes for services that require devices. Moreover, we have expanded their use within and beyond device-dependent APCs (see sections II.A.2. and II.A.4.c.(5) of this final rule with comment period for a discussion of the March 2007 APC Panel's recommendation and measures we are taking to improve claims data for diagnostic radiopharmaceuticals by using edits). In general, however, we limit edits to the services, items, and procedures we believe require extra vigilance to capture all associated charges in recognition of the additional administrative burden these edits create for hospitals, and the inherent complexity of ensuring that the edits we do implement appropriately anticipate all clinical circumstances. Particularly for packaged items and services including expensive devices, we believe these edits ensure that high cost items are reported on appropriate claims, so that the procedural payment rates fully incorporate the costs of the items that are required for the procedures. For other items, services, and procedures, we believe that hospitals have strong incentives to report charges accurately to Medicare and all other payers, and that these charges are sufficient to provide accurate data. Another important component of ensuring we use the most accurate data available for OPPS device-dependent APC ratesetting is using the most current claims data and cost reports. Therefore, we believe that it would be inconsistent to wait until we have 2 full years of claims data before we update payment rates.

We also do not believe it is necessary to adjust our standard device-dependent ratesetting methodology for CY 2008 by implementing a payment floor to ensure beneficiary access. The only decline of more than 10 percent between the CY 2008 final rule APC medians and the CY 2007 final rule medians is found in APC 0418 (Insertion of Left Ventricular Pacing Electrode). As discussed in the proposed rule (72 FR 42720), we believe that this decline and variation in the median cost for APC 0418 was the result of improvements in provider billing and a relatively small number of single bills from a small number of providers furnishing the service. We believe 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. Furthermore, the fluctuation of payment rates is to a certain degree inherent and expected in a prospective payment system (see section II.A of this final rule with comment period for a broader discussion of the variation in APC payment rates from year to year). We note that we have put into place reverse device edits for CY 2007 that will continue in CY 2008, where we require hospitals reporting certain implantable device HCPCS codes, such as ICDs, to report an appropriate procedure for the device's use. We do not believe it is necessary to implement a payment floor for this procedure, or any other device-

dependent procedure, to prevent large decreases in payment.

Comment: One commenter suggested that CMS should consider creation of composite APCs for device-dependent procedures, such as ICD implantation, where the device costs can vary significantly based on the type of device used. The commenter suggested that payment for these composite APCs would be based on the combination of the device implantation CPT code and the existing Level II HCPCS code for the particular device. According to the commenter, this would minimize administrative burden for providers, allow coding to remain consistent across payers, and enable more appropriate payment for procedures with varying device costs.

Response: Composite APCs provide a single payment for two or more major procedures that are commonly performed together, in order to promote efficiency by increasing the size of the payment bundle. We do not agree that the payment methodology outlined by this commenter, to base payment on the combination of the device implantation CPT code and the existing device code, is consistent with the concept of composite APCs as described in the proposed rule and as finalized in section II.A.4.d. of this final rule with comment period. The scenario described by the commenter largely describes the current packaging of device payment into the payment for the procedure, except that we generally base payment on all of the devices associated with a procedure as a mechanism to promote the efficient utilization of resources. The recommended approach could actually reduce packaging under the OPPS by creating small and more specific payment bundles, rather than increasing the size of the payment bundles to provide hospitals with the flexibility to manage their resources as they control costs. To establish a separate APC for each combination of a procedure and a particular device used, as described by the commenter, would create incentives for the use of the most expensive device rather than creating incentives for efficiency and therefore is contrary to the principles of a prospective payment system.

Comment: Several commenters requested that CMS use external data for ratesetting. While some commenters called for the broad-scale use of external data to identify and adjust payment for technologies they perceived to be underpaid both in the past and under the current proposal, other commenters focused on the use of external data in ratesetting for particular APCs (for example, several commenters asked that CMS redefine the token charge criteria and adjust payment for cochlear implants to reflect the device's estimated hospital invoice price). According to commenters, external data could be used to rectify the effects of charge compression, without committing CMS to reliance on any particular data source. In addition, commenters requested that CMS protect the confidentiality of any external data used in ratesetting, because manufacturers and hospitals may be unwilling to release proprietary information without assurances that CMS would not release that information to the public.

Response: We review all information that is brought to our attention by stakeholders as part of the public comment process, and we have a general policy that all data we consider in ratesetting, whether internal or external, will be made available to the public, including any personally identifiable or confidential business information (for example, see the discussion of Inspection of Public Comments in the CY 2008 OPPS/ASC proposed rule (72 FR 42628)). We have not systematically used external data to validate the median costs derived from claims data, because external data typically are furnished by parties with special interest in a particular item or service. The foundation of a system of relative weights is the relativity of the costs of all services to one another, as derived from a standardized system that uses standardized inputs and a consistent methodology. One of the principles behind the use of median costs for weight setting in a budget neutral payment system like the OPPS is to allow fair and equitable distribution of payment among hospitals, based on their mix of services provided to Medicare beneficiaries, by determining the appropriate relativity in resource use among services. The median costs are estimated relative costs that are converted to relative weights, scaled for budget neutrality, and then multiplied by a conversion factor to derive a payment under a prospective payment system that is not intended to pay reasonable costs. For these reasons, we believe that it is not appropriate to use external pricing information in place of the costs derived from the claims and Medicare cost report data, because we believe that to do so would distort the relativity that is so fundamental to the integrity of the OPPS. Similarly, we do not believe that it is reasonable or appropriate to exclude specific claims from ratesetting if the hospital charge for a particular item does not exceed an established threshold such as the manufacturer's estimated cost of the item.

After considering the public comments received on this proposal, we are finalizing our proposed payment policies for device-dependent APCs, without modification, for CY 2008. The CY 2008 payment rates for device-dependent APCs are based on their median costs calculated from CY 2006 claims and the most recent cost report data, using only claims that pass the device edits, do not contain token charges for devices, and do not have a modifier signifying that the device was furnished without cost or with full credit. We do not think it is necessary or appropriate to apply a maximum payment reduction floor. Consistent with data from the proposed rule, payment rates based on final rule data show increases for the majority of APCs for which comparison to CY 2007 payment rates is appropriate. As discussed in the proposed rule (72 FR 42720 through 42721), we found these differences in payment rates from CY 2007 to CY 2008 to be attributable to a variety of factors, including the availability of more complete claims data for CY 2008 and the packaging approach that is new for CY 2008. Furthermore, as we have stated in the past, some variation in relative costs from year to year is be expected in a prospective payment system, particularly for low volume device dependent APCs such as APC O681 (Knee Arthroplasty), which increases 37 percent from CY 2007 to CY 2008. 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. In addition, we note that we will maintain established device edits for procedures previously assigned to device-dependent APCs that were packaged or moved to APCs that are not device-dependent for CY 2008, in order to ensure that the full costs associated with these services continue to be represented adequately in claims data.

Discussions of HCPCS code and APC-specific issues for device-dependent APCs are found in section III.D. of this preamble, where other APC-specific policies are also discussed. As discussed in detail in section III.D.6.b. of this final rue with comment period, we are adding APC 0293 (Level V Anterior Segment Eye Procedures) to the

list of device-dependent APCs for CY 2008, as reflected in Table 24 below.

TABLE 24.—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 HCPCS code migration for CY 2008.]

APC	SI	APC title	CY 2007 final rule pass edit, nontoken median cost	CY 2008 final rule pass edit, nontoken median cost	CY 2008 final rule pass edit, nontoken frequency	Count of providers billing in the final CY 2008 data
0039	S	Level I Implantation of Neurostimulator	$11,451	$11,732	2,950	653
0040	S	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	$3,457	$4,013	5,177	1,040
0061	S	Laminectomy or Incision for Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	$5,145	$5,213	1,413	462
0082	T	Coronary or Non Coronary Atherectomy	N/A	$5,506	4,758	962
0083	T	Coronary or Non Coronary Angioplasty and Percutaneous Valvuloplasty.	N/A	$2,855	41,944	1,728
0084	S	Level I Electrophysiologic Procedures	N/A	$603	7,381	616
0085	T	Level II Electrophysiologic Evaluation	N/A	$2,976	4,291	719
0086	T	Level III Electrophysiologic Procedures	N/A	$5,842	420	164
0089	T	Insertion/Replacement of Permanent Pacemaker and Electrodes.	$7,557	$7,654	668	370
0090	T	Insertion/Replacement of Pacemaker Pulse Generator	$6,007	$6,344	584	334
0104	T	Transcatheter Placement of Intracoronary Stents	$5,360	$5,600	674	233
0106	T	Insertion/Replacement of Pacemaker Leads and/or Electrodes	$3,138	$4,374	406	281
0107	T	Insertion of Cardioverter-Defibrillator	$18,607	$21,001	501	228
0108	T	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	$23,205	$25,471	3,719	616
0115	T	Cannula/Access Device Procedures	N/A	$1,868	1,398	705
0202	T	Level VII Female Reproductive Proc	$2,627	$2,687	10,851	1,895
0222	S	Implantation of Neurological Device	$11,099	$15,150	1,465	612
0225	S	Implantation of Neurostimulator Electrodes, Cranial Nerve	$13,514	$13,889	254	168
0227	T	Implantation of Drug Infusion Device	$10,658	$11,569	1,117	477
0229	T	Transcatheter Placement of Intravascular Shunts	$4,184	$5,570	8,004	1,256
0259	T	Level VI ENT Procedures	$25,351	$24,739	868	174
0293	T	Level V Anterior Segment Eye Procedures	N/A	$5,335*	N/A	N/A
0315	S	Level II Implantation of Neurostimulator	$14,846	$16,988	691	203
0384	T	GI Procedures with Stents	$1,402	$1,572	7,484	1,464
0385	S	Level I Prosthetic Urological Procedures	$4,840	$5,262	648	340
0386	S	Level II Prosthetic Urological Procedures	$8,396	$9,067	3,683	887
0418	T	Insertion of Left Ventricular Pacing Elect	$18,778	$16,342	219	152
0425	T	Level II Arthroplasty with Prosthesis	$6,551	$7,688	441	278
0427	T	Level III Tube Changes and Repositioning	N/A	$966	13,556	1,293
0622	T	Level II Vascular Access Procedures	$1,385	$1,517	36,920	2,408
0623	T	Level III Vascular Access Procedures	N/A	$1,817	54,632	2,746
0625	T	Level IV Vascular Access Procedures	$5,100	$5,143	8	7
0648	T	Level IV Breast Surgery	$3,130	$3,560	503	321
0652	T	Insertion of Intraperitoneal and Pleural Catheters	$1,805	$1,932	3,801	1,099
0653	T	Vascular Reconstruction/Fistula Repair with Device	$1,979	$2,546	1,700	713
0654	T	Insertion/Replacement of a permanent dual chamber pacemaker.	$6,891	$6,876	1,896	634
0655	T	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker.	$9,328	$8,810	2,169	554
0656	T	Transcatheter Placement of Intracoronary Drug-Eluting Stents	$6,618	$7,451	3,486	399
0674	T	Prostate Cryoablation	$6,646	$7,720	2,222	383
0680	S	Insertion of Patient Activated Event Recorders	$4,437	$4,442	1,577	718
0681	T	Knee Arthroplasty	$12,569	$17,281	317	59

* In CY 2006, there were not HCPCS codes to describe all devices that could be used in this procedure.

3. Payment When Devices Are Replaced With Partial Credit to the Hospital

In recent years there have been several field actions and recalls as a result of implantable device failures. 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 proposed for CY 2008 pays hospitals appropriately when they incur the full cost of the device, we calculated the CY 2008 median costs for device dependent APCs using only claims that contain the correct device code for the procedure. We also did not use 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).

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 meet 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, which for purposes of this policy is 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.

As discussed in the CY 2008 proposed rule (72 FR 42726), 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. Based on data available for the proposed rule, we concluded that one additional APC met the criteria for inclusion under this policy and that one APC currently on the list ceases to meet the criteria. Specifically, we proposed 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 (as discussed below) 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 proposed to add APC 0625 and device code C1881 for CY 2008 because they met 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 was 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) ceased to meet the criteria because the device offset percent for this APC, when calculated from proposed rule data, was less than 40 percent. Moreover, we believed 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 proposed to remove APC 0229 from the list of APCs to which the no cost or full credit and proposed partial credit reduction policies would be applicable for CY 2008. Table 38 of the proposed rule (42 CFR 42727) contained the device offset amounts that we proposed to apply to the specified APCs in cases of no cost or full or partial credit for replaced devices for the CY 2008 OPPS.

As discussed in the proposed rule (72 FR 42724), 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). The credit would be prorated 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 believed 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 believed that hospitals should report occurrences of devices being replaced under warranty or otherwise with a partial credit granted to the hospital so that we could identify systematic failures of devices or device problems through claims analysis and so that we could 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. In the proposed rule, we explained that 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 worldwide recall of these 73,000 devices. 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. In the proposed rule, we specifically invited public comment on this issue to inform our future review and analyses (72 FR 42724).

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.

For CY 2008, we proposed to create an HCPCS modifier 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 the proposed rule (72 FR 42727). 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 would apply 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 partial credit 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 towards the cost of the replacement device being implanted. We believed that this proposal was 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 proposed 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 proposed to base the beneficiary's copayment on the reduced APC payment rate so that the beneficiary shares in the hospital's reduced costs. We believed that it would be 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 believed that it would be 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 proposed 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 had no data to determine empirically 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 proposed to reduce the payment for these device-dependent APCs by half of the reduction that would apply when the hospital receives a device without cost or receives a full credit for a device being replaced. That is, we proposed 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 believed 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.

In the proposed rule (72 FR 42725), we also 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 were 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. Therefore, we specifically requested 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 (72 FR 42725).

In addition, we proposed 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 would not be taken in cases in which more than 80 percent of the cost of the replacement device has been incurred by the hospital. We were concerned 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 would be 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 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 proposed 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.

As discussed in the proposed rule (72 FR 42725), even in the absence of specific instructions 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 believed 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. As proposed, if we found that hospitals were adjusting their charges to reflect the reduced costs of these devices, we would explore whether revising the amount of the reduction could be appropriate.

In summary, we proposed the following: (1) To create a HCPCS modifier to be reported on a procedure code listed in Table 38 of the proposed rule if a device listed in Table 39 of that rule 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 (2) 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 believed 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.

At the September 2007 meeting of the APC Panel, the Panel recommended that CMS explore whether hospitals could report a modifier to reflect the amount of a partial credit for a device as a percentage of the cost of the replacement device. According to the Panel, this approach could signify that there was a partial credit and provide data for use in determining the amount of reduction that could be taken in future years.

We received many public comments on our proposal to reduce the APC payment for certain implantation procedures when specific devices are replaced with a partial credit to the hospital. A summary of the public comments and our responses follow.

Comment: The majority of commenters agreed that neither Medicare nor beneficiaries should have to pay based on a device's full cost when the hospital receives a substantial credit from the manufacturer for that device, and supported the premise underpinning the proposed policy that hospitals'' charges and OPPS payment rates based on those charges currently do not reflect partial credits for replaced devices. Some commenters argued, however, that all manufacturer rebates, from volume discounts to partial credits for replaced devices, are applied to hospitals' cost reports, and as such are reflected in hospitals' CCRs. Others said that hospitals often do adjust their charges to reflect partial credits for replaced devices and that a payment adjustment in such cases was not necessary, because payment rates calculated according to the standard OPPS ratesetting methodology for device-dependent APCs already reflect such occurrences. Those opposed to the proposed policy in its entirety also noted that it would be operationally and administratively difficult to implement and that it would result in insufficient payment to hospitals.

Most commenters that agreed with the premise behind the proposed policy to reduce Medicare payment for devices replaced with partial credit supported implementation of the proposed policy, but requested modifications or a delay in implementation of the policy. The majority of these commenters argued that CMS should raise the partial credit threshold to which this policy would apply to 50 percent of the cost of the replacement device, consistent with the policy CMS recently implemented for devices replaced with partial credit for services paid under the FY 2008 IPPS. Commenters stated that consistency in policies across hospital inpatient and outpatient payment systems would reduce confusion, promote compliance, and decrease the administrative burden for hospitals. The commenters also argued that a threshold as low as a 20 percent credit toward the cost of the replacement device would not justify the operational and administrative burdens of returning the replaced devices to manufacturers for evaluation and applying manual billing adjustments. They were concerned that because of these administrative burdens, hospitals may not return the failed devices to manufacturers at all, thereby interfering with manufacturers' quality surveillance programs and preventing the type of data collection the proposed policy is meant to promote. According to commenters, a threshold of 50 percent would ensure that hospitals do not have to deal with these administrative burdens when the credit is nominal or relatively inconsequential relative to the overall procedure payment and unlikely to result in significant savings to the Medicare program. Some commenters noted that a partial credit threshold of 20 percent, with a payment reduction of 50 percent, would result in inadequate payment to hospitals when the credit received was anywhere between 20 percent and 50 percent of the cost of the device.

Response: We agree with the commenters' concerns regarding the threshold percentage to which a partial credit adjustment would be applied. We are increasing the threshold to which the partial credit reduction policy will apply to cases involving a credit of 50 percent or more toward the total cost of the replacement device. Commenters expressed significant concerns about potential administrative and operational burdens associated with partial credits for small percentages of device costs, and we agree that the partial credit adjustment policy should not apply if only a nominal portion of the cost of the device is at issue. We also agree that consistency in payment policies across hospital inpatient and outpatient payment systems is important and should be maintained whenever appropriate, as is true in this case. Raising the partial credit threshold to which this policy will apply also addresses concerns that the 50 percent reduction to Medicare payment for the replaced device would be more than the partial credit received in some cases.

We disagree with assertions that OPPS payment for device-dependent APCs already reflects partial credits to hospitals for replaced devices. We go to great lengths to ensure that payment rates for device-dependent APCs reflect the full costs of devices by excluding claims that contain token charges and/or the ''FB'' modifier. We continue to believe that in most cases, hospitals charge the full amount for the replaced device, although they may have incurred much less than the full cost of the device. While it may be true that some hospitals adjust their charges to reflect the partial credits they receive for replaced devices, we believe this is a small minority. Therefore, we believe our ratesetting methodology generally results in median costs that reflect the full costs of these devices. We also continue to believe that it is likely 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 device replacement procedures.

As discussed in the proposed rule (72 FR 42725 through 42726), we also do not agree 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 continue to 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 healthcare 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.

Comment: Many commenters urged OPPS adoption of the same billing options for hospitals as are available under the IPPS for billing devices replaced with partial credit. Specifically, they requested hospitals be allowed to: (1) Submit the claims for replacement devices immediately without the HCPCS modifier signifying partial credit for a replacement device and later, if a credit is ultimately issued, submit a claim adjustment with the appropriate coding; or (2) hold the claim until a credit determination is made. According to the commenters, credits are determined after a case-by-case review by the manufacturer following explant and replacement of the device, which can take 8 weeks or longer. During this time, hospitals often do not know whether or how much credit the manufacturer will provide and cannot submit a bill for the replacement device implantation procedure, creating substantial payment delays. In addition, commenters were concerned about the administrative burden of providing paper invoices or other information to their fiscal intermediary or MAC indicating the hospital's normal cost of the device or the amount of the credit received.

Several commenters referenced the September 2007 meeting of the APC Panel, where the Panel recommended that CMS explore whether hospitals could report a modifier to reflect the amount of a partial credit for a device as a percentage of the amount of the replacement device. While one commenter supported this approach, other commenters expressed concerns about the administrative burden associated with this alternative. They stated that constructing a modifier in this way may be too easily confused with existing numeric modifiers used in conjunction with CPT coding. Commenters also shared CMS' concerns about hospitals reducing their charges in proportion to the partial credit they receive for a replaced device. They encouraged CMS to work with providers to develop the least burdensome approach to incorporate payment reductions for devices replaced with partial credit based on empirical data.

Response: In order to report that they received a partial credit of 50 percent or more of the cost of a replacement device, hospitals will have the option of either: (1) Submitting the claims immediately without the HCPCS modifier signifying partial credit for a replacement device and submitting a claim adjustment with the HCPCS modifier at a later date once the credit determination is made; or (2) holding the claim until a determination is made on the level of credit. We understand commenters' concerns about potential delays that could occur while a returned device is being evaluated to determine whether and by how much a credit will be applied. We agree that hospitals should have the same billing options, when appropriate, under the OPPS as are available under the IPPS. As described in the FY 2008 IPPS final rule (72 FR 47250), we believe that these billing options will facilitate more efficient administration of the policy by allowing the hospital to gather and report all of the information it needs to be paid correctly by Medicare, without the need to suspend claims or delay payment.

We share commenters' concerns about the administrative and coding burdens that could be associated with the September 2007 APC Panel's recommendation to report a modifier to reflect the amount of a partial credit for a device as a percentage of the cost of the replacement device so we are not adopting that recommendation for CY 2008. We also note that the claims processing system for Part B hospital outpatient bills does not have the capacity to accommodate non-uniform HCPCS modifiers. Instead, CMS will recognize a new ''FC'' modifier, effective January 1, 2008, that reads: ''Partial credit received for replaced device.'' Hospitals will be instructed to append the modifier to the HCPCS code for the procedure in which the device was inserted on claims when the device that was replaced with partial credit under warranty, recall, or field action is one of the devices in Table 26 below (hospitals should not append the modifier to the HCPCS procedure code if the device is not listed in Table 26). Claims containing the ''FC'' modifier will not be accepted unless the modifier is on a procedure code with status indicator ''S,'' ''T,'' ''V,'' or ''X.'' If the APC to which the procedure code is assigned is one of the APCs listed in Table 25 below, the fiscal intermediary or MAC will reduce the unadjusted payment rate for the procedure by an amount equal to the percent in Table 26 for partial credit device replacement multiplied by the unadjusted payment rate (if the ''FC'' modifier is assigned to a procedure code that is not in Table 26, then no adjustment will be taken). The adjustment amounts for no cost, full credit, and partial credit cases are included in Table 25 below.

We believe that it is appropriate to treat the services subject to the APC payment reduction in cases of devices replaced with partial credit like any other service, and to apply the standard reduction policies. Therefore, the partial credit adjustment will occur before wage adjustment and before the assessment to determine if the reductions for multiple procedures (signified by the presence of more than one procedure on the claim with status indicator ''T''), discontinued services (signified by modifier 73) or reduced services (signified by modifier 52) apply, similar to what occurs when a device is replaced at full credit or with no cost to the hospital (see 71 FR 68076 for more discussion).

Comment: Some commenters requested that we provide clarification of key elements of the proposal, stating that it was unclear what ''cost'' should be considered when determining the situations to which the partial credit policy should apply, and what constitutes a ''replacement'' device. For example, some commenters pointed out that volume discounts can result in reduced costs for hospitals, and that at times devices are replaced at full cost when a new, improved technology becomes available. Some commenters also expressed interest in any OPPS data we may have about the number of cases to which this policy would apply.

Response: The partial credit policy only applies when hospitals receive partial credit for the cost of a device that is replaced due to failure or other problems while the device is still under warranty, or when there is a recall or field action. The policy does not apply when hospitals receive routine rebates such as volume discounts. Hospitals should continue to incorporate these other types of rebates into their cost reports so that these savings will be reflected in the hospitals' CCRs. Neither the partial credit payment reduction for replaced devices, nor the payment reduction for devices replaced with full credit or at no cost, apply if the hospital pays the full price for the device.

We acknowledge the interest providers have in the data resulting

from our reporting requirements for devices replaced at no cost or with full or partial credit. We will consider what types of information could be of value to hospitals as we continue to analyze claims-based reporting of full and partial device credit cases, particularly when CY 2007 claims data become available.

Comment: One commenter objected to the application of a different offset percentage to APC 0385 (Level I Prosthetic Urological Procedures) than to APC 0386 (Level II Prosthetic Urological Procedures) for purposes of the adjustment when a device is replaced in cases of no cost or full or partial credit. The commenter stated that the ratio of device costs to overall procedure costs is identical in APCs 0385 and 0386, and that the device offset percentage should be at least 80 percent for both APCs.

Response: Our hospital claims data and cost reports indicate the device offset percentage for APC 0385 is 52 percent, and the device offset percentage for APC 0386 is 64 percent, calculated according to our standard methodology for establishing the device offset percentage (71 FR 68073). Because the surgical procedures assigned to these two APCs are different from one another from clinical and resource perspectives as evidenced by the CY 2008 median costs of approximately $5,262 and $9,067 for APCs 0385 and 0386, respectively, and because the distinct HCPCS device codes allowed in the procedure-to-device-edits for the various services assigned to the two APCs are different, we would expect that their device offset percentages also would differ. Therefore, we conclude that the device cost in APC 0386 is higher than the device cost in APC 0385, and that neither device offset percentage should be equal to 80 percent.

After consideration of the public comments received, we are finalizing a modified policy for certain procedures involving partial credit for a replacement device. Specifically, we will reduce the payment for an implantation procedure assigned to APCs listed in Table 25, below, by one half of the device offset that would be applied if a replacement device were provided at no cost or with full credit, if the credit is 50 percent or more of the replacement device cost. We will recognize the new modifier ''FC'' for reporting these cases, and we are not adopting the recommendation of the APC Panel to utilize a modifier that specifically reflects the amount of a partial credit for a device as a percentage of the cost of the replacement device. Accordingly, we are implementing the proposed changes to §§ 419.45(a) and (b) with modification to reflect the 50 percent partial device credit threshold to which the policy will apply. Beneficiary copayment will be based on the reduced payment amount. We will continue to evaluate how we might refine our methodology for reducing the payment for the procedural APCs into which the costs of the devices in 25 below are packaged based on the claims data we receive as this policy is implemented. We also will continue to monitor charges that are submitted for devices reported with the partial credit modifier ''FC'' to see if hospitals appear to be reflecting partial device credits in their charges for these implantable devices.

We also are implementing our proposals to add APC 0625 to the list of APCs to be adjusted in cases of no cost or full or partial credit for replaced devices, to remove APC 0229 from that list, and to add the device described by device code C1881 that is implanted in a procedure assigned to APC 0625 to the list of devices to which this policy applies.

TABLE 25.—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)	CY 2008 reduction for full credit case (percent)	CY 2008 reduction for partial credit case (percent)	CY 2008 payment rate	CY 2008 adjusted payment for full credit case	CY 2008 adjusted payment for partial credit case
0039	S	Level I Implantation of Neurostimulator.	78.85	82.73	41.37	$11,877	$2,051	$6,964
0040	S	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	54.06	56.27	28.14	4,063	1,777	2,920
0061	S	Laminectomy or Incision for Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	60.06	60.60	30.30	5,278	2,079	3,679
0089	T	Insertion/Replacement of Permanent Pacemaker and Electrodes.	77.11	72.99	36.50	7,748	2,093	4,921
0090	T	Insertion/Replacement of Pacemaker Pulse Generator.	74.74	76.01	38.01	6,423	1,541	3,982
0106	T	Insertion/Replacement/Repair of Pacemaker and/or Electrodes.	41.88	56.25	28.13	4,428	1,937	3,183
0107	T	Insertion of Cardioverter-Defibrillator.	90.44	89.11	44.56	21,262	2,315	11,789
0108	T	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads.	89.40	89.24	44.62	25,787	2,775	14,281
0222	S	Implantation of Neurological Device.	77.65	84.86	42.43	15,337	2,322	8,830
0225	S	Implantation of Neurostimulator Electrodes, Cranial Nerve.	79.04	80.57	40.29	14,061	2,732	8,397
0227	T	Implantation of Drug Infusion Device.	80.27	80.73	40.37	11,713	2,257	6,985
0259	T	Level VI ENT Procedures	84.61	82.94	41.47	25,046	4,273	14,659
0315	S	Level II Implantation of Neurostimulator.	76.03	86.15	43.08	17,199	2,382	9,790
0385	S	Level I Prosthetic Urological Procedures.	83.19	51.56	25.78	5,327	2,580	3,954

TABLE 25.—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)	CY 2008 reduction for full credit case (percent)	CY 2008 reduction for partial credit case (percent)	CY 2008 payment rate	CY 2008 adjusted payment for full credit case	CY 2008 adjusted payment for partial credit case
0386	S	Level II Prosthetic Urological Procedures.	61.16	63.53	31.77	9,180	3,348	6,264
0418	T	Insertion of Left Ventricular Pacing Elect.	87.32	82.52	41.26	16,544	2,892	9,718
0625	T	Level IV Vascular Access Procedures.	N/A	58.88	29.44	5,207	2,141	3,674
0654	T	Insertion/Replacement of a permanent dual chamber pacemaker.	77.35	77.13	38.57	6,961	1,592	4,276
0655	T	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker.	76.59	74.62	37.31	8,919	2,264	5,591
0680	S	Insertion of Patient Activated Event Recorders.	76.40	73.15	36.58	4,497	1,208	2,852
0681	T	Knee Arthroplasty	73.37	82.86	41.43	17,495	2,993	10,244

TABLE 26.—DEVICES FOR WHICH THE "FB" OR "FC" 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.
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

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 of the CY 2008 OPPS/ASC proposed rule, 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 reported 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. Final Policy

In the CY 2008 OPPS/ASC proposed rule, we stated that we were implementing in CY 2008 the final decision that we discussed in the CY 2007 OPPS/ASC final rule with comment period that finalized the expiration date of pass-through status for device category C1820 (71 FR 68078). 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 OPPS update. See section III.D.8. of this final rule with comment period for a discussion of our

final CY 2008 payment for the implantation of neurostimulators.

The 2 device categories that were established for pass-through payment as of January 1, 2007, HCPCS code C1821 (Interspinous process distraction device (implantable)) and HCPCS code L8690 (Auditory osseointegrated device, includes all internal and external components), will be active categories for pass-through payment for 2 years as of December 31, 2008. Therefore, we proposed that these categories expire from pass through device payment as of December 31, 2008.

We received a number of public comments concerning this proposal. A summary of the public comments and our responses follow.

Comment: A number of commenters objected to our proposal to expire device category L8690 from pass-through payment after December 31, 2008 and recommended that we maintain category code L8690 on pass-through status until the end of CY 2009, allowing a third year of pass-through payment. These commenters claimed that one year of claims data, that is, CY 2007 (which would be used to develop the CY 2009 payment rates for the associated implantation procedures) would be insufficient to establish an accurate procedure payment rate that reflected the costs of implanting the device. They based this recommendation on several reasons. They claimed that there were low volumes of charges by hospitals to Medicare for HCPCS code L8690. One of the commenters, the applicant to establish the pass-through category, projected utilization of 525 devices in the first year of device pass-through payment at the time of the application, but stated that CMS CY 2006 claims data for the proposed rule included only 230 total claims for procedures to implant the device. The commenter indicated that it did not expect the number of implantation procedures to increase substantially in CYs 2007 and 2008. Commenters also claimed that given the history of hospital billing problems for implantable devices, the new code L8690 was generally unknown in CY 2006 and some data might not have been accurately reported. Several commenters explained that the four different procedure codes associated with implantation of osseointegrated devices, CPT codes 69714 (Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy) through 69718 (Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy) demonstrated wide variation in hospital costs, from $5,200 through $9,200, and this cost variation also pointed to current insufficient data for the procedures to implant osseointegrated devices. One commenter recommended that we extend pass-through status for L8690 through CY 2010.

Response: Several commenters reported that the procedures in which L8690 was implanted were low volume OPPS procedures. We agree that these procedures were low volume in CY 2006, with only 255 total claims under the OPPS. However, we would not expect that these procedures would ever be commonly performed in the Medicare population because the specific clinical indications for implantation of osseointegrated implants are most frequently found in younger populations. Therefore, the osseointegrated implant procedures would likely continue to exhibit low claim volumes relative to many other procedures paid under the OPPS. In fact, the projected utilization of 525 devices by one commenter for CY 2006 would also be considered low volume for the OPPS, but we regularly pay prospectively for many services where there are fewer than several hundred OPPS services performed each year. We believe that several hundred implantation procedure claims from CY 2007 should be sufficient for CY 2009 ratesetting, when we would first package payment for the device cost of osseointegrated devices that no longer had pass-through status. During CYs 2007 and 2008, hospitals have a strong financial incentive to report appropriate charges for the device's use, because they are paid separately for the device, based on charges adjusted to cost during the device's pass-through payment period. We note that while there are four CPT codes for the osseointegrated device implantation procedures, the vast majority of CY 2006 claims were for CPT code 69714, for which we had 240 total claims. The majority of these claims were single claims that would be available for use in establishing the procedure's median cost. While the other three procedures had only a few CY 2006 claims each and displayed the variable costs that commonly result from a small number of claims, we believe that they are similar to CPT code 69714 from both clinical and resource perspectives and note that all four procedures require the implantable device for their performance. Therefore, we believe that our CY 2007 data for implantation of osseointegrated device procedures should be sufficient to allow accurate ratesetting for CY 2009 when the device cost would be packaged, so there would be no reason to continue the pass-through status of L8690 beyond the 2 year period that ends as of December 31, 2008. Moreover, as to the commenter who requested pass-through status for L8690 through CY 2010, we note that the statute at section 1833(t)(6)(C) precludes pass-through payments for a category of devices for more than 3 years.

Comment: A commenter stated that we should extend pass-through payment for HCPCS code C1821 (Interspinous process distraction device (implantable)), presumably for the additional year allowed under the statute.

Response: The commenter stated that we should continue pass-through payment for the spinous process distraction device reported with C1821 but provided no explicit rationale for this recommendation or for how much longer than the 2 years we proposed for the pass-through payment for C1821. We expect that there would be sufficient CY 2007 claims data that reflected the cost of the interspinous distraction device for the CY 2009 OPPS update, so that the device cost could be appropriately packaged into the APC payment for the associated implantation procedures with which the device was reported. During CYs 2007 and 2008, hospitals have a strong financial incentive to report appropriate charges for the device's use, because they are paid separately for the device, based on charges adjusted to cost during the device's pass-through payment period. The associated procedure codes, specifically CPT codes 0171T (Insertion of posterior spinous process distraction device (including necessary removal of bone or ligament for insertion and imaging guidance), lumbar; single level) and 0172T (Insertion of posterior spinous process distraction device (including necessary removal of bone or ligament for insertion and imaging guidance), lumbar; each additional level (List separately in addition to code for primary procedure)) were new for CY 2006, where they were assigned to APC 0050 (Level II Musculoskeletal Procedures Except Hand and Foot) on an interim final basis. See section III.D.8. of this final rule with comment period for a discussion of the final CY 2008 APC assignments of these procedures to APC 0050. After CY 2008, HCPCS code C1821 would have had 2 full years of pass-through payment, and we believe that it would be appropriate

to package the costs of C1821 into payment for the implantation procedures with which the device was billed, according to our standard methodology, for CY 2009. We see no reason to extend the period of pass through payment for C1821 beyond December 31, 2008.

After consideration of the public comments received, we are finalizing our proposal, without modification, to expire device categories L8690 and C1821 from transitional pass-through payment after December 31, 2008.

2. Provisions for Reducing Transitional Pass Through Payments to Offset Costs Packaged Into APC Groups

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 believed that use of the most current claims data to establish offset amounts when they are needed to ensure appropriate payment was consistent with our stated policy; therefore, we proposed to continue to do so for the CY 2008 OPPS. Specifically, if we created a new device category for payment in CY 2008, to calculate potential offsets we proposed to examine the most current available claims data, including device costs, to determine whether device costs associated with the new category were already packaged into the existing APC structure, as indicated earlier. If we concluded that some related device costs were packaged into existing APCs, we proposed 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.

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For CY 2008, we proposed 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 were packaged into the existing APC structure. If we determined that, for any new device category, no device costs associated with the new category were packaged into existing APCs, we proposed 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 proposed that the offsets for CY 2008 for L8690 and C1821 remain set to $0, because we could not identify device costs packaged in the related procedural APCs that were 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 proposed to continue our existing policy of establishing new categories in any quarter when we determined that the criteria for granting pass through status for a device category were met. If we created a new device category and determined that our CY 2006 claims data contained a sufficient number of claims with identifiable costs associated with the new category of devices in any APC with which it is billed, we proposed 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 determined that a device offset amount greater than $0 was appropriate for any new category that we created, we proposed to announce the offset amount in the program transmittal that announced the new category.

In summary, for CY 2008, we proposed to use CY 2006 hospital claims data to calculate device percentages and potential offsets for new device categories established in CY 2008. We also proposed to publish through program transmittals any new or updated offsets that we calculated for CY 2008, corresponding to newly created categories or existing categories eligible for pass-through payment, respectively.

We received no public comments on our proposed continuation of our current policy to establish offset amounts for new device categories eligible for pass-through payments, and, therefore, we are adopting our proposed policy stated above as final for CY 2008.

V. OPPS Payment Changes for Drugs, Biologicals, and Radiopharmaceuticals

A. Transitional Pass-Through Payment for Additional Costs of Drugs and Biologicals

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 Benefits Improvement 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. For pass-through payment purposes, radiopharmaceuticals are included as ''drugs.'' Under the statute, transitional pass-through payments can be made for at least 2 years but not more than 3 years. CY 2008 pass-through drugs and biologicals are assigned status indicator ''G'' as indicated in Addenda A and B to the CY 2008 OPPS/ASC proposed rule and this final rule with comment period.

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) of the Act (or, if the drug or

biological is covered under a competitive acquisition contract under section 1847B of the Act, 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 final rule with comment period, 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 common Part 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. OPPS pass-through payment estimates for drugs and biologicals in CY 2008 can be found in section VI. of this final rule with comment period.

The pass through application and review process is explained on the CMS Web site at: *http://www.cms.hhs.gov/HospitalOutpatientPPS/04_passthrough_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 of the CY 2008 OPPS/ASC proposed rule (72 FR 42730), we proposed to allow the expiration of the pass-through status for seven drugs and biologicals on December 31, 2007. While it is standard OPPS practice to delete temporary C-codes if an alternate permanent HCPCS code becomes available for purposes of OPPS billing and payment, there were no temporary C-codes used to identify the seven pass-through drugs that were proposed for expiring pass-through status on December 31, 2007. Table 27 below includes the CY 2008 permanent HCPCS codes of drugs and biologicals with expiring pass-through status as of December 31, 2007.

We received several public comments regarding a drug proposed to expire from pass-through status at the end of CY 2007. A summary of the comments and our responses follow.

Comment: A few commenters requested that CMS continue pass-through status for HCPCS code Q4079 (Injection, Natalizumab, 1 mg) for an additional year. The commenters stated that, while HCPCS code Q4079 was granted pass-through status beginning April 2005, the manufacturer of this drug voluntarily suspended sales of the drug prior to that date in February 2005. Therefore, the commenters believed that the period of pass-through under the OPPS did not begin until the drug resumed marketing in June 2006 or until the manufacturer again began shipping the drug to providers in July 2006. The commenters noted that, under these circumstances, pass-through payment had not been made for the 2 year pass-through minimum. Therefore, they believed that pass-through status should continue through CY 2008.

Response: According to our regulations at 42 CFR 419.64, pass-through status begins on the date that CMS makes its first pass-through payment for the drug or biological. As the commenters noted, HCPCS code Q4079 was approved for OPPS pass-through status beginning in April 2005. However, the manufacturer of the product voluntary suspended marketing of the product 2 months prior to April 2005. Therefore, in order to determine when pass-through payments were first made for this product, we examined OPPS claims data for HCPCS code Q4079 for the second, third and fourth quarters of CY 2005. While we found a few claims from this time period from several different hospitals, we believe that these claims were incorrectly coded. The typical dose of HCPCS code Q4079 is 300 mg infused every 4 weeks. The hospital claims billed during these three quarters of 2005 reported a median of only one unit per day, although the descriptor of HCPCS code Q4079 specifies ''per 1 mg.'' In comparison, hospital claims show a median of 300 units per day billed after this product resumed marketing in July 2006. In addition, while there were a few hospital claims for HCPCS code Q4079 submitted in CY 2005, we received no claims for HCPCS code Q4079 during the first two quarters of CY 2006. Therefore, we believe that the CY 2005 claims were miscoded, so that the first pass-through payment for a correctly coded use for HCPCS code Q4079 was actually not made until July 2006. As a drug that began pass-through status in July 2006 would continue with pass-through status in CY 2008, we are continuing pass-through status in CY 2008 for HCPCS code Q4079.

In addition, in accordance with our standard practice to replace temporary HCPCS codes with permanent ones when a permanent HCPCS code becomes available, we are deleting HCPCS code Q4079 (Injection, Natalizumab, per 1 mg), effective December 31, 2007, and replacing it with HCPCS code J2323 (Injection, Natalizumab, 1 mg), effective January 1, 2008. We have identified this drug in Table 27 below and in Addendum B of this final rule with comment period

using HCPCS code J2323 and assigned it status indicator ''G.''

After consideration of the public comments received, we are finalizing our proposed listing of drugs and biologicals whose pass-through status expires on December 31, 2007, with modification so that pass-through status for HCPCS code Q4079 (HCPCS code J2323 beginning in CY 2008) continues in CY 2008. In Table 27 below, we list the six drugs and biologicals whose pass-through status will expire on December 31, 2007.

TABLE 27.—DRUGS AND BIOLOGICALS FOR WHICH PASS-THROUGH STATUS EXPIRES DECEMBER 31, 2007

CY 2008 HCPCS	CY 2007 HCPCS	CY 2008 Descriptor	CY 2008 SI	CY 2008 APC
J2278	J2278	Ziconotide injection	K	1694
J2503	J2503*	Pegaptanib sodium injection	K	1697
J7311	J7311	Fluocinolone acetonide implt	K	9225
J8501	J8501	Oral aprepitant	K	0868
J9027	J9027	Clofarabine injection	K	1710
J9264	J9264*	Paclitaxel protein bound	K	1712

* 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 Pass-Through Status in CY 2008

In the CY 2008 OPPS/ASC proposed rule (72 FR 42731), we proposed 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, were listed in Table 42 of the proposed rule. The APCs and HCPCS codes for these drugs and biologicals listed in Table 42 were assigned status indicator ''G'' in Addenda A and B to the 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) as the difference between the amount authorized under section 1842(o) of the Act (or, if the drug or biological is covered under a CAP under section 1847B of the Act, 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 final rule with comment period, in the proposed rule we stated our belief that 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, for CY 2008, we proposed 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 CAP 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 proposed 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 28 below with an asterisk.

In the CY 2008 OPPS/ASC proposed rule, we proposed to continue pass-through status for 13 drugs and biologicals. As stated previously, it is standard OPPS practice to delete temporary C-codes if an alternate permanent HCPCS code becomes available for purposes of OPPS billing and payment. For CY 2008, HCPCS code C9232 (Injection, idursulfase, 1 mg) is deleted and replaced with HCPCS code J1743 (Injection, idursulfase, 1 mg); HCPCS code C9233 (Injection, ranibizumab, 0.5 mg) is deleted and replaced with HCPCS code J2778 (Injection, ranibizumab, 0.1 mg); and HCPCS code C9235 (Injection, panitumumab, 10 mg) is deleted and replaced with HCPCS code J9303 (Injection, panitumumab, 10 mg).

In addition, in order to be consistent with the naming conventions of the CMS HCPCS Workgroup, we have deleted HCPCS code C9350 (Microporous collagen tube of non-human origin, per centimeter length), and replaced this code with HCPCS codes C9352 (Microporous collagen implantable tube (Neuragen Nerve Guide), per centimeter length) and C9353 (Microporous collagen implantable slit tube (NeuraWrap Nerve Protector), per centimeter length) in order to more accurately identify the two products that were previously described by HCPCS code C9350. Similarly, we have deleted HCPCS code C9351 (Acellular dermal tissue matrix of nonhuman origin, per square centimeter (Do not report C9351 in conjunction with J7345)) for CY 2008 and replaced it with HCPCS codes J7348 (Dermal (substitute) tissue of nonhuman origin, with or without other bioengineered or processed elements, without metabolically active elements (Tissuemend) per square centimeter) and J7349 (Dermal (substitute) tissue of nonhuman origin, with or without other bioengineered or processed elements, without metabolically active elements (Primatrix) per square centimeter).

We received several public comments regarding our proposal to continue the pass-through status of certain drugs and biologicals for CY 2008. A summary of the comments and our responses follow.

Comment: Several commenters noted support for specific drugs and biologicals proposed for pass-through status in CY 2008 and urged CMS to finalize the proposal for these items. The commenters also commended CMS for proposing to provide payment for pass-through drugs and biologicals at a

rate equal to the rate these drugs and biologicals would receive under the Part B drug CAP program or in the physician's office setting.

Response: We appreciate the commenters' support for our proposed policy. We are finalizing our proposal to provide pass-through payments in CY 2008 for the drugs listed in Table 28 below. This table includes the continuation of pass-through status for HCPCS code Q4079, as discussed previously, and accounts for the coding changes presented above.

Comment: One commenter disagreed with the decision to grant pass-through status to HCPCS code J3473 (Injection, hyaluronidase, recombinant, 1 USP unit) beginning in January 2007 and to continue this drug in pass-through status through CY 2008. The commenter believed that the product described by HCPCS code J3473 fails to meet the pass-through criteria of newness and ''not insignificant costs.'' The commenter claimed that hyaluronidase was available prior to December 31, 1996, and was captured in the initial OPPS payment rates and, therefore should not be considered new. In addition, the commenter explained that the FDA approval of this product was made based on the section 505(b)(2) criteria, meaning that the product claimed to be identical to products already approved by the FDA. This commenter also noted that the administration of HCPCS code J3473 is typically billed with ophthalmic procedures, not drug administration procedures. The commenter asserted that when the cost significance test is performed with APCs more likely to reflect ophthalmic procedures, such as APC 0246 (Cataract Procedures with IOL Insert), the cost significance test for drug and biological pass-through status is not met.

The commenter further noted that, as a result of this drug being granted pass through status, CMS created a market bias towards the use of this product, as all other hyaluronidase products are currently packaged. The commenter argued that this apparent market bias would be further exacerbated as a result of the revised ASC payment system policy of providing separate payment for OPPS separately payable drugs that are provided in the ASC setting beginning in CY 2008, because the majority of procedures that would be likely to use HCPCS code J3473 are frequently performed in ASCs.

Response: Our criteria for reviewing pass-through applications are available on the CMS Web site at: *http://www.cms.hhs.gov/HospitalOutpatientPPS/04_passthrough_payment.asp*. Based on these criteria, we reviewed the application submitted to us for HCPCS code J3473 and approved pass-through status beginning on January 1, 2007. We do not agree with the commenter that our decision was in error. The drug met all criteria established for pass through payment for drugs and biologicals. Therefore, as this drug has not met the 2-year minimum pass-through time requirement, we are adopting our proposal to continue pass-through status for HCPCS code J3473 for CY 2008.

Comment: One commenter requested that CMS clarify how payment would be made for radiopharmaceutical products that are granted pass-through status during CY 2008.

Response: Currently, there are no radiopharmaceuticals that would have pass-through status in CY 2008. Consistent with OPPS payment for drugs, biologicals, and radiopharmaceuticals without HCPCS codes, in CY 2008, payment for radiopharmaceuticals that are granted pass-through status would be based on the ASP methodology. As stated above, for purposes of pass-through payment, we consider radiopharmaceuticals to be drugs under the OPPS. Therefore, if a radiopharmaceutical receives pass through status during CY 2008, we will follow the standard ASP methodology to determine its pass-through payment rate under the OPPS. Because ASP data are not available for radiopharmaceuticals, we will base the pass-through payment on the product's WAC. If WAC data are also not available, we will then provide payment for the pass-through radiopharmaceutical at 95 percent of its most recent AWP.

In the OPPS/ASC CY 2008 proposed rule, we used payment rates for drugs with pass-through status 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 the proposed rule because these were the most recent data available to us at that time. These payment rates were the basis for drug payments in the physician's office setting, effective April 1, 2007. As proposed, we used updated data in the development of this final rule with comment period. That is, we used the ASP data from the second quarter of CY 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 this final rule with comment period. In addition, we are finalizing our proposal 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 data, 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.

As proposed, if a drug that has been granted pass-through status for CY 2008 becomes covered under the Part B drug CAP, we will 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 proposed to use the payment rates calculated under that program that are in effect as of April 1, 2007, which is the most recent update of these payment rates. We proposed to update these payment rates if the rates change in the future.

After consideration of the public comments received, we are finalizing our CY 2008 proposal, without modification, 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 CAP) only if we receive a pass-through application for the drug or biological and pass-through status is subsequently granted. Otherwise, we will pay ASP+5 percent for these products in CY 2008. New radiopharmaceuticals with pass-through status will be paid based on WAC or, if WAC is not available, based on 95 percent of the product's most recent AWP. We will update the payment rates for pass-through drugs and biologicals quarterly, as new data become available.

The drugs and biologicals that are continuing pass-through status or have been granted pass-through status as of January 2008 for CY 2008 are included in Table 28 below.

TABLE 28.—DRUGS AND BIOLOGICALS WITH PASS-THROUGH STATUS IN CY 2008

CY 2007 HCPCS	CY 2008 HCPCS	CY 2008 Descriptor	CY 2008 SI	CY 2008 APC
	C9239	Inj, temsirolimus	G	1168
C9350	C9352	Neuragen nerve guide, per cm	G	9350
C9350	C9353	Neurawrap nerve protector, cm	G	1169
J0129	J0129	Abatacept injection	G	9230
J0348	J0348	Anadulafungin injection	G	0760
J0894*	J0894*	Decitabine injection	G	9231
C9236	J1300	Eculizumab injection	G	9236
J1740	J1740	Ibandronate sodium injection	G	9229
C9232	J1743	Idursulfase injection	G	9232
J2248	J2248	Micafungin sodium injection	G	9227
Q4079	J2323	Natalizumab injection	G	9126
C9233	J2778	Ranibizumab injection	G	9233
J3243	J3243	Tigecycline injection	G	9228
J3473	J3473	Hyaluronidase recombinant	G	0806
Q4095	J3488	Reclast injection	G	0951
C9351	J7348	Tissuemend tissue	G	9351
C9351	J7349	Primatrix tissue	G	1141
J9261	J9261	Nelarabine injection	G	0825
C9235	J9303	Panitumumab injection	G	9235

* 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.

B. 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 at $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 final rule with comment period.

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 final rule with comment period our final CY 2008 payment policy for these anti–emetic products.

2. Criteria for Packaging Payment for Drugs and Biologicals

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)), as proposed, 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 were revised (compared with those used in the CY 2007 OPPS/ASC final rule with comment period) and were incorporated into our calculation. Based on the calculations described above, we proposed 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. As indicated in the proposed rule, we did not propose 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 that proposed rule and our desire to move the OPPS toward a more encounter-based and episode-based payment in the future. However, as noted in the proposed rule, we will consider expanded packaging of payment for drugs, biologicals, and radiopharmaceuticals for a future OPPS update (72 FR 42732). 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 proposed 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.c.(5) and (6) of this final rule with comment period. However, we continue to 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, in the proposed rule, we specifically solicited public comment 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 (72 FR 42732).

For the third year, we proposed to continue exempting the oral and injectable forms of 5HT3 anti-emetics products from packaging, thereby making separate payment for all of these 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 regiment. In the proposed rule, we stated our belief 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 the treating physician.

Comment: A few commenters disagreed with the proposed increase of the packaging threshold to $60 and asked CMS to retain the $55 threshold for CY 2008. The commenters noted that the threshold has experienced a 20 percent increase over 2 years, and that an increased threshold threatens hospitals' ability to provide quality care without compromising the range of services they offer. One commenter suggested that CMS implement a contingency that would limit increases to the drug packaging amount to the rate of increase in the ASP amount. Other commenters suggested increasing the OPPS drug packaging threshold either for a subset of items, or for all drugs, biologicals, and radiopharmaceuticals. Another commenter recommended that CMS consider a drug packaging methodology based on the relative cost of a drug in comparison with the associated procedure, instead of continuing the absolute cost methodology, proposed for CY 2008 at $60.

Response: We continue to believe that our approach of applying an annual inflation adjustment factor to update the packaging threshold is consistent with the practices of many health care payment policy areas, and many other areas of government policy, that acknowledge real costs by using an inflation adjustment factor instead of static dollar values. We continue to be concerned that, absent a mechanism to update the threshold, current relatively inexpensive drugs would begin to receive separate payment over time. While we understand the commenters' concerns that substantial increases in the threshold over a short period of time may be undesirable, we do not believe that the changes we have implemented over the past 2 years have jeopardized hospitals' ability to provide quality patient care. In addition, we again note that the updates to the OPPS drug packaging threshold have been predicated on relevant inflation rates for prescription drugs. Therefore, we continue to believe that our update methodology is aligned closely with national industry figures and standards.

We agree with some commenters that an increased packaging threshold would be supportive of our overall increased packaging efforts to increase the size of the OPPS payment bundles. As stated above, we believe that there are many benefits of increasing the drug packaging threshold beyond the current level, one benefit being that items within a group of drugs would potentially be paid according to a similar methodology. During the September 2007 APC Panel meeting, the Panel engaged in a discussion regarding a higher drug packaging threshold for the OPPS, and while this discussion did not yield a recommendation, the Panel expressed interest in the idea of an increased drug packaging threshold. While we understand that there may be benefits to hospitals when the drug packaging threshold is relatively low because they would be paid separately for many drugs, we believe that a higher packaging threshold could encourage efficiencies and provide hospitals more flexibility in managing their resources associated with drug administration services.

In addition, while we are unsure how a drug packaging threshold based on relative drug costs in comparison to the associated procedure costs would operate in a hospital outpatient setting, we believe that further investigation of such a methodology could be warranted. Therefore, in an effort to gain more information that may help us determine the potential effects of an increased drug packaging threshold based on either an absolute dollar amount or on a relative dollar amount, we are again specifically requesting comments from hospital stakeholders and interested individuals on the impact that such a change would have on hospitals, and how such a methodology could be developed, implemented, and updated.

Comment: Several commenters requested that CMS eliminate the drug packaging threshold and provide separate payment for all Part B drugs. The commenters noted that this would eliminate payment disparities between the OPPS and the physician's office setting, so there would be no site-of-service differential in providing drug therapies.

Response: We continue to believe that unpackaging payment for all drugs, biologicals, and radiopharmaceuticals is inconsistent with the concept of a prospective payment system and that such a change could create an additional reporting burden for

hospitals. The OPPS and the MPFS that apply to physician's office services are fundamentally different payment systems with essential differences in their payment policies. Specifically, the OPPS is a prospective payment system, based on the concept of paying for groups of services that share clinical and resource characteristics. Payment is made under the OPPS according to prospectively established payment rates that are related to the relative costs of hospital resources for services. The MPFS is a fee schedule that generally provides payment for each individual component of a service. Consistent with the MPFS approach, separate payment is made for each drug provided in the physician's office, but the OPPS packages payment for certain drugs into the associated procedure payments for the APC group. Because of the different payment policies, differences in the degrees of packaged payment and separate payment between these two systems are only to be expected. In general, we do not believe that our packaging methodology under the OPPS results in limited beneficiary access to drug administration services.

We note that, in CYs 2005 and 2006, the statutorily mandated drug packaging threshold was set at $50, and we believe it is currently appropriate to continue a modest drug packaging threshold for the CY 2008 OPPS. Therefore, because of our continued belief that packaging is a fundamental component of a prospective payment system that contributes to important flexibility and efficiency in the delivery of high quality outpatient hospital services, we are not adopting the recommendation to pay separately for all drugs, biologicals, and radiopharmaceuticals for CY 2008.

Comment: Several commenters supported the proposal to continue to exempt the oral and injectable forms of 5HT3 anti-emetic products (that were listed in Table 43 of the proposed rule that is reprinted as Table 29 below) from packaging, thereby making separate payment for all of the 5HT3 anti-emetic products. In addition, a few commenters requested that CMS apply the same principle to other groups of drugs in order to equalize payment methodologies across drugs in the same clinical group. One commenter recommended that payment for all hyaluronidase products be packaged.

Response: We appreciate the support of our proposal to continue exempting the 5HT3 anti-emetic products from our packaging determination. However, as discussed in the CY 2008 OPPS/ASC proposed rule, as we consider moving to additional encounter based and episode-based payment in future years, we may consider additional options for packaging in the future. If we were to increase the OPPS drug packaging threshold, we might no longer require a special exemption for these products because all these products might be packaged under such an approach. Similarly, a higher drug packaging threshold could eliminate existing disparities in payment methodologies for other drug groups and provide similar methods of payment across items in a group. Nevertheless, while we may be interested in alternative threshold methodologies for future ratesetting purposes, we realize that there are existing situations where drugs in a particular category vary in their payment treatment under the OPPS, with some drugs packaged and other separately paid. We believe the challenges associated with categorizing drugs to assess them for disparities are significant, and we are not convinced that ensuring the same payment treatment for other drug categories is essential at this time, beyond the proposal we made for 5HT3 anti-emetics. Therefore, we do not believe that it would be appropriate for CY 2008 to take any additional steps to ensure that all drugs in a specific category are either separately paid or packaged, as requested by some commenters.

After considering the public comments received, we are finalizing our CY 2008 proposal, without modification, to again exempt the oral and injectable forms of 5HT3 anti-emetic products listed in Table 29 below from our packaging methodology for CY 2008.

TABLE 29.—ANTI-EMETICS EXEMPTED FROM 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

For CY 2008, we proposed to calculate 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, to determine their CY 2008 packaging status. In order to calculate the per day costs for drugs, biologicals, and radiopharmaceuticals to determine their packaging status in CY 2008, we proposed 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 proposed for separately payable drugs and biologicals in CY 2008, as discussed in more detail subsequently). As noted in the CY 2008 OPPS/ASC proposed rule (72 FR 42733), 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) to determine the proposed per day cost. 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. As described in the proposed rule, we packaged items with a per day cost less than or equal to $60 and identified items with a 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 displayed in Addendum B to the proposed rule for payment in CY 2008.

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 that it is also our policy to make an annual packaging determination only when we develop the OPPS/ASC final rule for the update year. As indicated in the proposed rule (72 FR 42733), only items that are identified as separately payable in this final rule with comment period will be subject to quarterly updates. As proposed, for our calculation of per day costs of drugs, biologicals, and radiopharmaceuticals in this final rule with comment period, we used ASP data from the first quarter of CY 2007, which is 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 updated hospital claims data from CY 2006.

Consequently, the packaging status for drugs, biologicals, and radiopharmaceuticals in this final rule with comment period using the updated data may be different from their packaged status determined based on the data used for the proposed rule. Under such circumstances, we have

applied 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 were 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 were packaged in CY 2007 and that were 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 proposed packaged payment in CY 2008 but then have 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 HCPCS code J0594 (Injection, busulfan, 1 mg) was paid separately in CY 2007 and was proposed for separate payment in CY 2008, but had a final per day cost of approximately $37, which is less than the $60 threshold, based on the updated ASPs and hospital claims data used for this CY 2008 final rule with comment period. HCPCS code J0594 will continue to receive separate payment in CY 2008 according to the established methodology set forth above.

In addition, there were several drugs and biologicals that we proposed to package in the proposed rule and that now have per day costs greater than $60 using updated ASPs and all of the hospital claims data from CY 2006 used for this final rule with comment period. In accordance with our established policy for such cases, for CY 2008 we will pay for these drugs and biologicals separately. Table 30 lists the drugs and biologicals that were proposed as packaged, but that will be paid separately in CY 2008.

TABLE 30.—DRUGS AND BIOLOGICALS PROPOSED AS PACKAGED BUT WITH FINAL PER DAY COSTS ABOVE $60, FOR WHICH SEPARATE PAYMENT WILL BE MADE IN CY 2008

HCPCS	Description
J0190	Inj biperiden lactate/5 mg
J0600	Edetate calcium disodium inj
J1595	Injection glatiramer acetate
J2730	Pralidoxime chloride inj
J9270	Plicamycin (mithramycin) inj

Also, according to our packaging policy described above, two drugs, specifically HCPCS codes J0520 (injection, bethanechol chloride, myotonachol or urecholine, up to 5 mg) and J3364 (injection, urokinase, 5000 iu vial), were packaged in CY 2007, proposed for separate payment in CY 2008, but had final 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. Therefore, in accordance with our methodology, these two drugs will continue to be packaged in CY 2008.

In sections II.A.4.c.(5) and (6) of the CY 2008 OPPS/ASC proposed rule, we proposed 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 that proposed rule (72 FR 42671 and 42673 through 42674) listed the diagnostic radiopharmaceuticals and contrast agents, respectively, that we proposed to package in CY 2008. In section V.B.3.a.(4) of this final rule with comment period, we discuss our CY 2008 policies for providing payment for diagnostic and therapeutic radiopharmaceuticals.

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 did not have claims data available for ratesetting purposes for HCPCS code A9568, we estimated the number of units per day to also be one.

3. Payment for Drugs and Biologicals Without Pass-Through Status That Are Not Packaged

a. Payment for Specified Covered Outpatient Drugs

(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 has been established 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,'' known as 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 SCOD 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) Final 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.

We considered several options for payment for drug acquisition costs and pharmacy overhead for CY 2008 (72 FR 42735). 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 decided not to propose this option because we believed and continue to believe that it is undesirable to take steps that would ultimately lead to pharmacy overhead being unpackaged at the same time that we have proposed measures to expand packaging under the OPPS and have considered 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.

The second option we presented in the proposed rule was to continue 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 proposed a slight variant of this approach for CY 2008 instead.

For CY 2008, we proposed to continue our methodology of providing a combined payment rate for drug and biological acquisition costs and pharmacy overhead. However, in addition, we proposed 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. We believed that 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 proposed 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 did not propose 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.

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 final rule with comment period. In addition, this methodology is consistent with the increased packaging efforts discussed earlier in section II.A.4. of this final rule with comment period. Because we would not expect to have claims data reflecting these reporting changes until CY 2010, we proposed 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.

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 2007 ASP+6 percent payment rates for separately payable drugs and biologicals that do not have pass-through status.

During the September 2007 APC Panel meeting, the Panel recommended that hospitals not be required to separately report charges for pharmacy overhead and handling, and that pharmacy overhead and handling costs be recognized within drug charges and paid through the packaged or separate drug payment (as appropriate based on the drug packaging threshold). In addition, the Panel recommended that we continue to evaluate alternative methods to standardize the capture of pharmacy overhead costs in a manner that is simple to implement at the organizational level, similar to the three-phase approach recommended by the Panel during the March 2007 meeting. We discuss our responses to these recommendations below.

We received many public comments on our CY 2008 proposal to have hospitals report charges for pharmacy overhead on uncoded revenue code line. A summary of the public comments and our responses follow.

Comment: MedPAC supported the proposal to collect pharmacy overhead data via uncoded revenue code lines because it would allow hospitals to be paid more accurately for the variation in pharmacy overhead costs when payment for those costs would be packaged into the costs of the associated independent services. However, the vast majority of commenters echoed the APC Panel's recommendation to not require hospitals to separately report charges for pharmacy overhead and handling and the Panel's further recommendation that pharmacy overhead and handling costs be recognized within drug charges and be paid through the packaged or separate drug payment (as appropriate based on the drug packaging threshold). In general, the commenters cited overwhelming implementation issues, including administrative reporting burdens, challenges involved with identifying and splitting current charges for drugs and biologicals into acquisition costs and overhead, inflexible hospital accounting systems that are unable to combine and differentiate charges depending on the insurer, complexity requiring manual changes to individual claims, and beneficiary confusion regarding these charges on their bills. In addition, some commenters were concerned that secondary private insurers may not accept the charges when the claim is submitted after being processed by Medicare. The commenters noted that, due to these complex issues and the relatively short timeframe in which hospitals would have to make these changes, data obtained through this proposal are likely to be unreliable.

A few commenters expressed disappointment that CMS did not propose to adopt various methodologies they shared with CMS for capturing pharmacy overhead data. Several commenters reiterated their proposals for a three-phase system, similar to the three-phase plan recommended by the APC Panel and discussed above. The commenters also suggested that this plan could be altered, and that the survey contained in the second phase survey could be replaced with direct adoption of median costs from hospital claims data as long as prospective payments based on claims data were not implemented prematurely.

One commenter suggested a modification to the current hospital cost report by splitting the ''Pharmacy'' and ''Drugs Sold to Patient'' cost centers into two lines each—one for drug acquisition costs and the other for drug-related pharmacy and overhead costs. The commenters stated that providers would then apportion their drug charges between these two lines, and CMS would use the cost report to determine the relative cost of pharmacy overhead to total drug costs.

Other commenters suggested that CMS conduct hospital surveys, gather information through the fiscal intermediaries, or attach an additional worksheet to the hospital cost report.

Several commenters requested that, if CMS were to finalize this proposal, CMS should limit the reporting requirement to drugs with significant pharmacy overhead and administrative costs.

In addition to these suggested methodologies, several commenters expressed confusion regarding the phrases ''uncoded revenue code line'' and ''overhead and handling costs'' and requested clarification, while others requested that, if CMS finalized the proposed policy for pharmacy overhead services, CMS should delay the implementation date and provide hospitals additional time to update their systems.

Response: We appreciate the commenters' many suggestions on ways to collect hospital pharmacy data and the commenters' concerns regarding our proposal. While we considered the APC Panel's March 2007 recommendation, as well as similar suggestions from other stakeholders, we did not propose to adopt this recommendation (nor are we adopting this recommendation in this final rule with comment period) to implement a three-phase plan to address OPPS payment for pharmacy overhead costs. For CY 2008, we proposed to expand packaging under the OPPS by packaging payment for certain ancillary and supportive services as discussed in section II.A.4.c. of this final rule with comment period. Given our belief that packaging can be helpful in promoting hospital efficiency and long-term cost containment and our belief that pharmacy handling is ancillary and supportive to the administration of drugs and biologicals in the HOPD, 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.

As noted in the proposed rule (72 FR 42734 through 42735), the APC Panel recommended that CMS establish separate payment amounts for pharmacy overhead in addition to the current CY 2007 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 continue to 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. As we do consider the Panel's March 2007 recommendation to be aligned with the current OPPS trend towards increasing the size of payment bundles, we are accepting the Panel's September 2007 recommendation to continue to evaluate alternate methods to standardize the capture of pharmacy overhead costs in a manner that is simple to implement at the organizational level. As such, we are interested in continuing our dialogue with hospital stakeholders regarding the issue of pharmacy overhead. We generally accept requests from interested organizations to discuss their views about OPPS payment policy issues, including pharmacy handling issues. In addition, we establish the OPPS rates through regulations and, as such, 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 payment for the forthcoming year.

After reviewing the public comments we received on the CY 2008 proposal, we have a better understanding of the scope of our proposal and the burden that it would have on hospitals. While we continue to believe that packaging pharmacy overhead costs into the associated independent procedures for administration of the drugs could pay hospitals more appropriately for the variable pharmacy overhead costs associated with different types of drugs, we are concerned about the operational challenges and administrative burdens that hospitals would face in reporting drugs provided in the HOPD. Therefore, we are not finalizing our proposal to require hospitals to remove pharmacy overhead costs from drug acquisition costs and to report pharmacy overhead costs in an uncoded revenue code line.

We appreciate the suggestions to implement a hospital survey or to include a pharmacy overhead worksheet on the hospital cost report. However, we do not believe that it would be administratively feasible or reasonable from a resource perspective to develop and update information regarding pharmacy overhead costs through either of these methodologies. Presumably the commenters believe that, by collecting these data, we would provide additional separate payments to hospitals for pharmacy overhead services. As explained above, separate payment for pharmacy overhead would decrease the current size of the drug payment bundles and would not be aligned with the additional packaging we have implemented in this final rule with comment period.

In addition, several commenters expressed their preference to retain the pharmacy overhead payment packaged with the payment for the drug, stating that this is the most logical and appropriate grouping for payment purposes. We agree with these commenters and believe that a single OPPS payment that represents both drug acquisition and associated pharmacy overhead costs is the most reasonable and logical method of payment for these services. Therefore, we are adopting the September 2007 recommendation of the APC Panel that pharmacy overhead and handling costs be recognized within drug charges and be paid through the packaged or separate drug payment (as appropriate based on the drug packaging threshold). We do not believe that we need to provide specific guidance on the elements of pharmacy handling and overhead that hospitals should consider in setting their charges for drugs, because, as MedPAC found and many commenters confirmed, hospitals are currently including the costs of pharmacy overhead in their charges for drugs and biologicals.

After consideration of the public comments received, we are finalizing our proposal to provide a single bundled payment for separately payable drugs and biologicals, inclusive of both drug acquisition and pharmacy overhead costs. Hospitals should continue to consider the costs of pharmacy overhead in developing and reporting their charges for drugs and biologicals, maintaining their current practice.

For the CY 2008 OPPS/ASC 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 amount under both payment methodologies.

The results of our proposed rule data analysis for the proposed rule indicated 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 proposed to continue to provide a bundled payment for the acquisition costs of drugs and biologicals and the associated pharmacy overhead in CY 2008 at ASP+5 percent, where the ASP add-on percent was calculated based on mean costs from hospital claims data. In addition, as described in section II.A.4.c.(6) of this final rule with comment period, for contrast agents, we proposed a supplemental approach that would package payment for all contrast media under the CY 2008 OPPS.

During the September 2007 meeting of the APC Panel, the Panel recommended that we continue to provide payment for separately payable drugs at a rate of ASP+6 percent for CY 2008. We discuss our response to this recommendation below.

We received many public comments on our proposal to pay for separately payable drugs and biologicals and their pharmacy overhead at ASP+5 percent in CY 2008. A summary of the public comments and our responses follow.

Comment: Many commenters agreed with the Panel's recommendation to continue providing payment for separately payable drugs, including several specific groups of drugs such as blood clotting factors and IVIG, at ASP+6 percent. Some commenters noted that this would eliminate a site-of-service differential that would otherwise exist between the hospital outpatient and physicians' office settings if HOPDs were paid at ASP+5 percent while physicians' offices were paid at ASP+6 percent. The commenters also cited issues of charge compression. Specifically, the commenters explained that many lower cost packaged drugs have a higher markup and the relative ASP number is not inclusive of this pricing practice because only separately payable drugs are used in the comparison. A few commenters also noted that CMS has not demonstrated that concerns that led to a continuation of the ASP+6 percent methodology in CY 2007, such as a limited understanding of pharmacy overhead costs and their relationship to hospital outpatient drugs, have been resolved. Finally, some commenters expressed concern that, even at ASP+6 percent, hospitals may not be receiving adequate payments to account for both acquisition costs and overhead costs. Furthermore, some of these commenters requested payment increases for certain groups of drugs, such as IVIG and blood products.

Response: In analyzing data for the CY 2008 final rule with comment period, we again performed the analysis described in the CY 2008 proposed rule by comparing aggregate expenditures for separately payable drugs and biologicals to the ASP-based payment rates, weighting these HCPCS codes by their OPPS volumes, and calculating an equivalent average ASP-based payment rate for drugs and biologicals provided in HOPDs for CY 2008. As we did for our final rule analysis to determine the final packaging status for each drug, we used updated CY 2006 mean unit costs and drug volumes and updated ASP data. The result of our final analysis using updated hospital claims data for the full CY 2006 year and updated CCRs is that the equivalent average ASP-based payment amount for separately payable drugs and biologicals, including pharmacy handling costs, is equal to ASP+3 percent for CY 2008. Therefore, according to our CY 2008 proposal for payment of separately payable drugs and biologicals which includes pharmacy overhead payment, based on mean costs from CY 2006 hospital claims, the OPPS payment rate for separately payable drugs and biologicals would be ASP+3 percent.

We acknowledge that different payment rates for drugs and biologicals provided in the physician's office and HOPD settings are of concern to some commenters. However, the OPPS, the MPFS physician's office payments for services and physician's office payments for Part B drugs are based on very different payment methodologies. In particular, the OPPS relies upon costs from the most updated claims and Medicare cost report data to develop payment rates. On the other hand, the MPFS pays for services based on estimates of input costs and pays for drugs and biologicals at ASP+6 percent, as required by statute. Therefore, it is not surprising to us that the estimated costs of drug and biologicals and their associated pharmacy overhead, like many other OPPS services, could be different in the HOPD than in the physician's office, resulting in different payments in the two settings. We do not believe that different payment rates for drugs and biologicals in the HOPD or physician's office settings will create problems for beneficiaries regarding access to drug administration services because we have not seen problems with access in the two settings for other types of services, including diagnostic studies, surgical procedures, and visits, which generally have different payment rates under the two payment systems (unless there is an applicable externally applied statutory cap to payment, such as the cap on payment for imaging services provided in the physician's office based on the OPPS rates).

In response to the commenters' concerns regarding the effects of charge compression on drug payment, as described further in section II.A.1.c. of this final rule with comment period, we have contracted with RTI to estimate regression-based CCRs using charge data from both inpatient and outpatient claims for hospital ancillary departments. We will consider whether it would be appropriate to adopt regression-based CCRs for the OPPS in the future after we receive RTI's comprehensive review of the OPPS cost estimation methodology and review the results of the use of both inpatient and outpatient charges across all payers to reestimate regression-based CCRs.

After a period of continuing ASP+6 percent payment in CY 2007 while we gathered additional information regarding pharmacy overhead costs, we believe that it is most appropriate at this point to continue to pay for drugs and biologicals and their associated pharmacy overhead costs using an ASP-based system, but to determine the relative ASP percent based on mean costs from claims rather than continue to use ASP+6 percent. Therefore, we are not accepting the recommendation of the APC Panel to continue to pay for separately payable drugs and biologicals at ASP+6 percent for CY 2008. After reviewing the commenters' responses to our CY 2008 proposal, we are reassured that hospitals currently capture pharmacy overhead costs in their charges for drugs, and we have clear guidance from the APC Panel and some commenters that pharmacy overhead and handling costs should continue to be recognized within drug charges and paid through the drug payment.

Our claims data for the CY 2007 and CY 2008 final rules consistently have shown equivalent average ASP-based amounts for separately payable drugs and biologicals that are lower than ASP+6 percent, specifically ASP+4 percent and APC+3 percent, respectively. However, because we have been paying ASP+6 percent for separately payable drugs and biologicals under the OPPS for the last 2 years, we believe it is appropriate to transition to the use of hospital claims data as the basis for the relative ASP percent. Therefore, we will provide a 2-year transition, with a one year transitional payment rate in CY 2008, and pay for separately payable drugs and biologicals and associated pharmacy overhead based on a 50/50 blend of their CY 2007 payment rate of ASP+6 percent and their final CY 2008 equivalent average ASP-based payment amount of ASP+3 percent. This blend results in a payment amount of ASP+4.5 percent. However, because we pay based on whole percentages in relation to ASP, we are rounding the blend to ASP+5 percent for CY 2008. In summary, we will provide a transitional payment of ASP+5 percent for separately payable drugs and biologicals and associated pharmacy overhead in CY 2008 as we move toward a relative ASP percent based on mean costs from claims for CY 2009.

Comment: Several commenters disagreed with our calculation of an average ASP-based payment amount for drugs and biologicals and associated

pharmacy overhead costs based on aggregate costs from claims. One commenter stated that instead of an aggregate amount across all drugs, each drug should be individually examined in order to determine average hospital acquisition cost. This commenter noted that, by aggregating drug costs across all separately paid drugs to determine the equivalent average ASP-based payment rate, some drugs could be underpaid while others could be overpaid. Other commenters suggested that CMS include relatively inexpensive drugs, including drugs that are usually packaged as well as drugs that may not have their own HCPCS codes but are reported with charges on uncoded revenue code lines. The commenters noted that, because of charge compression and hospital billing practices, these drugs typically receive the highest markups because they are relatively inexpensive. Other commenters recommended that CMS include packaged drugs with HCPCS codes that are currently packaged in determining the average ASP-based amount. The commenters noted that if all drugs were paid separately in the HOPD, there would be better representation of pharmacy overhead costs associated with lower cost drugs in the average ASP-based amount calculated. The commenters explained that hospitals often attribute higher markups to lower cost drugs and lower markups to higher cost drugs, an issue known as charge compression. By providing separate payment for all drugs, the OPPS would then consider the full set of Part B drugs and their associated overhead as part of the average ASP-based amount, rather than relying on only separately paid, and therefore more expensive, drugs to perform this calculation. The commenters claimed that this change would more accurately account for the actual pharmacy overhead charges that hospitals have built into their accounting systems, and, as a result, the equivalent average ASP-based amount would be higher. A few commenters expressed concern that ASP reflects prices and discounts not passed along to providers and that ASP is a measure of sales to all entities, not just hospitals. Other commenters noted that the two quarter lag in updated ASP data is problematic for hospitals that experience varying purchasing conditions from quarter to quarter.

Response: We continue to believe that use of ASP as a payment methodology is appropriate under the OPPS because these rates are updated quarterly and are therefore more reflective of current market conditions that influence hospital purchasing prices than hospital claims data. Furthermore, comparison of the ASP data to our hospital claims data serves to ensure that we are paying for drugs in the OPPS in general at rates that are reflective of hospitals' costs for acquisition and overhead. While we understand that, by aggregating the costs of separately payable drugs and biologicals prior to developing an equivalent average ASP-based payment rate, the result could be that some drugs could be relatively underpaid in a given clinical scenario while others could be relatively overpaid, we continue to believe that ASP data are our best proxy for average hospital acquisition costs under the OPPS and that the calculation should be performed using aggregated drug costs. Given the information provided by commenters regarding hospitals' diverse charging practices and the differential inclusion of pharmacy overhead costs in charges for low and high cost drugs, we do not believe that it would be reasonable to conduct this comparison on a drug-specific level to calculate a distinct equivalent ASP-based payment for each drug under the OPPS that would reflect the acquisition and overhead costs of that particular drug. Instead, we continue to believe that it is more appropriate to develop an equivalent average ASP-based payment rate that determines the ASP add-on percent based on the aggregated hospital costs of separately payable drugs and biologicals calculated from claims data, recognizing that the OPPS is a system based on the averaging of costs for services.

In addition, we do not include packaged drugs and biologicals in this analysis because cost data for these items are already accounted for within the APC ratesetting process through the median cost calculation methodology discussed in section II.A.2. of this final rule with comment period. To include the costs of packaged drugs in both our APC ratesetting process (for associated procedures present on the same claim) and in our ratesetting process to establish a relative ASP-based payment amount for drugs and biologicals would give these data disproportionate emphasis in the OPPS system by skewing our analyses, as the costs of these packaged items would be, in effect, counted twice. Accordingly, we are not implementing the suggestion from commenters that we include all packaged and separately payable drugs and biologicals when establishing an average ASP-based rate to provide payment for the hospital acquisition and pharmacy handling costs of drugs and biologicals. However, we remind commenters that because the costs of packaged drugs, including their pharmacy overhead costs, are packaged into the payments for the procedures in which they are administered, the OPPS provides payment for both the drugs and the associated pharmacy overhead costs through the applicable procedural APC payments.

As noted in the CY 2007 OPPS final rule with comment period, the ASP methodology has been established through rulemaking, and specific requests regarding methodological changes to this established system are outside the scope of this final rule with comment period. We believe that updating drug payment rates quarterly based on the most currently available ASP, given that ASP data include sales to hospitals in addition to others, provides the most up-to-date payment possible that is reflective of contemporary market trends and hospital acquisition costs.

Comment: One commenter requested that CMS create a HCPCS J-code for tositumomab, currently provided under a radioimmunotherapy regimen and billed as part of HCPCS code G3001 (Administration and supply of tositumomab, 450 mg). The commenter argued that because tositumomab is listed in compendia, is approved by the FDA as part of the BEXXAR® regimen, and has its own National Drug Code (NDC) number, it should be recognized as a drug and, therefore, paid as other drugs are paid under the OPPS methodology instead of having a payment rate determined by hospital claims data. The commenter suggested that a payment rate could be established using the ASP methodology.

Response: As we have noted in the November 10, 2005 final rule with comment period for CY 2006 (70 FR 68654) and the November 7, 2003 final rule with comment period for CY 2004 (68 FR 63443), unlabeled tositumomab is not approved as either a drug or a radiopharmaceutical, but it is a supply that is required as part of the radioimmunotherapy treatment regiment. We do not make separate payment for supplies used in services provided under the OPPS. Payments for necessary supplies are packaged into payments for the separately payable services provided by the hospital. Specifically, administration of unlabeled tositumomab is a complete service that qualifies for separate payment under its own clinical APC. This complete service is currently described by HCPCS code G3001. Therefore, we do not agree with the commenter's recommendation that we should assign a separate HCPCS code to

the supply of unlabeled tositumomab. Rather, we will continue to make separate payment for the administration of tositumomab, and payment for the supply of unlabeled tositumomab is packaged into the administration payment.

After consideration of the public comments received, we are finalizing our CY 2008 proposal with a modification to provide a 2-year transition for payment for separately payable drugs and biologicals under the OPPS based on the equivalent average ASP-based payment amount calculated from aggregate costs from hospitals claims. While the payment amount without a transition would be ASP+3 percent for CY 2008, we will be providing a transitional payment of ASP+5 percent for these products in CY 2008.

(3) Payment for Blood Clotting Factors

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 proposed 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. For CY 2008, the furnishing fee increases by 4.0 percent to $0.158.

As indicated in the CY 2008 OPPS/ASC proposed rule (72 FR 42736), we have consistently noted that we would update the payment amount for the furnishing fee each year (based on the Consumer Price Index (CPI)) 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 (72 FR 38152), the CPI data for the 12-month period ending in June 2007 were not available when we developed the OPPS and the MPFS proposed rules.

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 believed 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 believed that the public's need for information and adequate notice regarding the updated furnishing fee could be better met by issuing program instructions which would eliminate the discussion of the furnishing fee update annually in rulemaking. In addition, by communicating the updated furnishing fee in program instructions, the actual figure for the percent change in the applicable CPI and the updated furnishing fee calculated based on that figure could 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 would adversely affect stakeholders or the public. Therefore, for CY 2009 and thereafter, until such time as the update methodology may be modified, we proposed to announce the blood clotting factor furnishing fee using applicable program instructions and posting on the CMS Web site.

We received a few public comments on our proposal for the blood clotting factor furnishing fee. A summary of the public comments and our responses follow.

Comment: Several commenters supported our proposal to announce the blood clotting factor furnishing fee using program instructions. The commenters agreed that, by communicating the updated furnishing fee in program instructions, the actual figure for the percent change in the applicable CPI and the updated furnishing fee calculated based on that figure could be announced more timely. To that end, the commenters also suggested that CMS post this information on the CMS Web site.

Response: We appreciate the support of these commenters for our proposal. We believe that program instructions allow additional flexibility regarding the announcement of the blood clotting factor furnishing fee. Therefore, we are finalizing the proposal, without modification, and in future years we will announce the updated blood clotting factor furnishing fee using applicable program instructions and posting on the CMS Web site. (We refer readers to the CY 2008 MPFS final rule for further discussion of this issue.)

(4) 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 did 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, we have classified radiopharmaceuticals under the OPPS as SCODs. As such, we have paid for radiopharmaceuticals 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 final rule with comment period.

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/ASC 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. As discussed in the CY 2008 proposed rule, 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 made 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) Payment for Diagnostic Radiopharmaceuticals

As discussed in section II.A.4.c.(5) and (6) of the CY 2008 OPPS/ASC proposed rule, we proposed 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 included 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 included 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.

In the proposed rule, we stated our belief that our proposed treatment of diagnostic radiopharmaceuticals and contrast agents differently from other SCODs was 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 proposed to continue to establish an updated cost threshold for packaging drugs, biologicals, and radiopharmaceuticals, we also proposed an approach specific to diagnostic radiopharmaceuticals and contrast agents that would otherwise be separately paid.

Second, diagnostic radiopharmaceuticals and contrast agents function 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. 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 believed 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 of 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 noted our belief that 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 proposed to package all diagnostic radiopharmaceuticals because we believed 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 final rule with comment period, we believed 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, in the context of our CY 2008 proposal, we viewed 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 proposed to package payment for contrast agents and diagnostic radiopharmaceuticals for CY 2008.

For more information on how rates were set for procedures in which diagnostic radiopharmaceuticals or contrast agents are used, and for a further discussion regarding our final packaging methodology for CY 2008, we refer readers to section II.B. of this final rule with comment period.

During its March 2007 meeting, the APC Panel made a recommendation 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.c.(5) of the proposed rule, we proposed to accept the APC Panel's recommendation, and we welcomed public comment on the burden hospitals would experience should we require such precise reporting. We also solicited comment specifically on the importance of such a requirement in light of our discussion in the 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. A summary of the public comments we received on this issue, our responses, and our response to the APC Panel recommendation can be found in section II.A.4.c.(5) of this final rule with comment period.

We received many comments on our proposal to package payment for all diagnostic radiopharmaceuticals and contrast agents for CY 2008. A summary of the public comments and our responses follow.

Comment: A number of commenters stated that diagnostic radiopharmaceuticals and contrast agents with per day costs over the proposed OPPS drug packaging threshold are defined as SCODs and, therefore, should be assigned separate APC payments. In particular, the commenters questioned CMS's authority to classify groups of drugs, such as diagnostic radiopharmaceuticals and contrast agents, and implement packaging and payment policies that do not reflect their status as SCODs. In addition, the commenters objected to the proposal to package payment for diagnostic radiopharmaceuticals and contrast agents because, as SCODs, the commenters believed these products were required by statute to be paid at average acquisition cost. The commenters explained that, when several different diagnostic radiopharmaceuticals or contrast agents may be used for a particular procedure, the costs of these diagnostic radiopharmaceuticals or contrast agents are averaged together and added to the amount for the procedure in order to determine the payment rate for the associated procedural APC. Therefore, the commenters argued that the amount added to the procedure cost through packaging, representing the cost of the diagnostic radiopharmaceutical or contrast agent, does not reflect the average acquisition cost of any one particular item but, rather, reflects the average cost of whatever items may be used with that particular procedure.

Response: As discussed above, we based our proposal to treat diagnostic radiopharmaceuticals and contrast agents differently from other SCODs upon our reasoning that the statutorily required OPPS drug packaging threshold has expired and our view that diagnostic radiopharmaceuticals and contrast agents function effectively as supplies that enable the provision of an independent service, rather than serving themselves as the therapeutic modality. We sought to package their payment as ancillary and supportive services in order to provide incentives for greater efficiency and to provide hospitals with additional flexibility in managing their resources. We note that we currently classify different groups of drugs for specific payment purposes, as evidenced by our policy regarding the oral and injectable forms of the 5HT3 anti-emetics and our fixed price drug packaging threshold.

Although our final CY 2008 policy, as described in section II.A.4.c.(5) and (6) of this final rule with comment period, packages payment for all diagnostic radiopharmaceuticals and contrast agents into the payment for their associated procedures, we will continue to provide payment for these items in CY 2008 based on a proxy for average acquisition cost. 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 of costs observed on the claims) with the cost of associated nuclear medicine procedures for rate setting, this packaging approach is consistent with considering the average cost for radiopharmaceuticals, rather than the median cost.

We further note that these drugs, biologicals, or radiopharmaceuticals for which we have not established a separate APC and, therefore, for which payment would be packaged rather than separately provided under the OPPS, could be considered to not be SCODs. Similarly, drugs, biologicals, and therapeutic radiopharmaceuticals with mean per day costs of less than $60 that are packaged and for which a separate APC has not been established would also not be SCODs. This reading is consistent with our final payment policy whereby we package payment for diagnostic radiopharmaceuticals and contrast agents and provide payment for these products through payment for their associated procedures.

Comment: A few commenters suggested that CMS misclassified

HCPCS codes A9542 (Indium In-111 ibritumomab tiuxetan, diagnostic, per study dose, up to 5 millicuries) and A9544 (Iodine I–131 tositumomab, diagnostic, per study dose) as ''diagnostic'' radiopharmaceuticals. The commenters explained that these are radiopharmaceutical products that are used as part of a therapeutic regimen and, therefore, should be considered therapeutic for OPPS payment purposes.

Response: As discussed above, for the proposed rule, we classified each radiopharmaceutical into one of two groups according to whether its long descriptor contained the term ''diagnostic'' or ''therapeutic.'' HCPCS codes A9542 and A9544 both contain the term ''diagnostic'' in their long code descriptors. Therefore, according to this methodology, we classified them as diagnostic for the purposes of OPPS payment. While we understand that these items are provided in conjunction with additional supplies, imaging tests, and therapeutic radiopharmaceuticals for patients already diagnosed with cancer, we continue to believe that the purpose of HCPCS codes A9542 and A9544 is diagnostic in nature. While the group of services may be considered a therapeutic regimen by the commenters, HCPCS codes A9542 and A9544 are provided in conjunction with a series of imaging scans. Many nuclear medicine studies using diagnostic radiopharmaceuticals are provided to patients who already have an established diagnosis. We would not consider HCPCS codes A9542 and A9544 to be therapeutic because these items are provided immediately prior to the furnishing of a diagnostic imaging procedure, and are used to identify the proper dose of the therapeutic agent at a later date.

Comment: One commenter requested that CMS reassign the dosage descriptor for HCPCS code A9524 (Iodine I–131 iodinated serum albumin, diagnostic, per 5 microcuries) to reflect the usual package size of this item. The commenter noted that there is only one manufacturer for this product, and it is only available in a single-unit, single-use, calibrated dose of 25 microcuries. The commenter claimed that many hospitals have been mistakenly billing one unit for this product, instead of correctly billing five units. Therefore, the commenter requested that the dosage descriptor reflect the single-unit, single-use, calibrated 25 microcurie dose.

Response: As we discussed in the CY 2008 proposed rule, at its March 2007 meeting, 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. As stated in the proposed rule (72 FR 42741), 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 were unable to accept the APC Panel's recommendation concerning the development of specific code descriptors because decisions regarding the creation of permanent Level II HCPCS codes, including code descriptors, are coordinated by the CMS HCPCS Workgroup 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 encouraged interested parties to submit requests for revisions of code descriptors to the CMS HCPCS Workgroup for its consideration.

We have learned that the commenter requested the CMS HCPCS Workgroup to change the descriptor for HCPCS code A9524 to more accurately reflect the dosing of this product. However, the CMS HCPCS Workgroup, under its authority and responsibility to create and maintain Level II HCPCS codes and their descriptors, has decided to retain the current descriptor that includes the ''per 5 microcuries'' dosage descriptor. Therefore, hospitals are reminded to ensure that units of drugs, biologicals, and radiopharmaceuticals administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor. For example, if the descriptor of the drug code includes 5 mg, and 5 mg of the drug was administered to the patient, the units billed should be 1. If the descriptor of the drug code includes 5 mg, but 25 mg of the drug was administered to the patient, the units billed should be 5. Hospitals should not bill the units for HCCPS codes based on the way the drug, biological, or radiopharmaceutical is packaged, stored, or stocked. HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the products. Therefore, before submitting Medicare claims for drugs, biologicals, and radiopharmaceuticals, we remind commenters that it is extremely important for hospitals to review the complete long descriptors for the applicable HCPCS codes in order to determine the appropriate units to be reported.

After consideration of the public comments received, we are finalizing our proposal, without modification, to identify diagnostic radiopharmaceuticals as those radiopharmaceuticals with the term ''diagnostic'' in their long code descriptors and therapeutic radiopharmaceuticals as those radiopharmaceuticals with the term ''therapeutic'' in their long code descriptors. Our final payment policy packages payment for all diagnostic radiopharmaceuticals in CY 2008. The related public comments and our responses to the proposed payment methodology for diagnostic radiopharmaceuticals are presented in section II.A.4.c.(5) of this final rule with comment period.

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 is packaged under the OPPS for CY 2008 based on the $60 per day packaging threshold. Therefore, as discussed in the proposed rule, we believed that it is most appropriate to package payment for all contrast agents for CY 2008 to better provide for payment for the associated tests and procedures that promotes hospital efficiency. Our final policy to package payment for all contrast agents in CY 2008, and the related public comments and our responses to the proposed payment methodology, is presented in section II.A.4.c.(6) of this final rule with comment period.

In summary, we view diagnostic radiopharmaceuticals and contrast agents as ancillary and supportive to the diagnostic tests and therapeutic procedures in which they are used. In light of our authority to make different packaging determinations for groups of items, and the improved reporting of hospital charges for radiopharmaceutical handling in the CY 2006 claims data, we are finalizing our proposal, without modification, to package payment for contrast agents and diagnostic radiopharmaceuticals for CY 2008. Additional discussion of our rationale and further response to public comments received and the APC Panel recommendations regarding our proposal to package payment for diagnostic radiopharmaceuticals and contrast agents appears in sections II.A.4.c.(5) and II.A.4.c.(6), respectively, of this final rule with comment period.

(c) Payment for Therapeutic Radiopharmaceuticals

For CY 2008, we proposed 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 believed 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 proposed 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 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 did not propose to use this methodology to set their payment rates for CY 2008.

The second option we considered, and proposed, 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). As discussed in the CY 2008 OPPS/ASC proposed rule, 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 (72 FR 42739). 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 charges-reduced-to-cost methodology would no longer affect these products under our CY 2008 proposal.

Although we received public comments on 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, as discussed in the CY 2008 OPPS/ASC proposed rule, we believed that the CY 2006 claims data that we are using to set the proposed 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 believed 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.

As we discussed in the CY 2008 OPPS/ASC proposed rule, 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. We did not propose a methodology based on special OPPS data trimming for CY 2008 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 high 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 at the time of the proposed rule, 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. That is, overall, the result of applying our systematic trimming methodology increased the mean unit cost reported in Table 44 of the proposed rule (72 FR 42740).

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 discussed further in section II.A.1. of this final rule with comment period, what is important for setting appropriate payment rates for most services 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 overall trimming methodology would result in the most appropriate cost estimates for therapeutic radiopharmaceuticals. We have noted our belief 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 did not believe it would be appropriate to utilize a ratesetting methodology that could disregard correctly coded claims. While we appreciated this recommendation, we did not propose a payment methodology that included additional trimming of hospital claims data for therapeutic radiopharmaceutical products for CY 2008.

Recommendations other than trimming centered around providing CMS with external data on radiopharmaceutical costs. One specific recommendation that we received from interested stakeholders suggested 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 costs could be packaged into the associated procedure payment for the radiopharmaceutical. Stakeholders also generally recommended that we could collect external data from various sources (such as manufacturers, nuclear pharmacies, and others) to use for therapeutic radiopharmaceuticals.

At its September 2007 meeting, the Panel recommended that CMS create a composite for BEXXAR® or related therapies and present it for the Panel's consideration at the next APC Panel meeting. We are accepting this recommendation and will provide information and analyses regarding commonly observed combinations of services provided with radioimmunotherapy treatments to the APC Panel at its 2008 winter meeting.

We received many public comments on our CY 2008 proposal to establish payments for separately payable therapeutic radiopharmaceuticals based on their mean unit costs from hospitals claims. A summary of the public comments and our responses follow.

Comment: Many commenters asked CMS to continue the CY 2007 CCR methodology for payments for all radiopharmaceutical products in CY 2008. The commenters cited inaccurate and incomplete data from hospitals as a reason to continue this methodology.

Response: For the CY 2007 rulemaking cycle, we also received many comments that we should not proceed with our CY 2007 proposal to establish a prospective payment methodology for radiopharmaceuticals. At that time, the commenters were concerned that hospital claims data may be inaccurate due to hospitals slow adoption of our billing guidance to include radiopharmaceutical pharmacy overhead charges in the charge for the radiopharmaceutical. Because of these and other concerns, we concluded that, for CY 2007, there was sufficient reason to extend the temporary policy of paying for radiopharmaceuticals at charges reduced to cost for one additional year. We noted that it was still our intention to move toward a prospective payment methodology for radiopharmaceuticals in the OPPS (71 FR 68095). In the CY 2008 OPPS/ASC proposed rule, we again noted our intent to move to a prospective payment for therapeutic radiopharmaceuticals under the OPPS and did not propose to continue providing payment for therapeutic radiopharmaceuticals at hospital charges reduced to cost using the hospital's overall CCR for the reasons cited previously. In particular, 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.

Comment: Several commenters requested that CMS implement a policy that would accept external data submissions from various groups, including nuclear pharmacies, hospitals, and manufacturers. The commenters recommended that CMS collect Estimated Average Acquisition Cost (EAAC), Calculated Pharmacy Sales Price (CPSP), or average selling nuclear pharmacy price (ADNPP) data through this process. In addition, the commenters suggested that CMS could collect hospital invoice data to 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.

Some commenters also recommended that, as CMS proposed the reporting of pharmacy overhead charges for drugs and biologicals on uncoded revenue code lines for CY 2008, CMS should change its instructions for reporting radiopharmaceutical handling charges. Some commenters suggested that the radiopharmaceutical handling charges be reported separately on uncoded revenue code lines instead of being included in the charge for the radiopharmaceutical under current CMS instructions. The commenters believed this would allow the costs of radiopharmaceutical handling to be packaged into payment for the associated procedure, such as a radiopharmaceutical administration procedure, in future years when CY

2008 claims data become available for ratesetting.

Response: We did not propose a therapeutic radiopharmaceutical payment methodology using external data for CY 2008 for the following reasons. First, any approach relying on external data has the disadvantage 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 or manufacturers 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 external information would generally exclude the costs of the hospital's handling of the radiopharmaceuticals. However, as noted in the CY 2008 OPPS/ASC proposed rule (72 FR 42740), 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. Therefore, we believed, and continue to 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 could be inconsistent with the charging practices of those hospitals that have been working over the past 2 years to align their charging practices with our stated instructions. Moreover, adoption of any methodology systematically relying on external data also would be administratively burdensome for us 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 did not propose and are not finalizing a policy to collect hospital invoices or otherwise rely on external data in order to establish prospective payment rates for therapeutic radiopharmaceuticals for CY 2008.

We are not adopting our proposal to have hospitals separately report charges for pharmacy overhead associated with drugs and biologicals on uncoded revenue code lines, as discussed earlier. Therefore, we also do not believe it would be appropriate to provide instructions to hospitals to separately report their radiopharmaceutical handling charges in addition to the charge for the radiopharmaceutical. Hospitals have recently become accustomed to our CY 2006 guidance that they should consider all handling costs in setting their charges for radiopharmaceuticals, and we see no reason for them to change this practice. We will continue to provide payment for the handling costs of radiopharmaceuticals through the packaged or separate payment for the products in CY 2008, just as we will for the pharmacy handling costs of drugs and biologicals.

Comment: Many commenters expressed concern over the proposed payment rates for very high cost therapeutic radiopharmaceuticals. The commenters stated that the proposed payment rates are inadequate to cover the cost of the therapeutic radiopharmaceutical itself, let alone the added costs of handling, shipping, and compounding. The commenters noted that inadequate payment rates may lead to beneficiary access issues. Some commenters suggested that systematic special trimming of claims data should be considered in order to products costs that reflect actual hospital purchase prices for radiopharmaceuticals. A few commenters recommended using ASP as an alternative payment methodology for the very costly therapeutic radiopharmaceuticals or other methodologies based on external data. One commenter noted its intent to submit ASP information for an expensive therapeutic radiopharmaceutical so that CMS would have an alternative methodology with which to price the product.

Response: While we understand the commenters' concerns regarding the unique circumstances associated with radiopharmaceutical products, especially very high cost therapeutic radiopharmaceuticals, for the majority of services under the OPPS, payment is made according to prospectively established payment rates that are related to hospitals' costs for those services as calculated from claims data. For the past 2 years, hospitals have been paid on a CCR methodology for separately payable therapeutic radiopharmaceuticals. Therefore, hospitals had every incentive to submit a charge representative of their acquisition cost and associated handling costs for these radiopharmaceuticals. To that extent, we believe that the hospital claims data that we have available for ratesetting purposes in CY 2008 are reliable and accurate.

We note that, for CY 2008, separately payable therapeutic radiopharmaceuticals meet the definition of SCODs and therefore are to be paid at average acquisition cost. While we are implementing a policy to provide payment for therapeutic radiopharmaceuticals through the standard OPPS methodology relying on hospital claims data for CY 2008 as a proxy for average acquisition cost as described below, we note that there is an established process already in place for submitting pricing data for other SCODs to be used for payment purposes. While we understand that the standard ASP methodology may not work for all therapeutic radiopharmaceuticals, we received comments that this approach would work for certain products. Therefore, to the extent that manufacturers or stakeholders believe that the ASP methodology that we currently use for the payment of separately payable drugs and biologicals under the OPPS is appropriate for their particular product, we seek comments on that approach and comments on how radiopharmaceutical ASP information could be used in future ratesetting.

As we discussed in the proposed rule (72 FR 42739), we do not agree with the suggestion of some commenters that special trimming methodologies should be applied to develop claims-based means costs for therapeutic radiopharmaceuticals. No commenters provided specific approaches for our consideration. We believe the standard OPPS data trimming methodology is appropriate for establishing the payment rates for therapeutic radiopharmaceuticals. Altering the systematic trimming methodology for these products in particular could inappropriately redistribute payments in the budget neutral OPPS, and we have no reason to believe that hospitals report costs differently for radiopharmaceuticals than they do for other items. We continue to believe that because hospitals were paid in CY 2006 for each therapeutic radiopharmaceutical according to a claim-specific charge that was adjusted to cost for payment, hospitals had an

incentive to accurately account for the full costs of these products in establishing their charges.

We examined the final rule claims data for the eight therapeutic radiopharmaceuticals that we proposed for separate payment in CY 2008 after we applied the standard OPPS data trimming methodology of ± 3 standard deviations from the geometric mean. The standard trim removes data outliers, which are rare observations with extremely different units and costs from most occurrences in the distribution. Our analysis showed that in the case of HCPCS code A9543 (Yttrium Y–90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries) and A9545 (Iodine I–131 tositumomab, therapeutic, per treatment dose), there were one and three providers, respectively, who consistently (more than 2 times) reported charges in the CY 2006 claims data that were less than $100 when converted to costs as part of the usual ratesetting process. In addition, we had relatively few claims overall for these two products from CY 2006, only 456 line-item charges on 455 days for HCPCS code A9543 (458 units) and 262 line-item charges on 261 days for HCPCS code A9545 (342 units). The numerous repetitive claims with exceptionally low costs had not been removed in the standard OPPS mean cost calculation because the significant number of these aberrant claims increased the standard deviation and were not rare observations. In light of the specialized nature of these radioimmunotherapy agents, we believe that these claims were incorrectly coded based on their extremely low costs. Therefore, these claims from the several providers with very low costs are highly unlikely to represent claims for treatment with the products described by HCPCS codes A9543 and A9545. After removing these likely incorrectly coded claims in the ratesetting process, we were left with 360 line-item charges on 359 days for HCPCS code A9543 (354 units) and 237 line-item charges on 326 days for HCPCS code A9545 (238 units). These very low cost claims constituted between one quarter and one third of the units for HCPCS codes A9543 and A9545, contributing significantly to the calculation of the products' mean unit costs. While the mean per unit cost was approximately $11,926 for HCPCS code A9543 based on all claims, when the repetitive claims from one provider with very low costs were removed, the mean per day cost was approximately $15,024. Similarly, while the mean per unit cost was approximately $7,844 for HCPCS code A9545 based on all claims, when the repetitive claims from three providers with very low costs were removed, the mean per day cost was approximately $11,264. We continue to believe that providing prospective payment for the costs of the eight separately payable therapeutic radiopharmaceuticals and their handling is the most appropriate payment methodology for CY 2008, because we believe that hospitals have set their charges for these products while taking into account a variety of factors, including acquisition and transportation costs. We believe this methodology provides us with the most consistent, accurate, and efficient methodology for prospectively establishing payment rates for separately payable therapeutic radiopharmaceuticals. The adoption of prospective payment based on historical hospital claims data is appropriate because it currently serves as our most accurate available proxy for the average hospital acquisition cost of separately payable therapeutic radiopharmaceutical products. In addition, in the cases of HCPCS codes A9543 and A9445, we have specifically removed the likely incorrectly coded claims from several providers before applying our standard ratesetting methodology to calculating their mean costs from CY 2006 claims.

After consideration of the public comments received, we are finalizing our CY 2008 proposal, with modification to eliminate likely incorrectly coded claims from several providers for HCPCS codes A9543 and A9545 as described above, to provide payment for separately payable therapeutic radiopharmaceuticals based on their mean unit costs from CY 2007 claims. These therapeutic radiopharmaceuticals and their final CY 2008 payment rates are shown in Table 31 below.

TABLE 31.—CY 2008 SEPARATELY PAYABLE THERAPEUTIC RADIOPHARMACEUTICALS

HCPCS Code	Short descriptor	Final CY 2008 APC	Final CY 2008 SI	Final CY 2008 payment rate
A9517	I131 iodide cap, rx	1064	K	$15.24
A9530	I131 iodide sol, rx	1150	K	11.22
A9543	Y90 ibritumomab, rx	1643	K	15,023.91
A9545	I131 tositumomab, rx	1645	K	11,264.25
A9563	P32 Na phosphate	1675	K	113.60
A9564	P32 chromic phosphate	1676	K	119.18
A9600	Sr89 strontium	0701	K	612.06
A9605	Sm 153 lexidronm	0702	K	1,361.07

Comment: Several commenters stated that charge compression may be adversely affecting estimates of the mean cost for expensive radiopharmaceuticals.

Response: As discussed in more detail in section II.A.1.c. of this final rule with comment period, while we did not propose to implement adjustments for charge compression for CY 2008 based on the RTI report for inpatient services, which focused only on inpatient charges, we planned steps to explore this issue further for the future. Under contract with RTI, we are currently examining an all-charges model that would compare variation in CCRs with variation in charges to establish regression-adjusted CCRs that could be applied to both inpatient and outpatient charges. We will consider whether it would be appropriate to adopt regression-based CCRs for the OPPS in the future after we receive RTI's comprehensive review of the OPPS cost estimation methodology and review the results of the use of both inpatient and outpatient charges across all payers to reestimate regression-based CCRs.

b. Payment for Nonpass-Through Drugs, Biologicals, and Radiopharmaceuticals with HCPCS Codes, but without OPPS Hospital 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, for CY 2008 we proposed 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.

We did not receive any public comments explicitly on the topic of our proposed payment methodology for nonpass-though drugs, biolgicals, and radiopharmaceuticals with HCPCS codes, but without OPPS hospital claims data. Therefore, we are finalizing our proposal, without modification, 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 final payment methodology for other separately payable nonpass-through drugs and biologicals. This policy ensures that new nonpass-through drugs and biologicals are treated like other drugs and biologicals under the OPPS, unless they are granted pass-through status. Only pass through drugs and biologicals receive a different payment for CY 2008, generally equivalent to the payment these drugs and biologicals receive in the physician's office setting, consistent with the requirements of the statute. Payment for all new nonpass through diagnostic radiopharmaceuticals will be packaged.

In accordance with the ASP methodology, in the absence of ASP data, we proposed, for CY 2008, 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 for new nonpass through drugs, and biologicals with HCPCS codes, but which are without OPPS claims data. As discussed in the proposed rule (72 FR 42741), if the WAC is also unavailable, we would make payment at 95 percent of the product's most recent AWP. We received no comments on this proposal and are finalizing it without modification.

We also proposed to assign status indicator ''K'' to HCPCS codes for new drugs and biologicals for which we have not received a pass-through application. Again, we received no comments and we are finalizing this proposal without modification. 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.

For CY 2008, we also proposed 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. As proposed, 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 proposed to assign status indicator ''K'' to HCPCS codes for new therapeutic radiopharmaceuticals for which we have not received a pass-through application. We received no comments and are finalizing this proposal without modification.

Consistent with other ASP-based payments, for CY 2008, we proposed to make any appropriate adjustments to the payment amounts for drugs and biologicals in this 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. As proposed, the payment rates for new therapeutic radiopharmaceuticals would also be adjusted accordingly. We also proposed 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. As noted in the proposed rule (72 FR 42741), the new CY 2008 HCPCS codes for drugs, biologicals, and therapeutic radiopharmaceuticals were not available at the time we developed the proposed rule. We have included these changes in Table 32 below.

TABLE 32.—NEW CY 2008 HCPCS CODES FOR DRUGS, BIOLOGICALS, AND RADIOPHARMACEUTICALS

CY 2007 HCPCS	CY 2008 SI for CY 2007 HCPCS code	CY 2008 HCPCS	CY 2008 SI	CY 2008 APC	CY 2008 long descriptor
A9565	D	A9572	N	—	Indium IN–111 pentetreotide, diagnostic, per study dose, up to 6 millicuries.
C9232	D	J1743	G	9232	Injection, idursulfase, 1mg.
C9233	D	J2778	G	9233	Injection, ranibizumab, 0.1 mg.
C9234	D	J0220	K	9234	Injection, aglucosidase alfa, 10 mg.
C9235	D	J9303	G	9235	Injection, panitumumab, 10 mg.
C9236	D	J1300	G	9236	Injection, eculizumab, 10 mg.
C9350	D	C9352	G	9350	Microporous collagen implantable tube (Neuragen Nerve Guide), per centimeter length.
C9350	D	C9353	G	1169	Microporous collagen implantable slit tube (NeuraWrap Nerve Protector), per centimeter length.
C9351	D	J7348	G	9351	Dermal (substitute) tissue of nonhuman origin, with or without other bioengineered or processed elements, without metabolically active elements (TissueMend) per square centimeter.

TABLE 32.—NEW CY 2008 HCPCS CODES FOR DRUGS, BIOLOGICALS, AND RADIOPHARMACEUTICALS—Continued

CY 2007 HCPCS	CY 2008 SI for CY 2007 HCPCS code	CY 2008 HCPCS	CY 2008 SI	CY 2008 APC	CY 2008 long descriptor
C9351	D	J7349	G	1141	Dermal (substitute) tissue of nonhuman origin, with or without other bioengineered or processed elements, without metabolically active elements (PriMatrix) per square centimeter.
J1567	D	J1561	K	0948	Injection, immune globulin, (Gamunex), intravenous, non-lyophilized (e.g. liquid), 500 mg.
J1567	D	J1568	K	0943	Injection, immune globulin, (Octagam), intravenous, non-lyophilized, (e.g. liquid), 500 mg.
J1567	D	J1569	K	0944	Injection, immune globulin, (Gammagard Liquid), intravenous, non-lyophilized, (e.g. liquid), 500 mg.
J1567	D	J1572	K	0947	Injection, immune globulin, (Flebogamma), intravenous, non-lyophilized (e.g. liquid), 500 mg.
J7319	D	J7321	K	0873	Hyaluronan or derivative, Hyalgan or Supartz, for intra-articular injection, per dose.
J7319	D	J7322	K	0874	Hyaluronan or derivative, Synvisc, for intra-articular injection, per dose.
J7319	D	J7323	K	0875	Hyaluronan or derivative, Euflexxa, for intra-articular injection, per dose.
J7319	D	J7324	K	0877	Hyaluronan or derivative, Orthovisc, for intra-articular injection, per dose.
J7345	D	J7348	G	9351	Dermal (substitute) tissue of nonhuman origin, with or without other bioengineered or processed elements, without metabolically active elements (Tissuemend) per square centimeter.
J7345	D	J7349	G	1141	Dermal (substitute) tissue of nonhuman origin, with or without other bioengineered or processed elements, without metabolically active elements (Primatrix) per square centimeter.
Q4079	D	J2323	G	9126	Injection, natalizumab, 1 mg.
Q4083	D	J7321	K	0873	Hyaluronan or derivative, Hyalgan or Supartz, for intra-articular injection, per dose.
Q4084	D	J7322	K	0874	Hyaluronan or derivative, Synvisc, for intra-articular injection, per dose.
Q4085	D	J7323	K	0875	Hyaluronan or derivative, Euflexxa, for intra-articular injection, per dose.
Q4086	D	J7324	K	0877	Hyaluronan or derivative, Orthovisc, for intra-articular injection, per dose.
Q4087	D	J1568	K	0943	Injection, immune globulin, (Octagam), intravenous, non-lyophilized, (e.g. liquid), 500 mg.
Q4088	D	J1569	K	0944	Injection, immune globulin, (Gammagard Liquid), intravenous, non-lyophilized, (e.g. liquid), 500 mg.
Q4089	D	J2791	K	0945	Injection, rho(d) immune globulin (human), (Rhophylac), intravenous, 100 iu.
Q4090	D	J1571	K	0946	Injection, hepatitis b immune globulin (Hepagam B), intramuscular, 0.5 ml.
Q4091	D	J1572	K	0947	Injection, immune globulin, (Flebogamma), intravenous, non-lyophilized (e.g. liquid), 500 mg.
Q4092	D	J1561	K	0948	Injection, immune globulin, (Gamunex), intravenous, non-lyophilized (e.g. liquid), 500 mg.
Q4095	D	J3488	G	0951	Injection, zoledronic acid (Reclast), 1 mg.
Q9945	D	Q9965	N	.....	Low osmolar contrast material, 100–199 mg/ml iodine concentration, per ml.
Q9946	D	Q9965	N	.....	Low osmolar contrast material, 100–199 mg/ml iodine concentration, per ml.
Q9947	D	Q9966	N	.....	Low osmolar contrast material, 200–299 mg/ml iodine concentration, per ml.
Q9948	D	Q9966	N	.....	Low osmolar contrast material, 200–299 mg/ml iodine concentration, per ml.
Q9949	D	Q9967	N	.....	Low osmolar contrast material, 300–399 mg/ml iodine concentration, per ml.
Q9950	D	Q9967	N	.....	Low osmolar contrast material, 300–399 mg/ml iodine concentration, per ml.
Q9952	D	A9579	N	.....	Injection, gadolinium-based magnetic resonance contrast agent, not otherwise specified (nos), per ml.
		A9501	N	.....	Technetium TC–99M teboroxime, diagnostic, per study dose.
		A9509	N	.....	Iodine I–123 sodium iodide, diagnostic, per millicurie.
		A9569	N	.....	Technetium TC–99M exametazime labeled autologous white blood cells, diagnostic, per study dose.
		A9570	N	.....	Indium IN–111 labeled autologous white blood cells, diagnostic, per study dose.
		A9571	N	.....	Indium IN–111 labeled autologous platelets, diagnostic, per study dose.
		A9576	N	.....	Injection, gadoteridol, (ProHance Multipack), per ml.
		A9577	N	.....	Injection, gadobenate dimeglumine (MultiHance), per ml.
		A9578	N	.....	Injection, gadobenate dimeglumine (MultiHance Multipack), per ml.
		C9238	K	9238	Injection, levetiracetam, 10 mg.
		C9239	G	1168	Injection, temsirolimus, 1 mg.
		J0400	K	1165	Injection, aripiprazole, intramuscular, 0.25 mg.
		J1573	K	1138	Injection, hepatitis b immune globulin (Hepagam B), intravenous, 0.5 ml.
		J2724	K	1139	Injection, protein c concentrate, intravenous, human, 10 iu.
		J9226	K	1142	Histrelin implant (Supprelin LA), 50 mg.

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. These items were shown in Table 45A of the proposed rule (72 FR 42762). 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 separately 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 proposed 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 proposed for drugs, biologicals, and radiopharmaceuticals in CY 2008. We proposed 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 nonpass-through drugs and biologicals under the OPPS. In accordance with the ASP methodology used in the physician's 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.

We did not receive any public comments on this proposal and, therefore, are finalizing the proposal without modification. Table 33 lists all of the nonpass-through drugs and biologicals without available CY 2006 claims data to which these final policies would apply in CY 2008.

TABLE 33.—DRUGS AND BIOLOGICALS WITHOUT CY 2006 CLAIMS DATA

HCPCS code	Short descriptor	ASP-based payment rate	Estimated average number of units per administration	Final CY 2008 SI	CY 2008 APC
J0288	Ampho b cholesteryl sulfate	$11.89	35	K	0735
J0364	Apomorphine hydrochloride	.....	6	N	
J1324	Enfuvirtide injection	$0.40	180	K	0767
J2170	Mecasermin injection	$15.62	15.6	K	0805
J2315	Naltrexone, depot form	$1.87	380	K	0759
J3355	Urofollitropin, 75 iu	$50.22	2	K	1741
J8650	Nabilone oral	$16.80	6	K	0808

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 stated in the CY 2008 OPPS/ASC proposed rule that 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 (72 FR 42742). We proposed 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 proposed 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 of the proposed rule (72 FR 42743). We believed 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 will 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 the 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 of the proposed rule). As noted in the proposed rule (72 FR 42742), 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.

We received a number of public comments on our proposal to recognize all HCPCS codes Part B drugs for payment under the OPPS. A summary of the public comments and our responses follow.

Comment: Many commenters supported the proposal 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. Some commenters supported this proposal so long as it was not mandatory to report all HCPCS codes. One commenter disagreed with our

proposal and expressed concern that this would increase hospital burden.

Response: We appreciate the general support of our proposal 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. Hospitals that may be burdened by reporting multiple HCPCS codes need not change their current billing practices, but hospitals that would like additional flexibility when billing for drugs with multiple HCPCS dosages may implement these changes beginning in CY 2008.

TABLE 34.—PREVIOUSLY UNRECOGNIZED HCPCS CODES AND STATUS INDICATORS FOR CY 2008

HCPCS codes newly recognized in CY 2008	CY 2007 SI	Long descriptor	Associated HCPCS Code recognized in CY 2007	Final CY 2008 SI
J1470	B	Injection, gamma globulin, intramuscular, 2 cc	J1460	K
J1480	B	Injection, gamma globulin, intramuscular, 3 cc		K
J1490	B	Injection, gamma globulin, intramuscular, 4 cc		K
J1500	B	Injection, gamma globulin, intramuscular, 5 cc		K
J1510	B	Injection, gamma globulin, intramuscular, 6 cc		K
J1520	B	Injection, gamma globulin, intramuscular, 7 cc		K
J1530	B	Injection, gamma globulin, intramuscular, 8 cc		K
J1540	B	Injection, gamma globulin, intramuscular, 9 cc		K
J1550	B	Injection, gamma globulin, intramuscular, 10 cc		K
J1560	B	Injection, gamma globulin, intramuscular, over 10 cc		K
J8521	B	Capecitabine, oral, 500 mg	J8520	K
J9094	B	Cyclophosphamide lyophilized, 200 mg	J9093	N
J9095	B	Cyclophosphamide lyophilized, 500 mg		N
J9096	B	Cyclophosphamide lyophilized, 1g		N
J9097	B	Cyclophosphamide lyophilized, 2g		N
J9140	B	Dacarbazine, 200 mg	J9130	N
J9290	B	Mitomycin, 20 mg	J9280	K
J9291	B	Mitomycin, 40 mg		K
J9062	B	Cisplatin, 50 mg	J9060	N
J9080	B	Cyclophosphamide, 200 mg	J9070	N
J9090	B	Cyclophosphamide, 500 mg		N
J9091	B	Cyclophosphamide, 1g		N
J9092	B	Cyclophosphamide, 2 g		N
J9110	B	Cytarabine, 500 mg	J9100	N
J9182	B	Etoposide, 100 mg	J9181	N
J9260	B	Methotrexate sodium, 50 mg	J9250	N
J9375	B	Vincristine sulfate, 2 mg	J9370	N
J9380	B	Vincristine sulfate, 5 mg		N

Finally, in Table 45C of the proposed rule (72 FR 42743), we proposed to package seven drugs and biologicals that were payable in CY 2006 because we lacked CY 2006 claims data and any other data related to the ASP methodology and, therefore, we were unable to determine the per day cost of these products. As in previous years of the OPPS, when we are unable to determine a drug's packaging status and payment rate due to the unavailability of hospital claims data and payment information at the time of the final rule, we package payment for those drugs. We did not receive any public comments on our proposal to apply this methodology to the seven drugs included in the proposed rule. As stated elsewhere in this rule, it is our policy to use updated claims data to inform our final rule. Since the time of the proposed rule, we have received hospital claims data for HCPCS code J0200 (Injection, alatrofloxacin mesylate, 100 mg). Therefore, as we now have payment information for HCPCS code J0200, we have determined its final CY 2008 packaging status based on hospital claims data and we will not finalize our proposal to package this drug for CY 2008 because of the lack of hospital claims data and payment rate information. Hospital claims data for HCPCS code J0200 indicate that there were a total of 100 units billed over 1 day, with a mean cost of $0.16 per unit. Therefore, the average per day cost estimate of HCPCS code J0200 is approximately $16. As this cost is below the $60 packaging threshold, its status is packaged for CY 2008, according to the standard OPPS packaging methodology for drugs and biologicals.

Therefore, we are finalizing our proposal, with modification to exclude HCPCS code J0200, to package payment for the drugs and biologicals listed in Table 35 below, due to missing data critical to calculating a per day cost.

TABLE 35.—DRUGS AND BIOLOGICALS WITHOUT INFORMATION ON PER DAY COST THAT ARE PACKAGED IN CY 2008

HCPCS code	Short descriptor	Final CY 2008 SI
90393	Vaccina ig, im	N
90477	Adenovirus vaccine, type 7	N
90581	Anthrax vaccine, sc	N
90727	Plague vaccine, im	N
J0395	Arbutamine HCl injection	N

TABLE 35.—DRUGS AND BIOLOGICALS WITHOUT INFORMATION ON PER DAY COST THAT ARE PACKAGED IN CY 2008—Continued

HCPCS code	Short descriptor	Final CY 2008 SI
J1452	Intraocular Fomivirsen na	N

VI. Estimate of OPPS Transitional Pass-Through Spending for Drugs, Biologicals, Radiopharmaceuticals, and Devices

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 of the Act, 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 finalizing our CY 2008 proposal to pay for nonpass-through separately payable drugs and biologicals under the CY 2008 OPPS at 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 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 drugs and biologicals that we know are newly eligible, or project would be newly eligible, 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. Estimate of CY 2008 Pass-Through Spending

As we proposed, in this final rule with comment period, we are setting 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 final rule with comment period, there are two device categories receiving pass-through payment in CY 2007 that will 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 proposed 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 analyses, our final estimate of pass-through spending attributable to the first group (that is, the two device categories continuing in CY 2008) described above is $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 36 below.

TABLE 36.—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.

In estimating 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 final rule with comment period will be newly eligible for pass-through payment in CY 2008 (of which there are none)) and contingent projections for new categories in the second through fourth quarters of CY 2008, we used the general methodology as described above, while also taking into account recent OPPS experience in approving new pass through device categories. The final estimate of CY 2008 pass-through spending for this second group is $7.5 million. Employing our proposed methodology that the estimate of pass through device spending in CY 2008 incorporates CY 2008 estimates of pass through spending for device categories continuing in CY 2008, those first effective January 1, 2008, and those device categories projected to be approved during subsequent quarters of CY 2007 and CY 2008, our total pass-through estimate for device categories for CY 2008 is $25.6 million.

We did not receive any public comments on our proposed methodology to estimate transitional pass-through spending for device categories in CY 2008. Therefore, we are finalizing our methodology for estimating pass-through spending for categories of devices in CY 2008 as proposed, without modification, resulting in a total pass-through spending estimate of $25.6 million for device categories in CY 2008.

In accordance with the methodology we proposed in the CY 2008 OPPS/ASC proposed rule, 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 utilized the most recent Medicare physician's office data regarding their utilization, information provided in the respective pass-through applications, historical hospital claims data, pharmaceutical industry information, and clinical information regarding the drugs or biologicals, in order to project the CY 2008 OPPS utilization of the products. For the known drugs and biologicals that will continue on pass-through status 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 analyses, we estimated 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 $1.2 million for CY 2008. This $1.2 million estimate of CY 2008 pass through spending for the first group of pass-through drugs reflects the current pass-through drugs that are continuing on pass-through status into CY 2008, which are displayed in Table 27 in section V.A.3. of this final rule with comment period.

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 development of this final rule with comment period are newly eligible for pass-through payment as of 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 used utilization estimates from applicants, pharmaceutical industry data, and clinical information as the basis for pass through spending estimates for these drugs and biologicals for CY 2008, while also considering the most recent OPPS experience in approving new pass through drugs and biologicals. Based on these analyses, we estimate pass-through spending attributable to this second group of drugs and biologicals will be $5.4 million for CY 2008.

In the CY 2008 OPPS/ASC proposed rule, we proposed that the estimate of pass through drug and biological spending in CY 2008 incorporate CY 2008 estimates of pass-through spending for drugs and biologicals with pass-through status in CY 2007 that would continue for CY 2008, those first effective January 1, 2008, and those drugs and biologicals projected to be approved during subsequent quarters of CY 2008.

We did not receive any public comments on our proposed methodology to estimate pass-through spending for drugs and biologicals in CY 2008. Therefore, we are finalizing our methodology for estimating pass-through spending for drugs and biologicals in CY 2008 as proposed, without modification, resulting in a total pass-through spending estimate of $6.6 million for drugs and biologicals in CY 2008.

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 are eligible for pass-through payment at the time of publication of this final rule with comment period. 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 historical data regarding payment for new radiopharmaceuticals with pass-through status under the methodology that we specified for the CY 2005 OPPS or the CY 2008 methodology that we describe in section V.A.3. of this 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 final 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 final rule with comment period.

We did not receive any public comments on our proposal to estimate that pass-through spending for radiopharmaceuticals in CY 2008 will be zero. Therefore, we are finalizing our methodology for estimating pass-through spending for radiopharmaceuticals in CY 2008 as proposed, without modification, resulting in a total pass-through spending estimate of zero for radiopharmaceuticals in CY 2008.

In accordance with the comprehensive methodology described above, we estimate that total pass through spending for the two device categories and the drugs and biologicals that are continuing for pass-through payment into CY 2008 and those devices, drugs, biologicals, and radiopharmaceuticals that first become eligible for pass-through status during CY 2008 will approximate $32.2 million, which represents 0.09 percent of total OPPS projected payments for CY 2008.

Because we estimate that pass-through spending in CY 2008 will not amount to 2.0 percent of total projected OPPS CY 2008 spending, we will return 1.91 percent of the pass-through pool to adjust the conversion factor, as we discuss in section II.C. of this final rule with comment period.

Accordingly, we are finalizing our proposed methodology for estimating CY 2008 OPPS pass-through spending for drugs, biologicals, radiopharmaceuticals, and categories of devices. Our final total pass-through estimate for CY 2008 is $32.2 million.

VII. OPPS Payment for Brachytherapy Sources

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 described 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 were required to continue payment for sources based on charges adjusted 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 also 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 that was 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). As indicated in the CY 2008 proposed rule, based upon comments to our CY 2007 proposed rule and industry

input, we are presently aware of three sources that are currently available in stranded and non-stranded forms: iodine-125; palladium-103; and cesium-131 (72 FR 42746).

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 replaced the three prior brachytherapy source HCPCS codes for iodine, palladium and cesium (C1718, C1720, and C2633, all of which were 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 of the proposed rule. We expected that these instructions would clearly indicate how hospitals should bill for stranded and non-stranded brachytherapy sources, and that hospital reporting of sources according to these instructions would 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 would create a code 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 37 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 our 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 noted 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. Payment for Brachytherapy Sources

As indicated above, the provision to pay for brachytherapy sources at charges adjusted 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.

In the CY 2008 proposed rule, we proposed to pay separately for each of the sources listed in Table 48 of that rule 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 proposed 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 the proposed rule, for CY 2008 we proposed specific prospective payment rates for brachytherapy sources, which would be subject to scaling for budget neutrality.

We stated that we believe that adopting prospective payment for brachytherapy sources would be 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 adjusted 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 adjusted to cost. Based on the proposals in the CY 2008 proposed rule, only pass-through devices would continue to be paid at charges adjusted to cost for CY 2008. As noted earlier, 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.

As explained in the proposed rule, the proposal to adopt prospective payment for brachytherapy sources provides opportunities for hospitals to receive additional payments under certain circumstances through the outlier provisions and the 7.1 percent rural SCH adjustment (72 FR 42748). Consistent with our policy regarding APC payments made on a prospective basis, we proposed that the cost of brachytherapy sources be subject to the outlier provision of section 1833(t)(5) of the Act. Therefore, sources could receive outlier payments if the costs of furnishing brachytherapy sources exceed the outlier threshold. Also, as discussed in section II.F. of the proposed rule, as a result of our CY 2008 proposal to pay prospectively for brachytherapy sources, we also proposed to include brachytherapy sources in the group of services eligible for the 7.1 percent payment increase for rural SCHs, including EACHs.

We proposed 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 proposed to make certain assumptions when we estimate the median costs for stranded and non-stranded (low activity) iodine-125, palladium-103, and cesium-131 sources based on our CY 2006 aggregate claims data. As stated earlier, commenters to our CY 2007 proposed rule explained that the costs of stranded iodine, palladium and cesium sources are higher than non-stranded versions of these sources but provided no data regarding the relative cost relationships. 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 believed it would be 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 proposed 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 proposed 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 proposed 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 resulted 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, appeared to provide a reasonable cost differential between stranded and non-stranded sources until such time when we have claims data reported separately for stranded and non-stranded sources.

We proposed 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 as discussed above and complies with the requirements of the MIEA–TRHCA to provide separate payment for stranded and non-stranded sources.

Table 48 of the proposed rule (72 FR 42750) included 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 proposed for CY 2008. We noted that some of the HCPCS codes for which we proposed payment rates for CY 2008 were not shown in Addendum B of the proposed rule because that addendum was based on HCPCS codes effective as of April 2007. As explained earlier, there are some brachytherapy source HCPCS codes that were added as of July 1, 2007. While these HCPCS codes were not shown in Addendum B, the proposed payment rates for all brachytherapy sources were shown in Table 48 of the proposed rule.

We invited public comment on all aspects of our proposed brachytherapy source payment for CY 2008. We particularly encouraged public comment on our proposed median costs estimates for stranded and non-stranded iodine-125, palladium-103, and cesium-131 sources, including the submission of any available information or data on cost differences between stranded and non stranded sources. We also indicated in the proposed rule that we were 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 (72 FR 42749).

Comment: A number of commenters recommended that CMS continue payment for brachytherapy sources using the charges adjusted to cost methodology for CYs 2008 and 2009. Some commenters claimed that establishing a single prospective payment rate per source would not account for the variable costs associated with the different sources used in brachytherapy. A commenter claimed that, based upon historical hospital claims data, it does not appear that hospitals are charging enough to recover their acquisition costs for expensive products in particular. Some commenters stated that some products have low volumes of claims from small numbers of hospitals, based on recent claims analyses. They explained their belief that the low volume of claims for certain sources and the wide variation in submitted charges for most sources demonstrate that equitable payment rates that approximate true acquisition costs for brachytherapy sources cannot be established using Medicare claims. Several commenters asserted that CMS' brachytherapy source claims data have unresolved problems, such as: (a) The cost of renewable high dose rate (HDR) iridium, which may be used to treat a number of people, is difficult to estimate, because the cost per source depends on the number of patients treated; (b) a lack of meaningful data to establish payment rates for stranded brachytherapy sources; (c) large variations in per unit costs across

sources; (d) a lack of sufficient claims to establish rates in the cases of 6 sources: ytterbium-169 (C2637), linear palladium (C2636), iodine-125 solution (C2632 correctly—coded in CY 2007 as A9527), gold-198 (C1716), cesium-131 (C2633), and non-HDR iridium (C1719); (e) two-thirds of the current sources have proposed payment rates based on claims from a small number (for example, fewer than 50 or 66) hospitals; and (f) a rank order anomaly exists between the proposed median costs of iodine-125 ($37.71) and high activity I-125 ($29.56), with the high activity source appearing to cost less than the low activity source, when high activity sources are reportedly more expensive. The commenters also explained that while claims data may be improving over time, the majority of hospitals still do not include a brachytherapy source code on brachytherapy treatment claims, even though a source is required, claiming that only about 31 percent of the claims for APC 0312 (Radioelement Applications), 73 percent of the claims for APC 0313 (Brachytherapy), and 36 percent of the claims for APC 0651 (Complex Interstitial Source Application) include a brachytherapy source code.

Some commenters supported the proposal to establish prospective payment rates for brachytherapy in CY 2008 using costs derived from CY 2006 claims data, rather than through cost-based reimbursement. A commenter supported the development of prospective payment rates for brachytherapy sources based on CMS' claims data but was concerned that the 2-year time lag between the hospital claims data used to establish the proposed payment rates for brachytherapy sources and the payment year of the proposed update would lead to CY 2008 payments that would not reflect the actual CY 2008 costs of brachytherapy sources. The commenters recommended the use of historical claims data, in addition to an annual inflation rate, to determine the prospective payment rates.

Regarding specific brachytherapy sources, a commenter claimed that the proposed payment rate of $11,944 per source for yttrium-90 is below the acquisition cost and provides no compensation to providers for storage, handling and disposal costs. Two commenters indicated that setting a fixed payment rate for High Dose Rate (HDR) iridium-192 is problematic, because the source can be used to treat multiple patients during its 90-day period of decay. They pointed out that the cost per use of the source, therefore, depends on the number of patients treated by a hospital during this period. Thus, they concluded there would be great variability in the cost of HDR iridium treatment so CMS should continue to pay for this source based on the charges adjusted to cost payment methodology.

Response: We believe that median costs based on our hospital claims data for brachytherapy sources have produced reasonably consistent per source cost estimates over the past several years, comparable to the patterns we have observed for many other OPPS services whose payments are set based upon relative payment weights from claims data. Concerning the claim that a single prospective payment per source would not account for the variable costs across sources used, we believe that our per source payment methodology specific to each source's radioisotope, radioactive intensity, and stranded or non-stranded configuration, supplemented by payment based on the number of sources used in a specific clinical case, adequately accounts for the major expected sources of variability across treatments.

As a prospective payment system, the OPPS relies on the concept of averaging, where the payment may be more or less than the estimated costs of providing a service for a particular patient, but with the exception of outlier cases, it is adequate to ensure access to appropriate care. In the case of brachytherapy sources for which the law requires separate payment groups, without packaging, the costs of these individual items could be expected to show greater variation than some other APCs under the OPPS because higher variability in costs for some component items and services is not balanced with lower variability for others and because relative weights are typically estimated using a smaller set of claims. Nevertheless, we believe that prospective payment for brachytherapy sources based on median costs from claims calculated according to the standard OPPS methodology is appropriate at this point in time and would provide hospitals with the greatest incentives for efficiency in providing brachytherapy treatment. Under the budget neutral OPPS, it is the relativity of costs of services, not their absolute costs, that is important, and we believe that brachytherapy sources can now be appropriately paid according to the standard OPPS payment approach. All services are similarly subjected to the same 2-year lag in costs from claims data available for ratesetting, so we believe the relative costs of OPPS services should generally be appropriate. It is important that the same measure of central tendency (median cost) from claims be used to establish the payment weights for all OPPS services in order to provide appropriate payment for all of these services. The inflation rate of medical services is taken into consideration through the conversion factor, which is updated annually to account for inflation and used to calculate payment rates from the relative payment weights based on median costs.

When the statutory requirement for payment of brachytherapy sources at charges adjusted to cost ends on December 31, 2007, prospective payment for brachytherapy sources based on their median costs would make the source payment an integral part of the OPPS, rather than a separate cost-based payment methodology within the OPPS. We believe that consistent and predictable prospectively established payment rates under the OPPS for brachytherapy sources are appropriate because we do not believe that the hospital resource costs associated with specific brachytherapy sources would vary greatly across hospitals or clinical conditions under treatment, other than through differences in the numbers of source utilized which would be accounted for in the standard OPPS payment methodology as proposed. We particularly note that, under the final CY 2008 payment policies for all OPPS services, only a few pass-through devices that we have determined result in significant clinical improvement would continue to be paid based on charges adjusted to cost, as required under section 1833(t)(6)(D)(ii) of the Act for these items.

Sources of brachytherapy have been separately paid for virtually all of the 7 year history of the OPPS, and hospitals have now had 7 years of experience in reporting the sources separately to receive payment for these relatively costly items. Therefore, hospitals historically have had a strong incentive to bill for sources at charges that reflected the costs of the sources, leading to CY 2006 data that are sufficient to provide the basis for prospective payment. Evolution of brachytherapy source technology, just like advances in the provision of other OPPS services, would be reflected in updated cost data for those sources over time, and those updated costs would be considered each year in the annual update cycle for the OPPS. We do not believe that special accommodation to support brachytherapy source innovation is necessary. We believe that hospitals and physicians regularly balance the additional benefits to

patients of improved products with the additional costs, if any, of those products. One of the functions of a prospective payment system is to encourage wise purchasing while simultaneously making appropriate payments for the services being furnished. We believe that payments based on the median unit costs of brachytherapy sources support this goal.

Because HDR iridium has a fixed active life and must be replaced every 90 days, we agree with commenters that hospitals' costs for the source will be highly dependent on the number of treatments provided by a hospital during that time period. The source cost must be amortized over the life of the sources so, in establishing their charges for the HDR iridium source, we expect that hospitals would project the number of treatments that would be provided over the life of the source and establish their charges accordingly. For most such OPPS services, our practice is to establish prospective payment rates based on the median hospital costs as calculated form claims data, to provide incentives for efficient and cost-effective delivery of these services. Under a prospective payment system methodology, payments generally account for the average costs of services and do not specifically account for varying circumstances. We believe that hospitals understand this prospective payment methodology and should recognize that a prospective payment system could pay more or less than the cost of delivering a specific service in an individual case. We have no reason to believe that a CY 2008 payment based on the median unit cost for HDR iridium would place continued access to this source at risk. Furthermore, as discussed earlier in this section and in section II.F. of this final rule with comment period, prospective payment for brachytherapy sources means that there would be opportunities for hospitals to receive additional payments under the outlier provisions and the rural adjustment.

We disagree that we are not able to set equitable rates per source because of low volumes for some sources and variability of source costs in our claims data. The prospective rates we proposed and are finalizing would be applied equitably to all sources of the same type (for example, all non-stranded iodine-125 sources, all stranded iodine-125 sources, and so on). The nature of basing payment weights on median costs is that the volume of services, by definition, controls the median cost because the median is the 50th percentile of the array of data. However, use of the median cost also simultaneously eliminates the influence of not only the highest but also the lowest values in the array. If the use of currently low volume sources increases in succeeding years or expands to other hospitals, these additional claims would be represented in our claims data in future years, leading to more robust claims data for each such source.

Comment: One commenter claimed that CMS' claims data for the cesium-131 source show significant variation in per unit costs reported on claims across hospitals. In addition, the commenter believed that the number of claims and the number of hospitals submitting data for cesium-131 sources are too low to be the basis of appropriate payment rates for CY 2008. The commenter also indicated that it has submitted a request for a new code for high activity cesium-131 to be effective for separate payment as of January 1, 2008.

Response: We disagree that the number of cesium claims is too low and the variability is too high to proceed with prospective payment for cesium sources. Our CY 2006 claims data used for the proposed rule included 7,435 sources and our final rule claims data include 8,652 cesium sources. The modest variability of costs observed on claims for cesium-131 is similar to the variability we observe for other items and services under the OPPS. We expect that some of the cost differences associated with claims for the single HCPCS code for cesium-131 sources reported in CY 2006 may be associated with the use of stranded versus non-stranded sources, and we have accounted for that potential variation through our proposal to utilize the 40th and 60th percentiles of aggregate cost data for the single source code for ratesetting for non-stranded and stranded sources, respectively.

We note that we have received a request for a new code for separate payment of high activity cesium-131 sources and are currently evaluating that request.

Comment: A number of comments expressed varying opinions concerning the proposed payment methodology for stranded versus non-stranded sources for iodine-125, palladium-103, and cesium-131 sources. Some commenters explained that the CY 2006 claims data do not distinguish between stranded and non-stranded devices, and that no meaningful data exist to support CMS' assumptions underpinning the payment proposal for stranded and non-stranded sources. They asserted that CMS' reasoning that these assumptions appear to provide a reasonable cost differential between stranded and non-stranded sources is not supported by data and is merely guesswork. Therefore, these commenters recommended that CMS not establish prospective payment rates for stranded and non-stranded configurations, especially when appropriate specific codes are now in place to collect data on these sources. The commenters also doubted that the assumptions CMS made should apply equally to the three isotopes with stranded and non-stranded configurations (iodine, palladium, and cesium). Those commenters recommended that CMS continue to pay for stranded and non-stranded sources based on charges adjusted to cost until accurate data are collected and available for ratesetting.

Several commenters specifically urged CMS not to modify the proposed payment rates based on ''anecdotal comments that the Agency may receive'' regarding stranded versus non-stranded sources. They believed that CMS should wait until a ''comprehensive database'' of accurate data is available. Many of these commenters generally recommended that not only should CMS pay for stranded and non-stranded brachytherapy sources based on charges adjusted to cost until robust data on the different costs of these sources are available, but that CMS should provide payment for all brachytherapy sources using the same cost-based methodology in CY 2008.

One commenter claimed that CMS does not have meaningful data for stranded and high activity cesium-131 to establish prospective payment levels. The commenter also stated that the stranded versus non-stranded cost estimate for cesium does not reflect the fact that this cost differential can vary significantly based on the radioactive half-life of the source, which is significant for cesium-131. In addition, the commenter explained that cesium decays at the rate of 7 percent per day and thus the cost differential between its loose seed and stranded seed configurations would not be consistent with the cost differential for stranded and non-stranded iodine and palladium sources, which also have different decay rates. The commenter believed that using the same cost assumptions for all sources would have a significant negative impact on the payment for brachytherapy sources and argued that the impact on cesium sources would be disproportionate in comparison to other sources, due to the radioactive isotope half-life alone.

This commenter offered information as to the actual cost differential between stranded and non-stranded sources, a specific request that was made of the public in the proposed rule. This

commenter stated that the cost of non-stranded cesium sources was $61 to $75 per source, and of stranded cesium sources, $82 to $94 per source, in comparison with proposed payment rates of approximately $51 and $97, respectively. Therefore, the commenter concluded that the proposed payment rates would provide a disincentive to utilize non-stranded cesium relative to stranded cesium sources, encouraging a shift of usage to stranded cesium sources. The commenter believed that CMS should not rush to establish prospective payment rates for stranded and non stranded cesium sources, especially when newly established specific source codes are now available.

Response: We agree with the commenters that our CY 2006 claims data do not differentiate between stranded and non-stranded sources, as we explained in the proposed rule. We proposed to apply certain assumptions that would allow us to make prospective payment for these sources while our newly established codes (as of July 1, 2007) would allow us to collect specific stranded and non-stranded cost data. In the CY 2008 OPPS/ASC proposed rule, we reiterated our intent that the proposed payment methodology for stranded and non-stranded sources would be a temporary payment methodology, and that we would use the newly established codes to collect differential cost data for stranded and non-stranded sources for future use.

While some commenters urged us not to modify the proposed payment levels based on ''anecdotal comments that the Agency may receive,'' many of those same commenters provided only anecdotal claims that the proposed payment levels are inappropriate and not based on meaningful data. Additionally, such commenters did not specifically define what they would consider to be a comprehensive database. Of note, for many of the brachytherapy sources without stranded configurations, we have a significant volume of claims that have demonstrated consistent hospital costs over the last several years, and our claims data for these sources is directly applicable to the currently reported HCPCS codes.

We thank the commenter for reporting invoice cost data on stranded versus non-stranded cesium sources. We have received no information on the cost differential between stranded versus non-stranded sources in previous comments or correspondence. We note that the median cost based on the 40th percentile for non-stranded cesium sources for this final rule with comment period is $63, increased from the proposed $51 based on proposed rule data, while the final rule 60th percentile for stranded cesium sources is $97, consistent with both the proposed and final rule data. Therefore, for the only case in which we received information from the public regarding the costs of stranded and non-stranded sources, the final rule 40th and 60th percentiles of aggregate source data are aligned with the cost information provided by the commenter for the two source configurations. While this limited comparison with external data does not allow us to draw definitive conclusions, it provides validation of our proposal to base the payment for stranded versus non-stranded cesium sources on the 60th versus 40th cost percentile from the source's aggregate CY 2006 claims data.

Comment: Other commenters were generally supportive of prospective payment of stranded and non-stranded iodine, palladium, and cesium sources, as well as other brachytherapy sources. Some of these commenters believed, however, that the payment differential for stranded versus non-stranded sources that resulted from our methodology to use the 60th percentile cost for stranded and the 40th percentile cost for non-stranded sources was too great. The likely result, one commenter explained, was to encourage the use of stranded sources for financial rather than clinical reasons. One commenter pointed out that while the payment differential might not appear to be significant on a per source basis, when the number of sources per procedure is considered (for example, 50–100 sources), the cost difference to providers would be significant. Another commenter asserted that all seed-type sources are essentially the same and that any price differential between stranded and non-stranded sources is a result of a successful marketing strategy by stranded source manufacturers, creating a price differential between stranded and non stranded sources as a result of customer loyalty to specific products with certain features that were initially provided at no additional cost.

Response: Prospective payment rates under the OPPS are based on the median cost for each APC from historical hospital claims, with trimming of claims data only at those extremes to eliminate those claims of exceptionally high or low cost from contributing to APC median cost development. The statute requires us to pay for stranded and non-stranded sources through different payment groups. As stated earlier, our proposal to pay at the 40th and 60th cost percentiles of aggregate data for the predecessor HCPCS codes for the three products with two clinical configurations is a temporary payment methodology that would provide appropriate prospective payment for these sources until more specific claims data are available. We note that partial year data will be available for CY 2009 ratesetting purposes. Information on the costs of stranded and non-stranded configurations of one source is consistent with our proposed costs for the two configurations. Therefore, we believe that our proposed assumptions about the distribution of non-stranded and stranded source costs in the CY 2006 aggregate data are reasonable and consistent with the standard OPPS ratesetting methodology, until more specific data become available. We do not believe, based on our claims data and review of public comments, that delaying implementation of prospective payment for any brachytherapy sources while we are waiting for more detailed cost information is reasonable. Coding changes occur on a regular basis, and we routinely account for them by crosswalking historical claims data from predecessor HCPCS codes to the newly available codes for purposes of payment.

After consideration of the public comments received, we are finalizing our proposal, without modification, to pay brachytherapy sources prospectively for CY 2008, based on median costs from our CY 2006 claims data. For stranded sources, that median cost is set at the 60th percentile of the aggregate claims data for the predecessor code for this source, and for non-stranded sources, that median cost is set at the 40th percentile of the aggregate claims data for the predecessor code for this source. The final brachytherapy source HCPCS codes, APC assignments, status indicators, and median costs are displayed in Table 37 below.

TABLE 37.—SEPARATELY PAYABLE BRACHYTHERAPY SOURCES

HCPCS code	Long descriptor	APC	CY 2008 median cost	CY 2008 status indicator
A9527	Iodine I–125, sodium iodide solution, therapeutic, per millicurie	2632	$27	K
C1716	Brachytherapy source, non-stranded, Gold–198, per source	1716	33	K
C1717	Brachytherapy source, non-stranded, High Dose Rate Iridium-192, per source	1717	173	K
C1719	Brachytherapy source, non-stranded, Non-High Dose Rate Iridium-192, per source	1719	64	K
C2616	Brachytherapy source, non-stranded, Yttrium-90, per source	2616	11,621	K
C2634	Brachytherapy source, non-stranded, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source.	2634	31	K
C2635	Brachytherapy source, non-stranded, High Activity, Palladium-103, greater than 2.2 mCi (NIST), per source.	2635	46	K
C2636	Brachytherapy linear source, non-stranded, Palladium-103, per 1MM	2636	42	K
C2637	Brachytherapy source, non-stranded, Ytterbium-169, per source	2637	N/A	B
C2638	Brachytherapy source, stranded, Iodine-125, per source	2638	*45	K
C2639	Brachytherapy source, non-stranded,Iodine-125, per source	2639	**32	K
C2640	Brachytherapy source, stranded,Palladium-103, per source	2640	*65	K
C2641	Brachytherapy source, non-stranded,Palladium-103, per source	2641	**51	K
C2642	Brachytherapy source, stranded,Cesium-131, per source	2642	*97	K
C2643	Brachytherapy source, non-stranded,Cesium-131, per source	2643	**63	K
C2698	Brachytherapy source, stranded, not otherwise specified, per source	2698	45	K
C2699	Brachytherapy source, non-stranded, not otherwise specified, per source	2699	31	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.

Furthermore, we proposed 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, on a per source basis (as opposed, for example, to per mci). This proposed payment methodology for NOS sources would provide payment to a hospital for new sources, while encouraging interested parties to quickly bring new sources to our attention so specific coding and payment could be established. As explained earlier, we may establish new brachytherapy source codes on a quarterly basis.

Comment: Some commenters recommended that CMS pay for all brachytherapy sources at charges adjusted to cost, including new sources. One commenter commended CMS for establishing two NOS codes for billing stranded and non-stranded sources, C2698 and C2699, until specific coding for new sources can be established.

Response: As discussed earlier in this final rule with comment period, we are finalizing our proposal to pay for specific brachytherapy sources prospectively based on median costs from claims. We also believe it is most appropriate to pay for new brachytherapy sources based on specific codes that reflect the number, radioisotope, radioactive intensity, and stranded or non-stranded configurations of those sources. Furthermore, we may establish new source codes on a quarterly basis to permit separate reporting of new sources. No commenters recommended an alternative prospective payment methodology for NOS source codes. It is most consistent with our payment policy for other NOS services under the OPPS to pay for NOS brachytherapy source codes at the same payment rate as the lowest level clinically related APC. In the case of these NOS sources that would be paid through their own APCs, we continue to believe it is most appropriate to pay for them at the lowest stranded or non-stranded brachytherapy source payment rate, as applicable to each NOS code. This payment policy should encourage prompt requests for more specific Level II HCPCS codes for new brachytherapy sources to ensure more accurate payment for those new sources.

After consideration of the public comments received, we are finalizing our proposal, without modification, to pay for 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, on a per source basis. For CY 2008, C2698 for unspecified stranded sources will be paid at the same rate as C2638 (Brachytherapy source, stranded, Iodine-125, per source) and C2699 will be paid at the same rate as C2634 (Brachytherapy source, non-stranded, High Activity, Iodine-125, greater than 1.01 mci (NIST), per source).

Because brachytherapy sources will no longer be paid on the basis of their charges adjusted to cost after December 31, 2007, we proposed to discontinue our use of payment status indicator ''H'' for APCs assigned to brachytherapy sources. For CY 2008, we proposed to use status indicator ''K'' for all brachytherapy source APCs. As described earlier, the definition of status indicator ''K'' was changed for CY 2007 to accommodate prospective payment for brachytherapy sources.

We received no comments specific to the proposal to change the status indicator for brachytherapy source APCs. Therefore, we are finalizing our proposal, without modification, to use status indicator ''K'' for all brachytherapy source APCs for CY 2008.

For CY 2008, we also proposed 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 earlier, we proposed 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 proposed to pay prospectively for brachytherapy sources beginning in CY 2008, we proposed to implement this policy beginning in CY 2008.

In the CY 2008 proposed rule (72 FR 42749), we pointed out that there is currently one brachytherapy source, ytterbium-169 (HCPCS code C2637, Brachytherapy source, ytterbium-169, per source), which has its own HCPCS code, but for which we believed we lacked claims data on its costs. In the CY 2007 OPPS/ASC proposed rule (71 FR 49598 through 49599), we explained 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 the nonpayable status indicator ''B'' and indicated that if we later received 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 superseded by section 107(a) of the MIEA–TRHCA, which required payment for brachytherapy sources in CY 2007 based on charges adjusted to cost. For the CY 2008 proposed rule, we believed that we continued to lack claims data or other information on the costs of ytteribium-169 on which to base an informed prospective payment rate. We noted that our CY 2006 claims data showed three claims for HCPCS code C2637. We believed these three CY 2006 claims may have been incorrectly coded claims that did not represent claims for ytterbium, as its manufacturer commented on the CY 2007 OPPS proposed rule that ytterbium-169 would first become available for market in CY 2007. Consequently, for CY 2008 we again proposed to not recognize HCPCS code C2637 and to assign it status indicator ''B'' under the OPPS. However, as indicated in the proposed rule, if in public comments to the proposed rule or later in CYs 2007 or 2008, we would receive relevant and reliable information on the hospital cost for ytterbium-169 and information that this source is being marketed, we could establish a prospective payment rate for the source in the CY 2008 final rule with comment period or in a quarterly OPPS update, respectively (72 FR 42749).

Comment: A few commenters recommended that CMS continue to pay for new brachytherapy sources (as well as established sources when there are no reliable claims-based cost data) at charges adjusted to cost, rather than adopting the proposed methodology of using external data and other relevant cost data on the expected cost to hospitals.

Response: As with other brachytherapy sources and other services under the OPPS, the development of cost data for new services through our claims data is an ongoing process. We regularly price new services, placing them in what we consider to be appropriate New Technology or clinical APCs. We make ongoing adjustments to their assignments as necessary, depending on information and data we develop or receive from interested stakeholders. We do not feel that initially having no or small amounts of Medicare claims data for new brachytherapy sources or established sources with lower volumes than other sources in our claims data is a compelling argument to deviate from our prospective payment methodology and pay for some sources at charges adjusted to cost while others would be paid prospectively based on their median cost. We note that we had no additional claims for ytterbium-169 for this final rule with comment period, beyond the three likely incorrectly coded CY 2006 claims discussed in the proposed rule.

After consideration of the public comments received, we are finalizing our proposal, without modification, 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. This policy will apply to the existing HCPCS code C2637 for the ytterbium-169 source, as well, which is assigned status indicator ''B'' in Addendum B to this final rule with comment period. We received no additional information on this source in comments to the CY 2008 proposed rule. In the event that we receive information regarding the costs and current marketing of HCPCS code C2637, we will consider changing its status indicator to ''K'' in a quarterly OPPS update and setting a prospective payment rate for this source.

Comment: Several commenters requested that CMS implement the APC Panel's March 2007 recommendation to edit and return for correction claims that contain a HCPCS code for a separately paid drug or device without a HCPCS code assigned to a procedural APC.

Response: We note that brachytherapy treatment services are paid separately from brachytherapy sources and do not have the costs of the brachytherapy sources packaged into the payment for the associated treatment services. While we encourage hospitals to code correctly in accordance with all 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 OCE edits for drugs and devices, including brachytherapy sources, which 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 understand that there may be some clinical or operational circumstances that could result in a hospital submitting an OPPS claim that only reported a separately paid drug or device, and we would not want to delay a hospital's ability to submit a claim timely because of claims edits that do not have the potential to improve the accuracy of OPPS ratesetting. Therefore, we are not adopting this APC Panel recommendation for broad claims processing edits.

Comment: A few commenters recommended that CMS revise the definition of brachytherapy sources to include all ''brachytherapy sources,'' without limitation to a device of brachytherapy.

Response: We finalized our definition of a source of brachytherapy in the CY 2007 final rule with comment period (71 FR 68113) in the context of current medical practice and with regard to the statutory language. We considered all comments, including some of the same arguments presented in comments to the CY 2008 proposed rule. We made no proposal to change this definition in our CY 2008 proposed rule and are not considering any changes to the established definition at this time.

Comment: One commenter opposed the proposal to include the costs of brachytherapy sources in the budget neutrality formula, if CMS adopted the proposal to pay for the sources on a prospective basis. The commenter believed that brachytherapy treatment is very costly and inclusion of the costs would decrease the payment for other OPPS services. The commenter also claimed that CMS has not factored into payment for brachytherapy treatment the special handling costs of radioactive materials.

Response: We take into account the estimated costs of brachytherapy sources under the methodology of charges adjusted to cost in calculating budget neutrality for the OPPS and have continued to do so under the prospective payment methodology for the sources that we are finalizing for CY 2008. The costs related to supervision, handling, and loading of brachytherapy sources are, in fact, also considered under the OPPS. As we have previously instructed, these costs are to be included by hospitals on claims in one of two ways, either reported as a separate charge using CPT code 77790 (Supervision, handling, loading of radiation source) or included in the charge reported with the HCPCS procedure code(s) for application of the radiation source. Reporting in either of these ways results in the costs of special handling being packaged into payments for brachytherapy treatment procedures.

VIII. OPPS Drug Administration Coding and Payment

A. Background

From the start of the OPPS until the end of CY 2004, three HCPCS codes were used to bill drug administration services provided in the hospital outpatient department (HOPD):

- Q0081 (Infusion therapy, using other than chemotherapeutic drugs, per visit)
- Q0083 (Chemotherapy administration by other than infusion technique only, (EG subcutaneous, Intramuscular, Push), per visit)
- Q0084 (Chemotherapy administration by infusion technique only, per visit).

A fourth OPPS drug administration HCPCS code, Q0085 (Administration of chemotherapy by both infusion and another route, per visit), was active from the beginning of the OPPS through the end of CY 2003.

Each of these four HCPCS codes mapped to an APC (that is, Q0081 mapped to APC 0120, Q0083 mapped to APC 0116, Q0084 mapped to APC 0117, and Q0085 mapped to APC 0118), and the APC payment rates for these codes were made on a per-visit basis. The per-visit payment included payment for all hospital resources (except separately payable drugs) associated with the drug administration procedures. For CY 2004, we discontinued using HCPCS code Q0085 to identify drug administration services and moved to a combination of HCPCS codes Q0083 and Q0084 that allowed more accurate calculations when determining OPPS payment rates.

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. 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 with comment period, 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 discriminated 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 were paid based on the costs of their predecessor HCPCS codes until updated data were available for review.

B. 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)). We proposed to continue to package payment for CPT code 90768 for CY 2008.

Comment: In addition to the APC Panel's recommendation to unpackage CPT code 90768, a few commenters also requested that CMS provide separate payment for it in CY 2008.

Response: As we discuss in section II.A.4.e. of this final rule with comment period, 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. CPT code 90768, by definition, is always provided in association with other intravenous infusions. As we discussed in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68122), CPT code 90768 was first introduced in the CY 2007 OPPS 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 noted in the CY 2008 OPPS/ASC proposed rule (72 FR 42751), because the services identified with CPT code 90768 were provided in previous years, we determined 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, all of these services were paid under the OPPS in previous years.

As data are not available for all current CPT codes 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 nor the commenters' request to provide a separate APC payment for this service. Furthermore, we describe in section II.A.4. of this final rule with comment period our CY 2008 packaging approach for certain (non-drug administration) services. We believe that continuing to package payment for CPT code 90768 is consistent with these broader efforts. Therefore, we are finalizing our proposal to assign status indicator ''N'' to CPT code 90768 for CY 2008.

For CY 2008, we examined CY 2006 claims data available for the proposed rule and continued to believe the CY 2007 drug administration APC configuration reflects clinical and resource homogeneous groupings of procedures. We noted in the proposed rule (72 FR 42751) that there is a violation of the 2 times rule in APC 0438 (Level III Drug Administration) as proposed for CY 2008. (For additional information on the 2 times rule, we refer readers to section III.B. of this final rule with comment period.) For this CY 2008 OPPS/ASC final rule with comment period, this 2 times violation continues to exist based upon updated data. 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 in 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 proposed to except APC 0438 from the 2 times rule for CY 2008.

We did not receive any public comments on this proposal. Therefore, for CY 2008, we are finalizing our proposed exception to the 2 times rule for APC 0438, without modification.

In the proposed rule, we also continued to ask hospitals to report all CPT drug administration codes, and indicated that we expect hospitals to report CPT codes consistently with CPT coding guidelines and applicable instructions.

Comment: Several commenters expressed appreciation for CMS' proposal to continue the CPT coding structure for drug administration services for CY 2008. These commenters noted that the changes made to coding and payment for these services in past years has put a burden on hospitals to train staff on frequent changes. Other commenters expressed frustration over complex CPT coding for drug administration services, noting that reporting requirements placed an unreasonable burden on hospitals to code correctly and increased hospital staffing needs. One commenter suggested that CMS return to simpler coding, such as the historical single per-episode-of-care code to report a ''nonchemotherapy infusion.'' The commenter noted that this methodology aligns with CMS' efforts to increase packaging for services and simplifies hospital coding requirements.

Response: We appreciate hospitals' continuing efforts to work with us to implement changes to drug administration coding and payment over the past few years. We believe that our individual and collaborative efforts to refine the codes used and ensure their accurate reporting have led to a robust dataset that accurately reflects hospital outpatient costs for these common services and results in appropriate payment. We understand that it requires significant hospital resources to ensure proper coding for drug administration services, and hospitals have worked diligently over the past several years to ensure that CMS' data appropriately reflect drug administration services provided in the HOPD. While we recognize the continued efforts that are necessary to accurately document and report drug administration services using CPT codes, we believe that hospitals have had sufficient experience with these codes, first for non Medicare insurers in CY 2006 and then for the Medicare OPPS in CY 2007, that the initial confusion corresponding to the new concepts of ''initial,'' ''sequential,'' and ''concurrent'' has subsided.

We agree with the commenter that a return to a single episode-of-care payment could align with the OPPS shift toward larger payment bundles, but we believe that a change in our approach toward drug administration payment would be premature at this time. While additional packaging for drug administration services could be warranted in a prospective payment system such as the OPPS in a movement toward encounter-based or episode-based payment, hospital stakeholders continue to express their preference for a single set of drug administration codes for use by all insurers. Currently, the CPT drug administration codes sufficiently meet the needs of non-Medicare insurers and Medicare. We do not have any reason to believe that hospitals generally would want to implement a per-episode-of-care set of drug administration codes for use only under the OPPS, nor do we have an operational need for such codes. Therefore, we are finalizing our proposal, without modification, to recognize all active CY 2008 CPT codes for drug administration services under the CY 2008 OPPS.

Comment: One commenter requested that CMS review payment methodologies for drug administration services across the hospital outpatient and physician's office settings. This commenter suggested that the OPPS consider implementing a methodology similar to the physician's office payment methodology, basing payment rates on the time and resource utilization required by the service. The commenter believed that standardizing payment rates across sites of care would eliminate site of service differentials

and allow beneficiaries the option of receiving care in either setting.

Response: We understand that the commenter is concerned about differences in payment methodologies and rates across ambulatory settings when some of the same services are provided to Medicare beneficiaries. Even though both settings use the standard CPT codeset for drug administration services, the costs of providing these services in one setting may not be the same as the costs in another setting. The OPPS and the MPFS are fundamentally different payment systems with essential differences in their payment policies. Specifically, the OPPS is a prospective payment system, based on the concept of paying for groups of services that share clinical and resource characteristics. Payment is made under the OPPS according to prospectively established payment rates that are related to the relative costs of hospital resources for services, as calculated from claims data and Medicare cost reports. The MPFS is a fee schedule that generally provides separate payment for each individual component of a service, reflecting the expected typical inputs into these services. The OPPS methodology allows hospitals to actively contribute on an ongoing basis to the ratesetting process through its annual updates and to influence future payment rates for services by submitting correctly coded and accurately priced claims for the services they provide.

Comment: A few commenters recommended that CMS create two new Level II HCPCS codes for IVIG infusion services, one for the first hour and the other for additional hours of infusion. The commenter cited additional complexities associated with IVIG infusion and increased chances of adverse events that are not fully captured in the CPT codes currently reported by hospitals for these infusions.

Response: While we acknowledge these concerns regarding IVIG administration, we believe that the current CPT coding structure and OPPS payment rates adequately provide for the possible complexities associated with IVIG administration services. Hospital costs for IVIG administration are taken into account during the ratesetting process, as claims for IVIG administration are used in that process for the pertinent CPT codes. Hospitals continue to note their strong preference for reporting CPT codes for drug administration services, as opposed to OPPS-specific Level II HCPCS codes that could be more specifically developed for certain services. In addition, in view of the shift toward larger payment bundles under the OPPS, we do not believe it would be appropriate to create even more specific coding for drug administration services than is available through the codeset developed by the CPT Editorial Panel.

As stated earlier, after consideration of the public comment received, we are finalizing our proposal, without modification, to recognize all active CY 2008 CPT codes for drug administration services under the OPPS for CY 2008. In addition, we are finalizing our proposal, without modification, to assign status indicator ''N'' to CPT code 90768 for CY 2008.

IX. 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 38. These codes are unchanged for CY 2008.

TABLE 38.—CY 2007 CPT EVALUATION AND MANAGEMENT (E/M) AND LEVEL II HCPCS CODES USED TO REPORT CLINIC AND EMERGENCY DEPARTMENT VISITS

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).
G0383	Type B emergency department visit (Level 4).
G0384	Type B emergency department visit (Level 5).

TABLE 38.—CY 2007 CPT EVALUATION AND MANAGEMENT (E/M) AND LEVEL II HCPCS CODES USED TO REPORT CLINIC AND EMERGENCY DEPARTMENT VISITS—Continued

HCPCS code	Descriptor
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 were no CPT codes at that time that fully described 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 G0390 (Trauma response team associated with hospital critical care service) for the reporting of a trauma response in association with critical care services.

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 fully describe 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. In the CY 2008 OPPS/ASC proposed rule, we did not propose to change our OPPS payment policy for critical care services for CY 2008. Our CY 2008 proposed and final policies for payment for trauma activation are described in section II.A.4. of this final rule with comment period.

B. 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 fully describe 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 earlier in Table 38. 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 were 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 were established.

In that same CY 2007 final rule with comment period (71 FR 68138), we finalized our proposal to make payment for 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. 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 might not be the most accurate method of payment for those very common hospital levels of visits that clearly demonstrate 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 of the CY 2008 OPPS/ASC proposed rule, which is reprinted below as Table 39, includes the median costs based on CY 2006 claims data processed through December 31, 2006, and displays the proposed HCPCS codes and APC median costs at the five payment levels that we proposed for the CY 2008 OPPS.

TABLE 39.—PROPOSED RULE ASSIGNMENT OF CLAIMS DATA FROM CY 2006 CPT E/MLEVEL II HCPCS CODES TO VISIT APCS FOR CY 2008

CY 2008 APC title	CY 2008 APC	Proposed CY 2008 APC median	APC service frequency (in millions)	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 OPPS 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 with respect to the hospital.

During CY 2006 and earlier, there was no payment difference between new and established patient visits of the same level because 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 indicated that new patients were more resource-intensive than established patients across all visit levels. The CY 2006 claims data available for the CY 2008 rulemaking confirmed that the cost difference between new and established patient visits increases as the visit level increases.

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. 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 was 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 was contingent upon CMS adopting its recommendation to eliminate the new and established patient distinction reporting requirement. The APC Panel 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 CY 2008 proposed clinic visit APC configuration, as indicated in Table 50 of the CY 2008 OPPS/ASC proposed rule (72 FR 42753), the APC level assignment did not always correspond to the visit level described by each code. For example, CPT code 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 code 99213 had a proposed rule median cost of $65, we proposed to map this code to the Level 2 Clinic Visit APC, which had a median cost of $63. 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.

In both the CY 2007 OPPS/ASC proposed and final rules (71 FR 49617 and 71 FR 68128, respectively), we solicited public comment on 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 would be reporting CPT E/M codes which distinguish between new and established patients for clinic visits and because we saw meaningful and consistent cost differences between visits for new and established patients, we proposed 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 did not propose to adopt the recommendation of the APC Panel to eliminate this differentiation for the reasons noted. We proposed to reexamine whether the coding distinction between new and established patient visits was necessary as we further considered national guidelines. We continued to encourage public comment about hospitals' experiences with assigning visit levels to new and established patients according to their own internal guidelines.

Table 51 of the CY 2008 OPPS/ASC proposed rule, which is reprinted below as Table 40, lists the CY 2008 proposed median costs of new and established patient clinic visit codes, which were based on CY 2006 claims data processed through December 31, 2006.

TABLE 40.—CY 2008 PROPOSED MEDIAN COSTS OF NEW AND ESTABLISHED PATIENT VISIT CPT CODES

Clinic visit level	CY 2008 new patient visit proposed median cost	CY 2008 established patient visit proposed 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

Comment: Most commenters on the proposals requested that CMS eliminate the need for hospitals to distinguish between new and established patient visits because they found it cumbersome to bill a different code for each type of visit. Specifically, the commenters asked CMS not to implement new and established patient visit codes. The commenters suggested that hospitals bill the appropriate code, based on the resources expended in the visit. Several commenters suggested that CMS require hospitals to bill the established patient visit code exclusively and change the status of the new patient visit codes to nonpayable. The commenters suggested setting the payment rate for the established patient visit code at a blend of the new and established patient visit rates. One commenter requested that both the new and established patient visit codes remain payable, but that the OPPS pay the same rate for the new and established patient visit, at each level, an approach which would remove any financial incentive for reporting one code instead of another. Several commenters supported the proposal to continue requiring hospitals to distinguish between new and established patient visits. Some of the commenters suggested that the AMA create hospital-specific Category I CPT visit codes that do not distinguish between new and established patient visits, as appropriate for reporting hospital resource use.

Response: Because hospitals will be reporting CPT codes for CY 2008 and we continue to observe significant cost differences between new and established patient visits of the same level, we will continue to recognize new and established patient visit codes under the CY 2008 OPPS, consistent with their CPT code descriptors. We agree with the commenters that it could be simpler and less burdensome from a coding perspective if hospitals only needed to report one set of codes and could report code levels that reflected their resources used, rather than distinguishing between new and established patient visits. However, in the absence of hospital-specific CPT codes for the reporting of visits in the HOPD, hospitals should continue to distinguish between new and established patient visits, consistent

with their CPT code descriptors. We will reexamine whether the coding distinction between new and established patient visits is necessary as we continue to explore national guidelines.

Comment: Several commenters requested that CMS define a new patient as a patient who does not have a hospital medical record, rather than a patient who does not have a medical record that was created within the past 3 years. The commenters cited the definitions of new and established patients that we discussed in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68128) where CMS stated that if the patient had a hospital medical record that was created within the past 3 years, that patient would be considered an established patient to the hospital. Several of the commenters believed that the ''new'' patient definition described in the April 7, 2000 OPPS final rule with comment period (65 FR 18451) did not require hospitals to determine if a medical record had been created for the patient within the past 3 years.

Response: We note that we neither proposed a change to the definitions of new and established patient visits in the CY 2008 OPPS/ASC proposed rule nor solicited comment on the definitions of new and established patient visits. While several commenters asked us to revise these definitions, we are reluctant to make these changes without hearing additional perspectives from the larger hospital community. Therefore, we are specifically soliciting comment on the definitions of new and established patient visits in the HOPD.

For CY 2008, we are finalizing our proposal, without modification, 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 above. We continue to encourage hospitals to submit comments regarding their experiences with assigning visit levels to new and established patients according to their own internal guidelines. In addition, as noted above, we are specifically soliciting comment on the definitions of new and established patient visits in the HOPD.

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.

In the CY 2008 OPPS/ASC proposed rule, we proposed to maintain the CY 2007 mapping for the clinic visit codes for established patients. As indicated in Table 50 of the proposed rule, which is reprinted earlier as Table 39 in this final rule with comment period, we proposed to map the Level 1 established patient visit to the Level 1 Clinic Visit APC, which resulted in the Level 1 Clinic Visit APC containing both the Level 1 new and established patient visit codes, in accordance with the APC Panel's recommendation. Similarly, we proposed to map both the Level 2 new and established patient visit codes to the Level 2 Clinic Visit APC. However, we also proposed to map the Level 3 established patient visit code to the Level 2 Clinic Visit APC because our cost data indicated that the costs associated with a Level 3 established patient visit most closely resembled 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 were mapped to the Level 3 Clinic Visit APC, which had a proposed median cost of approximately $86, we would significantly overpay CPT code 99213 every time it was billed. Therefore, we proposed to map the Level 3 new patient visit to the Level 3 Clinic Visit APC, consistent with the APC Panel's recommendation. We also proposed 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 proposed to map to the Level 5 Clinic Visit APC for CY 2008 payment was the Level 5 new patient visit. These APC assignments which were proposed for CY 2008 consistent with their CY 2007 APC assignments, were determined for each HCPCS code based on CY 2006 claims data available for CY 2008 ratesetting and clinical considerations. In the CY 2008 OPPS/ASC proposed rule, we indicated that we were not persuaded by the APC Panel's recommendation, which would have required us to ignore significant cost differences based on resource data that were clinically consistent and, therefore, we did not propose to map each code to its corresponding level APC.

In the proposed rule, we noted that historical cost data for these frequently provided services were extremely consistent. In addition, from a clinical perspective, we believed that in some cases, in the context of a five-level structure for visit reporting, the hospital resources required for a given visit level might only be slightly different from those used for a visit that was one level higher or lower. For example, it was 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 were similar because these patients would often utilize reasonably comparable hospital resources.

In the proposed rule, we performed data analyses using proposed rule data to determine how the median costs of the clinic visit APCs would have changed 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 were shown in Table 52 of the CY 2008 OPPS/ASC proposed rule, which is reprinted below as Table 41.

TABLE 41.—CY 2008 MEDIAN COST COMPARISON OF CLINIC VISIT APCS IN TWO DIFFERENT CONFIGURATIONS USING CY 2006 PROPOSED RULE DATA

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

In the CY 2008 OPPS/ASC proposed rule, we concluded that the APC median cost distribution did not improve when each new and established patient visit code was mapped to its corresponding level of APC. In fact, the APC Panel's recommended configuration resulted 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 were 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 acknowledged in the proposed rule 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 indicated that this would not be the most accurate payment method. Historical hospital cost data demonstrated that new patient visits were more costly than established patient visits of the same level, a finding that was consistent with the perspective of our medical advisors. Because we proposed 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 saw no reason to adjust the clinic visit APC configurations. Therefore, for CY 2008, we proposed to map the CPT E/M codes and other Level II HCPCS codes to the Clinic Visit APCs as configured in Table 50 of the proposed rule, and not fully adopt the APC Panel's recommendation to map each code to its corresponding APC level. We indicated that we would re-examine this issue using the claims data for CY 2009 OPPS ratesetting, and would also reconsider whether this mapping is appropriate in the future as we continue to work on developing national guidelines.

Comment: A few commenters opposed the proposal to map the CPT E/M codes and other Level II HCPCS codes to the Clinic Visit APCs based on resource cost and clinical homogeneity and stated that it made sense for each code to map to the corresponding APC level. For example, the commenters requested that the Level 3 new and established patient visit codes both map to the Level 3 Visits APC.

Response: While we understand that it would be more straightforward if each code mapped to its corresponding APC level, we did not receive any compelling reasons to ignore significant cost differences based on robust resource data that are clinically consistent. We note that we will not be adopting the APC Panel's recommendation that each code map to its corresponding APC level for CY 2008.

We are finalizing the proposed Clinic Visit APC configuration, with minor modification for CY 2008. Specifically, we are mapping the CPT E/M codes and other Level II HCPCS to the appropriate Clinic Visit APCs, based on resource costs. Several HCPCS codes more appropriately map to different Clinic Visit APCs than proposed in Table 50 as a result of analyzing the full year final rule resource cost data. In addition, several other HCPCS codes for services resembling visits have been assigned to the Clinic Visit APCs for CY 2008. We refer readers to Addendum B to this final rule with comment period for the complete listing of visit codes and their placements for CY 2008. Furthermore, as discussed in detail in section II.A.4.c.(7) of this final rule with comment period, in some cases when high-level visits are reported with a new or established patient Level 5 CPT E/M code, a Level 4 or 5 emergency department visit CPT code, a critical care CPT code, or direct admission to observation HCPCS code in association with 8 or more hours of nonsurgical observation services, we will provide a single payment in CY 2008 for the encounter through one of two new composite APCs, specifically APCs 8002 (Level I Extended Assessment and Management) and 8003 (Level II Extended Assessment and Management).

The APC Panel also recommended that CMS not recognize the CPT consultation codes: CPT code 99241 (Office consultation for a new or established patient (Level 1)), CPT code 99242 (Office consultation for a new or established patient (Level 2)), CPT code 99243 (Office consultation for a new or established patient (Level 3)), CPT code 99244 (Office consultation for a new or established patient (Level 4)), and CPT code 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. As we observed in the CY 2008 OPPS/ASC proposed rule, 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 stated our belief that it might be unnecessary for hospitals to report consultation CPT codes if either a new or established patient visit code accurately described the service provided. We stated that we were particularly interested in hearing whether consultation codes were a useful measure of hospital resource use under the OPPS, and how consultation visits were 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, was mapped to APC 0605 (Level 2 Clinic Visits), which was where CPT code 99212, the Level 2 established patient code, was also assigned for CY 2007. Moving the consultation codes to the same APCs as the corresponding established patient visit codes eliminated any incentive for hospitals to bill a consultation code instead of a new or established patient code.

TABLE 42.—CY 2008 MEDIAN COSTS AND FREQUENCIES OF CPT CONSULTATION VISIT CODES USING CY 2006 PROPOSED RULE DATA

Code descriptor	Median cost	Frequency
Level 1 Consultation	$66.48	62,000
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 were provided with much less frequency than all levels of established patient visits and low-level new patient visits in CY 2006 but were provided more frequently than high-level new patient visits. The median costs for consultation codes were generally similar to, or slightly higher than, the corresponding median costs of the same level of new patient visits.

Aside from the APC Panel's recommendation, we received a few public comments on the CY 2007 OPPS/ASC final rule related to this issue. In the CY 2008 OPPS/ASC proposed rule, we noted our continued belief that consultation codes were 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 code, as appropriate in these cases. In the interest of simplifying billing, for CY 2008, we proposed to assign status indicator ''B'' to the consultation codes (that is, not paid under the OPPS), and instructed 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 could build consultation services into their internal hospital guidelines related to reporting clinic visit levels, based on the complexity and resources used for these visits.

Comment: Many commenters supported the proposal to change the status of the consultation codes so that they are no longer recognized under the OPPS. The commenters stated that this would simplify outpatient hospital billing, and remove the option of reporting unnecessary codes. A few commenters requested that the consultation codes continue to be recognized under the OPPS because of the administrative burden involved with analyzing each consultation to determine if the visit should be new or established. In addition, the commenters noted that there is a resource cost difference between consultations and new and established patient visits. The commenters stated that the cognitive intensity and the time to fully establish a diagnosis and a treatment plan for consultation types of visits are much greater than that of established patient visits.

Response: We agree with the commenters who requested that we finalize our proposal not to recognize consultation codes under the OPPS for CY 2008. As described above, we do not believe consultation codes are a useful or necessary indicator of hospital resource use under the OPPS. The commenters who requested that CMS continue to recognize consultation codes may have been measuring physician resource use, rather than hospital resource use. In addition, if consultation services are more resource-intensive than established patient visits of the same level, our proposal would permit hospitals to factor this into their internal hospital guidelines that would determine the appropriate level of established patient visit to report.

In summary, we are finalizing our CY 2008 proposal, without modification, that hospitals continue to use 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 will continue to be payable under the OPPS, but we will 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. In the meantime, we will assign these clinic visits to different levels of Clinic Visit APCs based on the costs we observe from historical hospital claims data. For CY 2008, we are also finalizing our proposal, without modification, 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 have reported 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 (COBRA), Pub. L. 99–272.

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.

In the CY 2008 OPPS/ASC proposed rule, we reiterated our belief that every emergency department that meets the CPT definition of emergency department also qualifies as a dedicated emergency department under EMTALA. However, we indicated that we were 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.

Prior to CY 2007, 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 43 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 final 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 43.—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).

TABLE 43.—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
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).
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 was 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 believed 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 if in the future a proposal for 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. We noted that the OPPS rulemaking cycle for CY 2009 would be the first year that we would 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. 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 OPPS/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 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 Type A emergency departments to the five newly-created Emergency Department Visit APCs, 0609, 0613, 0614, 0615, and 0616.

We believed 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 are defined to reflect the activities of physicians, and do not always fully describe 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 noted that after the publication of the CY 2007 OPPS/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, in CY 2007 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 did not propose to modify the definitions of Type A or Type B emergency departments for CY 2008 because we believed that our current definition accurately distinguished between these two types of emergency departments. While we would not know definitively until CY 2009 how the costs of services provided in Type A emergency departments differed from the costs of services provided in Type B emergency departments, we believed that our current distinction between Type A and Type B emergency departments was appropriate, and was most likely to capture any resource cost differences between the two types of emergency departments. However, we specifically solicited 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 considered 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. In the CY 2008 OPPS/ASC proposed rule, we specifically solicited comments that described 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 did 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 proposed 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.

Comment: Many commenters requested that CMS adjust the policy to broaden the definition of Type A emergency departments, specifically to revise the rule that hospitals must carve out portions of the emergency department that are not available 24 hours a day. The commenters specifically requested that the definition be adjusted so that a ''fast track'' area of an emergency department, located within the same building as a Type A emergency department, would be considered Type A, regardless of its hours of operation, if it provides unscheduled emergency services and shares a common patient registration system with the Type A emergency department. Many of the commenters expressed concern that hospitals are currently overcrowded, and payment at clinic visit rates may cause hospitals to shut down their ''fast track'' or other areas of the hospital that deliver expedited care, yet are open less than 24 hours a day. The commenters noted that if these areas of the hospital were closed, emergency department overcrowding would be exacerbated. Other commenters requested that we allow hospitals to operate in the most efficient manner and not penalize them for creating efficiencies. Several commenters requested additional clarification regarding the difference between Type A and Type B emergency departments, but did not specifically describe which part of the policy was unclear. Several commenters noted that five payment levels for emergency department visits was appropriate and would continue to support a stable distribution of visit levels.

Response: As noted above, 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). We continue to believe that emergency

departments or areas of the emergency department that are available less than 24 hours a day may have lower resource costs than emergency departments or areas of the emergency department that are available 24 hours a day. 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. In addition, if our Type A emergency department payments provide support for 24 hour a day availability of services, then services provided in areas of the hospital that are not staffed 24 hours a day could be overpaid. This could also have the effect of diluting, and ultimately decreasing, the median resource costs associated with Type A emergency departments. We encourage hospitals that need more specific information related to the distinction between Type A and Type B emergency departments to contact their local fiscal intermediaries.

In response to several questions, we are slightly modifying the long descriptors of HCPCS codes G0380, G0381, G0382, G0383, and G0384 by replacing the words ''this section'' with ''42 CFR § 489.24'' in order to clarify the reference. The short descriptors remain unchanged for CY 2008. Table 44 lists the CY 2008 short and long descriptors for the Type B emergency department Visit HCPCS codes.

TABLE 44.—CY 2008 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 42 CFR § 489.24 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 42 CFR § 489.24 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 42 CFR § 489.24 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).
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 42 CFR § 489.24 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 42 CFR § 489.24 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).

In summary, we did not receive any public comments that described how the payment 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. Therefore, we are finalizing our CY 2008 proposal, without modification, to pay for Type A emergency department visits at the five Emergency Department Visit APC rates, while Type B emergency department visits will continue to be paid based on the five Clinic Visit APCs. We are also slightly modifying the long descriptors of HCPCS codes G0380 through G0384 for clarification.

C. Visit Reporting Guidelines

1. Background

As described in section IX.A. of this final rule with comment period, since April 7, 2000, we have instructed hospitals to report facility resources for clinic and emergency department hospital outpatient 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, in CY 2003 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 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 department 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 believed 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 was 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 hospital reporting of visits using CPT E/M codes that were 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 were the most appropriate and well-developed guidelines for use in the OPPS of which we were aware. Our particular interest in these guidelines was based upon the broad-based input into their development, the desire for CMS to move to promulgate national hospital outpatient visit coding guidelines in the near future, and full consideration of the characteristics of alternative types of guidelines. We also believed 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 noted that we had been told that a number of hospitals were successfully utilizing the AHA/AHIMA guidelines to report levels of hospital visits. However, other organizations had expressed concern that the AHA/AHIMA guidelines might 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, remained 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. As we explained in the CY 2008 OPPS/ASC proposed rule (72 FR 42761), we recognized that there could 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.

In the CY 2008 OPPS/ASC proposed rule (72 FR 42761), we noted that there were several types of concerns with the AHA/AHIMA guidelines that had been identified based upon extensive staff review and contractor use of the guidelines during the validation study. We believed that 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 provided some possibilities for addressing certain issues. We reviewed our eight general areas of concern regarding the AHA/AHIMA model as outlined below. In addition, we posted on the CMS Web site both the original AHA/AHIMA guidelines and our modified draft version.

In the CY 2008 OPPS/ASC proposed rule (72 FR 42761), we reiterated our commitment to 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 were 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 CY 2007 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; re-evaluation of the way in which additional hospital resources required for the treatment of new patients were captured; and recommendations for guidelines for the reporting of visits to Type B emergency departments.

In CY 2007, we had a number of meetings and discussions with interested stakeholders 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 with comment period, and alternative guidelines. In the CY 2008 OPPS/ASC proposed rule (72 FR 42761), we indicated our awareness that the AHA and AHIMA were conducting 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 had not received any additional suggestions or modifications from the AHA and AHIMA at the time of the development of the CY 2008 proposed rule. We had received a number of new suggestions for guidelines from other stakeholders, including individual hospitals and associations, that had 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 believed 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 demonstrated 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 on 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.

In the CY 2008 OPPS/ASC proposed rule (72 FR 42761), we expressed our appreciation of the thoughtful information that had been provided to us up to that time regarding hospitals' experiences and the insightful responses by the public to our concerns about the AHA/AHIMA model. We reiterated that we were actively engaged in evaluating and comparing various guideline models and suggestions that had been provided to us, and that we continued to welcome additional public input on this important and complex area of the OPPS. The public input we had received continued to reflect a wide variety of perspectives on the types and content of the guidelines different commenters recommended that we should implement nationally for the OPPS, and no single approach appeared to be broadly endorsed by the stakeholder community. In addition, we explained that commenters had 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 believed accurately captured the required hospital resources.

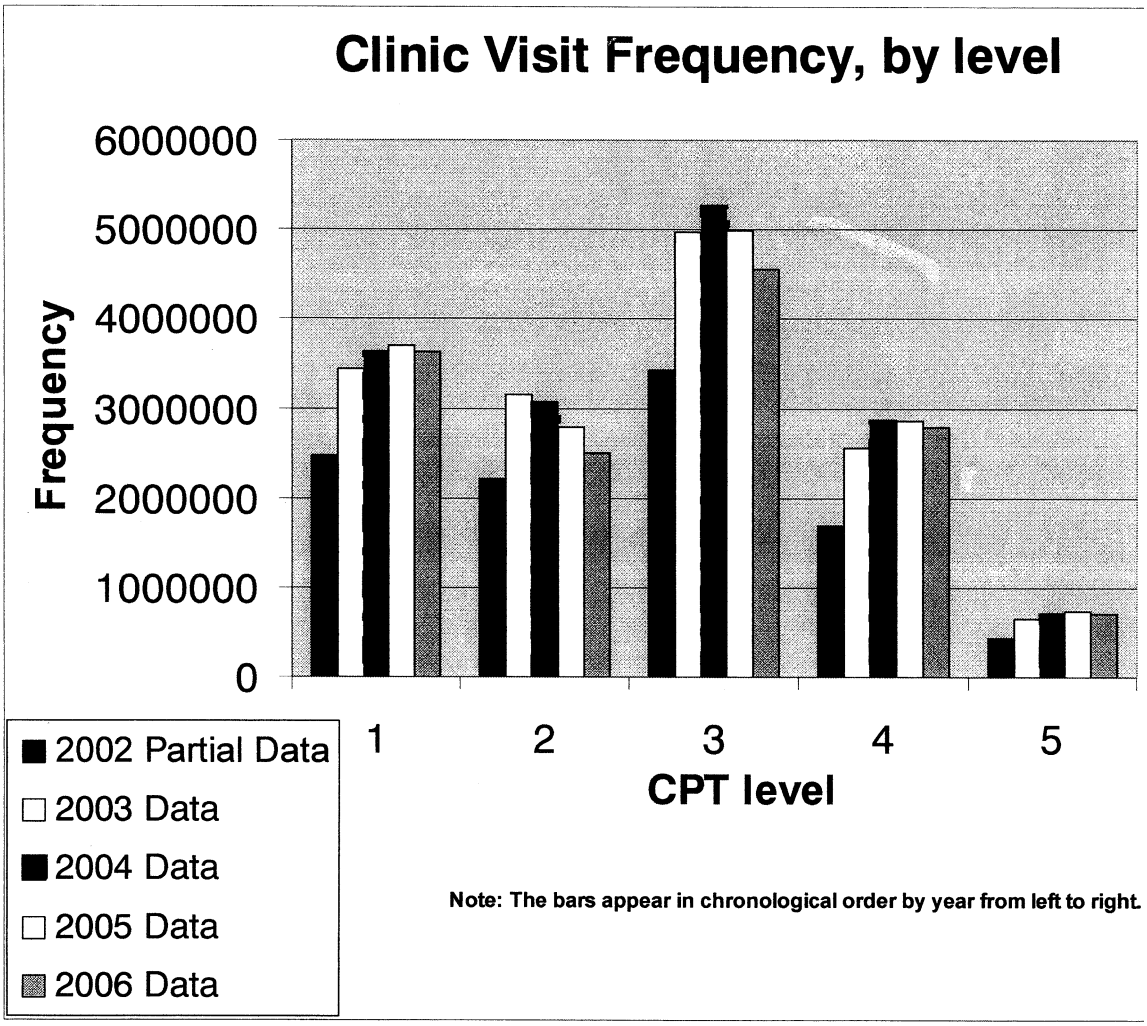
3. Visit Guidelines

In preparation for the CY 2008 OPPS/ASC proposed rule, we performed data analyses with the goal of studying the current and historical 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 that is reprinted from the CY 2008 OPPS/ASC proposed rule, 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, we noted that the visit distributions had been quite stable over the past 5 years.

Figure 1.—Frequency Distribution of New and Established Patient Clinic Visits, by Level of Code

Figure 1.--Frequency Distribution of New and Established Patient Clinic Visits, by Level of Code



The graph shown in Figure 1 indicated that hospitals, on average, were billing all five levels of visit codes with varying frequency, in a consistent pattern over time. It was striking to note how similar the annual distributions appeared from CY 2002 through CY 2006. We were not surprised that hospitals reported 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 to make 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 noted 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 would be inappropriate. If a visit and another service were both billed, such as chemotherapy, a diagnostic test, or a surgical procedure, the visit should be separately identifiable from the other service because the resources used to provide nonvisit services, including staff time, equipment, and supplies, among others, were captured in the line item for that service. We believed that hospitals by and large were abiding by this guidance because more than 90 percent of the CY 2006 claims for Level 1 established patient visits available for the CY 2008 OPPS/ASC proposed rule were single claims.

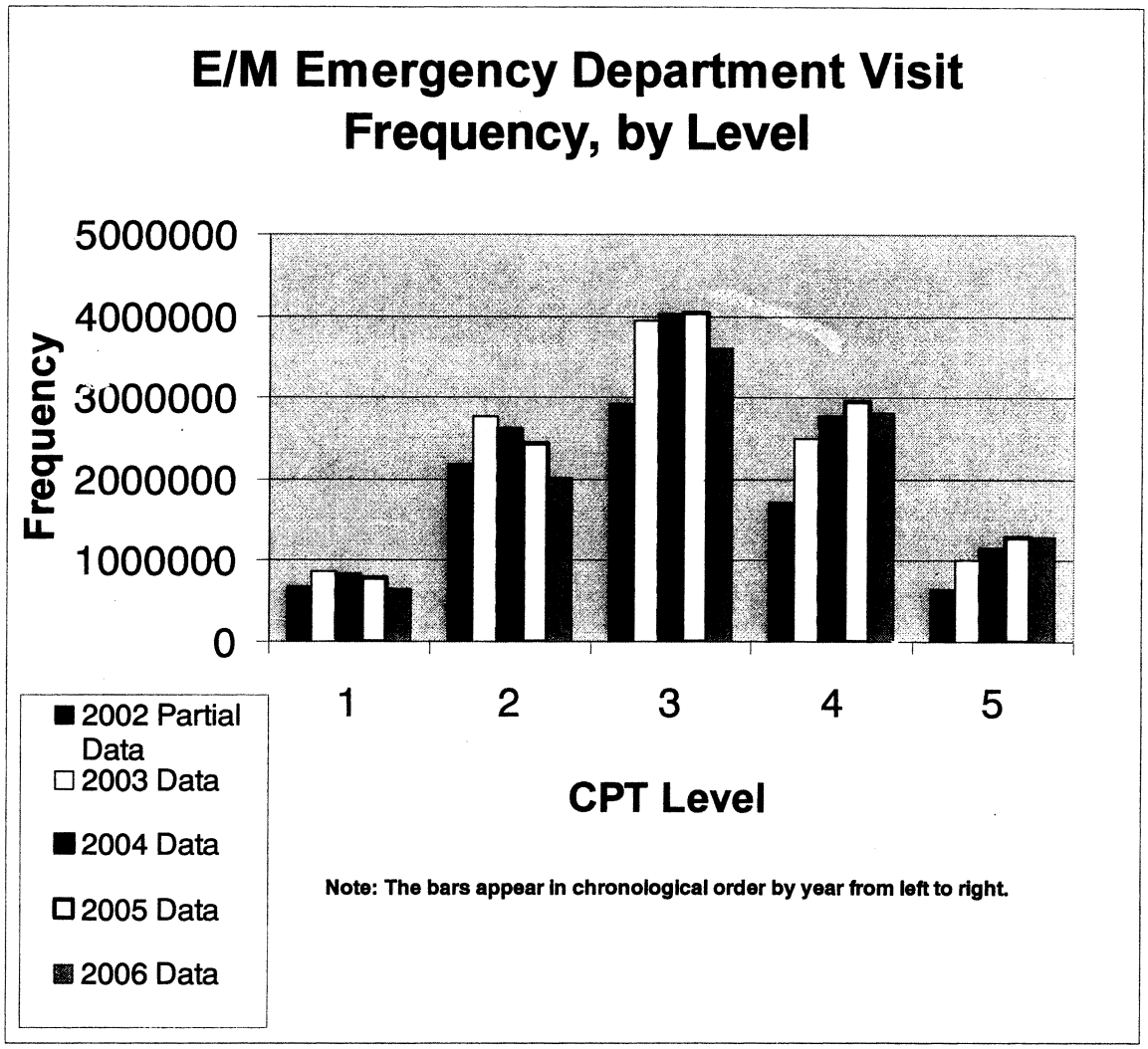
In the CY 2008 OPPS/ASC proposed rule (72 FR 42761), we also examined the billing patterns for various classes of hospitals, grouped by the hospital categories shown in the impact table (Table 61) in section XXIV.B. of this final rule with comment period, to see how the clinic visit distributions of levels reported 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 correlated positively 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 that is reprinted from the CY 2008 OPPS/ASC proposed rule, 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 were stable over the past 5 years as well.

Figure 2.—Frequency Distribution of Emergency Department Visits, by Level of Code

Figure 2.--Frequency Distribution of Emergency Department Visits, by Level of Code



In the CY 2008 OPPS/ASC proposed rule (72 FR 42761), we also looked at various classes of hospitals, grouped by the hospital categories that we show in the impact table in section XXIV.B. of this final rule with comment period, 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 were consistent with our expectations for care delivery at those hospitals.

Overall, both the clinic and emergency department visit distributions indicated that hospitals were billing consistently over time and in a manner that distinguished between visit levels, resulting in relatively normal distributions nationally for the OPPS, as well as for smaller classes of hospitals. These proposed rule analyses were generally consistent with our understanding of the clinical and resource characteristics of different levels of hospital outpatient clinic and emergency department visits.

In the CY 2008 OPPS/ASC proposed rule, we specifically invited public comment as to whether a pressing need for national guidelines continued 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 was currently more practical and appropriately flexible for hospitals. We explained that although we have reiterated our goal since CY 2000 to create national guidelines, this complex undertaking for these important and common hospital services was proving more challenging than we initially thought as we received new and expanded information from the public on current hospital reporting practices that led to appropriate payment for the hospital resources associated with clinic and emergency department visits. We believed that many hospitals had worked diligently and carefully to develop and implement their own internal guidelines that reflected the scope and types of services they provided throughout the hospital outpatient system. Based on public comments, as well as our own knowledge of how clinics operate, it seemed 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 indicated that hospitals, both nationally in the aggregate and grouped by specific hospital classes, were generally billing in an appropriate and consistent manner as we would expect in a system that accurately distinguished among different levels of service based on the associated hospital resources.

Therefore, while we explained in the CY 2008 OPPS/ASC proposed rule that we would continue to evaluate the information and input we had received from the public during CY 2007, as well as comments on the CY 2008 OPPS/ASC proposed rule, regarding the necessity and feasibility of implementing different types of national guidelines, we did not propose to implement national visit guidelines for clinic or emergency department visits for CY 2008. Instead, hospitals would continue to report visits during CY 2008 according to their own internal hospital guidelines.

In the absence of national guidelines, we will continue to regularly reevaluate patterns of hospital outpatient visit reporting at varying levels of disaggregation below the national level to ensure that hospitals continued to bill appropriately and differentially for these services. In addition, we note our expectation that hospitals' internal guidelines would comport with the principles listed below.

(1) 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).

(2) The coding guidelines should be based on hospital facility resources. The guidelines should not be based on physician resources (67 FR 66792).

(3) The coding guidelines should be clear to facilitate accurate payments and be usable for compliance purposes and audits (67 FR 66792).

(4) The coding guidelines should meet the HIPAA requirements (67 FR 66792).

(5) The coding guidelines should only require documentation that is clinically necessary for patient care (67 FR 66792).

(6) The coding guidelines should not facilitate upcoding or gaming (67 FR 66792).

We also proposed the following five additional principles for application 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 believed that it was reasonable to elaborate upon the standards for hospitals' internal guidelines that we proposed to apply in CY 2008, based on our knowledge of hospitals' experiences to date with guidelines for visits.

(7) The coding guidelines should be written or recorded, well-documented, and provide the basis for selection of a specific code.

(8) The coding guidelines should be applied consistently across patients in the clinic or emergency department to which they apply.

(9) The coding guidelines should not change with great frequency.

(10) The coding guidelines should be readily available for fiscal intermediary (or, if applicable, MAC) review.

(11) The coding guidelines should result in coding decisions that could be verified by other hospital staff, as well as outside sources.

In the CY 2008 OPPS/ASC proposed rule, we invited public comment on these principles, specifically, whether hospitals' guidelines currently met these principles, how difficult it would be for hospitals' guidelines to meet these principles if they did not meet them already, and whether hospitals believed 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, might find it more practical and appropriate to use a different set of guidelines than the general emergency department. Similarly, we believed that it was 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 were implemented for different clinics, we stated that hospitals should ensure that these guidelines reflected comparable resource use at each level to the other clinic guidelines that the hospital might apply.

Comment: A number of commenters were divided as to whether there is a need for national guidelines. The majority of the commenters requested that CMS continue work on national guidelines to ensure consistent reporting of hospital visits. Some of the commenters requested that the guidelines be implemented as soon as possible, ensuring 6 to 12 months of advance notice. Other commenters suggested that guidelines would be helpful, but that it was preferable to invest significant time reviewing and

perfecting guidelines rather than to quickly implement guidelines that could later prove to be problematic. Several commenters requested that CMS create national guidelines and then request the development of CPT codes specific to hospital visits. Several commenters offered their assistance in creating specialty clinic guidelines, reviewing guidelines, or helping in other ways, with the ultimate goal of creating national guidelines. One commenter believed it is absolutely necessary to create national guidelines, particularly because CMS is moving toward greater packaging.

Other commenters stated that the principles that were included in the CY 2008 OPPS/ASC proposed rule were appropriate, reasonable, and sufficient, and that it was unnecessary to implement national guidelines. The commenters stated that hospital specific guidelines are practical and appropriately flexible. Several of the commenters noted that their own internal guidelines already met all of the principles, or that the internal guidelines used by member hospitals or their associations likely already comply with these principles. Other commenters requested that the AMA include these principles in the CPT book to clarify that the CPT E/M code descriptors do not fully describe hospital resources, and that it is appropriate for hospitals to use their internal guidelines to code hospital outpatient visits.

Several commenters asked for clarification of details related to the principles, such as how often the guidelines should be updated, how ''readily available'' is defined, and whether hospitals can use physician guidelines to report hospital visits. Some commenters believed the principles were too vague and strongly encouraged the creation of national guidelines. Several commenters requested that CMS inform the fiscal intermediaries and MACs that they should use each hospital's internal guidelines as a reference when auditing hospital records, rather than using only the fiscal intermediary's own set of guidelines. One commenter requested clarification related to how a hospital could create several sets of guidelines for various areas of the hospital. Many commenters requested clarification about whether separately payable services could be included in internal guidelines, in the absence of national guidelines.

Response: We appreciate all the thoughtful comments that we received related to the creation of national guidelines, as well as offers from hospitals and associations to help create guidelines. We acknowledge that it would be desirable to many hospitals to have one set of national guidelines. However, we also understand that it would be disruptive to other hospitals that have successfully adopted internal guidelines to implement any new set of national guidelines, while we address the problems that would be inevitable in the case of any new set of guidelines that would be applied by thousands of hospitals. Creating national guidelines has proven more difficult than initially anticipated, as detailed above, and some hospitals have expressed significant concerns about virtually all of the models we have discussed.

Based on our analyses for the CY 2008 proposed rule, both clinic and emergency department national visit distributions appear normal and relatively stable over time, indicating that hospitals as a whole are billing the full range of visit codes in an appropriate manner, a reassuring finding. We noted similar distributions for subclasses of hospitals, as well. We will continue to work on national guidelines, and we continue to encourage comments and submission of successful models. In the meantime, before national guidelines are implemented, we will require each hospital's internal guidelines to meet the principles stated above. We agree with commenters that it could be useful for the AMA to publish these principles in order to clarify that it is appropriate for hospitals to apply different guidelines than physicians' guidelines to report visits provided in HOPDs. We encourage interested parties to contact the AMA to determine whether there is an appropriate forum to publish these principles, so that they are broadly distributed and readily available.

We will elaborate on the principles that were commented on by several commenters. The second principle states that the guidelines should not be based on physician resources. Hospitals are responsible for reporting the CPT E/M visit code that appropriately represents the resources utilized by the hospital, rather than the resources utilized by the physician. This does not preclude a hospital from using or adapting the physician guidelines if the hospital believes that such guidelines adequately describe hospital resources. We note that the first principle states that coding guidelines should follow the *intent* of the CPT code descriptor to relate the intensity of resources to different levels of effort represented by the code, not that the hospital's guidelines need to specifically consider the three factors included in the CPT E/M codes for consideration regarding physician visit reporting.

Regarding principle 8, a hospital with multiple clinics (for example, primary care, oncology, wound care, etc.) may have different coding guidelines for each clinic, but the guidelines must be applied uniformly within each separate clinic. We note that the hospital's assorted set of internal guidelines must measure resource use in a relative manner, in relation to each other. For example, the hospital resources required for a Level 3 established patient visit under one set of guidelines should be comparable to the resources required for a Level 3 established patient visit under all other sets of clinic visit guidelines used by the hospital.

Regarding principle 9, we would generally expect hospitals to adjust their guidelines less frequently than every few months, and we believe it would be reasonable for hospitals to adjust their guidelines annually, if necessary.

Regarding principle 10, hospitals should use their judgment to ensure that coding guidelines are readily available, in an appropriate and reasonable format. We would encourage fiscal intermediaries and MACs to review a hospital's internal guidelines when an audit occurs.

Regarding principle 11, hospitals should use their judgment to ensure that their coding guidelines can produce results that are reproducible by others.

In the absence of national visit guidelines, hospitals have the flexibility to determine whether or not to include separately payable services as a proxy to measure hospital resource use that is not associated with those separately payable services. The costs of hospital resource use associated with those separately payable services would be paid through separate OPPS payment for the other services. We encourage hospitals with more specific questions related to the creation of internal guidelines to contact their local fiscal intermediary or MAC.

Comment: Many commenters requested that CMS allow hospitals to bill critical care without a minimum time requirement or with a time requirement of 15 minutes. The commenters noted that the hospital may have its greatest resource use in the first 10 minutes of critical care, much earlier than the 30-minute minimum required in the code descriptor.

Response: The CPT instructions for reporting of critical care services with CPT code 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30–74 minutes) and the CPT code descriptor specify that the code can only

be billed if 30 minutes or more of critical care services are provided. Because hospitals will be reporting CPT codes for critical care services for CY 2008, they must continue to provide a minimum of 30 minutes of critical care services in order to bill CPT code 99291, according to the CPT code descriptor and CPT instructions. We note that hospitals can report the appropriate clinic or emergency department visit code consistent with their internal guidelines if fewer than 30 minutes of critical care is provided.

We appreciate all of the comments we have received in the past from the public on visit guidelines, and we encourage at any time continued submission of comments 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 to determine the appropriate reporting of different levels of clinic and emergency department visits. 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 currently observed and as we would also 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 a greater percentage of low-level services than high-level services, while an academic medical center or trauma center might provide a greater percentage of 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.

In addition, we are adopting our CY 2008 proposal, without modification, that all hospital-specific guidelines for reporting visits should meet the 11 guideline principles listed earlier in this final rule with comment period.

While we understand the interest of some hospitals in our moving quickly to promulgate national guidelines that will ensure standardized reporting of hospital outpatient visit levels, we believe that the issues and concerns 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 to 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. OPPS Payment for Blood and Blood Products

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).

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 was based.

B. Payment for Blood and Blood Products

In the CY 2008 OPPS/ASC proposed rule (72 FR 42766 through 42767), we proposed 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 the 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, using the actual or simulated CCRs from the most recently available hospital cost reports. The median costs derived from this data process were relatively stable compared to the median costs on which payment is based for CY 2007. Of the 34 blood and blood products, the proposed median costs increased for 24 products and declined for 10 products compared to the adjusted medians on which payment is based in CY 2007. Products with the largest proposed declines were, like the products with the greatest increases, mostly those products with low volume use in the hospital outpatient setting. The products whose proposed costs declined 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 declined by more than 18 percent in the proposed rule data. The products whose proposed median costs increased account for 79 percent of the total volume of blood and blood products in the claims used to calculate the proposed rates.

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 available for the proposed rule 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 proposed 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.

We received several public comments regarding this proposal. A summary of the comments and our responses follows.

Comment: Some commenters supported CMS' proposal to increase the APC payment rates for many blood products. One commenter expressed support for our methodology of utilizing hospital-specific actual or simulated CCRs for blood cost centers to convert hospital charges for blood and blood products to costs, noting that this methodology is consistent with the principles of a prospective payment system.

Other commenters, however, stated that the payment rates for many blood and blood products do not adequately reflect their acquisition, management, and processing costs. They noted that the costs of blood and blood products continue to increase due to safety requirements, technological advances, and donor recruitment and retention challenges, and that the 2-year lag inherent in OPPS ratesetting would not allow these costs to be captured.

In particular, these commenters were concerned that the median unit cost published in the proposed rule for the blood product with the highest Medicare volume, leukocyte-reduced red blood cells, is less than the acquisition cost of the product and would fail to pay hospitals for overhead costs (for example, storage, handling, inventory management). One commenter referred to data submitted by 1,600 hospitals in response to a survey of 2004 blood costs that was conducted by the Department of Health and Human Services under a contract with the American Association of Blood Banks (AABB). According to the AABB survey, the proposed CY 2008 payment for leukocyte reduced red blood cells is less than what hospitals paid for this product in 2004.

Response: The median costs for blood and blood products in this final rule with comment period are derived from the CY 2006 hospital outpatient claims data and have the benefit of reflecting the reporting clarifications that were provided through CMS Program Transmittal 496, dated March 4, 2005. This instruction articulated and clarified many questions that had been raised by hospitals and others about how hospitals should report charges for blood and blood products. 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. Thus, we expect that the reporting of charges and units for blood and blood products in CY 2006 has improved over past years, especially with respect to hospitals' inclusion of all charges related to acquisition, processing, and handling of blood and blood products as specifically described in each of the relevant HCPCS P-code descriptors. As such, we believe that the median costs for blood and blood products from the CY 2006 claims data reflect this improved reporting of charges and units for these products, particularly with

regard to the most commonly furnished blood and blood products, such as leukocyte-reduced red blood cells. We do not believe it is necessary or appropriate to incorporate external data such as the AABB survey into our ratesetting process for blood and blood products because in a relative weight system, it is the relativity of costs to one another, rather than absolute cost, that is most important. External data lack relativity to the estimated costs derived from the claims and cost report data and generally are not appropriate for determining relative weights that result in payment rates.

Comment: One commenter noted that charges billed under revenue code 0391 are mapped to the blood bank cost center under cost reporting rules and in the revenue code to cost center crosswalk that we use to reduce charges to estimated costs. According to the commenter, blood transfusion or blood administration services billed under this revenue code represent charges for nursing costs to administer the blood products, rather than blood bank costs for the products themselves. The commenter stated that the CCR used by CMS to calculate median unit costs for blood is lowered as a result of revenue code 0391 mapping to the blood bank cost center, because charges associated with blood administration are included in the divisor for the blood bank CCR. Accordingly, the commenter requested that CMS not map charges billed under 0391 to the blood bank cost center.

Response: Revenue code 0391 maps to cost report center 4700, Blood Storing, Processing, and Transfusing. Because this cost center includes transfusion services in its title, it is appropriate for hospitals to report charges under revenue code 0391 for nursing costs to administer blood products, as well as for blood storage and processing, and for revenue code 0391 to map to this cost center. We do not agree that we should change our revenue code to cost center crosswalk.

After consideration of the public comments received on this proposal, we are finalizing, without modification, our proposal to establish 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. We continue to believe that using blood-specific CCRs applied to hospital claims data will result in payments that more fully reflect hospitals' true costs of providing blood and blood products than our general methodology of defaulting to the overall hospital CCR when more specific CCRs are unavailable.

Table 45 below reflects the final median unit costs developed using the methodology described above and compares the difference between the CY 2008 simulated CCR median unit costs and the CY 2007 adjusted simulated CCR median unit costs. Of the 34 blood products, median costs per unit (calculated using the simulated blood-specific CCR methodology) for CY 2008 rise for 19 of them compared to their CY 2007 adjusted simulated median unit costs. These 19 products account for about 77 percent of all units of blood and blood products furnished to Medicare beneficiaries in the HOPD as reflected in our CY 2006 claims data. The median costs decline for 15 products, which constitute approximately 23 percent of all units of blood and blood products furnished to Medicare beneficiaries in the HOPD in CY 2006. Unlike in previous years, none of the high-volume products experience decreases of more than 25 percent. While it is true that more blood and blood products experienced a decline compared to CY 2007 adjusted simulated median costs using final rule data compared with proposed rule data, these changes are relatively minor and consistent with normal fluctuations due to CCR changes and inclusion of claims from additional providers that are commonly observed for OPPS services when additional data are considered for the final rule.

As has been the case in the past, the low-volume products (which we have historically defined as fewer than 1,000 units per year) show the most volatility, with medians increasing as much as 84 percent compared to CY 2007 adjusted simulated median costs. Overall, of the 11 low-volume products, 7 products show increases in their median unit costs compared to their CY 2007 adjusted simulated median unit costs, and 4 products show decreases in their median unit costs compared to their CY 2007 adjusted simulated median unit costs. The 4 low-volume products for which the median costs decline compared to their CY 2007 adjusted simulated median unit costs represent only 0.18 percent of the total units of blood products furnished in the CY 2006 OPPS claims data.

In summary, we are setting the final payment rates for blood and blood products for CY 2008 based on the unadjusted medians for blood and blood products (calculated using the simulated blood-specific CCR methodology) that are derived from CY 2006 claims data as we have described. 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 when charging for those products under the OPPS. Unlike in previous years, we do not believe it is necessary to provide a transitional payment adjustment. Under this final policy, we expect that payments would increase for approximately 77 percent of blood and blood product units if patterns of furnishing blood products in CY 2008 remain similar to those in CY 2006.

TABLE 45.—CY 2008 MEDIAN COSTS FOR BLOOD AND BLOOD PRODUCTS

HCPCS code*	Short descriptor	CY 2008 units	CY 2007 Payment median: Higher of CY 2007 simulated CCR median unit cost or 75% of CY 2006 adjusted median unit cost	CY 2008 simulated CCR median unit cost
P9010	Whole blood for transfusion	2,687	$131	$252
P9011	Blood split unit	330	136	147
P9012	Cryoprecipitate each unit	5,811	48	41

TABLE 45.—CY 2008 MEDIAN COSTS FOR BLOOD AND BLOOD PRODUCTS—Continued

HCPCS code*	Short descriptor	CY 2008 units	CY 2007 Payment median: Higher of CY 2007 simulated CCR median unit cost or 75% of CY 2006 adjusted median unit cost	CY 2008 simulated CCR median unit cost
P9016	RBC leukocytes reduced	624,120	175	183
P9017	Plasma 1 donor frz w/in 8 hr	47,159	70	66
P9019	Platelets, each unit	21,160	59	69
P9020*	Plaelet rich plasma unit	791	208	359
P9021	Red blood cells unit	155,886	129	128
P9022	Washed red blood cells unit	2,473	210	274
P9023*	Frozen plasma, pooled, sd	376	57	73
P9031	Platelets leukocytes reduced	18,608	95	106
P9032	Platelets, irradiated	10,940	129	120
P9033	Platelets leukoreduced irrad	4,970	125	138
P9034	Platelets, pheresis	9,858	450	436
P9035	Platelet pheres leukoreduced	51,624	486	493
P9036	Platelet pheresis irradiated	1,437	416	413
P9037	Plate pheres leukoredu irrad	26,026	614	622
P9038	RBC irradiated	6,091	196	193
P9039	RBC deglycerolized	908	356	343
P9040	RBC leukoreduced irradiated	79,642	216	237
P9043*	Plasma protein fract, 5%, 50ml	24	51	93
P9044	Cryoprecipitate reduced plasma	5,437	82	83
P9048*	Plasmaprotein fract, 5%, 250ml	624	237	213
P9050*	Granulocytes, pheresis unit	13	746	1,371
P9051*	Blood, l/r, cmv-neg	3,831	156	146
P9052	Platelets, hla-m, l/r, unit	1,723	668	638
P9053	Plt, pher, l/r cmv-neg, irr	1,627	701	678
P9054	Blood, l/r, froz/degly/wash	668	210	216
P9055*	Plt, aph/pher, l/r, cmv-neg	922	395	483
P9056	Blood, l/r, irradiated	3,986	143	145
P9057	RBC, frz/deg/wsh, l/r, irrad	156	493	369
P9058	RBC, l/r, cmv-neg, irrad	3,552	261	260
P9059	Plasma, frz between 8–24hour	3,480	74	77
P9060	Fr frz plasma donor retested	319	74	52

* Indicates CY 2007 payment at 75 percent of CY 2006 adjusted median cost.

XI. OPPS Payment for Observation Services

A. Observation Services (HCPCS code G0378)

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 to 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 approximately $51. 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 recommendation was that CMS consider adding syncope and dehydration to the list of 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 the subcommittee's work.

In response to the August 2006 APC Panel recommendations and public comments on the CY 2007 OPPS/ASC 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 included specific minor or routine procedures that have ''T'' status indicators (71 FR 68150).

At the March 2007 APC Panel meeting, 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 were less complete than the claims data available for the 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 cost for APC 0339 slightly to $443, based on 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 were 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. However, the Panel requested that, if CMS added syncope and dehydration to the list of conditions eligible for separate observation payment, 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. 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.

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 be made for all conditions for which observation is indicated.

In the CY 2008 OPPS/ASC proposed rule, we indicated that, in light of the broader CY 2008 OPPS proposal to move toward expanded packaging of payment for supportive, dependent HOPD services, we were 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. Instead, we proposed to package all observation services (reported with HCPCS code G0378) as part of the proposed changes to packaged services discussed in section II.A.4. of the proposed rule. Because we proposed to package payment for all observation services, we did not propose 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 agreed 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 recognized 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 stated that we believe that the 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. We stated in the proposed rule that the 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.c. of the CY 2008 OPPS/ASC proposed rule (and discussed in the same section of this final rule with comment period), observation care is one of seven categories of services for which we proposed to make packaged payment in CY 2008. In view of the recent rapid growth in HOPD services, we proposed 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.

We proposed to package observation care reported with HCPCS code G0378 for CY 2008 because of our belief that the facility portion of observation care is supportive and ancillary to other primary services being furnished in the HOPD. Payment for observation would be made as part of the payment for the separately payable independent services with which it is billed. We indicated in the CY 2008 OPPS/ASC proposed rule that, 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 indicated that 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 proposed 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 to 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.

At the September 2007 APC Panel meeting, the Observation and Visit Subcommittee and the full Panel recommended that the work of the subcommittee continue. After two presentations and robust discussion of the proposal to package observation services, the Panel made two additional recommendations. First, the Panel recommended that CMS not finalize the proposal to implement observation services packaging for CY 2008, stating that it would be detrimental for patients receiving medically necessary services and would increase costs. The Panel also requested that CMS provide specific data on observation in order to understand trends and utilization for review at the 2008 winter meeting of the Panel. This includes data related to inappropriate reporting or overutilization of observation services; frequency and utilization data for the three conditions for which observation services are now separately payable; association of observation services with emergency department and clinic visits; analysis of the frequency of claims for

observation services compared with the inpatient error rate; and a frequency distribution showing length of stay data for observation services.

Second, the Panel recommended that, if CMS finalizes the packaging of observation services, CMS should create a composite emergency department/clinic and observation APC (or a group of composite APCs) that is only paid when both services are provided. The Panel added that, if the composite APC is paid, neither the clinic nor emergency department visit would be paid separately. Also, coding and service requirements currently applicable to separately payable observation would remain the same, with the exception that there would be no clinical condition restriction on payment for the composite APC and payment rates for this composite APC would need to be adjusted based on readily available historical data. Finally, the Panel recommended that CMS evaluate any potential negative impact that the CY 2008 packaging proposal and the component specifically concerning observation would have on Medicare beneficiaries. We accept the Panel's request that CMS provide the Panel with further data related to observation services at the next meeting of the APC Panel.

After considering the APC Panel presentations, the Panel recommendations, and the public comments we received, we will neither maintain the current CY 2007 payment methodology for observation services nor implement the packaging proposal as proposed. Instead, we are accepting the recommendation of the APC Panel and the commenters to package observation services and provide payment through a composite APC methodology when the specified criteria apply, as discussed in detail in section II.A.4.c.(7) of this final rule with comment period. We note that this payment methodology will require no changes to the reporting practices of hospitals, so there should be no associated administrative burden on hospitals. The OCE will determine the payment for observation as packaged into a composite APC payment or packaged into payment for other separately payable services provided in the encounter.

As discussed earlier in section II.A.4.c.(7) of this final rule with comment period, HCPCS code G0378 is assigned a status indicator ''N,'' meaning that its payment will always be packaged, either into one of the two composite APCs or, when the composite criteria are not met, into the payment for the major services on the claim. In addition, we no longer require a qualifying diagnosis but, for the purposes of composite APC payment, will retain all other criteria required in CY 2007 for separate observation care payment, including: a minimum number of 8 hours; a qualifying visit, direct admission to observation care, or critical care; and no ''T'' status procedure reported on the day before or day of observation services. Additionally, we are retaining the general reporting requirements for all observation services. These are the requirements related to the physician order and evaluation, documentation, and observation beginning and ending times. They are more general criteria 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.

Comment: Many commenters, as well as the APC Panel, urged CMS to consider the inpatient error rate as well as QIO review practices before packaging observation services. Many commenters pointed to a decrease in inpatient admissions as evidence of the impact of separate payment for observation services on the decrease in hospital admissions. In addition, several commenters were concerned about pressure to bill 1 to 2 day stays as outpatient claims with observation, resulting in confusion as to the appropriate billing for observation services. For example, one commenter stated that care provided during outpatient observation is no different than the care and monitoring provided to an inpatient, often because patients in observation may be placed in a bed within the inpatient setting. One commenter requested that CMS review 1 to 2 day inpatient QIO denials for accuracy of observation status utilization and denial appropriateness.

Response: We appreciate the commenters' thoughts regarding the impact of our OPPS payment policy to pay separately for observation care for three clinical conditions on brief inpatient admissions. We continue to believe that observation care is a clinically appropriate hospital outpatient service that includes 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. We expect that Medicare beneficiaries who require an inpatient level of care will be admitted to the hospital as inpatients by the physicians who care for them. We also believe that our final CY 2008 payment policy to pay for extended assessment and management services that involve lengthy observation through composite APCs should pay hospitals appropriately for the services they provide as they are caring for patients until a decision about inpatient admission or safe discharge can be made.

We will work to further educate hospitals, physicians, and all Medicare contractors on appropriate billing for observation services. We also will analyze the effects of our final CY 2008 OPPS payment policy for observation services over time on patterns of Medicare beneficiary inpatient admissions, high level clinic and ED visits, and observation care.

Comment: Several commenters discussed the typical length of observation stays as support for separate payment of observation care. The stays in the comments ranged from 12 to 16 hours (in reference to patients with chest pain) to 23 hours (in reference to patients in dedicated observation units versus 2 to 3 day stays for inpatient care). The topic was also discussed by the APC Panel, which requested that CMS provide a frequency distribution of observation lengths of stay at the next APC Panel meeting.

Response: We have stated in past rules and in the Internet Only Manual (IOM) that, ''in only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. In the majority of cases, the decision whether to discharge the patient from the hospital * * * or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours.'' We refer readers to the Medicare Claims Processing Manual, Pub. 100–4, Chapter 4, Section 290.1 for more information. We will conduct a study of observation lengths of stay for the next APC Panel meeting. However, preliminary analyses of CY 2006 claims for observation show that, of all observation claims (packaged and paid separately), 43 percent lasted 13 to 24 hours (about 358,600 claims), 37 percent lasted 24 to 48 hours (about 303,000 claims), and 3 percent lasted more than 48 hours (about 26,000 claims). Less than 10 percent of claims were for observation lasting less than 8 hours, and about 8 percent of claims were for stays of 8 to 12 hours. With respect to separately payable observation, the numbers were very similar: 45 percent lasted 13 to 24 hours (133,000 claims), 38 percent lasted 24 to 48 hours (112,000 claims), and 3 percent lasted more than 48 hours (8,600 claims). The mean and median number of hours were the same for packaged

and separately payable observation services: a mean of 25 hours and a median of 22 hours.

We are concerned about the significant number of beneficiaries who are receiving observation services for more than 24 hours, especially the 26,000 with stays of more than 48 hours. This finding seems to indicate that the latter stays are not as rare and exceptional as we have stated they should be in the context of contemporary hospital outpatient clinical practice. As we stated earlier in section II.A.4.c.(7) of this final rule with comment period, we do not expect to see an increase in claims for high level visits as a result of the new composite APCs adopted for CY 2008. We also do not expect to see a large increase in the number of claims or lengths of stay for observation care. Depending on our future claims data, we may choose to modify the composite APCs that we are adopting for CY 2008, or to move to packaging observation services more broadly into payment for all other associated services as we originally proposed, if we see that observation care is being provided to many more patients than reflected in our current data. Since we first established HCPCS code G0378 as an hourly code for hospitals to report observation services beginning in CY 2006, in accordance with our reporting instructions, hospitals have been asked to report all observation services provided with HCPCS code G0378.

Comment: Several commenters stated that providing care through outpatient observation versus inpatient admission saves beneficiary inpatient benefit days and decreases beneficiary expenses for the inpatient deductible and coinsurance. The APC Panel also recommended that we evaluate the effect of packaging on beneficiaries.

Response: We intend to evaluate the effects of packaging payment for services, including observation care, on Medicare beneficiaries, but note that it is not clear whether care provided through a hospital outpatient observation stay would increase or decrease a beneficiary's expenditures in comparison with an inpatient admission. In addition, as stated earlier, we do not consider observation services and inpatient care to be the same level of care and, therefore, they would not be interchangeable and appropriate for the same clinical scenario. Under the OPPS, the beneficiary copayment increases as the number and payment amount of separately payable services on the claim increase. The OPPS beneficiary copayment is 20 to 40 percent, depending on the service provided. Therefore, to the extent that the resulting APC payments for a specific set of services are less under the packaging approach we have adopted for CY 2008, as many commenters have indicated they would be, beneficiary copayment could be reduced. Additionally, the length of stay may greatly impact beneficiary OPPS copayment as the number of diagnostic tests and services provided may increase as the stay lengthens. Also, self-administered drugs are excluded from Part B payment by statute, whereas payment for those costs would be included in an inpatient DRG payment. Therefore, a beneficiary placed in observation care for an extended period could have a greater or lesser out-of-pocket expense than for an inpatient stay, once all direct beneficiary expenses are included.

In summary, we are adopting our proposal to package payment for observation care reported with HCPCS code G0378 for CY 2008, with a modification to establish two new composite APCs for extended assessment and management. For CY 2008, payment for observation services reported with HCPCS code G0378 will remain packaged with status indicator ''N.'' We are creating two composite APCs for extended assessment and management, of which observation care is a component. In addition, we will not require a qualifying diagnosis for composite APC payment, but for the purposes of composite APC payment, will retain all other criteria, including a minimum number of eight hours; a qualifying visit, direct admission, or critical care; and no ''T'' status procedure reported on the day before or day of observation services. Additionally, we are retaining the general reporting requirements for all observation services, whether fully packaged or included in the composite APC payment. These are criteria related to the physician order and evaluation, documentation, and observation beginning and ending times. These are the 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.

B. Direct Admission to Observation (HCPCS code G0379)

For CY 2007, 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 was approximately $53. We proposed 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 proposed that in order to receive separate payment for a direct admission into observation (APC 0604), 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 proposed to package payment for all observation services reported by HCPCS code G0378, we indicated in the proposed rule that we believe it is necessary to continue the OCE claims processing logic in order to make appropriate payment for direct admission.

We did not receive any public comments specific to our proposed payment policy for HCPCS code G0379.

As explained in section II.A.4.c.(7) of this final rule with comment period, payment for direct admission to observation will be made either under composite APC 8002 (Level I Prolonged Assessment and Management Composite) or under APC 0604. The composite APC will apply, regardless of the patient's particular clinical condition, if the hours of observation services (HCPCS code G0378) are greater than or equal to eight and billed on the same date as HCPCS code G0378 and there is not a ''T'' status procedure on the same date or day before the date of HCPCS code G0378. If the composite is not applicable, payment for HCPCS code G0379 may be made under APC 0604. In general, this would occur when the units of observation reported under HCPCS code G0378 are less than eight and 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. The final median cost of APC 0604 for CY 2008 is approximately $53. The criteria for payment of HCPCS code G0379 under

APC 0604 will be the same as in CY 2007:

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. No service with a status indicator of ''T'' or ''V'' or Critical Care (APC 0617) is provided on the same day of service as HCPCS code G0379.

If either of the above criteria is not met, HCPCS code G0379 will be assigned status indicator ''N.''

Comment: One commenter asked CMS to clarify whether there is a discrepancy between language describing observation time in the current CY 2007 criteria for separate payment of observation services through APC 0339, listed on page 42768 of the CY 2008 OPPS/ASC proposed rule (72 FR 42628) and language in the Medicare Claims Processing Manual, Pub. 100–4, Chapter 4, Section 290.2.2. The commenter requested clarification as to whether a physician order is still required for observation.

Response: The language cited in the CY 2008 OPPS/ASC proposed rule and earlier in this section is also located in the Medicare Claims Processing Manual, Pub. 100–4, Chapter 4, section 290.4.3 ''Separate and Packaged Payment for Observation.'' Sections 290.2.2 and 290.4.3 do not conflict, although the language is not identical. Section 290.2.2 is overarching guidance for the reporting of observation services that supports and explains section 290.4.3. In regard to the requirement of a physician order, although the words ''physician order'' are not written in section 290.4.3, a physician order is clearly contemplated, as the language in criterion number 4, Physician Evaluation, states, ''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.'' This criterion will be retained under the new payment methodology, as we proposed. Additionally, section 290.1 ''Observation Services Overview'' explicitly states that ''Observation services are only covered when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient services.'' We are not removing the physician order requirement. The IOM will be revised to reflect the payment changes finalized in this final rule with comment period. We will revise all sections for consistency and accuracy, but we also remind hospitals that Section 290 of the Claims Processing Manual should be read in its totality.

In summary, CY 2008 payment for HCPCS code G0379, direct admission for hospital observation care, will be made either through composite APC 8002 (Level I Extended Assessment and Management Composite) or APC 0604 (Level 1 Hospital Clinic Visits). In cases where the criteria for payment under either APC are not met, HCPCS code G0379 is assigned status indicator ''N.''

XII. Procedures That Will Be Paid Only as Inpatient Procedures

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 may use any of 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 has been 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. 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 the CY 2008 OPPS/ASC 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, in the CY 2008 OPPS/ASC proposed rule (72 FR 42771), we proposed 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 of the proposed rule and republished in this final rule with comment period as Table 46. In the proposed rule, we indicated that we also are accepting the recommendation from the APC Panel to gather additional utilization information for CPT codes 20660 and 64818, which we would provide to the APC Panel at its next meeting.

We received several comments in response to our proposal for the CY 2008 OPPS inpatient list. A summary of the comments and our responses follows.

Comment: A few commenters supported the proposal to remove the 13 codes listed in Table 56 of the proposed rule from the inpatient list for CY 2008. One commenter requested that, for CY 2009, CMS reassess the APC assignment for CPT code 61770 (Stereotactic localization, including burr hole(s), with insertion of catheter(s) or probe(s) for placement of radiation source). The commenter supported the proposed CY 2008 assignment of CPT code 61770 to APC 0221 (Level II Nerve Procedures) but asked CMS to ensure that, as data become available, CMS makes appropriate adjustments to the APC assignment for this CPT code.

Response: We appreciate the commenters' support and will review the APC assignment for CPT code 61770, and all other procedures payable under the OPPS, when updating the OPPS for CY 2009, in order to maintain clinical and resource homogeneity within APCs.

After consideration of the public comments received, we are finalizing our proposal, without modification, to remove 13 procedures from the OPPS inpatient list for CY 2008 and to assign them to clinically appropriate APCs as shown in Table 46 below. Also, as stated earlier, we will present data regarding CPT codes 20660 and 64818 to the APC Panel at its winter 2008 meeting. We note that we did not have additional new data available for CPT code 20660 for the APC Panel to consider at its September 2007 meeting.

TABLE 46.—HCPCS CODES FOR REMOVAL FROM INPATIENT LIST AND THEIR APC ASSIGNMENTS FOR CY 2008

HCPCS code	Long descriptor	CY 2008 APC	CY 2008 SI
21360	Open treatment of depressed malar fracture, including zygomatic arch and malar tripod	0254	T
21365	Open treatment of complicated (e.g., 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

Comment: Several commenters submitted recommendations for improving the effectiveness of the inpatient list. One commenter stated that although CMS believes that the inpatient list is serving a protective purpose, the payment policy and the format for the list limit its effectiveness. The commenter recommended a number of steps that CMS could take to improve the usefulness of the inpatient list. The first of these recommendations was for CMS to provide the CPT code long descriptors for the procedures on the inpatient list instead of listing the procedures' CPT code short descriptors. The commenter stated that the short descriptors do not provide enough information for hospital staff and physicians to readily determine in a specific clinical case whether a planned procedure is, or is not, on the inpatient list. The commenter believed that inclusion of the long descriptors would make the CMS inpatient list a more useful and readily available tool that could be used during outpatient scheduling. Further, the commenter believed that easier access to the long descriptors would assist hospital staff in scheduling, promote appropriate physician planning, and provide time to notify any affected beneficiary of his or her liability if an inpatient list procedure is to be performed in the OPD.

In addition, the commenter recommended that CMS consider developing a code that would enable hospitals to indicate to Medicare those cases in which the physician failed, or refused, to notify the patient that the procedure was on the inpatient list and would not be paid by Medicare if performed in the hospital outpatient setting. The commenter suggested that the physician could then be held accountable for those cases, and Medicare could track physicians who repeatedly chose inappropriate admission status for procedures on the inpatient list. Further, the commenter recommended that CMS implement financial disincentives for physicians' performance of the inpatient list procedures in the HOPD through proposed professional payment reductions and/or practice audits of physicians who repeatedly perform these procedures in inappropriate settings.

The commenter also recommended that CMS consider expanding the ability

of hospital staff and utilization review committees to overturn outpatient status orders when procedures on the inpatient list are performed, but the services are either not reported timely by the attending physician or are not revised upon notification of the status conflict.

Finally, the commenter recommended that if CMS is not willing to refocus the payment policy associated with the inpatient list to address physician behavior, it should drop the inpatient list altogether because the list presents a financial burden that beneficiaries and hospitals are no longer willing to bear on behalf of noncompliant and noncooperative physicians.

A number of other commenters also recommended that CMS discontinue use of the inpatient list. They stated that the continuing problem associated with the list is that the list is not binding on physicians and that, therefore, efforts by hospitals to educate them are useless.

Response: We appreciate the recommendations for improving the effectiveness of the inpatient list. We continue to believe that the inpatient list serves an important purpose in identifying those procedures that cannot be safely and effectively provided to Medicare beneficiaries in the HOPD. We are concerned that elimination of the inpatient list could result in unsafe or uncomfortable care for Medicare beneficiaries and, therefore, we will not discontinue our use of the inpatient list at this time. While we are aware that there are ongoing hospital concerns related to inpatient procedures being performed inappropriately for beneficiaries who are not inpatients and that, as a result, beneficiaries may be liable for the charges for the services, among the potential results of eliminating the list are long observation stays after some procedures and imposition of OPPS copayments that could differ significantly from a beneficiary's inpatient cost-sharing responsibilities.

In addition, we have no current plans to develop coding that would permit us to identify cases of the outpatient performance of inpatient listed procedures on Medicare beneficiaries because information on such occurrences is currently available in our OPPS claims data. Payment for physicians' services and monitoring of physicians' practice patterns are outside of the scope of this OPPS/ASC final rule with comment period. We continue to believe that it is very important for hospitals to educate physicians on Medicare services covered under the OPPS to avoid inadvertently providing services in a hospital outpatient setting that only are covered during an inpatient stay.

We will explore the feasibility of the commenter's recommendation that CMS could assist hospitals in this effort by providing the CPT code long descriptors for the inpatient list (Addendum E to this final rule with comment period). CMS' use of CPT code short and long descriptors is governed by its agreement with the AMA, the owner and maintainer of the CPT codeset. If we are able to provide a listing of long descriptors for the inpatient list procedures, we will post that information to the CMS Web site as soon as it is available. We believe that enhanced information regarding specific procedures may foster increased understanding by physicians about the status of the inpatient list procedures and the payment implications for beneficiaries and hospitals when the procedures are performed on beneficiaries who are not admitted to the hospital.

Comment: Several commenters recommended that if CMS does not eliminate the inpatient list, it should consider developing an appeals process to address those circumstances in which payment for a service is denied because it is on the inpatient list. One commenter asserted that the process would provide an opportunity for the hospital to submit documentation to appeal the denial, such as physician intent, patient clinical condition, and the circumstances that allowed the patient to be sent home safely without an inpatient admission.

Response: We appreciate these comments and suggestions. As we stated in the immediately preceding response, we continue to believe that the inpatient list is a valuable tool that is appropriate for the OPPS, and we will not eliminate it at this time. We intend to continue to encourage physicians' awareness of the implications for beneficiaries of performing the inpatient list procedures on beneficiaries who are not inpatients. We do not plan to adopt a specific appeals process for claims related to inpatient list procedures performed in the HOPD, as recommended by some commenters, at this time. However, the existing established processes for a beneficiary or provider to appeal a specific claim remain in effect.

Comment: Two commenters requested that CMS remove certain procedures from the inpatient list. One commenter requested that CMS remove the following three CPT codes that were proposed for removal from the inpatient list in the CY 2008 proposed rule: 25931 (Transmetacarpal amputation; re-amputation), 27006 (Tenotomy, abductors and/or extensor(s) of hip, open (separate procedure), and 27720 (Repair of nonunion or malunion, tibia; without graft, (eg, compression technique)).

The other commenter requested that CMS remove the following four additional CPT codes from the inpatient list: 20660 (Application of cranial tongs, caliper, or stereotactic frame, including removal), 27886 (Amputation, leg, through tibia and fibula; reamputation), 43420 (Closure of esophagostomy or fistula; cervical approach) and 50727 (Revision of urinary-cutaneous anastomosis (any type urostomy)).

Response: As discussed earlier in this section, we are finalizing our proposal to remove CPT codes 25931, 27006, and 27720 from the OPPS inpatient list for CY 2008.

We appreciate the additional recommendations for procedures to be removed from the inpatient list. We note that CPT code 20660 was discussed at the APC Panel's March 2007 meeting and, in accordance with the APC Panel's recommendation, we will provide utilization information regarding this service at the APC Panel's winter 2008 meeting for its consideration. We will undertake a clinical review of the additional procedures requested for removal from the inpatient list for CY 2008. However, we will not remove those procedures from the inpatient list without obtaining additional input from the APC Panel. We will provide appropriate information on CPT codes 27886, 43420, and 50727 to the APC for its review of these procedures at the APC Panel's winter 2008 meeting, along with other procedures that we may identify as candidates for proposed removal from the inpatient list for CY 2009.

XIII. Nonrecurring Technical and Policy Changes

A. Outpatient Hospital Services and Supplies Incident to a Physician Service

In the CY 2008 OPPS/ASC proposed rule (72 FR 42771), we proposed 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 proposed 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). The 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.

In the proposed rule, we also reminded 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.

As discussed in the CY 2008 OPPS/ASC proposed rule, 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 the potential for ASCs to provide ''incident to'' services under arrangements with HOPDs, in the proposed rule, we noted 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.'' In the proposed rule, we indicated that we did 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 section 1861(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.

Comment: One commenter generally supported the proposed technical change to § 410.27(a)(1)(iii) and (f), but cautioned CMS against precluding a hospital's ability to offer the best patient care by limiting physician and hospital relationships.

Response: We appreciate the commenter's support for the proposed technical change. We do support hospitals' efforts to develop business models that lead to the provision of high quality patient care to the extent that these models comply with all applicable laws and regulations, including, but not limited to, the Stark law and other anti-kickback laws.

After consideration of the public comment received, we are finalizing our CY 2008 proposal, without modification, to remove from both paragraphs (a)(1)(iii) and (f) of § 410.27 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.'' In place of the deleted phrase, we are inserting the phrase ''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.'' This finalized technical change removes an outdated reference to ''designation of a department of a provider'' by CMS and replaces it with language that conforms to current policy under the provider-based rules specified in § 413.65 of the regulations.

B. Interrupted Procedures

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.

In the CY 2008 OPPS/ASC proposed rule (72 FR 42772), we proposed to amend § 419.44 (Payment reductions for surgical procedures) to more accurately reflect the current OPPS payment policy for interrupted procedures. First, we proposed 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 proposed to change the

heading of § 419.44(b) from ''Terminated procedures'' to ''Interrupted procedures.'' We proposed 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 proposed 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.

Comment: One comment supported our proposed changes to § 419.44.

Response: We appreciate the commenter's support of our proposed changes.

After consideration of the public comment received, we are finalizing the proposed changes to § 419.44, as described above, without modification.

C. Transitional Adjustments—Hold Harmless Provisions

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. In the CY 2008 OPPS/ASC proposed rule (72 FR 42772), we proposed 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).

We did not receive any public comments on our proposal. Therefore, we are finalizing the proposed technical correction, without modification, for CY 2008.

D. Reporting of Wound Care Services

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 (e.g., 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 (e.g., 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 (e.g., 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 (e.g., 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 (e.g., 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 directs 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.

In the CY 2008 OPPS/ASC proposed rule (72 FR 42772), we proposed 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 proposed 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 proposed 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, we proposed 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 certified therapy plan of care.

We received several comments on our proposal to modify the list of therapy revenue codes that are reported with certain wound care services to signify that those services were provided by a qualified therapist under a certified therapy plan of care.

Comment: Several commenters supported the proposal to modify the revenue code list to conform to hospital billing practices. One commenter opposed the proposal; the commenter stated that changing CPT codes 97597, 97598, 97602, 97605, and 97606 to ''always therapy'' codes and revising the list of revenue codes that may be reported with these wound care codes would unreasonably restrict the use of the codes to a limited group of health care providers, thereby limiting beneficiaries' access to care.

Response: We appreciate the commenters' support for our proposal. We believe the commenter who expressed concern about the proposal has misunderstood our explanation of the proposal. We did not propose to change the five CPT codes for wound care from ''sometimes therapy'' to ''always therapy'' codes. Hospitals will be paid for these wound care codes under either the OPPS or the MPFS in CY 2008, just as they have been since CY 2006. When hospital outpatients receive wound care services by individuals outside of a certified therapy plan of care, the hospital reports the appropriate CPT code and nontherapy revenue code and is paid under the OPPS. When these services are provided to hospital outpatients by a qualified therapist under a therapy plan of care and reported using either one of the appropriate therapy modifiers, the therapy revenue code series (42X, 43X, or 44X), or both, hospitals are paid based on the MPFS. We proposed to make this minor conforming change to make our billing policy consistent with the current billing practices of hospitals. Therefore, we do not expect the change to affect Medicare beneficiaries' access to wound care services provided by hospitals.

After consideration of the public comments received, we are finalizing our CY 2008 proposal, without modification, to pay for certain wound care services as therapy services when they are reported with any revenue code in the 42X, 43X, or 44X series.

E. Reporting of Cardiac Rehabilitation Services

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 status indicator ''S'' and are currently mapped to APC 0095 (Cardiac Rehabilitation) for payment.

In the CY 2008 OPPS/ASC proposed rule (72 FR 42773), for CY 2008, we proposed to discontinue recognizing the current CPT codes for cardiac rehabilitation services and to establish two new Level II HCPCS codes that we believed would be more appropriate for specifically reporting cardiac rehabilitation services under the OPPS. The proposed HCPCS codes were: 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 indicated that we believed 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 proposed to assign these new HCPCS codes to APC 0095 for CY 2008, with a status indicator of ''S.'' Accordingly, we proposed 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 would be recognized for payment under the OPPS.

At the September 2007 meeting of the APC Panel, after a public presentation pertaining to the proposed coding change, the Panel recommended that CMS continue to use the existing CPT codes for cardiac rehabilitation services (CPT codes 93797 and 93798) and not replace them with the proposed per hour HCPCS G-codes, GXXX1 and GXXX2.

We received many public comments on our CY 2008 proposal to adopt two new G-codes, rather than continue to use the two available CPT codes, for the reporting of cardiac rehabilitation services under the OPPS. A summary of the public comments and our responses follow.

Comment: Some commenters supported the proposal to use G-codes for the reporting of cardiac rehabilitation services under the CY 2008 OPPS. They believed that this proposed coding change would allow for more appropriate coding and payment for cardiac rehabilitation services in those cases where intensive programs provide multiple sessions each day. The commenters argued that appropriate payment for these programs was particularly important because of their success in improving the health and health outcomes of patients through secondary prevention. In addition, the commenters requested that CMS explicitly state that multiple sessions of cardiac rehabilitation can be paid for the same date of service when modifier 59 is reported. They also requested that CMS crosswalk the payments for both of the proposed G-codes to the higher cost CPT code 93798 to ensure that the full range of modalities provided in certain intensive cardiac rehabilitation programs are available.

Many commenters opposed the proposed change to G-codes under the OPPS for several reasons. First, they stated that the proposed change would pose an administrative burden on hospitals, which would have to report G-codes on Medicare claims and CPT codes on claims to all other payers. Although the commenters asserted that most cardiac rehabilitation sessions last for approximately 1 hour, they explained that it would be difficult to accurately crosswalk codes reported for each hour of service to codes reported for each session, in order to ensure that Medicare and other payers were charged the same for like services. Second, some commenters argued that CMS would gather no new useful data with the reporting of ''per hour'' codes because over 90 percent of cardiac rehabilitation programs provide sessions lasting about 1 hour (specifically 45 minutes to 1½ hours), and costs from historical hospital claims data and payment rates for the ''per session'' CPT codes have been stable for years. A few commenters also stated that this proposal conflicts with the National Coverage Determination (NCD) for cardiac rehabilitation, which describes cardiac rehabilitation coverage in terms of sessions. They also stated that the proposal does not comport with CMS' CY 2008 proposed packaging approach and CMS' stated goal of using CPT codes and CPT coding guidelines.

Almost all of the commenters, both supporting and opposing the proposal,

were concerned that the use of the term ''physician services'' in the G-code descriptors could be misinterpreted by Medicare contractors as requiring a physician to directly deliver the care or be in attendance during each service episode.

Some commenters who recommended the adoption of the proposed G-codes requested that CMS provide additional guidance related to reporting of the cardiac rehabilitation G-codes, such as: (1) Explaining that it is likely to be reasonable and necessary to cover 72 cardiac rehab sessions when multiple sessions are provided in one day; (2) encouraging contractors to factor the ''proven results'' of a program into coverage decisions and that 72 sessions should be ''presumptively covered'' when they are furnished by a certain intensive cardiac rehabilitation program; and (3) providing further clarification and expansion of nutritional counseling by registered dieticians, indicating that they could independently bill for nutritional counseling within cardiac rehabilitation programs using the medical nutrition therapy codes because the NCD does not specifically mention these services.

Response: We understand hospitals' concerns related to the administrative burden associated with reporting cardiac rehabilitation services for Medicare differently from other payers and related to the potential reporting confusion that could be caused by moving to G-codes for the many hospitals whose program sessions last about 1 hour per day. However, we also are aware of several intensive cardiac rehabilitation programs that provide multiple sessions in a day, lasting several hours total. Current OPPS payment policy would provide payment for only one session per day for cardiac rehabilitation. The NCD for cardiac rehabilitation currently states that cardiac rehabilitation programs are covered for certain categories of patients and they must be comprehensive. To be comprehensive, the programs must include a medical evaluation, a program to modify cardiac risk factors (for example, nutritional counseling), prescribed exercise, education, and counseling. The NCD does not distinguish between different approaches to the delivery of cardiac rehabilitation services, whether the more common practice of two sessions per week or the more intensive programs of several sessions per day. We have not been prescriptive regarding the precise amount of time that must be spent on each component of the program to allow for flexibility and tailoring based on patient needs. Regarding intensity, we expect the intensity of cardiac rehabilitation programs to vary by patient and by program.

We believe that it is important that our CY 2008 OPPS payment policy provide appropriate payment for cardiac rehabilitation services. In order to minimize the administrative burden on hospitals related to our proposal but permit accurate reporting and payment for cardiac rehabilitation programs that provide more than one session per day, we believe that continuing the use of CPT codes 93797 and 93798 and allowing hospitals to bill more than one session per day under some circumstances would be the most appropriate course. Therefore, for CY 2008, we will allow hospitals to report more than one unit for a date of service if more than one cardiac rehabilitation session lasting at least 1 hour each is provided on the same day. We will provide a separate APC payment for each reported session.

We note that the concern of some commenters regarding crosswalking of payment for the two proposed ''per hour'' G-codes to CPT code 93798 is not an issue under the OPPS because we will be continuing to use both CPT codes that map to the same clinical APC for payment in CY 2008. With respect to the commenters' concerns about the use of the term ''physician services'' in the proposed G-code descriptors, we note that these codes were proposed to be parallel to the descriptors of the CPT codes for cardiac rehabilitation sessions that contain the term ''physician services'' in their descriptors. We are not aware that hospitals have problems with Medicare contractors' interpretation of the CPT codes, which we will continue to use for CY 2008.

This approach adopts the recommendation of the APC Panel and many commenters, as well as addresses some commenters' concerns about payment for appropriate cardiac rehabilitation services. We expect that most cardiac rehabilitation programs will continue to provide approximately 1 hour long session per date of service. We will monitor the trends in our claims data to ensure that reporting of cardiac rehabilitation remains consistent with expected patterns of utilization. We will provide coding and payment instructions for cardiac rehabilitation services in the program instructions implementing the January 2008 OPPS update. We will not provide the additional coverage-related guidance requested by some commenters, such as presumptive coverage and independent billing for registered dieticians. These recommendations effectively request changes to the NCD and, therefore, are outside of the scope of the OPPS and this final rule with comment period.

After consideration of the public comments received, we are not finalizing our proposal to establish two new G-codes for reporting cardiac rehabilitation services. Instead, we will continue to use CPT codes 93797 and 93798 to report cardiac rehabilitation services under the CY 2008 OPPS. CPT codes 93797 and 93798 are assigned to APC 0095 (Cardiac Rehabilitation), with a CY 2008 median cost of approximately $36 and status indicator ''S.'' Beginning in CY 2008, we will allow hospitals to report more than one unit of service per day if more than one cardiac rehabilitation session lasting at least 1 hour each is provided on the same day, but will monitor the claims data to ensure that utilization of cardiac rehabilitation services remains appropriate.

F. Reporting of Bone Marrow and Stem Cell Processing Services

The OPPS has historically recognized 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.''

In the CY 2008 OPPS/ASC proposed rule (72 FR 42774), we proposed to discontinue recognizing HCPCS code G0267, assign it status indicator ''B,'' and recognize the six more specific CPT codes, which we proposed to assign to APC 0110 with a status indicator of ''S.'' We also proposed to continue to assign the historical claims data for HCPCS code G0267 to APC 0110. 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 stated that we believe that, by recognizing the six CPT codes for bone marrow and stem cell processing services, we would obtain more specific claims data for ratesetting that would enable us to pay more appropriately for these services in the future. Consistent with our general OPPS practice, we proposed 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, in the CY 2008 OPPS/ASC proposed rule (72 FR 42774), we proposed to discontinue recognition of HCPCS code G0265 (Cryopreservation, freezing and storage of cells for therapeutic use) and G0266 (Thawing and expansion of frozen cells for therapeutic use), currently assigned status indicator ''A'' under the OPPS and paid according to the Medicare Clinical Laboratory Fee Schedule (CLFS), by assigning them status indicator ''B'' for CY 2008. We proposed 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. We believed these services were similar to blood processing services that are currently paid under the OPPS. We proposed to assign CPT codes 38207 through 38209 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 to be paid under the OPPS. Although HCPCS codes 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 were proposed for assignment to APC 0344 under the CY 2008 OPPS. We indicated in the CY 2008 OPPS/ASC proposed rule that 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.

At the September 2007 meeting of the APC Panel, following a public presentation regarding these bone marrow and stem cell processing services, the APC Panel recommended that CMS reevaluate its decision to place CPT codes 38210, 38211, 38212, 38213, 38214 and 38215 in APC 0110 and also to reevaluate its decision to place CPT codes 38207, 38208, and 38209 in APC 0344.

We received several public comments on our proposal to recognize the nine CPT codes for bone marrow and stem cell processing services under the CY 2008, as well on their proposed APC assignments. A summary of the comments and our response follows.

Comment: Commenters universally supported the proposal to discontinue using HCPCS codes G0265, G0266, and G0267) and to recognize the nine existing CPT codes for bone marrow and stem cell processing services. Several commenters also urged reconsideration of the proposed APC assignments of the CPT codes. Some commenters objected to the placement of CPT codes 38207 through 38209, for cryopreservation and thawing, in APC 0344 because they believed that the bone marrow and stem cell cryopreservation and thawing services require much greater hospital resources than the preparation of laboratory tissue specimens. Instead, they recommended that CMS place these codes in APC 0111 (Blood Product Exchange) because the proposed payment rate of approximately $777 for that APC would pay an average amount for the services as a whole, paying less than the commenters' estimated costs of freezing and storing the products based upon their survey data from hospital centers that perform bone marrow transplantation services and substantially more than their average estimated cost of thawing the material.

A few commenters also disagreed with the proposed assignments of CPT codes 38210 through 38215 to APC 0110. They argued that the APC is populated mainly by transfusion procedures that do not resemble the bone marrow and stem cell depletion services either from the clinical or hospital resource perspective. The commenters also believed that, of the few single claims for G0267 that were available for ratesetting, most of those claims were for the lower cost depletion services instead of the much more uncommon and costly services reported with CPT codes 38210, for T-cell depletion, and 38211, for tumor cell depletion. Based on external cost data they collected from hospital transplant centers performing specialized bone marrow and stem cell processing services, the commenters presented two options for CPT codes 38210 and 38211: (1) Place them in APC 0112 (Apheresis and Stem Cell procedures); or (2) pay for them based on the hospital's charges adjusted to cost using the hospital's overall CCR, similar to the payment methodology for pass-through devices. The commenters recommended that the remaining CPT codes, 38212 through 38215, be placed in a separate APC as an interim step, using the median cost data for the predecessor HCPCS code G0267 to establish the APC payment rate.

Response: We appreciate the support of commenters and the APC Panel for our proposal to discontinue use of the three G-codes currently used to report bone marrow and stem cell processing services and recognize CPT codes 38207 through 38215 instead. We agree with the commenters that using the most specific CPT codes for reporting these bone marrow and stem cell processing services would reduce the administrative reporting burden for hospitals and provide more specific claims-based costs for future ratesetting. We also accept the APC Panel's recommendations to reconsider our proposed placements of these bone marrow and stem cell processing codes. We have reviewed available claims data in view of the comments, as discussed below.

After reviewing our claims data available for this final rule with comment period, we agree with the commenters that, in order to ensure clinical and resource homogeneity, it would be preferable to group CPT codes 38207 through 38209 for cryopreservation, thawing, and washing procedures with other services that involve the handling of blood products, rather than to APC 0344, where most procedures involve the processing of

tissue specimens for laboratory analysis. However, we disagree with the commenters that APC 0111, with a median cost of approximately $724 for apheresis and autologous progenitor cell harvesting services, is an appropriate assignment. We do not believe that CPT codes 38207 through 38209 are clinically similar to apheresis services. We note that the limited claims data we have for the predecessor codes, specifically HCPCS codes G0265 and G0266, reveal median costs of approximately $118 and $244 based on 23 and 548 single claims, respectively. Even though these services were previously paid in the HOPD through the CLFS, CY 2006 claims data are available for OPPS ratesetting. Instead, we believe that CPT codes 38207 through 38209 should be assigned, along with other procedures involving blood products, to APC 0110 with a status indicator of ''S'' and an APC median cost of approximately $214. This is consistent with the historical hospital costs for the cryopreservation and thawing services as reported under the G-codes.

Additionally, we are assigning CPT codes 38210 through 38215, reported for bone marrow and stem cell depletion services, to APC 0393 with other services that involve red blood cells and plasma. We are renaming APC 0393 ''Hematologic Processing and Studies'' so that the title more accurately describes all the services assigned to the APC. We are maintaining a status indicator of ''S.'' for APC 0393. The median cost of APC 0393 is approximately $358, the same median cost as HCPCS code G0267, the predecessor code recognized under the OPPS. We agree with the commenters that, based on our proposed assignment of the depletion services to APC 0110 according to the data for their predecessor code, while there was no violation of the 2 times rule, HCPCS code G0267 had a high median cost compared to the proposed median cost of approximately $220 for that APC. Our reassignment of CPT codes 38210 through 38215 to APC 0393 will pay appropriately for these CPT codes while we collect more specific data on their individual resource costs.

We do not agree with the commenters that the two specific services for T-cell or tumor depletion, which that they believe are particularly costly, would be appropriately paid through APC 0112, which contains procedures for extracorporeal adsorption of cells during apheresis and reinfusion into the patient. Furthermore, we believe that a cost-based methodology for payment of these procedures would not be consistent with the principles of a prospective payment system that provides prospectively established payment for services. The cost-based payment methodology is statutorily required for payment of pass-through devices. As we stated in the proposed rule, it is consistent with our general practice under the OPPS to make payment 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.

After consideration of the public comments received and the recommendations of the APC Panel, we are finalizing our proposal, without modification, to discontinue use of HCPCS codes G0265, G0266, and G0267 and recognize CPT codes 38207 through 38215 to report bone marrow and stem cell processing services under the OPPS. However, we are not finalizing the APC assignments of these services as proposed. Instead, we are assigning CPT codes 38207, 38208 and 38209 for cryopreserving, thawing and washing bone marrow and stem cells to APC 0110, with a median cost of approximately $214 and a status indicator of ''S.'' In addition, we are assigning CPT codes 38210 through 38215, reported for depletion services of bone marrow and stem cells, to APC 0393, which is renamed ''Hematologic Processing and Studies,'' with a median cost of approximately $358 and a status indicator of ''S.''

G. Reporting of Alcohol and/or Substance Abuse Assessment and Intervention Services

For CY 2008, the CPT Editorial Panel has created two new Category I CPT codes for reporting alcohol and/or substance abuse screening. They are CPT code 99408 (Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes); and CPT code 99409 (Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes).

The code descriptions for these CPT codes suggest that these CPT codes may describe services that include screening services. For Medicare purposes, screening services are typically considered to be provided to beneficiaries in the absence of signs or symptoms of illness or injury; therefore, to the extent that services described by these two CPT codes have a screening element, the screening component would not meet the statutory requirements for coverage under section 1862(a)(1)(A) of the Act. Screening services are not covered by Medicare without specific statutory authority, such as has been provided for mammography, diabetes, and colorectal cancer screening. Accordingly, we will not recognize these CPT codes that incorporate screening for payment under the OPPS.

Therefore, for CY 2008, we have created two parallel G-codes to allow for appropriate Medicare reporting and payment for alcohol and substance abuse assessment and intervention services that are not provided as screening services, but that are performed in the context of the diagnosis or treatment of illness or injury. The codes are HCPCS code G0396 (Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST) and brief intervention, 15 to 30 minutes); and HCPCS code G0397 (Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g,. AUDIT, DAST) and intervention, greater than 30 minutes). We will instruct Medicare contractors to pay for these codes only when considered reasonable and necessary. We will also provide coding and payment instructions for these assessment and intervention services in the program instructions implementing the January 2008 OPPS update.

CPT codes 99408 and 99409 are assigned status indicator ''E'' for CY 2008 on an interim final basis under the OPPS, meaning that they will not be recognized for payment under the OPPS or any other Medicare payment system. HCPCS codes G0396 and G0397 are assigned status indicator ''S.'' They are assigned, on an interim final basis, with other health and behavioral assessment and intervention services to APC 0432 (Health and Behavioral Services). We believe that HCPCS codes G0396 and G0397 share significant clinical and resources characteristics with other services also assigned to APC 0432 for CY 2008, thereby ensuring the clinical and resource homogeneity of the APC. The final CY 2008 median cost of APC 0432 is approximately $20. Because these CPT and Level II HCPCS codes were not available for the CY 2008 OPPS/ASC proposed rule, we have flagged them with comment indicator ''NI'' in Addendum B of this OPPS final rule with comment period to signify that their interim payment status is subject to public comment following publication of the final rule that implements the annual OPPS update.

XIV. OPPS Payment Status and Comment Indicators

A. Payment Status Indicator Definitions

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 final CY 2008 status indicator assignments for APCs and HCPCS codes are shown in Addendum A and Addendum B, respectively, to this final rule with comment period. As we proposed in the CY 2008 OPPS/ASC proposed rule, in this final rule with comment period we are using the status indicators and definitions that are listed in Addendum D1, which we discuss below in greater detail.

1. 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	(1) Paid under OPPS; separate APC payment.
H	Pass-Through Device Categories	Separate cost-based pass-through payment; not subject to co-payment.
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.
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 discussed in section VII.A. of the proposed rule and this final rule with comment period, 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 continued the OPPS cost-based payment for brachytherapy sources through CY 2007, and are using status indicator ''H'' during CY 2007 to designate non-pass-through brachytherapy sources paid on a cost basis.

However, as discussed in detail in section VII.A. of this final rule with comment period, we are implementing prospective payment for brachytherapy sources paid under the OPPS in CY 2008. In accordance with this final policy, as proposed we also are discontinuing our use of payment status indicator ''H'' for APCs assigned to brachytherapy sources. As indicated in section VII.A. of this final rule with comment period, for CY 2008 we are using payment status indicator ''K'' to designate all brachytherapy source APCs that will be paid under the OPPS.

As discussed in detail in section V.B.3.a.(4)(c) of this final rule with comment period, we are implementing prospective payment for therapeutic radiopharmaceuticals separately paid under the OPPS in CY 2008. In accordance with this final policy, as proposed, we also are discontinuing our use of payment status indicator ''H'' for APCs assigned to therapeutic radiopharmaceuticals. Similar to the identification of other non-pass-through drugs and biologicals, for CY 2008, we are using payment status indicator ''K'' to designate all therapeutic radiopharmaceutical APCs that will be paid under the OPPS.

We received several public comments regarding the appropriateness of the status indicator assignments for specific HCPCS codes that are discussed in the sections of this final rule with comment period that are specific to those topics. There were also recommendations about specific payment policies for certain items and services and recommended status indicators that are discussed elsewhere in this final rule with comment period.

Comment: One commenter believed that composite APCs differ significantly from the conditional packaging methodology for special packaged codes, where CMS provides a payment for a service only if there is no other service on the claim for the same date with status indicator ''X,'' ''V,'' ''S,'' or ''T.'' The commenter believed that CMS should assign a status indicator other than ''Q'' to services that may be subject to a composite APC methodology, where the service would be paid through the composite APC payment for two or more services on the same date.

Response: We appreciate the commenter's interest in refining the use of status indicator ''Q'' under the OPPS. However, we are adopting our proposal, without modification, to identify HCPCS codes that are members of composite APCs with status indicator ''Q'' for CY 2008, because we believe the definition of this status indicator appropriately describes the payment policy for these codes as well as special packaged codes, specifically that separate payment is only made if certain criteria are met. As we continue to explore the possibilities of greater packaging and encounter- and episode-based payment under the OPPS, we will consider how to further refine the OPPS status indicators to provide the most relevant information concerning payment of OPPS services.

After considering the public comments received concerning the proposed use of status indicators for services that are paid under the OPPS, we are adopting as final, without

modification, the status indicators for payable OPPS services for CY 2008 as displayed in the table above.

2. 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:	Not paid under OPPS. Paid by fiscal intermediaries/MACs under a fee schedule or payment system other than OPPS.
	• Ambulance Services.	
	• Clinical Diagnostic Laboratory Services	Not subject to deductible or coinsurance.
	• 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 subject to deductible.
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/MAC	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.

We did not receive any public comments regarding the status indicators to designate services paid under a payment system other than the OPPS. Therefore, we are finalizing our CY 2008 proposal, without modification. The final status indicators are displayed in the table above.

3. 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/MACs 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.

We did not receive any public comments regarding the status indicators to designate services that are not recognized under the OPPS but that may be recognized by other institutional providers. Therefore, we are finalizing our CY 2008 proposal, without modification. The final status indicators are displayed in the table above.

4. 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.

We did not receive any public comments regarding the status indicators to designate services that are not payable by Medicare. Therefore, we are finalizing our CY 2008 proposal, without modification. The final status indicators are displayed in the table above.

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 final rule with comment period all active HCPCS codes for CY 2008 and currently active HCPCS codes that will be discontinued at the end of CY 2007 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 universe of CY 2008 status indicators that we proposed for these items and services and are adopting as final without modification in this final rule with comment period are listed in the tables above.

A complete listing of HCPCS codes with 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. Comment Indicator Definitions

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 or active HCPCS code that will be discontinued at the end of the current calendar year.

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. In the CY 2008 OPPS/ASC proposed rule, for CY 2008, we proposed to continue that policy which we are now adopting in this CY 2008 OPPS/ASC final rule with comment period. When used in this OPPS/ASC final rule with comment period, the ''CH'' indicator is only intended to facilitate the public's review of changes made from one calendar year to another.

Only HCPCS codes with comment indicator ''NI'' in this CY 2008 OPPS/ASC final rule with comment period are subject to comment during the comment period for this final rule with comment period.

We are using the ''CH'' indicator in this final rule with comment period to call attention to changes in the payment status indicator and/or APC assignment for HCPCS codes for CY 2008 compared to their assignment as of December 31, 2007 and to identify HCPCS codes that will be discontinued at the end of CY 2007. The use of the comment indicator ''CH'' in association with a composite APC in this final rule with comment period indicates that the configuration of the composite APC is changed from CY 2007. We believe that using the ''CH'' indicator in this final rule with comment period will facilitate the public's review of the changes that we are making final for CY 2008.

As we proposed, we are terminating comment indicator ''NF'' because we believe its use is not relevant in the final rule.

We did not receive any public comments regarding the CY 2008 proposed OPPS comment indicators. Therefore, we are finalizing our proposed use of comment indicators for the CY 2008 OPPS/ASC final rule with comment period, without modification. The two comment indicators, ''NI'' and ''CH,'' that are finalized for continued use in CY 2008 and their definitions are listed in Addendum D2 to this final rule with comment period.

XV. OPPS Policy and Payment Recommendations

A. MedPAC Recommendations

MedPAC is an independent Federal commission established under section 1805 of the Act to advise the U.S. Congress on issues affecting the Medicare program. As required under the statute, MedPAC submits reports to Congress in March and June of each year that present its payment policy recommendations. The March 2007 MedPAC report, ''Report to the Congress: Medicare Payment Policy,'' 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: As proposed in the CY 2008 OPPS/ASC proposed rule, in this final rule with comment period, we are increasing 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 final rule with comment period). We are also implementing, effective for CY 2009, the reduction in the annual update factor by 2.0 percentage points for hospitals that are defined under section 1886(d)(1)(B) of the Act and that do not meet the hospital outpatient quality data reporting required by section 1833(t)(17) of the Act, as added by section 109(a) of the MIEA–TRHCA. Our adoption and implementation of hospital quality measure reporting for the CY 2008 OPPS are discussed in detail in section XVII. of this final rule with comment period.

In its June 2007 ''Report to the Congress: Promoting Greater Efficiency in Medicare,'' MedPAC did not make any recommendations specific to the OPPS for CY 2008. As noted in the FY 2008 IPPS final rule with comment period (72 FR 47344), the June 2007 MedPAC report includes analysis and recommendations on alternatives to the method to compute the IPPS wage index for FY 2009. (See chapter 6 of the June 2007 MedPAC report to Congress.) Under our current policy, we adopt the same wage index for the OPPS as the IPPS, and, therefore, such analysis and recommendations may have possible implications for the CY 2009 OPPS. As indicated in the FY 2008 IPPS final rule with comment period (72 FR 47344), we will consider MedPAC's recommendations and analysis in making a proposal (or proposals) to revise the IPPS wage index in the FY 2009 IPPS proposed rule, as required by section 106(b)(2) of the MIEA–TRHCA. The full report can be downloaded from MedPAC's Web site at: *http://www.medpac.gov/document/Jun07_EntireReport.pdf*.

MedPAC submitted comments to CMS on the CY 2008 OPPS/ASC proposed rule. We have responded to these comments in each relevant section of this final rule with comment period.

B. APC Panel Recommendations

Recommendations made by the APC Panel at its March 2007 meeting are discussed in sections of this final rule with comment period that correspond to topics addressed by the APC Panel. The report and recommendations from the APC Panel's March 7–8, 2007 meeting are available on the CMS Web site at: *http://www.cms.hhs.gov/FACA/05_AdvisoryPanelonAmbulatoryPaymentClassificationGroups.asp*.

Recommendations made by the APC Panel at its September 2007 meeting, when it met to discuss the CY 2008 OPPS/ASC proposed rule and to hear testimony from concerned members of the public, are also discussed in sections of this final rule with comment period that correspond to topics addressed by the APC Panel. The report and recommendations of the APC Panel's September 5–6, 2007 meeting are also available on the CMS Web site at: *http://www.cms.hhs.gov/FACA/05_AdvisoryPanelonAmbulatoryPaymentClassificationGroups.asp*.

XVI. 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, (MMA) 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 626(c) of the MMA amended section 1833(a)(1) of the Act to require that beginning with implementation of the revised ASC payment system, payment for surgical procedures furnished in ASCs shall be 80 percent of the lesser of the actual charge for the services or the amount determined by the Secretary under the revised payment system.

Section 5103 of the Deficit Reduction Act of 2005, Pub. L. 109–171 (DRA), 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 (that is, January 1, 2008).

Section 109(b) of the Medicare Improvements and Extension Act of 2006 of the Tax Relief and Health Care Act of 2006, Pub. L. 109–432 (MIEA–TRHCA), 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 the 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 final rule with comment period for further discussion of this provision and our plans for future ASC implementation.

B. Rulemaking for the Revised ASC Payment System

On August 2, 2007, we published in the **Federal Register** (72 FR 42470) the final rule for the revised ASC payment system, effective January 1, 2008. 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 August 2, 2007 revised ASC payment system final rule, we also adopted the method we will use to set payment rates for ASC services furnished in association with covered surgical procedures beginning in CY 2008. 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.

On August 2, 2007, we published in the **Federal Register** (72 FR 42778) a proposed rule which proposed to update the revised ASC payment system, along with the OPPS. We also proposed to revise the ASC regulations to provide practice expense payments 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. We note that the reference throughout the August 2, 2007 OPPS/ASC proposed rule to the final rule for the CY 2008 revised ASC payment system erroneously cited that final rule as the July 2007 final rule.

In this CY 2008 OPPS/ASC final rule with comment period, we are performing our annual update of the revised ASC payment system for CY 2008.

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 August 2, 2007 revised ASC payment system final rule, 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 an ASC. 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).

The list of surgical procedures that we have excluded from payment in ASCs may be found in Addendum EE posted on the CMS Web site at: *http://www.cms.hhs./ASCPayment*. As discussed above, the surgical procedures on that exclusionary list are those that are on the OPPS inpatient list, CPT unlisted codes, surgical procedures that are not recognized for payment under Medicare, and those that our clinical staff determined are not safe for Medicare beneficiaries or would be expected to require an overnight stay when provided in ASCs.

c. Payment for Covered Surgical Procedures under the Revised ASC Payment System

(1) General Policies

To make payment for most covered surgical procedures, beginning in CY 2008, 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 this 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 CY 2009 and beyond, according to our established methodology, 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, beginning with the CY 2009 payment year. The purpose of scaling the relative weights is to ensure that the estimated aggregate payments under the ASC payment system for an upcoming year will 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 August 2, 2007 revised ASC payment system final rule (72 FR 42470). The budget neutrality adjustment for CY 2008 is based on updated CY 2008 OPPS and MPFS rates, along with updated utilization data. The ASC CY 2008 budget neutrality adjustment is multiplied by the OPPS conversion factor to establish the ASC conversion factor. The standard ASC payment for most of the covered surgical procedures displayed in Addendum AA of this final rule with comment period is calculated as the product of that ASC conversion factor multiplied by the OPPS relative payment weight for each separately payable procedure. A more detailed discussion of the methodology is provided in section XVI.L. of this final rule with comment period.

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 (72 FR 42519).

(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 August 2, 2007 revised ASC payment system final rule, 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 (72 FR 42509).

Under the August 2, 2007 revised ASC payment system final rule, we finalized our policy to 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 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. When procedures are finalized as being office based procedures, they remain designated as office-based in future updates. 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 recently 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 final rule with comment period 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 payment indicator designation as office-based is temporary for CY 2008 are identified in Addendum AA by an asterisk. We use the temporary designation to indicate that the office-based payment indicator (''P2,'' ''P3,'' or ''R2'') assigned to the procedure is subject to change because the HCPCS code is new and we believe we have insufficient data upon which to base a final decision regarding the code's office-based status. We will reevaluate the procedure during the next annual rulemaking cycle, and when there are data upon which to base a proposal for a final payment indicator, we will include that in our proposed rule. The remainder of the office-based procedure designations that are not identified as temporary were either already finalized in the August 2, 2007 revised ASC payment system final rule or are being finalized in this CY 2008 OPPS/ASC final rule with comment period.

(3) Device-Intensive Procedures

Under the payment policy finalized in the revised ASC payment system final rule, we use a modified payment methodology to establish the ASC payment rates for device-intensive procedures (72 FR 42503). We identify device-intensive procedures under the revised ASC payment system 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 OPPS final device-dependent APCs and device offset percentages are discussed in section IV.A. of this final rule with comment period.

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 revised ASC payment system, we also pay $80 for the device portion of the procedure but the service portion of the OPPS payment, $20, is adjusted by the budget neutrality adjustment (for example, using the final ASC budget neutrality adjustment, the calculation is $\$20 \times 0.65 = \$13$) and, if it is subject to the transition (as set forth in section XVI.C.1.c.(5) of this final rule with comment period), it is also adjusted accordingly. If the procedure in the example is not subject to the transition, its CY 2008 payment is equal to approximately $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 is 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 final rule with comment period.

(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 are 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 are exempt from the multiple procedure reduction

in ASCs because they are not subject to this reduction under the OPPS, are identified in Addendum AA to this final rule with comment period with an ''N'' in the column labeled ''Subject to multiple procedure discounting.'' 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 are reported with modifier 73, and the ASC payment for the covered surgical procedure is reduced by 50 percent. Procedures requiring anesthesia that are terminated after administration of anesthesia or initiation of the procedure are reported with modifier 74, and the ASC payment for the covered surgical procedure is 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 over 4 years for all services on the CY 2007 ASC list of covered surgical procedures (72 FR 42519). 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 final rule with comment period 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 final rule with comment period 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).

We received many public comments on the final payment policies for covered surgical procedures under the revised ASC payment system. A summary of the public comments and our responses follow.

Comment: A number of commenters suggested that CMS: (1) Alter the definition for surgical procedures and the criteria for evaluating procedures for exclusion from the list of covered procedures; (2) not implement the office-based designations for procedures; (3) use a lower threshold to designate which procedures are eligible for payment as device-intensive; (4) allow procedures with high supply costs to go to fully implemented revised payment system rates rather than being paid at the transitional rates during the first 3 years under the revised system; and (5) use either a higher budget neutrality adjustment or differential adjustments for high and low volume procedures. Within those topics, the commenters made a range of recommendations for changes to our final policies.

Response: We appreciate the commenters' suggestions. However, the payment policies for the revised ASC payment system that are addressed by the commenters were finalized in the August 2, 2007 revised ASC payment system final rule after we received and addressed public comments. Therefore, we are not addressing these comments in this final rule with comment period. Only the comments we received during the comment period related to the proposed annual update of the revised ASC payment system that were included in the August 2, 2007 OPPS/ASC proposed rule are addressed in this final rule with comment period. Any additional changes to the payment policies in that final rule would need to be subjected to the notice and comment rulemaking procedures through issuance of a proposed rule before any such changes could be finalized.

Comment: Several commenters recommended that CMS establish an advisory group of clinically-trained ASC experts to work with CMS staff prior to release of the annual proposed rule to review and provide clinical safety and procedure-specific data on procedures that CMS may initially deem a safety risk.

Response: We appreciate the commenters' suggestion. However, we believe that the current process for identifying procedures for exclusion from the list of covered procedures is sufficient. The process we have established allows for clinical review by our medical staff and expert advisors, as well as comments from the public on an annual basis prior to making final decisions regarding surgical procedures for exclusion from the list of ASC covered surgical procedures. Further, in contrast to the biennial process to update the ASC list under the existing ASC payment system in effect through CY 2007, the process for updating the list annually under the revised payment system increases opportunities for the public to comment on our proposed changes to the list and other aspects of the payment system that may be included in the proposed rule.

Comment: One commenter suggested CMS should develop and implement modifiers for hospitals and ASCs to use to monitor beneficiaries who, after undergoing procedures in ASCs, are discharged to hospitals. The commenter stated that, with the greatly expanded list of covered surgical procedures in place, ASCs will be prone to provide services that are beyond their capabilities. The commenter believed that ASCs may underestimate the severity of certain types of patients or cases, or both, and that as a result, beneficiaries requiring continued care will be transferred to the hospital. The commenter argued that this would result in increased health care costs. The commenter believed that, in this way, the revised ASC payment system may introduce payment inequities whereby hospitals lose money by caring for patients transferred from ASCs, many times for hospital outpatient services that would not be paid by Medicare under existing OPPS payment policy. Further, the commenter was concerned that transferred beneficiaries also may be exposed to increased financial liability for hospital services not covered by Medicare under the OPPS and that the quality of care would

suffer due to the transfer, which would require the involvement of multiple providers. For those reasons, the commenter suggested that CMS develop and implement a method to monitor ASC-to-hospital transfer activity.

Response: We do not anticipate a significant influx of transfers from ASCs to hospitals to accompany implementation of the revised payment system. As discussed above, we have an established review policy to identify and exclude from ASC payment those procedures that could pose a significant safety risk to beneficiaries when performed in the ASC setting or that are expected to require an overnight stay. We have expanded the ASC list of covered surgical procedures in order to increase physicians' choices when selecting the most appropriate place of care for beneficiaries. To this end, the implementation of the revised ratesetting methodology removes site-of-service payment differentials that may have affected physicians' decisions in the past. We believe that, under the revised payment system, physicians will choose the setting for a procedure that best suits the needs of the individual beneficiary, and that beneficiaries will benefit from expanded access to surgical services in the most efficient and appropriate setting available.

Thus, although we are sensitive to the commenter's concerns, we see no reason to implement modifiers as suggested by the commenter at this time. We will continue to analyze claims and other available data during our annual rulemaking cycle to assess the effectiveness of our policies and to make our annual updates.

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 performed in an ASC, for which separate payment is made under the revised ASC payment system.

''Covered ancillary services'' include the following, as specified in § 416.164(b): 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.

Under the revised ASC payment system, we designate specific services that are separately payable under the OPPS as ''covered ancillary services'' and make separate payment to ASCs when any of the services so designated are provided on the same day as integral to a covered surgical procedure provided in the ASC (72 FR 42477). Payment for ancillary services that are packaged under the OPPS also is packaged under the revised ASC payment system (and those services are not considered to be ASC covered ancillary services). Furthermore, only the ASC can receive payment for the facility resources required to provide the covered ancillary radiology or other covered ancillary 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.

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.

We received one public comment specific to our general final payment policy for separate payment of covered ancillary services in ASCs under the revised ASC payment system. A summary of the public comment and our response follow.

Comment: MedPAC expressed concern regarding our final payment policy under the revised ASC payment system for covered ancillary services. The revised ASC payment system pays separately for covered ancillary services in order to align the ASC payment bundles with the OPPS. However, MedPAC was concerned that separate payment for these services for which payment is currently packaged under the existing ASC payment system may lead to growth of the covered ancillary services in ASCs. MedPAC recommended that CMS pursue broader packaging policies for both ASCs and the OPPS to promote efficient resource use in both settings.

Response: We appreciate this comment from MedPAC, and as evidenced by the packaging approach that we are finalizing for the CY 2008 OPPS, as described in section II.A.4.c. of this final rule with comment period, we are expanding the packaging of ancillary services to increase the size of the payment bundles in both the OPPS and ASC settings. In particular, there are a number of radiology services, including guidance procedures, that are newly packaged under the OPPS, but which otherwise would have been paid separately in the ASC setting as covered ancillary services. We do not expect significant growth of separately payable covered ancillary services in ASCs as a direct result of providing separate payment for these services beginning in CY 2008 because, to be paid, these services must always be provided integral to covered surgical procedures in ASCs.

As discussed above, we have revised the ASC payment system to more appropriately pay for surgical procedures that are covered in that setting; that is, those procedures we have determined do not pose a significant risk to beneficiary safety and would not be expected to require an overnight stay. Because we are paying for these surgical procedures using the OPPS APCs as the grouper, we believe it is most appropriate to align the payment bundles under the OPPS and the revised ASC payment system. Increased packaging under the OPPS that alters the OPPS payment bundles will also occur under the revised ASC payment system. We believe that the changes to the ASC payment system will allow beneficiaries to receive the care they require in the most appropriate setting and ASCs to be appropriately paid for that care. We have no reason to believe that increased service growth for covered ancillary services provided in ASCs will be more likely than growth for those services provided in other settings.

b. Payment Policies for Specific Items and Services

(1) Radiology Services

Under the revised ASC payment system, we designate as ''covered ancillary services'' those ancillary radiology services that are separately payable under the OPPS. Thus, ASCs receive a separate payment for a covered ancillary radiology service which, by definition, is provided in the ASC integral to the performance of a covered surgical procedure. ASC payment for those covered 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 ancillary services that are designated as packaged under the OPPS. We specify that a covered ancillary 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 covered 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 covered ancillary radiology services, and ASCs are no longer able to bill as independent diagnostic testing facility (IDTF) suppliers to receive payment for any 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 will also occur under the revised ASC payment system.

Ancillary 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 list that includes all covered ancillary radiology services may be found in Addendum BB to this final rule with comment period. Covered ancillary 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 those services are identified in Addendum BB to this final rule with comment period with payment indicator ''N1'' (Packaged service/item; no separate payment made). ASC payment for covered ancillary radiology services is not subject to the 4-year transition.

(2) Brachytherapy Sources

Under the revised ASC payment system, we designate as ''covered ancillary services'' those brachytherapy sources that are separately payable under the OPPS. Thus, ASCs receive separate payment for those covered ancillary brachytherapy sources that are implanted in conjunction with covered surgical procedures billed by ASCs. The application of the brachytherapy sources is integrally related to the covered 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. The Level II HCPCS codes for brachytherapy sources and their payment rates under the CY 2008 revised ASC payment system, the same as those finalized for the CY 2008 OPPS, are included in Addendum BB to this final rule with comment period. 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 we are finalizing our proposal to change the brachytherapy source payment indicator from ''H4,'' defined as ''Brachytherapy source paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced'' to ''H2,'' in order to be consistent with the final CY 2008 OPPS policy for payment of brachytherapy sources, as described in section VII. of this final rule with comment period. For CY 2008, we are paying under the OPPS at prospective rates calculated from historical claims data and, therefore, the ASC payment for brachytherapy sources will be at those same rates. The HCPCS codes for all brachytherapy sources and their ASC payment amounts and ASC payment indicators are listed in Table 47 below.

TABLE 47.—CY 2008 PAYMENTS FOR BRACHYTHERAPY SOURCES IMPLANTED IN ASCS

HCPCS code	Short descriptor	ASC payment indicator	CY 2008 ASC payment rate
A9527	Iodine I-125 sodium iodide	H2	$27.55
C1716	Brachytx, non-str, Gold-198	H2	33.30
C1717	Brachytx, non-str, HDR Ir-192	H2	175.19
C1719	Brachytx, NS, Non-HDRIr-192	H2	65.13
C2616	Brachytx, non-str,Yttrium-90	H2	11,764.95
C2634	Brachytx, non-str, HA, I-125	H2	30.94
C2635	Brachytx, non-str, HA, P-103	H2	46.92
C2636	Brachy linear, non-str, P-103	H2	42.04
C2638	Brachytx, stranded, I-125	H2	45.31

TABLE 47.—CY 2008 PAYMENTS FOR BRACHYTHERAPY SOURCES IMPLANTED IN ASCS—Continued

HCPCS code	Short descriptor	ASC payment indicator	CY 2008 ASC payment rate
C2639	Brachytx, non-stranded, I-125	H2	32.10
C2640	Brachytx, stranded, P-103	H2	65.66
C2641	Brachytx, non-stranded, P-103	H2	51.45
C2642	Brachytx, stranded, C-131	H2	97.72
C2643	Brachytx, non-stranded, C-131	H2	64.08
C2698	Brachytx, stranded, NOS	H2	45.31
C2699	Brachytx, non-stranded, NOS	H2	30.94

(3) Drugs and Biologicals

Under the revised ASC payment system, we designate as ''covered ancillary services'' all drugs and biologicals that are separately paid under the OPPS. Thus, ASCs receive separate payment for those covered ancillary drugs and biologicals which, by definition, are provided integral to a covered surgical procedure performed in an ASC. 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 covered ancillary drugs and biologicals under the revised ASC payment system for a calendar year are equal to the OPPS payment rates for those drugs and biologicals 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 covered ancillary drugs and biologicals under the CY 2008 revised ASC payment system and their payment rates are included in Addendum BB to this final rule with comment period. Covered ancillary 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). Ancillary drugs and biologicals for which payment is packaged into the ASC payment for the covered surgical procedure in CY 2008 are also listed in Addendum BB, and 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 other services designated as covered ancillary 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 continuing 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 covered ancillary services, including pass-through devices, is not subject to the geographic wage adjustment.

The pass-through device category HCPCS codes are included in Addendum BB to this final rule with comment period 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 final rule with comment period, where they are assigned payment indicator ''N1'' (Packaged service/item; no separate payment made).

The associated nondevice facility resources for the device implantation procedures are paid through the ASC surgical procedure service payment, based upon the payment weight for the nondevice 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 final rule with comment period rule, and it is assigned payment indicator ''F4'' (Corneal tissue processing; paid at reasonable cost).

3. General Payment Policies

a. Adjustment for Geographic Wage Differences

Under the revised ASC payment system policy, we utilize 50 percent as the labor related share to adjust national ASC payment rates for geographic wage differences. 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.

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.

Comment: Several commenters suggested that CMS limit the beneficiary coinsurance amount for ASC services to the Medicare Part A hospital deductible, as occurs under the OPPS. The commenters stated that the potential for higher coinsurance in the ASC setting could have a negative financial impact on beneficiaries.

Response: Although this comment is outside of the scope for this final rule with comment period, we are responding in order to provide further clarification to interested stakeholders. The revised ASC payment system results in many different payment rates effective January 1, 2008, some lower than under the existing system and some higher. The final beneficiary coinsurance policy may be found in the August 2, 2007 revised ASC payment system final rule (72 FR 42519). For the first year of the revised payment system in CY 2008, there are 171 procedures with payment rates higher than $1,339, the highest rate under the existing ASC payment system. That means that beneficiary liability for those procedures will be greater under the revised payment system than under the existing ASC payment system. Of those procedures, 27 will result in beneficiary liability that is greater than the CY 2008 Medicare Part A hospital deductible amount of $1,024.

While we have statutory authority to limit beneficiary copayments under the OPPS to no more than the Medicare Part A deductible for the year, Medicare program payments to ASCs are required by section 1833(a)(1)(G) of the Act to be 80 percent of the lesser of the payment amount or actual ASC charges, and beneficiaries are responsible for the remaining 20 percent. We have no authority to revise those policies. However, we point out that the coinsurance amounts under the revised ASC payment system are limited to 20 percent of the payment rate and, as such, other than for the 27 procedures noted above, are almost without exception lower than the copayment amounts under the OPPS because most of the ASC rates are lower than OPPS rates and because beneficiary copayments vary from 20 to 40 percent under the OPPS. We note that, just like under the OPPS, the ASC coinsurance amounts are applied to each separate payment made for covered surgical procedures and covered ancillary services.

D. 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 August 2, 2007 revised ASC payment system final rule to evaluate each year all new HCPCS codes that describe surgical procedures to make preliminary determinations in the annual OPPS/ASC final rule with comment period regarding whether or not they meet the criteria for payment in the ASC setting and, if so, whether they are office-based procedures. These interim determinations must be made in the OPPS/ASC final rule with comment period because the new HCPCS codes and their descriptors for the upcoming calendar year are not available at the time of development of the OPPS/ASC proposed rule. 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 use other available information to make interim decisions regarding assignment of payment indicators for the new codes. The other sources 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**. Each year, 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 on 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 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, will 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 volume and utilization data for the procedure code and/or, if appropriate, the clinical characteristics, utilization, and volume of related codes, the code will be assigned permanently to the list of office-based procedures subject to the ASC payment limitation, as discussed in section XVI.C.1.c.(2) of this final rule with comment period.

New HCPCS codes for ASC implementation on January 1, 2008 are designated in Addenda AA and BB to this 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 final rule with comment period for a discussion of the ASC payment and comment indicators.)

2. 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 only could 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 predictable quarterly updates for the OPPS 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 August 2, 2007 revised ASC payment system final rule, we also provide quarterly ASC updates 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 CPT Category I and Category III codes that are released in July by the AMA for implementation in January of the upcoming calendar year. Thus, 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, in the CY 2008 OPPS/ASC proposed rule (72 FR 42783), we proposed to adopt that same policy under the revised ASC payment system.

Some of the new Category III CPT codes may describe services that our clinical 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 new Category III CPT codes as covered surgical procedures. Similarly, a new code may represent an ancillary service that directly crosswalks or is clinically similar to an ancillary service for which separate ASC payment is allowed when it is performed integral to an ASC covered surgical procedure, and, as such, the new code also may be determined to be eligible for ASC payment as a covered ancillary service.

We did not receive any public comments regarding our proposal to recognize for ASC payment new CPT Category III codes, as appropriate, in July of each year as we do under the OPPS and MPFS. Therefore, beginning in CY 2008, we are including in the July quarterly 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 will 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 proposed to assign it to the list of covered ancillary services with payment indicator ''Z2'' for payment in ASCs beginning January 1, 2008. This service has no MPFS nonfacility PE RVUs assigned to it. Therefore, we proposed 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.

We did not receive any public comments about our proposed assignment of ASC payment indicator ''Z2'' to CPT code 0182T. Therefore, we are finalizing our assignment of ASC payment indicator ''Z2'' to CPT code 0182T for CY 2008.

3. 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. Therefore, we proposed to update the coding and payment for the services in ASCs at the same time that the OPPS is updated. We proposed 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. Just as we provide a predictable quarterly update for the OPPS occurring throughout each calendar year (January, April, July, and October), we also would provide predictable quarterly updates for ASCs 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.

In the CY 2008 OPPS/ASC proposed rule, we also proposed to update the lists of covered surgical procedures and ancillary services that qualify for separate payment in ASCs in CY 2008 by adding eight new CY 2007 Level II HCPCS codes that were implemented in the OPPS in July 2007. Because of the timing of the proposed rule, the new Level II HCPCS codes implemented through the July 2007 OPPS update were not included in Addendum BB to the proposed rule.

We did not receive any comments regarding the proposed payment indicators for the eight new CY 2007 Level II HCPCS codes that were implemented in the OPPS in July 2007. Therefore, we are finalizing our payment for them in the ASC setting, as proposed. The eight codes are listed in Table 48 below, as well as in Addendum BB to this final rule with comment. Beginning in CY 2008, with implementation of the revised ASC payment system, the Level II HCPCS codes describing new procedures, drugs, and biologicals will be payable in ASCs in the same calendar quarter as they are initially paid under the OPPS.

We assigned payment indicator ''K2'' to seven of the eight new codes for drugs to indicate that separate payment will be made for those drugs when they are provided to beneficiaries in ASCs integral to covered surgical procedures. 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) is 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 a payment indicator of ''P3.'' While we believe both procedures are office-based, there are currently no MPFS 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 48.—LEVEL II HCPCS CODES IMPLEMENTED UNDER THE OPPS IN JULY 2007 THAT WILL BE PAID IN CY 2008 IN ASCS

CY 2007 HCPCS code	CY 2008 HCPCS code	Descriptor	CY 2008 ASC payment indicator
C9728	C9728	Placement of interstitial device(s) for radiation therapy/surgery guidance (e.g., fiducial markers, dosimeter), other than prostate (any approach), single or multiple.	R2
Q4087	J1568	Injection, immune globulin, (Octagam), intravenous, non-lyophilized, (e.g. liquid), 500 mg	K2
Q4088	J1569	Injection, immune globulin, (Gammagard Liquid), intravenous, non-lyophilized, (e.g. liquid), 500 mg.	K2
Q4089	J2791	Injection, rho(d) immune globulin (human), (Rhophylac), intravenous, 100 iu	K2
Q4090	J1571	Injection, hepatitis b immune globulin (Hepagam B), intramuscular, 0.5 ml	K2
Q4091	J1572	Injection, immune globulin, (Flebogamma), intravenous, non-lyophilized (e.g. liquid), 500 mg	K2
Q4092	J1561	Injection, immune globulin, (Gamunex), intravenous, non-lyophilized (e.g. liquid), 500 mg	K2
Q4095	J3488	Injection, zoledronic acid (Reclast), 1 mg	K2

We did not receive any public comments regarding our proposal to implement new Level II HCPCS codes for ASC payment on a quarterly basis each year and new Category III CPT codes on a semiannual basis, to parallel the policies under the MPFS and OPPS for the recognition of those codes. Therefore, beginning in CY 2008 with implementation of the revised ASC payment system, we are implementing new Level II HCPCS codes for ASC payment on a quarterly basis each year and new Category III CPT codes on a semiannual 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 HCPCS codes implemented on January 1 of a calendar year is to publish the new codes and interim payment indicators annually in the OPPS/ASC final rule with comment period.

E. Updates to Covered Surgical Procedures and Covered Ancillary Services

1. Identification of Covered Surgical Procedures

a. General Policies

We published Addendum AA to the August 2, 2007 revised ASC payment system final rule 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 August 2, 2007 revised ASC payment system final rule, we finalized the addition of approximately 790 new covered surgical procedures for payment under the revised ASC payment system beginning in CY 2008. In the CY 2008 OPPS/ASC proposed rule, we proposed to remove 13 procedures from the OPPS inpatient list and, of those 13, we believe that 3 are safe for performance in ASCs. Therefore, we proposed to add the following three additional surgical procedures to the ASC list of covered surgical procedures eligible for Medicare ASC payment in CY 2008: CPT codes 25931 (Amputation, forearm, through radius and ulna; re-amputation); 50580 (Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or uteropyelography, exclusive of radiologic service; with removal of foreign body or calculus); and 58805 (Drainage of ovarian cyst(s), unilateral or bilateral, (separate procedure); abdominal approach).

We did not receive any public comments about our proposal to designate CPT codes 25931, 50580, and 58805 as payable in ASCs as covered surgical procedures beginning CY 2008. Therefore, we are finalizing our proposal to designate the three procedures as payable in ASCs as covered surgical procedures, assigning them payment indicator ''G2,'' beginning in CY 2008.

In the CY 2008 OPPS/ASC proposed rule, we also solicited comments and recommendations regarding additional surgical procedures that commenters believe should not be excluded from ASC payment beginning in CY 2008. We specifically encouraged 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.

We received many public comments from individuals and organizations requesting that specific procedures be added or removed from the CY 2008 proposed list of ASC covered surgical procedures. A summary of the public comments and our responses follow.

Comment: Some commenters stated that certain procedures CMS had proposed to exclude from coverage as payable in ASCs do not pose a risk to beneficiary safety and are not expected to require an overnight stay, and as such, should not be excluded from the ASC list. Table 49 below includes a list of all procedures for which the commenters requested designation as covered surgical procedures in ASCs.

TABLE 49.—SPECIFIC PROCEDURES THAT COMMENTERS REQUESTED NOT BE EXCLUDED FROM ASC PAYMENT IN CY 2008

HCPCS code	Short descriptor
0088T ...	Rf tongue base vol reduxn
0135T ...	Perq cryoablate renal tumor.
0137T ...	Prostate saturation sampling.
0170T ...	Anorectal fistula plug rpr.
0184T ...	Transanal resect rectal tumor.
0186T ...	Suprachoroidal drug delivery.
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.
21360 ...	Treat cheek bone fracture.
21365 ...	Treat cheek bone fracture.
21385 ...	Treat eye socket fracture.
21386 ...	Treat eye socket fracture.
21387 ...	Treat eye socket fracture.
22526 ...	Idet, single level.
22527 ...	Idet, 1 or more levels.
27093 ...	Injection for hip x-ray.
27096 ...	Inject sacroiliac joint.
29866 ...	Autgrft implnt, knee w/scope.
29867 ...	Allgrft implnt, knee w/scope.
29868 ...	Meniscal trnspl, knee w/scpe.
32998 ...	Perq rf ablate tx, pul tumor.
35470 ...	Repair arterial blockage.
35471 ...	Repair arterial blockage.
35472 ...	Repair arterial blockage.
35490 ...	Atherectomy, percutaneous.
35491 ...	Atherectomy, percutaneous.
35493 ...	Atherectomy, percutaneous.
35494 ...	Atherectomy, percutaneous.
35495 ...	Atherectomy, percutaneous.
37182 ...	Insert hepatic shunt (tips).
37182 ...	Remove hepatic shunt (tips).
37201 ...	Transcatheter therapy infuse.
37202 ...	Transcatheter therapy infuse.
37204 ...	Transcatheter occlusion.
37205 ...	Transcath iv stent, precut.
37206 ...	Transcath iv stent/perc addl.
37209 ...	Change iv cath at thromb tx.
37210 ...	Embolization uterine fibroid.
37620 ...	Revision of major vein.
44300 ...	Open bowel to skin.
44500 ...	Intro, gastrointestinal tube.
44901 ...	Drain app abscess, precut.
47011 ...	Percut drain, liver lesion.
47490 ...	Incision of gallbladder.
48511 ...	Drain pancreatic pseudocyst.
49021 ...	Drain abdominal abscess.
49041 ...	Drain, percut, abdom abscess.
49061 ...	Drain, percut, retroper absc.
50021 ...	Renal abscess, percut drain.
50080 ...	Removal of kidney stone.
50081 ...	Removal of kidney stone.
58823 ...	Drain pelvic abscess, precut.
62290 ...	Inject for spine disk x-ray.
62291 ...	Inject for spine disk x-ray.
63020 ...	Neck spine disk surgery.
63030 ...	Low back disk surgery.
63035 ...	Spinal disk surgery add-on.
63040 ...	Laminotomy, single cervical.
63042 ...	Laminotomy, single lumbar.
63044 ...	Laminotomy, add'l lumbar.
63047 ...	Removal of spinal lamina.
63056 ...	Decompress spinal cord.
64448 ...	N block inj fem, cont inf.
64449 ...	N block inj, lumbar plexus.
64910 ...	Nerve repair w/allograft.

TABLE 49.—SPECIFIC PROCEDURES THAT COMMENTERS REQUESTED NOT BE EXCLUDED FROM ASC PAYMENT IN CY 2008—Continued

HCPCS code	Short descriptor
G0289 ..	Arthro, loose body + chondro.
0171T ...	Lumbar spine process distract.
0172T ...	Lumbar spine process addl.

Response: In response to the public comments received, our clinical advisors evaluated each of the procedures listed in Table 49 to determine whether it poses a significant safety risk to beneficiaries or would be expected to require an overnight stay. Several of those procedures, specifically CPT codes 27093 (Injection procedure for hip arthrography); 62290 (Injection procedure for discography, each level; lumbar) 62291 (Injection procedure for discography, each level; cervical or thoracic); and G0289 (Arthroscopy, knee, surgical, for removal of loose body, foreign body, debridement/shaving of articular cartilage (chondroplasty) at the time of other surgical knee arthroscopy in a different compartment of the same knee), are packaged procedures under the OPPS and, therefore, are not eligible for designation as separately payable procedures under the revised ASC payment system. However, we note that these packaged procedures are also not excluded from Medicare payment when performed in the ASC setting. Their payment will be packaged into payment for the ASC covered surgical procedure performed in the ASC.

As a result of our review of the other procedures listed in Table 49 that would be candidates for separate ASC payment according to their OPPS payment policies, we are not excluding 11 additional procedures from Medicare payment when performed in the ASC setting in CY 2008. In making our determinations, even where procedures had high inpatient utilization due to their frequent performance on hospital inpatients, we considered the clinical characteristics of the surgical procedure itself. As we stated in the August 2, 2007 revised ASC payment system final rule, we examine all the clinical information regarding the 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 (72 FR 42482). Of the procedures that commenters requested not be excluded from the list of covered surgical procedures, those that we determined are appropriate for payment in an ASC and their final CY 2008 payment indicators are displayed in Table 50.

TABLE 50.—SPECIFIC PROCEDURES NEWLY DESIGNATED AS COVERED ASC SURGICAL PROCEDURES FOR CY 2008

HCPCS code	Short descriptor	CY 2008 payment indicator
0088T ...	Rf tongue vol reduxn	G2
0137T ...	Prostate saturation sampling.	G2
0170T ...	Anorectal fistula plug rpr.	G2
0186T ...	Suprachoroidal drug delivery.	G2
21360 ...	Treat cheek bone fracture.	G2
22526 ...	Idet, single level	G2
22527 ...	Idet, 1 or more levels	G2
29866 ...	Autgrt implnt, knee w/scope.	G2
32998 ...	Perq rf ablate tx, pul tumor.	G2
44500 ...	Intro, gastrointestinal tube.	G2
64910 ...	Nerve repair w/allograft.	G2

We determined that each of the remaining 57 procedures (those not packaged or listed in Table 50) requested by the commenters and listed in Table 49 would pose a significant risk to beneficiary safety or be expected to require an overnight stay, so they will continue to be excluded from the list of ASC covered surgical procedures for CY 2008. A complete list of surgical procedures that are excluded from Medicare payment when provided in ASCs may be found in Addendum EE posted on the CMS Web site at: http://www.cms.hhs.gov/ASCPayment.

Comment: Several commenters requested that specific procedures be removed from the ASC list of covered procedures in order to enhance the safety and quality of care that is delivered by ASCs. The commenters stated that CMS should exercise caution in granting patients and physicians the flexibility to determine appropriate sites of care, particularly for procedures that could have catastrophic outcomes if the appropriate emergent care equipment and training are not available in the site where care is delivered. Specifically, the commenters requested removal of percutaneous transluminal angioplasty procedures, transvenous electrode procedures, and certain cardiac electrophysiology procedures, as well as palatal surgical procedures. Table 51 below lists the procedures for which the

commenters requested removal from the ASC list of covered surgical procedures.

TABLE 51.—PROCEDURES RECOMMENDED BY COMMENTERS FOR REMOVAL FROM THE ASC LIST OF COVERED SURGICAL PROCEDURES

HCPCS code	Short descriptor
33206 ...	Insertion of heart pacemaker.
33207 ...	Insertion of heart pacemaker.
33208 ...	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, one.
33220 ...	Repair lead pace-defib, dual.
33224 ...	Insert pacing lead & connect.
33225 ...	L ventric pacing lead add-on.
33226 ...	Reposition l ventric lead.
33234 ...	Removal of pacemaker system.
33235 ...	Removal pacemaker electrode.
33249 ...	Eltrd/insert pace-defib.
35473 ...	Repair arterial blockage.
35474 ...	Repair arterial blockage.
35476 ...	Repair venous blockage.
35492 ...	Atherectomy, percutaneous.
42200 ...	Reconstruct cleft palate.
42205 ...	Reconstruct cleft palate.
42210 ...	Reconstruct cleft palate.
42215 ...	Reconstruct cleft palate.
42220 ...	Reconstruct cleft palate.

Response: In response to the public comments received, our clinical advisors reevaluated each of the procedures listed in Table 51 to determine whether it poses a significant safety risk to beneficiaries or would be expected to require an overnight stay. We note that while CPT codes 42200 (Palatoplasty for left palate, soft and/or hard palate only); 42205 (Palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only); 42210 (Palatoplasty for cleft palate; with closure of alveolar ridge; with bone graft to alveolar ridge (includes obtaining graft)); 42215 (Palatoplasty for cleft palate; major revision); and 42220 (Palatoplasty for cleft palate; attachment pharyngeal flap) were eligible for payment when performed in the ASC in CY 2007, the remainder of the codes listed in Table 51 were added to the ASC list of covered surgical procedures in the August 2, 2007 revised ASC payment system final rule for CY 2008.

We continue to believe that these palatoplasty procedures that have been on the ASC list of covered surgical procedures for more than 5 years do not pose a significant risk to beneficiary safety in the ASC setting, nor would they be expected to require an overnight stay. We are not aware of any safety problems regarding the performance of these procedures in ASCs over the years Medicare has included them on the list of ASC covered surgical procedures.

With respect to the pacemaker and ICD lead placement, repositioning, and removal procedures, we proposed a number of these procedures for addition to the ASC list for CY 2008 in the August 23, 2006 proposed rule for the revised ASC payment system. We received a number of comments on the proposed rule regarding these procedures, as well as related surgical procedures, which we carefully reviewed prior to placing them on the ASC list of covered surgical procedures in the August 2, 2007 revised ASC payment system final rule. We have once again examined these procedures in light of comments received on the CY 2008 OPPS/ASC proposed rule and, we believe, under the safety and overnight stay criteria that were adopted to exclude procedures from ASC payment, all of these procedures are appropriate for ASC performance. In particular, we do not believe they pose a significant safety risk, nor would be expected to require an overnight stay when provided in ASCs.

We also closely reexamined the transluminal balloon angioplasty services described by CPT codes 35473 (Transluminal balloon angioplasty, percutaneous; iliac); 35474 (Transluminal balloon angioplasty, percutaneous; femoral-popliteal); and 35476 (Transluminal balloon angioplasty, percutaneous; venous). All three of these procedures were proposed for addition to the ASC list for CY 2008 in the August 23, 2006 OPPS/ASC proposed rule. We received requests to add CPT code 36476 to the ASC list for CY 2007, but we did not add this code at that point, based on the evaluation criteria for the existing ASC payment system. We then added all three codes to the CY 2008 ASC list in the August 2, 2007 revised ASC payment system final rule after evaluating the public comments and concluding that the procedures should not be excluded from ASC performance, consistent with the final exclusion criteria for the revised system. In response to the comments on the CY 2008 OPPS/ASC proposed rule that reflected the commenters' ongoing concerns about the safety of these procedures in ASCs, our clinical advisors engaged in a comprehensive assessment of their safety based on current clinical practice patterns and the contemporary medical literature. We have concluded that CPT codes 35473 and 35476 do not pose a significant safety risk to beneficiaries nor would either procedure be expected to require an overnight stay in ASCs. Therefore, we are including CPT codes 35473 and 35476 on the CY 2008 ASC list of covered surgical procedures. However, we have determined that CPT code 35474 would pose a significant safety risk to beneficiaries when performed in an ASC. Therefore, we are excluding CPT code 35474 from the CY 2008 ASC list of covered surgical procedures.

In summary, as a result of our review of the procedures the commenters requested that we remove from the proposed CY 2008 ASC list of covered surgical procedures, we are retaining all of the procedures in Table 51 on the final CY 2008 list of ASC covered surgical procedures except CPT code 35474. The full CY 2008 list of ASC covered surgical procedures is included in Addendum AA to this final rule with comment period.

b. 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 those 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 August 2, 2007 revised ASC payment system final rule took into account the most recently 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 August 2, 2007 revised ASC payment system final rule, each of the office-based procedures was 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 the CY 2008 OPPS/ASC 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 August 2, 2007 revised ASC payment system final rule. 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 that were assigned payment indicator ''G2'' in the August 2, 2007 revised ASC payment system final rule that we proposed to assign to the office-based procedure list, effective January 1, 2008, with payment indicator ''P2,'' ''P3,'' or ''R2,'' as appropriate. We refer readers to Addendum DD1 to this final rule with comment period for the definitions of the ASC payment indicators.

In the CY 2008 OPPS/ASC proposed rule, we indicated that we would consider comments submitted timely on the proposed designation of these 19 new procedures as office-based for CY 2008. For example, in the August 2, 2007 revised ASC payment system final rule, 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 believed the procedure should be designated as an office-based procedure. Therefore, we proposed to assign payment indicator ''P3'' to CPT code 64650, effective for CY 2008. In the proposed rule, we proposed to assign an office based payment indicator for CPT code 64650 and 18 other procedures.

We also reviewed the five procedures that were assigned temporary office-based payment indicators in the August 2, 2007 revised ASC payment system final rule. Using CY 2006 data, we believed there were adequate claims data for two of those procedures upon which to base assignment of permanent payment indicators. Therefore, we proposed to assign CPT code 36598 (Contrast injection(s) for radiologic evaluation of existing central venous access device, including fluoroscopy, image documentation and report) permanently to the office-based list, with payment indicator ''P3'' for CY 2008. In the case of the second procedure, CPT code 58110 (Endometrial sampling (biopsy) performed in conjunction with colposcopy), in accordance with the CY 2008 OPPS proposal to package its payment, we also proposed to package payment for that procedure under the ASC payment system and assign it payment indicator ''N1.''

We proposed to maintain the temporary office-based payment indicator assignments for the other three procedures. We have only a few claims for CPT code 0099T (Implantation of intrastromal corneal ring segments) and no claims for CPT code 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 proposed not to make any change to the temporary office-based designation of these procedures at that time.

We received many public comments on our general payment policy for office-based surgical procedures under the revised ASC payment system and on our proposal to add 19 additional procedures to the office-based list for CY 2008. A summary of the public comments and our responses follow.

Comment: Many commenters opposed the policies related to the designation of procedures as office-based and the subsequent payment limitations for procedures that are so designated. Some commenters recommended that, if CMS is going to maintain a list of office-based procedures, it should restrict the criteria used to make office-based determinations. They stated that designation of a procedure as office-based should be made either based on utilization data for multiple years or on the frequency of performance of the procedure in the HOPD or ASC settings. The commenters stated that CMS's consideration of clinical information and utilization data for related procedures is not transparent, making it impossible for the public to assess whether its determinations are rational and fair.

Several commenters specifically requested that one or more of the 19 additional procedures proposed for designation as office-based not receive that designation. The commenters recommended that CMS not finalize the proposal to designate 15 of the 19 procedures as office-based because commenters believe they are not performed in physicians' offices 50 percent or more of the time. Each of those codes the commenters recommended not be designated as office-based is marked by a plus (+) in Table 52 below.

Several commenters recommended that CMS not finalize the proposal to designate CPT code 28890 (Extracorporeal shock wave, high energy, performed by a physician, requiring anesthesia other than local, including ultrasound guidance, involving the plantar fascia) as office-based because they believe the CMS data that indicate the procedure's performance in physicians' offices more than 50 percent of the time are erroneous. The commenters stated that CMS assigned payment indicator ''G2'' to three high energy extracorporeal shock wave therapy (ESWT) procedures, CPT codes 28890, 0101T (Extracorporeal shock wave involving musculoskeletal system, not otherwise specified, high energy); and 0102T (Extracorporeal shock wave, high energy, performed by a physician, requiring anesthesia other than local, involving lateral humeral epicondyle) in the August 2, 2007 revised ASC payment system final rule but then proposed to designate only CPT code 28890 as office-based in the CY 2008 OPPS/ASC proposed rule. They stated that CMS provided no explanation for the proposed change to the payment indicator of CPT code 28890. Furthermore, the commenters argued that the procedure is most appropriately provided in a facility setting and that the proposed ASC payment for the procedure would be limited to the MPFS nonfacility PE RVU amount, which is too low to cover the costs associated with providing the procedure. The commenters recommended that, because the CPT code was new for CY 2006, CMS should wait until sufficient time has passed to collect and review adequate Medicare data for its decision-making.

Another commenter requested that CMS not designate CPT codes 64650 (Chemodenervation of eccrine glands; both axillae) and 64653 (Chemodenervation of eccrine glands; other area(s) (e.g., scalp, face, neck), per day) as office-based procedures because the codes were new for CY 2006 and there are not yet adequate data on which to base that determination.

Response: While we appreciate the concerns of commenters regarding the limitation on payment for office-based procedures under the revised ASC payment system, we note that we finalized that payment policy in the August 2, 2007 revised ASC payment system final rule that set forth the final policies for the revised system after receiving and responding to public

comments (72 FR 42486). In that rule, we also finalized the evaluation criteria for the designation of surgical procedures as office-based (72 FR 42512). Therefore, the evaluation criteria and payment policy for office-based procedures were not open to comment in the CY 2008 OPPS/ASC proposed rule and we are not addressing additional comments in this final rule with comment period.

Based on the public comments we received, we reexamined the relevant data and clinical characteristics for each of the 15 procedures for which we received comments. Although, as the commenters asserted, many of the 15 procedures are performed in physicians' offices somewhat less than 50 percent of the time, our final policy for designating ASC procedures as office-based allows us to take into account the clinical characteristics, volume, and utilization data of related HCPCS codes to supplement our consideration of data specific to the codes of interest (72 FR 42512). Our review of the clinical characteristics of the 15 procedures and volume and utilization data for them and for similar procedures convinced us that our proposed designations are correct for all but 1 of the procedures.

We are not finalizing our proposal to designate CPT code 46505 (Chemodenervation of internal anal sphincter) as an office-based procedure. After reviewing the currently available utilization data for this code and related codes, we believe this procedure is not predominantly performed in physicians' offices and should maintain the ''G2'' payment indicator assigned to CPT code 46505 in the August 2, 2007 revised ASC payment system final rule for CY 2008.

In the case of CPT code 28890, although Medicare utilization data show that over 70 percent of CY 2006 utilization occurred in the physician's office, we are persuaded by commenters that this code was new for CY 2006 and some providers may have confused this service with the performance of low energy ESWT procedures. Stakeholders have explained to us that, although the physician utilization data may reflect that the service is performed mainly in the physician's office, this finding could be due to miscoding of low energy procedures that use only local anesthesia, rather than correct use of the CPT code 28890 to report high energy procedures that require anesthesia other than local. Nevertheless, we do not believe it would be appropriate to consider CPT code 28890 to be nonoffice-based for CY 2008 based on the significant utilization reported for the physician's office setting. Under the MPFS, this service has been priced specifically for performance in the office; therefore, we believe it can be appropriately performed in the physician's office. Furthermore, we note that there is an existing Category III CPT code for reporting the low energy services, specifically CPT code 0019T (Extracorporeal shock wave involving musculoskeletal system, not otherwise specified, low energy), for which the facility resources would be expected to differ. Nevertheless, given the concerns over the utilization data in the code's first year of use, while we follow the utilization of CPT code 28890 for another year, we will maintain the office-based designation of this procedure as temporary to allow for the possibility that coding for high energy ESWT for the plantar fascia will improve as providers gain more experience with the CPT code. This designation is indicated with an asterisk in Table 52 below. When we have sufficient data, we will either propose to finalize the office-based designation of the service or propose to change its payment indicator to ''G2'' as a nonoffice-based procedure.

While we are aware of the existence of CPT codes 0101T and 0102T for high energy ESWT for body areas other than treatment of the plantar fascia, utilization data available for the proposed rule did not support a proposal to designate those codes as office-based for CY 2008. Furthermore, these services have no MPFS nonfacility PE RVUs at this time. Therefore, a payment limitation based on the MPFS nonfacility PE RVUs could not be applied. We will review their utilization data for the next ASC annual update.

The procedures proposed for designation as office-based and their final CY 2008 payment indicators are listed in Table 52 below. All office-based designations are final, with the exception of the designation of CPT code 28890 as office-based, which will remain temporary until we have adequate utilization data to support a proposal to remove it from the office-based list or finalize the office-based designation.

TABLE 52.—CY 2008 FINAL NEW DESIGNATIONS OF ASC COVERED SURGICAL PROCEDURES PROPOSED AS OFFICE-BASED

HCPCS code (+ indicates procedures commenters recommended not be designated as office-based)	Short descriptor	Proposed CY 2008 payment indicator	Final CY 2008 payment indicator (* if designation is temporary for CY 2008)
24640+	Treat elbow dislocation	P3	P3
26641+	Treat thumb dislocation	P2	P2
26670+	Treat hand dislocation	P2	P2
26700+	Treat knuckle dislocation	P2	P2
26775+	Treat finger dislocation	P3	P3
28630+	Treat toe dislocation	P3	P3
28660+	Treat toe dislocation	P3	P3
28890+	High energy eswt, plantar fascia	P3	P3*
29035	Application of body cast	P2	P2
29305	Application of hip cast	P2	P2
29325	Application of hip casts	P2	P2
29505+	Application, long leg splint	P3	P3
29515+	Application lower leg splint	P3	P3
36469+	Injection(s), spider veins	R2	R2
46505+	Chemodenervation anal misc	P3	G2
62292	Injection into disk lesion	R2	R2
64447+	Nblock inj fem, single	R2	R2
64650+	Chemodenerv, eccrine glands	P3	P3

TABLE 52.—CY 2008 FINAL NEW DESIGNATIONS OF ASC COVERED SURGICAL PROCEDURES PROPOSED AS OFFICE-BASED—Continued

HCPCS code (+ indicates procedures commenters recommended not be designated as office-based)	Short descriptor	Proposed CY 2008 payment indicator	Final CY 2008 payment indicator (* if designation is temporary for CY 2008)
64653+	Chemodenerv, eccrine glands	P3	P3

We did not receive any public comments regarding our proposal to maintain as temporary the office-based designation for CPT codes 0099T (Implantation of intrastromal corneal ring segments); 0124T (Conjunctival incision with posterior juxtascleral placement of pharmacological agent (does not include supply of medication); and 55876 (Placement of interstitial device(s) for radiation therapy guidance (e.g., fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple) or our proposal to make permanent the designation of CPT code 36598 (Contrast injection(s) for radiologic evaluation of existing central venous access device, including fluoroscopy, image documentation and report) as office-based. Although we received public comments about the proposed policy to package more procedures for CY 2008 under the OPPS, we did not receive any specific public comments regarding the designation of CPT code 58110 (Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)) as packaged for CY 2008.

Therefore, we are finalizing our CY 2008 proposals, without modification, to maintain the temporary office-based designations of CPT codes 0099T, 0124T, and 55876, the permanent office-based designation of CPT code 36598, and the packaged status of CPT code 58110. The procedures and the final payment indicators for CY 2008 are displayed below in Table 53.

Displayed in Table 53 are the new CY 2008 HCPCS codes (excluding renumbered codes) to which we have assigned temporary office-based payment indicators. Those designations are temporary and are open to comment during the 60-day comment period for this final rule with comment period. We will respond to public comments on those designations in the OPPS/ASC final rule with comment period for CY 2009.

TABLE 53.—CY 2008 PAYMENT INDICATORS FOR PROCEDURES ASSIGNED TEMPORARY OFFICE-BASED PAYMENT INDICATORS IN THE AUGUST 2, 2007 REVISED ASC PAYMENT SYSTEM FINAL RULE

HCPCS code	Short descriptor	Final CY 2008 ASC payment indicator (* if designation is temporary for CY 2008)
0099T	Implant corneal ring	R2*
0124T	Conjunctival drug placement	R2*
36598	Inj w/fluor, eval cv device	P3
55876	Place rt device/marker, pros	P3*
58110	Bx done w/colposcopy add-on	N1

TABLE 54.—CY 2008 PAYMENT INDICATORS FOR NEW CY 2008 ASC COVERED SURGICAL PROCEDURES ASSIGNED TEMPORARY OFFICE-BASED PAYMENT INDICATORS ON AN INTERIM FINAL BASIS

HCPCS code	Short descriptor	Final CY 2008 ASC payment indicator (* if designation is temporary for CY 2008)
21073	Mnpj of tmj w/anesth	P3*
67229	Tr retinal les preterm inf	R2*
68816	Probe nl duct w/balloon	P3*

c. Changes in Designation of Covered Surgical Procedures as Device-Intensive

As explained in section XVI.C.1.c.(3) of this final rule with comment period, 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 August 2, 2007 revised ASC payment system final rule, 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 in the CY 2008 OPPS/ASC proposed rule, we proposed to designate as device-intensive for ASC payment in CY 2008 an additional 10 ASC covered surgical procedures. We also proposed to remove 4 procedures from their estimated designation as device-intensive because we proposed to recognize CPT codes instead of Level II HCPCS codes for ICD implantation procedures as discussed in section III.D.1.c. of this final rule with comment period. We proposed to assign payment indicators ''H8'' or ''J8,'' as appropriate, to the covered surgical procedures identified as device-intensive so that payment would be made consistent with our final revised ASC payment system payment policy.

We received a number of public comments on our proposal for payment of device-intensive procedures in ASCs for CY 2008. A summary of the public comments and our responses follow.

Comment: Most commenters were generally pleased with the final payment policy, but several commenters requested that CMS apply the device-intensive payment methodology to either all ASC covered procedures assigned to device-dependent APCs or to those assigned to APCs with a lower offset percentage threshold than 50 percent so that more ASC covered surgical procedure rates would be calculated using the device-intensive methodology. Many commenters requested that covered procedures for which ASCs billed separately for implantable prosthetic devices under the CY 2007 payment system also be treated like those procedures CMS has identified as device-intensive, even though the device offset percentage under the OPPS for the procedures may be less than the 50 percent threshold. Specifically, some of the commenters requested that the ASC payment rates for the CPT codes listed in Table 55 of this final rule with comment period be calculated as device-intensive procedure rates, that they be allowed to be paid at revised ASC rates without being subject to the transitional ASC rates for CYs 2008, 2009, and 2010 or that the device cost be added to the CY 2007 ASC rate which would be used to calculate the transitional rate. The commenters stated that the payment rates during the transition period for procedures like these, that require high cost implantable products, are too low for ASCs to be able to continue to provide the services. The commenters advised CMS to monitor the migration of these procedures, and others like them, into the higher cost HOPD setting during the first years under the revised ASC payment system.

TABLE 55.—SPECIFIC PROCEDURES FOR WHICH COMMENTERS REQUESTED CY 2008 PAYMENT RATES THAT FULLY RECOGNIZE THE COSTS OF IMPLANTABLE DEVICES

HCPCS code	Long descriptor	Final CY 2008 payment indicator
51715	Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck	A2
57288	Sling operation for stress incontinence (e.g., fascia or synthetic)	A2
65105	Enucleation of eye; within implant, muscles attached to implant	A2
65140	Insertion of ocular implant secondary; after enucleation, muscles attached to implant	A2
65155	Reinsertion of ocular implant; with use of foreign material for reinforcement and/or attachment of muscles to implant.	A2
65770	Keratoprosthesis	A2
66180	Aqueous shunt to extraocular reservoir (e.g., Molteno, Schocket, Denver-Krupin)	A2
67912	Correction of lagophthalmos, with implantation of upper eyelid lid load (e.g., gold weight)	A2

Response: We appreciate the information shared by the commenters and their suggestions for payment policies for ASC procedures included on the CY 2007 ASC list for which separate payment is currently made for implantable prosthetic devices. Nonetheless, the policy for payment of these procedures was made final in the August 2, 2007 revised ASC payment system final rule after we received and addressed public comments (72 FR 42503). Only two of the procedures cited by the commenter, CPT codes 57288 and 65770, are assigned to device-dependent APCs under the OPPS, and neither APC has a device offset percentage above 50 percent. Payment will be made for all of these services at the transitional rates for CY 2008, based on their status as nondevice-intensive procedures.

Comment: Several commenters suggested that CMS should create additional payment policies to provide special payment for new technologies, procedures on the CY 2007 ASC list of covered procedures that never were provided in ASCs, and previous pass-through devices. The commenters were concerned about procedures included on the CY 2007 ASC list that are not currently provided in ASCs. They stated that the very low payment amounts under the existing system precluded the performance of those procedures and, therefore, the procedures should not be subject to the transitional payment rates. In effect, the commenters explained, those procedures are new to the ASC list for CY 2008 and as such, they should be allowed to bypass the transition to be paid at the revised ASC rates in CY 2008. For example, one commenter suggested that CPT code 55873 (Cryosurgical ablation of the prostate (includes ultrasonic guidance for interstitial cryosurgical probe placement)), a device-intensive procedure, should not be subject to the transition at all because it was not performed in ASCs prior to CY 2008, even though it was included on the ASC list of covered surgical procedures beginning in CY 2005.

The commenter who suggested additional policies for new technology and pass through payments under the ASC payment system stated that adequate payment for newer advanced technologies in the most appropriate setting would ensure beneficiary access to optimum care.

Response: The payment policies for the revised ASC payment system to be implemented January 1, 2008 were finalized in the August 2, 2007 revised ASC payment system final rule after we received and addressed public comments (72 FR 42493). With respect to device-intensive procedures such as CPT codes 55873 that were on the CY 2008 ASC list, the device portion of the payment is not subject to the transition, while the payment portion will receive

transitional payment. The final policies do not incorporate a methodology to exclude from the transitional payment any procedures on the CY 2007 ASC list. We will not consider any changes to those policies in this final rule with comment period.

The final policies for the revised ASC payment system will pay separately for those implantable devices with pass-through status under the OPPS and will pay for new technology surgical procedures described by Category III CPT codes or Level II HCPCS codes that crosswalk directly or are clinically similar to established procedures already on the ASC list of covered surgical procedures. In this way, we believe these policies will serve to appropriately incorporate payment for new technologies under the revised ASC payment system.

In summary, after consideration of the public comments received, we are implementing, without modification, the proposal to designate the procedures listed in Table 56 as device-intensive ASC covered surgical procedures for CY 2008, based on their CY 2008 final assignments to APCs under the OPPS that are device-dependent and which have device offset percentages greater than 50 percent. We are not making any changes to our final ASC policies related to the designation of device-intensive procedures, transitional payment for procedures covered in the ASC setting in CY 2007, or payment for new technologies.

TABLE 56.—ASC COVERED SURGICAL PROCEDURES DESIGNATED AS DEVICE-INTENSIVE FOR CY 2008

HCPCS code	Short descriptor	CY 2008 OPPS APC	CY 2008 device-dependent APC offset percentage
33206	Insertion of heart pacemaker	0089	72.99
33207	Insertion of heart pacemaker	0089	72.99
33208	Insertion of heart pacemaker	0655	74.62
33210	Insertion of heart electrode	0106	56.25
33211	Insertion of heart electrode	0106	56.25
33212	Insertion of pulse generator	0090	76.01
33213	Insertion of pulse generator	0654	77.13
33214	Upgrade of pacemaker system	0655	74.62
33216	Insert lead pace-defib, one	0106	56.25
33217	Insert lead pace-defib, dual	0106	56.25
33224	Insert pacing lead & connect	0418	82.52
33225	Lventric pacing lead add-on	0418	82.52
33240	Insert pulse generator	0107	89.11
33249	Eltrd/insert pace-defib	0108	89.24
33282	Implant pat-active ht record	0680	73.15
36566	Insert tunneled cv cath	0625	58.88
53440	Male sling procedure	0385	51.56
53444	Insert tandem cuff	0385	51.56
53445	Insert uro/ves nck sphincter	0386	63.53
53447	Remove/replace ur sphincter	0386	63.53
54400	Insert semi-rigid prosthesis	0385	51.56
54401	Insert self-contd prosthesis	0386	63.53
54405	Insert multi-comp penis pros	0386	63.53
54410	Remove/replace penis prosth	0386	63.53
54416	Remv/repl penis contain pros	0386	63.53
55873	Cryoablate prostate	0674	60.27
61885	Insrt/redo neurostim 1 array	0039	82.73
61886	Implant neurostim arrays	0315	86.15
62361	Implant spine infusion pump	0227	80.73
62362	Implant spine infusion pump	0227	80.73
63650	Implant neuroelectrodes	0040	56.27
63655	Implant neuroelectrodes	0061	60.60
63685	Insrt/redo spine n generator	0222	84.86
64553	Implant neuroelectrodes	0225	80.57
64555	Implant neuroelectrodes	0040	56.27
64560	Implant neuroelectrodes	0040	56.27
64561	Implant neuroelectrodes	0040	56.27
64565	Implant neuroelectrodes	0040	56.27
64573	Implant neuroelectrodes	0225	80.57
64575	Implant neuroelectrodes	0061	60.60
64577	Implant neuroelectrodes	0061	60.60
64580	Implant neuroelectrodes	0061	60.60
64581	Implant neuroelectrodes	0061	60.60
64590	Insrt/redo pn/gastr stimul	0222	84.86
69930	Implant cochlear device	0259	82.94

2. Changes for Identification of Covered Ancillary Services

In the August 2, 2007 revised ASC payment system final rule, 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 the CY 2008 OPPS/ASC proposed rule (72 FR 42788), we proposed to make changes to the list of covered ancillary services eligible for separate ASC payment, as proposed in Addendum BB to that 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 final rule with comment period. Accordingly, we are finalizing changes to the list of covered ancillary services eligible for ASC payment in Addendum BB of this final rule with comment period to reflect the policies finalized for the CY 2008 OPPS and to add Category III CPT code 0182T to the list of covered ancillary services.

F. Payment for Covered Surgical Procedures and Covered Ancillary Services

1. Payment for Covered Surgical Procedures

a. 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 final rule with comment period. In the CY 2008 OPPS/ASC proposed rule (72 FR 42788), for CY 2008, we proposed to update payment for procedures with payment indicators ''G2'' and ''A2,'' using CY 2006 utilization data. We did not propose to make any changes to the final policies established in the August 2, 2007 revised ASC payment system final rule 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 the proposed rule, compared with the August 2, 2007 revised ASC payment system final rule, were 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 proposed to update the payment amounts for the office-based procedures in the CY 2008 OPPS/ASC proposed 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 proposed for payment of the procedure according to the final policy of the revised ASC payment system. The proposed update to the rates resulted 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 August 2, 2007 revised ASC payment system final rule may have been assigned payment indicator ''P3'' in the CY 2008 OPPS/ASC proposed rule, depending on the outcome of that rate comparison.

In addition, we proposed to update the payment amounts for the device intensive procedures in the proposed rule, based on the CY 2008 OPPS proposal and updated OPPS claims data.

We received many public comments on the proposed CY 2008 payment rates for covered surgical procedures. A summary of the public comments and our responses follow.

Comment: Many commenters were concerned that the proposed ASC rates for covered surgical procedures that require expensive equipment and single-use, disposable supplies would not be adequate to cover the costs, especially during the first 3 years of the revised payment system. The commenters offered a number of suggestions, such as establishing a class of procedures that are ''equipment-intensive'' for which an alternate payment methodology similar to that for ''device-intensive'' procedures could be used to set rates, to address their concern that payments, even at the revised ASC rates, would be inadequate for procedures like lithotripsy (CPT code 50590 (Lithotripsy, extracorporeal shock wave)), which requires equipment that costs the same wherever the procedure is performed. Other commenters suggested that procedures that include use of expensive single-use supplies be paid at the fully implemented rate beginning in CY 2008.

Response: We appreciate the commenters' concerns. However, the payment methodologies for the revised ASC payment system were made final in the revised ASC payment system final rule published on August 2, 2007 after we received and addressed public comments. As explained in that final rule (72 FR 42503), we believe that it would not be appropriate to provide separate payment for aspects of procedures (for example, implantable prosthetics or equipment) that are packaged into the ASC payment rates for the procedures under the revised payment system.

Comment: None of the commenters opposed updating the payment rates for covered surgical procedures by using the most recent available MPFS and OPPS data. However, several commenters asked that CMS review the proposed payment rate for CPT code 64517 (Injection, anesthetic agent; superior hypogastric plexus) because they believed that the proposed CY 2008 rate included in Addendum AA to the proposed rule might be erroneous.

Response: We reviewed the proposed rate for CPT code 64517, which is assigned payment indicator ''A2,'' and found that the rate for CY 2008 displayed in Addendum AA of the proposed rule was correct. The method for calculating the rate for procedures with ''A2'' payment indicator, like CPT code 64517, is displayed in Table 57. As can be seen in the table, the proposed rate of $178.12 for CPT code 64517 included in the CY 2008 OPPS/ASC proposed rule Addendum AA was correct. We believe the example presented is helpful in understanding the transitional payment rate calculations.

TABLE 57.—SAMPLE CALCULATION OF YEAR ONE (CY 2008) NATIONAL UNADJUSTED TRANSITIONAL PAYMENT RATE FOR COVERED SURGICAL PROCEDURES ASSIGNED PAYMENT INDICATOR ''A2''

Steps in calculation of year one (CY 2008) transitional ASC payment rate	CY 2008 rate calculation for procedures with payment indicator ''A2''	CY 2008 proposed rule calculation for CPT code 64517
Step 1	Multiply transition year one CY 2007 ASC portion of blended rate by the CY 2007 ASC rate.	0.75 x $139 = $104.25.
Step 2	Calculate CY 2008 fully implemented ASC rate by multiplying ASC relative weight by ASC conversion factor.	7.1370 x $41.400 = $295.4718.
Step 3	Multiply transition year one CY 2008 portion of blended rate by the fully implemented ASC rate.	0.25 x $295.4718 = $73.86795.
Step 4	Add the 75 percent and 25 percent amounts of the blended rate to equal the year one (CY 2008) transitional rate; round to two decimal places.	$104.25 + $73.86795 = $178.11795 which rounds to $178.12.

Therefore, after consideration of all public comments received, we are implementing our policy to update the CY 2008 ASC rates using the most recently available OPPS and MPFS data. The ASC national unadjusted rates for all covered surgical procedures are displayed in Addendum AA to this final rule with comment period.

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 August 2, 2007 revised ASC payment system final rule, 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 58 below is performed in an ASC and the case involves implantation of a no cost or full credit device listed in Table 59, 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 59 was furnished without cost. The devices listed in Table 59 are the same devices to which the policy applies under the OPPS, and the procedures listed in Table 58 are those ASC covered surgical procedures assigned to APCs under the OPPS to which the policy applies.

As finalized in the August 2, 2007 revised ASC payment system final rule (72 FR 42506), when the ''FB'' modifier is reported with a procedure code that is listed in Table 58, 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) Policy When Implantable Devices Are Replaced with Partial Credit

Consistent with our CY 2008 OPPS proposal discussed in section IV.A.3. of this final rule with comment period, we proposed 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 (72 FR 42788). We proposed that the 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 proposed 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.

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 the partial credit scenarios would likely not be reflected in our proposed OPPS rates for these device-dependent procedures. Therefore, we proposed 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 proposed 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. We listed the ASC procedures to which this proposed policy would apply in Table 64 of the CY 2008 OPPS/ASC proposed rule (72 FR 42790).

Moreover, we proposed 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. Accordingly, we proposed that the new HCPCS partial credit modifier must be reported for cases in which the device credit is equal to or greater than 20 percent of the cost of the new replacement device if the device was listed in Table 65 of the CY 2008 OPPS/ASC proposed rule with comment period (72 FR 42790). 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.

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 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 proposed 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.

Comment: As described in section IV.A.3. of this final rule with comment period, we received several public comments on our proposal to reduce payment if an expensive implantable device is replaced and the facility receives a partial credit toward the cost of the replacement device. Principally, the commenters agreed that neither Medicare nor beneficiaries should have to pay based on a device's full cost when the hospital receives a substantial credit from the manufacturer for that device and supported the premise underpinning the proposed policy that hospitals' charges and the payment rates based on those charges currently do not reflect partial credits for replaced devices. However, the commenters argued that CMS should raise the partial credit threshold to which this policy would apply to 50 percent of the cost of the replacement device, consistent with the policy CMS recently implemented for devices replaced with partial credit for services paid under the FY 2008 IPPS. Many commenters also urged adoption of the same billing options that are available under the IPPS for billing devices replaced with partial credit. Specifically, they requested that hospitals and ASCs be allowed to: (1) Submit the claims for replacement devices immediately without the HCPCS modifier signifying partial credit for a replacement device and later, if a credit is ultimately issued, submit a claim adjustment with the appropriate coding; or (2) hold the claim until a credit determination is made. We refer readers to section IV.A.3. of this final rule with comment period for a more detailed summary of the comments we received on this proposal.

Response: After consideration of the public comments received, we are adopting a modified policy for certain procedures involving partial credit for a replacement device. Consistent with the final CY 2008 OPPS policy described in detail in section IV.A.3. of this final rule with comment period, and the recently implemented FY 2008 IPPS policy, we will reduce the ASC payment for implantation procedures listed in Table 58 below by one half of the device offset that would be applied if a replacement device were provided at no cost or with full credit, if the credit is 50 percent or more of the replacement device cost, rather than the proposed 20 percent. We believe that payment policies across hospital payment systems, including the OPPS, the IPPS, and the revised ASC payment system, should align whenever possible and appropriate, as is true in this case. We refer readers to section IV.A.3. of this final rule with comment period for a more detailed discussion of our decision to implement a 50 percent rather than 20 percent threshold to which the partial credit policy will apply.

ASCs will be instructed to append the new ''FC'' modifier to the HCPCS code for the procedure in which the device was inserted on claims when the device that was replaced with partial credit under warranty, recall, or field action is one of the devices in Table 59 below (ASCs should not append the modifier to the HCPCS procedure code if the device is not listed in Table 59 below). The partial credit adjustment will be made to the national unadjusted rate, similar to what occurs when a device is replaced at full credit or with no cost, and beneficiary coinsurance will be adjusted to reflect the reduced payment amount.

As discussed in section IV.A.3. of this final rule with comment period, we understand commenters' concerns about potential delays that could occur while a returned device is being evaluated to determine whether and by how much a credit will be applied. In order to report that they received a partial credit of 50 percent or more of the cost of a replacement device, ASCs will have the option of either: (1) Submitting the claim for the device replacement procedure to their Medicare contractor after the procedure's performance but prior to manufacturer acknowledgment of credit for a replacement device, and subsequently contacting the contractor regarding a claims adjustment once the credit determination is made; or (2) holding the claim for the device replacement procedure until a determination is made by the manufacturer on the partial credit and submitting the claim with the ''FC'' modifier appended to the implantation procedure HCPCS code if the partial credit is 50 percent or more of the cost of the replacement device. If choosing the first billing option, to request a claim adjustment once the credit determination is made, ASCs should keep in mind that the initial Medicare payment for the procedure involving the replacement device is conditional and subject to adjustment. These billing instructions are consistent with instructions issued for billing under the IPPS and OPPS. We will issue additional billing instructions in a separate transmittal after publication of this final rule with comment period.

In summary, after consideration of the public comments received, we are finalizing a modified policy for certain procedures involving partial credit for a replacement device. Specifically, we will reduce the payment for implantation procedures listed in Table 58 below by one half of the device offset that would be applied if a replacement device were provided at no cost or with full credit, if the credit is 50 percent or more of the replacement device cost. In order to implement this policy, we will require ASCs to report the new modifier

''FC'' in all cases in which the ASC receives a partial credit toward the replacement of a medical device listed in Table 59 below when used in a surgical procedure listed in Table 58 for which the ASC received at least a 50 percent credit. In order to report that they received a partial credit of 50 percent or more of the cost of a replacement device, ASCs will have the option of either: (1) Submitting the claim for the device replacement procedure to their Medicare contractor after the procedure's performance but prior to manufacturer acknowledgment of credit for a replacement device, and subsequently contacting the contractor regarding a claims adjustment once the credit determination is made; or (2) holding the claim for the device replacement procedure until a determination is made by the manufacturer on the partial credit and submitting the claim with the ''FC'' modifier appended to the implantation procedure HCPCS code if the partial credit is 50 percent or more of the cost of the replacement device. Beneficiary coinsurance will be based on the reduced payment amount.

TABLE 58.—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	CY 2008 OPPS APC	APC title	CY 2008 OPPS offset percentage	50 percent of CY 2008 OPPS offset percentage
61885	Insrt/redo neurostim 1 array	0039	Level I Implantation of Neurostimulator	82.73	41.37
64590	Insrt/redo perph n generator.				
63650	Implant neuroelectrodes	0040	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	56.27	28.14
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.	60.60	30.30
64575	Implant neuroelectrodes.				
64577	Implant neuroelectrodes.				
64580	Implant neuroelectrodes.				
64581	Implant neuroelectrodes.				
33206	Insertion of heart pacemaker	0089	Insertion/Replacement of Permanent Pacemaker and Electrodes.	72.99	36.50
33207	Insertion of heart pacemaker.				
33212	Insertion of pulse generator	0090	Insertion/Replacement of Pacemaker Pulse Generator.	76.01	38.01
33210	Insertion of heart electrode	0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes.	56.25	28.13
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	89.11	44.56
33249	Eltrd/insert pace-defib	0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads.	89.24	44.62
63685	Insrt/redo spine n generator	0222	Implantation of Neurological Device	84.86	42.43
64553	Implant neuroelectrodes	0225	Implantation of Neurostimulator Electrodes, Cranial Nerve.	80.57	40.29
64573	Implant neuroelectrodes.				
62361	Implant spine infusion pump	0227	Implantation of Drug Infusion Device	80.73	40.37
62362	Implant spine infusion pump.				
69930	Implant cochlear device	0259	Level VI ENT Procedures	82.94	41.47
61886	Implant neurostim arrays	0315	Level II Implantation of Neurostimulator	86.15	43.08
53440	Male sling procedure	0385	Level I Prosthetic Urological Procedures	51.56	25.78
53444	Insert tandem cuff.				
54400	Insert semi-rigid prosthesis.				

TABLE 58.—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	CY 2008 OPPS APC	APC title	CY 2008 OPPS offset percentage	50 percent of CY 2008 OPPS offset percentage
53445	Insert uro/ves nck sphincter	0386	Level II Prosthetic Urological Procedures	63.53	31.77
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	82.52	41.26
33225	L ventric pacing lead add-on.				
36566	Insert tunneled cv cath	0625	Level IV Vascular Access Procedures	58.88	29.44
33213	Insertion of pulse generator	0654	Insertion/Replacement of a permanent dual chamber pacemaker.	77.13	38.57
33214	Upgrade of pacemaker system	0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker.	74.62	37.31
33208	Insertion of heart pacemaker.				
33282	Implant pat-active ht record	0680	Insertion of Patient Activated Event Recorders.	73.15	36.58

TABLE 59.—DEVICES FOR WHICH THE ''FB'' OR ''FC'' 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.
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. 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 provide separate ASC payment for brachytherapy sources and drugs and biologicals that are separately paid under the OPPS at the OPPS rates, while we 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, in the CY 2008 OPPS/ASC proposed rule (72 FR 42790), we also proposed 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 proposed to package for the CY 2008 OPPS were assigned payment indicator ''Z2'' or ''Z3'' in the August 2, 2007 revised ASC payment system final rule, but they were assigned payment indicator ''N1'' in Addendum BB to the CY 2008 OPPS/ASC proposed rule. We refer readers to section II.A.4.c. of this final rule with comment period for a description of the CY 2008 OPPS proposed packaging approach that we also proposed to adopt in ASCs. In addition, OPPS payments for brachytherapy sources and separately payable drugs and biologicals are discussed in sections VII.B. and V. of this final rule with comment period, 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 final rule with comment period.

We received many public comments on our proposal for payment of covered ancillary services under the CY 2008 revised ASC payment system. A

summary of the public comments and our response follow.

Comment: Many commenters disagree with the proposal to package payment for CPT codes 72285 (Discography, cervical or thoracic, radiologic supervision and interpretation) and 72295 (Discography, lumbar, radiological supervision and interpretation), in accordance with the proposed packaging policy under the OPPS. The commenters were concerned that the surgical procedures that are packaged into CPT codes 72285 and 72295 (CPT codes 62290 (Injection procedure for discography, each level; lumbar) and 62291 (Injection procedure for discography, each level; cervical or thoracic)), as well as a number of other surgical procedures that are packaged into other codes in the range of CPT codes for radiology services, will no longer be available in ASCs as a result of the new packaging policy. The commenters requested that CMS develop a payment policy like that applied to these codes under the OPPS to allow separate payment for the services when they are provided without a covered surgical procedure.

Response: As explained in the August 2, 2007 revised ASC payment system final rule (72 FR 42485), we continue to believe that packaging payment for those surgical procedures that are packaged under the OPPS is appropriate under the revised ASC payment system. Our policy is aligned with the recommendation of the Practicing Physicians Advisory Council (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 the services, consistent with the recommendation of MedPAC to maintain consistent payment bundles under both payment systems.

Under the OPPS, the services described by CPT codes 72285 and 72295 may be provided without another separately paid surgical procedure and, therefore, have been assigned to the OPPS status indicator ''Q'' to indicate that payment for the service is usually packaged into payment for another procedure but that under some circumstances, the service may be paid separately. For example, in the HOPD, if the service described by CPT code 72285 is provided without another separately paid service (into which it usually would be packaged), then a separate payment is made for it under the OPPS.

According to the revised ASC payment system policies, there is no instance in which payment for a service is packaged only sometimes. The services that are packaged into covered surgical procedures are always packaged; that is, they are unconditionally packaged. There is no payment policy for ASCs that parallels the OPPS policy for the ''Q'' status indicator which, under OPPS conditional packaging policies, provides packaged payment for the service unless it is billed without any other separately payable OPPS service (or in some cases, without any other separately payable surgical procedure) on the same day, in which case separate OPPS payment is allowed for the status indicator ''Q'' service. In ASCs, there is no circumstance in which Medicare would make separate payment to an ASC for a service if it was not performed with a covered surgical procedure. Only covered surgical procedures may be paid when billed alone, without other separately payable services. Our policy is to make separate payment for all covered surgical procedures and for all covered ancillary services which, by definition, are provided integral to a covered surgical procedure performed in an ASC. Therefore, under the revised ASC payment system, the radiology services of concern to the commenters are packaged for CY 2008.

After consideration of the public comments received, we are providing CY 2008 payment for covered ancillary procedures in accordance with their final payment policies under the revised ASC payment system as described in the August 2, 2007 revised ASC payment system final rule and their final treatment under the CY 2008 OPPS. Covered ancillary services and their final payment indicators are listed in Addendum BB to this final rule with comment period.

G. Physician Payment for Procedures and Services Provided in ASCs

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 MPFS 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)(5)(i)(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 August 2, 2007 revised ASC payment system final rule, 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, which are integral to the 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, as explained in the CY 2008 OPPS/ASC

proposed rule, 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 proposed to revise §§ 414.22(b)(5)(i)(A) and (b)(5)(i)(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, the services would not be covered ASC services. Consistent with Medicare payment policy in other care settings, no payment for facility costs would be made for the noncovered services. In this case, the noncovered 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.

We received a number of public comments on our proposal to pay physicians at the facility PE rate instead of the nonfacility PE amount for excluded procedures, to not pay physicians the technical component (TC) payment for ancillary services, and to make beneficiaries responsible for the ASC charges for noncovered services furnished to them in ASCs. A summary of the public comments and our responses follow.

Comment: Several commenters requested that CMS not proceed with the proposal and continue the existing payment policy for excluded services performed in ASCs and payment for the TC associated with ancillary services to physicians who provide those services. One commenter stated that he provides permanent seed prostate brachytherapy services to Medicare beneficiaries in hospital and ASC settings. Under current Medicare payment policy, the commenter received the TC payment for a number of services in the radiology range of CPT codes because he brought the necessary equipment to the facility with him when he came to provide the brachytherapy procedures. The commenter stated that he would be able to provide prostate brachytherapy services to a larger number of Medicare patients if he could continue to receive the TC payment for the ancillary services.

Response: Our proposed policy for physician payment would preclude physicians from receiving the TC payment for procedures performed in ASCs because, under the revised ASC payment system, Medicare will make payment only to ASCs for ancillary services provided integral to covered surgical procedures. The costs associated with the provision of covered ancillary services are facility resources, and Medicare will provide separate ASC payment for those costs. However, the ASC is not precluded from contracting with another entity to provide the equipment and supplies required to provide specific services. The ASC would make payment to its contractors.

Comment: Some commenters stated that beneficiaries should not be liable for the costs of procedures and services that are not covered when performed in ASCs. A few commenters believed that the beneficiary should only be liable for his or her deductible and coinsurance amounts, just as he or she would be for covered procedures in ASCs. One commenter stated that the course of a planned, covered procedure cannot always be determined in advance because the physician may have to alter the procedure intraoperatively, and sometimes that alteration results in performance of an excluded, noncovered procedure. The commenter did not believe it would be fair to hold the beneficiary liable in such cases. One commenter suggested that CMS create a modifier that the ASC would use to identify cases in which the planned, covered procedure was altered intraoperatively due to unexpected circumstances. The commenter indicated that payment in those cases could be priced by the contractor based on review of the operative report. The commenter stated that use of the modifier would enable CMS to track such occurrences and could audit as needed.

Response: We appreciate the commenters'' concern regarding beneficiary liability for excluded ASC procedures. However, because we have adopted a final policy for the revised ASC payment system that identifies and excludes from ASC payment only those procedures that pose a significant risk to beneficiary safety or would be expected to require an overnight stay, we continue to 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. Therefore, consistent with Medicare payment policy in other care settings, no payment for facility costs would be made for the noncovered services, and the beneficiary would be liable. As we explained in the CY 2008 OPPS/ASC proposed rule, because of the significant expansion of the ASC list of covered surgical procedures, we expect that excluded procedures will not be performed in ASCs beginning in CY 2008.

After consideration of the public comments received, we are finalizing our CY 2008 proposal, without modification, to pay physicians only the facility PE amount and exclude payment of the TC if applicable, for the performance of surgical procedures and nonsurgical services in ASCs and to make beneficiaries liable for the facility charges for procedures provided in the ASC that are excluded from ASC payment.

H. 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'' and ''outpatient prescription drugs.'' The definition of ''designated health services'' at § 411.351 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 previously excluded x-ray, fluoroscopy, and ultrasound procedures that require the insertion of a needle, catheter, tube, or probe through the skin or into a body orifice. In addition, the definition of ''radiology and certain other imaging services'' excludes radiology procedures that are integral to the performance of a nonradiological medical procedure and (1) performed during the nonradiological medical procedure or (2) performed 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 have been subject to the physician self-referral prohibition.

Taken together, these provisions effectively excluded from the physician self-referral prohibition referrals for: (1) Radiology and certain other imaging services that were paid through the ASC composite payment rate; and (2) radiology procedures that were integral to the performance of an ASC covered surgical procedure, that were paid separately, and that were performed in the ASC either (a) during the surgical procedure or (b) 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 and certain other imaging 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.)

Under the August 2, 2007 revised ASC payment system final rule (72 FR 42470), effective January 1, 2008, Medicare makes a bundled or composite payment for facility services and a separate payment for each covered ancillary service that is integral to a covered surgical procedure and performed in the ASC on the same day. Because facility services continue to be paid under a composite rate, a physician referral for any radiology or other imaging service or outpatient prescription drug that is paid for as a facility service under § 416.164(a) is excluded from the physician self-referral prohibition under paragraph (2) of the definition of ''designated health services'' at § 411.351.

Covered ancillary services for which separate payment is made per item or service include many radiology and certain other imaging services. The August 2, 2007 revised ASC payment system final rule discusses the radiology services that are included in new § 416.164(b) as covered ancillary services integral to, and furnished on the same day as the ASC surgical procedure (72 FR 42496 through 42498).

Under the revised ASC payment system, a greater variety of surgical procedures than previously allowed can be provided as ASC services, and, thus, a greater number of ''radiology and certain other imaging services'' would be subject to the physician self-referral prohibition. Accordingly, in the August 2, 2007 rule proposing changes to both the outpatient hospital prospective payment system and the ASC payment system, we proposed to revise the physician self-referral definition of ''radiology and certain other imaging services'' to exclude those radiology and imaging services that are ''covered ancillary services,'' as defined at 416.164(b), for which separate payment is made under the revised ASC payment system (72 FR 42792). That is, we proposed 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 (that is, on the same day) would not constitute ''radiology and certain other imaging procedures'' for purposes of the physician self-referral law. We noted that if we did not revise the definition of ''radiology and certain other imaging services'' for physician self-referral purposes to exclude these radiology and other imaging procedures, the physician self-referral law would prohibit an ASC from billing Medicare for these separately payable, integral ancillary services rendered to patients who had been referred by a physician with an ownership or investment interest in, or compensation relationship with, an ASC unless an exception applies.

For the reasons that warrant our revising the definition of ''radiology and certain other imaging services,'' we also proposed to exclude from the definition of ''outpatient prescription drugs'' at § 411.351, drugs that are ''covered as 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 our proposal, such drugs would not constitute DHS, although the physician self-referral provisions would continue to be applicable when an ASC furnishes outpatient prescription drugs for use in the patient's home.

Although we believe that physician referrals to entities with which they have a financial relationship are susceptible to abuse, we believe that our revision to the definitions of ''radiology and certain other imaging services'' and ''outpatient prescription drugs'' promote quality of care without posing a risk of abuse. The change will promote quality of care by allowing patients timely, convenient access to outpatient drugs and radiology and imaging services that are integral to an ASC procedure and necessary for its safe performance in an ASC. The risk of program abuse is avoided by the requirement that the items and services must be ''integral to'' the ASC procedure (that is, performed in the ASC immediately preceding, during, or immediately following the covered surgical procedure). We caution that only those items and services that

are integral to an ASC procedure and performed on the same day as the covered surgical procedure will qualify for the exclusion from the definitions of ''radiology and certain other imaging services'' and ''outpatient prescription drugs.'' Other separately billable services that do not satisfy these conditions will remain subject to the physician self-referral prohibition. We will continue to monitor the provision of services in ASCs for potential abuse.

In addition, for clarity, we proposed to make a technical correction to paragraph (2) of the definition of ''radiology and certain other imaging services'' at § 411.351 to exclude from the definition not only ''radiology procedures'' that are integral to the performance of a ''nonradiological procedure,'' but also 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 received one public comment supporting the proposed change in the definition of ''radiology and other imaging services.'' Two additional public comments concern radioactive seeds and ribbons (radioactive sources) implanted during brachytherapy procedures performed in an ASC. These items are included within the DHS category of ''radiation therapy and supplies.''

Comment: Two commenters asked CMS to exclude from the definition of DHS radioactive sources (including seeds and ribbons) furnished during a brachytherapy procedure performed in an ASC because DHS, as defined at § 411.351, does not include ''services that are reimbursed by Medicare as part of a composite rate (for example, ambulatory surgical center services * * *).'' In addition, the commenter suggested that, consistent with our proposal to exclude radiology services and outpatient prescription drugs that are ''covered ancillary services'' furnished on the same day as an ASC procedure, we should exclude from the definition of ''radiation therapy services and supplies'' brachytherapy sources that are also ASC covered ancillary services integral to a covered surgical procedure for which separate payment is made under new § 416.164(b). The commenters pointed out that, if these radioactive sources were not excluded from the physician self-referral prohibition, many urologist-owners of ASCs would not be able to order and furnish brachytherapy services because the ASC must bill Medicare for the radioactive sources and they are not included in a composite rate.

Response: The DHS category ''radiation therapy services and supplies'' includes radioactive sources used in connection with brachytherapy procedures. The commenters are correct that a urologist or other type of physician who has an ownership or investment interest in, or a compensation relationship with, an ASC may not refer a Medicare patient to the ASC for a brachytherapy procedure, unless an exception is satisfied.

Previously, except for brachytherapy procedures performed as inpatient or outpatient hospital procedures, Medicare made payment for the radioactive sources to the individual or entity that furnished the radioactive sources. Under the ASC payment system effective for procedures performed on or after January 1, 2008, Medicare pays the ASC for facility services that are packaged into the ASC payment. In addition, Medicare makes a separate payment to an ASC for certain ancillary items and services, including brachytherapy sources.

The commenters are correct that, without an exception under the physician self-referral provisions, a urologist who refers a Medicare patient for an ASC-covered brachytherapy procedure may not have either an ownership or investment interest in the ASC or a compensation relationship with the ASC because the brachytherapy sources are DHS.

Although we did not propose to exclude, nor are we excluding in this final rule with comment period, brachytherapy sources supplied in connection with an ASC-covered brachytherapy procedure, we intend to consider this issue, and if we decide to propose an exception, we will include such changes in a proposed rule and seek public comment.

We are adopting the proposed physician self-referral provisions without change and we are making one additional technical, nonsubstantive change. We are revising the definition of ''designated health services'' at § 411.351 to reflect the fact that CMS no longer pays for all ASC procedures under a composite rate. Specifically, the definition will refer to ''SNF Part A payments or ASC services identified at § 416.164(a)'' as examples of services that Medicare pays as part of a composite rate. Section 416.164(a) sets forth the facility services for which a bundled or composite payment is made under the revised ASC payment system.

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, Pub. L. 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), Pub. L. 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), Pub. L. 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), Pub. L. 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's 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 will 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://www.cms.hhs.gov/ASCPayment/05_NTIOLs.asp.*

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.

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 February 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 complete the review of such a request within 90 days of receipt, and upon completion of our review, we 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.
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, ZA9003 and AR40xEM; Alcon Acrysof® IQ Model SN60WF and Acrysert Delivery System Model SN60WS; Bausch & Lomb Sofport AO model 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 did not propose to revise, nor are we revising in this final rule with comment period, 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. 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. We included the proposed CY 2008 ASC payment rates for IOL insertion procedures in Table 66 of the proposed rule (72 FR 42795) that is reprinted, with final CY 2008 ASC payment rates, below.

Comment: Several commenters supported the revision to the process for recognizing IOLs inserted during or subsequent to cataract extraction as belonging to a new or active NTIOL class. One commenter suggested that, for purposes of administrative simplicity, CMS should make the comment period on requests for new NTIOL classes 60 days, rather than 30 days as proposed. The commenter believed that Congress intended that CMS provide at least a 30-day comment period and argued that further adjusting the comment period for NTIOLs to 60 days would be consistent with the comment period for the rest of the OPPS/ASC proposed rule.

Response: We appreciate the commenters' continuing support regarding our recent revision to the process for recognizing IOLs inserted during or subsequent to cataract extraction as belonging to a new or active NTIOL class. We continue to believe that aligning the NTIOL process with annual updates to the OPPS and the revised ASC payment system promotes coordination and efficiency, thereby streamlining and expediting the NTIOL notification, comment, and review process. In response to the comment urging us to adjust the comment period regarding requests to establish new classes of NTIOLs to 60 days, we note that section 141(b)(3) of the Social Security Act Amendments of 1994 (SSAA 1994), Pub. L. 103-432, clearly requires us to provide a 30-day comment period on lenses that are the subject of requests for recognition as belonging to a new class of NTIOLs. Therefore, we will continue to provide a 30-day comment period on lenses that are the subject of requests for recognition as members of a new class of NTIOLs.

After considering the public comments received, we are finalizing,

without modification, the process and timelines proposed for NTIOL consideration under the ASC payment system. The payment adjustment for NTIOLs will continue to be $50 for CY 2008.

7. Announcement of CY 2008 Deadline for Submitting Requests for CMS Review of Appropriateness of ASC Payment for Insertion of an NTIOL Following Cataract Surgery

In accordance with § 416.185(a) of our regulations, as revised by the CY 2007 OPPS/ASC final rule with comment period, CMS announces that, in order to be considered for payment effective January 1, 2009, requests for a review of an application for a new class of new technology IOLs must be received at CMS by 5 p.m., EST, on March 14, 2008. Send requests to: ASC/NTIOL, Division of Outpatient Care, Mailstop C4–05–17, Centers for Medicare and Medicaid Services,7500 Security Boulevard, Baltimore, MD 21244–1850.

To be considered, requests for NTIOL reviews must include the information posted on the CMS Web site at *http://cms.hhs.gov/ASCPayment/05_NTIOLs.asp#TopOfPage.*

TABLE 60.—INSERTION OF IOL PROCEDURES AND THEIR CY 2008 ASC PAYMENT RATES

HCPCS code	Long descriptor	CY 2008 ASC payment
66983	Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)	$976.76
66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification).	976.76
66985	Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract removal	866.51
66986	Exchange of intraocular lens	866.51

J. ASC Payment and Comment Indicators

In addition to the payment indicators that we introduced in the August 2, 2007 revised ASC payment system final rule, we also introduced comment indicators for the ASC payment system in the CY 2008 OPPS/ASC proposed rule (72 FR 42795). 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 that lists the ASC comment indicators. Like the comment indicators used in the OPPS, the ASC comment indicators used in Addenda AA and BB to this OPPS/ASC final rule with comment period 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'' is used in this final rule with comment period to indicate new HCPCS codes for which the interim payment indicator assigned is subject to comment in this final rule.

The changes for CY 2008 that we proposed to the payment indicators assigned to HCPCS codes for procedures and services in the August 2, 2007 revised ASC payment system final rule were identified with a ''CH'' in the OPPS/ASC proposed rule and were subject to comment during the 60-day comment period provided for that proposed rule. ''CH'' is used in Addenda AA and BB to this CY 2008 OPPS/ASC final rule with comment period to indicate that a new payment indicator (in comparison with that in the August 2, 2007 revised ASC payment system final rule) has been assigned to an active HCPCS code for the 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. The ''CH'' comment indicators that are published in this CY 2008 OPPS/ASC final rule with comment period are provided to alert our readers that a change has been made since the August 2, 2007 revised ASC payment system final rule, 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 final rule with comment period.

We did not receive any comments that addressed our proposal related to implementation and use of comment indicators for the revised ASC payment system. Therefore, we are finalizing our proposal, without modification, to adopt the comment indicators as defined in Addendum DD2 to this final rule with comment period.

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 August 2, 2007 revised ASC payment system final rule. 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 as 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 HOPDs. 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: One commenter expressed concern that the public was denied time to analyze and respond to the findings in the congressionally mandated GAO report on ASC costs. The commenter believed that CMS' reliance on the GAO Report findings in finalizing the development of the revised payment system for ASCs, without also considering comments from the public about those findings, potentially violated principles of fairness and transparency. The commenter specifically stated that the report's findings are flawed and that the OPPS is not a relative cost proxy for ASCs' costs for gastrointestinal (GI) procedures.

Response: As we discussed in our response to comments on this topic in the August 2, 2007 revised ASC payment system final rule (72 FR 42475), 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. We appreciate the public's interest in providing us with detailed input regarding the revised ASC payment system from a variety of perspectives. We noted that the GAO's recommendations were in complete accord with our proposal for the revised ASC payment system (71 FR 49635), and we provided a 90-day comment period on our proposal for CY 2008. We believe that the comment period for the August 23, 2006 proposed rule provided the public with ample opportunity to comment on the policies that ultimately were recommended by the GAO.

L. Calculation of the ASC Conversion Factor and ASC Payment Rates

1. Overview

As discussed in section XVI.C. of this final rule with comment period, 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. In the August 2, 2007 revised ASC payment system final 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 August 2, 2007 revised ASC payment system final rule, our estimate of the CY 2008 budget neutral ASC conversion factor was $42.542. In the CY 2008 OPPS/ASC proposed rule, the proposed ASC conversion factor for CY 2008 was $41.400. For this final rule with comment period, the ASC conversion factor for CY 2008 is $41.401. Although this final ASC conversion factor differs little from the estimate in the August 2, 2007 revised ASC payment system final rule and the CY 2008 OPPS/ASC proposed rule, it reflects several changes, including: (1) Use of the final OPPS relative payment weights for CY 2008; (2) use of the final MPFS nonfacility PE RVU amounts for CY 2008; (3) use of updated utilization data from CY 2006; and (4) application of an adjustment to reflect differences in the geographic wage adjustment policy between the current and revised systems (discussed in further detail below). As in the proposed rule, in this final rule with comment period, we use the final methodology described in the August 2, 2007 revised ASC payment system final rule (72 FR 42522) to calculate the final CY 2008 ASC conversion factor and the final ASC relative payment weights and rates.

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 payment 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 2, 2007 revised ASC payment system final rule, 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 consider the term ''expenditures'' in the context of the budget neutrality requirement under section 626(b) of Pub. L. 108–173 to mean expenditures from the Medicare Part B Trust Fund. We do 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 August 2, 2007 revised ASC payment system final rule and as applied to updated data available for this final rule with comment period.

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 August 2, 2007 revised ASC payment system final rule (72 FR 42521).

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 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 August 2, 2007 revised ASC payment system final rule).

(b) For each new ASC procedure, we multiply the results of Step 1(a) by the 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 CY 2008 physician in-office payment rates. ''Physician in-office payment rate'' is equal to the MPFS nonfacility PE RVUs multiplied by the 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 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 August 2, 2007 revised ASC payment system 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 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 August 2, 2007 revised ASC payment system final rule).

Step 7: Migration of new ASC office-based procedures from physicians' offices to ASCs is valued based on CY 2008 OPPS payment rates capped at the 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 CY 2008 OPPS rate for the procedure; or

(2) The 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 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 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 CY 2008 MPFS physician out-of-office payment rate. ''Physician out of-office payment rate'' is equal to the facility PE RVUs multiplied by the CY 2008 MFPS conversion factor.

(a) For each new ASC procedure, we multiply the results of Step 2(a) from above by the 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 CY 2008 OPPS payment rates.

To estimate the aggregate amount of expenditures that would be made in CY 2008, we use 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 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 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 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 final rule with comment period results in a budget neutrality adjustment of 0.65. This number does not differ from the estimated budget neutrality adjustment of 0.65 for the CY 2008 OPPS/ASC proposed rule for the revised ASC payment system that was based on partial year CY 2006 utilization and proposed CY 2008 OPPS and MPFS payment rates (72 FR 42797).

We built an estimate of differences in total payment created by differences in the geographic adjustment policy between current and revised systems into the above model. Medicare currently accounts for geographic wage variations when calculating individual ASC payments under the existing payment system by applying the relevant IPPS wage index values and localities that were established under the IPPS prior to the implementation of Core Based Statistical Areas (CBSAs) issued by the Office of Management and Budget in June 2003 to a labor-related portion of 34.45 percent of the ASC payment amount. As discussed in the August 2, 2007 revised ASC payment system final rule (72 FR 42518), the revised payment system will account for geographic wage variations when calculating individual ASC payments by applying the pre-reclassification wage index to a labor-related portion of 50 percent of the ASC payment amount.

In the CY 2008 OPPS/ASC proposed rule, we noted that we did not have a provider-level dataset of ASC utilization that accurately identified unique ASCs and their geographic information and that this prevented us from calculating a budget-neutral wage adjustment. In our August 2, 2007 revised ASC payment system final rule, we estimated that the change in the wage policy would not significantly change aggregate ASC payment. We have since constructed this provider-level database using several sources to verify the validity of geographic information on the file. We have also crosswalked deleted HCPCS codes and their associated utilization to the CY 2008 HCPCS codes. Items previously paid under the ASC system, for which payment was not adjusted for differences in labor costs (for example, NTIOLs), were not included in this analysis. Using this provider-level dataset of CY 2006 ASC claims, we estimated total CY 2008 payment using revised ASC payment rates, the existing payment system labor-related portion of 34.45 percent, and the existing payment system wage index values. Using the same dataset, we also estimated total CY 2008 payment using revised ASC payment rates, a labor-related portion of 50 percent, and the pre-reclassification wage index values based on CBSAs. Comparing the two totals, we calculated an adjustment of 1.00464, suggesting that the revised wage index values and labor-related portion would modestly reduce payments under the revised wage policy compared to the current policy. We built this adjustment factor into our budget neutrality model to calculate the final budget neutrality adjustment for the revised ASC payment system. Incorporating an adjustment for geographic wage differences did not change the final budget neutrality adjustment.

The final budget neutrality adjustment of 0.65 for the CY 2008 revised ASC payment system reflects updated data, including complete CY 2006 utilization and final CY 2008 OPPS and MPFS payment rates, as well as the addition of an adjustment for the final geographic wage adjustment policy of the revised ASC payment system.

d. Calculation of the CY 2008 ASC Payment Rates

After developing the final CY 2008 budget neutrality adjustment of 0.65 according to the policies established in the August 2, 2007 revised ASC payment system final rule, to determine the final CY 2008 ASC conversion factor, we multiplied the final CY 2008 OPPS conversion factor by the ASC budget neutrality adjustment. The final CY 2008 OPPS conversion factor is $63.694, and multiplying that by the 0.65 budget neutrality adjustment yields our final CY 2008 ASC conversion factor of $41.401. To determine the fully implemented ASC payment rates for this final rule with comment period, including beneficiary coinsurance, according to the final payment methodology that applies to most covered surgical procedures and certain covered ancillary services under the revised ASC payment system, we multiplied the ASC conversion factor by the ASC relative payment weight (which equals the OPPS payment weight in CY 2008) for each procedure or service. As further discussed in section XVI.C. of this final rule with comment period, 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 PE RVU 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. The CY 2008 ASC payment rates of covered ancillary drugs and biologicals and brachytherapy sources are set equal to their final CY 2008 OPPS payment rates, so the ASC conversion factor is not applicable to these items. We then calculated the 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 final 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 final rule with comment period. We refer readers to Addenda AA and BB to this final rule with comment period for the final 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 August 2, 2007 revised ASC payment system final rule, 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 (72 FR 42531). 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 services whose payment rates are related to OPPS relative payment weights. Scaling would not apply in the case of ASC payment for 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. 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.

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 August 2, 2007 revised ASC payment system final rule, we adopted a final policy to update the ASC conversion factor using the CPI–U in order to adjust ASC payment rates for inflation (72 FR 42518). 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.

We received a number of public comments regarding the update of the ASC conversion factor using the CPI–U. A summary of the public comments and our responses follow.

Comment: Several commenters were concerned that updating the conversion factor for the revised ASC payment system using the CPI–U would cause divergence in the relationship between payment to HOPDs (the OPPS is updated annually as the statute requires, using the hospital market basket percentage increase, as described in section II.C. of this final rule with comment period) and ASCs over time that would not be based on growing differences between the costs of providing procedures in those two different settings. The commenters believed that hospitals and ASCs experienced similar inflationary pressures. Therefore, they recommended that CMS use the hospital market basket as the update for inflation under the revised ASC payment system because that update would more appropriately reflect inflation in the costs of providing surgical services. In addition, the commenters believed that the same update under the two payment systems would allow for a consistent relationship between their payment for the same surgical procedures.

Response: While we appreciate the commenters' concerns, the update policy for the revised ASC payment system was not open to comment in the CY 2008 OPPS/ASC proposed rule because we finalized that policy in the August 2, 2007 revised ASC payment system final rule after we received and addressed public comments (72 FR 42519). Beginning in CY 2010, when the period of the zero update for ASCs that the statute requires ends, we will apply the CPI–U to update the ASC conversion factor for inflation under the revised ASC payment system.

M. Annual Updates

Under the revised ASC payment system, we 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 ASC payment. To the extent possible under the rules and policies of the revised ASC payment system, we 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 will 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 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 believe that including the ASC update as part of the OPPS rulemaking cycle will ensure that updates of the ASC payment rates and the list of covered surgical procedures for which Medicare makes payment to ASCs will be issued in a regular, predictable, and timely manner. Moreover, the ASC payment system will 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 addition, we 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 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 will be open to comment on that final rule, and we will respond to comments about our interim determinations in the OPPS/ASC 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 be included 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 are able to consider more recent volume and utilization data for each individual procedure code or, if appropriate, the clinical characteristics, utilization, and volume of related codes. Using that information, if we confirm our determination that the new code was appropriately assigned to an office-based payment indicator, it will then be permanently assigned to the list of office-based procedures subject to the payment limitation.

Accordingly, this annual rulemaking and publication of revised payment methodologies and payment rates are reflected in § 416.173 of the regulations.

Comment: A few commenters urged us to complete the alignment of the OPPS and ASC by migrating from the CMS–1500 form to the UB–04 billing form for ASC claims submission, the same claim form that is used by HOPDs for Medicare payment and by ASCs for some other payers. They recommended that CMS initiate a transition process for providers and the agency's administrative contractors to implement the UB–04 form for ASCs in CY 2010. The commenters stated that during CYs 2008 and 2009 ASCs would gain experience with the revised payment system and reporting quality measures and by CY 2010 could be ready to adopt the UB–04 for submitting their Medicare claims.

Response: This same comment was addressed in the August 2, 2007 revised ASC payment system final rule (72 FR 42534). As we discussed in that final rule, we will explore the feasibility of adopting the ASC billing change recommended by commenters. We reiterate here that a policy change that requires ASCs to use a different billing format would have to allow 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. 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.

XVII. Reporting Quality Data for Annual Payment Rate Updates

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. 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 in order 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 the CY 2008 OPPS/ASC proposed rule (72 FR 42799), we proposed to establish a separate reporting program and proposed 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.I. of this final rule with comment period for a discussion of our decision to introduce implementation of ASC quality data reporting in a later rulemaking.

3. Reporting Hospital Inpatient Quality Data for Annual Payment Update

Section 5001(a) of the Deficit Reduction Act of 2005, Pub. L. 109–171, set out the current requirements for the IPPS RHQDAPU program. We established the RHQDAPU program in order to implement section 501(b) of Pub. L. 108–173. The program builds on our ongoing voluntary Hospital Quality Initiative. The Initiative is intended to empower consumers with quality of care information so that they can make more informed decisions about their health care while also encouraging hospitals and clinicians to improve the quality of their care. Under the current statutory provisions found in section 1886(b)(3)(B)(viii) of the Act, the IPPS annual payment update for ''subsection (d)'' hospitals that do not submit inpatient quality data in a form, and manner, and at a time specified by the Secretary is reduced by 2.0 percentage points.

We used an initial ''starter set'' of 10 quality measures for the IPPS RHQDAPU program under section 501(b) of Pub. L. 108–173 and have expanded the measures as required under section 1886(b)(3)(B)(viii)((IV) and (V) of the Act, as added by section 5001(a) of Pub. L. 109–171. We initially added measures as a part of the annual IPPS rulemaking process. In response to public comments asking that we issue IPPS RHQDAPU program quality measures and other requirements as far in advance as possible, we also have used the OPPS annual payment update rulemaking process to adopt IPPS RHQDAPU program measures and requirements. In the CY 2007 OPPS final rule (71 FR 68201), we added six additional IPPS RHQDAPU program quality measures for FY 2008 update.

Most recently, in the FY 2008 IPPS proposed rule (72 FR 24805), we proposed adding 5 additional quality measures in for the FY 2009 update. However, in the FY 2008 IPPS final rule with comment period (72 FR 47351), we only adopted one of the proposed additional five measures. We indicated that we intended to adopt three additional measures in this CY 2008 OPPS/ASC final rule with comment period, but only if the measures were adopted by the National Quality Forum (NQF). The NQF is a voluntary consensus standard-setting organization established to standardize health care quality measurement and reporting through its consensus development process. Under section 1886(b)(3)(B)(viii)(V) of the Act, we are required, to the extent feasible and practicable, to use measures set forth by entities such as NQF when adding new measures.

Section XVII.J. of this final rule with comment period contains a discussion of our decision to add two additional NQF-endorsed quality measures to the IPPS RHQDAPU program, with reporting to begin with the first calendar quarter of 2008 discharges, for the FY 2009 annual payment update.

B. Hospital Outpatient Measures

For the initial implementation of the HOP QDRP, we proposed 10 quality measures that we believed to be 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: *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

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, CMS identified five quality measures that were directly related to conditions treated or interventions provided in hospital outpatient settings and that we believed were also appropriate and fully developed for use in the HOP QDRP. These measures were specified in a form that assessed the care provided by physicians, however, these measures are also relevant to assessing care at the facility level. CMS was engaged in reviewing, and where appropriate, revising these measure specifications so that they explicitly assess care provided in hospital outpatient settings. he five measures included 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.

Therefore, for hospitals to receive the full OPPS payment update for services furnished in CY 2009, in the CY 2008 OPPS/ASC proposed rule (72 FR 42800) we proposed 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. The specifications for outpatient measures were then completed for hospital data collection using the same format that is used for inpatient measures. CMS finalized the specifications for these 10 measures and released them publicly on August 28, 2007. In addition these 10 measures have gone through the NQF steering committee process.

Nine of the ten proposed 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 that patient noncompliance with prescribed treatment regimen can also lead to poor diabetes control and elevated A1c levels. Patients with comorbidities or diabetes complications may also have a harder time controlling their diabetes and thus have higher A1c levels. Therefore, we specifically requested comments on this intermediate outcome measure and whether it may lead to unintended consequences.

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 was 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 invited public comment on our rationale for choosing a diabetes outcome measure rather than a process measure.

Comment: Several commenters supported collecting quality measure data for outpatient hospital services. Several commenters agreed with not using any inpatient quality measures for the outpatient hospital setting. One commenter stated that the proposed indicators are things that providers should be achieving for patients, and if done correctly, this endeavor will help to drive down the overall expenditures in health care.

Response: We thank the commenters for their support.

Comment: Several commenters supported the emergency room measures. However, the commenters also expressed concern that these measures would most affect smaller facilities that may not have the resources required for such data collection. One commenter stated that its facility does not transfer such patients and would not have any data for this set of measures.

Response: We appreciate the support expressed by commenters for the five ED–AMI measures. We agree that these measures will mostly apply to smaller facilities that do not admit such patients, transferring them instead. In fact, these measures were designed specifically for smaller facilities that were not included under quality measure reporting for inpatient measures. We recognize that some facilities, usually larger ones, do not transfer such patients; information on these patients for these facilities is captured under quality measure reporting for inpatient measures. Including the five ED–AMI measures in the required measure set for HOP QDRP will allow smaller facilities the opportunity to report quality measure data. We acknowledge that there are resource costs associated with collecting quality measure data, however, we also view it important that an opportunity to report such data be provided to smaller facilities and that consumers have information available from this type of facility. There is no penalty for not reporting quality measure data in the event that the provider does not have relevant cases.

Comment: One commenter did not support the use of the ED–AMI–4–Median Time to Electrocardiogram as this measure has not been adopted by NQF, nor is it collected for inpatients and, thus, is not ready for reporting.

Response: As statutorily required, affected parties reached consensus on the 10 proposed quality measures for outpatient hospital services. In addition, the ED–AMI–4 measure has been submitted for NQF endorsement with the other ED–AMI measures; all of these

measures have gone through the NQF steering committee process and have been recommended for endorsement.

Comment: One commenter expressed concern that for the five ED–AMI measures, the specifications contain no mention of observation patients.

Response: Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment, before a decision can be made regarding whether a patient will require further treatment as a hospital inpatient. Observation status is commonly assigned to patients who present to the emergency room. Thus, the five ED–AMI measures are specifically designed to capture care rendered to such patients; patients that receive care but are not admitted as inpatients, that is, have outpatient status.

Comment: Many comments addressed the use of the Hemoglobin A1c measure. Several commenters expressed opinions ranging from concern with to strong opposition to the use of the Hemoglobin A1c measure for measuring outpatient hospital quality of care. While agreeing with the importance of hemoglobin A1c levels as a clinical measure for diabetes care, some commenters viewed this as more reflective of physician care and patient compliance. As the proposed Hemoglobin A1c measure is an outcome measure that is not risk adjusted; the need to use only process measures or risk adjust any outcome measures was also stated. One commenter agreed with the use of the proposed Hemoglobin A1c measure and that this measure did not require risk adjustment, but stated that this measure does need definition of the expected frequency of what the inclusion and exclusion criteria are. One commenter supported the Hemoglobin A1c measure but suggested a revision to being <7 percent, consistent with clinical guidelines.

Response: We agree with these comments regarding the Hemoglobin A1c measure. As noted in the proposed rule, the Hemoglobin A1c measure is an intermediate outcome measure that has not been risk adjusted. Recognizing the individual patient challenges with regard to this measure, as well as the need to otherwise modify the measure, we will not include the Hemoglobin A1c measure in the final HOP QDRP measure set at this time.

Comment: Several commenters stated that, except for the ED patients, it was unclear what the patient populations of interest are under the proposed outpatient hospital measures. For example, surgery patients could come from several areas of the hospital and PQRI #1 and #5 could apply to outpatients that present for services unrelated to their conditions. Two commenters expressed concerns about patients that walk out from the ED and requested that these patients be excluded from any ED measures.

Response: As discussed previously and noted below, data collection on the PQRI #1 measure will not be required for any CY 2009 HOP QDRP determinations. We thank the commenters for raising the issue of patients that walk out from the ED and will consider this issue in the formulation of future measure specifications. We are also concerned about the comments received concerning the administrative burden for collection on PQRI #5-Heart failure and PQRI #59-communicty acquired pneumonia. We agree with the commenters that, at this point, those proposed quality measures may not be sufficiently refined for use in the outpatient setting. Therefore, we are not adopting PQRI #5 and PQRI #59 at this point as quality measures for the HOP QDRP.

Comment: Several commenters disagreed with the use of any or all of the five, non-ED-AMI measures as measures of quality of care for hospital outpatient services on the grounds that these measures were more indicative of the care provided by other settings, especially physician practices.

Response: We acknowledge that the five non-ED AMI measures were initially developed for measurement of quality of care provided by physician practices, and are all part of CMS'' physician quality reporting initiative. However, the two surgical infection prevention measures would also apply to patients who have surgery in the hospital outpatient department. The diabetes measure and the heart failure measure apply to hospital outpatient department clinics that provide primary care services, and the pneumonia measure applies to hospital outpatient clinic departments and patients who are seen in an emergency department and discharged to home from the ED. Thus, it is our view that all of these measures could be fairly applied to hospital outpatient services as these patients are seen and services are rendered in this setting. However, in understanding of various concerns with some of these measures, we have decided to not include collection of data for the proposed heart failure, pneumonia, and diabetes measures as discussed in this section, for making HOP QDRP decisions for the CY 2009 payment update determinations. Data for the two perioperative care measures will be required.

Comment: Commenters supported some of the non-ED measures. One commenter stated that perioperative care and timing of antibiotics (PQRI #20) are currently captured for inpatients and would be suitable reporting indicators for outpatient surgical cases if hospitals are provided specific surgical procedures to be included, are informed whether interventional procedures would be included, and are notified which prophylactic antibiotics would be included. One commenter stated that the proposed pneumonia measure was logical for measuring quality of care related to antibiotic administration in the ED and for patients under observation status.

Response: We thank the commenters for their support of these quality measures and intend to provide necessary specifications for data collection. At this time, there are no requirements to sample cases for the perioperative care measures by surgery type and thus there is no need to separate out specific surgical procedures for the purposes of selecting cases for the perioperative measures.

Comment: Several commenters expressed concern about the administrative and financial burden that would be associated with collecting outpatient hospital quality measure data, and indicated that the effort to be expended to collect such information would outweigh the benefit of this collection. Two commenters stated that data should be collected to improve clinical practice not just for payment purposes.

Response: We recognize that there are administrative and financial costs associated with collecting quality measure data. The reporting of quality measures for hospital outpatient services builds on our previous efforts in the inpatient arena, having the same purpose. Reporting is intended to encourage hospitals and clinicians to improve their quality of care and to empower consumers with quality of care information to make more informed decisions about their health care. We also note the requirement to report hospital outpatient quality measure data is statutory with the payment implication contingent upon the reporting of such information.

Comment: Several commenters stated that the infrastructure did not exist to support collecting outpatient hospital data as it did for collecting inpatient hospital data. The commenters stated that it would be extremely difficult if not impossible to meet the

implementation timeline due to the complexities of building data collection information systems. In particular, some of the commenters pointed out differences in storage of outpatient hospital services information and the possible need to connect information systems and people from different parts of a hospital and the lack of existing vendors as important differences.

Response: We recognize that the data infrastructure necessary to support collecting outpatient hospital data varies considerably among hospitals. To lessen the burden associated with this effort and recognizing the need for further refinement of some of the proposed measures for the outpatient setting, we have reduced the number of required measures and delayed implementation as discussed later in this final rule with comment period. Also, to aid hospitals in collecting these data, we will be providing a data collection tool in sufficient advance timing of required data submission.

Comment: Several commenters expressed concerns for training/support. For example, the commenters asked if a Quest or Quest-like entity would be provided and whether QIOs would be involved for the HOP QDRP. One commenter urged that QIOs be involved in providing support to hospitals for the HOP QDRP.

Response: We recognize the need for hospital support under the HOP QDRP. It is our intent that a Quest or Quest-like entity be provided to support this effort. In addition, we are in the process of procuring a contractor to assist in supporting implementation of HOP QDRP. Under the initial implementation of the HOP QDRP, there will be no QIO involvement.

Comment: Several commenters asked questions related to the source of required data, in particular, what claim submission form would be the data source, what is the definition of outpatient hospital services, what is the population or universe for sampling purposes, what is considered a hospital-based outpatient clinic (for example if a hospital owns an outside clinic, are these cases included or are only the clinics within the hospital to be included).

Response: Under MIEA–TRCHA, Quality Measure Reporting for Outpatient Hospital Services applies to ''subsection (d)'' hospitals subject to the OPPS. The Medicare Benefit Policy Manual, Chapter 6, under Hospital Services Covered Under Part B, provides the following definition of ''hospital outpatient'': ''A hospital outpatient is a person who has not been admitted by the hospital as an inpatient but is registered on the hospital records as an outpatient and received services (rather than supplies alone) from the hospital.'' Under this definition, such services must be directly received from the hospital. Thus, the population of interest consists of services rendered to Medicare beneficiaries reimbursed to hospitals under the OPPS or comparable services rendered under other payers. For Medicare beneficiaries, the claims data source for this information would be the UB–04, formally known as the UB–92. The UB–04 is a uniform institutional provider bill suitable for use in billing multiple third party payers. All other information necessary would come from the medical record.

Comment: Several commenters asked when the algorithms used for the measures would be available for review. In particular, they asked if the algorithms would be available for review at least 120 days prior to any start date to allow for vendor programming.

Response: The measure specifications were posted on August 28, 2007, far in advance of any proposed data reporting requirements. The following Web site includes the 10 proposed Hospital Outpatient (HOP) Measures: *http://www.cms.hhs.gov/QualityInitiativesGenInfo/01_overview.asp*. These measure specifications are final for April 2008 discharges forward. As discussed later in this section, data collection will begin with services rendered beginning April 2008 rather than beginning January 2008. From our perspective, the specifications for the final HOP measures finalized in this final rule with comment period are ready to use for programming purposes. It is possible that we will issue a revised version of the measure specifications for services after April 2008, but sufficient time for programming and data submission will be allowed.

Comment: One commenter asked whether vendor tools would be required to have reporting capabilities.

Response: We do not supply external vendors with requirements; we provide the measure specifications. We will consider providing such functionality in any reporting tool supplied by CMS.

Comment: Several commenters asked whether critical access hospitals would be required to report quality measures for hospital outpatient services. One commenter stated that critical access hospitals should be required to report data on the five ED–AMI measures proposed.

Response: The statute specifically notes the entities subject to the reporting quality measure data requirement for OPPS annual payment updates. Section 1833(t)(17)(A)(i) of the Act, as added by section 109(a) of the MIEA–TRHCA (Pub. L. 109–432), requires a 2.0 percentage point reduction to the OPPS conversion factor update for those ''subsection (d)'' hospitals that do not submit to the Secretary data required to be submitted on measures selected in a form and manner, and at a time, specified by the Secretary. Subsection (d) hospitals are defined in section 1886(d)(1)(B) of the Act and do not include critical access hospitals. Additionally, outpatient hospital services at critical access hospitals are not reimbursed under the OPPS, so a reduction in the OPPS update factor would not affect critical access hospitals.

Comment: Several commenters asked whether the proposed payment reduction would apply to all services reported in CY 2009.

Response: As stated in the statute, the payment reduction would affect the annual OPPS payment increase by 2.0 percentage points. Thus, all hospital outpatient services subject to this update would be affected.

Comment: Several commenters urged CMS to not proceed with implementation of measures that have not received NQF endorsement and to wait until HQA finalizes their list of measures; field testing of measures was also recommended.

Response: The statute requires that we develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings and that these measures reflect consensus among affected parties and, to the extent feasible and practicable, we include measures set forth by one or more national consensus building entities. The five ED–AMI measures address care provided to outpatients that receive many of the same interventions as inpatients who are evaluated and admitted at the same facility, and whose care is currently assessed in measures that are endorsed by NQF. Also, these five ED–AMI measures are inpatient AMI measures that have long been reported under the IPPS RHQDAPU program. As of the publication of this final rule with comment period, the two perioperative measures, Perioperative Care: Timing of Antibiotic Prophylaxis and Perioperative Care: Selection of Prophylactic Antibiotic, have received NQF endorsement. As discussed in this final rule with comment period, data collection for the remaining three proposed measures for heart failure, pneumonia, and diabetes mellitus will

not be required for CY 2009 payment decisions.

We utilize field-testing to the extent it is feasible and practical. The five ED–AMI transfer measures have been extensively tested for use in the inpatient setting. We have removed the transfer exclusion in order to incorporate the ED–AMI measure into the outpatient hospital setting. We believe the five ED–AMI measures are optimal for use in the outpatient hospital setting and will help fulfill our MIEA–TRCHA requirements for outpatient quality measure reporting. We intend to begin additional field testing in November 2007 and plan to make changes as necessary to specifications for future reporting.

Comment: One commenter recommended that any CMS-supplied tool should have separate modules for inpatient and outpatient data collection and reporting.

Response: It is our intent that the CMS-supplied tool will have separate modules for inpatient and outpatient data collection and reporting.

Comment: Several commenters noted that in the specifications of the two surgical measures in the Specifications Manual for hospital outpatient measures, CPT codes as opposed to ICD–9 codes were used to define the relevant procedures and questioned this approach. Several commenters also suggested that for any NQF-endorsed measures, the ''all codes'' versions should be used.

Response: CPT, E/M (Evaluation and Management) and ICD–9–CM Codes are used to identify eligible cases in the outpatient measures. Because the set of measures crosses settings (clinic, emergency department, hospital outpatient surgery department), it is necessary to utilize a variety of codes to adequately capture and sample the appropriate populations. For the surgical measures, each procedure is assigned a CPT code on the claim form and hospitals will use this information to pull the charts to be abstracted. The CPT–4 is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. More information regarding coding can be found on the CMS Web site at: *http://www.cms.hhs.gov/MedHCPCSGenInfo/20_HCPCS_Coding_Questions.asp.*

Comment: Several commenters expressed concerns about OPPS data reliability due to coding disparities from the high volume of many closely related codes.

Response: We understand the complexities of coding for outpatient services and have designed specifications with this in consideration. While data validation will not be used in the CY 2009 HOP QDRP determinations, as discussed below, future validation efforts can help to reduce coding disparities.

After consideration of the public comments received and as discussed in the above responses to those comments, for the CY 2009 annual payment update we are requiring HOP QDRP reporting using 7 of the proposed measures—the five ED–AMI measures as well as the two Perioperative Care measures, PQRI #20 Perioperative Care: Timing of Antibiotic Prophylaxis and PQRI #21 Perioperative Care: Selection of Prophylactic Antibiotic. As noted previously, we have decided to not implement three of the proposed measures, specifically those related to heart failure, diabetes, and community-acquired pneumonia for CY 2009 payment decisions. These decisions are based upon the recognition of the burden placed on providers in developing systems to collect outpatient quality measure data and need to utilize quality measures sufficiently refined for use in the outpatient setting.

C. Other Hospital Outpatient Measures

In addition to the 10 measures discussed above, we are considering a number of other possible quality measures for use in assessing the care provided by hospital outpatient settings, for the HOP QDRP determinations for CY 2010 or subsequent calendar year payment updates. 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. In the CY 2008 OPPS/ASC proposed rule, (72 FR 42801), we expressed interest 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. In the CY 2008 OPPS/ASC proposed rule, (72 FR 42801), we also expressed interest 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 sought 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 percent 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.
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.

	Measure	NQF endorsed for inpatient or ambulatory setting	Description
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.
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.

As with the Hemoglobin A1c diabetes intermediate outcome measure described in XVII.B of this preamble, we included two diabetes intermediate outcome measures in this list of 30 additional measures—that is, good control of blood pressure (less than 140/80 mm Hg) and LDL–C levels (less than 100 mg/dl). We specifically invited comment on these outcome measures.

We solicited comments on these 30 additional measures for inclusion in the HOP QDRP for CY 2010 or subsequent calendar years and welcomed 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.

Comment: Several commenters questioned in general the appropriateness of the proposed measures for hospital outpatient care. In particular, several commenters stated that the listed additional 30 measures were not suitable for hospital outpatient care in their present form and that the measures should be refined to be more specific to the hospital outpatient setting. The commenters viewed the listed additional 30 measures as more relevant to care provided in other settings, especially physician-based settings.

Response: We acknowledged in the proposed rule that the listed additional 30 measures are either in use or were developed for use in settings other than hospital outpatient (72 FR 42801). As we stated, it is our intent to develop, where feasible, hospital outpatient measures that are ''harmonized,'' with measures for assessing comparable inpatient and ambulatory care, that is, comparable care rendered in different settings can be evaluated in similar ways. We intend to expand the set of measures on which hospital outpatient settings must report data for payment decisions for CY 2010 and subsequent calendar years.

Comment: Several commenters stated that it was difficult to comment on the additional 30 measures proposed for future use as it was difficult to know if any of them would be considered best practice in the near future, noting the period of endorsement was short for many. Several commenters stated that any quality measure chosen for public reporting and pay for performance should be generally accepted as best practice. One commenter stated that quality measures with longer ''shelf-life'' be used.

Response: We agree with the commenters'' position that any quality measures chosen for public reporting and pay for performance should be generally accepted as best practice. We understand that it is more desirable to utilize quality measures with more longevity. We will take these comments into consideration when we review additional measures for possible inclusion in the HOP QDRP measure set.

Comment: Three commenters stated that the requirement to collect

information that affected hospital payment that was dependent on physician activity fostered a hostile environment. One commenter emphasized that there is no financial incentive for physicians to participate in improving hospital outpatient quality measures. One commenter stated that creation of this hostile environment affected larger hospitals to a lesser extent and made recruitment/retention more difficult for smaller hospitals.

Response: Under section 1833(t)(17) of the Act, as added by section 109(a) of the MIEA–TRHCA, CMS is statutorily required to establish a hospital outpatient care data reporting program. We will continue to utilize a consensus process in devising measures applicable to the hospital outpatient setting. As discussed in this final rule with comment period, a sampling scheme devised around hospital outpatient volume will be devised to lessen the burden for smaller hospitals. It is our intent that quality measure reporting will encourage providers and clinicians to improve their quality of care.

Comment: One commenter provided strong support for one potential indicator, ''Radiation therapy is administered within 1 year of diagnosis for women under age 70 receiving breast conserving surgery for breast cancer.''

Response: We thank the commenter for supplying information supporting this quality measure and will consider it in the selection of future HOP QDRP measures.

Comment: Several commenters stated that in regard to the 30 additional measures listed, given the lack of operational data collection processes for outpatient hospital data and the associated costs of collecting quality measure data, CMS should not consider any additional measures, especially for the first year of reporting.

Response: We acknowledge that there is a burden with collecting quality measure data. As stated in the proposed rule, we indicated that we were considering the additional listed 30 measures for CY 2010 or subsequent calendar year reporting requirements, although we also solicited comments on whether any of the listed 30 additional measures should be included in reporting for the CY 2009 payment year. Further, as discussed elsewhere in this final rule with comment period, we have reduced the number of required reporting measures for the CY 2009 payment year from the 10 we proposed. However, given the importance of outpatient hospital quality measure reporting it is our intent to propose additional measures in the future.

Comment: One commenter expressed concern with the use of PQRI #2 and PQRI #3 as these are outcome measures and as such should not be used as a basis for determining payment. One commenter strongly opposed the PQRI #14 measure, stating that a needle biopsy is not always appropriate. One commenter strongly opposed the PQRI #18 measure, stating that ordering an ECG is a judgment call, and that an ECG is not always indicated with non-traumatic chest pain. Several commenters expressed support for cancer care related measures.

Response: We thank the commenters for expressing these concerns and will hold these concerns in consideration of future measure requirements.

Comment: One commenter strongly supported imaging-related quality measures.

Response: CMS appreciates this comment and intends to incorporate imaging measures in the future.

Comment: One commenter stated that the term ''outpatient'' needed to be more clearly defined and that an approach that narrowed the population of interest for outpatient care by service as do the five ED–AMI measures and the surgical day care measures (PQRI #21 and PQRI #22) should be used for other measures.

Response: Although PQRI #21 and PQRI #22 were not in the list of 30 measures included in the proposed rule, we understand the commenter's intent and thank the commenter for this suggestion. We will keep it in mind as we consider future measures.

Comment: Several commenters recommended that the same numbering system be used in the specifications manuals for both the inpatient and outpatient data tables and in particular, that CMS use of the same number for corresponding tables.

Response: We thank the commenters for this suggestion and will look to aligning the specification manuals for inpatient and outpatient quality measures to the extent possible.

Comment: Several commenters suggested that osteoporosis measures (PQRI #24, #39, #40, and #41) be included in the HOP QDRP; and also asked that data collection for these measures begin in CY 2008. One commenter stated that CMS should promote the prevention of fragility fractures by distinguishing DXA testing from pharmacologic therapy in HOP QDRP measures.

Response: We thank the commenters for support of these measures and for the suggestions. As noted above, to reduce provider burden and recognizing the need for further refinement of some of the proposed measures for the outpatient setting, the number of required measures has been reduced for CY 2008 quality data reporting efforts. We will consider these measures for future implementation.

Comment: One commenter stated that with respect to the 30 additional listed measures, populations to be included must be carefully defined so that any public reporting will compare like populations, to the extent that outcomes data are reported, risk adjustment was critical, and that process measures be reasonable.

Response: We thank the commenter for these comments to be used in consideration of future measures.

After consideration of the public comments received and as noted in the above responses to those comments, we are not collecting data for any of the additional 30 listed measures under the HOP QDRP for purposes of the CY 2009 update.

D. Implementation of the HOP QDRP and Request for Additional Suggested Measures

In the CY 2008 OPPS/ASC proposed rule, (72 FR 42803), we stated that for purposes of CY 2009 payments, we would require hospitals to begin to submit data on the 10 measures that we identified under section XVII.B. of the proposed rule. We also noted that, while we would expect to focus on these 10 measures and would consider comments on them for the CY 2009 payment year, we would 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 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 ensuring 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.

In the CY 2008 OPPS/ASC proposed rule, (72 FR 42803), we welcomed suggestions 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.

Comment: Two commenters asked for the consideration of the PQRI #4 Screening for Future Fall Risk outpatient quality measure as well as the following occupational therapist measures, Patient Co-Development of Plan of Care, Pain Assessment Prior to Initiation of Patient Treatment, and Universal Documentation and Verification of Current Medications in the Medical Record. One commenter suggested measures for preventive care for future use. Several commenters suggested the inclusion of administration of anti-platelet therapy for patients with coronary artery disease. One commenter suggested the inclusion of measures on venous thromboembolism and care coordination. One commenter suggested the inclusion of additional medical prophylaxis safety measures including 2 SCIP measures (SCIP–VTE1, venous thromboembolism prophylaxis ordered for a surgery patient and SCIP–VTE2, prophylaxis within 24 hours pre/post surgery). One commenter suggested the development of additional VTE measures. One commenter suggested that in addition to quality measures, the hospital component of the Consumer Assessment of Health Providers and Systems (HCAHPS) has several questions directed to patients that are applicable to hospital outpatient care and, thus, could provide useful information about outpatient quality care.

Response: We thank the commenters for supplying additional, potential quality measures for consideration in the HOP QDRP measure set.

Comment: One commenter noted that there is a discrepancy between the SCIP VTE–1 and PQRI #23 measures and that while these are not proposed measures under this rule, CMS should review all of its quality measures to ensure compatibility and lack of conflict. One commenter suggested aligning the PQRI measures with the outpatient quality measures.

Response: We thank the commenters for these observations, and we will continue to strive to ensure compatibility and alignment of measures across settings.

Comment: Several commenters suggested that any financial implications related to outpatient quality measure reporting be deferred.

Response: Under section 1833(t)(17)(A)(i) of the Act, as added by section 109(a) of the MIEA–TRHCA, the HOP QDRP is established to affect payments effective beginning in CY 2009.

E. Requirements for HOP QDRP for CY 2009 and Subsequent Calendar Years

In the CY 2008 OPPS/ASC proposed rule, (72 FR 42803), we stated that in order 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.

We proposed the following requirements for participation in the HOP QDRP:

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.

Comment: Several commenters requested delays in implementation in general, though the November 15, 2007 date for submitting the Notice of Participation form was not mentioned. One commenter urged that communication of this requirement be made clearly and frequently so that all hospitals are aware of the steps they need to take to participate in the HOP QDRP.

Response: We understand the concerns of these commenters and have decided to delay the deadline for completing the Notice of Participation form. The deadline for submission of the Notice of Participation form will be revised from November 15, 2007 to January 31, 2008. It is our intent that the forms for the inpatient and outpatient programs will be available on the same Web site. We understand the difficulties inherent in implementing a new data collection system and have revised the deadline for completion of the Notice of Participation form as part of efforts to reduce hospital burden as discussed further later in this section.

Comment: Several commenters expressed appreciation that CMS was working to utilize existing processes in implementing data collection of hospital outpatient quality measures.

Response: We thank the commenters for their support of our efforts.

Comment: One commenter suggested that small or low volume hospitals be held harmless on the reporting of outpatient hospital quality measure data

due to the undue burden of an essentially unfunded mandate.

Response: We acknowledge the commenter's concern regarding burden on smaller hospitals, but continue to view the importance of quality measure data from all providers of comparable services. As discussed throughout this section of the final rule with comment period, in response to such burden concerns, several aspects of the HOP QDRP have been revised for the first reporting year.

Comment: One commenter asked that there be a single Notice of Participation form for reporting inpatient and outpatient hospital quality measure data.

Response: We agree that it would be preferable to have a single Notice of Participation form for the inpatient and outpatient hospital quality measure data reporting programs. However, a single form is not possible at this time due to separations of the data and administrative systems for the two programs. We will seek to consolidate processes as much as possible in the future to ease burdens associated with meeting the different requirements of these two programs.

We are finalizing the administrative requirements as proposed, with the modification of changing the deadline for the Notice of Participation form to January 31, 2008.

2. Data Collection and Submission Requirements

We proposed 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 proposed 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 was May 31, 2008 with proposed submission deadlines for all other data submissions being 4 months after the last day of the calendar quarter. Data would 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.

HOP QDRP data submission will be through the CMS contractor's secure Web site. Detailed information about the Web site for submitting quality measure data under the HOP QDRP is not available as of the publication of this final rule with comment period. We anticipate awarding the contract to design and manage the OPPS Clinical Warehouse in the near future. 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 the proposed rule, we noted it was 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 proposed 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 would 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.

In the CY 2008 OPPS/ASC proposed rule (72 FR 42804), we stated our expectation that hospitals will 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.

In addition to collecting and submitting data as noted above, we proposed that, to be eligible for the full OPPS payment update in CY 2009 and subsequent years, hospitals must also:

- Submit complete and accurate data. A ''complete'' submission would be 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.
- 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.

Comment: Several commenters recommended that CMS adopt some delay in implementation. The commenters suggested that this delay could be accomplished by phasing in or reducing the number of measures that hospitals would be required to collect data and delaying the deadline for initial data submission. Several commenters viewed some or all of the additional five non-emergency department measures as an unnecessary, additional burden, asking for delay or elimination of some or all of these five measures until a system for collecting and reporting can be evaluated.

Response: As noted previously, we have revised the number of required outpatient hospital measure information by reducing the required measure set from 10 to 7 measures for initial implementation. For the reporting of quality measures for HOPD affecting CY 2009 payments, data will be required only for the five ED–AMI measures and the two perioperative care measures (PQRI #20 Perioperative Care: Timing of Antibiotic Prophylaxis and PQRI #21 Perioperative Care: Selective of Prophylactic Antibiotic). For reasons discussed above related to hospital burden and refinement of measures for the outpatient setting, data collection on PQRI #5 Heart Failure: Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) for Left Ventricular Systolic Dysfunction (LSVD), PQRI #59: Empiric Antibiotic for Community-Acquired Pneumonia, and PQRI #1: Hemoglobin A1c Poor Control in Type I or II Diabetes Mellitus will not be required in the initial HOP QDRP measure set.

With regard to commenters' requests that we delay the deadline for initial data submission, we agree. Due to the importance of the HOP QDRP and the need for accurate and timely submission of required data, we are revising our proposed submission period and deadline. Rather than requiring initial submission for services furnished on or after January 1, 2008, we are requiring initial submission for services furnished on or after April 1, 2008. The data submission deadline for April to June 2008 discharges is November 1, 2008, 4 months from the last day of the calendar quarter. As proposed, 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 participate in the HOP QDRP. As noted, we are statutorily required to establish a program under which hospitals will report data on the quality of hospital outpatient care using standardized measures of care in order to receive the full annual OPPS update effective for payments beginning in CY 2009. In balancing the commenters' concerns and the statutory requirements, we have delayed the initial data submission as much as we believe is possible while still meeting statutory deadline. For the subsequent data submissions for CY 2008 services the submission deadlines will be February 1, 2009 for July to September 2008 services and May 1, 2009 for October to December 2008 services.

Comment: One commenter asked if the quarterly data submission was due November 1, 2009, as stated in the proposed rule, or if this date should be November 1, 2008.

Response: As stated above, the deadline for submitting data for the initial quarterly data submission of April–June 2008 services will be November 1, 2008.

Comment: One commenter noted that the OPPS appeared to have 1st of the month data submission deadlines, whereas, the inpatient measures have a 15th of the month submission deadline and asked for alignment of the submission deadlines for both.

Response: We understand that there is an interest in alignment to reduce confusion and data submission errors. However, the dates were deliberately chosen and spaced accordingly to avoid issues with concurrent submission of large amounts of data.

Comment: Due to the large volume of outpatient services potentially involved for quality measure reporting, several commenters suggested the use of sampling of cases.

Response: We agree with the idea of sampling of cases for reporting under the HOP QDRP and it is our intent to devise a methodology for determining sample size requirements based on hospital volume as is done for inpatient quality measure reporting.

We are finalizing the proposed data collection and submission requirements with modifications. The initial submission will be for services furnished on or after April 1, 2008. The final submission date for the initial quarterly data for April–June 2008 services is November 1, 2008.

3. HOP QDRP Validation Requirements

In the CY 2008 OPPS/ASC proposed rule, we proposed that data submitted under this program meet validation requirements. The proposed validation requirements were similar to the FY 2006 IPPS RHQDAPU program validation requirement (the initial year validation requirement was added to the IPPS RHQDAPU program) and included independent re-abstraction of medical record data elements by a clinical data abstraction center (CDAC). The CMS contractor would randomly select 5 medical records from all January 2008 discharge cases successfully submitted to the OPPS Clinical Warehouse. The CDAC would mail requests to the hospitals to send the selected medical records to the CDAC within 30 calendar days. The CDAC would independently re-abstract the medical record data elements. We proposed to provide abstraction feedback to all hospitals on abstracted data elements.

We also proposed 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, CMS proposed that 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 IPPS RHQDAPU program validation reliability threshold. Based on our previous IPPS RHQDAPU program 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 IPPS 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.

We proposed that the data for the first reporting period would be due to the CMS designated contractor by May 31, 2008. We would 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 proposed 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 proposed to 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 would 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 would be 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 proposed 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.

Comment: Many commenters asked that validation not be used in determining payment decisions; that is, that receipt of full OPPS payment update be attached only to the submission of quality data, especially for the first year of the program. Commenters urged that for the CY 2009 HOP QDRP, data validation should be conducted only as a learning tool for hospitals.

Response: In response to the many comments received on the validation requirement, acknowledging this is a new data collection effort, and consistent with the initial implementation of the IPPS RHQDAPU program, we have decided not to use the HOP QDRP validation requirement for purposes of the CY 2009 payment update. Thus, there will be no validation requirement for April–June 2008 services for the CY 2009 payment update. However, it is our intent to use validation requirements for determining the CY 2010 payment update.

Comment: Several commenters addressed the reliability threshold set for validation. Some commenters suggested that reliability thresholds should start at lower levels and gradually be raised to 80 percent.

Response: We understand that there may be difficulties with validation levels due to this being a new data collection effort. As discussed in this final rule with comment period, validation will not be required for payment decisions affecting the CY 2009 payment update. We continue to believe that a reliability threshold of 80 percent for data validation purposes for future years is appropriate, and we intend to use it beginning with the CY 2010 payment update.

Comment: Several commenters expressed concern about validating data from a single month for determining payment. Several commenters stated that at least 6 months of reporting should be required for any measure before any data validation is done or any decisions regarding payment are made.

Response: As noted previously, in response to comments on data volume for determining payment and validation concerns, for purposes of the CY 2009 payment update, we will consider data reported for the second calendar quarter of 2008, April to June 2008 without any validation requirement. It is our intent to use at least 6 months of reported data for the HOP QDRP for purposes of the CY 2010 payment update and for subsequent calendar years. Thus, we intend to begin validation efforts on data submitted from July–September 2008 services forward.

We are revising our validation requirements from our proposal and not requiring validation for purposes of the CY 2009 payment update. We intend to use validation for purposes of the CY 2010 HOP QDRP, beginning with July–September 2008 services and for subsequent services.

In summary, after consideration of the public comments received and as discussed in the above responses to those comments, we are requiring hospitals to meet the below outlined administrative, data collection, and submission requirements under the HOP QDRP for payment determinations affecting the CY 2009 payment update.

1. Administrative Requirements

- 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 January 31, 2008 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 Notice of Participation form indicating non-participation in the HOP QDRP. Hospitals that have completed a notice of participation form and subsequently wish to stop participating must submit a withdrawal form. Hospitals not participating in the HOP QDRP 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.

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

- Collect data required for the finalized set of 7 measures outlined below, beginning with the specifications of the finalized set of measures identified in this 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.cms.hhs.gov*.

Participating hospitals must collect data on the 7 required measures listed below if they have cases meeting the data collection specifications. Hospitals will be allowed to sample cases and this

sampling scheme will be provided in advance of required data collection.

- 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 #20 Perioperative Care: Timing of Antibiotic Prophylaxis.
- PQRI #21 Perioperative Care: Selection of Prophylactic Antibiotic.

Providers must collect data for the required finalized set of measures identified in this final rule to receive the full payment update for CY 2009 OPPS services. The measure specifications will be published and maintained in a specifications manual to be found on the CMS Web site at: *http://www.cms.hhs.gov*.

- Submit the data according to a data submission schedule that will be available on the QualityNet Exchange Web site. HOP data will be 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. Data for the 7 quality measures finalized in this rule from services occurring during second calendar quarter of 2008 (April–June 2008) are to be collected. The submission deadline for April–June 2008 service data will be November 1, 2008. All 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. Detailed information about the Web site for submitting quality measure data under the HOP QDRP is not available as of the publication of this final rule with comment period. We anticipate awarding the contract to design and manage the OPPS Clinical Warehouse in the near future. 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. It is possible that the information in the OPPS Clinical Warehouse may be considered QIO information. If so, it may be subject to the stringent QIO confidentiality regulations in 42 CFR part 480.

Hospitals are 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 must be, at a minimum, 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.

In addition to collecting and submitting data as noted above, to be eligible for the full OPPS payment update in CY 2009 and subsequent years, hospitals must also:

- 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. As stated previously in this section, we are revising our validation requirement from the proposed rule for purposes of the CY 2009 payment update. Thus, there is no validation requirement for the initial reporting period (April to June 2008) affecting the CY 2009 payment update. It is our intention that there will be validation requirements under the HOP QDRP as outlined in this section for reporting periods beginning July–September 2008 services forward that will be considered for payment decisions beginning with the CY 2010 payment update.
- Submit the aggregate numbers of outpatient episodes of care which were eligible for submission under the HOP QRDP beginning with the first reporting period (April–June 2008) forward. 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.

Hospitals must submit data under the HOP QDRP on outpatient episodes of care to which the required measures apply. Data submission deadlines for the submission of this data will be the same as for submission of quality measure data, will begin with the submission of April–June 2008 services forward, and will be due 4 months from the last day of the calendar quarter. 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.

3. HOP QDRP Validation Requirements

As discussed above, we are not implementing a data validation requirement for data submitted for the April–June 2008 time period for the purposes of the CY 2009 annual payment update. It is our intention that there will be validation requirements as discussed previously and outlined below for data submitted for July 2008 services forward to affect payment determinations for CY 2010 and subsequent calendar years. The validation requirements include independent reabstraction of medical data elements by a clinical data abstraction center (CDAC). The CMS contractor will randomly select 5 cases from all cases successfully submitted to the OPPS Clinical Warehouse for any relevant time period. The CDAC will mail requests to the hospitals to send the selected medical records or other supporting documentation to the CDAC within 30 calendar days. The CDAC will independently reabstract the medical record data elements. Abstraction feedback will be provided to all hospitals on abstracted data elements.

At this time, the following audit validation requirements are intended to

apply for full CY 2010 payment updates forward:

- A time period of services after the initial April to June 2008 time period will be determined. At this time, we intend to use data from July 2008 services forward for the HOP QDRP for the CY 2010 payment update.
- Submission of supporting documentation for 5 selected cases sampled from each hospital is required.
- A passing threshold of 80 percent reliability reflecting the accuracy of submitted data elements is set to calculate quality measures.
- An upper bound of 95 percent confidence interval to measure accuracy is set.
- Clustering of variability at the chart level will be incorporated into the confidence interval.

To receive the full OPPS payment rate update, the hospital must pass our validation requirement of a minimum of 80 percent reliability, based upon our audit validation process, for the designated time periods.

The methodology to be used for calculating the confidence intervals under the HOP QDRP is that currently utilized for the IPPS RHQDAPU program. Due to the small sample sizes during CY 2010 (as noted above, data from only 5 cases will be used), we anticipate that the calculated confidence intervals will be larger. However, as CY 2010 is only the second year of the HOP QDRP, we view this as appropriate. We anticipate estimating the percent reliability based upon a review of 5 documentation audits and then calculating the upper 95 percent confidence limit for that estimate. If that upper limit is above the required 80 percent reliability threshold, we anticipate considering the hospital's data valid for payment update purposes for CY 2010 forward. As proposed, we intend 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.

Comment: Several commenters provided thoughts on the publication of quality data collected. The commenters believed that consumers should be able to access quality data and cost information electronically that is organized to allow comparison of information that is correct, current, and clear. They suggested that the information be presented on all available sites of service so consumers can compare a hospital outpatient department with an ASC for a procedure that can be performed in both settings. They also suggested that there be a provider narrative section to address information regarding reliability or accuracy, and provider-specific information such as accreditation status.

Response: We thank the commenters for their support of providing public access to hospital outpatient quality data. We strive to present information contained on Web sites in as complete and clear manner possible. We also thank the commenters for their thoughts on additional information that could be included that would aid consumers in assessing a provider's quality measure data.

After consideration of the public comments received and as discussed in the above responses to those comments, we intend that information collected under the HOP QDRP will be made public in CY 2009 by posting it on the CMS Web site. Information from non-validated data, including the initial reporting period (April–June 2008) will not be posted. Participating hospitals will be granted the opportunity to preview this information prior to its public posting as we have recorded it.

G. Attestation Requirement for Future Payment Years

CMS also solicited 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 anticipated that the attestation form submission deadlines would parallel the HOP QDRP periodic data submission deadlines.

Comment: One commenter stated that an attestation statement would be acceptable as long as providers have sufficient time to review and verify that data were submitted accurately. No comments against the requirement of an attestation statement were received.

Response: Under any attestation procedure we implement, providers would have time to review and verify that data were submitted accurately.

In light of the public comments received we intend that an attestation procedure similar to the attestation requirement utilized in the IPPS RHQDAPU program will be included in the HOP QDRP for CY 2010 and subsequent payment years.

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, in the CY 2008 OPPS/ASC proposed rule (72 FR 42805) we proposed to establish a reconsideration process for the HOP QDRP for those hospitals that fail to meet the CY 2009 HOP QDRP requirements with the procedural details of that process posted to the QualityNet Exchange Web site, *https://www.qnetexchange.org.* In the CY 2008 OPPS/ASC proposed rule (72 FR 42805), we sought public comment specifically on the need for a structured reconsideration process for CY 2009 and subsequent calendar years. We also requested 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 requested comments on the reasons for not establishing such a reconsideration process. We indicated that we planned 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.

Comment: While we did not receive any comments opposing a reconsideration process, two commenters suggested that the reconsideration process be straightforward, transparent, and timely. One commenter requested that clear guidance on how to submit appeals be provided, and that any appeals be expedited. One commenter stated that it was important to have a reconsideration process in the case of disputes regarding submitted data. One commenter supported having a reconsideration process similar to the one used under the inpatient quality measure reporting program.

Response: We thank the commenters for voicing their support for a reconsideration process. CMS always strives to implement processes that are straightforward, transparent, and timely and fully intend to provide guidance on any reconsideration process used for outpatient hospital data. It is our intent to model a reconsideration process for the HOP QDRP similar to the one used under the inpatient quality measure reporting program.

Comment: Several commenters stated there should be an expeditious mechanism for corrections or resolution of disagreements about any information posted for public presentation.

Response: We intend that any process put in place for corrections or resolution of disagreements about any information posted for public presentation will be as expeditious as possible.

After consideration of the public comments received and as discussed in the above responses to those comments, we intend that a reconsideration process modeled after that for reporting inpatient quality measures will be included in the HOP QDRP for CY 2009 and subsequent calendar years.

I. Reporting of ASC Quality Data

As discussed in section XVII.A.2. of this final rule with comment period, 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.

In the CY 2008 OPPS/ASC proposed rule, we did not propose to introduce quality measures for reporting in ASCs for CY 2008 as we did for the OPPS as described in sections XVII.B. through H. of the proposed rule. 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. However, we also believe that the transition to the revised ASC 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 HOPDs 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.

Comment: Several commenters agreed with our decisions to delay implementation of quality measures for ASCs. However, one commenter urged CMS to implement a quality reporting system for ASCs as soon as possible as all providers that perform the same services should be held to the same accountability standards with respect to the quality of the care the deliver. There were no other comments in disagreement with the planned delay.

Response: We appreciate these commenters' support for our decision to delay implementation of collection of ASC quality measure data. We also recognize the necessity of equal accountability for providers of the same services and appreciate this reminder.

Comment: Several commenters stated that an administrative claims-based quality measure reporting system should be implemented for ASCs, similar to that in place for physician reporting. Commenters suggested that a claims-based system would reduce the financial and administrative burden for these smaller facilities that more resemble physician offices than hospitals, noting that ASCs will continue submitting Medicare claims using the CMS 1500 form as do physicians at least through 2008, providing ASCs the ability to report data in the same manner as physicians. One commenter suggested CMS work with ASC leaders to develop HCPCS level II G codes that would allow facility-level quality measures to be reported using an administrative claims-based approach.

Response: We thank the commenters for their suggestions for our consideration in implementing a quality measure program for ASCs.

Comment: Several commenters stated that CMS should consider the use of five ASC measures currently under development if the five were NQF-endorsed. These five measures focus on patient falls, patient burns, hospital transfer/admission, wrong site/patient/procedure/implant situations, and prophylactic antibiotic timing similar to PQRI #20 and #21.

Response: We thank the commenters for supplying this information for our consideration in developing quality measures for ASCs.

After consideration of the public comments received, and as discussed in the above responses to those comments, we are finalizing to our decision to delay implementation of ASC quality measure reporting. We expect to implement the provisions of section 109(b) of the MIEA–TRHCA, Pub. L. 109–432, in a future rulemaking.

J. FY 2009 IPPS Quality Measures Under the RHQDAPU Program

As stated in FY 2008 IPPS proposed rule (72 FR 24805), we proposed to add 1 outcome measure and 4 process measures to the existing 27 measure set to establish a new set of 32 quality measures to be used under the RHQDAPU program for the FY 2009 IPPS annual payment determination. We proposed to add the following five measures for the FY 2009 IPPS annual payment determination:

• PNE 30-day mortality measure (Medicare patients)

- SCIP Infection 4: Cardiac Surgery Patients With Controlled 6AM Postoperative Serum Glucose
- SCIP Infection 6: Surgery Patients With Appropriate Hair Removal
- SCIP Infection 7: Colorectal Patients With Immediate Postoperative Normothermia
- SCIP Cardiovascular 2: Surgery Patients on a Beta-Blocker Prior to Arrival Who Received a Beta-blocker During the Perioperative Period

We stated that we planned to formally adopt these measures a year in advance in order to provide time for hospitals to prepare for changes related to the RHQDAPU program. We also stated that we anticipated that the proposed measures would be endorsed by the NQF. Finally, we stated that any proposed measure that was not endorsed by the NQF by the time that we published the FY 2008 IPPS final rule would not be finalized in that final rule.

At the time we published the FY 2008 IPPS final rule, only the PNE 30-day mortality measure had been endorsed by the NQF. Therefore, we finalized only that measure as part of the FY 2009 IPPS measure set and stated that we would further address adding additional measures in the CY 2008 OPPS final rule (that is, this CY 2008 OPPS/ASC final rule with comment period) and, if necessary, in the FY 2009 IPPS proposed and final rules. We also responded to comments we had received on the 5 proposed measures. (72 FR 47348 through 47351)

The NQF has endorsed the following additional process measures that we proposed to include in the FY 2009 RHQDAPU measure set:

- SCIP Infection 4: Cardiac Surgery Patients With Controlled 6AM Postoperative Serum Glucose
- SCIP Infection 6: Surgery Patients With Appropriate Hair Removal

As we stated in the FY 2008 IPPS proposed rule (72 FR 24805), these measures reflect our continuing commitment to quality improvement in both clinical care and quality, and they demonstrate our commitment to include in the RHQDAPU program only those quality measures that reflect consensus among affected parties and that have been reviewed by a consensus building process. Because these measures are now endorsed by the NQF, we are finalizing them for the FY 2009 measure set, bringing the total number of measures in that measure set to 30.

The measure set to be used for FY 2009 annual payment determination is as follows:

Topic	Quality measure
Heart Attack (Acute Myocardial Infarction)	• Aspirin at arrival.* • Aspirin prescribed at discharge.* • ACE inhibitor (ACE–I) or Angiotensin Receptor Blocker (ARBs) for left ventricular systolic dysfunction.* • Beta blocker at arrival.* • Beta blocker prescribed at discharge.* • Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival.** • Primary Percutaneous Coronary Intervention (PCI) received within 120 minutes of hospital arrival.** • Adult smoking cessation advice/counseling.**
Heart Failure (HF)	• Left ventricular function assessment.* • ACE inhibitor (ACE–I) or Angiotensin Receptor Blocker (ARBs) for left ventricular systolic dysfunction.* • Discharge instructions.** • Adult smoking cessation advice/counseling.**
Pneumonia (PNE)	• Initial antibiotic received within 4 hours of hospital arrival.* • Oxygenation assessment.* • Pneumococcal vaccination status.* • Blood culture performed before first antibiotic received in hospital.** • Adult smoking cessation advice/counseling.** • Appropriate initial antibiotic selection.** • Influenza vaccination status.**
Surgical Care Improvement Project (SCIP) named SIP for discharges prior to July 2006 (3Q06).	• Prophylactic antibiotic received within 1 hour prior to surgical incision.** • Prophylactic antibiotics discontinued within 24 hours after surgery end time.** • SCIP–VTE 1: Venous thromboembolism (VTE) prophylaxis ordered for surgery patients.*** • SCIP–VTE 2: VTE prophylaxis within 24 hours pre/post surgery.*** • SCIP–Infection 2: Prophylactic antibiotic selection for surgical patients.*** • SCIP–Infection 4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose.***** • SCIP–Infection 6: Surgery Patients with Appropriate Hair Removal.*****
Mortality Measures (Medicare patients)	• Acute Myocardial Infarction 30-day mortality Medicare patients.*** • Heart Failure 30-day mortality Medicare patients.*** • Pneumonia 30-day mortality Medicare patients.****
Patients' Experience of Care	• HCAHPS patient survey.***

* Measure included in 10 measure starter set.
** Measure included in 21 measure expanded set.
*** Measure added in CY 2007 OPPS final rule.
**** Measure added in FY 2008 IPPS final rule.
***** Measure added in CY 2008 OPPS final rule.

We also stated in the FY 2008 final rule that the RHQDAPU participation requirements for the FY 2009 program would apply to additional measures we adopt for that year's program (72 FR 47361).

Therefore, hospitals must start submitting data for SCIP Infection 4 and SCIP Infection 6 starting with first quarter calendar year 2008 discharges and subsequent quarters until further notice, and hospitals must submit their aggregate population and sample size counts for Medicare and non-Medicare patients. These requirements are consistent with the requirements for the other 24 AMI, HF, PN, and SCIP process measures included in the FY 2009 measure set. The complete list of procedures for participating in the RHQDAPU program for FY 2009 is provided in the FY 2008 final rule (72 FR 47359–47361).

We plan to propose in the FY 2009 IPPS proposed rule that we will add these two measures to the current 24 process measures included in the RHQDAPU chart audit validation requirement starting with first quarter 2008 calendar year discharges. These validation results would be included as part of a RHQDAPU FY 2010 chart validation requirement if they are finalized in the FY 2009 IPPS final rule. We are announcing our intention to make this proposal to provide hospitals with sufficient advance notice when abstracting and submitting these measures to CMS.

Since SCIP Cardiovascular 2 is not currently endorsed by the NQF, CMS will not adopt this measure as part of the official FY 2009 IPPS measure set for annual payment determination at this time. In addition, as stated in the FY 2008 IPPS final rule, CMS is not adopting the SCIP Infection 7 measure as part of the FY 2009 IPPS measure set for annual payment determination at this time.

XVIII. Changes Affecting Critical Access Hospitals (CAHs) and Hospital Conditions of Participation (CoPs)

A. Changes Affecting CAHs

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 section 1820(c)(2)(B)(i)(I) of the Act and § 485.610(c) of our regulations, 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, the CAH minimum distance eligibility requirement was not applicable to entities States had certified as necessary provider CAHs. Approximately 850 current CAHs have been designated by their States as necessary providers. 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. 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 Public Law 108–173 amended section 1820(c)(2)(B)(i)(II) of the Act by adding language that ended States' authority to certify a CAH as a necessary provider, effective January 1, 2006. In addition, section 405(h)(2) of Public Law 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, in the CY 2008 OPPS/ASC proposed rule (72 FR 42806), we took 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 Public Law 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 Public Law 108–173 included several provisions that permit CAHs themselves to address such access to care issues.

Specifically, section 405(e) of Public Law 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 Public Law 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 proposed to no longer allow a necessary provider CAH to enter into co-location arrangements between CAHs and hospitals, unless such arrangements were 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.

Currently, co-location arrangements seem to involve psychiatric or rehabilitation hospitals. However, we are concerned that, without this change, there may be situations where more necessary provider CAHs will co-locate with PPS hospitals. 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 new authority for CAHs to operate psychiatric and rehabilitation units in addition to their expanded ceiling for inpatient beds should provide sufficient flexibility for necessary provider CAHs to operate within the statutory framework without engaging in additional arrangements.

We also proposed to clarify 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, the provider agreement will be assigned to the new owner unless the new owner rejects assignment of the provider agreement. 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. CAH Provider-Based Facilities

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 regulations 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 as a necessary provider by the State prior to January 1, 2006. 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, regardless of whether the main provider CAH is a necessary provider CAH.

Therefore, in the CY 2008 OPPS/ASC proposed rule (72 FR 42807), we proposed 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). (In the proposed § 485.610(e)(2), we inadvertently used the phrase ''after January 1, 2008'' instead of ''on or after January 1, 2008.'' We have corrected this language in this final rule with comment period. We also included the words ''off-campus'' before the words ''provider-based locations'' in the same regulation to conform to the references in the section for off campus location.)

4. Termination of Provider Agreement

In the event that a CAH with a necessary provider designation enters into a co location arrangement on or after January 1, 2008, or acquires or creates an off-campus facility on or after January 1, 2008, that does not satisfy the CAH distance requirements in § 485.610(c), we proposed that we would terminate that CAH's provider agreement, in accordance with the provisions of § 489.53(a)(3). (In proposed § 485.610(e)(3), we inadvertently used the phrase ''after January 1, 2008'' instead of ''on or after January 1, 2008.'' We have corrected this language in this final rule with comment period.) 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 noted 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. Regulation Changes

In the CY 2008 OPPS/ASC proposed rule (72 FR 42807), we proposed 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 all CAHs (including CAHs with necessary provider designations).

Comment: Several commenters stated that while it is a good policy to eliminate future co-location

arrangements between CAHs and acute care hospitals, they do not believe it is a good policy to eliminate relationships between CAHs and other hospitals in opening psychiatric or rehabilitation services. They indicated that such a policy change would only limit access to care without providing cost savings or improving efficiency. The commenters stated that co-locating with other providers would lead to cost-effective high quality delivery of health care services to Medicare beneficiaries and others who need the services. Another commenter stated that CMS provided no basis for this proposal in the background material to the proposed rule.

Response: We disagree with the comment that we did not provide a basis for the proposed requirements. Additionally, we are not seeking to eliminate Medicare beneficiary access to inpatient psychiatric and rehabilitation services specifically, or access to any type of care in general. As we explained in the preamble to the proposed rule, we proposed the revisions to § 485.610 in light of recent changes to the statute. These statutory changes allow for: (1) An increase in the number of CAH inpatient beds from 15 to 25; and (2) a CAH to operate distinct part inpatient psychiatric and/or rehabilitation units, each with a 10-bed limit that is not included as part of the CAH's 25-bed limit. By allowing a CAH to operate a 45-bed facility, these amendments to the statute permit CAHs themselves to address the access to care issues mentioned by the commenters.

These statutory provisions clearly provide an opportunity for the CAH to directly meet the wide range of needs in the rural community it serves. However, co-location arrangements between CAHs and hospitals that were in effect before January 1, 2008 would still be permitted, provided that there is no change in the type and scope of services offered by the facility co-located with the necessary provider CAH.

Comment: One commenter expressed complete support for the proposal, and saw it as a clarification of existing policy. The commenter stated that a CAH provider-based clinic was built across the street from its outpatient clinic to increase market share as its population was dwindling. The commenter stated that CAHs were financed and designed to serve the needs of the underserved, not to compete in the market against not-for-profit hospitals that are not subsidized like CAHs. The commenter also stated that since the regulation is a clarification and is not new, the existing provider-based clinics should not be grandfathered.

Another commenter stated that it valued the cost-based financial support that CMS extends to CAHs. The commenter supported CMS' proposed rule and viewed the proposed policy changes as a step towards restoring the ''intended spirit'' of the CAH designation.

Response: We appreciate the commenters' support. However, we disagree with the comment that existing provider-based clinics should not be grandfathered. The current regulations did not explicitly address the issue of necessary provider CAHs from acquiring or creating off-campus facilities that do not meet the minimum distance requirements. However, our policy has been that CAHs are required to meet the distance requirement, including any off-campus facilities. In light of the statutory change to the designations for necessary provider CAHs, we believe that it is necessary to grandfather existing provider-based clinics.

Comment: Numerous commenters requested that rural health clinics (RHCs) be excluded from the category of provider-based entities that must comply with the proposed change. Some commenters stated that operating an RHC is the only way to provide healthcare to the medically underserved population in their service area. One commenter stated that if CMS does not exempt RHCs from the proposed policy, CMS should allow grandfathered CAH/provider-based RHCs to move the location of the RHC without jeopardizing the CAH status of the parent provider.

Response: To be certified as an RHC, the clinic must be located in an area designated, either by population or geographic area or location, as a Medically Underserved Area (MUA) or Health Professional Shortage Area (HPSA). In addition, State governors are allowed to designate areas with a shortage of professional health services through the use of statewide shortage designation plans approved by HRSA's Bureau of Health Professions. Because RHCs have their own location requirements and because, unlike other provider-based clinics, a provider-based RHC is a separate entity which undergoes a separate certification process and has a unique provider identification number from the base provider, we believe that our concerns leading to our provider based proposal do not apply to CAH provider-based RHCs. Accordingly, in this final rule with comment period, we are excluding RHCs from the list of provider-based facilities at § 413.65(a)(2) that must comply with this requirement.

Comment: One commenter stated that for any CAH that is landlocked against future growth, this proposed change would severely restrict the CAH's ability to provide the quality services required by the community. At the very least, the commenter urged that CMS increase the current on-campus yards from 250 yards to 500 or 750 yards. Another commenter stated that it is reasonable that CAHs are prohibited from creating new services that are close to competing organizations, but believed that limiting all off-campus services to only those in place by the end of the year, would freeze the CAH into an increasingly out-of-date delivery modality.

Response: We acknowledge the CAH's constraints of having to locate a provider-based clinic on its campus. However, this rule will not restrict a CAH from building or obtaining an off-site provider-based clinic on or after January 1, 2008. The CAH can have a provider-based clinic that complies with the provider-based rules in § 413.65. In addition, the off-site clinic must be located more than a 35-mile (or 15-mile) drive from another CAH or hospital. For example, the CAH could have a provider-based clinic located 2 miles or 10 miles from the provider CAH, providing the clinic complies with the distance requirements and is 35 (or 15) miles away from another CAH or hospital. The regional offices will evaluate these issues on a case-by-case basis, consistent with all existing regulations. Also, as discussed above, because we are now excluding RHCs from these CAH provider-based requirements, a CAH would have even more flexibility in choosing the location of its provider-based RHC.

Comment: Several commenters stated that they have started plans (and, in some cases, construction) for a new provider-based facility that will not be completed by January 1, 2008. They have requested an exemption to be able to move forward with their plans that were initiated prior to the publication of the proposed rule.

Response: We recognize that a number of CAHs have plans underway to build or acquire provider-based facilities that will not be completed before January 1, 2008. For those CAHs that demonstrate that they have begun such planning and/or construction, our regional offices will evaluate those issues on a case-by-case basis. A demonstration that construction plans were ''under development'' prior to January 1, 2008 could include supporting documentation such as the drafting of architectural specifications,

the letting of bids for construction, the purchase of land and building supplies, documented efforts to secure financing for construction, expenditure of funds for construction, and compliance with State requirements for construction such as zoning requirements, application for a certificate of need, and architectural review. However, we recognize that it may not have been feasible for a CAH to have completed all of these activities noted above as examples prior to January 1, 2008. Thus, we expect the CMS Regional Offices to consider all of the factors involved in each CAH's plan and make case by case determinations of whether a CAH can continue its plans to acquire or construct an off-campus provider-based clinic. We note that we have also used the above documentation guidelines in Publication 100–20 for grandfathered specialty hospitals to determine if construction plans were ''under development.''

Comment: Many commenters stated that CMS should not adopt the provisions in the proposed rule because limiting off-site clinics would impede the provision of health care in their surrounding communities due to the fact that it could not be provided without cost-based reimbursements. Also, the commenters suggested that as physicians cannot be paid competitively without cost-based reimbursement, this would further compound the difficulties in recruiting healthcare providers to work in rural areas. Other commenters stated that the only way to recruit and maintain physicians is for hospitals to offer the competitive salaries that are afforded through a provider-based arrangement. A few commenters stated that denying CAHs the opportunity to invest in physician offices in communities where physicians are desperately needed will disadvantage the patients living in those areas. One commenter requested that CMS not adopt the provisions of the proposed rule and enter into a dialogue with CAHs about an approach that would allow for the level of community-based access and collaboration being called for by the Institute of Medicine (IOM), the National Advisory Committee on Rural Health and Human Services, and other national bodies.

Response: We do not agree that CMS should not adopt the provisions in the proposed rule because, in addition to grandfathering the existing provider-based clinics, CAHs will still be able to provide needed services in their communities through existing and new provider-based clinics that meet the distance requirements and through on-campus facilities. In addition, and perhaps most importantly for those CAHs concerned about access to primary care services in the communities that they serve, we have revised our initial proposal in order to permit CAHs to continue to operate provider-based RHCs. Additionally, physician offices, owned by CAHs, that are not provider-based (billed under the CAH's provider number) can continue to be operated by CAHs.

We agree with the IOM and other national bodies that contend that quality of care in rural areas can be maximized through collaboration. The IOM report entitled, ''Quality through Collaboration: The Future of Rural Health'' [1] states that some of the quality shortcomings in rural areas stem from the lack of access to ''core health care services'' such as primary care in the community, emergency medical services, and hospital care. We believe that CAH provider-based facilities that are located in the immediate communities of the CAH will help to ensure that the people in those communities have access to primary care. Also, CAHs will be able to utilize provider-based RHCs to provide primary care to Medicare beneficiaries.

Comment: By providing specific details and scenarios about their own CAHs, many commenters expressed other reasons for requesting that CMS not adopt this proposal. Overall, the commenters believed that the proposed requirements, if implemented, would have the unintended effect of limiting access to healthcare services for the residents of their communities. The reasons these commenters gave for requesting that CMS not adopt the proposal were as follows:

- Several commenters stated that the rule would have a devastating impact on many senior citizens who do not drive and who would therefore not have access to quality health care in their rural community. One commenter stated that the proposed change would take away their organization's opportunity to be cost reimbursed from Medicare and Medicaid. The commenters stated that this would be a roadblock to increased access to care for the elderly and low income.
- One commenter expressed concern about linking an off-campus or distinct part unit's compliance to the CAH distance requirements with the hospital's continued designation as a CAH and believed that such applications of the distance requirements could result in decreasing patients' access to surgical and other procedures that are provided in the CAH. Other commenters were concerned that this proposed rule would ban necessary provider CAHs from operating an off-site facility.
- One commenter stated that its Medicare designation as a sole community hospital has geographic limitations, but that it should not be threatened with loss of its special reimbursement status if it meets community needs by developing provider-based or off-campus services. The commenter questioned why CMS is treating CAHs differently.
- Several commenters stated that access will be diminished in many rural communities because those areas are experiencing an increasing inability to recruit or retain physicians in non-provider-based practices due to perceived inadequate Medicare and Medicaid payment to free-standing RHCs, insufficient payment for physicians under the fee-schedule, and healthcare professional workforce shortages. One commenter stated that to continue to apply the ''necessary provider'' designation to off-site services will preserve one of the only methods that a CAH has to recruit physicians to rural service areas. The commenter stated that CMS should allow the necessary provider CAH to have a waiver provision for off-site services beyond January 1, 2008 if other hospitals within the radius have no objections to the services.
- One commenter stated that the proposed rule indicates CMS' interest in constraining CAHs. The commenter encouraged CMS to adopt a philosophy that limits unnecessary constraints and enables CAHs to serve their patients. The commenter urged CMS to remain supportive of the CAH program. Additionally, one commenter stated that CMS has already weighed in on the issues where cost-based reimbursement could be a major advantage and has eliminated cost-based reimbursement for certain lab services. The commenter noted that there may be situations where other services need to be considered, but that they should be dealt with on a case-by-case basis. If competitive advantage for CAHs is a concern for CMS, the commenter asked that examples be given of such arrangements and suggested that a more narrowly tailored rule should be designed to address such issues.
- Several commenters stated that the purpose of the CAH program is to provide financial stability for small rural hospitals to serve their communities. The commenters believed that this rule would eliminate the CAH's ability to provide care to rural seniors. Another commenter stated that the

[1] Institute of Medicine of the National Academies of Science; Report released on November 1, 2004.

regulation would be devastating to many provider-based clinics because they would be unable to provide the same level of care, services, and staffing as independent sites. Several commenters stated that by forcing CAHs to have services on-campus, CMS will be leaving some community members without access to services.

Response: We appreciate the varied comments. We first note that the proposed change will not eliminate the 101 percent reasonable cost reimbursement that CAHs currently receive. As stated earlier, we do not believe access to these needed services will be diminished as CAHs will still be able to increase access to care for the population of its community through a variety of means. Both the grandfathering provision of this rule, which allows for provider-based locations and off-campus distinct part psychiatric and rehabilitation units that were created or acquired before January 1, 2008, and the exclusion of provider-based RHCs from the rule provide CAHs with excellent opportunities to not only maintain access to care but to expand it as well. The role that RHCs play in providing rural communities with essential access to primary care services cannot be overemphasized.

From the inception of the CAH program, which started with the essential access community hospitals and rural primary care hospitals (EACH/RPCH) 7-State demonstration program, we have been sensitive to the special needs of, not only the CAH program, but of all rural and remote providers. This sensitivity has been demonstrated in regulations we recently adopted that provide flexibility in staffing requirements and physician oversight of nonphysician practitioners in CAHs.

Ultimately though, the distance-based requirement, as one of the requirements to become certified as a CAH, is provided for in the statute and in the regulation. We believe the distance requirement is a statutory requirement that reflects the intent of the CAH program to provide hospital-level services in essentially small rural communities. Our proposal reflects this understanding and the special status of CAHs (as opposed to other rural entities) and should not limit access to care. In addition, as the distance requirement is statutory, a waiver of the distance requirement for some CAHs, as one commenter requested, would not be allowed under the statute. However, CAHs (including necessary provider CAHs) will still be able to acquire and create new provider-based clinics as long as those provider-based clinics are either RHCs or entities that comply with the distance requirements for a CAH that are allowed under the Act and under the requirements. In addition, all CAHs will be able to establish provider-based entities on their campus.

Comment: One commenter requested that CMS clarify provider-based location and indicate whether it includes on-campus.

Response: Provider-based status means the relationship between a main provider and a provider-based entity or a department of a provider (with all terms being defined in detail under § 413.65(a)(2)). Provider-based locations can be both on-campus and off-campus. This rule would not restrict CAHs from having a provider-based entity on campus.

Comment: One commenter stated that if CMS adopted the proposed change for CAHs it should apply to all providers, such as RHCs and Federally qualified health centers (FQHCs).

Response: We appreciate the commenter's opinion regarding treatment of all rural providers; however, we note that RHCs and FQHCs have different requirements for participating in the Medicare/Medicaid programs than those for CAHs. As we noted previously, we are excluding RHCs from the CAH provider-based requirement in light of the specific RHC certification requirements.

Comment: One commenter stated that the proposed change would limit CAH's ability to compete on a level playing field with PPS or other for-profit providers who have no restrictions on location of facilities. Another commenter stated that it is cheaper for the CAH or other hospitals to move offsite the care that does not need high cost hospital wing space, such as that provided in physical therapy. The commenters suggested that it would save CMS money on the cost-report to allow CAHs to open these offsite locations. A few commenters also stated that offsite locations may be secured much more reasonably to offer additional services than additional space which may be obtained through construction of new facilities on campus.

Response: As stated previously, there are statutory requirements that dictate the location of CAHs. These statutory location requirements support the original intent of the CAH program, that is, to ensure and extend access to healthcare services for rural and remote communities. The program was never intended to encourage competition between CAHs and PPS hospitals. However, it might be a reasonable course of action for a CAH to reevaluate whether the CAH program still meets the needs of the immediate and surrounding communities. If the community's needs have changed, the facility may want to reconsider their CAH status and may elect to become a PPS acute care hospital without the location limitations that are imposed on CAHs and their provider-based locations.

Comment: A few commenters stated that since all of their CAHs are necessary provider CAHs, it would be geographically impossible to find a new off-campus location that would meet the 35-mile requirement and that this rule should not apply to necessary provider CAHs.

Response: We believe that there are other options for necessary provider CAHs that cannot meet the mileage requirements. Some examples that we have previously discussed are on-campus clinics, provider-based RHCs, or non-provider-based physician offices owned by CAHs.

Comment: One commenter stated that instead of a 35 (or 15)-mile restriction, a minimum mileage limitation (for example 10 miles) would be effective without the potential effect of reducing and/or limiting resources for rural citizens. Additionally, one commenter stated that it objected to CMS' classification of this new policy as a ''clarification.''

Response: As we have stated previously, the statute, at section 1820(c)(2)(B)(i)(I) of the Act, and the regulation, at 42 CFR § 485.610, both state that the criteria for designation as a CAH is that it must be 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. We note a provider-based clinic (other than an RHC) is considered part of the CAH and it is paid the same as the CAH, that is, 101 percent of reasonable cost. As stated above, CAHs by statute and regulation must comply with the distance requirements. As such, we view this rule as a clarification on the distance requirements of participation for CAHs and their provider-based locations and off-campus distinct part units in light of the change in statute concerning necessary provider designations.

Comment: One commenter objected to CMS proposing these changes in the hospital OPPS proposed rule because they believed that many CAHs will not evaluate, pay attention to, or read the OPPS proposed rule. The commenter believed that such proposed changes should be the subject of a separate proposed rule. They also believe that, as a result of CMS proposing these changes

in the OPPS rule, CMS might not have all the information necessary to finish the rulemaking on the proposed requirements.

Response: On occasion, we have proposed changes to the CAH program in an OPPS rulemaking. We point out that the subject of the CAH proposed changes was included in the title of the OPPS rule. In addition, CMS has announced the proposed changes during its Open Door Forums. Having received comments from approximately 200 commenters (including various rural health and hospital associations), we are confident that we have received sufficient information, through the public comment process, necessary to complete the rulemaking process.

Comment: One commenter requested clarification on what CMS means in the termination discussion of the proposed rule and suggested that clarification was needed to explain how such a process would work in practice and how a CAH could avoid losing CAH status. In addition the commenter believed that the threat of closure is an unduly harsh punishment when payment for an offending facility could be withheld.

Response: Failure to substantially meet one or more conditions of participation is a cause for termination in the Medicare program, not closure of the CAH. A CAH with a necessary provider designation that enters into a co-location arrangement on or after January 1, 2008, or acquires or creates an off-campus facility on or after January 1, 2008, that does not satisfy the CAH distance requirements in § 485.610(c), will be placed on a 90-day termination track as outlined in section 3012 of the State Operations Manual. During this 90-day period, the CAH will be afforded every opportunity to come back into compliance and meet all conditions of participation. As we noted in the proposed rule, if the CAH corrects the situation that led to the non-compliance, the termination action against the CAH will cease.

Comment: Several commenters asked if current facilities would be allowed to relocate or be replaced and keep the current relationship under the grandfather provisions.

Response: We have addressed in greater detail the situation of a relocated CAH in the FY 2006 IPPS final rule (70 FR 47490). Generally, we believe that it would be reasonable for a CAH to be able to move its facility as long as the new facility can meet the relocation requirements contained under § 485.610(d), which specify the criteria a necessary provider CAH must satisfy upon relocation in order to retain its Medicare provider agreement as a CAH. The requirements permit such CAHs to relocate as long as they remain essentially the same provider and continue to provide services to the same rural service area.

Comment: Several commenters requested that we state which types of entities to which this policy applies.

Response: While we do not provide a complete list of provider-based entities in this final rule with comment period, we define a provider-based entity at § 413.65(a)(2). Generally, with the exception of RHCs, this CAH provider-based rule will apply to an entity that is provider-based to a CAH that will bill Medicare under its provider number for services rendered.

After consideration of the public comments received, we are finalizing the requirements as proposed with the following revisions. For the reasons noted previously, in § 485.610(e)(2), we have revised the language of the regulation to exclude RHCs, as defined under § 405.2401(b), from the list of provider-based facilities that must comply with this requirement. We revised proposed § 485.610(e)(2) and § 485.610(e)(3) to correct the date references to ''on or after January 1, 2008.'' Finally, we also added the words ''off-campus'' before the words ''provider-based locations'' in § 485.610(e)(2) and § 485.610(e)(3) to conform these references to the preamble language.

B. Revisions to Hospital CoPs

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 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 isolated the relevant issues regarding outpatient care and proposed 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.

In the CY 2008 OPPS/ASC proposed rule (72 FR 42808), we proposed 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, in the CY 2008 OPPS/ASC proposed rule (72 FR 42809), we proposed 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 took the opportunity in the proposed rule to correct this error through a proposed technical amendment.

2. Provisions of the Final Regulations

a. Timeframes for Completion and Documentation of the Medical History and Physical Examination

The proposed revisions to § 482.22(c)(5) retained 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 proposed 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 proposed 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 proposed 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 believed 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, would achieve 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 proposed to retain under the proposed rule.

Further, we proposed 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 proposed 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 proposed to add the words ''and documented'' after ''be completed'' as well as the word ''licensed'' after ''qualified'' to further clarify this requirement. In addition, we proposed 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 proposed 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 proposed this revision here as well as in § 482.24 and § 482.51, where appropriate.

We proposed 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 proposed 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 proposed 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 the proposed rule was 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 proposed to retain the language regarding the requirement for a medical history and physical examination prior to surgery, except in the case of emergencies, and proposed to extend this to a requirement for an updated examination. We proposed 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. Requirements for Preanesthesia and Postanesthesia Evaluations

In the CY 2008 OPPS/ASC proposed rule (72 FR 42810), we proposed to revise the requirement at § 482.52(b)(1), under the ''Delivery of services'' standard of the ''Anesthesia services'' CoP for a preanesthesia evaluation to include the language ''or a procedure requiring anesthesia services.'' We proposed this revision in order to include the range of procedures that require anesthesia services but that are not necessarily surgical in nature. We proposed to add this language under § 482.52(b)(3) for the postanesthesia evaluation requirement.

Further, we proposed 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 proposed 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 was to eliminate the distinctions currently found in the regulations between inpatients and outpatients with regard to anesthesia services.

Comment: One commenter supported CMS's efforts to eliminate the distinctions, currently found in the hospital CoPs, between inpatients and outpatients with regard to history and physical examinations, examination updates, and anesthesia evaluations. They noted that the proposed changes would help to dispel misconceptions regarding documentation completion and timeframe requirements. Additionally, the commenter expressed the opinion that such revisions to the CoPs would not only ensure complete, accurate, and timely documentation, which is vital for the protection of patients and for the monitoring of the quality of care provided by clinical staff but would also ensure the efficient and effective coordination of care by case managers, discharge planners, and social services staff.

Response: We appreciate the commenter's support of the proposed changes and agree that the accurate and timely documentation of patient medical information is an essential component of quality across the spectrum of patient care.

Comment: One commenter stated that the proposed requirements for an updated examination of the patient to be completed and documented in the patient's medical record within 24 hours after admission or registration but prior to surgery or any procedure requiring anesthesia services, would be operationally and unnecessarily burdensome on hospitals. The commenter noted that the requirement would lead to surgical scheduling inefficiencies, since surgeons would need to stop procedures so that they could dictate a medical history and physical examination or an update. The commenter also expressed the opinion that it was operationally difficult, if not impossible, to ensure that documentation of a medical history and physical examination or an update was placed in the patient's medical record prior to the beginning of surgery. The commenter requested clarification on these proposed changes, particularly on which provider could complete the update and whether it would need to be dictated.

Response: The changes contained in the proposal are a clarification of the current medical history and physical examination requirements, which were contained in the Carve-out rule (71 FR 68672) published November 27, 2006, and which were discussed above. At the time of the publication of that final rule, we explained in the preamble that if the patient's medical history and physical examination was completed before admission to the hospital, the updated examination must be completed and documented within 24 hours after admission but before a surgical procedure. This original intention from the Carve-out rule has been clarified in this final rule with comment period.

Both the medical history and physical examination and the update can 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. The individual who completes the update does not have to be the same individual who did the medical history and physical examination. Both documents may be handwritten, dictated and transcribed, or completed electronically. Under these requirements, hospitals have the flexibility to establish their own policies for the format in which this essential patient information is documented in the medical record.

Comment: One commenter stated that they were opposed to the removal of the language in the current CoPs that requires that the medical history and physical examination be documented and placed ''on the medical record'' [sic] within 24 hours. The commenter expressed concerns about physicians who continue to believe that a dictated, but not yet transcribed, medical history and physical examination is adequate because it is ''in the system,'' even though it is not yet physically in the patient's medical record. The commenter stated that the current JCAHO standards require that the medical history and physical examination be in the medical record. The commenter believed that this requirement should be reinforced in the Medicare hospital CoPs.

Response: As we stated in our discussion of the proposed change, we believe that the requirements for the physical placement of the medical history and physical examination, as well as those for its update, are more appropriately located where they currently are, that is, under the Medical record services CoP at § 482.24(c)(2), which we will retain under this rule. Furthermore, we appreciate the commenter's concerns regarding medical histories and physical examinations that have been dictated but not yet transcribed, and, thus, are not physically present in the patient's medical record. Supporting the overall intent of this rule to require that the most current information regarding a patient's condition be *available* to hospital staff *prior* to surgery or a procedure requiring anesthesia services, we proposed to delete the language currently contained under the Surgical services CoP at § 482.51(b)(1) which allows for medical histories and physical examinations that have been dictated but which are not yet recorded in the chart. Additionally, the proposed revisions at §§ 482.22, 482.24, and 482.51 all require that the medical history and physical examination (and its update) be completed and documented in the patient's medical record within 24 hours after admission or registration but prior to surgery or a procedure requiring anesthesia services (and except in the case of emergencies as allowed for under § 482.51(b)(1)). We intend to finalize the proposed requirements without further revision. We believe that these requirements will address concerns regarding documentation and will emphasize the important role that the timely and complete documentation of patient information plays in reducing patient risk.

Comment: One commenter stated that the term ''anesthesia services'' should be defined in the requirements and that it should include standard terminology such as moderate sedation, deep sedation, and general anesthesia. The commenter also asked whether CMS intends to apply the same requirements regarding medical histories and physical examinations and postanesthesia evaluations to moderate sedation administered by a physician or surgeon and to general anesthesia administered by an anesthesiologist.

Response: We expect hospitals, which furnish anesthesia services, to follow the current standards of anesthesia care, along with the accepted definitions of such care, that have been established by nationally recognized bodies such as the American Society of Anesthesiologists (ASA) and the American Association of Nurse Anesthetists (AANA). We also expect that those established guidelines should be reflected in the hospital's policies and procedures regarding anesthesia services as appropriate to the scope of services offered.

The requirements for H&Ps and postanesthesia evaluations are not the same. As previously discussed, a medical history and physical examination (and its update, if applicable) is required for each patient admitted or registered to the hospital. This requirement is not based on whether the patient is undergoing surgery or a procedure requiring anesthesia services. However, the medical history and physical examination (and its update) are required prior to surgery or a procedure requiring anesthesia services, except in the case of emergencies.

A postanesthesia evaluation would be required after surgery or a procedure requiring anesthesia services and must be completed and documented by an individual qualified to administer anesthesia. The list of individuals who are qualified to administer anesthesia is set out at § 482.52(a).

Comment: One commenter supported the proposed changes to the preanesthesia and postanesthesia evaluation requirements and believed that they reflected current standards of care. The commenter agreed with CMS' decision to remove the distinctions between inpatients and outpatients with regard to the postanesthesia evaluation. The commenter also agreed with the application of the standards to all patients receiving anesthesia services regardless of whether they were undergoing surgical or non-surgical procedures.

However, several commenters took exception to the proposed requirement that the postanesthesia evaluation be completed and documented before the patient is discharged or transferred from the postanesthesia recovery area. Several commenters stated that this part of the provision does not reflect current standards of postanesthesia care. One commenter noted that its State's regulations allow for the use of approved medical staff postanesthesia recovery area criteria, which means that qualified postanesthesia recovery area staff can discharge patients from the recovery area if they meet certain standards established by qualified anesthesia practitioners.

Another commenter pointed out that, as proposed, § 482.52(b)(3) would create a situation where patients who could be safely transferred to another unit of the hospital or discharged home would be held for hours in the recovery area. The commenter further stated that completing the postanesthesia evaluation in the recovery area is simply too soon to fully capture or address the patient's complete postanesthesia experience, including any anesthesia-related complications, which is more effectively done by anesthesia providers who make follow-up visits or phone

calls to patients either later that day or the next.

One commenter stressed that it is the surgeon or lead physician who determines when the patient is ready for discharge or transfer and that this decision is based on the monitoring and documentation of the patient by the recovery nurse. This commenter noted that though there may be some residual effects from anesthesia, this does not mean that it is inappropriate to discharge or transfer the patient from the recovery area. This commenter believed that with proper discharge instructions specific to that patient, a patient may be safely discharged home to rest following a procedure and that follow-up over the phone by the anesthesia provider would then complete the postanesthesia evaluation.

Two commenters also stated that the proposed requirement for the timing of the postanesthesia evaluation would place an undue burden on small rural hospitals where there are a limited number of anesthesia providers. They argued that such constraints would limit access to surgical services in these communities by significantly slowing down the number of cases each day. These commenters argued that such hospitals would have to hire an additional provider to comply with this requirement without yielding any benefits to patient safety or access to care.

Response: We appreciate the comments received. After consideration of the public comments and a further review of the current standards of anesthesia care, we agree that our proposed changes to the postanesthesia evaluation requirements may not truly reflect current and safe anesthesia practice, may in fact impose a burden on hospitals and anesthesia providers, and, as an unintended consequence, limit some patients' access to health care services. Therefore, we have revised the proposed requirements for the postanesthesia evaluation in this final rule with comment period to better reflect current standards of care. We are requiring that the postanesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia no later than 48 hours after surgery or a procedure requiring anesthesia services, and that the postanesthesia evaluation for anesthesia recovery must be completed in accordance with State law and with hospital policies and procedures that have been approved by the medical staff and that reflect current standards of anesthesia care.

Comment: One commenter requested that CMS regularly update the online Interpretive Guidelines to reflect changes in the hospital CoPs and that healthcare professionals and their professional associations be notified by CMS on a timely basis regarding such updates.

Response: This request is outside of the scope of this rule. However, we will forward this comment to the appropriate component within CMS responsible for the Interpretive Guidelines.

c. Technical Amendment to Nursing Services CoP

In the CY 2008 OPPS/ASC proposed rule (72 FR 42810), we proposed 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 proposed a technical amendment to this provision to correct the cross-reference to § 488.54(c).

We did not receive any public comments on this proposed change.

After consideration of the public comments received, we are finalizing the proposed changes without revision, with the exception of those under § 482.52(b)(3). We are revising the proposed revision to require that the postanesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia no later than 48 hours after surgery or a procedure requiring anesthesia services, and that the postanesthesia evaluation for anesthesia recovery must be in accordance with State law and with hospital policies and procedures, which have been approved by the medical staff and which reflect current standards of anesthesia care. As finalized in this final rule with comment period, these requirements will provide hospitals greater flexibility while ensuring the quality and safety of care provided to patients.

XIX. Changes to the FY 2008 Hospital Inpatient Prospective Payment System (IPPS) Payment Rates

A. Background

On August 1, 2007, we issued a final rule with comment period to update the hospital inpatient prospective payment system (IPPS) for FY 2008. (This rule was printed in the August 22, 2007 **Federal Register** at 72 FR 47130 through 48175.) In that final rule with comment period, as part of the annual update of policies and payment rates under the IPPS, we adopted a new patient diagnosis classification system, the Medicare severity diagnosis-related group (MS–DRG) system, to replace the existing CMS–DRG system, effective October 1, 2007. To maintain budget neutrality for the transition to the MS–DRG patient classification system, using the Secretary's authority under section 1886(d)(3)(A)(vi) of the Act to adjust the standardized amount to eliminate the effect of changes in coding or classification that do not reflect real change in case-mix, we also provided for a documentation and coding adjustment to the IPPS payment rates of −1.2 percent. On September 28, 2007, we issued a correction notice to the FY 2008 IPPS final rule with comment period that corrected an inadvertent technical calculation error made in the FY 2008 IPPS final rule with comment period that affected IPPS payment rates, factors, and thresholds. (This notice, which we will refer to as the ''second FY 2008 IPPS correction notice,'' was printed in the October 10, 2007 **Federal Register** at 72 FR 57634.)

On September 29, 2007, the TMA, Abstinence Education, and QI Programs Extension Act of 2007 TMA), Public Law 110–90, was enacted. As discussed in more detail in section XIX.B. of this final rule, section 7 of Public Law 110–90 included a provision that reduces the −1.2 percent documentation and coding adjustment for the MS–DRG system that we adopted in the FY 2008 IPPS final rule to −0.6 percent. To comply with the provision of section 7 of Public Law 110–90, we are revising certain FY 2008 IPPS payment rate, thresholds, and factors that were included in the October 10, 2007 correction notice for the FY 2008 final rule with comment period.

In addition, in this final rule, we are making a policy change to the IPPS that was not part of Public Law 110–90. In the FY 2008 IPPS final rule, we established a policy of applying the documentation and coding adjustment to the hospital-specific rates for Medicare-dependent, small rural hospitals (MDHs) and sole community hospitals (SCHs) for FY 2008. We have determined that application of the documentation and coding adjustment to the hospital-specific rates is not consistent with the plain meaning of section 1886(d)(3)(A)(vi) of the Act. Therefore, we have decided to change this policy, effective October 1, 2007, as discussed in section XIX.B.2. of this final rule.

B. Revised IPPS Payment Rates

1. MS–DRG Documentation and Coding Adjustment

As stated earlier, we adopted the new MS–DRG patient classification system for the IPPS, effective October 1, 2007. The intent of the MS–DRG system is to better recognize severity of illness in

Medicare payment rates. Adoption of the MS–DRGs resulted in the expansion of the number of DRGs from 538 to 745. By increasing the number of DRGs and more fully taking into account severity of illness in Medicare payment rates, the MS–DRGs encourage hospitals to improve their documentation and coding of patient diagnoses. Because of the incentives that the MS–DRGs provide for improved documentation and coding of patient diagnoses, we indicated in the FY 2008 IPPS final rule that we believe the adoption of the MS–DRGs would lead to increases in aggregate payments due to improved documentation and coding without a corresponding increase in actual patient severity of illness. To maintain budget neutrality, using the Secretary's authority under section 1886(d)(3)(A)(vi) of the Act to adjust the standardized amount to eliminate the effect of changes in coding or classification that do not reflect real change in case-mix, we established a documentation and coding adjustment of −1.2 percent for FY 2008.

Section 7 of Public Law 110–90 included a provision concerning this documentation and coding adjustment for the MS–DRGs. Specifically, section 7 of Public Law 110–90 requires the Secretary to apply a prospective documentation and coding adjustment for discharges during FY 2008 of −0.6 percent rather than the −1.2 percent adjustment specified in the FY 2008 IPPS final rule. To comply with the provision of section 7 of Public Law 110–90, we are changing the IPPS documentation and coding adjustment for FY 2008 to −0.6 percent and recalculating the operating standardized amounts, capital standard Federal payment rates, the outlier threshold, the offset factors that are applied to the standardized amounts to account for projected outlier payments, and the thresholds that are used to evaluate applications for new technology add-on payments for FY 2008. All of these revised rates, factors, and thresholds are effective October 1, 2007. These revised rates, factors, and thresholds replace those rates, factors, and thresholds published in the FY 2008 IPPS final rule and in the second FY 2008 IPPS correction notice. We issued the second FY 2008 IPPS correction notice prior to enactment of Public Law 110–90 and, consequently, that correction notice did not reflect the change from the −1.2 percent to the −0.6 percent documentation and coding adjustment for FY 2008.

The revised standardized amounts are shown in Table 1A, 1B, 1C, and 1D. As expected, the standardized amounts have increased by about 0.6 percent as a result of changes in the documentation and coding adjustment required under section 7 of Public Law 110–90.

We also have recalculated the outlier threshold based on the revised standardized amounts. As a result of the change made by section 7 of Public Law 110–90, the revised outlier threshold for FY 2008 is $22,185. This represents a decrease of $275 from the previously published FY 2008 outlier threshold. The revised outlier factors are: 0.948983 for operating national; 0.964060 for operating Puerto Rico; 0.952336 for capital national; and 0.959464 for capital Puerto Rico.

In addition, we have recalculated the thresholds that are being used to evaluate applications for new technology add-on payments for FY 2008 under the IPPS, as shown in Table 10 below. (We note that, for ease of reference, we have retained the original table numbering from the FY 2008 IPPS final rule and the second FY 2008 IPPS correction notice. As a result, table numbering in this section is not sequential because only certain tables from the FY 2008 IPPS final rule and the second FY 2008 IPPS correction notice require changes to comply with the provisions of section 7 of Public Law 110–90.) These thresholds, which are equal to the geometric mean standardized charges plus the lesser of 75 percent of the national adjusted operating standardized payment amount (increased to reflect the differences between costs and charges) or 75 percent of 1 standard deviation of mean charges by MS–DRG, were recalculated due to the change in the standardized operating amount resulting from the change made by section 7 of Public Law 110–90. Depending on the particular MS–DRG, the revised new technology thresholds are either the same as, or have increased slightly from, the previously published amounts.

Both the FY 2008 IPPS final rule and the second FY 2008 IPPS correction notice included a table entitled ''Comparison of FY 2007 Standardized Amounts to the FY 2008 Single Standardized Amount with Full Update and Reduced Update.'' We are including an updated version of that table in this final rule, which reflects the payment rates, factors, and thresholds that have been revised to comply with section 7 of Public Law 110–90.

We note that section 7 of Public Law 110–90 includes provisions concerning documentation and coding adjustments to payment rates for years after FY 2008. We will address those provisions in future years' rulemaking for the IPPS.

2. Application of the Documentation and Coding Adjustment to the Hospital-Specific Rates

Under section 1886(d)(5)(D)(i) of the Act, SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal national rate; the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; or the updated hospital-specific rate based on FY 1996 costs per discharge. Under section 1886(d)(5)(G) of the Act, MDHs are paid based on the Federal national rate or, if higher, the Federal national rate plus 75 percent of the difference between the Federal national rate and the updated hospital-specific rate based on either the FY 1982, 1987, or 2002 costs per discharge. When we recalculated the FY 2008 IPPS rates to comply with the provision of section 7 of Public Law 110–90, we reviewed the policy we established in the FY 2008 IPPS final rule of applying the document and coding adjustment to the hospital-specific rates for MDHs and SCHs. In that final rule, we stated that we believe the hospital-specific rates for MDHs and SCHs should be subject to the documentation and coding adjustment that we were applying under section 1886(d)(3)(A)(vi) of the Act to maintain budget neutrality for the adoption of the MS–DRGs. That is, as these hospitals use the same DRG system as all other hospitals, we believe they should be equally subject to the budget neutrality adjustment that we were applying for adoption of the MS–DRGs to all other hospitals.

After further review of this issue, we have decided that the application of the documentation and coding adjustment to the hospital-specific rates is not consistent with the plain meaning of the statute. Section 1886(d)(3)(A)(vi) of the Act provides the Secretary with the authority to adjust ''the average standardized amounts'' so as to eliminate the effect of changes in coding or classification of discharges that do not reflect real changes in case-mix. However, section 1886(d)(3)(A)(vi) of the Act only provides authority to adjust the average standardized amounts, and does not refer to the hospital-specific rates. We continue to believe that it would be appropriate to apply the documentation and coding adjustment to the hospital-specific rates because we believe that aggregate IPPS payments will increase after implementation of the MS–DRGs due to incentives to improve coding and documentation. However, we believe that such an adjustment is not authorized under

section 1886(d)(3)(A)(vi) of the Act. As a result, we are establishing a policy of not applying the documentation and coding adjustment to the hospital-specific rates for FY 2008. Consequently, the revised DRG classification and recalibration factor of 0.995743, established in the October 10, 2007 correction notice for the FY 2008 IPPS final rule, which corrected the budget neutrality factor established in the FY 2008 IPPS final rule (72 FR 47416 and 47423), will be applied to the hospital-specific rates of MDHs and SCHs for FY 2008 without application of a −1.2 percent or a −0.6 percent documentation and coding adjustment. This policy is effective October 1, 2007, for FY 2008.

TABLE 1A.—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS; LABOR/NONLABOR

[69.7 Percent Labor Share/30.3 Percent Nonlabor Share if Wage Index Greater Than 1]

Full update (3.3 percent)		Reduced update (1.3 percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$3,478.45	$1,512.15	$3,411.10	$1,482.87

TABLE 1B.—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR

[62 Percent Labor Share/38 Percent Nonlabor Share if Wage Index Less Than Or Equal to 1]

Full update (3.3 percent)		Reduced update (1.3 percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$3,094.17	$1,896.43	$3,034.26	$1,859.71

TABLE 1C.—ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR PUERTO RICO, LABOR/NONLABOR

	Rates if wage index greater than 1		Rates if wage index less than or equal to 1	
	Labor	Nonlabor	Labor	Nonlabor
National	$3,478.45	$1,512.15	$3,094.17	$1,896.43
Puerto Rico	1,462.27	896.23	1,384.44	974.06

TABLE 1D.—CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	$426.14
Puerto Rico	201.67

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY MEDICARE SEVERITY-DIAGNOSIS-RELATED GROUP (MS DRG) OCTOBER 2007 [1]

MS–DRG	Number of cases	Threshold ($)
1	652	$345,031
2	335	178,142
3	24,400	248,318
4	21,825	149,288
5	634	167,763
6	296	92,366
7	378	134,606
8	583	92,357
9	1,388	97,098
10	182	73,504

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY MEDICARE SEVERITY-DIAGNOSIS-RELATED GROUP (MS DRG) OCTOBER 2007 [1]—Continued

MS–DRG	Number of cases	Threshold ($)
11	1,297	71,694
12	1,956	51,613
13	1,476	37,000
20	910	138,461
21	566	108,125
22	249	74,864
23	3,564	81,082
24	2,168	57,415
25	8,493	77,774
26	12,059	52,410
27	14,191	41,344
28	1,623	74,228
29	3,089	45,957
30	3,592	30,059
31	1,061	60,385
32	3,064	35,538
33	4,237	28,788
34	821	58,431
35	2,911	41,625

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY MEDICARE SEVERITY-DIAGNOSIS-RELATED GROUP (MS DRG) OCTOBER 2007 [1]—Continued

MS–DRG	Number of cases	Threshold ($)
36	7,454	36,602
37	4,803	51,825
38	16,531	32,848
39	53,619	23,940
40	4,585	57,599
41	8,005	39,541
42	5,216	34,291
52	1,188	29,379
53	590	21,941
54	4,750	30,273
55	16,945	24,952
56	7,800	28,358
57	48,665	18,154
58	796	28,750
59	2,676	21,475
60	4,240	16,415
61	1,368	53,087
62	2,320	42,059
63	1,150	36,344

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY MEDICARE SEVERITY-DIAGNOSIS-RELATED GROUP (MS DRG) OCTOBER 2007 [1]—Continued

MS–DRG	Number of cases	Threshold ($)
64	56,448	33,903
65	115,423	26,274
66	91,644	19,975
67	1,403	30,850
68	12,512	21,801
69	104,325	17,613
70	7,165	33,429
71	10,283	26,043
72	5,811	19,097
73	8,728	27,072
74	32,760	19,857
75	1,229	34,005
76	861	22,530
77	1,112	33,155
78	1,386	23,660
79	896	18,688
80	2,095	24,178
81	8,250	15,979
82	1,664	34,288
83	2,070	28,476
84	2,527	21,042
85	5,383	34,836
86	10,921	26,197
87	11,827	18,483
88	730	30,589
89	2,836	22,350
90	3,285	16,402
91	6,763	29,413
92	15,467	20,636
93	15,043	15,988
94	1,533	55,314
95	1,101	41,950
96	749	35,573
97	1,266	50,432
98	1,065	35,836
99	637	30,059
100	16,012	28,517
101	57,312	17,754
102	1,373	24,528
103	15,199	15,977
113	592	31,418
114	593	19,667
115	1,110	25,665
116	715	23,533
117	1,406	15,540
121	609	21,777
122	666	12,422
123	2,865	17,881
124	684	24,261
125	4,742	15,308
129	1,401	38,113
130	1,063	27,826
131	895	36,667
132	910	26,200
133	2,057	31,674
134	3,781	19,478
135	430	34,472
136	503	21,916
137	847	27,054

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY MEDICARE SEVERITY-DIAGNOSIS-RELATED GROUP (MS DRG) OCTOBER 2007 [1]—Continued

MS–DRG	Number of cases	Threshold ($)
138	926	17,071
139	1,710	19,625
146	696	35,254
147	1,457	25,264
148	924	17,390
149	39,487	14,828
150	945	25,286
151	6,840	12,717
152	2,363	22,142
153	16,167	14,126
154	1,857	28,071
155	4,431	20,298
156	4,969	14,819
157	1,164	28,432
158	3,158	19,955
159	2,365	14,144
163	13,502	78,360
164	18,484	48,016
165	14,267	37,961
166	20,398	57,329
167	21,074	39,878
168	5,555	30,256
175	12,032	33,180
176	40,330	25,127
177	57,526	35,918
178	72,497	29,908
179	26,495	23,293
180	22,628	33,071
181	32,425	26,996
182	6,085	21,762
183	1,679	29,948
184	4,279	21,041
185	2,607	14,730
186	8,586	31,572
187	10,362	25,688
188	4,840	19,425
189	105,009	28,936
190	57,361	27,734
191	126,608	22,656
192	193,798	17,011
193	88,637	29,505
194	274,002	23,196
195	142,476	16,909
196	5,173	30,869
197	7,087	25,433
198	4,822	19,617
199	3,279	33,401
200	8,321	23,384
201	3,470	16,338
202	32,849	19,060
203	40,990	13,891
204	26,244	16,200
205	5,816	26,248
206	22,615	17,512
207	46,394	81,181
208	79,797	41,263
215	154	151,824
216	8,437	161,730
217	7,940	116,752

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY MEDICARE SEVERITY-DIAGNOSIS-RELATED GROUP (MS DRG) OCTOBER 2007 [1]—Continued

MS–DRG	Number of cases	Threshold ($)
218	2,963	97,926
219	10,112	131,361
220	14,302	93,832
221	7,644	81,272
222	2,862	150,295
223	5,774	116,655
224	1,930	138,362
225	5,882	109,348
226	7,078	112,911
227	50,687	88,751
228	3,099	124,543
229	4,351	88,368
230	1,797	72,722
231	1,484	138,797
232	1,799	107,899
233	16,996	118,324
234	39,349	86,766
235	9,680	95,767
236	33,005	68,343
237	22,981	84,187
238	43,967	53,516
239	13,900	59,293
240	13,862	40,658
241	2,927	30,323
242	17,243	63,797
243	40,609	50,067
244	65,831	42,281
245	6,081	54,243
246	41,300	65,115
247	272,543	46,643
248	5,558	58,161
249	29,332	41,991
250	5,768	53,663
251	39,992	38,522
252	44,846	48,444
253	52,457	42,864
254	53,894	34,709
255	2,624	38,540
256	3,944	29,847
257	694	21,430
258	599	50,000
259	7,342	35,334
260	872	47,409
261	2,921	28,499
262	3,284	21,635
263	792	29,116
264	30,336	39,332
280	61,020	35,621
281	62,050	27,981
282	57,249	21,202
283	16,022	31,225
284	5,089	23,429
285	3,008	16,066
286	23,379	40,375
287	173,151	27,701
288	3,262	48,462
289	1,471	35,223
290	447	27,620
291	184,689	29,043

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY MEDICARE SEVERITY-DIAGNOSIS-RELATED GROUP (MS DRG) OCTOBER 2007 [1]—Continued

MS–DRG	Number of cases	Threshold ($)
292	245,075	22,187
293	200,858	16,283
294	1,756	20,506
295	1,631	12,987
296	1,844	26,712
297	893	18,216
298	518	11,608
299	17,570	27,717
300	49,533	20,057
301	37,733	14,452
302	7,919	23,176
303	81,896	14,065
304	2,116	24,314
305	36,019	13,919
306	1,385	27,686
307	6,479	17,568
308	33,741	27,391
309	85,320	19,164
310	156,223	13,820
311	25,143	12,408
312	170,267	16,986
313	222,163	13,782
314	60,587	30,529
315	33,354	22,371
316	18,077	15,239
326	11,616	86,300
327	11,348	49,623
328	8,994	31,842
329	48,381	78,446
330	68,497	46,925
331	29,611	34,940
332	1,897	72,565
333	6,490	45,834
334	3,751	34,051
335	7,194	67,395
336	12,815	43,093
337	8,636	32,710
338	1,513	58,176
339	3,289	39,849
340	3,551	29,763
341	878	43,074
342	2,662	32,095
343	6,796	22,560
344	897	51,758
345	3,090	33,808
346	2,758	25,650
347	1,577	36,724
348	4,295	27,903
349	5,539	17,498
350	1,802	41,307
351	4,663	28,433
352	8,835	18,578
353	3,076	44,840
354	9,041	30,936
355	16,621	21,562
356	8,411	57,588
357	8,336	39,793
358	2,477	30,966
368	3,069	31,708

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY MEDICARE SEVERITY-DIAGNOSIS-RELATED GROUP (MS DRG) OCTOBER 2007 [1]—Continued

MS–DRG	Number of cases	Threshold ($)
369	4,850	24,300
370	3,104	18,383
371	16,940	32,006
372	23,722	26,630
373	14,227	19,299
374	9,505	34,394
375	20,165	26,552
376	4,486	20,960
377	50,797	30,805
378	118,928	22,456
379	95,521	17,322
380	2,934	32,459
381	5,702	25,732
382	4,681	18,936
383	1,307	28,384
384	8,723	19,941
385	2,119	33,612
386	7,449	24,853
387	5,105	19,162
388	18,375	29,468
389	47,827	21,609
390	47,010	15,176
391	47,836	25,010
392	308,502	16,603
393	24,053	29,116
394	48,058	22,377
395	24,695	16,159
405	3,949	82,266
406	5,420	49,216
407	2,195	36,325
408	1,682	68,612
409	1,771	46,946
410	693	35,927
411	985	65,669
412	1,098	47,894
413	850	37,530
414	5,643	59,314
415	7,154	40,716
416	6,018	30,467
417	16,735	46,569
418	28,654	36,593
419	37,427	27,109
420	738	62,636
421	1,118	37,131
422	359	28,797
423	1,528	64,794
424	934	44,801
425	148	35,332
432	16,397	30,728
433	9,146	21,794
434	931	15,756
435	12,004	32,834
436	14,157	26,609
437	4,304	23,809
438	14,497	31,835
439	25,932	25,153
440	26,506	17,450
441	14,036	29,059
442	13,192	22,508

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY MEDICARE SEVERITY-DIAGNOSIS-RELATED GROUP (MS DRG) OCTOBER 2007 [1]—Continued

MS–DRG	Number of cases	Threshold ($)
443	6,445	16,775
444	12,529	31,163
445	17,390	25,361
446	16,434	18,758
453	852	162,946
454	1,700	108,994
455	1,715	84,036
456	770	132,720
457	2,084	93,391
458	1,282	76,799
459	3,212	91,603
460	51,227	61,623
461	1,071	78,604
462	14,292	59,135
463	5,317	58,718
464	6,589	40,875
465	2,748	30,484
466	3,914	70,332
467	14,340	53,276
468	21,479	45,819
469	29,879	56,126
470	412,628	41,706
471	2,241	71,743
472	6,629	48,496
473	22,659	39,769
474	2,857	47,857
475	3,709	34,489
476	1,560	23,529
477	2,262	56,532
478	7,379	41,594
479	10,118	33,437
480	25,993	50,104
481	74,669	37,466
482	49,780	31,682
483	6,572	44,289
484	17,287	37,116
485	1,152	55,664
486	2,066	41,511
487	1,345	33,504
488	2,541	33,357
489	6,198	25,879
490	21,668	34,253
491	57,424	22,157
492	4,761	47,754
493	16,833	36,159
494	29,419	27,047
495	1,888	49,306
496	5,499	34,296
497	7,196	26,140
498	1,258	36,549
499	1,173	20,709
500	1,359	47,311
501	3,956	30,725
502	6,635	21,338
503	743	38,573
504	2,274	30,902
505	3,142	22,627
506	921	23,455
507	840	33,200

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY MEDICARE SEVERITY-DIAGNOSIS-RELATED GROUP (MS DRG) OCTOBER 2007 [1]—Continued

MS–DRG	Number of cases	Threshold ($)
508	2,717	24,377
509	674	24,413
510	994	38,968
511	4,183	30,425
512	12,088	21,576
513	1,104	28,511
514	1,175	18,054
515	3,601	50,850
516	11,512	37,284
517	17,926	30,578
533	835	26,707
534	3,647	14,482
535	6,888	26,510
536	34,492	14,330
537	694	19,017
538	1,139	12,077
539	3,397	33,275
540	4,317	26,909
541	1,787	20,216
542	6,196	32,603
543	18,834	24,660
544	12,389	16,758
545	4,061	33,895
546	6,159	23,684
547	4,717	16,961
548	592	32,830
549	1,139	25,116
550	855	16,440
551	9,580	29,166
552	88,568	17,262
553	2,820	24,459
554	20,429	13,865
555	2,006	21,701
556	19,316	13,456
557	3,196	28,928
558	14,252	17,984
559	1,646	27,945
560	4,208	19,203
561	7,439	12,631
562	5,051	26,500
563	36,361	14,373
564	1,622	27,272
565	3,385	19,726
566	2,673	14,394
573	5,721	44,240
574	12,468	32,357
575	6,221	24,293
576	563	45,021
577	2,305	31,260
578	3,228	21,726
579	3,359	42,843
580	11,019	29,022
581	12,249	19,890
582	5,787	22,538
583	9,356	17,024
584	801	29,827
585	1,687	19,824
592	4,026	29,402
593	13,080	21,992
594	2,828	15,050
595	1,092	29,735
596	5,792	18,108
597	555	29,944
598	1,502	23,666
599	342	14,643
600	611	21,165
601	841	13,706
602	21,456	26,755
603	132,037	16,799
604	2,652	25,338
605	22,943	15,043
606	1,371	23,134
607	7,242	13,623
614	1,429	44,434
615	1,594	32,741
616	1,145	57,824
617	6,944	36,311
618	268	26,622
619	675	60,418
620	2,007	41,247
621	6,560	35,467
622	1,241	43,164
623	3,392	32,438
624	392	23,639
625	1,107	40,382
626	2,751	27,124
627	14,146	17,672
628	3,297	50,999
629	4,125	39,920
630	551	30,418
637	16,431	26,770
638	46,657	17,852
639	36,178	12,405
640	56,149	24,007
641	189,293	15,306
642	1,570	23,279
643	5,072	30,747
644	12,220	23,221
645	8,140	17,134
652	10,695	57,657
653	1,591	83,632
654	3,387	53,616
655	1,514	40,319
656	3,739	56,790
657	7,946	38,780
658	7,957	31,512
659	4,484	50,404
660	7,985	36,216
661	4,264	28,963
662	998	41,878
663	2,288	29,568
664	4,543	21,878
665	693	47,261
666	2,405	30,788
667	3,765	17,825
668	3,768	39,776
669	13,307	27,864
670	12,685	17,652
671	917	28,789
672	940	17,260
673	12,678	43,365
674	13,848	38,562
675	8,371	31,105
682	76,428	30,069
683	128,229	25,154
684	28,358	16,191
685	2,520	18,480
686	1,596	31,266
687	3,467	24,382
688	1,098	16,621
689	55,794	25,693
690	201,347	16,948
691	908	32,141
692	653	23,510
693	2,256	27,791
694	19,345	16,454
695	982	24,103
696	10,646	13,740
697	585	16,016
698	21,255	27,734
699	27,064	21,858
700	11,141	15,265
707	6,053	34,784
708	15,996	27,483
709	796	33,829
710	2,015	28,079
711	953	34,060
712	793	18,806
713	12,009	24,773
714	32,647	14,452
715	662	34,122
716	1,367	26,199
717	666	31,542
718	601	17,543
722	881	29,202
723	2,078	23,886
724	648	14,696
725	808	23,735
726	3,956	15,110
727	1,106	26,438
728	6,224	15,600
729	603	22,575
730	533	13,176
734	1,528	39,574
735	1,278	24,152
736	842	68,949
737	3,487	39,556
738	912	26,791
739	980	48,297
740	4,638	31,766
741	6,330	22,182
742	11,685	29,942
743	34,686	19,452
744	1,634	28,687
745	2,080	18,005
746	2,664	27,898
747	11,073	19,176

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY MEDICARE SEVERITY-DIAGNOSIS-RELATED GROUP (MS DRG) OCTOBER 2007 [1]—Continued

MS–DRG	Number of cases	Threshold ($)
748	21,289	18,499
749	1,048	42,978
750	477	22,403
754	1,097	31,885
755	3,219	24,350
756	783	15,311
757	1,326	31,206
758	1,659	24,086
759	1,141	17,474
760	1,815	17,766
761	1,844	12,285
765	2,606	19,738
766	2,664	13,500
767	123	14,158
768	10	28,544
769	87	30,064
770	188	15,884
774	1,476	11,268
775	5,343	8,224
776	495	14,028
777	180	17,674
778	494	7,925
779	107	12,859
780	50	5,097
781	3,062	11,922
782	129	7,495
790	1	10,892
793	1	7,090
799	631	76,408
800	730	45,534
801	581	35,405
802	693	51,922
803	1,030	33,848
804	978	23,443
808	8,276	34,018
809	15,783	25,043
810	3,694	19,852
811	18,481	24,822
812	83,743	16,735
813	15,112	25,412
814	1,649	29,868
815	3,483	23,384
816	2,274	16,506
820	1,490	83,924
821	2,593	40,916
822	2,108	28,993
823	2,452	64,964
824	3,130	40,720
825	1,940	29,726
826	566	77,536
827	1,354	40,320
828	851	29,066
829	1,386	44,486
830	520	24,753
834	5,293	50,536

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY MEDICARE SEVERITY-DIAGNOSIS-RELATED GROUP (MS DRG) OCTOBER 2007 [1]—Continued

MS–DRG	Number of cases	Threshold ($)
835	1,458	30,848
836	1,554	23,636
837	1,638	86,041
838	942	41,650
839	1,368	27,174
840	15,248	37,709
841	11,355	28,818
842	7,431	22,926
843	1,498	32,726
844	2,893	25,240
845	988	19,989
846	2,498	37,638
847	23,816	25,436
848	1,695	18,894
849	1,507	27,052
853	31,591	74,820
854	6,945	49,005
855	429	35,456
856	6,215	64,154
857	10,284	36,043
858	3,362	28,370
862	7,481	32,201
863	21,957	20,215
864	19,959	19,205
865	2,032	28,153
866	9,474	15,750
867	5,387	37,627
868	2,507	24,427
869	1,129	18,549
870	13,815	88,107
871	204,810	33,501
872	92,533	25,285
876	971	40,709
880	10,578	14,303
881	4,636	10,640
882	1,673	11,353
883	799	16,323
884	21,747	17,521
885	78,937	14,233
886	377	13,044
887	427	17,908
894	4,627	7,335
895	6,777	14,018
896	5,447	25,226
897	36,860	12,339
901	924	48,983
902	2,217	31,794
903	1,687	22,773
904	980	39,791
905	779	24,032
906	751	22,406
907	8,164	53,029
908	8,553	34,813
909	5,427	25,547
913	828	26,581

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY MEDICARE SEVERITY-DIAGNOSIS-RELATED GROUP (MS DRG) OCTOBER 2007 [1]—Continued

MS–DRG	Number of cases	Threshold ($)
914	7,082	15,123
915	928	24,288
916	5,418	9,886
917	14,498	28,189
918	35,052	13,329
919	10,672	28,054
920	14,259	20,512
921	9,672	13,742
922	1,027	26,694
923	4,264	14,600
927	187	176,359
928	819	59,807
929	448	32,905
933	158	31,820
934	701	23,903
935	2,209	21,647
939	428	42,892
940	732	32,945
941	1,058	25,659
945	5,485	19,140
946	2,759	16,452
947	6,597	22,649
948	34,624	14,331
949	767	17,139
950	463	11,233
951	1,008	13,228
955	456	82,569
956	3,769	54,324
957	1,324	98,399
958	1,221	65,730
959	295	44,733
963	1,509	46,426
964	2,538	32,437
965	1,105	23,186
969	676	74,072
970	159	41,796
974	6,358	38,864
975	4,516	27,898
976	2,770	20,952
977	5,016	23,376
981	26,444	75,197
982	19,320	52,409
983	6,143	37,918
984	671	56,061
985	1,108	38,816
986	833	27,982
987	8,040	53,190
988	12,302	35,697
989	6,162	25,762
999	30	11,270

[1] Cases taken from the FY 2006 MedPAR file; MS–DRGs are from GROUPER Version 25.0.

COMPARISON OF FY 2007 STANDARDIZED AMOUNTS TO THE FY 2008 SINGLE STANDARDIZED AMOUNT WITH FULL UPDATE AND REDUCED UPDATE

	Full update (3.3 percent); wage index is greater than 1.0000	Full update (3.3 percent); wage index is less than 1.0000	Reduced update (1.3 percent); wage index is greater than 1.0000	Reduced update (1.3 percent); wage index is less than 1.0000
FY 2007 Base Rate, after removing reclassification budget neutrality, demonstration budget neutrality, wage index transition budget neutrality factors and outlier offset (based on the labor and market share percentage for FY 2008).	Labor: $3,609.23 Nonlabor: $1,569.01	Labor: $3,210.51 Nonlabor: $1,967.73	Labor: $3,609.23 Nonlabor: $1,569.01	Labor: $3,210.51 Nonlabor: $1,967.73.
FY 2008 Update Factor	1.033	1.033	1.013	1.013.
FY 2008 DRG Recalibrations and Wage Index Budget Neutrality Factor.	0.996383	0.996383	0.996383	0.996383.
FY 2008 Reclassification Budget Neutrality Factor.	0.991290	0.991290	0.991290	0.991290.
Adjusted for Blend of FY 2007 DRG Recalibration and Wage Index Budget Neutrality Factors.	Labor: $3,682.49 Nonlabor: $1,600.86	Labor: $3,275.68 Nonlabor: $2,007.67	Labor: $3,611.20 Nonlabor: $1,569.86	Labor: $3,212.26. Nonlabor: $1,968.80.
Imputed Rural Floor Budget Neutrality Factor.	0.999265	0.999265	0.999265	0.999265.
FY 2008 Outlier Factor	0.948983	0.948983	0.948983	0.948983.
Rural Demonstration Budget Neutrality Factor.	0.999902	0.999902	0.999902	0.999902.
FY 2008 Documentation and Coding Adjustment.	0.994	0.994	0.994	0.994.
Rural Floor Adjustment	1.002214	1.002214	1.002214	1.002214.
Rate for FY 2008	Labor: $3,478.45 Nonlabor: $1,512.15	Labor: $3,094.17 Nonlabor: $1,896.43	Labor: $3,411.10 Nonlabor: $1,482.87	Labor: $3,034.26. Nonlabor: $1,859.71.

XX. Medicare Graduate Medical Education Affiliation Provisions for Teaching Hospitals in Certain Emergency Situations

If you choose to comment on issues in this section, please include the caption ''Medicare GME Affiliations'' at the beginning of your comment.

A. Background

1. Legislative Authority

The stated purpose of section 1135 of the Act is to enable the Secretary to ensure, to the maximum extent feasible, in any emergency area and during an emergency period, that sufficient health care items and services are available to meet the needs of enrollees in Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). Section 1135 of the Act authorizes the Secretary, to the extent necessary to accomplish the statutory purpose, to temporarily waive or modify the application of certain types of statutory and regulatory provisions (such as conditions of participation or other certification requirements, program participation or similar requirements, or preapproval requirements) with respect to health care items and services furnished by health care provider(s) in an emergency area during an emergency period.

The Secretary's authority under section 1135 of the Act arises in the event there is an ''emergency area'' and continues during an ''emergency period'' as those terms are defined in the statute. Under section 1135(g) of the Act, an emergency area is a geographic area in which there exists an emergency or disaster that is declared by the President according to the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act, and a public health emergency declared by the Secretary according to section 319 of the Public Health Service Act. (Section 319 of the Public Health Service Act authorizes the Secretary to declare a public health emergency and take the appropriate action to respond to the emergency, consistent with existing authorities.) Throughout the remainder of this discussion, we will refer to such emergency areas and emergency periods as ''section 1135'' emergency areas and emergency periods.

Under section 1886(h) of the Act, as amended by section 9202 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (Public Law 99–272), the Secretary is authorized to make payments to hospitals for the direct costs of approved GME programs. Section 1886(d)(5)(B) of the Act provides for an additional payment per Medicare discharge for acute care hospitals paid under the inpatient prospective payment system (IPPS) that have residents in an approved GME program. This additional payment is to reflect the higher patient care costs of teaching hospitals, that is, the indirect graduate medical education (IME) costs. Sections 1886(h)(4)(F) and 1886(d)(5)(B)(v) of the Act establish limits on the number of allopathic and osteopathic residents that hospitals may count for purposes of calculating direct GME payments and the IME adjustment, respectively, establishing hospital-specific direct GME and IME full-time equivalent (FTE) resident caps. Under the authority granted by section 1886(h)(4)(H)(ii) of the Act, the Secretary has issued rules to allow institutions that are members of the same affiliated group to apply their direct GME and IME FTE resident caps on an aggregate basis through a Medicare GME affiliation agreement. The Medicare regulations at §§ 413.75 and 413.79 permit hospitals, through a Medicare GME affiliation agreement, to adjust IME and direct GME FTE resident caps to reflect the rotation of residents among affiliated hospitals.

2. Existing Medicare Direct GME and Indirect GME Policies

The Medicare program makes payments to teaching hospitals to account for two types of costs, the direct costs (direct GME) and the indirect costs (IME) of a hospital's GME program. Direct GME payments represent the direct costs of training residents (for

example, resident salaries and fringe benefits, and teaching physician costs associated with an approved GME program) and generally are calculated by determining the product of the Medicare patient load (that is, the Medicare percentage of the hospital's inpatient days), the hospital's per resident payment amount, and the weighted number of FTE residents training at the hospital.

The IME adjustment is made to teaching hospitals for the additional indirect patient care costs attributable to teaching activities. For example, teaching hospitals typically offer more technologically advanced treatments to their patients, and therefore, patients who are sicker and need more sophisticated treatment are more likely to go to teaching hospitals. Furthermore, there are additional costs associated with teaching residents resulting from the additional tests or procedures ordered by residents and the demands put on physicians who supervise, and staff who support, the residents. IME payments are made as a percentage add-on adjustment to the per discharge IPPS payment, and are calculated based on the hospital's ratio of FTE residents to available beds as defined at § 412.105(b). The statutory formula for calculating the IME adjustment is: $c \times [(1 + r)^{.405} - 1]$, where ''r'' represents the hospital's ratio of FTE residents to beds, and ''c'' represents an IME multiplier, which is set by the Congress.

The amount of IME payment a hospital receives for a particular discharge is dependent upon the number of FTE residents the hospital trains, the hospital's number of available beds, the current level of the statutory IME multiplier, and the otherwise payable per discharge IPPS payment. Sections 1886(d)(5)(B)(v) and 1886(h)(4)(F) of the Act established hospital-specific limits (that is, caps) on the number of allopathic and osteopathic FTE residents that hospitals may count for purposes of calculating indirect and direct GME payments, respectively.

3. Regulatory Changes Issued in 2006 To Address Certain Emergency Situations

As explained above, when Hurricane Katrina occurred on August 29, 2005, disrupting health care operations and medical residency training programs at teaching hospitals in New Orleans and the surrounding area, the conditions were met to establish an emergency area and emergency period under section 1135(g) of the Act. Shortly after Hurricane Katrina occurred, we were informed by hospitals in New Orleans that the training programs at many teaching hospitals in the city were closed as a result of the disaster and that the displaced residents were being transferred to training programs at host hospitals in other parts of the country. For purposes of discussion in this rule, a host hospital is a hospital that trains residents displaced from a training program in a section 1135 emergency area. Also, a home hospital is one that meets all of the following: (1) Is located in a section 1135 emergency area (2) had its inpatient bed occupancy decreased by 20 percent or more due to the disaster so that it is unable to train the number of residents it originally intended to train in that academic year, and (3) needs to send the displaced residents to train at a host hospital.

Section 413.79(h) allows a hospital that closed, or that closed one or more of its residency training programs, to temporarily transfer FTE residents and part or all of its FTE resident caps to another hospital in order to allow the accepting hospital to count the displaced residents for direct GME and IME payment and to enable the displaced residents to complete their training despite closure of either the hospital or the residency training program in which they were originally training. In the aftermath of Hurricanes Katrina and Rita, the training programs at many teaching hospitals in New Orleans and surrounding areas were temporarily closed (or substantially reduced), and the displaced residents were even transferred to other hospitals in other parts of the country to continue their training programs. We initially suggested that hospitals whose GME programs were affected by Hurricanes Katrina and Rita could use these ''closed hospital'' and ''closed program'' regulations to address issues relating to displaced residents. (We refer readers to the CMS Q&A's Web site at: *http://questions.cms.hhs.gov.* The Web site link is located at ID 5696.)

While a number of the residents have since returned to the hurricane-affected hospitals, others remain displaced to other hospitals, including hospitals located in States outside of the section 1135 emergency area. In response to immediate concerns relating to displaced residents, CMS issued regulations on April 12, 2006 in an interim final rule with comment period published in the **Federal Register** (71 FR 18654). The regulatory changes in that rule allowed home and host hospitals under certain circumstances to form emergency Medicare GME affiliations. The purpose of these emergency Medicare GME affiliation rules was to permit Medicare GME support to be maintained while displaced residents are training at various hospitals, even as the hurricane affected hospitals are rebuilding their training programs. The modifications to the regulations at § 413.75(b) and § 413.79(f) provided flexibility for home hospitals whose residency programs have been disrupted in an emergency area to enter into *emergency* Medicare GME affiliation agreements with host hospitals where the hospitals may not meet the regulatory requirements for regular Medicare GME affiliations. Due to the infrastructure damage and continued disruption of operations experienced by medical facilities, and the consequent disruption in residency training, caused by Hurricanes Katrina and Rita in 2005, there became an urgent need for these regulation changes to be applied retroactively.

Section 1871(e)(1)(A) of the Act, as amended by section 903(a)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Public Law 108–173), generally prohibits the Secretary from making retroactive substantive changes in policy unless retroactive application of the change is necessary to comply with statutory requirements, or failure to apply the change retroactively would be contrary to the public interest. Because existing regulations did not adequately address the issues faced by hospitals that are located in the emergency areas, or hospitals that assisted by training displaced residents from the emergency area, and because we believed hospitals affected by Hurricanes Katrina and Rita would otherwise have faced dramatic financial hardship and the recovery of graduate medical education programs in the emergency area would have been impeded, we found that failure to apply the regulatory changes in the April 12, 2006, interim final rule retroactively would be contrary to the public interest. Thus, the provisions of this interim final rule were made effective retroactively as of August 29, 2005.

To provide regulatory relief, especially in situations not addressed under existing regulations (for example, where hospitals had initially closed, but were in the process of gradually reopening their programs, or where hospitals had severely reduced but never completely closed their programs after Hurricanes Katrina and Rita), we established the emergency Medicare GME affiliation provisions in the April 12, 2006 interim final rule with comment period. In summary, the April 12, 2006 interim final rule with comment period made changes as follows:

• To provide hospitals with more flexibility to train displaced residents at various sites, and to allow host hospitals to count displaced residents for IME and direct GME payment purposes, home hospitals were permitted to enter into emergency Medicare GME affiliation agreements effective retroactive to the date of the first day of the section 1135 emergency period.

• Home hospitals were permitted to affiliate with host hospitals anywhere in the country. That is, a host hospital may be located in any State and may receive a temporary adjustment to its FTE caps to reflect displaced residents added or subtracted because the hospital is participating in an emergency Medicare GME affiliated group as defined at § 413.75(b).

• Emergency Medicare GME affiliation agreements were required to be submitted to CMS with a copy to the CMS fiscal intermediary or Medicare administrative contractor (MAC) by the later of 180 days after the section 1135 emergency period begins or by July 1 of the academic year in which the emergency Medicare GME affiliation agreement is effective. However, for hospitals affected by Hurricanes Katrina and Rita, the deadline was subsequently extended to October 9, 2006. (We refer readers to the final rule published in the **Federal Register** on July 6, 2006, for a detailed discussion (71 FR 38264 through 38266).

• The effective period of the emergency Medicare GME affiliation agreement was permitted to begin on or after the first day of a section 1135 emergency period, and must terminate no later than at the conclusion of 2 academic years following the academic year during which the section 1135 emergency period began.

• During the effective period of the emergency Medicare GME affiliation agreement, hospitals in the emergency Medicare GME affiliated group were not required to participate in a shared rotational arrangement (as they would be under a regular Medicare GME affiliation agreement).

• Host hospitals were allowed an exception from the otherwise applicable rolling average resident count for FTE residents added as a result of an emergency Medicare GME affiliation agreement, but only during the period from August 29, 2005 to June 30, 2006.

For a detailed discussion on each of the above emergency Medicare GME affiliation provisions, we refer readers to the April 12, 2006 interim final rule with comment period. (71 FR 18654 through 18667).

In the April 12, 2006 interim final rule with comment period, we revised the regulations at § 413.79(f) to provide for more flexibility than would have been possible under regular Medicare GME affiliations to allow home hospitals to efficiently find training sites for displaced residents. Under the flexibility provided by the emergency Medicare GME affiliated group provisions as specified at § 413.79(f)(6), decisions regarding the transfer of FTE resident cap slots, including how to distribute slots up to the home hospital's FTE resident caps in situations where the home hospital was training a number of residents in excess of its cap before the disaster, as well as the tracking of those FTE resident slots, was left to the home and host hospitals to work out among themselves. However, the home and host hospitals were required to include much of this information in their emergency Medicare GME affiliation agreements submitted both to CMS and the CMS contractor, as specified under § 413.79(f)(6). Furthermore, since hospitals were permitted to amend their emergency Medicare GME affiliation agreements (on or before June 30 of the relevant academic year) to reflect the actual training situation among the hospitals participating in the emergency Medicare GME affiliated group, hospitals were provided with a great degree of flexibility to accommodate any changing residency training circumstances within the emergency Medicare GME affiliated group. We note that the emergency Medicare GME affiliation provisions are intended for the purpose of enabling the continued training of residents displaced from a section 1135 emergency area, and *not* to enable hospitals to take advantage of the increased flexibility in order to shift FTE resident cap slots to other hospitals in the country (for instance, in order to maximize Medicare IME and direct GME payments).

We stated in the April 12, 2006 interim final rule with comment period that, in developing a policy to provide hospitals increased flexibility in response to a disaster, we intended to address two priorities. First, we believe that in disaster situations, to the extent that the statute permits, the policy should facilitate the continuity of GME, minimizing the disruption of residency training. Second, the policy should take into account that the training programs in the section 1135 emergency area have been severely disrupted by a disaster and that the hospitals affected by the disaster will usually want to rebuild their GME programs as soon as possible.

B. Additional Changes in This Interim Final Rule With Comment Period

1. Summary of Regulatory Changes

Since the establishment of the emergency provisions in the April 12, 2006 interim final rule with comment period, we have been monitoring the application of the emergency Medicare GME affiliation agreement rules in order to assess whether those regulatory changes were adequate to address the needs of hospitals located in the section 1135 emergency area in the aftermath of Hurricanes Katrina and Rita. We understand that hospitals with GME programs in the section 1135 area continue to find it necessary to adjust the location of resident training both within and outside the emergency area, as affected hospitals continue to reopen beds at different rates, and as feedback from accreditation surveys warrants educational adjustments. Furthermore, stakeholders in Louisiana have informed CMS that they believe fluidity in GME programs will continue for several more years, and are not likely to stabilize until permanent replacement facilities are established and functioning in the emergency area. As a result, we believe the provisions first established in the April 12, 2006 interim final rule need to be further modified to meet the two priorities stated earlier. Therefore, through this interim final rule with comment period, we are modifying the regulations for emergency Medicare GME affiliated groups at § 413.79(f)(6) to provide continuing relief to home and host hospitals affected by disruptions in residency programs in the section 1135 emergency area declared after Hurricanes Katrina and Rita, as well as to provide relief for similar challenges in any future emergency situation. We note that we did receive a number of comments on the interim final rule with comment period issued on April 12, 2006. However, we believe it would be beneficial to provide the public with the opportunity to submit formal comments on these latest changes in the context of the current training situation in the area affected by Hurricanes Katrina and Rita. We intend to respond to comments submitted on both this interim final rule with comment period and the April 12, 2006 interim final rule with comment period in a future final rule.

Under existing regulations, the emergency Medicare GME affiliation agreement must be written, signed, and dated by responsible representatives of each participating hospital and must: (1) List each participating hospital and its provider number, and specify whether the hospital is a home or host hospital; (2) specify the effective period of the

emergency Medicare GME affiliation agreement (which must, in any event, terminate at the conclusion of two academic years following the academic year in which the section 1135 emergency period began); (3) list each participating hospital's IME and direct GME FTE caps in effect for the current academic year before the emergency Medicare GME affiliation (that is, if the hospital was already a member of a regular Medicare GME affiliated group before entering into the emergency Medicare GME affiliation, the emergency Medicare GME affiliation must be premised on the FTE caps of the hospital as adjusted per the regular Medicare GME affiliation agreement, and not include any slots gained under section 422 of the MMA); and (4) specify the total adjustment to each hospital's FTE caps in each year that the emergency Medicare GME affiliation agreement is in effect, for both direct GME and IME, that reflects a positive adjustment to the host hospital's direct and indirect FTE caps that is offset by a negative adjustment to the home hospital's (or hospitals') direct and indirect FTE caps of at least the same amount. The sum total of all the participating hospitals' FTE caps under the emergency Medicare GME affiliation agreement may not exceed the aggregate adjusted caps of the hospitals participating in the emergency Medicare GME affiliated group. A home hospital's IME and direct GME FTE cap reduction under an emergency Medicare GME affiliation agreement is limited to the home hospital's IME and direct GME FTE resident caps in effect for the academic year, in accordance with regulations at § 413.79(c) or § 413.79 (f)(1) through (f)(5), that is, the hospital's base year FTE resident caps as adjusted by any and all existing affiliation agreements in effect as of the first day of the section 1135 period. Finally, as we stated in the April 12, 2006 interim final rule with comment period, amendments to the emergency Medicare GME affiliation agreement to adjust the distribution of the FTE resident caps specified in the original emergency Medicare GME affiliation among the hospitals that are part of the emergency Medicare GME affiliated group in order to reflect the actual placement of residents can be made through June 30 of the academic year for which it is effective. [71 FR 18662]

In this interim final rule with comment period, we are further modifying the regulations at § 413.75(b) and § 413.79(f) to allow hospitals to enter into emergency Medicare GME affiliation agreements with the following increased flexibility. First, for emergency Medicare GME affiliation agreements involving a host hospital located in a different State from the home hospital (hereinafter, an ''out-of-State host hospital''), the permissible effective period for such agreements is extended from up to 3 years (i.e., the year in which the section 1135 emergency period began plus two subsequent academic years) to up to 5 years (i.e., the year in which the section 1135 emergency period began plus four subsequent academic years). However, emergency Medicare GME affiliation agreements involving out of State host hospitals during these two additional periods may only apply with respect to the actual residents that were displaced from training in a hospital located in the section 1135 emergency area. By ''actual residents that were displaced from training in a hospital located in the section 1135 area,'' we mean residents in an approved medical residency training program at a home hospital at the time of the disaster that were either actually training at the home hospital or were scheduled to rotate to the home hospital during the training program. For emergency Medicare GME affiliation agreements involving a host hospital located in the same State as the home hospital (hereinafter, an ''in-State host hospital''), the permissible effective period for such agreements is extended from up to 3 years to up to 5 years for any resident (even those not displaced from training in a hospital located in the 1135 emergency area). Emergency Medicare GME affiliation agreements involving in-State host hospitals during these additional two academic years need not apply only with respect to the actual residents that were displaced immediately following the disaster. In other words, such agreements may apply with respect to residents that were actually displaced as a result of the disaster, as well as to new residents that were not training in the program at the time the disaster occurred. With the 2-year extension described above, the effective period of an emergency Medicare GME affiliation agreement may begin with the first day of a section 1135 emergency period, and must terminate no later than at the end of the fourth academic year following the academic year during which the section 1135 emergency period began (for Hurricanes Katrina and Rita, this would be June 30, 2010). As home hospitals recover the ability to train residents after a disaster, the effective period for emergency Medicare GME affiliation agreements is intended to allow home hospitals to balance their desire to return residents to their original training sites, with their need to be given the opportunity to rebuild their programs incrementally. We believe extending the applicability of emergency affiliations for out of State host hospitals for 2 years (for a total of up to 5 years) only for the actual residents displaced from home hospitals allows such displaced residents to complete their training outside the affected area while providing an incentive for home hospitals to begin training new incoming residents locally (or closer to the home hospital), increasing the likelihood for the residents to stay and practice in the area after their training is completed. Affected hospitals in the New Orleans area have informed CMS that residents will tend to go into practice where they train. We believe this makes intuitive sense and the policy established in this interim final rule with comment period will provide additional impetus for residents to return to the State where their ''home hospital'' is located, increasing the odds that the physicians will stay and practice there, and encouraging regeneration of the health care system affected by the section 1135 emergency. We note that this is consistent with needs expressed by affected hospitals in the New Orleans area for more physicians to replace the large numbers that left immediately after the hurricane Furthermore, after the expiration of the initial 3 years of the emergency Medicare GME affiliation agreement effective period, we believe it would be appropriate to begin bringing emergency Medicare GME affiliation rules into accord with regular Medicare GME affiliation rules which specify geographical limits. That is, regular Medicare GME affiliation rules limit hospitals geographically to affiliations with other hospitals that are located in the same urban or rural area (as those terms are defined under § 412.62(f)) or in a contiguous area.

In addition, home or host hospitals that have emergency Medicare GME affiliation agreements and are training displaced residents in nonhospital sites are permitted to submit written agreements with nonhospital sites, as described under § 413.78, that may be effective beginning with the first day of the section 1135 emergency period to cover the displaced residents training at nonhospital sites. We discuss the policy for training that occurs in the nonhospital setting and the requirements for written agreements in further detail in the following section. However, in brief, this interim final rule with comment period provides hospitals

that are participating in emergency Medicare GME affiliation agreements with increased flexibility in submitting written agreements relating to training that occurs in nonhospital sites. Home or host hospitals with valid emergency Medicare GME affiliation agreements training displaced residents in a nonhospital site may submit a copy of the written agreement, as specified under § 413.78(e)(iii) and (f)(iii) as applicable, to the CMS contractor servicing the hospital by 180 days after the first day the resident began training at the nonhospital site. We note that, as with the existing rules for written agreements specified at § 413.78(f), adjustments to the amounts specified (in other words, the total program costs and the portion of certain costs to be incurred by the hospital) in the written agreement can be made through June 30 of the academic year for which it is effective.

Furthermore, under current rules, hospitals that are training residents at nonhospital sites have two options as specified by the regulations at § 413.78(e). That is, hospitals must either have a written agreement in place before the training occurs or they must pay ''all or substantially all'' of the costs for the training program in the nonhospital setting attributable to training that occurs during a month by the end of the third month following the month in which the training in the nonhospital site occurred. We discuss this ''concurrent payment'' option in more detail in the following section. In this interim final rule with comment period, we are providing additional flexibility in the ''concurrent payment'' option for home or host hospitals that have emergency Medicare GME affiliation agreements and are training displaced residents in nonhospital sites by extending the time allowable for ''concurrent payment'' from 3 months to 6 months. That is, a home or host hospital with a valid emergency Medicare GME affiliation agreement is permitted to incur ''all or substantially all'' of the costs for the training program in the nonhospital setting attributable to training that occurs during a month by the end of the sixth month following the month in which the training in the nonhospital site occurred.

In the case of the section 1135 emergency resulting from Hurricanes Katrina and Rita, the time limit we are adopting to submit written agreements or to meet the ''concurrent payment'' requirement may have already passed. Therefore, as discussed in detail in the following section, we are providing that, for residents training in nonhospital sites during the period of August 29, 2005, to November 1, 2007, home or host hospitals with valid emergency Medicare GME affiliation agreements may submit written agreements or incur ''all or substantially all'' of the costs of the training program (that is, the ''concurrent payment'' option) to cover those specific residents by April 29, 2008.

Based on what we have learned about the impact of a disaster on teaching hospitals, we continue to believe it is necessary to provide hospitals with greater flexibility to distribute FTE resident caps within a group of home and host hospitals if there is an emergency at a home hospital resulting in the designation of a section 1135 emergency area. We believe that this modified emergency Medicare GME affiliation policy will allow affected hospitals an appropriate degree of flexibility following the disaster so that residents displaced by the disaster can continue their residency training at other hospitals, while the home hospitals can remain committed to reopening their programs.

Emergency Medicare GME affiliation agreements should be submitted to: Centers for Medicare & Medicaid Services, Division of Acute Care, Attention: Elizabeth Truong or Renate Rockwell,Mailstop C4–08–06, 7500 Security Boulevard, Baltimore, MD 21244.

''Emergency Medicare GME Affiliation Agreement'' should be clearly labeled on the outside envelope.

2. Discussion of Training in Nonhospital Settings

Under the existing regulations at § 413.78(e) and (f), for portions of cost reporting periods occurring on or after October 1, 2004, the time residents spend in nonhospital settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs may be included in determining the hospital's number of FTE residents for purposes of calculating both direct GME and IME payments, if all of the following conditions are met:

(1) The resident spends his or her time in patient care activities.

(2) The hospital incurs ''all or substantially all'' of the costs for the training program in the nonhospital setting. In the May 11, 2007 final rule (72 FR 26948), we revised the definition of ''all or substantially all of the costs for the training program in the nonhospital setting'' to mean: (a) Effective on or after January 1, 1999 and for cost reporting periods beginning before July 1, 2007, the residents'' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians'' salaries and fringe benefits attributable to direct graduate medical education (GME); and (b) effective for cost reporting periods beginning on or after July 1, 2007, at least 90 percent of the total of the costs of the residents'' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians'' salaries attributable to non-patient care direct GME activities.

(3) There is a written agreement between the hospital and the nonhospital site that indicates that the hospital will incur the costs of the resident's salary and fringe benefits while the resident is training in the nonhospital site, and the hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities. The agreement must indicate the compensation the hospital is providing to the nonhospital site for supervisory teaching activities. In addition, in the same May 11, 2007 final rule cited above, we clarified the regulations at § 413.78(f)(3)(ii) to specify that the written agreement must be in place between the hospital and the nonhospital site before the training begins in that nonhospital site. We also specified that the written agreement must specify the total cost of the training program in the nonhospital site, the amount of the total cost that the hospital will incur (at least 90 percent of the total cost of the training program), and must indicate the portion of the amount the hospital will incur that reflects residents'' salaries and fringe benefits (and travel and lodging where applicable), and the portion of the amount the hospital will incur that reflects teaching physician compensation. Furthermore, we revised the regulations to indicate that the amounts specified in the written agreement may be modified by June 30 of the applicable academic year.

(4) Alternatively, for portions of cost reporting periods occurring on or after October 1, 2004, hospitals have two options as specified by the regulations at § 413.78(e). Hospitals must either have a written agreement in place before the training occurs or they must incur ''all or substantially all'' of the costs for the training program in the nonhospital setting attributable to training that occurs during a month by the end of the third month following the month in which the training in the nonhospital site occurred (the ''concurrent payment'' option).

For a more detailed discussion on the requirements a hospital must meet in order to count residents training in

nonhospital sites for IME and direct GME payment purposes, we refer readers to the May 11, 2007 final rule (72 FR 26948 through 26977).

Recently, it has come to our attention that in the wake of Hurricanes Katrina and Rita, host hospitals, many of which received large numbers of displaced residents, were hard-pressed to find training sites for these unanticipated residents. Many host hospitals called upon community physician practices, clinics, and other nonhospital settings to supplement existing training locations and accommodate the displaced residents. Some of the host hospitals that took in displaced residents had never before had any residency training programs, and were therefore new to Medicare rules regarding graduate medical education. In the haste and confusion surrounding this unprecedented displacement of residents, many host hospitals arranged for displaced residents to begin training in nonhospital sites without first establishing a written agreement, as specified in § 413.78(e), between the hospital and nonhospital site. Similarly, home hospitals that may have sent some of their residents away to train at host hospitals while continuing to train a reduced number of residents in the home hospital program, may find that the usual nonhospital sites for the residents in that program have also been negatively affected by the disaster. Consequently, home hospitals may have hastily arranged for displaced residents to begin training in nonhospital sites and due to the reduced administrative capability in the aftermath of the disaster, home hospitals may not have been able to establish a written agreement, as specified in § 413.78(e), with the nonhospital site before residents started training in the nonhospital site. Also, in the confusion and haste under which arrangements were made for displaced residents to train in nonhospital sites, many hospitals did not actually incur all or substantially all of the costs of the training program in the nonhospital site in accordance with our regulations at § 413.78(e)(3)(i) or (f)(3)(i).

In the April 12, 2006 interim final rule with comment period, we did not specifically mention the policies that pertain to training in nonhospital sites, although we did indicate that, to determine direct GME and IME payments under an emergency Medicare GME affiliation, all of the normal rules for counting FTEs as specified at § 413.78 apply. Based on what we have learned since the occurrence of Hurricanes Katrina and Rita, we believe it would be appropriate to provide home hospitals that have been adversely affected by the disaster and host hospitals that accept residents pursuant to an emergency Medicare GME affiliation agreement greater flexibility in the timeframes for compliance with our nonhospital site policies. Consequently, we are providing additional flexibility in regards to the submission of written agreements by home and host hospitals by specifying in this interim final rule with comment period that home or host hospitals with a valid emergency Medicare GME affiliation agreement may submit the written agreement required under our regulations even after the residents have begun training at the nonhospital site. The submission deadline for written agreements after a disaster is subject to the following requirements: (1) A home or host hospital must be participating in a valid emergency Medicare GME affiliation and (2) a home or host hospital training displaced residents in a nonhospital site must submit a copy of the written agreement, subject to the requirements of a written agreement as specified under § 413.78 (e)(iii) or (f)(iii) as applicable, to the CMS fiscal intermediary or MAC servicing the hospital by 180 days after the first day the resident began training at the nonhospital site. We are also specifying that amendments to the written agreement can be made through June 30 of the academic year for which it is effective.

Furthermore, as we discussed above, under current rules hospitals that are training residents at nonhospital sites have the option of paying ''all or substantially all'' of the costs for the training program in the nonhospital setting attributable to training that occurs during a month by the end of the third month following the month in which the training in the nonhospital site occurred. For the same reasons cited above supporting our belief that it is appropriate to extend the deadline to submit written agreements after a disaster, we are also providing additional flexibility in the ''concurrent payment'' option for home or host hospitals that have emergency Medicare GME affiliation agreements and are training displaced residents in nonhospital sites by extending the time allowable for ''concurrent payment'' from 3 months to 6 months. That is, a home or host hospital with a valid emergency Medicare GME affiliation agreement is permitted to pay ''all or substantially all'' of the costs for the training program in the nonhospital setting attributable to training that occurs during a month by the end of the sixth month following the month in which the training in the nonhospital site occurred.

In the case of Hurricanes Katrina and Rita, the time limits we are adopting regarding the submission of written agreements to cover residents training in nonhospital sites for home or host hospitals with a valid emergency Medicare GME affiliation agreement may have already passed. Therefore, we are providing that a home or host hospitals with valid emergency Medicare GME affiliation agreements may submit written agreements to cover residents training in nonhospital sites during the period of August 29, 2005, to November 1, 2007, by April 29, 2008. Similarly, for residents training in nonhospital sites during the period of August 29, 2005, to November 1, 2007, home or host hospitals with valid emergency Medicare GME affiliation agreements may pay ''all or substantially all'' of the costs of the training program (i.e., the ''concurrent payment'' option) to cover those specific residents by April 29, 2008.

C. Response to Comments on the April 12, 2006 Interim Final Rule With Comment Period and This Interim Final Rule With Comment Period

We note that we did receive a number of comments on the interim final rule with comment issued on April 12, 2006. We believe it would be beneficial to provide the public with the opportunity to submit formal comments on the latest changes in this interim final rule with comment period in the context of the current training situation in the area affected by Hurricanes Katrina and Rita. We intend to respond to comments submitted on both this interim final rule with comment period (to be submitted as specified in the **ADDRESSES** section of this document) and the April 12, 2006 interim final rule with comment period in a future final rule.

XXI. 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 final rule with comment period provide various data pertaining to the CY 2008 payment for items and services under the OPPS. Addendum A, which includes a complete list of all APCs payable under the OPPS, and Addendum B, which includes a complete list of all active HCPCS codes for CY 2008 and all currently active HCPCS codes that will be discontinued at the end of CY 2007 with assigned payment status and comment indicators, are 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 comment 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 Outpatient Code Editor (OCE) logic that applies to the APC. We refer readers to the discussion of composite APCs in section II.A.4.d of this final rule with comment period for a complete description of the 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 final rule with comment period 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 final for CY 2008 as a result of applying the revised ASC payment system methodology established in the final rule for the revised ASC payment system published in the **Federal Register** on August 2, 2007 (72 FR 42470) to the final CY 2008 OPPS and MPFS ratesetting information.

Addendum DD1 defines the payment indicators that are used in Addenda AA and BB to this final rule with comment period. 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 using to provide additional information about the status of ASC covered surgical procedures and covered ancillary services.

Addendum EE (available only on the Internet) lists the surgical procedures that are excluded from Medicare payment in ASCs. The excluded procedures listed in Addendum EE are surgical procedures that either are assigned to the OPPS inpatient list, are not covered by Medicare, are reported using a CPT unlisted code, or are determined to pose a significant safety risk or are expected to require an overnight stay when performed in ASCs.

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 are published in this CY 2008 OPPS/ASC final rule with comment period, and related data files are 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 are used for the CY 2008 OPPS) from the FY 2008 IPPS final rule with comment period (72 FR 47436 through 47539) as corrected in the October 10, 2007 **Federal Register** notice to the FY 2008 IPPS final rule with comment period (72 FR 57634 through 57738) 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.

XXII. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 30-day notice in the **Federal Register** and solicit public comment when 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.

In the CY 2008 OPPS/ASC proposed rule, we solicited public comment on each of these issues for the following sections included in the proposed rule that contain information collection requirements.

Section 419.43(h) Adjustment to national program payment and beneficiary copayment 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 the proposed rule, we proposed 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. 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.

In this final rule with comment period, for CY 2009, we have delayed implementation of our validation process which will require 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 × 5 charts per hospital) submitted by the hospitals to CMS for a total burden of 7,000 hours. However, as noted above, this validation process will not apply for the CY 2009 update. Therefore, we expect the total burden for all hospitals for the CY 2009 updates to be 921,000 hours per year.

In section XVII.J. of this final rule with comment period, we are finalizing a provision from the FY 2008 IPPS final rule with comment period relating to the FY 2009 RHQDAPU quality measure set to include SCIP Infection 4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose and SCIP Infection 6: Surgery Patients with Appropriate Hair Removal, bringing the total number of measures in that measure set to 30.) The burden associated with the collection of these two measures was included in the burden estimates in the FY 2008 IPPS final rule with comment period (72 FR 47409 and 48169). There is no additional burden imposed in this final rule with comment period.

Section 482.22 Condition of participation: Medical staff

We proposed under § 482.22(c)(5)(i) to 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 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.

We proposed under § 482.22(c)(5)(ii) to 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 individuals as required under § 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

We proposed under § 482.24(c)(2)(i) to require 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.

(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.

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

We proposed under § 482.51(b)(1) to 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 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

We proposed under § 482.52(b)(1) to 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. We proposed under § 482.52(b)(3) to 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.

As discussed in section XVIII.B.2. of this final rule with comment period, in response to public comments, we have revised § 482.52(b)(3) to specify that a postanesthesia evaluation must be completed and documented no later than 48 hours after surgery or a procedure requiring anesthesia services. The postanesthesia evaluation must be completed in accordance with State law and with hospital policies and procedures that are approved by the medical staff and that reflect current standards of anesthesia care.

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.

In section XX. of this document, we are specifying the requirement for the submittal of emergency Medicare GME affiliation agreements under the provisions of § 413.79(f) of the regulations by hospitals in declared emergency areas. The burden associated with this requirement is the time and effort it would take for the GME affiliated hospital to develop and submit the emergency Medicare GME affiliation agreement. It is difficult for us to determine estimated annual burden because we do not know how many hospitals will be affected in any given disaster. It would depend on what resources are available to the affected hospitals after sustaining damage from the disaster. This could take a few hours per hospital or much longer depending on if they keep records available and current. Hospitals also have to coordinate with other hospitals to draw up an affiliation agreement which may

take more time if the hospitals have to negotiate.

We have submitted a copy of this final rule with comment period and this interim final rule with comment period 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–FC for OPPS/ASC matters, or CMS–1531–IFC2, for Medicare GME Affiliation Agreement matters) 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–FC for OPPS/ASC matters, or CMS–1531–IFC2, for Medicare GME Affiliation Agreement matters *carolyn_lovett@omb.eop.gov.* Fax (202) 395–6974.

XXIII. 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 final rule with comment period, and, when we proceed with a subsequent document(s), we will respond to those comments in the preamble to that document(s).

XXIV. Regulatory Impact Analysis

A. Overall Impact

We have examined the impacts of this final rule with comment period as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Public Law 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Public Law 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 final rule with comment period will result in expenditures exceeding $100 million in any 1 year. We estimate the total increase (from changes in this final rule with comment period as well as enrollment, utilization, and case-mix changes) in expenditures under the OPPS for CY 2008 compared to CY 2007 to be approximately $3.4 billion.

We estimate that implementing the revised ASC payment system in CY 2008 based on the August 2, 2007 final rule for the revised ASC payment system and the final policies in this CY 2008 OPPS/ASC final rule with comment period (such as adding 11 procedures to the ASC list of covered surgical procedures and designating 18 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 XXIV.C. of this final rule with comment period.

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 ASC provisions of this final rule with comment period, we estimate that the revised system will result in savings of $220 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 final rule with comment period.

Our estimate in this final rule with comment period 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 August 2, 2007 revised ASC payment system final rule. The ASC budget neutrality adjustment and the resulting savings estimates in the August 2, 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 final rule with comment period are calculated using the newly available CY 2006 utilization data, the CY 2008 OPPS relative payment weights finalized in this final rule with comment period, and the CY 2008 MPFS PE RVUs finalized in the CY 2008 MPFS final rule. As we indicated in the August 2, 2007 revised ASC payment system final rule, the estimates in that rule were meant to be illustrative of the final policies only, in large part because we used the existing CY 2007 OPPS relative payment weights and the existing CY 2007 MPFS PE RVUs to estimate the CY 2008 values. Because the savings estimates in this final rule with comment period are based on the final CY 2008 OPPS relative payment weights that have just become available in this final rule with comment period and the final CY 2008 MPFS PE RVUs that recently became available in the CY 2008 MPFS final rule with comment period, the estimates in this final rule with comment period based on that newly available information represent our best estimates at this time.

This final rule with comment period 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 refer readers to the standards at the Web site: *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 2,141 voluntary hospitals that we consider to be not for-profit organizations to which this final rule with comment period 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 (Public Law 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 final rule with comment period rule will 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 final rule with comment period will 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 (Public Law 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 with comment period does not mandate any requirements for State, local, or tribal government, nor does 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 with comment period in accordance with Executive Order 13132, Federalism, and have determined that it will not have an impact on the rights, roles, and responsibilities of State, local or tribal governments. As reflected in Table 61, we estimate that OPPS payments to governmental hospitals (including State and local governmental hospitals) will increase by 3.9 percent under this final rule with comment period. The provisions related to payments to ASCs in CY 2008 will not affect payments to government hospitals.

B. Effects of OPPS Changes in This Final Rule With Comment Period

We are making 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 final rule with comment period, we are updating 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 final rule with comment period. We also are revising 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 Public Law 108–173 that we analyze the cost of outpatient services in rural hospitals relative to urban hospitals, we are continuing increased payments to rural SCHs, including EACHs. Section II.F. of this final rule with comment period provides greater detail on this rural adjustment. Finally, we are removing 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 final rule with comment period, the update change to the conversion factor as provided by statute will increase total OPPS payments by 3.3 percent in CY 2008. The one time wage reclassification under section 508 expired September 30, 2007, and therefore, is not contemplated in this final rule with comment period. The changes to the APC weights, including the changes that will result from the expansion of packaging, changes to the wage indices, and the continuation of a payment adjustment for rural SCHs and EACHs with extension to brachytherapy sources in CY 2008 will not increase OPPS payments because these changes to the OPPS are budget neutral. However, these updates do change the distribution of payments within the budget neutral system as shown in Table 61 and described in more detail in this section.

1. Alternatives Considered

Alternatives to the changes we are making and the reasons that we have chosen the options are discussed throughout this final rule with comment period. Some of the major issues discussed in this final rule with comment period and the options considered are discussed below.

a. Alternatives Considered for the Packaging Policies for CY 2008 OPPS

In section II.A.4.c. of this final rule with comment period, we are packaging payment for the following seven categories of ancillary and supportive services into payment for the independent service with which they are billed. We are also making payment for several composite APCs in which a single payment is made for multiple major services that are commonly performed on the same date. We discuss below each category of services that we are packaging and each set of services for which we are establishing a composite APC.

(1) Guidance Services

We are packaging 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

will 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 final rule with comment period for the complete discussion of this final policy. We considered several policy options for the payment of guidance services in CY 2008.

The first alternative we considered was to not make any changes to packaging for the CY 2008 OPPS. Under this alternative, codes that were packaged for CY 2007 would have remained packaged for CY 2008 and codes that were separately paid for CY 2007 would have remained 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 unconditionally 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 packaging 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 will pay separately for that service. We believe that this alternative will 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 packaging 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 final rule with comment period for the complete discussion of this final policy. We considered several policy options for the payment of image processing services in CY 2008.

The first alternative we considered was to make no changes to packaging for the CY 2008 OPPS. Under this alternative, codes that were packaged for CY 2007 would have remained packaged for CY 2008 and codes that were separately paid for CY 2007 would have remained 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. Therefore, we believe that this alternative will 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 packaging payment for intraoperative services into the payment for the independent procedure to which the intraoperative service is ancillary and supportive. In the case of two intraoperative services, 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 will permit separate payment if the services are billed without an independent procedure on the same date of service. We refer readers to section II.A.4.c.(3) of this final rule with comment period for the complete discussion of this final policy. We considered several policy options for the payment of intraoperative services in CY 2008.

The first alternative we considered was to make no changes to packaging for the CY 2008 OPPS. Under this alternative, codes that were packaged for CY 2007 would have remained packaged for CY 2008 and codes that were separately paid for CY 2007 would have remained 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 two particular intraoperative procedures, those procedures 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 services.

The third alternative we considered, and ultimately selected, was to unconditionally package the costs of intraoperative services in all cases except two, to allow for the possibility of these two intraoperative services being furnished without an independent service on the same date of service. We believe that there is some possibility that these procedures 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 proposed to unconditionally package. We selected this alternative because we believe it unlikely that intraoperative services other than the two particular services 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 will provide the most appropriate incentives to control volume and spending for these services.

(4) Imaging Supervision and Interpretation Services

We are unconditionally packaging payment for some imaging supervision and interpretation services into the payment for the independent service to which the imaging supervision and interpretation service is ancillary and supportive and conditionally packaging payment for other imaging supervision and interpretation services when the independent service has a status indicator of ''T.'' For this latter subset of codes, we are permitting separate payment if there is no service with status indicator of ''T'' billed the same date of service. We refer readers to section II.A.4.c.(4) of this final rule with comment period for the complete discussion of this final policy. We considered several policy options for the payment of imaging supervision and interpretation services in CY 2008.

The first alternative we considered was to make no changes to packaging for the CY 2008 OPPS. Under this alternative, codes that were packaged for CY 2007 would have remained packaged and codes that were separately paid for CY 2007 would have remained 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 imaging supervision and interpretation services that are appropriate in each situation.

The second alternative we considered 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 did not accept this alternative because commenters convinced us that to do this would sometimes result in packaging these services with services for which packaging of the imaging supervision and interpretation services was inappropriate (for example, visits and minor diagnostic tests).

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 certain imaging supervision and interpretation services only when they are provided on the same date of service as a service with a status indicator of ''T.'' 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 an individual patient when the supervision and interpretation service is furnished as an ancillary and supportive adjunct to the independent procedural service and does not package the payment for the supervision and interpretation service with the payment for a visit or other service. We will pay separately for some imaging supervision and interpretation services in those cases where they are not furnished on the same date as a service with status indicator of ''T.'' Therefore, we believe that this alternative will provide the most appropriate incentives to control volume and spending for these services, without discouraging the performance of the services in those cases when they are furnished with a service with a status indicator other than ''T.''

(5) Diagnostic Radiopharmaceuticals

We are packaging payment for diagnostic radiopharmaceuticals into the payment for their associated nuclear medicine procedures. In response to comments, we are using only claims for nuclear medicine procedures that contain a Level II HCPCS code for a diagnostic radiopharmaceutical to set the median costs for the nuclear medicine services, and we are implementing claims processing edits that require that a nuclear medicine service must have a diagnostic radiopharmaceutical HCPCS code on the same claim to be accepted for processing. We refer readers to section II.A.4.c.(5) of this final rule with comment period for the complete discussion of this final policy. We considered several policy options for the payment of diagnostic radiopharmaceuticals in CY 2008.

The first alternative we considered was to make 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 less 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. Because 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, to calculate the median costs of nuclear medicine procedures using only claims that contain a Level II HCPCS code for a diagnostic radiopharmaceutical, and to implement claims processing edits that require that a claim that reports a code for a nuclear medicine procedure must also contain a code for a diagnostic radiopharmaceutical to be accepted for processing. 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 final rule with comment period. Moreover, calculating the median cost of nuclear medicine procedures using only claims that also contain at least one diagnostic radiopharmaceutical will ensure that the cost of the radiopharmaceuticals used in the procedure will be captured in the median cost. In addition, implementing a claims processing edit that will require that a claim that contains a code for a nuclear medicine procedure must also contain a code for a diagnostic radiopharmaceutical will ensure that in future years, all claims for nuclear medicine procedures will include the cost of the radiopharmaceuticals used to furnish the service.

(6) Contrast Media

We are packaging payment for contrast media into their associated independent diagnostic and therapeutic procedures. We refer readers to section II.A.4.c.(6) of this final rule with comment period for the complete discussion of this final policy. We considered several policy options for the payment of contrast media in CY 2008.

The first alternative we considered was to make 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 less 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 $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 believe it is 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 will currently be packaged under the $60 packaging threshold. Given that most contrast agents will 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. In the case of echocardiography procedures that are performed with contrast, we have established separate Level II HCPCS codes to report these services, so that we will pay for contrast and noncontrast studies through separate APC groups as section 1833(t)(2)(G) of the Act requires. The median cost of the APC for noncontrast echocardiography services was set based on those claims for the studies that also reported a contrast agent, to ensure that the procedure payment includes the cost of the necessary contrast agent.

(7) Observation Services

We are packaging payment for all observation care, reported under HCPCS code G0378 (Hospital observation services, per hour) for CY 2008. Payment for observation will be packaged as part of the payment for the separately payable services with which it is billed. In addition, we created two additional composite APCs for extended assessment and management, of which observation care is a component. We refer readers to section II.A.4.c.(7) of this final rule with comment period for the complete discussion of this final policy. We considered several policy options for the payment of observation services in CY 2008.

The first alternative we considered was to make 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 will 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 final rule with comment period. 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 was to package payment for all observation services reported with HCPCS code G0378 under the CY 2008 OPPS. We believe this is the most appropriate alternative within the context of our 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 will 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.

However, based on the public comments we received, while we are adopting our proposal to package payment for all observation services reported with HCPCS code G0378 under the CY 2008 OPPS, we will also create two additional composite APCs for extended assessment and management, of which observation care is a major component. This refinement of the third alternative responds to commenters who stated that observation care is sometimes a major component of a patient's visit. We continue to believe that observation services are usually ancillary and supportive to the other independent services that are provided to the patient on the same day. However, we believe that observation care may sometimes rise to the level of a major component service, specifically, when it is provided for 8 hours or more in association with a high level clinic or emergency department visit, direct admission to observation, or critical care services and it is not provided in conjunction with a surgical procedure. Therefore, we have created two composite APCs that will provide payment to hospitals in certain circumstances when extended assessment and management of a patient occur. These composite APCs describe an extended encounter for care provided to a patient. Specifically, we are creating two new composite APCs for CY 2008, APC 8002 (Level I Extended Assessment and Management Composite) and APC 8003 (Level II Extended Assessment and Management Composite). The payment associated with APCs 8002 and 8003 is intended to pay the hospital for the costs associated with a single episode of care involving more intense extended assessment and management that includes a high level clinic or emergency department visit, direct admission to observation, or critical care services; 8 hours or more of observation services; and any associated packaged services.

In summary, for CY 2008, payment for observation services will remain packaged with a status indicator ''N.'' We are creating two composite APCs for extended assessment and management, of which observation care is a major component service. When criteria for payment of one of the composite APCs are met, separate payment will be made to the hospital through the composite APC. This composite APC payment methodology will 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.

(8) Composite APCs

We are establishing five composite APCs for the CY 2008 OPPS. In addition to the two composite APCs that we proposed for the CY 2008 OPPS and for which we discuss the alternatives considered in this section, we have also created two composite APCs for extended assessment and management (of which observation care is a part), and we identify APC 0034 (Mental Health Services Composite), the longstanding limit on per diem payment for mental health services, as a composite APC. We refer readers to the discussion of alternatives considered for observation services, above, and to section II.A.4.c.(7) of this final rule with comment period for further discussion of the composite APCs of which observation is a part. We refer readers to section II.A.4.d. of this final rule with comment period for a discussion of APC 0034.

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, as proposed, we are establishing composite APC 8000 for low dose rate prostate brachytherapy (which will 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 on the same date of service) and APC 8001 for cardiac electrophysiologic evaluation and ablation services (which will be paid when at least one designated cardiac electrophysiologic 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 final rule with comment period for a detailed discussion of the policies 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 those 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 creating 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. We did not select this alternative because 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 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 establishing composite APCs 0034, 8000, 8001, 8002, and 8003 for the CY 2008 OPPS.

b. Partial Device Credits

We are reducing 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 50 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 final rule with comment period for a complete discussion of this final policy. 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 policy 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 we considered was 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. We would 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 not adopting this policy, which we proposed in the CY 2008 OPPS/ASC proposed rule, for several reasons. We note it would not be consistent with the FY 2008 IPPS partial credit device policy, and we were concerned that 20 percent is a nominal portion of the cost of a device and would not justify the administrative and operational burden posed by the policy and, accordingly, the 50-percent payment reduction would be more than the partial credit received in some cases.

The fourth alternative, which we are adopting, is a modification of the third alternative described above. This alternative 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 50 percent or more of the cost of the new replacement device being implanted. We are requiring hospitals to report the ''FC'' modifier when the hospital receives a partial credit that is 50 percent or more of the cost of the device being replaced. We are adopting 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 final rule with comment period, we are adopting prospective payment for all brachytherapy sources under the CY 2008 OPPS, 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 making payment 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 basing 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 alternative 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, that is, 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 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 provide prospective payment for each brachytherapy source based on its median costs. For the sources which only have non-stranded versions, we are using our standard median cost methodology. For the 3 sources that have stranded and non-stranded versions and for which we do not yet have separately reported stranded and non-stranded claims data, we are calculating 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 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 post our hospital-specific estimated payments for CY 2008 with the other supporting documentation for this final rule with comment period. To view the hospital-specific estimates, we refer readers to the Web site at: *http://www.cms.hhs.gov/HospitalOutpatientPPS/*. Select ''regulations and notices'' from the left side of the page and then select CMS–1392–FC from the list of regulations and notices. The hospital-specific file layout and the hospital-specific file are listed with the other supporting documentation for this final rule with comment period. We show hospital-specific data only for hospitals whose claims were used for modeling the impacts shown in Table 61. We do not show hospital-specific impacts for hospitals whose claims we were unable to use. We refer readers to Section II.A.2. of this final with comment period for a discussion of the hospitals whose claims we do not use for ratesetting and impact purposes.

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 solicited comments and information about the anticipated effect of the 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 increase in packaging and our payment for multiple procedures based on one composite payment rate. Specifically, it is possible that there could be a behavioral response to our final policy to package payment for guidance services, image processing services, intraoperative services, imaging supervision and interpretation services, diagnostic radiopharmaceuticals, contrast agents, and observation services, and to pay for certain services through composite APCs when the services are furnished in specified combinations. However, we are unable to estimate what the effect of possible behavioral responses may be on payment to hospitals. We refer readers to section II.A.4. of this final rule with comment period for further discussion of the 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. However, we believe that this will be uncommon for several reasons. We anticipate that hospitals will 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 unconditionally packaged in CY 2008, the services 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 policies 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 will 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 policy 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 policy on hospital payments under the 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 or partial 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. Similarly, we have no estimate of the extent to which hospitals will receive partial credits for devices under warranty actions in CY 2008. Beginning January 1, 2008, hospitals will report cases in which they receive a partial credit for a device if the credit is 50 percent or more of the cost of the replacement device. However, these data will not be available until the development of the CY 2010 OPPS, which will be based on CY 2008 claims.

Fourth, for purposes of this impact analysis, for those brachytherapy sources with new codes to distinguish between stranded and non-stranded version, we assume 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 make this assumption. In the CY 2008 OPPS/ASC proposed rule, we welcomed data that would provide the expected CY 2008 ratio of stranded sources to non-stranded sources for purposes of this CY 2008 final rule impact analysis. We did not receive any information regarding the ratio of stranded to non-stranded sources in the public comments on the proposed rule.

The final limitation of our analysis is that we cannot predict the utilization of new CY 2007 and CY 2008 CPT codes that replace existing CY 2006 CPT codes for which we have cost data on which we base the 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 final rule with comment period, we applied the AMA's estimates of new code utilization which are used for the MPFS final rule with comment period. However, we do not know whether these estimates of physician utilization are equally applicable to hospital outpatient services.

In the CY 2008 OPPS/ASC proposed rule, we requested comments regarding whether it would be appropriate for us to use the AMA estimates of utilization for new codes in the estimation of the impact of the final CY 2008 payments for hospitals. We received no comments on this issue.

3. Estimated Impacts of This Final Rule With Comment Period on Hospitals and CMHCs

Table 61 below shows the estimated impacts of this final rule with comment period 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 changes on CMHCs alone because CMHCs bill only one service under the OPPS, partial hospitalization, and each CMHC can easily estimate the impact of the changes by referencing payment for APC 0033 (Partial Hospitalization) in Addendum A to this final rule with comment period. As discussed in section II.B. of this final rule with comment period, the payment for APC 0033 (Partial Hospitalization) for CY 2008 will decline by 13 percent compared to the payment for APC 0033 for CY 2007.

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 Public Law 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 expired for CY 2008 rates, no additional payments under section 508 are considered for CY 2008 in this impact analysis.

Table 61 shows the estimated redistribution of hospital and CMHC payments among providers as a result of APC reconfiguration and recalibration including the expansion of 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 expansion of 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 final rule with comment period will 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 final OPPS rates for CY 2008 will have a positive effect for providers paid under the OPPS,

resulting in a 3.6 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 will result in a 3.8 percent increase in Medicare payments to all other hospitals, exclusive of transitional pass-through payments.

To illustrate the impact of the final 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 2 in Table 61 shows the independent effect of changes resulting from the reclassification of services among APC groups, the recalibration of APC weights and the changes to packaging that we adopted for this final rule with comment period, based on 12 months of CY 2006 hospital OPPS claims data and more recent cost report data. We modeled the effect of APC recalibration and packaging changes for CY 2008 by varying only the weights (the final CY 2007 weights versus the estimated CY 2008 weights including expanded packaging in our baseline model) and calculating the percent difference in payments. Column 2 also reflects the effect of changes resulting from the APC reclassification and recalibration changes and changes in multiple procedure discount patterns that occur as a result of the changes to packaging. When services are packaged, the resulting median costs at the HCPCS code level often change, requiring migration of HCPCS codes to different APCs to address violations of the 2 times rule (that is, to ensure that the HCPCS codes within the APC remain 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 packaging approach often changes 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, changes the relative weight ranking of services on a claim subject to the multiple procedure discount policy, significantly changing discounting patterns in some cases.

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 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 final rule with comment period. We modeled the independent effect of updating the wage index and the rural adjustment by varying only the wage index, using the 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 APC recalibration with the packaging policy (that is, Column 2), the wage index update and the adjustment for rural SCHs and EACHs (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 budget neutrality adjustments and the market basket update by using the weights and wage indices for each year, and using a CY 2007 conversion factor that included the 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 CY 2008 policy on each hospital group by including the effect of all the 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 Public Law 108 173. Column 5 shows the combined budget neutral effects of Columns 2 through 4, plus the impact of the change to the fixed outlier threshold from $1,825 to $1,575, expiring section 508 reclassification wage index increases, and the impact of reducing the percentage of total payments dedicated to transitional pass-through payments. We estimate that these cumulative changes increase payments by 3.6 percent. We modeled the independent effect of all changes in Column 5 using the final weights for CY 2007 and the final weights for CY 2008. We used the final conversion factor for CY 2007 of $61.468 and the final CY 2008 conversion factor of $63.694. Column 5 also contains simulated outlier payments for each year. We used the charge inflation factor used in the FY 2008 IPPS final rule of 6.2 percent (1.062) to increase individual costs on the CY 2006 claims to reflect CY 2007 dollars, and we used the most recent overall CCR in the July 2007 Outpatient Provider-Specific File. Using the CY 2006 claims and a 6.2 percent charge inflation factor, we currently estimate that outlier payments for CY 2007, using a multiple threshold of 1.75 and a fixed-dollar threshold of $1,825 would be approximately 0.73 percent of total payments. Outlier payments of 0.73 percent appear in the CY 2007 comparison in Column 5. We used the same set of claims and a charge inflation factor of 12.78 percent (1.1278) and the CCRs on the July 2007 Outpatient Provider-Specific File, with an adjustment of 1.0027 to reflect relative changes in cost and charge inflation between CY 2006 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 $1,575.

Column 1: Total Number of Hospitals

The first line in Column 1 in Table 61 shows the total number of providers (4,250), 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 final rule with comment period. 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 (3,984) 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 changes.

Column 2: APC Changes Due to Reassignment, Recalibration and Packaging

This column shows the combined effects of reconfiguration, recalibration, finalizing the packaging proposal and other policies (for example, changes to

payment for brachytherapy sources and therapeutic radiopharmaceuticals). In many cases, the redistribution created by the reduction in the partial hospitalization payment offsets other recalibration losses. Specifically, the reduction in partial hospitalization payment is redistributed to hospitals and reflected in the 0.2 percent increase for the 3,984 hospitals that remain after excluding hospitals held harmless and CMHCs. Overall, these changes will increase payments to urban hospitals by 0.3 percent. We estimate that large urban hospitals will see an increase of 0.1 percent and other urban hospitals will see a 0.4 percent increase in payments attributable to all recalibration.

Overall, rural hospitals will show a modest 0.2 percent decrease as a result of changes to the APC structure and the expansion of packaging. Rural hospitals of all bed sizes will experience no change or will experience decreases ranging from 0.1 to 0.6 percent. The declines for rural hospitals for this final rule with public comment period compared to the projected increases of 0.2 to 0.6 for rural hospitals in the proposed rule is attributable to the changes in packaging that we made as a result of public comments with regard to observation and imaging supervision and interpretation services. The proposed packaging of these services into payment for any service with a status indicator of ''S,'' ''T,'' ''V,'' or ''X'' would have increased OPPS payments for visits and other services provided in rural hospitals. However, in response to public comments, we created composite APCs for extended assessment and management involving significant observation stays and we are packaging imaging supervision and interpretation services only into services with a status indicator of ''T.'' The services for which the median costs are increased as a result of these final policies are performed more often in urban hospitals than in rural hospitals, and this utilization is reflected in the negative percents in Column 2.

Among teaching hospitals, the largest observed impacts resulting from APC recalibration and the expansion of packaging include an increase of 0.2 percent for major teaching hospitals and an increase of 0.4 percent for minor teaching hospitals.

Classifying hospitals by type of ownership suggests that proprietary hospitals will see an increase of 0.3 percent while governmental and voluntary hospitals will each see an increase of 0.2 percent.

We note also that both low volume urban and rural hospitals with less than 5,000 lines and hospitals for which DSH payments are not available will experience decreases of 3.7 to 5.5 percent as a result of the decline in payment for partial hospitalization from CY 2007 to CY 2008. These declines are somewhat moderated in Column 5 as a result of the increased outlier payments that result from the lower payment rates.

Column 3: New Wage Indices and the Effect of the Rural Adjustment

This column estimates the impact of applying the final 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 will not change the payments to urban hospitals. Overall, rural hospitals show a decrease of 0.1 percent.

Among teaching hospitals, the largest observed impacts resulting from changes to the wage indices and the continuation of the rural adjustment include a decrease of 0.1 percent for major teaching hospitals and no change for minor teaching hospitals.

Classifying hospitals by type of ownership suggests that proprietary hospitals will gain 0.1 percent and that governmental hospitals and voluntary hospitals will each experience no change.

Column 4: All Budget Neutrality Changes and Market Basket Update

The addition of the market basket update of 3.3 percent alleviates any negative impacts on payments for CY 2008 created by the 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 long term care hospitals (DSH not available). In general, all hospitals see an increase of 3.5 percent, attributable to the 3.3 percent market basket increase and the 0.2 percent increase in payment weight created by the reduction in payment for partial hospitalization that is then redistributed to other services.

Overall, these changes will increase payments to urban hospitals by 3.6 percent. We estimate that large urban hospitals will see an increase of 3.5 percent and other urban hospitals will see a 3.7 percent increase. In contrast, small urban hospitals that bill fewer than 5,000 lines per year will experience a decrease in payment of 0.4 percent, largely as a result of the decrease in payment for partial hospitalization and mental health services appearing in Column 2.

Overall, rural hospitals show a 3.0 percent increase as a result of the market basket update. Rural hospitals that bill less than 5,000 lines will see a 1.8 percent decrease, also as a result of decreases in payment for partial hospitalization appearing in Column 2. Rural hospitals that bill more than 5,000 lines will experience increases of 2.8 to 3.5 percent.

Among teaching hospitals, the observed impacts resulting from the market basket update include an increase of 3.6 percent for minor teaching hospitals and an increase of 3.3 percent for major teaching hospitals.

Classifying hospitals by type of ownership suggests that proprietary hospitals will increase 3.8 percent and governmental and voluntary hospitals will experience an increase of 3.5 percent.

Column 5: All Changes for CY 2008

Column 5 compares all changes for CY 2008 to final payment for CY 2007 and includes the expired section 508 reclassification wage indices, the 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 will see an increase of 3.6 percent under this final rule with comment period in CY 2008 relative to total spending in CY 2007. The 3.6 percent increase for all providers in Column 5, which is rounded from 3.56 percent, reflects the 3.3 percent market basket increase, plus 0.12 percent for the change in the pass-through estimate between CY 2007 and CY 2008, plus 0.27 percent for the difference in estimated outlier payments between CY 2007 (0.73 percent) and CY 2008 (1.0 percent), less 0.13 percent for the expired section 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 3.8 percent.

The combined effect of all changes for CY 2008 will increase payments to urban hospitals by 3.9 percent. We estimate that large urban hospitals will see a 3.9 percent increase, while ''other'' urban hospitals will experience an increase of 3.8 percent. Urban hospitals that bill less than 5,000 lines will experience an increase of 0.8 percent, up from the 0.4 percent decrease in Column 4 due to increases in outlier payments for partial hospitalization.

Overall, rural hospitals will show a 3.1 percent increase as a result of the combined effects of all changes for CY 2008. Rural hospitals will experience a

lower increase than the 3.8 percent overall hospital increase as a result of the combined effects of the changes to the packaging policies that were made in response to public comments and the expiration of the section 508 reclassification wage indices. Rural hospitals that bill less than 5,000 lines experience a decrease of 1.5 percent, which is less than the 1.8 percent decrease 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 2.9 percent to 3.7 percent.

Among teaching hospitals, the largest observed impacts resulting from the combined effects of all changes include an increase of 3.8 percent for major teaching hospitals and minor teaching hospitals.

Classifying hospitals by type of ownership suggests that proprietary hospitals will gain 4.1 percent, governmental hospitals will experience an increase of 3.9 percent, and voluntary hospitals will experience an increase of 3.7 percent.

TABLE 61.—IMPACT OF CHANGES FOR CY 2008 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

	Number of hospitals (1)	APC changes (2)	New wage index and rural adjustment (3)	Combined (cols 2,3) with market basket update (4)	All changes (5)
ALL PROVIDERS *	4,250	0.0	0.0	3.3	3.6
ALL HOSPITALS (excludes hospitals held harmless and CMHCs)	3,984	0.2	0.0	3.5	3.8
URBAN HOSPITALS	2,978	0.3	0.0	3.6	3.9
Large urban (GT 1 MILL.)	1,620	0.1	0.1	3.5	3.9
Other urban (LE 1 MILL.)	1,358	0.4	0.0	3.7	3.8
RURAL HOSPITALS	1,006	−0.2	−0.1	3.0	3.1
Sole community	407	−0.2	0.1	3.1	3.0
Other rural	599	−0.2	−0.3	2.8	3.1
BEDS (URBAN):					
0–99 Beds	1,002	0.3	0.1	3.7	3.9
100–199 Beds	919	0.1	0.1	3.5	3.6
200–299 Beds	476	0.4	0.0	3.7	4.0
300–499 Beds	399	0.3	0.1	3.7	4.0
500 + Beds	182	0.3	−0.1	3.5	3.9
BEDS (RURAL):					
0–49 Beds ***	350	−0.1	−0.2	3.1	3.3
50–100 Beds ***	391	−0.2	0.0	3.1	3.3
101–149 Beds	156	0.0	−0.1	3.2	3.4
150–199 Beds	66	−0.2	−0.7	2.4	2.5
200 + Beds	43	−0.6	0.1	2.8	2.6
VOLUME (URBAN):					
LT 5,000 Lines	616	−3.7	0.0	−0.4	0.8
5,000–10,999 Lines	174	0.2	0.1	3.6	4.0
11,000–20,999 Lines	247	0.6	0.1	4.0	4.4
21,000–42,999 Lines	526	0.5	0.2	4.0	4.2
GT 42,999 Lines	1,415	0.3	0.0	3.6	3.9
VOLUME (RURAL):					
LT 5,000 Lines	83	−4.8	−0.3	−1.8	−1.5
5,000–10,999 Lines	92	−0.1	−0.1	3.1	3.6
11,000–20,999 Lines	189	0.1	−0.1	3.3	3.4
21,000–42,999 Lines	314	0.1	0.1	3.5	3.7
GT 42,999 Lines	328	−0.3	−0.2	2.8	2.9
REGION (URBAN):					
New England	157	−0.3	0.2	3.2	3.3
Middle Atlantic	378	0.2	−0.1	3.4	3.5
South Atlantic	462	0.2	−0.1	3.5	3.8
East North Cent.	469	0.4	−0.1	3.6	3.7
East South Cent.	194	0.4	−0.3	3.5	3.8
West North Cent.	186	0.4	0.1	3.8	4.1
West South Cent.	493	0.6	−0.4	3.5	3.8
Mountain	189	0.7	0.0	4.0	4.4
Pacific	398	−0.1	0.9	4.2	4.7
Puerto Rico	52	1.0	0.0	4.3	4.7
REGION (RURAL):					
New England	25	−0.5	−0.6	2.2	2.6
Middle Atlantic	70	−0.7	0.0	2.7	2.9
South Atlantic	172	−0.3	−0.2	2.7	3.0
East North Cent.	129	−0.1	−0.1	3.2	3.0
East South Cent.	177	−0.1	−0.4	2.8	3.0
West North Cent.	115	−0.2	0.0	3.1	3.1
West South Cent.	205	−0.1	−0.8	2.4	2.7
Mountain	76	0.0	0.3	3.6	3.8
Pacific	37	0.0	1.9	5.2	5.1
TEACHING STATUS:					
Non-teaching	2,956	0.1	0.1	3.5	3.7

TABLE 61.—IMPACT OF CHANGES FOR CY 2008 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM—Continued

	Number of hospitals (1)	APC changes (2)	New wage index and rural adjustment (3)	Combined (cols 2,3) with market basket update (4)	All changes (5)
Minor	748	0.4	0.0	3.6	3.8
Major	280	0.2	−0.1	3.3	3.8
DSH PATIENT PERCENT:					
0	5	4.4	−0.5	7.3	7.5
GT 0–0.10	416	0.3	0.1	3.6	3.9
0.10–0.16	451	0.3	−0.1	3.4	3.4
0.16–0.23	796	0.3	0.0	3.6	3.7
0.23–0.35	948	0.2	0.0	3.4	3.7
GE 0.35	754	0.3	0.1	3.7	4.2
DSH not available**	614	−5.5	0.4	−1.9	−1.3
URBAN TEACHING/DSH:					
Teaching & DSH	920	0.3	−0.1	3.6	3.9
No teaching/DSH	1,472	0.3	0.1	3.7	4.0
No teaching/no DSH	5	4.4	−0.5	7.3	7.5
DSH not available**	581	−5.5	0.4	−1.8	−1.3
TYPE OF OWNERSHIP:					
Voluntary	2,141	0.2	0.0	3.5	3.7
Proprietary	1,255	0.3	0.1	3.8	4.1
Government	588	0.2	0.0	3.5	3.9

Column (1) shows total hospitals.

Column (2) shows the impact of changes resulting from the reclassification of HCPCS codes among APC groups and the recalibration of APC weights based on 2006 hospital claims data.

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 extended to 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 a change in the pass-through estimate, and adds outlier payments. The change in outlier payments reflects a decrease in the fixed dollar threshold resulting from updated claim, CCR, and inflation estimates. This column also shows the impact of the expired section 508 wage reclassification, which ended on September 30, 2007.

*These 4,250 providers include children and cancer hospitals, which are held harmless to pre-BBA payments, and CMHCs.

**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 SCHs) 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 the difference for CY 2008.

4. Estimated Effect of This Final Rule With Comment Period on Beneficiaries

For services for which the beneficiary pays a copayment of 20 percent of the payment rate, the beneficiary share of payment will increase for services for which the OPPS payments will rise and will decrease for services for which the OPPS payments will fall. For example, for an electrocardiogram (APC 0099), the minimum unadjusted copayment in CY 2007 was $4.66. In this final rule with comment period, the minimum unadjusted copayment for APC 0099 is $4.96 because the OPPS payment for the service will increase under this final rule with comment period. In another example, for a service assigned to Level IV Needle Biopsy/Aspiration Except Bone Marrow (APC 0037) in the CY 2007 OPPS, the national unadjusted copayment was $228.76, and the minimum unadjusted copayment was $126.20. In this final rule with comment period, the national unadjusted copayment for APC 0037 is $228.76, the same national unadjusted copayment in effect for CY 2007. The minimum unadjusted copayment for APC 0037 is $172.95, or 20 percent of the payment for APC 0037. The minimum unadjusted copayment will rise because the payment rate for APC 0037 will 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 2008, the inpatient deductible is $1,024.

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 4,250 hospitals and CMHCs on which our modeling is based, that total beneficiary liability for copayments will decline as an overall percentage of total payments from 26.5 percent in CY 2007 to 25.1 percent in CY 2008. This estimated decline in beneficiary liability is a consequence of the APC recalibration and reconfiguration we are making for CY 2008.

With respect to partial hospitalization, the copayment in CY 2007 of $46.95 will decline to $41.03 under this final rule with comment period as a result of the decline in the per diem payment for partial hospitalization from $234.73 in CY 2007 to $205.16 for CY 2008.

5. Conclusion

The changes in this final rule with comment period will affect all classes of hospitals. Some classes of hospitals experience significant gains and others less significant gains, but almost all classes of hospitals will experience positive updates in OPPS payments in CY 2008. Table 61 demonstrates the estimated distributional impact of the OPPS budget neutrality requirements and an additional 3.6 percent increase in payments for CY 2008, after considering all changes to APC reconfiguration and recalibration, including those resulting from the expansion of packaging and the payment for brachytherapy sources on a prospective payment basis, as well as

the market basket increase, and the estimated cost of outliers and changes to the pass through estimate. The accompanying discussion, in combination with the rest of this final rule with comment period 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 62, we have prepared an accounting statement showing the CY 2008 estimated hospital OPPS incurred benefit impact associated with the CY 2008 outpatient hospital market basket update shown in this final rule with comment period, based on the Mid-Session Review of the FY 2008 President's Budget baseline. All estimated impacts are classified as transfers.

TABLE 62.—ACCOUNTING STATEMENT: CY 2008 ESTIMATED HOSPITAL OPPS INCURRED BENEFIT IMPACT ASSOCIATED WITH THE CY 2008 HOSPITAL OUTPATIENT MARKET BASKET UPDATE

[In billions]

Category	Transfers
Annualized Monetized Transfers	$0.9.
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 Final Rule With Comment Period

On August 2, 2007, we published in the **Federal Register** the final rule for the revised ASC payment system, effective January 1, 2008 (72 FR 42470). In that final rule for the revised ASC payment system, we adopted the methodologies 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, and established that the OPPS relative payment weights 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 August 2, 2007 revised ASC payment system final rule, we established that we will update the ASC payment system annually as part of the OPPS rulemaking cycle. As part of the annual OPPS rulemaking cycle, we indicated we will update the lists of 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 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 the CY 2008 OPPS/ASC proposed rule, we proposed to update the revised ASC payment system for CY 2008 to reflect the CY 2008 OPPS relative payment weights and rates, as well as update the lists of covered surgical and covered ancillary services (72 FR 42778). We also proposed 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 (72 FR 42791) 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 (72 FR 42792). We are finalizing those proposals in this final rule with comment period.

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 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 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 (72 FR 42796).

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 August 2, 2007 OPPS/ASC proposed rule (42 FR 42628), we estimated the CY 2008 ASC payment rates, budget neutrality adjustment factor, and impacts using the proposed CY 2008 OPPS relative payment weights and update factor for CY 2008, the proposed CY 2008 MPFS PE RVUs, and partial CY 2006 utilization data projected forward to CY 2008. In this final rule with comment period, we are establishing the final CY 2008 ASC payment rates and budget neutrality adjustment in accordance with the methodology for calculating budget neutrality established in the August 2, 2007 revised ASC payment system final rule and based on the final CY 2008 OPPS payment weights, the final CY 2008 MPFS PE RVUs, and updated CY 2006 utilization data projected forward to CY 2008.

Our final methodology for calculating the budget neutrality adjustment established in the August 2, 2007 revised ASC payment system final rule considered not only the effects of the new payment rates to be implemented under the revised ASC payment system, but also the estimated net effect of migration of new ASC procedures across ambulatory care settings. Both the

proposed budget neutrality adjustment presented in the August 2, 2007 OPPS/ASC proposed rule and the budget neutrality adjustment in this final rule with comment period 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 will 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 will 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 will 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 final rule with comment period. Some of the major issues discussed in this final rule with comment period 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 August 2, 2007 OPPS/ASC proposed rule, we proposed to designate 19 additional procedures as office-based, based on our evaluation of the most recent available CY 2006 volume and utilization data for each individual procedure code and/or related codes. In developing this final rule with comment period, we reviewed the newly available CY 2006 utilization data for all the surgical procedures we proposed to designate as office-based. Based on that review, we are designating 18 additional procedures as office-based for CY 2008. We considered two alternatives in developing this policy.

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 data for these services and related procedures indicated that 18 of the procedures we proposed to designate as office-based could be considered to be predominantly performed in physicians' offices. Consistent with our final policy adopted in the August 2, 2007 revised ASC payment system final rule (72 FR 42509), we were concerned that if these services were not designated as office-based, it could create financial incentives for the 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 designate 18 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's 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, consistent with our final policy adopted in the August 2, 2007 revised ASC payment system final rule.

b. Partial Device Credits

We are reducing 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 will apply when the amount of the device credit is greater than or equal to 50 percent of the cost of the new replacement device being implanted. Under this policy, both the Medicare payment to the ASC and the beneficiary coinsurance liability will be reduced when an ASC receives a partial device credit. This policy is an extension of the policy established in the August 2, 2007 revised ASC payment system final rule, 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. The final partial device credit policy for ASCs mirrors the final partial device credit for the OPPS in this final rule with comment period. We considered several alternatives in developing this partial device credit policy 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 the cost of the replacement device. Similarly, we believe that the beneficiary cost sharing should be based on an amount that also reflects the device 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 adopting in this final rule with comment period, is to reduce the ASC procedure payment by 50 percent of the offset amount (that will be applied if the ASC received full credit) in cases in which the ASC receives a partial credit greater than or equal to 50 percent of the cost of the new replacement device being implanted. This is consistent with the final CY 2008 OPPS policy described in detail in section IV.A.3. of this final rule with comment period. We will reduce the ASC payment for the specific procedure to implant the device by one-half of the device offset that would be applied if a replacement device were provided at no cost or with full credit, if the credit is 50 percent or more of the new replacement device cost, rather than the proposed 20 percent. We believe that payment policies across the OPPS and the ASC payment system should align whenever possible and appropriate, as is true in this case. Moreover, we are requiring the ASC to report a new modifier when the ASC receives a partial credit that is greater than or equal to 50 percent of the cost of the device being replaced. We are selecting 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 final rule with comment period, we are providing that regardless of whether a procedure is on the ASC list of covered surgical procedures, a physician performing that procedure in an ASC will receive payment based on the facility PE RVUs and excluding the technical component (TC) payment, if applicable. We considered two alternatives in developing this policy.

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 for performing 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 PE rate). We adopted a final policy to identify and exclude 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 the excluded procedures have been specifically identified by CMS as procedures that are unsafe for Medicare beneficiaries in ASCs because they 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. Consequently, we did not select this alternative.

The second alternative that we considered, and that we selected, was to provide payment to physicians for performing procedures in ASCs 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 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 second 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 final rule with comment period. We believe that the net effect on Medicare expenditures resulting from 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 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.

3. Estimated Effects of This Final Rule With Comment Period 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, digestive system, or orthopedic procedures. 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 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 reflected in our CY 2006 claims data. Table 63 depicts the aggregate percent change in payment by surgical specialty group and Table 64 shows a comparison of payment for procedures that we estimate would receive the most Medicare payment in CY 2008 under the current payment system.

In section XVI.C.1.c.(5) of this final rule with comment period, we reiterate the transition of 4 years under the revised ASC payment system, where payments for most surgical procedures will 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 CY 2008 revised 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 for these procedures at the fully implemented ASC rate, beginning in CY 2008.

Table 63 shows the effects on aggregate Medicare payments under the revised ASC 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 CY 2008 transitional rate and the fully implemented revised ASC 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 63.

- 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 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 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 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 comparisons to the percentage changes under the transition policy in column 3 and do not depict the impact of the fully implemented policy in 2011.

As seen in Table 63, for all but digestive system procedures, if an ASC offers the same mix of services in CY 2008 that is reflected in our national CY 2006 claims data, 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 expect all but digestive system procedures and nervous system procedures to receive greater Medicare payment. In addition to the effects on Medicare payments for current ASC procedures shown in Table 63, 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 physicians' 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 63.—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	$1,247	2	3

TABLE 63.—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—Continued

Surgical specialty group (1)	Estimated CY 2008 ASC payments (in millions) (2)	Estimated CY 2008 percent change with transition (75/25 Blend) (3)	Estimated CY 2008 percent change without transition (fully implemented) (4)
Digestive system	708	−4	−16
Nervous system	260	3	−4
Musculoskeletal system	165	24	94
Integumentary system	75	8	32
Genitourinary system	74	11	43
Respiratory system	18	16	64
Cardiovascular system	8	24	94
Auditory system	4	23	80
Hemic and lymphatic systems	2	31	124
Other systems	0.1	27	108

Table 64 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 most Medicare 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 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 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 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 to the percentage changes under the transition policy in Column 4 and do not depict the impact of the fully implemented policy in 2011.

TABLE 64.—ESTIMATED CY 2008 IMPACT OF REVISED ASC PAYMENT SYSTEM ON AGGREGATE PAYMENTS FOR PROCEDURES WITH THE MOST MEDICARE 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)
66984	Cataract surg w/iol, 1 stage	1,017	0	1
43239	Upper GI endoscopy, biopsy	156	−5	−17
45378	Diagnostic colonoscopy	141	−4	−14
45380	Colonoscopy and biopsy	115	−4	−14
45385	Lesion removal colonoscopy	95	−4	−14
66821	After cataract laser surgery	89	−8	−25
62311	Inject spine l/s (cd)	75	−3	−10
64483	Inj foramen epidural l/s	43	−3	−10
66982	Cataract surgery, complex	39	0	1
45384	Lesion remove colonoscopy	39	−4	−14
G0121	Colon ca scrn not hi rsk ind	36	−7	−22
G0105	Colorectal scrn; hi risk ind	28	−7	−22
15823	Revision of upper eyelid	26	4	12
43235	Uppr gi endoscopy, diagnosis	24	1	4
52000	Cystoscopy	23	−6	−21
64475	Inj paravertebral l/s	23	−3	−10

TABLE 64.—ESTIMATED CY 2008 IMPACT OF REVISED ASC PAYMENT SYSTEM ON AGGREGATE PAYMENTS FOR PROCEDURES WITH THE MOST MEDICARE 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)
64476	Inj paravertebral l/s ADD-on	22	−18	−65
29881	Knee arthroscopy/surgery	17	22	55
64721	Carpal tunnel surgery	16	17	43
43248	Uppr gi endoscopy/guide wire	14	−5	−17
62310	Inject spine c/t	13	−3	−10
67904	Repair eyelid defect	12	6	16
29880	Knee arthroscopy/surgery	12	22	55
64484	Inj foramen epidural ADD-on	12	−12	−42
28285	Repair of hammertoe	10	17	44
G0260	Inj for sacroiliac jt anesth	10	−3	−10
29848	Wrist endoscopy/surgery	9	−3	−8
64623	Destr paravertebral n ADD-on	9	−3	−10
45383	Lesion removal colonoscopy	8	−4	−14
26055	Incise finger tendon sheath	8	13	35

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 will support the ASC's continued operation. We note 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 note that procedures with existing ASC payment rates that are substantially lower than the OPPS rates are 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 64 identifies a number of ASC procedures receiving the most Medicare 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 63. In fact, Table 63 shows only one surgical specialty group of procedures for which the 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 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 very small increase, less than 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 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 payment to ASCs for the group of genitourinary procedures currently performed in ASCs is expected to increase by 11 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, 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, if there were no transition period, we estimate that CY 2008 payments also would decrease slightly for the nervous system surgical specialty group.

We note that the estimated percent changes in payment under the revised ASC payment system for the surgical procedures with the highest aggregate Medicare ASC payments closely resemble those presented in the CY 2008 OPPS/ASC proposed rule, with the exception of CPT codes 64476 (Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)); and 64484 (Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)). Our estimates of the percent changes in ASC payment for these two injection procedures are

considerably greater for this final rule than they were for the CY 2008 OPPS/ASC proposed rule. Both of these nervous system procedures had significantly more single claims available for OPPS ratesetting for this final rule with comment period, reflecting much lower costs that their median costs for the proposed rule. These data resulted in the reassignment of CPT codes 64476 and 64484 to different clinical APCs for CY 2008 than proposed, in order to ensure the clinical and resource homogeneity of the OPPS APCs for CY 2008. Their lower OPPS payment rates in turn resulted in lower payments than those estimated in the proposed rule for the two services under the revised ASC payment system. However, as shown in Table 63, above, the final estimated decrease in ASC payment for nervous system procedures overall without the transition is estimated to be 4 percent in this final rule with comment period, very close to the CY 2008 OPPS/ASC proposed rule estimated decrease of 2 percent for nervous system procedures. Thus, we believe that our final policies will continue to ensure Medicare beneficiary access to surgical procedures involving the nervous system in ASCs under the revised ASC payment system in CY 2008.

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 are the rates for 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 for its report to Congress on ASC costs, as described in the August 2, 2007 revised ASC payment system final rule (72 FR 42474), appear in Table 64 with payment decreases under the revised ASC payment system. The GAO concluded that for those 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 payment amounts in CY 2008 are much higher than the CY 2007 rates currently paid to ASCs. For example, payments for CPT codes 29880 (Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving)) and 29881 (Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including meniscal shaving)) increase by 22 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 indicated elsewhere in this final rule with comment period, payments for most of the highest volume colonoscopy and upper gastrointestinal endoscopy procedures will decrease under the revised payment system. Table 63 estimates that payment decreases also are expected for the digestive system surgical specialty group overall. We believe that the reason for decreased payments for so many of the digestive system procedures is that the 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 digestive system procedures are not large (all less than or equal to 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 ratesetting methodology of the revised ASC payment system or the MPFS nonfacility PE RVU amount, whichever is lower, the other covered ancillary items and services 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 August 2, 2007 revised ASC payment system final rule 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.

b. Payment to Physicians for Performing Excluded ASC Procedures in an ASC

As discussed in section XVI.G. of this final rule with comment period, we are paying 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 HOPDs.

We believe that the effect of the 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, the excluded procedures are generally more complex than procedures furnished in physicians' offices. Consequently, most surgical procedures that are excluded from the list of ASC covered surgical procedures in CY 2008 do not have nonfacility PE RVUs. Specifically, only about 46 of approximately 2,000 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 policy to pay physicians for excluded ASC procedures performed in ASCs based on the facility PE RVUs will only affect Medicare payment rates for the small proportion of excluded procedures that have nonfacility PE RVUs.

4. Estimated Effects of This Final Rule With Comment Period 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 800 surgical procedures to the ASC list of covered surgical services eligible for Medicare payment in CY 2008. 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 revision to §§ 414.22(b)(5)(i)(A) and (B) will impose beneficiary liability for facility costs associated with surgical procedures that are not Medicare covered surgical procedures in ASCs. In the August 2, 2007 revised ASC payment system final rule, 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 revision to §§ 414.22(b)(5)(i)(A) and (B) will also provide for no payment to physicians for the facility resources required to furnish excluded services in ASCs, 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. We do not expect that the change will result in a meaningful increase in beneficiary liability because we do not expect that 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. Furthermore, we expect that physicians and ASCs will 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 are provided in ASCs.

5. Conclusion

The changes to the ASC payment system for CY 2008 will affect each of the approximately 4,800 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 final rule with comment period). Furthermore, we estimate that the revised ASC payment system will result in Medicare savings of $220 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 with comment period 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 65 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 with comment period. 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 final rule with comment period. All expenditures are classified as transfers.

TABLE 65.—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 Requirements for Reporting of Quality Data for Hospital Outpatient Settings

In section XVII. of this final rule with comment period, we discuss our measures and requirements for reporting of quality data to CMS for services furnished in hospital outpatient settings under the HOP QDRP. We note that we have reduced the number of initial quality measures to be reported from the 10 we proposed to 7. We have also modified the date for which the initial submission of quality data begins from services furnished on or after January 2008 to services furnished on or after April 2008. The initial submission for data for April–June 2008 services is due to the OPPS Clinical Warehouse by November 1, 2008. CMS and its contractors will provide assistance to all hospitals that wish to submit data. In addition, we have modified our proposal for the CY 2009 payment update, so that hospitals are not required to submit charts for or pass our validation requirement of a minimum of 80 percent reliability, based upon our chart-audit validation process for January 2008 services. As noted in section XVII.E. of this final rule with comment period, we are providing validation criteria for services furnished on or after July 1, 2008 for purposes of the CY 2010 and subsequent years' payment updates to ensure that the quality data being sent to CMS are accurate. The requirement of five charts per hospital per quarter will result in the submission of approximately 21,500 charts per quarter for services furnished on or after July 1, 2008 to the agency. We believe that a requirement for five charts per hospital per quarter for services furnished on or after July 1, 2008, represents a minimal burden to the participating hospital.

E. Effects of Policy Revisions on CAH Off-Campus and Co-Location Requirements

In section XVIII.A. of the preamble of this final rule with comment period, we discuss our 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 clarified in this final rule with comment period 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) acquires or creates an off-campus provider-based location or an off-campus distinct part psychiatric or rehabilitation unit on or after January 1, 2008, the CAH off-campus provider-based facility must comply with the location requirements. We revised the language of the regulation to exclude RHCs, as defined under § 405.2401(b), from the list of provider-based facilities that must comply with this regulation. Because CAHs can continue current co-location and off-campus arrangements that are in place before January 1, 2008, we believe there is no burden associated with this regulation.

F. Effects of Policy Revisions to the Hospital CoPs

In section XVIII.B. of the preamble of this final rule with comment, we discuss changes to the hospital CoPs relating to timeframes for completion of medical history and physical examinations and requirements for preanesthesia and postanesthesia evaluations of Medicare beneficiaries. We believe that these revisions would impose minimal additional costs on hospitals. In fact, hospitals may realize some minimal cost savings. The cost of implementing these 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 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 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 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 revisions as these practices are usual and customary business practices.

In accordance with the provisions of Executive Order 12866, this final rule with comment period was reviewed by the OMB.

G. Impact of the Changes to the Hospital Inpatient Prospective Payment System (IPPS) Payment Rates

1. Overall Impact

We have examined the impacts of this final rule relating to the changes to hospital inpatient prospective payment system payment rates as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Public Law 104–4), and Executive Order 13132. We have also examined the impacts of this final rule in the context of the Regulatory Flexibility Act (RFA) (September 19, 1980, Public Law 96–354).

Based on the IPPS provisions specified in section XIX. of this final rule, we have determined that this rule is a major rule as defined in 5 U.S.C. 804(2). This final rule includes changes in FY 2008 IPPS payments due to the enactment of Public Law 110–90, which requires the Secretary to apply a prospective documentation and coding adjustment for discharges during FY 2008 of −0.6 percent rather than the −1.2 percent specified in the FY 2008 IPPS final rule. In addition, this final rule includes a change in policy to not apply the documentation and coding adjustment to the hospital-specific payment rates. We estimate that the increase in FY 2008 IPPS operating and capital payments to hospitals resulting from the provisions of this final rule will be in excess of $100 million.

With the exception of the IPPS changes included in this final rule, all FY 2008 IPPS payment policies were established in the FY 2008 IPPS final rule (72 FR 47130) issued on August 1, 2007. As noted in section XIX. of this document, on September 28, 2007, we issued a notice relating to the FY 2008 IPPS final rule that corrected a technical calculation and typographical errors in that final rule. The correction notice appeared in the October 10, 2007 **Federal Register** and is hereinafter referred to as the ''second FY 2008 IPPS correction notice.'' In the second FY 2008 IPPS correction notice, we estimated a $4.0 billion increase in FY 2008 operating and capital payments as a result of the market basket update to the FY 2008 IPPS rates required by the statute, in conjunction with the other payment policies established in the FY

2008 IPPS final rule. In this final rule, we have updated our estimate of the increase in FY 2008 IPPS operating and capital payments based on the policies and market basket update established in the FY 2008 IPPS final rule and the addition of the IPPS provisions included in this final rule. We now estimate an increase in FY 2008 operating and capital payments of approximately $4.6 billion, an increase of about $665 million over our prior estimate. Our current estimate includes the statutorily mandated −0.6 percent adjustment for documentation and coding changes to the IPPS standardized amounts and capital Federal rates for FY 2008 under section 7 of Public Law 110–90, and the removal of the application of the documentation and coding adjustment to the hospital-specific rates. For purposes of the impact analysis, we also assume a 1.2 percent increase in case-mix growth, as determined by the Office of the Actuary, because we believe the adoption of the MS–DRGs will result in case-mix growth due to documentation and coding changes that do not reflect real changes in patient severity of illness. The estimates do not reflect any other changes in hospital admissions or case-mix intensity in operating PPS payments, which will also affect overall payment changes.

The RFA requires agencies to analyze options for regulatory relief of small businesses for any rule for which the agency publishes a general notice of proposed rulemaking. Since we have waived notice and comment rulemaking for the IPPS provisions in this final rule as discussed in section XIX.C. of this final rule, we do not believe the Regulatory Flexibility Act requires a regulatory flexibility analysis in this case. While we do not believe we are required to perform a regulatory flexibility analysis, we are including in section XIX. of this final rule and in this impact analysis section final rule all of the components that would be required of a final regulatory flexibility analysis.

For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are considered to be small entities, either by nonprofit status or by having revenues of $31.5 million or less in any 1 year. (For details on the latest standards for heath care providers, we refer readers to page 33 of the Table of Small Business Size Standards at the Small Business Administration Web site at: *http://www.sba.gov/services/contractingopportunities/sizestandardstopics/tableofsize/index.html*.) For purposes of the RFA, all hospitals and other providers and suppliers are considered to be small entities. Individuals and States are not included in the definition of a small entity. We believe that the IPPS payment rate changes in this final rule will have a significant impact on small entities as explained subsequently.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any proposed or final rule that 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 now define a small rural hospital as a hospital that is located outside of an urban area and has fewer than 100 beds. Section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21) designated hospitals in certain New England counties as belonging to the adjacent urban area. Thus, for purposes of the IPPS, we continue to classify these hospitals as urban hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (Public Law 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 IPPS changes in this final rule will not mandate any requirements for State, local, or tribal governments, nor will it affect private sector costs.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. As stated above, the IPPS changes in this final rule will not have a substantial effect on State and local governments.

The following analysis, in conjunction with the section XIX. of this document, demonstrates that this rule is consistent with the regulatory philosophy and principles identified in Executive Order 12866, the RFA, and section 1102(b) of the Act. The rule will affect payments to a substantial number of small rural hospitals, as well as other classes of hospitals, and the effects on some hospitals may be significant.

2. Objectives

The primary objective of the IPPS is to create incentives for hospitals to operate efficiently and minimize unnecessary costs while at the same time ensuring that payments are sufficient to adequately compensate hospitals for their legitimate costs. In addition, we share national goals of preserving the Medicare Hospital Insurance Trust Fund.

We believe that the policies established in the FY 2008 IPPS final rule and the IPPS provisions of this final rule will further each of these goals while maintaining the financial viability of the hospital industry and ensuring access to high quality health care for Medicare beneficiaries. We expect that these changes will ensure that the outcomes of this payment system are reasonable and equitable while avoiding or minimizing unintended adverse consequences.

3. Limitations of Our Analysis

The following quantitative analysis presents the projected effects of our IPPS policy changes, as well as statutory changes effective for FY 2008, on various hospital groups. We use the best available data, but generally do not attempt to make adjustments for future changes in such variables as admissions, length of stay, or case-mix. However, as stated in the FY 2008 IPPS final rule, we believe that adoption of the MS–DRGs will create a risk of increased aggregate levels of payment as a result of more comprehensive documentation and coding. As explained in section XIX. of this final rule, the FY 2008 IPPS final rule established a documentation and coding adjustment of −1.2 percent to maintain budget neutrality for the transition to the MS–DRGs. Subsequently, Congress enacted Public Law 110–90, which reduced the FY 2008 IPPS documentation and coding adjustment from −1.2 percent to −0.6 percent. Therefore, in section XIX. of this final rule, we have revised the payment rates, factors and thresholds to reflect the −0.6 percent documentation and coding adjustment. While the documentation and coding adjustment has been changed for payment purposes, we continue to believe that an increase in case mix of 1.2 percent in FY 2008 is likely as a result of the adoption of the MS–DRGs. The impacts shown below illustrate the impact of the FY 2008 IPPS changes on hospital operating payments, including the −0.6 percent documentation and coding adjustment to the IPPS standardized amounts, both prior to and following the projected 1.2 percent growth in case-mix.

4. Quantitative Effects of the IPPS Policy Changes for Operating Costs

In this final rule, we are employing the same operating payment simulation model as used in the FY 2008 IPPS final rule. Our methodology underlying the simulation model is discussed in detail in the FY 2008 IPPS final rule (72 FR 48158 through 48159). The difference between the impact estimates in this final rule and the FY 2008 IPPS final rule reflects the application of a documentation and coding adjustment of −0.6 percent (instead of −1.2 percent) and the removal of the application of the documentation and coding adjustment to the hospital-specific rates. Our impact estimates in this final rule also reflect a technical correction to a calculation error made in our previously published impact estimates, as discussed in more detail subsequently.

5. Analysis of Table I

Table I displays the estimated increase in IPPS operating payments between FY 2007 and FY 2008. It compares the impact estimates previously published in the second FY 2008 IPPS correction notice to the FY 2008 IPPS final rule, which is based on the payment policies and market basket update established in the FY 2008 IPPS final rule, with our current impact estimates, which are based on both the IPPS policies established in the FY 2008 IPPS final rule and the IPPS policy changes included in this final rule.

As noted previously, we believe that the adoption of the MS–DRGs in FY 2008 will create a financial risk of increased aggregate payments as a result of more comprehensive documentation and coding. To maintain budget neutrality, the FY 2008 IPPS final rule established a documentation and coding adjustment of −1.2 percent for FY 2008. Subsequently, Public Law 110–90 was enacted, which reduces the FY 2008 documentation and coding adjustment from −1.2 percent to −0.6 percent. Thus, our previously published impact estimates reflect a −1.2 percent documentation and coding adjustment and our current impact estimates reflect a −0.6 percent adjustment. While the documentation and coding adjustment has been changed for payment purposes, we continue to believe that an increase in case-mix of 1.2 percent for FY 2008 is likely to occur. Table 1 illustrates the impact of the FY 2008 IPPS changes on hospital payments, including the documentation and coding adjustment to the IPPS standardized amounts, both prior to and following the projected 1.2 percent growth in case-mix.

The table categorizes hospitals by various geographic and special payment considerations to illustrate the varying impacts on different types of hospitals. The top row of the table shows the overall impact on the 3,534 hospitals included in the analysis.

The next four rows of Table I contain hospitals categorized according to their geographic location: All urban, which is further divided into large urban and other urban; and rural. There are 2,539 hospitals located in urban areas included in our analysis. Among these, there are 1,406 hospitals located in large urban areas (populations over 1 million), and 1,133 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 995 hospitals in rural areas. The next two groupings are by bed size categories, shown separately for urban and rural hospitals. The final groupings by geographic location are by census divisions, also shown separately for urban and rural hospitals.

The second part of Table I shows hospital groups based on hospitals' FY 2008 payment classifications, including any reclassifications under section 1886(d)(10) of the Act. For example, the rows labeled urban, large urban, other urban, and rural show that the number of hospitals paid based on these categorizations after consideration of geographic reclassifications (including reclassifications under section 1886(d)(8)(B) and section 1886(d)(8)(E) of the Act that have implications for capital payments) are 2,578, 1,425, 1,153, and 956, respectively.

The next three groupings examine the impacts of the changes on hospitals grouped by whether or not they have GME residency programs (teaching hospitals that receive an IME adjustment) or receive DSH payments, or some combination of these two adjustments. There are 2,480 nonteaching hospitals in our analysis, 815 teaching hospitals with fewer than 100 residents, and 239 teaching hospitals with 100 or more residents.

In the DSH categories, hospitals are grouped according to their DSH payment status, and whether they are considered urban or rural for DSH purposes. The next category groups together hospitals considered urban after geographic reclassification, in terms of whether they receive the IME adjustment, the DSH adjustment, both, or neither.

The next five rows examine the impacts of the changes on rural hospitals by special payment groups (SCHs, RRCs, and MDHs), as well as rural hospitals not receiving a special payment designation. There were 194 RRCs, 367 SCHs, 150 MDHs, 99 hospitals that are both SCHs and RRCs, and 8 hospitals that are both an MDH and an RRC.

The next series of groupings concern the geographic reclassification status of hospitals. The first grouping displays all urban hospitals that were reclassified by the MGCRB for FY 2008. The second grouping shows the MGCRB rural reclassifications.

The final two groupings are based on the type of ownership and the hospital's Medicare utilization expressed as a percent of total patient days. These data were taken from the FY 2004 Medicare cost reports.

TABLE I.—IMPACT ANALYSIS OF CHANGES FOR FY 2008

	No. of hospitals	Previously published all FY 2008 changes w/ CMI adjustment prior to estimated growth [11]	Current estimate of all FY 2008 changes w/ CMI adjustment prior to estimated growth [12]	Previously published all FY 2008 changes w/ CMI adjustment and estimated growth [13]	Current estimate of all FY 2008 changes w/ CMI adjustment and estimated growth [14]
	(1)	(2a)	(2b)	(3a)	(3b)
All Hospitals	3,534	2.5	3.1	3.7	4.3
By Geographic Location:					
Urban hospitals	2,539	2.6	3.3	3.9	4.5
Large urban areas	1,406	3.1	3.7	4.3	5.0
Other urban areas	1,133	2	2.7	3.3	3.9

TABLE I.—IMPACT ANALYSIS OF CHANGES FOR FY 2008—Continued

	No. of hospitals	Previously published all FY 2008 changes w/ CMI adjustment prior to estimated growth [11]	Current estimate of all FY 2008 changes w/ CMI adjustment prior to estimated growth [12]	Previously published all FY 2008 changes w/ CMI adjustment and estimated growth [13]	Current estimate of all FY 2008 changes w/ CMI adjustment and estimated growth [14]
	(1)	(2a)	(2b)	(3a)	(3b)
Rural hospitals	995	1.2	1.7	2.4	2.9
Bed Size (Urban):					
0–99 beds	630	1	1.6	2.2	2.8
100–199 beds	851	2.3	2.9	3.6	4.2
200–299 beds	480	2.5	3.1	3.8	4.4
300–499 beds	411	3	3.6	4.2	4.8
500 or more beds	167	2.9	3.5	4.1	4.8
Bed Size (Rural):					
0–49 beds	337	0.1	0.5	1.3	1.7
50–99 beds	372	1.2	1.6	2.4	2.9
100–149 beds	173	1.2	1.8	2.5	3.0
150–199 beds	68	1.2	1.8	2.5	3.0
200 or more beds	45	1.8	2.3	3.1	3.6
Urban by Region:					
New England	122	2.4	3.0	3.7	4.3
Middle Atlantic	350	2.2	2.9	3.5	4.1
South Atlantic	390	2.7	3.4	4	4.6
East North Central	395	2.4	3.0	3.7	4.3
East South Central	166	2.1	2.7	3.3	3.9
West North Central	157	2.4	3.0	3.6	4.2
West South Central	355	2.6	3.2	3.8	4.4
Mountain	153	2.6	3.2	3.8	4.4
Pacific	398	4	4.6	5.2	5.8
Puerto Rico	53	2.9	3.5	4.1	4.8
Rural by Region:					
New England	23	1.2	1.6	2.4	2.8
Middle Atlantic	72	1.4	1.8	2.6	3.0
South Atlantic	173	1.6	2.2	2.8	3.4
East North Central	122	1.4	1.8	2.7	3.1
East South Central	177	0.9	1.5	2.1	2.7
West North Central	115	1.4	1.8	2.6	3.0
West South Central	199	–0.3	0.3	0.9	1.5
Mountain	77	2	2.4	3.2	3.6
Pacific	37	2.9	3.3	4.2	4.6
By Payment Classification:					
Urban hospitals	2,578	2.6	3.3	3.9	4.5
Large urban areas	1,425	3.1	3.7	4.3	4.9
Other urban areas	1,153	2	2.6	3.3	3.9
Rural areas	956	1.3	1.7	2.5	3.0
Teaching Status:					
Nonteaching	2,480	2.1	2.7	3.3	3.9
Fewer than 100 residents	815	2.5	3.1	3.8	4.4
100 or more residents	239	3.1	3.8	4.4	5.0
Urban DSH:					
Non-DSH	859	1.7	2.3	3	3.6
100 or more beds	1,512	2.9	3.5	4.1	4.7
Less than 100 beds	355	1.9	2.5	3.1	3.7
Rural DSH:					
SCH	384	1.6	2.0	2.9	3.2
RRC	203	1.3	1.9	2.5	3.1
100 or more beds	46	1.4	2.0	2.6	3.3
Less than 100 beds	175	0.2	0.8	1.4	2.1
Urban teaching and DSH:					
Both teaching and DSH	807	3	3.6	4.2	4.8
Teaching and no DSH	186	1.9	2.5	3.2	3.8
No teaching and DSH	1,060	2.6	3.2	3.8	4.4
No teaching and no DSH	525	1.7	2.3	2.9	3.6
Special Hospital Types:					
RRC	194	1.5	2.1	2.7	3.3
SCH	367	1.3	1.6	2.5	2.8
MDH	150	2	2.3	3.2	3.6
SCH and RRC	99	1.7	2.0	2.9	3.3
MDH and RRC	8	1.3	1.5	2.6	2.7
Type of Ownership:					

TABLE I.—IMPACT ANALYSIS OF CHANGES FOR FY 2008—Continued

	No. of hospitals	Previously published all FY 2008 changes w/ CMI adjustment prior to estimated growth [11]	Current estimate of all FY 2008 changes w/ CMI adjustment prior to estimated growth [12]	Previously published all FY 2008 changes w/ CMI adjustment and estimated growth [13]	Current estimate of all FY 2008 changes w/ CMI adjustment and estimated growth [14]
	(1)	(2a)	(2b)	(3a)	(3b)
Voluntary	2,064	2.4	3.0	3.6	4.2
Proprietary	823	2.7	3.3	4	4.6
Government	597	2.7	3.3	3.9	4.5
Medicare Utilization as a Percent of Inpatient Days:					
0–25	230	4.2	4.9	5.5	6.1
25–50	1,289	3.1	3.7	4.3	4.9
50–65	1,451	1.9	2.4	3.1	3.7
Over 65	440	1.2	1.8	2.5	3.0
FY 2008 Reclassifications by the Medicare Geographic Classification Review Board:					
All Reclassified Hospitals	738	2.2	2.8	3.4	4.0
Non-Reclassified Hospitals	2,796	2.6	3.2	3.8	4.4
Urban Hospitals Reclassified	372	2.4	3.1	3.7	4.3
Urban Nonreclassified, FY 2008:	2,147	2.7	3.3	3.9	4.5
All Rural Hospitals Reclassified Full Year FY 2008:	366	1.6	2.1	2.8	3.3
Rural Nonreclassified Hospitals Full Year FY 2008:	566	0.4	0.9	1.7	2.1
All Section 401 Reclassified Hospitals:	26	0.6	0.8	1.8	2.0
Other Reclassified Hospitals (Section 1886(d)(8)(B))	63	1.5	2.0	2.8	3.3
Former 508 Hospitals	107	–0.6	0.0	0.6	1.2
Specialty Hospitals:					
Cardiac specialty Hospitals	22	–0.4	0.2	0.8	1.4

[11] This column shows our previous estimate published in the second FY 2008 IPPS correction notice of the changes in payments from FY 2007 to FY 2008 including a 0.988 CMI adjustment for coding and documentation improvements that are anticipated with the adoption of the MS–DRGs prior to the estimated growth occurring. It also reflects all FY 2008 IPPS policies adopted in the FY 2008 IPPS final rule.

[12] This column shows our current estimate of the changes in payments from FY 2007 to FY 2008 including a 0.994 CMI adjustment for coding and documentation improvements that are anticipated with the adoption of the MS–DRGs prior to the estimated growth occurring. It also reflects all FY 2008 IPPS policies adopted in the FY 2008 IPPS final rule and this final rule.

[13] This column shows our previous estimate published in CMS–1533–CN2 of the changes in payments from FY 2007 to FY 2008 including a .988 CMI adjustment and the estimated case-mix growth of 1.2 percent as a result of improvements in documentation and coding. It also reflects all FY 2008 IPPS policies adopted in the FY 2008 IPPS final rule.

[14] This column shows our current estimate of the changes in payments from FY 2007 to FY 2008 including a .994 CMI adjustment and the estimated case-mix growth of 1.2 percent (when comparing column 2b to column 3b) as a result of improvements in documentation and coding. It also reflects all FY 2008 IPPS policies adopted in the FY 2008 IPPS final rule and this final rule.

a. Effects of All Changes With CMI Adjustment Prior to Estimated Growth (Columns 2a and 2b)

Columns 2a and 2b show our previously published and current estimates of the change in IPPS payments from FY 2007 to FY 2008, reflecting all FY 2008 IPPS policies including a documentation and coding adjustment to the FY 2008 rates, but not taking into account the expected 1.2 percent growth in case-mix due to the anticipated improvement in documentation and coding as a result of the MS–DRGs. Because columns 2a and 2b model the impact to include the documentation and coding adjustment for anticipated case-mix increase without accounting for the actual case-mix increase itself, these columns illustrate a total payment change that is less than what is anticipated to occur.

Column 2a shows our previously published estimate in the October 10, 2007 correction notice to the FY 2008 IPPS proposed rule based on the policies established in the FY 2008 IPPS final rule, including a −1.2 percent documentation and coding adjustment. Column 2b shows our current estimate based on the same FY 2008 IPPS payment policies, except it also includes the policy changes established in this final rule (that is, the statutorily mandated −0.6 percent documentation and coding adjustment and the change in policy of not applying the documentation and coding adjustment to the hospital specific rates). Column 2b also corrects for a technical error that occurred in the second FY 2008 IPPS correction notice that inadvertently overestimated FY 2008 payments to providers that receive the hospital specific rate.

Comparing columns 2a and 2b, the average increase in FY 2008 IPPS payment for all hospitals is approximately 0.6 percentage points higher than in the second FY 2008 IPPS correction notice, as would be expected with the statutorily mandated change in the documentation and coding adjustment from −1.2 percent to −0.6 percent. As a result of the combination of the law change and a policy of not applying the documentation and coding adjustment to the hospital-specific rates for MDHs and SCHs, certain categories of hospitals (MDHs, SCHs, rural hospitals, and certain rural geographic areas with relatively large numbers of SCHs and MDHs) are estimated to experience an increase in their operating payments of slightly more than 0.6 percentage points compared with the policies articulated in the FY 2008 IPPS final rule. However, column 2b shows an increase in operating payments for these categories of hospitals of only about 0.2 to 0.5 percentage points greater than our previously published impact estimates in column 2a (rather than more than 0.6 percentage points) due to a technical error in our previously published impact estimates that had overstated the

FY 2008 increase in payments to these hospitals.

b. Effects of All Changes With CMI Adjustment and Estimated Growth (Column 3)

Columns 3a and 3b show our previously published and current estimates of the change in IPPS payments from FY 2007 to FY 2008, reflecting all FY 2008 IPPS policies including a documentation and coding adjustment to the FY 2008 rates and taking into account the expected 1.2 percent growth in case-mix in FY 2008 due to anticipated improvements in documentation and coding as a result of the MS–DRGs.

Column 3a shows our previously published estimate in the correction notice to the FY 2008 IPPS proposed rule of the FY 2008 increase in operating payments based on the policies established in the FY 2008 IPPS final rule, including a −1.2 percent documentation and coding adjustment which is assumed to be fully offset by a 1.2 percent increase in case-mix. Column 3b shows our current estimate based on the same FY 2008 IPPS payment policies, except it also includes the policy changes established in this final rule (that is, the statutorily mandated −0.6 percent documentation and coding adjustment and the change in policy of not applying the documentation and coding adjustment to the hospital-specific rates). In column 3b, even though the documentation and coding adjustment reduces the standardized amount by 0.6 percent, this column assumes a 1.2 percent increase in case-mix due to improved documentation and coding that is estimated to occur equally across all hospitals as determined by the Office of the Actuary. Furthermore, it assumes that a 1.2 percent increase in case-mix from improved documentation and coding will occur for hospitals that receive the hospital-specific rate. Similar to column 2b, column 3b also corrects for a technical error that occurred in the second FY 2008 IPPS correction notice that inadvertently overstated the FY 2008 increase in payments to providers that receive the hospital specific-rate.

Column 3b reflects our current estimate of the impact of all FY 2008 changes relative to FY 2007. The average increase for all hospitals is approximately 4.3 percent. This is a 0.6 percent increase in expected payments compared to the 3.7 percent average increase to all hospitals published in the second FY 2008 IPPS correction notice. This estimated increase in payments can be attributed to the statutorily mandated change in the documentation and coding adjustment to the standardized amounts from −1.2 percent to −0.6 percent. As shown in table 1, columns 3a and 3b, most classes of hospitals are estimated to experience an additional 0.6 percent increase in payments in FY 2008 compared with our previously published estimates with the increases shown in the table sometimes appearing to be slightly more (0.7 percentage points) due to rounding. As noted previously, as a result of the combination of the law change and a policy change to not apply the documentation and coding adjustment to the hospital-specific rates for MDHs and SCHs, certain categories of hospitals (MDHs, SCHs, rural hospitals, and certain rural geographic areas with relatively large numbers of SCHs and MDHs) are estimated to experience an increase in their operating payments of slightly more than 0.6 percentage points compared with the policies articulated in the FY 2008 IPPS final rule. However, column 3b shows an increase in operating payments for these categories of hospitals of only about 0.1 to 0.5 percentage points greater than our previously published impact estimates in column 3a (rather than more than 0.6 percentage points) due to a technical error in our previously published impact estimates that had overstated the FY 2008 increase in payments to these hospitals.

6. Overall Conclusion

The IPPS changes we are making in this final rule will affect all classes of hospitals. All classes of hospitals are expected to experience increases in their FY 2008 IPPS payments as a result of the provisions of this final rule. Table I of this section demonstrates the statutorily mandated change to the documentation and coding adjustment applied to the standardized amount, the policy change of the nonapplication of the documentation and coding adjustment to the hospital-specific rate and all other policies reflected in the FY 2008 IPPS final rule. Table I also shows an overall increase of 4.3 percent in operating payments, an estimated increase of $4.29 billion, which includes hospital reporting of quality data program costs ($1.89 million) and all operating payment policies as described in this section XXIV.G. Capital payments are estimated to increase by 1.2 percent per case from FY 2007 to FY 2008. The average increase in FY 2008 capital IPPS payments for all hospitals is approximately 0.6 percentage points higher than in the second FY 2008 IPPS correction notice, as expected based on the statutorily mandated change in the FY 2008 documentation and coding adjustment from −1.2 percent to −0.6 percent. Therefore, we project that capital payments will increase by $342 million in FY 2008 compared to FY 2007. The operating and capital payments should result in a net increase of $4.635 billion to IPPS providers. This is an additional increase in estimated payments by $665 million compared to the estimated increase in payments published in the second FY 2008 IPPS correction notice. The discussions presented in the previous subsections, in combination with section XIX. of this final rule, constitute a regulatory impact analysis.

7. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehousegov/omb/circulars/a004/a-4.pdf*), in Table II below, we have prepared an accounting statement showing the classification of the expenditures associated with the IPPS provisions of this final rule. This table provides our best estimate of the increase in Medicare payments to providers from FY 2007 to FY 2008 as a result of the IPPS policies established in the FY 2008 IPPS final rule and in section XIX. of this final rule. All expenditures are classified as transfers to Medicare providers.

TABLE II.—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES FROM FY 2007 TO FY 2008

Category	Transfers
Annualized Monetized Transfers.	$4.635 Billion.
From Whom to Whom	Federal Government to IPPS Medicare Providers.
Total	$4.635 Billion.

8. Executive Order 12866

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

H. Impact of the Policy Revisions Related to Emergency Medicare GME Affiliated Groups for Hospitals in Certain Declared Emergency Areas

As we discussed in detail in section XX. of this document, we are issuing an interim final rule with comment period that modifies the current GME regulations as they apply to emergency Medicare GME affiliated groups to provide for greater flexibility in training residents in approved residency programs during times of disaster.

Specifically, the interim final rule with comment period modifies provisions for ''emergency Medicare GME affiliated groups'' to address the needs of teaching hospitals that are forced to find alternate training sites for residents that were displaced by a disaster.

1. Overall Impact

This interim final rule with comment period rule is not a major rule under Executive Order 12866 because we anticipate that the cost to the Medicare program will be negligible under the provisions included in this rule.

2. RFA

For purposes of the RFA, we believe that the impact on the affected hospitals will not be significant and will not affect a substantial number of small entities.

3. Small Rural Hospitals

For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. This interim final rule with comment period is not anticipated to have a significant effect on small rural hospitals because the provisions of this interim final rule with comment period are most likely to be used by large teaching hospitals that have established residency programs and the capacity to train a larger complement of displaced residents. The majority of this type of teaching hospital is located in non-rural areas.

4. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 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 interim final rule with comment period will not have an effect on State, local, or tribal governments in the aggregate and the private sector costs will be less than the $120 million threshold.

5. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. This interim final rule with comment period will not have a substantial effect on State or local governments.

6. Anticipated Effects

We believe that there are limited effects associated with modifying the existing emergency Medicare GME affiliation regulations to extend the effective period as well as to permit certain written agreements for training that occurs in the nonhospital setting to be submitted retroactively. We note that these changes do not allow hospitals to count for Medicare IME or direct GME payment purposes additional FTE residents that had not been counted by Medicare before a qualifying emergency. Hospitals participating in emergency Medicare GME affiliated groups are held to their respective FTE resident caps as specified by the emergency affiliation agreement. IME and direct GME payments to the hospitals under this provision will not be based upon any FTE residents in excess of the caps specified under the emergency Medicare GME affiliation agreements.

7. Alternatives Considered

We considered making no changes at this time to the existing emergency Medicare GME affiliation provisions. However, teaching hospitals affected by Hurricanes Katrina and Rita have reported to us that they are still experiencing difficulties in reestablishing their training programs and they have requested the extension of the effective period for emergency Medicare GME affiliation agreements to continue beyond June 30, 2008. We understand that GME programs in the affected area are finding it necessary to continue to adjust the location of resident training both within the emergency area and in other States, as affected hospitals in the section 1135 emergency area continue to reopen beds at different rates, and as feedback from accreditation surveys warrant educational adjustments. Extending the effective period of emergency Medicare GME affiliation agreements for two more academic years (for a total effective period of up to 5 academic years) would allow these hospitals the time to stabilize their training programs. Furthermore, we considered the option of extending the effective period for emergency Medicare GME affiliations for two additional academic years without limiting the out of State emergency affiliations to apply to only the residents that were immediately displaced following the disaster. However, we ultimately specified that in the additional 2 years, only the residents that were immediately displaced following the disaster would be eligible to participate in out of State emergency affiliations while residents that entered the program after the disaster occurred would be limited to in State emergency affiliations. We believe that the policy established in this interim final rule with comment period extends additional flexibility while providing an incentive for home hospitals to bring displaced residents back to train in the State in which the home hospital is located, increasing the probability that the physicians would stay and practice locally after their training is completed. In addition, we believe that providing for flexibility in submitting written agreements after residents begin training in the nonhospital sites for hospitals participating in emergency Medicare GME affiliation agreements alleviates an additional deadline burden and allows appropriate GME payments to be made to those hospitals that are facing financial and programmatic hardships due to a disaster. We believe failure to apply the regulatory changes in this interim final rule with comment would be contrary to the public interest because hospitals affected by Hurricanes Katrina and Rita could otherwise face dramatic disruptions in their Medicare GME funding, with possible dire effects on their GME programs and financial stability.

8. Conclusion

For these reasons, we are not preparing analyses for either the RFA or section 1102(b) of the Act because we have determined that this interim final rule with comment period would not have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals.

9. Executive Order 12866

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

XXV. Waiver of Proposed Rulemaking, Waiver of Delay in Effective Date, and Retroactive Effective Date

A. Requirements for Waivers and Retroactive Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide for public comment before the provisions of a rule take effect in accordance with section 553(b) of the Administrative Procedure Act (APA). However, we can waive notice-and-comment procedures if the Secretary finds, for good cause, that the notice-and-comment process is impracticable,

unnecessary, or contrary to the public interest, and incorporates a statement of the finding and the reasons therefore in the rule. Section 553(d) of the APA also ordinarily requires a 30-day delay in effective date of final rules after the date of their publication. However, this 30-day delay in effective date can be waived if an agency finds for good cause that the delay is impracticable, unnecessary, or contrary to the public interest, and the agency incorporates a statement of the findings and its reasons in the rule issued. Moreover, section 1871(e)(1)(A) of the Act generally prohibits the Secretary from making retroactive substantive changes in policy unless retroactive application of the change is necessary to comply with statutory requirements or failure to apply the change retroactively would be contrary to the public interest.

B. IPPS Payment Rate Policies

We are waiving notice-and-comment procedures and the 30-day delay in effective date with respect to the revised payment factors, rates, and thresholds discussed in section XIX.B.1. of this final rule. In section XIX.B.1. of this final rule, we are revising certain payment factors, rates, and thresholds under the IPPS to reflect the changes to the documentation and coding adjustment mandated under section 7 of Public Law 110–90. The policies adopted in the FY 2008 IPPS final rule were subjected to notice-and-comment procedures. The payment factors, rates, and thresholds discussed in section XIX.B.1. of this final rule reflect the payment policies adopted in the FY 2008 IPPS final rule, but have been recalculated using the reduced coding and documentation adjustment to the standardized amounts. Therefore, we find that it would be unnecessary and contrary to the public interest to delay correction of payment factors and rates under the IPPS by undertaking further notice-and-comment procedures. For the same reasons, we are also waiving the 30-day delay in effective date with respect to the revised payment factors, rates, and thresholds discussed in section XIX.B.1. of this final rule. We believe that it is in the public interest to ensure that these revised payment factors, rates, and thresholds are effective as of the October 1, 2007 effective date of the FY 2008 IPPS final rule.

The revised payment factors, rates, and thresholds discussed in section XIX.B.1. of this final rule do not substantively change policies adopted in the FY 2008 IPPS final rule. Under section 7 of Public Law 110–90, we are required to reduce the documentation and coding adjustment that we adopted in the FY 2008 IPPS final rule and, as a result, the standardized amounts for FY 2008 will be higher. In section XIX.B.1. of this final rule, we merely are announcing new payment factors, rates, and thresholds that result from applying the statutorily mandated documentation and coding adjustment pf −0.6 percent to the payment policies we adopted in the FY 2008 IPPS final rule. Therefore, we do not believe these changes implicate section 1871(e)(1)(A) of the Act.

With respect to the application of the documentation and coding adjustment to hospital-specific rates discussed in section XIX.B.2. of this final rule, we are waiving notice-and-comment procedures, the 30-day delay in effective date, and making a retroactive substantive change to a policy adopted in the FY 2008 IPPS final rule. As discussed in section XIX.B.2. of this final rule, we believe that the policy we adopted in the FY 2008 IPPS final rule was not consistent with the plain meaning of section 1886(d)(3)(A)(vi) of the Act. Therefore, we are waiving notice-and-comment procedures with respect to this policy change because we believe it would be unnecessary and contrary to the public interest to undertake notice-and-comment procedures prior to changing our policy to make the policy consistent with the plain meaning of the statute. For the same reasons, we are waiving the 30-day delay in effective date because we believe it would be unnecessary and contrary to the public interest to delay the policy change beyond the October 1, 2007 effective date of the FY 2008 IPPS final rule. We are also applying this policy change retroactive to October 1, 2007 under section 1871(e)(1)(A)(i) of the Act because it would be contrary to the public interest for our policy not to be consistent with the plain meaning of the statute. Furthermore, because an adjustment to the hospital-specific rates to account for changes in documentation and coding is not authorized under section 1886(d)(3)(A)(vi) of the Act, retroactive application of this change is necessary to comply with the statute.

C. Medicare GME Affiliation Agreement Provisions

We find that failure to apply the provisions of this interim final rule with comment period retroactively to August 29, 2005, which is the first date on which there was an emergency area and emergency period under section 1135 of the Act resulting from the impact of Hurricane Katrina, would be contrary to the public interest. Due to the infrastructure damage and disruption of operations experienced by medical facilities, and the consequent and continuing disruption in residency training, caused by Hurricanes Katrina and Rita in August of 2005, there is an urgent need for the regulation changes provided in this interim final rule with comment period to be applied retroactively. The existing regulations specify that the effective period for emergency Medicare GME affiliation agreements must end no later than June 30, 2008, even though many hospitals within the section 1135 emergency area have not fully recovered from the disruption caused by Hurricanes Katrina and Rita. Hospitals have informed CMS that it is critical for the permissible effective period for emergency Medicare GME affiliation agreements to be extended because the current regulations do not adequately address the continuing issues relating to Medicare GME payment policy faced by both home and host hospitals. Specifically, where home or host hospitals with valid emergency Medicare GME affiliation agreements have been training displaced residents in non-hospital sites at any time since August 29, 2005, the provisions in this interim final rule with comment period allow these home or host hospitals to submit written agreements or incur all or substantially all of the costs of the program at the nonhospital site retroactive to that date in order to permit the home or host hospitals to count the FTE residents training in non-hospital sites for direct GME and IME payment purposes. We believe failure to apply the regulatory changes contained in this interim final rule with comment period retroactively would be contrary to the public interest because hospitals whose graduate medical education programs were affected by Hurricanes Katrina and Rita could otherwise face dramatic disruptions in their Medicare GME funding, with possible dire effects on the residency training programs and financial stability of the hospitals, and possible adverse consequences for the Medicare program in terms of access to hospital and physician health care resources.

Furthermore, the training programs at many teaching hospitals in New Orleans and surrounding areas were temporarily closed or significantly reduced in the aftermath of the hurricanes, and the displaced residents were transferred to other hospitals to continue their training programs in other parts of the country. While some residents have returned to the hurricane-affected hospitals, others remain displaced from their home

hospitals to hospitals located out-of-state. Immediate regulatory changes are required in order to maintain Medicare GME funding relating to displaced residents training at various hospitals outside of the emergency area, and at the same time, to encourage re-establishment of residency training within the hurricane-affected State, and to assist home hospitals to rebuild incrementally their GME programs. Existing regulations relating to closed hospitals and closed residency training programs, and relating to regular and emergency Medicare GME affiliation agreements, as well as to residency training that occurs in non-hospital settings, contain certain limitations that render them inapplicable or ineffective to address the issues faced by hospitals as a result of disruptions caused by Hurricanes Katrina and Rita.

We also ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substance of the proposed rule or a description of the subjects and issues involved. However, this procedure can be waived if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary or contrary to the public interest and incorporates a statement of the finding and supporting reasons in the rule issued. We find that good cause exists to waive the requirement for publication of a notice of proposed rulemaking and public comment prior to the effective date of this rule because such a procedure would be impracticable and contrary to the public interest. As explained above, in order to respond to the urgent needs of the hospitals and GME programs affected by Hurricanes Katrina and Rita, particularly in the provision regarding the retroactive submission of written agreements or payment of all or substantially all of the costs of the program at the non-hospital site to allow hospitals that have been training residents in non-hospital sites since the first day of the section 1135 emergency period relating to Hurricanes Katrina and Rita on August 29, 2005, it is necessary for the regulation to take effect retroactively to August 29, 2005. Furthermore, as hospitals engage in planning for the training of residents in programs for the upcoming academic year which begins on July 1, 2008, hospitals need adequate time to arrange emergency Medicare GME affiliation agreements with respect to remaining displaced residents training at host hospitals. The ordinary notice-and-comment procedures would serve to delay (or, in certain cases, preclude) hurricane-affected hospitals and GME programs from responding effectively to their circumstances by availing themselves of the flexibility permitted under this interim final rule with comment period.

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 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, 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 final rule with comment period, 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 410.27 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 paragraph (2) of the definition of ''designated health services'' and the definitions of ''outpatient prescription drugs'' and ''radiology and certain other imaging services'' to read as follows:

§ 411.351 Definitions.

* * * * *

Designated health services (DHS) means * * *

(2) Except as otherwise noted in this subpart, the term ''designated health services'' or DHS means only DHS payable, in whole or in part, by Medicare. DHS do not include services that are reimbursed by Medicare as part of a composite rate (for example, SNF Part A payments or ASC services identified at § 416.164(a)), except to the extent that services listed in paragraphs (1)(i) through (1)(x) of this definition are themselves payable through a composite rate (for example, all services provided as home health services or inpatient and outpatient hospital services are DHS).

* * * * *

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 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

■ 5. The authority citation for Part 413 is revised to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww); and sec. 124 of Public Law 106–133 (113 Stat. 1501A–332).

■ 6. Section 413.75(b) is amended by revising paragraph (2) under the definition of ''Emergency Medicare GME affiliated group'' to read as follows:

§ 413.75 Direct GME payments: General requirements.

* * * * *

(b) * * *

Emergency Medicare GME affiliated group * * *

(2) *Host hospital* means a hospital training residents displaced from a home hospital.

(a) *In-State host hospital* means a host hospital located in the same State as a home hospital.

(b) *Out-of-State host hospital* means a host hospital located in a different State from the home hospital.

* * * * *

■ 7. Section 413.78 is amended by—

■ a. Removing the semicolon and the word ''or'' at the end of paragraph (e)(3)(i) and replacing them with a period.

■ b. Adding a new paragraph (e)(3)(iii).

■ c. Removing the semicolon and the word ''or'' at the end of paragraph (f)(3)(i) and replacing them with a period.

■ d. Adding a new paragraph (f)(3)(iii).

The additions read as follows:

§ 413.78 Direct GME payments: Determination of the total number of FTE residents.

* * * * *

(e) * * *

(3) * * *

(iii) If the hospital has in place an emergency Medicare GME affiliation agreement in accordance with § 413.79(f)(6), during the period covered by the emergency Medicare GME affiliation agreement—

(A) The hospital must pay all or substantially all of the costs of the training program in a nonhospital setting(s) attributable to training that occurs during a month by the end of the sixth month following the month in which the training in the nonhospital site occurred. For the costs that would otherwise be required to be paid by the hospital during the period of August 29, 2005 through November 1, 2007, the participating hospital must pay the costs by April 29, 2008; or

(B) There is a written agreement that specifies that the hospital is incurring the cost of the resident's salary and fringe benefits while the resident is training in the nonhospital site and the hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities. The agreement must indicate the compensation the hospital is providing to the nonhospital site for supervisory teaching activities. The written agreement must be submitted to the contractor by 180 days after the training at the nonhospital site begins. For written agreements that would otherwise be required to be submitted prior to the date the resident(s) begin training at the nonhospital site during the period of August 29, 2005 through November 1, 2007, the written agreement must be submitted to the CMS contractor by April 29, 2008.

* * * * *

(f) * * *

(3) * * *

(iii) If the hospital has in place an emergency Medicare GME affiliation agreement in accordance with § 413.79(f)(6), during the period covered by the emergency Medicare GME affiliation agreement—

(A) The hospital must pay all or substantially all of the costs of the training program in a nonhospital setting(s) attributable to training that occurs during a month by the end of the sixth month after the month in which the training in the nonhospital site occurs. For the costs that would otherwise be required to be incurred by the hospital during the period of August 29, 2005 through November 1, 2007, the participating hospital must incur the costs by April 29, 2008; or

(B) There is a written agreement that specifies that the hospital will incur at least 90 percent of the total of the costs of the resident's salary and fringe benefits (and travel and lodging where applicable) while the resident is training in the nonhospital site and the portion of the cost of the teaching physician's salary attributable to nonpatient care direct GME activities. The written agreement must specify the total cost of the training program at the nonhospital site, and the amount the hospital will incur (at least 90 percent of the total), and must indicate the portion of the amount the hospital will incur that reflects residents' salaries and fringe benefits (and travel and lodging where applicable), and the portion of this amount that reflects teaching physician compensation. The written agreement must be submitted to the contractor by 180 days after the training at the nonhospital site begins. Hospitals may modify the amounts specified in the

written agreement by the end of the academic year (that is, June 30) to reflect that at least 90 percent of the costs of the training program in the nonhospital site has been incurred. For written agreements that would otherwise be required to be submitted prior to the date the training begins in the nonhospital site during the period of August 29, 2005 through November 1, 2007, the hospital must submit the written agreement to its contractor by April 29, 2008.

* * * * *

■ 8. Section 413.79 is amended by—
■ a. Revising the introductory text of paragraph (f)(6).
■ b. Revising paragraph (f)(6)(i)(D).
■ c. Revising paragraph (f)(6)(ii)(A)(2).

The revisions read as follows:

§ 413.79 Direct GME payments: Determination of the weighted number of FTE residents.

* * * * *

(f) * * *

(6) *Emergency Medicare GME affiliated group.* Effective on or after August 29, 2005, home and host hospitals as defined in § 413.75(b) may form an emergency Medicare GME affiliated group by meeting the requirements provided in this section. The emergency Medicare GME affiliation agreements may be made effective beginning on or after the first day of a section 1135 emergency period, and must terminate no later than at the conclusion of 4 academic years following the academic year during which the section 1135 emergency period began.

* * * * *

(i) * * *

(D) Specify the total adjustment to each participating hospital's FTE caps in each academic year that the emergency Medicare GME affiliation agreement is in effect, for both direct GME and IME, that reflects a positive adjustment to the host hospital's direct and indirect FTE caps that is offset by a negative adjustment to the home hospital's (or hospitals') direct and indirect FTE caps of at least the same amount subject to the following—

(*1*) The sum total of adjustments to all the participating hospitals' FTE caps under the emergency Medicare GME affiliation agreement may not exceed the aggregate adjusted FTE caps of the hospitals participating in the emergency Medicare GME affiliated group.

(*2*) A home hospital's IME and direct GME FTE cap reductions in an emergency Medicare GME affiliation agreement are limited to the home hospital's IME and direct GME FTE resident caps at § 413.79(c) or § 413.79(f)(1) through (f)(5), that is, as adjusted by any and all existing affiliation agreements as applicable.

(*3*) For emergency Medicare GME affiliation agreements for the third or fourth academic years subsequent to the year in which the section 1135 emergency period began and involving an out-of-State host hospital, the positive adjustment to the out-of-State host hospital's direct and indirect FTE caps pursuant to the agreement shall reflect only FTE residents that were actually displaced from a home hospital immediately following the emergency.

* * * * *

(ii) * * *

(A) * * *

(*2*) *Four subsequent academic years.* The later of 180 days after the section 1135 emergency period begins, or by July 1 of each academic year for 4 subsequent years.

* * * * *

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

■ 9. 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)).

■ 10. 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

■ 11. 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).

■ 12. Section 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. Revising paragraph (b).

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 50 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

■ 13. 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).

■ 14. 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.

* * * * *

■ 15. 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.

■ 16. 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 50 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]

■ 17. 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

■ 18. 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).

■ 19. 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]

■ 20. 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.

■ 21. 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.

* * * * *

■ 22. 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.

* * * * *

■ 23. 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, no later than 48 hours after surgery or a procedure requiring anesthesia services. The postanesthesia evaluation for anesthesia recovery must be completed in accordance with State law and with hospital policies and procedures that have been approved by the medical staff and that reflect current standards of anesthesia care.

* * * * *

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

■ 24. 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).

■ 25. 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 an off-campus provider-based location, excluding an RHC as defined in § 405.2401(b) of this chapter, but 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 on or after January 1, 2008, the CAH can continue to meet the location requirement of paragraph (c) of this section only if the off-campus 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 on or after January 1, 2008, or creates or acquires an off-campus provider-based location or off-campus distinct part unit on or 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) of this subchapter, unless the CAH terminates the off-campus arrangement or the co-location arrangement, or both.

Authority: (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: October 25, 2007.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: October 30, 2007.

Michael O. Leavitt,

Secretary.

ADDENDUM A.—OPPS APCS FOR CY 2008

APC	Group title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0001	Level I Photochemotherapy	S	0.4806	$30.61	$7.00	$6.12
0002	Level I Fine Needle Biopsy/Aspiration	T	1.1097	$70.68		$14.14
0003	Bone Marrow Biopsy/Aspiration	T	3.1008	$197.50		$39.50
0004	Level I Needle Biopsy/ Aspiration Except Bone Marrow	T	4.3270	$275.60		$55.12
0005	Level II Needle Biopsy/Aspiration Except Bone Marrow	T	7.1147	$453.16		$90.63
0006	Level I Incision & Drainage	T	1.4066	$89.59		$17.92
0007	Level II Incision & Drainage	T	11.5594	$736.26		$147.25
0008	Level III Incision and Drainage	T	18.3197	$1,166.85		$233.37
0012	Level I Debridement & Destruction	T	0.2963	$18.87		$3.77
0013	Level II Debridement & Destruction	T	0.7930	$50.51		$10.10
0015	Level III Debridement & Destruction	T	1.4595	$92.96		$18.59
0016	Level IV Debridement & Destruction	T	2.6604	$169.45		$33.89
0017	Level VI Debridement & Destruction	T	19.9041	$1,267.77		$253.55
0019	Level I Excision/ Biopsy	T	4.3039	$274.13	$71.87	$54.83
0020	Level II Excision/ Biopsy	T	8.6850	$553.18		$110.64
0021	Level III Excision/ Biopsy	T	16.1001	$1,025.48	$219.48	$205.10
0022	Level IV Excision/ Biopsy	T	21.1098	$1,344.57	$354.45	$268.91

ADDENDUM A.—OPPS APCS FOR CY 2008—Continued

APC	Group title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0023	Exploration Penetrating Wound	T	9.6341	$613.63		$122.73
0028	Level I Breast Surgery	T	20.6417	$1,314.75	$303.74	$262.95
0029	Level II Breast Surgery	T	31.7134	$2,019.95	$581.52	$403.99
0030	Level III Breast Surgery	T	39.8191	$2,536.24	$747.07	$507.25
0031	Smoking Cessation Services	X	0.1648	$10.50		$2.10
0033	Partial Hospitalization	P	3.2211	$205.16		$41.03
0034	Mental Health Services Composite	P	3.2211	$205.16		$41.03
0035	Arterial/Venous Puncture	T	0.2143	$13.65		$2.73
0037	Level IV Needle Biopsy/Aspiration Except Bone Marrow	T	13.5764	$864.74	$228.76	$172.95
0039	Level I Implantation of Neurostimulator	S	186.4739	$11,877.27		$2,375.45
0040	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	S	63.7866	$4,062.82		$812.56
0041	Level I Arthroscopy	T	28.7803	$1,833.13		$366.63
0042	Level II Arthroscopy	T	45.7072	$2,911.27	$804.74	$582.25
0043	Closed Treatment Fracture Finger/Toe/Trunk	T	1.7682	$112.62		$22.52
0045	Bone/Joint Manipulation Under Anesthesia	T	14.7658	$940.49	$268.47	$188.10
0047	Arthroplasty without Prosthesis	T	35.9040	$2,286.87	$537.03	$457.37
0048	Level I Arthroplasty with Prosthesis	T	50.8876	$3,241.23		$648.25
0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	21.2689	$1,354.70		$270.94
0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	29.1900	$1,859.23		$371.85
0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	42.9850	$2,737.89		$547.58
0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	79.4244	$5,058.86		$1,011.77
0053	Level I Hand Musculoskeletal Procedures	T	16.4637	$1,048.64	$253.49	$209.73
0054	Level II Hand Musculoskeletal Procedures	T	26.3105	$1,675.82		$335.16
0055	Level I Foot Musculoskeletal Procedures	T	20.8284	$1,326.64	$355.34	$265.33
0056	Level II Foot Musculoskeletal Procedures	T	44.2687	$2,819.65		$563.93
0057	Bunion Procedures	T	29.4167	$1,873.67	$475.91	$374.73
0058	Level I Strapping and Cast Application	S	1.0931	$69.62		$13.92
0060	Manipulation Therapy	S	0.4482	$28.55		$5.71
0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	S	82.8597	$5,277.67		$1,055.53
0062	Level I Treatment Fracture/Dislocation	T	26.1592	$1,666.18	$372.87	$333.24
0063	Level II Treatment Fracture/Dislocation	T	41.1091	$2,618.40	$548.33	$523.68
0064	Level III Treatment Fracture/Dislocation	T	59.2233	$3,772.17	$835.79	$754.43
0065	Level I Stereotactic Radiosurgery, MRgFUS, and MEG	S	16.5911	$1,056.75		$211.35
0066	Level II Stereotactic Radiosurgery, MRgFUS, and MEG	S	45.0693	$2,870.64		$574.13
0067	Level III Stereotactic Radiosurgery, MRgFUS, and MEG	S	61.6965	$3,929.70		$785.94
0069	Thoracoscopy	T	32.5666	$2,074.30	$591.64	$414.86
0070	Thoracentesis/Lavage Procedures	T	5.2024	$331.36		$66.27
0071	Level I Endoscopy Upper Airway	T	0.8224	$52.38	$11.20	$10.48
0072	Level II Endoscopy Upper Airway	T	1.6115	$102.64	$21.27	$20.53
0073	Level III Endoscopy Upper Airway	T	3.9940	$254.39	$69.15	$50.88
0074	Level IV Endoscopy Upper Airway	T	17.0160	$1,083.82	$292.25	$216.76
0075	Level V Endoscopy Upper Airway	T	22.7191	$1,447.07	$445.92	$289.41
0076	Level I Endoscopy Lower Airway	T	9.9575	$634.23	$189.82	$126.85
0077	Level I Pulmonary Treatment	S	0.3877	$24.69	$7.74	$4.94
0078	Level II Pulmonary Treatment	S	1.3362	$85.11		$17.02
0079	Ventilation Initiation and Management	S	2.4783	$157.85		$31.57
0080	Diagnostic Cardiac Catheterization	T	38.9204	$2,479.00	$838.92	$495.80
0082	Coronary or Non-Coronary Atherectomy	T	87.5137	$5,574.10		$1,114.82
0083	Coronary or Non-Coronary Angioplasty and Percutaneous Valvuloplasty	T	45.3845	$2,890.72		$578.14
0084	Level I Electrophysiologic Procedures	S	9.5834	$610.41		$122.08
0085	Level II Electrophysiologic Procedures	T	47.2949	$3,012.40		$602.48
0086	Level III Electrophysiologic Procedures	T	92.8564	$5,914.40		$1,182.88
0088	Thrombectomy	T	38.7673	$2,469.24	$655.22	$493.85
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	T	121.6508	$7,748.43	$1,682.28	$1,549.69
0090	Insertion/Replacement of Pacemaker Pulse Generator	T	100.8341	$6,422.53	$1,612.80	$1,284.51
0091	Level II Vascular Ligation	T	42.6114	$2,714.09		$542.82
0092	Level I Vascular Ligation	T	25.8410	$1,645.92		$329.18
0093	Vascular Reconstruction/Fistula Repair without Device	T	30.1294	$1,919.06		$383.81
0094	Level I Resuscitation and Cardioversion	S	2.4590	$156.62	$46.29	$31.32
0095	Cardiac Rehabilitation	S	0.5685	$36.21	$13.86	$7.24
0096	Non-Invasive Vascular Studies	S	1.4689	$93.56	$37.42	$18.71
0097	Cardiac and Ambulatory Blood Pressure Monitoring	X	1.0015	$63.79	$23.79	$12.76
0099	Electrocardiograms	S	0.3892	$24.79		$4.96
0100	Cardiac Stress Tests	X	2.5547	$162.72	$41.44	$32.54
0101	Tilt Table Evaluation	S	4.1973	$267.34	$100.24	$53.47
0103	Miscellaneous Vascular Procedures	T	14.6576	$933.60		$186.72
0104	Transcatheter Placement of Intracoronary Stents	T	89.0159	$5,669.78		$1,133.96
0105	Repair/Revision/Removal of Pacemakers, AICDs, or Vascular Devices	T	23.9802	$1,527.39		$305.48
0106	Insertion/Replacement of Pacemaker Leads and/or Electrodes	T	69.5217	$4,428.12		$885.62
0107	Insertion of Cardioverter-Defibrillator	T	333.8096	$21,261.67		$4,252.33
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	T	404.8543	$25,786.79		$5,157.36
0109	Removal/Repair of Implanted Devices	T	5.6614	$360.60		$72.12
0110	Transfusion	S	3.3967	$216.35		$43.27
0111	Blood Product Exchange	S	11.5058	$732.85	$198.40	$146.57
0112	Apheresis and Stem Cell Procedures	S	30.6035	$1,949.26	$433.29	$389.85
0113	Excision Lymphatic System	T	22.9584	$1,462.31		$292.46
0114	Thyroid/Lymphadenectomy Procedures	T	44.3240	$2,823.17		$564.63
0115	Cannula/Access Device Procedures	T	29.6965	$1,891.49		$378.30

ADDENDUM A.—OPPS APCS FOR CY 2008—Continued

APC	Group title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0121	Level I Tube changes and Repositioning	T	3.2383	$206.26	$43.80	$41.25
0125	Refilling of Infusion Pump	T	2.3544	$149.96		$29.99
0126	Level I Urinary and Anal Procedures	T	1.0356	$65.96	$16.21	$13.19
0127	Level IV Stereotactic Radiosurgery, MRgFUS, and MEG	S	126.4653	$8,055.08		$1,611.02
0128	Echocardiogram with Contrast	S	8.4896	$540.74	$216.29	$108.15
0130	Level I Laparoscopy	T	34.3958	$2,190.81	$659.53	$438.16
0131	Level II Laparoscopy	T	45.5317	$2,900.10	$1,001.89	$580.02
0132	Level III Laparoscopy	T	69.6652	$4,437.26	$1,239.22	$887.45
0133	Level I Skin Repair	T	1.2792	$81.48	$25.67	$16.30
0134	Level II Skin Repair	T	2.1051	$134.08	$42.24	$26.82
0135	Level III Skin Repair	T	4.5263	$288.30		$57.66
0136	Level IV Skin Repair	T	15.0458	$958.33		$191.67
0137	Level V Skin Repair	T	20.2069	$1,287.06		$257.41
0140	Esophageal Dilation without Endoscopy	T	5.8431	$372.17	$91.40	$74.43
0141	Level I Upper GI Procedures	T	8.5030	$541.59	$143.38	$108.32
0142	Small Intestine Endoscopy	T	9.5292	$606.95	$152.78	$121.39
0143	Lower GI Endoscopy	T	8.8486	$563.60	$186.06	$112.72
0146	Level I Sigmoidoscopy and Anoscopy	T	5.0972	$324.66		$64.93
0147	Level II Sigmoidoscopy and Anoscopy	T	8.7031	$554.34		$110.87
0148	Level I Anal/Rectal Procedures	T	4.7935	$305.32		$61.06
0149	Level III Anal/Rectal Procedures	T	22.7451	$1,448.73	$293.06	$289.75
0150	Level IV Anal/Rectal Procedures	T	30.1606	$1,921.05	$437.12	$384.21
0151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP)	T	20.9510	$1,334.45		$266.89
0152	Level I Percutaneous Abdominal and Biliary Procedures	T	28.6884	$1,827.28		$365.46
0153	Peritoneal and Abdominal Procedures	T	25.6947	$1,636.60	$397.95	$327.32
0154	Hernia/Hydrocele Procedures	T	30.6788	$1,954.06	$464.85	$390.81
0155	Level II Anal/Rectal Procedures	T	10.9132	$695.11		$139.02
0156	Level III Urinary and Anal Procedures	T	3.0469	$194.07		$38.81
0157	Colorectal Cancer Screening: Barium Enema	S	2.0651	$131.53		$26.31
0158	Colorectal Cancer Screening: Colonoscopy	T	7.8504	$500.02		$125.01
0159	Colorectal Cancer Screening: Flexible Sigmoidoscopy	S	4.7010	$299.43		$74.86
0160	Level I Cystourethroscopy and other Genitourinary Procedures	T	5.9735	$380.48		$76.10
0161	Level II Cystourethroscopy and other Genitourinary Procedures	T	17.9420	$1,142.80	$241.15	$228.56
0162	Level III Cystourethroscopy and other Genitourinary Procedures	T	24.7749	$1,578.01		$315.60
0163	Level IV Cystourethroscopy and other Genitourinary Procedures	T	36.0774	$2,297.91		$459.58
0164	Level II Urinary and Anal Procedures	T	2.0077	$127.88		$25.58
0165	Level IV Urinary and Anal Procedures	T	19.3414	$1,231.93		$246.39
0166	Level I Urethral Procedures	T	19.1505	$1,219.77		$243.95
0168	Level II Urethral Procedures	T	29.7864	$1,897.21	$388.16	$379.44
0169	Lithotripsy	T	41.5299	$2,645.21	$997.74	$529.04
0170	Dialysis	S	6.5383	$416.45		$83.29
0181	Level II Male Genital Procedures	T	33.9306	$2,161.18	$621.82	$432.24
0183	Level I Male Genital Procedures	T	22.3251	$1,421.97		$284.39
0184	Prostate Biopsy	T	11.0338	$702.79		$140.56
0188	Level II Female Reproductive Proc	T	1.3520	$86.11		$17.22
0189	Level III Female Reproductive Proc	T	2.7584	$175.69		$35.14
0190	Level I Hysteroscopy	T	21.6576	$1,379.46	$424.28	$275.89
0191	Level I Female Reproductive Proc	T	0.1309	$8.34	$2.36	$1.67
0192	Level IV Female Reproductive Proc	T	6.0783	$387.15		$77.43
0193	Level V Female Reproductive Proc	T	19.0203	$1,211.48		$242.30
0195	Level VI Female Reproductive Procedures	T	32.4237	$2,065.20	$483.80	$413.04
0202	Level VII Female Reproductive Procedures	T	42.7099	$2,720.36	$981.50	$544.07
0203	Level IV Nerve Injections	T	14.4879	$922.79	$240.33	$184.56
0204	Level I Nerve Injections	T	2.3213	$147.85	$40.13	$29.57
0206	Level II Nerve Injections	T	4.0964	$260.92	$56.01	$52.18
0207	Level III Nerve Injections	T	7.0546	$449.34		$89.87
0208	Laminotomies and Laminectomies	T	46.7724	$2,979.12		$595.82
0209	Level II Extended EEG and Sleep Studies	S	11.2822	$718.61	$268.73	$143.72
0212	Nervous System Injections	T	8.5263	$543.07		$108.61
0213	Level I Extended EEG and Sleep Studies	S	2.2980	$146.37	$53.58	$29.27
0215	Level I Nerve and Muscle Tests	S	0.5804	$36.97		$7.39
0216	Level III Nerve and Muscle Tests	S	2.6846	$170.99		$34.20
0218	Level II Nerve and Muscle Tests	S	1.1550	$73.57		$14.71
0220	Level I Nerve Procedures	T	18.0518	$1,149.79		$229.96
0221	Level II Nerve Procedures	T	33.2707	$2,119.14	$463.62	$423.83
0222	Level II Implantation of Neurostimulator	S	240.7990	$15,337.45		$3,067.49
0224	Implantation of Catheter/Reservoir/Shunt	T	36.2768	$2,310.61		$462.12
0225	Implantation of Neurostimulator Electrodes, Cranial Nerve	S	220.7642	$14,061.35		$2,812.27
0227	Implantation of Drug Infusion Device	T	183.8928	$11,712.87		$2,342.57
0229	Transcatherter Placement of Intravascular Shunts	T	88.5367	$5,639.26		$1,127.85
0230	Level I Eye Tests & Treatments	S	0.5903	$37.60		$7.52
0231	Level III Eye Tests & Treatments	S	2.1790	$138.79		$27.76
0232	Level I Anterior Segment Eye Procedures	T	5.1169	$325.92	$81.65	$65.18
0233	Level II Anterior Segment Eye Procedures	T	16.1710	$1,030.00	$266.33	$206.00
0234	Level III Anterior Segment Eye Procedures	T	23.1758	$1,476.16	$511.31	$295.23
0235	Level I Posterior Segment Eye Procedures	T	4.1331	$263.25	$58.93	$52.65
0236	Level II Posterior Segment Eye Procedures	T	18.2350	$1,161.46		$232.29
0237	Level III Posterior Segment Eye Procedures	T	27.8450	$1,773.56		$354.71
0238	Level I Repair and Plastic Eye Procedures	T	2.9022	$184.85		$36.97
0239	Level II Repair and Plastic Eye Procedures	T	7.2847	$463.99		$92.80

ADDENDUM A.—OPPS APCS FOR CY 2008—Continued

APC	Group title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0240	Level III Repair and Plastic Eye Procedures	T	18.7307	$1,193.03	$309.52	$238.61
0241	Level IV Repair and Plastic Eye Procedures	T	24.3077	$1,548.25	$383.45	$309.65
0242	Level V Repair and Plastic Eye Procedures	T	37.7243	$2,402.81	$597.36	$480.56
0243	Strabismus/Muscle Procedures	T	24.1291	$1,536.88	$430.35	$307.38
0244	Corneal and Amniotic Membrane Transplant	T	37.4896	$2,387.86	$803.26	$477.57
0245	Level I Cataract Procedures without IOL Insert	T	14.9171	$950.13	$217.05	$190.03
0246	Cataract Procedures with IOL Insert	T	23.8649	$1,520.05	$495.96	$304.01
0247	Laser Eye Procedures	T	5.2001	$331.22	$104.31	$66.24
0249	Level II Cataract Procedures without IOL Insert	T	28.7035	$1,828.24	$524.67	$365.65
0250	Nasal Cauterization/Packing	T	1.1251	$71.66	$25.10	$14.33
0251	Level I ENT Procedures	T	2.5002	$159.25		$31.85
0252	Level II ENT Procedures	T	7.4474	$474.35	$109.16	$94.87
0253	Level III ENT Procedures	T	16.3288	$1,040.05	$282.29	$208.01
0254	Level IV ENT Procedures	T	23.9765	$1,527.16	$321.35	$305.43
0256	Level V ENT Procedures	T	39.8776	$2,539.96		$507.99
0258	Tonsil and Adenoid Procedures	T	22.2557	$1,417.55	$437.25	$283.51
0259	Level VI ENT Procedures	T	393.2242	$25,046.02	$8,543.66	$5,009.20
0260	Level I Plain Film Except Teeth	X	0.6954	$44.29		$8.86
0261	Level II Plain Film Except Teeth Including Bone Density Measurement	X	1.1570	$73.69		$14.74
0262	Plain Film of Teeth	X	0.5749	$36.62		$7.32
0263	Level I Miscellaneous Radiology Procedures	X	2.6838	$170.94		$34.19
0265	Level I Diagnostic and Screening Ultrasound	S	0.9570	$60.96	$22.35	$12.19
0266	Level II Diagnostic and Screening Ultrasound	S	1.5094	$96.14	$37.80	$19.23
0267	Level III Diagnostic and Screening Ultrasound	S	2.3792	$151.54	$60.50	$30.31
0269	Level II Echocardiogram Without Contrast Except Transesophageal	S	6.3751	$406.06		$81.21
0270	Transesophageal Echocardiogram Without Contrast	S	8.2165	$523.34	$141.32	$104.67
0272	Fluoroscopy	X	1.3271	$84.53	$31.64	$16.91
0274	Myelography	S	7.5589	$481.46		$96.29
0275	Arthrography	S	4.0031	$254.97	$69.09	$50.99
0276	Level I Digestive Radiology	S	1.3834	$88.11	$34.97	$17.62
0277	Level II Digestive Radiology	S	2.2222	$141.54	$54.52	$28.31
0278	Diagnostic Urography	S	2.6121	$166.38	$59.40	$33.28
0279	Level II Angiography and Venography	S	28.8788	$1,839.41		$367.88
0280	Level III Angiography and Venography	S	44.7114	$2,847.85		$569.57
0282	Miscellaneous Computed Axial Tomography	S	1.5839	$100.88	$37.81	$20.18
0283	Computed Tomography with Contrast	S	4.3564	$277.48	$100.37	$55.50
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast.	S	6.2350	$397.13	$148.40	$79.43
0288	Bone Density:Axial Skeleton	S	1.1384	$72.51	$28.90	$14.50
0293	Level V Anterior Segment Eye Procedures	T	84.8039	$5,401.50	$1,128.29	$1,080.30
0299	Hyperthermia and Radiation Treatment Procedures	S	5.7996	$369.40		$73.88
0300	Level I Radiation Therapy	S	1.4229	$90.63		$18.13
0301	Level II Radiation Therapy	S	2.2167	$141.19		$28.24
0303	Treatment Device Construction	X	2.8878	$183.94	$66.95	$36.79
0304	Level I Therapeutic Radiation Treatment Preparation	X	1.5576	$99.21	$38.68	$19.84
0305	Level II Therapeutic Radiation Treatment Preparation	X	3.9276	$250.16	$91.38	$50.03
0307	Myocardial Positron Emission Tomography (PET) imaging	S	21.9955	$1,400.98	$292.49	$280.20
0308	Non-Myocardial Positron Emission Tomography (PET) imaging	S	16.6001	$1,057.33		$211.47
0310	Level III Therapeutic Radiation Treatment Preparation	X	13.5621	$863.82	$325.27	$172.76
0312	Radioelement Applications	S	8.5140	$542.29		$108.46
0313	Brachytherapy	S	11.6779	$743.81		$148.76
0315	Level III Implantation of Neurostimulator	S	270.0190	$17,198.59		$3,439.72
0317	Level II Miscellaneous Radiology Procedures	X	5.3623	$341.55	$77.89	$68.31
0320	Electroconvulsive Therapy	S	5.7299	$364.96	$80.06	$72.99
0322	Brief Individual Psychotherapy	S	1.1729	$74.71		$14.94
0323	Extended Individual Psychotherapy	S	1.6044	$102.19		$20.44
0324	Family Psychotherapy	S	2.3616	$150.42		$30.08
0325	Group Psychotherapy	S	0.9913	$63.14	$13.81	$12.63
0330	Dental Procedures	S	9.1677	$583.93		$116.79
0332	Computed Tomography without Contrast	S	3.0109	$191.78	$75.24	$38.36
0333	Computed Tomography without Contrast followed by Contrast)	S	5.1125	$325.64	$119.01	$65.13
0335	Magnetic Resonance Imaging, Miscellaneous	S	4.8830	$311.02	$111.92	$62.20
0336	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast.	S	5.3933	$343.52	$137.40	$68.70
0337	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast followed by Contrast.	S	8.2463	$525.24	$199.53	$105.05
0340	Minor Ancillary Procedures	X	0.6310	$40.19		$8.04
0341	Skin Tests	X	0.0844	$5.38	$2.14	$1.08
0342	Level I Pathology	X	0.0969	$6.17	$2.02	$1.23
0343	Level III Pathology	X	0.5142	$32.75	$10.84	$6.55
0344	Level IV Pathology	X	0.8167	$52.02	$15.66	$10.40
0345	Level I Transfusion Laboratory Procedures	X	0.2140	$13.63	$2.87	$2.73
0346	Level II Transfusion Laboratory Procedures	X	0.3346	$21.31	$4.37	$4.26
0347	Level III Transfusion Laboratory Procedures	X	0.7739	$49.29	$11.28	$9.86
0350	Administration of flu and PPV vaccine	S	0.3945	$25.13		$0.00
0360	Level I Alimentary Tests	X	1.5330	$97.64	$33.88	$19.53
0361	Level II Alimentary Tests	X	3.9276	$250.16	$83.23	$50.03
0363	Level I Otorhinolaryngologic Function Tests	X	0.8067	$51.38	$17.10	$10.28
0364	Level I Audiometry	X	0.4490	$28.60	$7.06	$5.72
0365	Level II Audiometry	X	1.2549	$79.93	$18.52	$15.99

ADDENDUM A.—OPPS APCS FOR CY 2008—Continued

APC	Group title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0366	Level III Audiometry	X	1.7624	$112.25	$25.79	$22.45
0367	Level I Pulmonary Test	X	0.5677	$36.16	$13.76	$7.23
0368	Level II Pulmonary Tests	X	0.9253	$58.94	$22.77	$11.79
0369	Level III Pulmonary Tests	X	2.7550	$175.48	$44.18	$35.10
0370	Allergy Tests	X	1.0430	$66.43		$13.29
0373	Level I Neuropsychological Testing	X	1.2448	$79.29		$15.86
0375	Ancillary Outpatient Services When Patient Expires	S	78.5966	$5,006.13		$1,001.23
0377	Level II Cardiac Imaging	S	11.8512	$754.85	$158.84	$150.97
0378	Level II Pulmonary Imaging	S	4.9509	$315.34	$125.33	$63.07
0379	Injection adenosine 6 MG	K		$25.10		$5.02
0381	Single Allergy Tests	X	0.2773	$17.66		$3.53
0382	Level II Neuropsychological Testing	X	2.6169	$166.68		$33.34
0383	Cardiac Computed Tomographic Imaging	S	4.7005	$299.39	$117.06	$59.88
0384	GI Procedures with Stents	T	24.9814	$1,591.17		$318.23
0385	Level I Prosthetic Urological Procedures	S	83.6366	$5,327.15		$1,065.43
0386	Level II Prosthetic Urological Procedures	S	144.1246	$9,179.87		$1,835.97
0387	Level II Hysteroscopy	T	34.2048	$2,178.64	$655.55	$435.73
0388	Discography	S	20.1823	$1,285.49	$289.72	$257.10
0389	Level I Non-imaging Nuclear Medicine	S	1.8190	$115.86	$33.81	$23.17
0390	Level I Endocrine Imaging	S	2.0471	$130.39	$52.15	$26.08
0391	Level II Endocrine Imaging	S	3.4513	$219.83	$66.18	$43.97
0392	Level II Non-imaging Nuclear Medicine	S	2.9022	$184.85	$49.31	$36.97
0393	Hematologic Processing & Studies	S	5.6921	$362.55	$82.04	$72.51
0394	Hepatobiliary Imaging	S	4.4603	$284.09	$102.61	$56.82
0395	GI Tract Imaging	S	3.7911	$241.47	$89.73	$48.29
0396	Bone Imaging	S	3.8039	$242.29	$95.02	$48.46
0397	Vascular Imaging	S	3.1433	$200.21	$49.58	$40.04
0398	Level I Cardiac Imaging	S	4.8620	$309.68	$100.06	$61.94
0400	Hematopoietic Imaging	S	3.9293	$250.27	$93.22	$50.05
0401	Level I Pulmonary Imaging	S	3.3954	$216.27	$78.19	$43.25
0402	Level II Nervous System Imaging	S	8.8235	$562.00	$114.12	$112.40
0403	Level I Nervous System Imaging	S	3.2295	$205.70	$79.87	$41.14
0404	Renal and Genitourinary Studies	S	5.0824	$323.72	$84.11	$64.74
0406	Level I Tumor/Infection Imaging	S	5.0681	$322.81	$98.18	$64.56
0407	Level I Radionuclide Therapy	S	3.3020	$210.32	$78.13	$42.06
0408	Level III Tumor/Infection Imaging	S	15.4033	$981.10		$196.22
0409	Red Blood Cell Tests	X	0.1190	$7.58	$2.20	$1.52
0412	IMRT Treatment Delivery	S	5.4582	$347.65		$69.53
0413	Level II Radionuclide Therapy	S	5.2741	$335.93		$67.19
0414	Level II Tumor/Infection Imaging	S	8.4176	$536.15	$214.44	$107.23
0415	Level II Endoscopy Lower Airway	T	24.0654	$1,532.82	$459.92	$306.56
0418	Insertion of Left Ventricular Pacing Elect	T	259.7486	$16,544.43	.	$3,308.89
0422	Level II Upper GI Procedures	T	25.3233	$1,612.94	$448.81	$322.59
0423	Level II Percutaneous Abdominal and Biliary Procedures	T	42.9980	$2,738.71		$547.74
0425	Level II Arthroplasty with Prosthesis	T	122.2057	$7,783.77		$1,556.75
0426	Level II Strapping and Cast Application	S	2.2910	$145.92		$29.18
0427	Level II Tube Changes and Repositioning	T	15.3545	$977.99		$195.60
0428	Level III Sigmoidoscopy and Anoscopy	T	21.4632	$1,367.08		$273.42
0429	Level V Cystourethroscopy and other Genitourinary Procedures	T	45.2042	$2,879.24		$575.85
0430	Drug Preadministration-Related Services	S	0.5921	$37.71		$7.54
0432	Health and Behavior Services	S	0.3128	$19.92		$3.98
0433	Level II Pathology	X	0.2397	$15.27	$5.17	$3.05
0434	Cardiac Defect Repair	T	132.4129	$8,433.91		$1,686.78
0436	Level I Drug Administration	S	0.2545	$16.21		$3.24
0437	Level II Drug Administration	S	0.3945	$25.13		$5.03
0438	Level III Drug Administration	S	0.8041	$51.22		$10.24
0439	Level IV Drug Administration	S	1.6544	$105.38		$21.08
0440	Level V Drug Administration	S	1.7998	$114.64		$22.93
0441	Level VI Drug Administration	S	2.3446	$149.34		$29.87
0442	Dosimetric Drug Administration	S	27.4298	$1,747.11		$349.42
0604	Level 1 Hospital Clinic Visits	V	0.8388	$53.43		$10.69
0605	Level 2 Hospital Clinic Visits	V	0.9964	$63.46		$12.69
0606	Level 3 Hospital Clinic Visits	V	1.3226	$84.24		$16.85
0607	Level 4 Hospital Clinic Visits	V	1.6604	$105.76		$21.15
0608	Level 5 Hospital Clinic Visits	V	2.1740	$138.47		$27.69
0609	Level 1 Emergency Visits	V	0.7970	$50.76	$12.70	$10.15
0613	Level 2 Emergency Visits	V	1.3137	$83.67	$21.06	$16.73
0614	Level 3 Emergency Visits	V	2.0750	$132.17	$34.50	$26.43
0615	Level 4 Emergency Visits	V	3.3377	$212.59	$48.49	$42.52
0616	Level 5 Emergency Visits	V	4.9535	$315.51	$72.86	$63.10
0617	Critical Care	S	7.3166	$466.02	$111.59	$93.20
0618	Trauma Response with Critical Care	S	5.1854	$330.28	$132.11	$66.06
0621	Level I Vascular Access Procedures	T	10.9092	$694.85		$138.97
0622	Level II Vascular Access Procedures	T	24.1069	$1,535.46		$307.09
0623	Level III Vascular Access Procedures	T	28.8743	$1,839.12		$367.82
0624	Phlebotomy and Minor Vascular Access Device Procedures	X	0.5689	$36.24	$12.65	$7.25
0625	Level IV Vascular Access Procedures	T	81.7482	$5,206.87		$1,041.37
0648	Level IV Breast Surgery	T	56.5774	$3,603.64		$720.73
0651	Complex Interstitial Radiation Source Application	S	18.1228	$1,154.31		$230.86
0652	Insertion of Intraperitoneal and Pleural Catheters	T	30.7096	$1,956.02		$391.20

ADDENDUM A.—OPPS APCS FOR CY 2008—Continued

APC	Group title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0653	Vascular Reconstruction/Fistula Repair with Device	T	40.4667	$2,577.49		$515.50
0654	Insertion/Replacement of a permanent dual chamber pacemaker	T	109.2851	$6,960.81		$1,392.16
0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker.	T	140.0317	$8,919.18		$1,783.84
0656	Transcatheter Placement of Intracoronary Drug-Eluting Stents	T	118.4265	$7,543.06		$1,508.61
0659	Hyperbaric Oxygen	S	1.5579	$99.23		$19.85
0660	Level II Otorhinolaryngologic Function Tests	X	1.4312	$91.16	$28.06	$18.23
0661	Level V Pathology	X	2.6949	$171.65	$62.09	$34.33
0662	CT Angiography	S	5.1641	$328.92	$118.88	$65.78
0663	Level I Electronic Analysis of Devices	S	1.5313	$97.53		$19.51
0664	Level I Proton Beam Radiation Therapy	S	12.8205	$816.59		$163.32
0665	Bone Density:AppendicularSkeleton	S	0.5087	$32.40	$12.95	$6.48
0667	Level II Proton Beam Radiation Therapy	S	15.3404	$977.09		$195.42
0668	Level I Angiography and Venography	S	9.3506	$595.58		$119.12
0672	Level IV Posterior Segment Eye Procedures	T	37.2078	$2,369.91		$473.98
0673	Level IV Anterior Segment Eye Procedures	T	39.7101	$2,529.30	$649.56	$505.86
0674	Prostate Cryoablation	T	122.7133	$7,816.10		$1,563.22
0676	Thrombolysis and Thrombectomy	T	2.4824	$158.11		$31.62
0678	External Counterpulsation	T	1.7187	$109.47		$21.89
0679	Level II Resuscitation and Cardioversion	S	5.4502	$347.15	$95.30	$69.43
0680	Insertion of Patient Activated Event Recorders	S	70.6073	$4,497.26		$899.45
0681	Knee Arthroplasty	T	274.6715	$17,494.93		$3,498.99
0682	Level V Debridement & Destruction	T	6.8816	$438.32	$158.65	$87.66
0683	Level II Photochemotherapy	S	2.6045	$165.89		$33.18
0685	Level III Needle Biopsy/Aspiration Except Bone Marrow	T	9.3354	$594.61		$118.92
0687	Revision/Removal of Neurostimulator Electrodes	T	22.4734	$1,431.42	$438.47	$286.28
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver	T	34.4166	$2,192.13	$874.57	$438.43
0689	Electronic Analysis of Cardioverter-defibrillators	S	0.5946	$37.87		$7.57
0690	Electronic Analysis of Pacemakers and other Cardiac Devices	S	0.3504	$22.32	$8.67	$4.46
0691	Level III Electronic Analysis of Devices	S	2.3269	$148.21	$50.49	$29.64
0692	Level II Electronic Analysis of Devices	S	1.8376	$117.04	$29.72	$23.41
0694	Mohs Surgery	T	3.6321	$231.34	$91.69	$46.27
0697	Level I Echocardiogram Without Contrast Except Transesophageal	S	3.3401	$212.74		$42.55
0698	Level II Eye Tests & Treatments	S	0.8696	$55.39		$11.08
0699	Level IV Eye Tests & Treatments	T	13.7453	$875.49		$175.10
0701	Sr89 strontium	K	9.6094	$612.06		$122.41
0702	Sm 153 lexidronm	K	21.3689	$1,361.07		$272.21
0726	Dexrazoxane HCl injection	K		$162.11		$32.42
0728	Filgrastim 300 mcg injection	K		$193.79		$38.76
0730	Pamidronate disodium	K		$28.31		$5.66
0731	Sargramostim injection	K		$24.86		$4.97
0732	Mesna injection	K		$7.97		$1.59
0735	Ampho b cholesteryl sulfate	K		$11.89		$2.38
0736	Amphotericin b liposome inj	K		$16.21		$3.24
0738	Rasburicase	K		$144.43		$28.89
0747	Chlorothiazide sodium inj	K		$141.07		$28.21
0748	Bleomycin sulfate injection	K		$42.93		$8.59
0750	Dolasetron mesylate	K		$4.66		$0.93
0751	Mechlorethamine hcl inj	K		$143.08		$28.62
0752	Dactinomycin actinomycin d	K		$488.78		$97.76
0759	Naltrexone, depot form	K		$1.87		$0.37
0760	Anadulafungin injection	G		$1.91		$0.38
0763	Dolasetron mesylate oral	K		$43.77		$8.75
0764	Granisetron HCl injection	K		$5.74		$1.15
0765	Granisetron HCl 1 mg oral	K		$49.96		$9.99
0767	Enfuvirtide injection	K		$0.40		$0.08
0768	Ondansetron hcl injection	K		$0.26		$0.06
0769	Ondansetron HCl 8mg oral	K		$18.37		$3.67
0800	Leuprolide acetate	K		$452.58		$90.52
0802	Etoposide oral	K		$29.46		$5.89
0804	Vivaglobin, inj	K		$7.01		$1.40
0805	Mecasermin injection	K		$15.62		$3.12
0806	Hyaluronidase recombinant	G		$0.40		$0.08
0807	Aldesleukin/single use vial	K		$788.84		$157.77
0808	Nabilone oral	K		$16.80		$3.36
0809	Bcg live intravesical vac	K		$113.75		$22.75
0810	Goserelin acetate implant	K		$192.29		$38.46
0811	Carboplatin injection	K		$7.44		$1.49
0812	Carmus bischl nitro inj	K		$152.24		$30.45
0814	Asparaginase injection	K		$54.26		$10.85
0820	Daunorubicin	K		$19.33		$3.87
0821	Daunorubicin citrate liposom	K		$55.23		$11.05
0823	Docetaxel	K		$310.85		$62.17
0825	Nelarabine injection	G		$86.84		$17.37
0827	Floxuridine injection	K		$54.63		$10.93
0828	Gemcitabine HCl	K		$127.31		$25.46
0830	Irinotecan injection	K		$124.61		$24.92
0831	Ifosfomide injection	K		$38.13		$7.63
0832	Idarubicin hcl injection	K		$302.42		$60.48
0834	Interferon alfa-2a inj	K		$41.37		$8.27

ADDENDUM A.—OPPS APCS FOR CY 2008—Continued

APC	Group title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0835	Inj cosyntropin	K		$64.01		$12.80
0836	Interferon alfa-2b inj	K		$13.92		$2.78
0838	Interferon gamma 1-b inj	K		$306.66		$61.33
0840	Inj melphalan hydrochl	K		$1,548.88		$309.78
0842	Fludarabine phosphate inj	K		$226.67		$45.33
0843	Pegaspargase/singl dose vial	K		$2,080.19		$416.04
0844	Pentostatin injection	K		$2,051.68		$410.34
0849	Rituximab cancer treatment	K		$504.40		$100.88
0850	Streptozocin injection	K		$146.93		$29.39
0851	Thiotepa injection	K		$41.12		$8.22
0852	Topotecan	K		$859.62		$171.92
0855	Vinorelbine tartrate	K		$21.41		$4.28
0856	Porfimer sodium	K		$2,532.53		$506.51
0858	Inj cladribine	K		$32.04		$6.41
0861	Leuprolide acetate injeciton	K		$7.98		$1.60
0862	Mitomycin 5 MG inj	K		$14.39		$2.88
0863	Paclitaxel injection	K		$14.57		$2.91
0864	Mitoxantrone hydrochl	K		$107.96		$21.59
0865	Interferon alfa-n3 inj	K		$9.03		$1.81
0868	Oral aprepitant	K		$4.99		$1.00
0873	Hyalgan/supartz inj per dose	K		$101.81		$20.36
0874	Synvisc inj per dose	K		$178.11		$35.62
0875	Euflexxa inj per dose	K		$110.95		$22.19
0877	Orthovisc inj per dose	K		$174.50		$34.90
0878	Gallium nitrate injection	K		$1.61		$0.32
0880	Pentastarch 10% solution	K		$21.98		$4.40
0882	Melphalan oral	K		$4.14		$0.83
0883	Fondaparinux sodium	K		$5.92		$1.18
0884	Rho d immune globulin inj	K		$80.79		$16.16
0887	Azathioprine parenteral	K		$47.88		$9.58
0888	Cyclosporine oral	K		$3.52		$0.70
0890	Lymphocyte immune globulin	K		$336.10		$67.22
0891	Tacrolimus oral	K		$3.69		$0.74
0898	Gamma globulin 2 CC inj	K		$23.82		$4.76
0899	Gamma globulin 3 CC inj	K		$35.72		$7.14
0900	Alglucerase injection	K		$38.85		$7.77
0901	Alpha 1 proteinase inhibitor	K		$3.28		$0.66
0902	Botulinum toxin a per unit	K		$5.21		$1.04
0903	Cytomegalovirus imm IV /vial	K		$870.53		$174.11
0904	Gamma globulin 4 CC inj	K		$47.64		$9.53
0906	RSV-ivig	K		$16.02		$3.20
0910	Interferon beta-1b / .25 MG	K		$106.57		$21.31
0911	Inj streptokinase /250000 IU	K		$129.75		$25.95
0912	Interferon alfacon-1	K		$4.62		$0.92
0913	Ganciclovir long act implant	K		$4,707.90		$941.58
0916	Injection imiglucerase /unit	K		$3.89		$0.78
0917	Adenosine injection	K		$67.89		$13.58
0919	Gamma globulin 5 CC inj	K		$59.54		$11.91
0920	Gamma globulin 6 CC inj	K		$71.50		$14.30
0921	Gamma globulin 7 CC inj	K		$83.30		$16.66
0922	Gamma globulin 8 CC inj	K		$95.27		$19.05
0923	Gamma globulin 9 CC inj	K		$107.25		$21.45
0924	Gamma globulin 10 CC inj	K		$119.09		$23.82
0925	Factor viii	K		$0.75		$0.15
0927	Factor viii recombinant	K		$1.07		$0.21
0928	Factor ix complex	K		$0.80		$0.16
0929	Anti-inhibitor	K		$1.42		$0.28
0930	Antithrombin iii injection	K		$1.82		$0.36
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		$119.09		$23.82
0934	Capecitabine, oral	K		$14.19		$2.84
0935	Clonidine hydrochloride	K		$62.78		$12.56
0941	Mitomycin 20 MG inj	K		$57.56		$11.51
0942	Mitomycin 40 MG inj	K		$115.11		$23.02
0943	Octagam injection	K		$33.19		$6.64
0944	Gammagard liquid injection	K		$31.06		$6.21
0945	Rhophylac injection	K		$5.29		$1.06
0946	HepaGam B IM injection	K		$63.51		$12.70
0947	Flebogamma injection	K		$32.27		$6.45
0948	Gamunex injection	K		$32.06		$6.41
0949	Frozen plasma, pooled, sd	K	1.1598	$73.87		$14.77
0950	Whole blood for transfusion	K	4.0011	$254.85		$50.97
0951	Reclast injection	G		$220.81		$44.16
0952	Cryoprecipitate each unit	K	0.6474	$41.24		$8.25
0954	RBC leukocytes reduced	K	2.9069	$185.15		$37.03
0955	Plasma, frz between 8-24hour	K	1.2235	$77.93		$15.59
0956	Plasma protein fract,5%,50ml	K	1.4739	$93.88		$18.78
0957	Platelets, each unit	K	1.0911	$69.50		$13.90
0958	Plaelet rich plasma unit	K	5.7070	$363.50		$72.70

ADDENDUM A.—OPPS APCS FOR CY 2008—Continued

APC	Group title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0959	Red blood cells unit	K	2.0356	$129.66		$25.93
0960	Washed red blood cells unit	K	4.3494	$277.03		$55.41
0961	Albumin (human),5%, 50ml	K	0.3413	$21.74		$4.35
0963	Albumin (human), 5%, 250 ml	K	1.0987	$69.98		$14.00
0964	Albumin (human), 25%, 20 ml	K	0.4118	$26.23		$5.25
0965	Albumin (human), 25%, 50ml	K	1.1362	$72.37		$14.47
0966	Plasmaprotein fract,5%,250ml	K	3.3792	$215.23		$43.05
0967	Blood split unit	K	2.3409	$149.10		$29.82
0968	Platelets leukoreduced irrad	K	2.1971	$139.94		$27.99
0969	RBC leukoreduced irradiated	K	3.7722	$240.27		$48.05
0998	Inj biperiden lactate/5 mg	K		$88.15		$17.63
0999	Edetate calcium disodium inj	K		$49.64		$9.93
1009	Cryoprecipitatereducedplasma	K	1.3139	$83.69		$16.74
1010	Blood, l/r, cmv-neg	K	2.3221	$147.90		$29.58
1011	Platelets, hla-m, l/r, unit	K	10.1413	$645.94		$129.19
1013	Platelets leukocytes reduced	K	1.6879	$107.51		$21.50
1015	Injection glatiramer acetate	K		$52.04		$10.41
1016	Blood, l/r, froz/degly/wash	K	3.4353	$218.81		$43.76
1017	Plt, aph/pher, l/r, cmv-neg	K	7.6733	$488.74		$97.75
1018	Blood, l/r, irradiated	K	2.3099	$147.13		$29.43
1019	Plate pheres leukoredu irrad	K	9.8923	$630.08		$126.02
1020	Plt, pher, l/r cmv-neg, irr	K	10.7787	$686.54		$137.31
1021	RBC, frz/deg/wsh, l/r, irrad	K	5.8716	$373.99		$74.80
1022	RBC, l/r, cmv-neg, irrad	K	4.1363	$263.46		$52.69
1023	Pralidoxime chloride inj	K		$35.20		$7.04
1032	Aud osseo dev, int/ext comp	H				.
1041	Plicamycin (mithramycin) inj	K		$172.41		$34.48
1052	Injection, voriconazole	K		$4.93		$0.99
1064	I131 iodide cap, rx	K	0.2393	$15.24		$3.05
1083	Adalimumab injection	K		$329.58		$65.92
1084	Denileukin diftitox	K		$1,386.59		$277.32
1086	Temozolomide	K		$7.49		$1.50
1138	Hepagam B intravenous, inj	K		$63.51		$12.70
1139	Protein C concentrate	K		$12.08		$2.42
1140	Integra matrix tissue	K		$33.14		$6.63
1141	Primatrix tissue	G		$67.96		$13.59
1142	Supprelin LA implant	K		$14,700.00		$2,940.00
1150	I131 iodide sol, rx	K	0.1762	$11.22		$2.24
1165	Aripiprazole injection	K		$0.28		$0.06
1166	Cytarabine liposome	K		$412.21		$82.44
1167	Inj, epirubicin hcl	K		$19.79		$3.96
1168	Inj, temsirolimus	G		$48.41		$9.68
1169	Neurawrap nerve protector,cm	G		$482.56		$96.51
1178	Busulfan injection	K		$9.17		$1.83
1203	Verteporfin injection	K		$8.99		$1.80
1207	Octreotide injection, depot	K		$99.04		$19.81
1280	Corticotropin injection	K		$169.77		$33.95
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

ADDENDUM A.—OPPS APCS FOR CY 2008—Continued

APC	Group title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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
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		$420.17		$84.03
1606	Injection anistreplase 30 u	K		$2,693.80		$538.76
1607	Eptifibatide injection	K		$17.67		$3.53
1608	Etanercept injection	K		$167.12		$33.42
1609	Rho(D) immune globulin h, sd	K		$15.62		$3.12
1612	Daclizumab, parenteral	K		$322.28		$64.46
1613	Trastuzumab	K		$58.51		$11.70
1629	Nonmetabolic act d/e tissue	K		$20.22		$4.04
1630	Hep b ig, im	K		$122.02		$24.40
1631	Baclofen intrathecal trial	K		$69.73		$13.95
1632	Metabolic active D/E tissue	K		$28.45		$5.69
1633	Alefacept	K		$26.47		$5.29
1643	Y90 ibritumomab, rx	K	235.8764	$15,023.91		$3,004.78
1645	I131 tositumomab, rx	K	176.8495	$11,264.25		$2,252.85
1670	Tetanus immune globulin inj	K		$103.46		$20.69
1675	P32 Na phosphate	K	1.7835	$113.60		$22.72
1676	P32 chromic phosphate	K	1.8711	$119.18		$23.84
1682	Aprotonin, 10,000 kiu	K		$2.66		$0.53
1683	Basiliximab	K		$1,541.03		$308.21
1684	Corticorelin ovine triflutal	K		$4.43		$0.89
1685	Darbepoetin alfa, non-esrd	K		$2.88		$0.58
1686	Epoetin alfa, non-esrd	K		$8.97		$1.79
1687	Digoxin immune fab (ovine)	K		$478.88		$95.78
1688	Ethanolamine oleate	K		$79.23		$15.85
1689	Fomepizole	K		$12.80		$2.56
1690	Hemin	K		$7.08		$1.42
1691	Iron dextran 165 injection	K		$11.82		$2.36
1692	Iron dextran 267 injection	K		$10.30		$2.06
1693	Lepirudin	K		$159.44		$31.89
1694	Ziconotide injection	K		$6.46		$1.29

ADDENDUM A.—OPPS APCS FOR CY 2008—Continued

APC	Group title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
1695	Nesiritide injection	K		$32.95		$6.59
1696	Palifermin injection	K		$11.24		$2.25
1697	Pegaptanib sodium injection	K		$1,035.69		$207.14
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	Humate-P, inj	K		$0.88		$0.18
1705	Factor viia	K		$1.15		$0.23
1709	Azacitidine injection	K		$4.35		$0.87
1710	Clofarabine injection	K		$114.41		$22.88
1711	Vantas implant	K		$1,412.46		$282.49
1712	Paclitaxel protein bound	K		$8.79		$1.76
1716	Brachytx, non-str, Gold-198	K	0.5228	$33.30		$6.66
1717	Brachytx, non-str, HDR Ir-192	K	2.7505	$175.19		$35.04
1719	Brachytx, NS, Non-HDRIr-192	K	1.0226	$65.13		$13.03
1738	Oxaliplatin	K		$9.15		$1.83
1739	Pegademase bovine, 25 iu	K		$197.51		$39.50
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		$13.04		$2.61
2616	Brachytx, non-str,Yttrium-90	K	184.7105	$11,764.95		$2,352.99
2632	Iodine I-125 sodium iodide	K	0.4325	$27.55		$5.51
2634	Brachytx, non-str, HA, I-125	K	0.4858	$30.94		$6.19
2635	Brachytx, non-str, HA, P-103	K	0.7366	$46.92		$9.38
2636	Brachy linear, non-str,P-103	K	0.6600	$42.04		$8.41
2638	Brachytx, stranded, I-125	K	0.7113	$45.31		$9.06
2639	Brachytx, non-stranded,I-125	K	0.5039	$32.10		$6.42
2640	Brachytx, stranded, P-103	K	1.0308	$65.66		$13.13
2641	Brachytx, non-stranded,P-103	K	0.8077	$51.45		$10.29
2642	Brachytx, stranded, C-131	K	1.5342	$97.72		$19.54
2643	Brachytx, non-stranded,C-131	K	1.0060	$64.08		$12.82
2698	Brachytx, stranded, NOS	K	0.7113	$45.31		$9.06
2699	Brachytx, non-stranded, NOS	K	0.4858	$30.94		$6.19
2731	Immune globulin, powder	K		$26.89		$5.38
2770	Quinupristin/dalfopristin	K		$126.44		$25.29
2940	Somatrem injection	K		$168.90		$33.78
3030	Sumatriptan succinate	K		$61.27		$12.25
3041	Bivalirudin	K		$1.84		$0.37
3043	Gamma globulin 1 CC inj	K		$11.91		$2.38
3050	Sermorelin acetate injection	K		$1.74		$0.35
7000	Amifostine	K		$490.93		$98.19
7005	Gonadorelin hydroch	K		$178.59		$35.72
7011	Oprelvekin injection	K		$247.02		$49.40
7015	Oral busulfan	K		$2.26		$0.45
7028	Fosphenytoin	K		$5.76		$1.15
7034	Somatropin injection	K		$48.52		$9.70
7035	Teniposide	K		$280.26		$56.05
7036	Urokinase 250,000 IU inj	K		$453.41		$90.68
7038	Monoclonal antibodies	K		$977.75		$195.55
7041	Tirofiban HCl	K		$7.56		$1.51
7042	Capecitabine, oral	K		$4.28		$0.86
7043	Infliximab injection	K		$54.42		$10.88
7045	Inj trimetrexate glucoronate	K		$148.30		$29.66
7046	Doxorubicin hcl liposome inj	K		$396.15		$79.23
7048	Alteplase recombinant	K		$33.39		$6.68
7049	Filgrastim 480 mcg injection	K		$298.39		$59.68
7051	Leuprolide acetate implant	K		$1,648.41		$329.68
7308	Aminolevulinic acid hcl top	K		$109.92		$21.98
8000	Cardiac Electrophysiologic Evaluation and Ablation Composite	T	134.1189	$8,542.57		$1,708.51
8001	LDR Prostate Brachytherapy Composite	T	53.8937	$3,432.71		$686.54
8002	Level I Extended Assessment & Management Composite	V	5.5113	$351.04		$70.21
8003	Level II Extended Assessment & Management Composite	V	10.0270	$638.66		$127.73
9001	Linezolid injection	K		$25.17		$5.03
9002	Tenecteplase injection	K		$2,034.65		$406.93
9003	Palivizumab	K		$810.67		$162.13
9004	Gemtuzumab ozogamicin	K		$2,411.98		$482.40
9005	Reteplase injection	K		$841.28		$168.26
9006	Tacrolimus injection	K		$138.64		$27.73
9012	Arsenic trioxide	K		$34.44		$6.89
9015	Mycophenolate mofetil oral	K		$2.66		$0.53
9018	Botulinum toxin type B	K		$8.63		$1.73
9019	Caspofungin acetate	K		$24.05		$4.81
9020	Sirolimus, oral	K		$7.50		$1.50
9022	IM inj interferon beta 1-a	K		$118.84		$23.77
9023	Rho d immune globulin	K		$26.41		$5.28
9024	Amphotericin b lipid complex	K		$10.40		$2.08
9032	Baclofen 10 MG injection	K		$193.29		$38.66
9033	Cidofovir injection	K		$754.39		$150.88
9038	Inj estrogen conjugate	K		$66.64		$13.33

ADDENDUM A.—OPPS APCS FOR CY 2008—Continued

APC	Group title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
9042	Glucagon hydrochloride	K		$68.84		$13.77
9044	Ibutilide fumarate injection	K		$287.15		$57.43
9046	Iron sucrose injection	K		$0.36		$0.08
9047	Itraconazole injection	K		$39.68		$7.94
9051	Urea injection	K		$74.16		$14.83
9054	Metabolically active tissue	K		$36.40		$7.28
9104	Antithymocyte globuln rabbit	K		$337.82		$67.56
9108	Thyrotropin injection	K		$834.18		$166.84
9110	Alemtuzumab injection	K		$549.77		$109.95
9115	Zoledronic acid	K		$205.76		$41.15
9119	Injection, pegfilgrastim 6mg	K		$2,145.12		$429.02
9120	Injection, Fulvestrant	K		$80.60		$16.12
9121	Injection, argatroban	K		$18.96		$3.79
9122	Triptorelin pamoate	K		$159.38		$31.88
9124	Daptomycin injection	K		$0.35		$0.07
9125	Risperidone, long acting	K		$4.86		$0.97
9126	Natalizumab injection	G		$7.51		$1.50
9133	Rabies ig, im/sc	K		$68.22		$13.64
9134	Rabies ig, heat treated	K		$71.69		$14.34
9135	Varicella-zoster ig, im	K		$122.74		$24.55
9137	Bcg vaccine, percut	K		$118.98		$23.80
9139	Rabies vaccine, im	K		$150.80		$30.16
9140	Rabies vaccine, id	K		$119.86		$23.97
9141	Measles-rubella vaccine, sc	K		$45.53		$9.11
9143	Meningococcal vaccine, sc	K		$85.29		$17.06
9144	Encephalitis vaccine, sc	K		$98.17		$19.63
9145	Meningococcal vaccine, im	K		$82.00		$16.40
9156	Nonmetabolic active tissue	K		$94.53		$18.91
9167	Valrubicin, 200 mg	K		$77.96		$15.59
9207	Bortezomib injection	K		$33.20		$6.64
9208	Agalsidase beta injection	K		$126.00		$25.20
9209	Laronidase injection	K		$23.64		$4.73
9210	Palonosetron HCl	K		$16.45		$3.29
9213	Pemetrexed injection	K		$44.49		$8.90
9214	Bevacizumab injection	K		$56.93		$11.39
9215	Cetuximab injection	K		$49.43		$9.89
9216	Abarelix injection	K		$67.97		$13.59
9217	Leuprolide acetate suspnsion	K		$236.06		$47.21
9219	Mycophenolic acid	K		$2.41		$0.48
9222	Injectable human tissue	K		$774.46		$154.89
9224	Galsulfase injection	K		$306.88		$61.38
9225	Fluocinolone acetonide implt	K		$19,162.50		$3,832.50
9227	Micafungin sodium injection	G		$1.44		$0.29
9228	Tigecycline injection	G		$0.96		$0.19
9229	Ibandronate sodium injection	G		$138.96		$27.79
9230	Abatacept injection	G		$18.69		$3.74
9231	Decitabine injection	G		$26.48		$5.30
9232	Idursulfase injection	G		$455.03		$91.01
9233	Ranibizumab injection	G		$2,030.23		$406.05
9234	Aglucosidase alfa injection	K		$126.00		$25.20
9235	Panitumumab injection	G		$83.15		$16.63
9236	Eculizumab injection	G		$176.38		$35.28
9238	Inj, levetiracetam	K		$6.30		$1.26
9300	Omalizumab injection	K		$17.12		$3.42
9350	Neuragen nerve guide, per cm	G		$482.56		$96.51
9351	Tissuemend tissue	G		$67.96		$13.59
9500	Platelets, irradiated	K	1.9110	$121.72		$24.34
9501	Platelet pheres leukoreduced	K	7.8426	$499.53		$99.91
9502	Platelet pheresis irradiated	K	6.5581	$417.71		$83.54
9503	Fr frz plasma donor retested	K	0.8264	$52.64		$10.53
9504	RBC deglycerolized	K	5.4516	$347.23		$69.45
9505	RBC irradiated	K	3.0643	$195.18		$39.04
9506	Granulocytes, pheresis unit	K	21.7847	$1,387.55		$277.51
9507	Platelets, pheresis	K	6.9242	$441.03		$88.21
9508	Plasma 1 donor frz w/in 8 hr	K	1.0524	$67.03		$13.41

ADDENDUM AA.—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	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
0016T	Thermotx choroid vasc lesion	Y		R2		4.1331	$171.11	$171.11
0017T	Photocoagulat macular drusen	Y		R2		4.1331	$171.11	$171.11
0027T	Endoscopic epidural lysis	Y		G2		18.0518	$747.36	$747.36
0031T	Speculoscopy	N		N1				
0032T	Speculoscopy w/direct sample	N		N1				
0046T	Cath lavage, mammary duct(s)	Y		R2		16.1001	$666.56	$666.56
0047T	Cath lavage, mammary duct(s)	Y		R2		16.1001	$666.56	$666.56
0062T	Rep intradisc annulus;1 lev	Y		G2		29.19	$1,208.50	$1,208.50
0063T	Rep intradisc annulus;>1lev	Y		G2		29.19	$1,208.50	$1,208.50
0084T	Temp prostate urethral stent	Y		G2		2.0077	$83.12	$83.12
0088T	Rf tongue base vol reduxn	Y	CH	G2		16.3288	$676.03	$676.03
0099T*	Implant corneal ring	Y		R2		16.171	$669.50	$669.50
0100T	Prosth retina receive&gen	Y		G2		37.2078	$1,540.44	$1,540.44
0101T	Extracorp shockwv tx,hi enrg	Y		G2		29.19	$1,208.50	$1,208.50
0102T	Extracorp shockwv tx,anesth	Y		G2		29.19	$1,208.50	$1,208.50
0123T	Scleral fistulization	Y		G2		23.1758	$959.50	$959.50
0124T*	Conjunctival drug placement	Y		R2		5.1169	$211.84	$211.84
0137T	Prostate saturation sampling	Y	CH	G2		11.0338	$456.81	$456.81
0170T	Anorectal fistula plug rpr	Y	CH	G2		30.1606	$1,248.68	$1,248.68
0176T	Aqu canal dilat w/o retent	Y		A2	$1,339.00	39.7101	$1,644.04	$1,415.26
0177T	Aqu canal dilat w retent	Y		A2	$1,339.00	39.7101	$1,644.04	$1,415.26
0186T	Suprachoroidal drug delivery	Y	NI	G2		18.235	$754.95	$754.95
10021	Fna w/o image	Y		P2		1.1097	$45.94	$45.94
10022	Fna w/image	Y		G2		4.327	$179.14	$179.14
10040	Acne surgery	Y		P2		0.793	$32.83	$32.83
10060	Drainage of skin abscess	Y		P3		1.1108	$45.99	$45.99
10061	Drainage of skin abscess	Y		P2		1.4066	$58.23	$58.23
10080	Drainage of pilonidal cyst	Y		P2		1.4066	$58.23	$58.23
10081	Drainage of pilonidal cyst	Y		P3		3.1023	$128.44	$128.44
10120	Remove foreign body	Y		P2		1.4066	$58.23	$58.23
10121	Remove foreign body	Y		A2	$446.00	16.1001	$666.56	$501.14
10140	Drainage of hematoma/fluid	Y		P3		1.6541	$68.48	$68.48
10160	Puncture drainage of lesion	Y	CH	P3		1.4154	$58.60	$58.60
10180	Complex drainage, wound	Y		A2	$446.00	18.3197	$758.45	$524.11
11000	Debride infected skin	Y		P3		0.5348	$22.14	$22.14
11001	Debride infected skin add-on	Y		P3		0.1894	$7.84	$7.84
11010	Debride skin, fx	Y		A2	$251.52	4.3039	$178.19	$233.19
11011	Debride skin/muscle, fx	Y		A2	$251.52	4.3039	$178.19	$233.19
11012	Debride skin/muscle/bone, fx	Y		A2	$251.52	4.3039	$178.19	$233.19
11040	Debride skin, partial	Y		P3		0.4937	$20.44	$20.44
11041	Debride skin, full	Y		P3		0.5679	$23.51	$23.51
11042	Debride skin/tissue	Y		A2	$164.42	2.6604	$110.14	$150.85
11043	Debride tissue/muscle	Y		A2	$164.42	2.6604	$110.14	$150.85
11044	Debride tissue/muscle/bone	Y		A2	$423.10	6.8816	$284.91	$388.55
11055	Trim skin lesion	Y		P3		0.5596	$23.17	$23.17
11056	Trim skin lesions, 2 to 4	Y		P3		0.6253	$25.89	$25.89
11057	Trim skin lesions, over 4	Y		P3		0.7077	$29.30	$29.30
11100	Biopsy, skin lesion	Y		P2		0.793	$32.83	$32.83
11101	Biopsy, skin add-on	Y		P3		0.3046	$12.61	$12.61
11200	Removal of skin tags	Y	CH	P2		0.793	$32.83	$32.83
11201	Remove skin tags add-on	Y		P3		0.1316	$5.45	$5.45
11300	Shave skin lesion	Y		P2		0.793	$32.83	$32.83
11301	Shave skin lesion	Y		P2		0.793	$32.83	$32.83
11302	Shave skin lesion	Y		P2		0.793	$32.83	$32.83
11303	Shave skin lesion	Y		P3		1.4811	$61.32	$61.32
11305	Shave skin lesion	Y		P3		0.7901	$32.71	$32.71
11306	Shave skin lesion	Y	CH	P2		0.793	$32.83	$32.83
11307	Shave skin lesion	Y		P2		0.793	$32.83	$32.83
11308	Shave skin lesion	Y		P2		0.793	$32.83	$32.83
11310	Shave skin lesion	Y	CH	P2		0.793	$32.83	$32.83
11311	Shave skin lesion	Y		P2		0.793	$32.83	$32.83
11312	Shave skin lesion	Y		P2		0.793	$32.83	$32.83
11313	Shave skin lesion	Y	CH	P2		0.793	$32.83	$32.83
11400	Exc tr-ext b9+marg 0.5 < cm	Y		P3		1.5963	$66.09	$66.09
11401	Exc tr-ext b9+marg 0.6-1 cm	Y		P3		1.7444	$72.22	$72.22
11402	Exc tr-ext b9+marg 1.1-2 cm	Y		P3		1.9009	$78.70	$78.70
11403	Exc tr-ext b9+marg 2.1-3 cm	Y		P3		2.0326	$84.15	$84.15
11404	Exc tr-ext b9+marg 3.1-4 cm	Y		A2	$333.00	16.1001	$666.56	$416.39
11406	Exc tr-ext b9+marg > 4.0 cm	Y		A2	$446.00	16.1001	$666.56	$501.14

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
11420	Exc h-f-nk-sp b9+marg 0.5 <	Y		P3		1.4729	$60.98	$60.98
11421	Exc h-f-nk-sp b9+marg 0.6-1	Y		P3		1.7611	$72.91	$72.91
11422	Exc h-f-nk-sp b9+marg 1.1-2	Y		P3		1.9256	$79.72	$79.72
11423	Exc h-f-nk-sp b9+marg 2.1-3	Y		P3		2.156	$89.26	$89.26
11424	Exc h-f-nk-sp b9+marg 3.1-4	Y		A2	$446.00	16.1001	$666.56	$501.14
11426	Exc h-f-nk-sp b9+marg > 4 cm	Y		A2	$446.00	21.1098	$873.97	$552.99
11440	Exc face-mm b9+marg 0.5 < cm	Y		P3		1.728	$71.54	$71.54
11441	Exc face-mm b9+marg 0.6-1 cm	Y		P3		1.9338	$80.06	$80.06
11442	Exc face-mm b9+marg 1.1-2 cm	Y		P3		2.1313	$88.24	$88.24
11443	Exc face-mm b9+marg 2.1-3 cm	Y		P3		2.3864	$98.80	$98.80
11444	Exc face-mm b9+marg 3.1-4 cm	Y		A2	$333.00	8.685	$359.57	$339.64
11446	Exc face-mm b9+marg > 4 cm	Y		A2	$446.00	21.1098	$873.97	$552.99
11450	Removal, sweat gland lesion	Y		A2	$446.00	21.1098	$873.97	$552.99
11451	Removal, sweat gland lesion	Y		A2	$446.00	21.1098	$873.97	$552.99
11462	Removal, sweat gland lesion	Y		A2	$446.00	21.1098	$873.97	$552.99
11463	Removal, sweat gland lesion	Y		A2	$446.00	21.1098	$873.97	$552.99
11470	Removal, sweat gland lesion	Y		A2	$446.00	21.1098	$873.97	$552.99
11471	Removal, sweat gland lesion	Y		A2	$446.00	21.1098	$873.97	$552.99
11600	Exc tr-ext mlg+marg 0.5 < cm	Y		P3		2.2135	$91.64	$91.64
11601	Exc tr-ext mlg+marg 0.6-1 cm	Y		P3		2.5263	$104.59	$104.59
11602	Exc tr-ext mlg+marg 1.1-2 cm	Y		P3		2.7403	$113.45	$113.45
11603	Exc tr-ext mlg+marg 2.1-3 cm	Y		P3		2.9294	$121.28	$121.28
11604	Exc tr-ext mlg+marg 3.1-4 cm	Y		A2	$418.49	8.685	$359.57	$403.76
11606	Exc tr-ext mlg+marg > 4 cm	Y		A2	$446.00	16.1001	$666.56	$501.14
11620	Exc h-f-nk-sp mlg+marg 0.5 <	Y		P3		2.2384	$92.67	$92.67
11621	Exc h-f-nk-sp mlg+marg 0.6-1	Y		P3		2.5509	$105.61	$105.61
11622	Exc h-f-nk-sp mlg+marg 1.1-2	Y		P3		2.8224	$116.85	$116.85
11623	Exc h-f-nk-sp mlg+marg 2.1-3	Y		P3		3.061	$126.73	$126.73
11624	Exc h-f-nk-sp mlg+marg 3.1-4	Y		A2	$446.00	16.1001	$666.56	$501.14
11626	Exc h-f-nk-sp mlg+mar > 4 cm	Y		A2	$446.00	21.1098	$873.97	$552.99
11640	Exc face-mm malig+marg 0.5 <	Y		P3		2.3451	$97.09	$97.09
11641	Exc face-mm malig+marg 0.6-1	Y		P3		2.7403	$113.45	$113.45
11642	Exc face-mm malig+marg 1.1-2	Y		P3		3.061	$126.73	$126.73
11643	Exc face-mm malig+marg 2.1-3	Y		P3		3.3246	$137.64	$137.64
11644	Exc face-mm malig+marg 3.1-4	Y		A2	$446.00	16.1001	$666.56	$501.14
11646	Exc face-mm mlg+marg > 4 cm	Y		A2	$446.00	21.1098	$873.97	$552.99
11719	Trim nail(s)	Y		P3		0.2551	$10.56	$10.56
11720	Debride nail, 1-5	Y		P3		0.3292	$13.63	$13.63
11721	Debride nail, 6 or more	Y		P3		0.4031	$16.69	$16.69
11730	Removal of nail plate	Y	CH	P2		0.793	$32.83	$32.83
11732	Remove nail plate, add-on	Y		P3		0.4031	$16.69	$16.69
11740	Drain blood from under nail	Y	CH	P2		0.2963	$12.27	$12.27
11750	Removal of nail bed	Y		P3		2.1065	$87.21	$87.21
11752	Remove nail bed/finger tip	Y		P3		2.8965	$119.92	$119.92
11755	Biopsy, nail unit	Y		P3		1.4729	$60.98	$60.98
11760	Repair of nail bed	Y		G2		2.1051	$87.15	$87.15
11762	Reconstruction of nail bed	Y	CH	P3		2.7072	$112.08	$112.08
11765	Excision of nail fold, toe	Y		P2		1.4595	$60.42	$60.42
11770	Removal of pilonidal lesion	Y		A2	$510.00	21.1098	$873.97	$600.99
11771	Removal of pilonidal lesion	Y		A2	$510.00	21.1098	$873.97	$600.99
11772	Removal of pilonidal lesion	Y		A2	$510.00	21.1098	$873.97	$600.99
11900	Injection into skin lesions	Y		P3		0.6418	$26.57	$26.57
11901	Added skin lesions injection	Y		P3		0.6831	$28.28	$28.28
11920	Correct skin color defects	Y		P2		2.1051	$87.15	$87.15
11921	Correct skin color defects	Y		P2		2.1051	$87.15	$87.15
11922	Correct skin color defects	Y		P3		0.8476	$35.09	$35.09
11950	Therapy for contour defects	Y		P3		0.8311	$34.41	$34.41
11951	Therapy for contour defects	Y		P3		0.9792	$40.54	$40.54
11952	Therapy for contour defects	Y	CH	P2		1.2792	$52.96	$52.96
11954	Therapy for contour defects	Y		P2		1.2792	$52.96	$52.96
11960	Insert tissue expander(s)	Y		A2	$446.00	20.2069	$836.59	$543.65
11970	Replace tissue expander	Y		A2	$510.00	42.985	$1,779.62	$827.41
11971	Remove tissue expander(s)	Y		A2	$333.00	21.1098	$873.97	$468.24
11976	Removal of contraceptive cap	Y		P3		1.4154	$58.60	$58.60
11980	Implant hormone pellet(s)	N		P2		0.631	$26.12	$26.12
11981	Insert drug implant device	N		P2		0.631	$26.12	$26.12
11982	Remove drug implant device	N		P2		0.631	$26.12	$26.12
11983	Remove/insert drug implant	N		P2		0.631	$26.12	$26.12
12001	Repair superficial wound(s)	Y		P2		1.2792	$52.96	$52.96
12002	Repair superficial wound(s)	Y		P2		1.2792	$52.96	$52.96
12004	Repair superficial wound(s)	Y		P2		1.2792	$52.96	$52.96
12005	Repair superficial wound(s)	Y		A2	$91.24	1.2792	$52.96	$81.67
12006	Repair superficial wound(s)	Y		A2	$91.24	1.2792	$52.96	$81.67

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ADDENDUM AA.—ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

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12007	Repair superficial wound(s)	Y		A2	$91.24	1.2792	$52.96	$81.67
12011	Repair superficial wound(s)	Y		P2		1.2792	$52.96	$52.96
12013	Repair superficial wound(s)	Y		P2		1.2792	$52.96	$52.96
12014	Repair superficial wound(s)	Y		P2		1.2792	$52.96	$52.96
12015	Repair superficial wound(s)	Y		G2		1.2792	$52.96	$52.96
12016	Repair superficial wound(s)	Y		A2	$91.24	1.2792	$52.96	$81.67
12017	Repair superficial wound(s)	Y		A2	$91.24	1.2792	$52.96	$81.67
12018	Repair superficial wound(s)	Y		A2	$91.24	1.2792	$52.96	$81.67
12020	Closure of split wound	Y		A2	$91.24	4.5263	$187.39	$115.28
12021	Closure of split wound	Y		A2	$91.24	4.5263	$187.39	$115.28
12031	Layer closure of wound(s)	Y		P2		2.1051	$87.15	$87.15
12032	Layer closure of wound(s)	Y		P2		2.1051	$87.15	$87.15
12034	Layer closure of wound(s)	Y		A2	$91.24	2.1051	$87.15	$90.22
12035	Layer closure of wound(s)	Y		A2	$91.24	2.1051	$87.15	$90.22
12036	Layer closure of wound(s)	Y		A2	$91.24	2.1051	$87.15	$90.22
12037	Layer closure of wound(s)	Y		A2	$323.28	2.1051	$87.15	$264.25
12041	Layer closure of wound(s)	Y		P2		2.1051	$87.15	$87.15
12042	Layer closure of wound(s)	Y		P2		2.1051	$87.15	$87.15
12044	Layer closure of wound(s)	Y		A2	$91.24	2.1051	$87.15	$90.22
12045	Layer closure of wound(s)	Y		A2	$91.24	2.1051	$87.15	$90.22
12046	Layer closure of wound(s)	Y		A2	$91.24	2.1051	$87.15	$90.22
12047	Layer closure of wound(s)	Y		A2	$323.28	2.1051	$87.15	$264.25
12051	Layer closure of wound(s)	Y		P2		2.1051	$87.15	$87.15
12052	Layer closure of wound(s)	Y		P2		2.1051	$87.15	$87.15
12053	Layer closure of wound(s)	Y		P2		2.1051	$87.15	$87.15
12054	Layer closure of wound(s)	Y		A2	$91.24	2.1051	$87.15	$90.22
12055	Layer closure of wound(s)	Y		A2	$91.24	2.1051	$87.15	$90.22
12056	Layer closure of wound(s)	Y		A2	$91.24	2.1051	$87.15	$90.22
12057	Layer closure of wound(s)	Y		A2	$323.28	2.1051	$87.15	$264.25
13100	Repair of wound or lesion	Y		A2	$323.28	4.5263	$187.39	$289.31
13101	Repair of wound or lesion	Y		A2	$323.28	4.5263	$187.39	$289.31
13102	Repair wound/lesion add-on	Y		A2	$91.24	4.5263	$187.39	$115.28
13120	Repair of wound or lesion	Y		A2	$91.24	2.1051	$87.15	$90.22
13121	Repair of wound or lesion	Y		A2	$91.24	4.5263	$187.39	$115.28
13122	Repair wound/lesion add-on	Y		A2	$91.24	2.1051	$87.15	$90.22
13131	Repair of wound or lesion	Y		A2	$91.24	4.5263	$187.39	$115.28
13132	Repair of wound or lesion	Y		A2	$91.24	4.5263	$187.39	$115.28
13133	Repair wound/lesion add-on	Y		A2	$91.24	4.5263	$187.39	$115.28
13150	Repair of wound or lesion	Y		A2	$323.28	4.5263	$187.39	$289.31
13151	Repair of wound or lesion	Y		A2	$323.28	4.5263	$187.39	$289.31
13152	Repair of wound or lesion	Y		A2	$323.28	4.5263	$187.39	$289.31
13153	Repair wound/lesion add-on	Y		A2	$91.24	2.1051	$87.15	$90.22
13160	Late closure of wound	Y		A2	$446.00	20.2069	$836.59	$543.65
14000	Skin tissue rearrangement	Y		A2	$446.00	15.0458	$622.91	$490.23
14001	Skin tissue rearrangement	Y		A2	$510.00	15.0458	$622.91	$538.23
14020	Skin tissue rearrangement	Y		A2	$510.00	15.0458	$622.91	$538.23
14021	Skin tissue rearrangement	Y		A2	$510.00	15.0458	$622.91	$538.23
14040	Skin tissue rearrangement	Y		A2	$446.00	15.0458	$622.91	$490.23
14041	Skin tissue rearrangement	Y		A2	$510.00	15.0458	$622.91	$538.23
14060	Skin tissue rearrangement	Y		A2	$510.00	15.0458	$622.91	$538.23
14061	Skin tissue rearrangement	Y		A2	$510.00	15.0458	$622.91	$538.23
14300	Skin tissue rearrangement	Y		A2	$630.00	20.2069	$836.59	$681.65
14350	Skin tissue rearrangement	Y		A2	$510.00	20.2069	$836.59	$591.65
15002	Wnd prep, ch/inf, trk/arm/lg	Y		A2	$323.28	4.5263	$187.39	$289.31
15003	Wnd prep, ch/inf addl 100 cm	Y		A2	$323.28	4.5263	$187.39	$289.31
15004	Wnd prep ch/inf, f/n/hf/g	Y		A2	$323.28	4.5263	$187.39	$289.31
15005	Wnd prep, f/n/hf/g, addl cm	Y		A2	$323.28	4.5263	$187.39	$289.31
15040	Harvest cultured skin graft	Y		A2	$91.24	2.1051	$87.15	$90.22
15050	Skin pinch graft	Y		A2	$323.28	4.5263	$187.39	$289.31
15100	Skin splt grft, trnk/arm/leg	Y		A2	$446.00	20.2069	$836.59	$543.65
15101	Skin splt grft t/a/l, add-on	Y		A2	$510.00	20.2069	$836.59	$591.65
15110	Epidrm autogrft trnk/arm/leg	Y		A2	$446.00	4.5263	$187.39	$381.35
15111	Epidrm autogrft t/a/l add-on	Y		A2	$333.00	4.5263	$187.39	$296.60
15115	Epidrm a-grft face/nck/hf/g	Y		A2	$446.00	4.5263	$187.39	$381.35
15116	Epidrm a-grft f/n/hf/g addl	Y		A2	$333.00	4.5263	$187.39	$296.60
15120	Skn splt a-grft fac/nck/hf/g	Y		A2	$446.00	20.2069	$836.59	$543.65
15121	Skn splt a-grft f/n/hf/g add	Y		A2	$510.00	20.2069	$836.59	$591.65
15130	Derm autograft, trnk/arm/leg	Y		A2	$446.00	15.0458	$622.91	$490.23
15131	Derm autograft t/a/l add-on	Y		A2	$333.00	15.0458	$622.91	$405.48
15135	Derm autograft face/nck/hf/g	Y		A2	$446.00	15.0458	$622.91	$490.23
15136	Derm autograft, f/n/hf/g add	Y		A2	$333.00	15.0458	$622.91	$405.48
15150	Cult epiderm grft t/arm/leg	Y		A2	$446.00	4.5263	$187.39	$381.35
15151	Cult epiderm grft t/a/l addl	Y		A2	$333.00	4.5263	$187.39	$296.60

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
15152	Cult epiderm graft t/a/l +%	Y		A2	$333.00	4.5263	$187.39	$296.60
15155	Cult epiderm graft, f/n/hf/g	Y		A2	$446.00	4.5263	$187.39	$381.35
15156	Cult epidrm grft f/n/hfg add	Y		A2	$333.00	4.5263	$187.39	$296.60
15157	Cult epiderm grft f/n/hfg +%	Y		A2	$333.00	4.5263	$187.39	$296.60
15200	Skin full graft, trunk	Y		A2	$510.00	15.0458	$622.91	$538.23
15201	Skin full graft trunk add-on	Y		A2	$323.28	15.0458	$622.91	$398.19
15220	Skin full graft sclp/arm/leg	Y		A2	$446.00	15.0458	$622.91	$490.23
15221	Skin full graft add-on	Y		A2	$323.28	4.5263	$187.39	$289.31
15240	Skin full grft face/genit/hf	Y		A2	$510.00	15.0458	$622.91	$538.23
15241	Skin full graft add-on	Y		A2	$323.28	4.5263	$187.39	$289.31
15260	Skin full graft een & lips	Y		A2	$446.00	15.0458	$622.91	$490.23
15261	Skin full graft add-on	Y		A2	$323.28	15.0458	$622.91	$398.19
15300	Apply skinallogrft, t/arm/lg	Y		A2	$323.28	4.5263	$187.39	$289.31
15301	Apply sknallogrft t/a/l addl	Y		A2	$323.28	4.5263	$187.39	$289.31
15320	Apply skin allogrft f/n/hf/g	Y		A2	$323.28	4.5263	$187.39	$289.31
15321	Aply sknallogrft f/n/hfg add	Y		A2	$323.28	4.5263	$187.39	$289.31
15330	Aply acell alogrft t/arm/leg	Y		A2	$323.28	4.5263	$187.39	$289.31
15331	Aply acell grft t/a/l add-on	Y		A2	$323.28	4.5263	$187.39	$289.31
15335	Apply acell graft, f/n/hf/g	Y		A2	$323.28	4.5263	$187.39	$289.31
15336	Aply acell grft f/n/hf/g add	Y		A2	$323.28	4.5263	$187.39	$289.31
15340	Apply cult skin substitute	Y	CH	G2		2.1051	$87.15	$87.15
15341	Apply cult skin sub add-on	Y		G2		2.1051	$87.15	$87.15
15360	Apply cult derm sub, t/a/l	Y		G2		2.1051	$87.15	$87.15
15361	Aply cult derm sub t/a/l add	Y		G2		2.1051	$87.15	$87.15
15365	Apply cult derm sub f/n/hf/g	Y		G2		2.1051	$87.15	$87.15
15366	Apply cult derm f/hf/g add	Y		G2		2.1051	$87.15	$87.15
15400	Apply skin xenograft, t/a/l	Y		A2	$323.28	4.5263	$187.39	$289.31
15401	Apply skn xenogrft t/a/l add	Y		A2	$323.28	4.5263	$187.39	$289.31
15420	Apply skin xgraft, f/n/hf/g	Y		A2	$323.28	4.5263	$187.39	$289.31
15421	Apply skn xgrft f/n/hf/g add	Y		A2	$323.28	4.5263	$187.39	$289.31
15430	Apply acellular xenograft	Y		A2	$323.28	4.5263	$187.39	$289.31
15431	Apply acellular xgraft add	Y		A2	$323.28	4.5263	$187.39	$289.31
15570	Form skin pedicle flap	Y		A2	$510.00	20.2069	$836.59	$591.65
15572	Form skin pedicle flap	Y		A2	$510.00	20.2069	$836.59	$591.65
15574	Form skin pedicle flap	Y		A2	$510.00	20.2069	$836.59	$591.65
15576	Form skin pedicle flap	Y		A2	$510.00	20.2069	$836.59	$591.65
15600	Skin graft	Y		A2	$510.00	20.2069	$836.59	$591.65
15610	Skin graft	Y		A2	$510.00	20.2069	$836.59	$591.65
15620	Skin graft	Y		A2	$630.00	20.2069	$836.59	$681.65
15630	Skin graft	Y		A2	$510.00	20.2069	$836.59	$591.65
15650	Transfer skin pedicle flap	Y		A2	$717.00	20.2069	$836.59	$746.90
15731	Forehead flap w/vasc pedicle	Y		A2	$510.00	20.2069	$836.59	$591.65
15732	Muscle-skin graft, head/neck	Y		A2	$510.00	20.2069	$836.59	$591.65
15734	Muscle-skin graft, trunk	Y		A2	$510.00	20.2069	$836.59	$591.65
15736	Muscle-skin graft, arm	Y		A2	$510.00	20.2069	$836.59	$591.65
15738	Muscle-skin graft, leg	Y		A2	$510.00	20.2069	$836.59	$591.65
15740	Island pedicle flap graft	Y		A2	$446.00	15.0458	$622.91	$490.23
15750	Neurovascular pedicle graft	Y		A2	$446.00	20.2069	$836.59	$543.65
15760	Composite skin graft	Y		A2	$446.00	20.2069	$836.59	$543.65
15770	Derma-fat-fascia graft	Y		A2	$510.00	20.2069	$836.59	$591.65
15775	Hair transplant punch grafts	Y		A2	$323.28	1.2792	$52.96	$255.70
15776	Hair transplant punch grafts	Y		A2	$323.28	1.2792	$52.96	$255.70
15780	Abrasion treatment of skin	Y		P3		9.3563	$387.36	$387.36
15781	Abrasion treatment of skin	Y		P2		4.3039	$178.19	$178.19
15782	Abrasion treatment of skin	Y		P2		4.3039	$178.19	$178.19
15783	Abrasion treatment of skin	Y		P2		2.6604	$110.14	$110.14
15786	Abrasion, lesion, single	Y		P2		0.793	$32.83	$32.83
15787	Abrasion, lesions, add-on	Y		P3		0.7901	$32.71	$32.71
15788	Chemical peel, face, epiderm	Y		P2		0.793	$32.83	$32.83
15789	Chemical peel, face, dermal	Y		P2		1.4595	$60.42	$60.42
15792	Chemical peel, nonfacial	Y		P2		1.4595	$60.42	$60.42
15793	Chemical peel, nonfacial	Y		P2		0.793	$32.83	$32.83
15819	Plastic surgery, neck	Y		G2		2.1051	$87.15	$87.15
15820	Revision of lower eyelid	Y		A2	$510.00	20.2069	$836.59	$591.65
15821	Revision of lower eyelid	Y		A2	$510.00	20.2069	$836.59	$591.65
15822	Revision of upper eyelid	Y		A2	$510.00	20.2069	$836.59	$591.65
15823	Revision of upper eyelid	Y		A2	$717.00	20.2069	$836.59	$746.90
15824	Removal of forehead wrinkles	Y		A2	$510.00	20.2069	$836.59	$591.65
15825	Removal of neck wrinkles	Y		A2	$510.00	20.2069	$836.59	$591.65
15826	Removal of brow wrinkles	Y		A2	$510.00	20.2069	$836.59	$591.65
15828	Removal of face wrinkles	Y		A2	$510.00	20.2069	$836.59	$591.65
15829	Removal of skin wrinkles	Y		A2	$717.00	20.2069	$836.59	$746.90
15830	Exc skin abd	Y		A2	$510.00	21.1098	$873.97	$600.99

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
15832	Excise excessive skin tissue	Y		A2	$510.00	21.1098	$873.97	$600.99
15833	Excise excessive skin tissue	Y		A2	$510.00	21.1098	$873.97	$600.99
15834	Excise excessive skin tissue	Y		A2	$510.00	21.1098	$873.97	$600.99
15835	Excise excessive skin tissue	Y		A2	$323.28	21.1098	$873.97	$460.95
15836	Excise excessive skin tissue	Y		A2	$510.00	16.1001	$666.56	$549.14
15837	Excise excessive skin tissue	Y		G2		16.1001	$666.56	$666.56
15838	Excise excessive skin tissue	Y		G2		16.1001	$666.56	$666.56
15839	Excise excessive skin tissue	Y		A2	$510.00	16.1001	$666.56	$549.14
15840	Graft for face nerve palsy	Y		A2	$630.00	20.2069	$836.59	$681.65
15841	Graft for face nerve palsy	Y		A2	$630.00	20.2069	$836.59	$681.65
15842	Flap for face nerve palsy	Y		G2		20.2069	$836.59	$836.59
15845	Skin and muscle repair, face	Y		A2	$630.00	20.2069	$836.59	$681.65
15847	Exc skin abd add-on	Y		A2	$510.00	21.1098	$873.97	$600.99
15850	Removal of sutures	Y		G2		2.6604	$110.14	$110.14
15851	Removal of sutures	Y		P3		1.2343	$51.10	$51.10
15852	Dressing change not for burn	N		G2		0.631	$26.12	$26.12
15860	Test for blood flow in graft	N		G2		0.631	$26.12	$26.12
15876	Suction assisted lipectomy	Y		A2	$510.00	20.2069	$836.59	$591.65
15877	Suction assisted lipectomy	Y		A2	$510.00	20.2069	$836.59	$591.65
15878	Suction assisted lipectomy	Y		A2	$510.00	20.2069	$836.59	$591.65
15879	Suction assisted lipectomy	Y		A2	$510.00	20.2069	$836.59	$591.65
15920	Removal of tail bone ulcer	Y		A2	$251.52	4.3039	$178.19	$233.19
15922	Removal of tail bone ulcer	Y		A2	$630.00	20.2069	$836.59	$681.65
15931	Remove sacrum pressure sore	Y		A2	$510.00	21.1098	$873.97	$600.99
15933	Remove sacrum pressure sore	Y		A2	$510.00	21.1098	$873.97	$600.99
15934	Remove sacrum pressure sore	Y		A2	$510.00	20.2069	$836.59	$591.65
15935	Remove sacrum pressure sore	Y		A2	$630.00	20.2069	$836.59	$681.65
15936	Remove sacrum pressure sore	Y		A2	$630.00	15.0458	$622.91	$628.23
15937	Remove sacrum pressure sore	Y		A2	$630.00	20.2069	$836.59	$681.65
15940	Remove hip pressure sore	Y		A2	$510.00	21.1098	$873.97	$600.99
15941	Remove hip pressure sore	Y		A2	$510.00	21.1098	$873.97	$600.99
15944	Remove hip pressure sore	Y		A2	$510.00	20.2069	$836.59	$591.65
15945	Remove hip pressure sore	Y		A2	$630.00	20.2069	$836.59	$681.65
15946	Remove hip pressure sore	Y		A2	$630.00	20.2069	$836.59	$681.65
15950	Remove thigh pressure sore	Y		A2	$510.00	21.1098	$873.97	$600.99
15951	Remove thigh pressure sore	Y		A2	$630.00	21.1098	$873.97	$690.99
15952	Remove thigh pressure sore	Y		A2	$510.00	15.0458	$622.91	$538.23
15953	Remove thigh pressure sore	Y		A2	$630.00	15.0458	$622.91	$628.23
15956	Remove thigh pressure sore	Y		A2	$510.00	15.0458	$622.91	$538.23
15958	Remove thigh pressure sore	Y		A2	$630.00	15.0458	$622.91	$628.23
16000	Initial treatment of burn(s)	Y		P3		0.65	$26.91	$26.91
16020	Dress/debrid p-thick burn, s	Y		P3		0.9874	$40.88	$40.88
16025	Dress/debrid p-thick burn, m	Y		A2	$67.11	2.6604	$110.14	$77.87
16030	Dress/debrid p-thick burn, l	Y		A2	$99.83	2.6604	$110.14	$102.41
16035	Incision of burn scab, initi	Y		G2		2.6604	$110.14	$110.14
17000	Destruct premalg lesion	Y		P2		0.793	$32.83	$32.83
17003	Destruct premalg les, 2-14	Y		P3		0.0906	$3.75	$3.75
17004	Destroy premlg lesions 15+	Y		P3		1.9502	$80.74	$80.74
17106	Destruction of skin lesions	Y		P2		2.6604	$110.14	$110.14
17107	Destruction of skin lesions	Y		P2		2.6604	$110.14	$110.14
17108	Destruction of skin lesions	Y		P2		2.6604	$110.14	$110.14
17110	Destruct b9 lesion, 1-14	Y		P2		0.793	$32.83	$32.83
17111	Destruct lesion, 15 or more	Y		P2		1.4595	$60.42	$60.42
17250	Chemical cautery, tissue	Y		P3		1.0451	$43.27	$43.27
17260	Destruction of skin lesions	Y		P3		1.1026	$45.65	$45.65
17261	Destruction of skin lesions	Y		P2		1.4595	$60.42	$60.42
17262	Destruction of skin lesions	Y		P2		1.4595	$60.42	$60.42
17263	Destruction of skin lesions	Y		P2		1.4595	$60.42	$60.42
17264	Destruction of skin lesions	Y		P2		1.4595	$60.42	$60.42
17266	Destruction of skin lesions	Y		P3		2.4685	$102.20	$102.20
17270	Destruction of skin lesions	Y		P2		1.4595	$60.42	$60.42
17271	Destruction of skin lesions	Y		P2		1.4595	$60.42	$60.42
17272	Destruction of skin lesions	Y		P2		1.4595	$60.42	$60.42
17273	Destruction of skin lesions	Y	CH	P3		2.2299	$92.32	$92.32
17274	Destruction of skin lesions	Y		P3		2.5345	$104.93	$104.93
17276	Destruction of skin lesions	Y		P2		2.6604	$110.14	$110.14
17280	Destruction of skin lesions	Y	CH	P2		1.4595	$60.42	$60.42
17281	Destruction of skin lesions	Y	CH	P3		1.9091	$79.04	$79.04
17282	Destruction of skin lesions	Y	CH	P3		2.1724	$89.94	$89.94
17283	Destruction of skin lesions	Y	CH	P3		2.5098	$103.91	$103.91
17284	Destruction of skin lesions	Y		P2		2.6604	$110.14	$110.14
17286	Destruction of skin lesions	Y		P2		2.6604	$110.14	$110.14
17311	Mohs, 1 stage, h/n/hf/g	Y		P2		3.6321	$150.37	$150.37

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ADDENDUM AA.—ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

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17312	Mohs addl stage	Y		P2		3.6321	$150.37	$150.37
17313	Mohs, 1 stage, t/a/l	Y		P2		3.6321	$150.37	$150.37
17314	Mohs, addl stage, t/a/l	Y		P2		3.6321	$150.37	$150.37
17315	Mohs surg, addl block	Y		P3		0.9381	$38.84	$38.84
17340	Cryotherapy of skin	Y		P3		0.2961	$12.26	$12.26
17360	Skin peel therapy	Y		P2		0.793	$32.83	$32.83
17380	Hair removal by electrolysis	Y		R2		0.793	$32.83	$32.83
19000	Drainage of breast lesion	Y		P3		1.6046	$66.43	$66.43
19001	Drain breast lesion add-on	Y		P3		0.2058	$8.52	$8.52
19020	Incision of breast lesion	Y		A2	$446.00	18.3197	$758.45	$524.11
19030	Injection for breast x-ray	N		N1				
19100	Bx breast percut w/o image	Y		A2	$240.00	4.327	$179.14	$224.79
19101	Biopsy of breast, open	Y		A2	$446.00	20.6417	$854.59	$548.15
19102	Bx breast percut w/image	Y		A2	$240.00	7.1147	$294.56	$253.64
19103	Bx breast percut w/device	Y		A2	$395.77	13.5764	$562.08	$437.35
19105	Cryosurg ablate fa, each	Y		G2		31.7134	$1,312.97	$1,312.97
19110	Nipple exploration	Y		A2	$446.00	20.6417	$854.59	$548.15
19112	Excise breast duct fistula	Y		A2	$510.00	20.6417	$854.59	$596.15
19120	Removal of breast lesion	Y		A2	$510.00	20.6417	$854.59	$596.15
19125	Excision, breast lesion	Y		A2	$510.00	20.6417	$854.59	$596.15
19126	Excision, addl breast lesion	Y		A2	$510.00	20.6417	$854.59	$596.15
19290	Place needle wire, breast	N		N1				
19291	Place needle wire, breast	N		N1				
19295	Place breast clip, percut	N	CH	N1				
19296	Place po breast cath for rad	Y		A2	$1,339.00	56.5774	$2,342.36	$1,589.84
19297	Place breast cath for rad	Y		A2	$1,339.00	56.5774	$2,342.36	$1,589.84
19298	Place breast rad tube/caths	Y		A2	$1,339.00	56.5774	$2,342.36	$1,589.84
19300	Removal of breast tissue	Y		A2	$630.00	20.6417	$854.59	$686.15
19301	Partical mastectomy	Y		A2	$510.00	20.6417	$854.59	$596.15
19302	P-mastectomy w/ln removal	Y		A2	$995.00	39.8191	$1,648.55	$1,158.39
19303	Mast, simple, complete	Y		A2	$630.00	31.7134	$1,312.97	$800.74
19304	Mast, subq	Y		A2	$630.00	31.7134	$1,312.97	$800.74
19316	Suspension of breast	Y		A2	$630.00	31.7134	$1,312.97	$800.74
19318	Reduction of large breast	Y		A2	$630.00	39.8191	$1,648.55	$884.64
19324	Enlarge breast	Y		A2	$630.00	39.8191	$1,648.55	$884.64
19325	Enlarge breast with implant	Y		A2	$1,339.00	56.5774	$2,342.36	$1,589.84
19328	Removal of breast implant	Y		A2	$333.00	31.7134	$1,312.97	$577.99
19330	Removal of implant material	Y		A2	$333.00	31.7134	$1,312.97	$577.99
19340	Immediate breast prosthesis	Y		A2	$446.00	39.8191	$1,648.55	$746.64
19342	Delayed breast prosthesis	Y		A2	$510.00	56.5774	$2,342.36	$968.09
19350	Breast reconstruction	Y		A2	$630.00	20.6417	$854.59	$686.15
19355	Correct inverted nipple(s)	Y		A2	$630.00	31.7134	$1,312.97	$800.74
19357	Breast reconstruction	Y		A2	$717.00	56.5774	$2,342.36	$1,123.34
19366	Breast reconstruction	Y		A2	$717.00	31.7134	$1,312.97	$865.99
19370	Surgery of breast capsule	Y		A2	$630.00	31.7134	$1,312.97	$800.74
19371	Removal of breast capsule	Y		A2	$630.00	31.7134	$1,312.97	$800.74
19380	Revise breast reconstruction	Y		A2	$717.00	39.8191	$1,648.55	$949.89
19396	Design custom breast implant	Y		G2		31.7134	$1,312.97	$1,312.97
20000	Incision of abscess	Y		P2		1.4066	$58.23	$58.23
20005	Incision of deep abscess	Y		A2	$446.00	21.2689	$880.55	$554.64
20103	Explore wound, extremity	Y		G2		9.6341	$398.86	$398.86
20150	Excise epiphyseal bar	Y		G2		42.985	$1,779.62	$1,779.62
20200	Muscle biopsy	Y		A2	$446.00	16.1001	$666.56	$501.14
20205	Deep muscle biopsy	Y		A2	$510.00	16.1001	$666.56	$549.14
20206	Needle biopsy, muscle	Y		A2	$240.00	7.1147	$294.56	$253.64
20220	Bone biopsy, trocar/needle	Y		A2	$251.52	8.685	$359.57	$278.53
20225	Bone biopsy, trocar/needle	Y		A2	$418.49	8.685	$359.57	$403.76
20240	Bone biopsy, excisional	Y		A2	$446.00	21.1098	$873.97	$552.99
20245	Bone biopsy, excisional	Y		A2	$510.00	21.1098	$873.97	$600.99
20250	Open bone biopsy	Y		A2	$510.00	21.2689	$880.55	$602.64
20251	Open bone biopsy	Y		A2	$510.00	21.2689	$880.55	$602.64
20500	Injection of sinus tract	Y		P3		1.4811	$61.32	$61.32
20501	Inject sinus tract for x-ray	N		N1				
20520	Removal of foreign body	Y		P3		2.2712	$94.03	$94.03
20525	Removal of foreign body	Y		A2	$510.00	21.1098	$873.97	$600.99
20526	Ther injection, carp tunnel	Y		P3		0.7323	$30.32	$30.32
20550	Inj tendon sheath/ligament	Y		P3		0.5514	$22.83	$22.83
20551	Inj tendon origin/insertion	Y		P3		0.5432	$22.49	$22.49
20552	Inj trigger point, 1/2 muscl	Y		P3		0.5348	$22.14	$22.14
20553	Inject trigger points, =/> 3	Y		P3		0.6007	$24.87	$24.87
20555	Place ndl musc/tis for rt	Y	NI	G2		29.19	$1,208.50	$1,208.50
20600	Drain/inject, joint/bursa	Y		P3		0.5432	$22.49	$22.49
20605	Drain/inject, joint/bursa	Y		P3		0.6171	$25.55	$25.55

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
20610	Drain/inject, joint/bursa	Y		P3		0.8311	$34.41	$34.41
20612	Aspirate/inj ganglion cyst	Y		P3		0.5761	$23.85	$23.85
20615	Treatment of bone cyst	Y	CH	P3		2.5591	$105.95	$105.95
20650	Insert and remove bone pin	Y		A2	$510.00	21.2689	$880.55	$602.64
20662	Application of pelvis brace	Y		R2		21.2689	$880.55	$880.55
20663	Application of thigh brace	Y		R2		21.2689	$880.55	$880.55
20665	Removal of fixation device	N		G2		0.631	$26.12	$26.12
20670	Removal of support implant	Y		A2	$333.00	16.1001	$666.56	$416.39
20680	Removal of support implant	Y		A2	$510.00	21.1098	$873.97	$600.99
20690	Apply bone fixation device	Y		A2	$446.00	29.19	$1,208.50	$636.63
20692	Apply bone fixation device	Y		A2	$510.00	29.19	$1,208.50	$684.63
20693	Adjust bone fixation device	Y		A2	$510.00	21.2689	$880.55	$602.64
20694	Remove bone fixation device	Y		A2	$333.00	21.2689	$880.55	$469.89
20822	Replantation digit, complete	Y		G2		26.3105	$1,089.28	$1,089.28
20900	Removal of bone for graft	Y		A2	$510.00	29.19	$1,208.50	$684.63
20902	Removal of bone for graft	Y		A2	$630.00	29.19	$1,208.50	$774.63
20910	Remove cartilage for graft	Y		A2	$510.00	20.2069	$836.59	$591.65
20912	Remove cartilage for graft	Y		A2	$510.00	20.2069	$836.59	$591.65
20920	Removal of fascia for graft	Y		A2	$630.00	15.0458	$622.91	$628.23
20922	Removal of fascia for graft	Y		A2	$510.00	15.0458	$622.91	$538.23
20924	Removal of tendon for graft	Y		A2	$630.00	29.19	$1,208.50	$774.63
20926	Removal of tissue for graft	Y		A2	$630.00	4.5263	$187.39	$519.35
20950	Fluid pressure, muscle	Y		G2		1.4066	$58.23	$58.23
20972	Bone/skin graft, metatarsal	Y		G2		44.2687	$1,832.77	$1,832.77
20973	Bone/skin graft, great toe	Y		R2		44.2687	$1,832.77	$1,832.77
20975	Electrical bone stimulation	N	CH	N1				
20979	Us bone stimulation	N		P3		0.5843	$24.19	$24.19
20982	Ablate, bone tumor(s) perq	Y		G2		42.985	$1,779.62	$1,779.62
20985	Cptr-asst dir ms px	N	NI	N1				
20986	Cptr-asst dir ms px io img	N	NI	N1				
20987	Cptr-asst dir ms px pre img	N	NI	N1				
21010	Incision of jaw joint	Y		A2	$446.00	23.9765	$992.65	$582.66
21015	Resection of facial tumor	Y		A2	$510.00	16.3288	$676.03	$551.51
21025	Excision of bone, lower jaw	Y		A2	$446.00	39.8776	$1,650.97	$747.24
21026	Excision of facial bone(s)	Y		A2	$446.00	39.8776	$1,650.97	$747.24
21029	Contour of face bone lesion	Y		A2	$446.00	39.8776	$1,650.97	$747.24
21030	Excise max/zygoma b9 tumor	Y		P3		5.5627	$230.30	$230.30
21031	Remove exostosis, mandible	Y		P3		4.5588	$188.74	$188.74
21032	Remove exostosis, maxilla	Y		P3		4.6823	$193.85	$193.85
21034	Excise max/zygoma mlg tumor	Y		A2	$510.00	39.8776	$1,650.97	$795.24
21040	Excise mandible lesion	Y		A2	$446.00	23.9765	$992.65	$582.66
21044	Removal of jaw bone lesion	Y		A2	$446.00	39.8776	$1,650.97	$747.24
21046	Remove mandible cyst complex	Y		A2	$446.00	39.8776	$1,650.97	$747.24
21047	Excise lwr jaw cyst w/repair	Y		A2	$446.00	39.8776	$1,650.97	$747.24
21048	Remove maxilla cyst complex	Y		R2		39.8776	$1,650.97	$1,650.97
21050	Removal of jaw joint	Y		A2	$510.00	39.8776	$1,650.97	$795.24
21060	Remove jaw joint cartilage	Y		A2	$446.00	39.8776	$1,650.97	$747.24
21070	Remove coronoid process	Y		A2	$510.00	39.8776	$1,650.97	$795.24
21073*	Mnpj of tmj w/anesth	Y	NI	P3		4.526	$187.38	$187.38
21076	Prepare face/oral prosthesis	Y		P3		8.3769	$346.81	$346.81
21077	Prepare face/oral prosthesis	Y		P3		20.457	$846.94	$846.94
21079	Prepare face/oral prosthesis	Y		P3		14.5815	$603.69	$603.69
21080	Prepare face/oral prosthesis	Y		P3		16.7129	$691.93	$691.93
21081	Prepare face/oral prosthesis	Y		P3		15.3467	$635.37	$635.37
21082	Prepare face/oral prosthesis	Y		P3		14.0796	$582.91	$582.91
21083	Prepare face/oral prosthesis	Y		P3		13.8492	$573.37	$573.37
21084	Prepare face/oral prosthesis	Y		P3		16.1532	$668.76	$668.76
21085	Prepare face/oral prosthesis	Y		P3		6.254	$258.92	$258.92
21086	Prepare face/oral prosthesis	Y		P3		15.067	$623.79	$623.79
21087	Prepare face/oral prosthesis	Y		P3		14.9354	$618.34	$618.34
21088	Prepare face/oral prosthesis	Y		R2		39.8776	$1,650.97	$1,650.97
21100	Maxillofacial fixation	Y		A2	$446.00	39.8776	$1,650.97	$747.24
21110	Interdental fixation	Y		P2		7.4474	$308.33	$308.33
21116	Injection, jaw joint x-ray	N		N1				
21120	Reconstruction of chin	Y		A2	$995.00	23.9765	$992.65	$994.41
21121	Reconstruction of chin	Y		A2	$995.00	23.9765	$992.65	$994.41
21122	Reconstruction of chin	Y		A2	$995.00	23.9765	$992.65	$994.41
21123	Reconstruction of chin	Y		A2	$995.00	23.9765	$992.65	$994.41
21125	Augmentation, lower jaw bone	Y		A2	$995.00	23.9765	$992.65	$994.41
21127	Augmentation, lower jaw bone	Y		A2	$1,339.00	39.8776	$1,650.97	$1,416.99
21137	Reduction of forehead	Y		G2		23.9765	$992.65	$992.65
21138	Reduction of forehead	Y		G2		39.8776	$1,650.97	$1,650.97
21139	Reduction of forehead	Y		G2		39.8776	$1,650.97	$1,650.97

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
21150	Reconstruct midface, lefort	Y		G2		39.8776	$1,650.97	$1,650.97
21181	Contour cranial bone lesion	Y		A2	$995.00	23.9765	$992.65	$994.41
21198	Reconstr lwr jaw segment	Y		G2		39.8776	$1,650.97	$1,650.97
21199	Reconstr lwr jaw w/advance	Y		G2		39.8776	$1,650.97	$1,650.97
21206	Reconstruct upper jaw bone	Y		A2	$717.00	39.8776	$1,650.97	$950.49
21208	Augmentation of facial bones	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
21209	Reduction of facial bones	Y		A2	$717.00	39.8776	$1,650.97	$950.49
21210	Face bone graft	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
21215	Lower jaw bone graft	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
21230	Rib cartilage graft	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
21235	Ear cartilage graft	Y		A2	$995.00	23.9765	$992.65	$994.41
21240	Reconstruction of jaw joint	Y		A2	$630.00	39.8776	$1,650.97	$885.24
21242	Reconstruction of jaw joint	Y		A2	$717.00	39.8776	$1,650.97	$950.49
21243	Reconstruction of jaw joint	Y		A2	$717.00	39.8776	$1,650.97	$950.49
21244	Reconstruction of lower jaw	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
21245	Reconstruction of jaw	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
21246	Reconstruction of jaw	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
21248	Reconstruction of jaw	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
21249	Reconstruction of jaw	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
21260	Revise eye sockets	Y		G2		39.8776	$1,650.97	$1,650.97
21267	Revise eye sockets	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
21270	Augmentation, cheek bone	Y		A2	$717.00	39.8776	$1,650.97	$950.49
21275	Revision, orbitofacial bones	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
21280	Revision of eyelid	Y		A2	$717.00	39.8776	$1,650.97	$950.49
21282	Revision of eyelid	Y		A2	$717.00	16.3288	$676.03	$706.76
21295	Revision of jaw muscle/bone	Y		A2	$333.00	7.4474	$308.33	$326.83
21296	Revision of jaw muscle/bone	Y		A2	$333.00	23.9765	$992.65	$497.91
21310	Treatment of nose fracture	Y		A2	$150.72	2.5002	$103.51	$138.92
21315	Treatment of nose fracture	Y		A2	$150.72	2.5002	$103.51	$138.92
21320	Treatment of nose fracture	Y		A2	$446.00	16.3288	$676.03	$503.51
21325	Treatment of nose fracture	Y		A2	$630.00	23.9765	$992.65	$720.66
21330	Treatment of nose fracture	Y		A2	$717.00	23.9765	$992.65	$785.91
21335	Treatment of nose fracture	Y		A2	$995.00	23.9765	$992.65	$994.41
21336	Treat nasal septal fracture	Y		A2	$630.00	26.1592	$1,083.02	$743.26
21337	Treat nasal septal fracture	Y		A2	$446.00	16.3288	$676.03	$503.51
21338	Treat nasoethmoid fracture	Y		A2	$630.00	23.9765	$992.65	$720.66
21339	Treat nasoethmoid fracture	Y		A2	$717.00	23.9765	$992.65	$785.91
21340	Treatment of nose fracture	Y		A2	$630.00	39.8776	$1,650.97	$885.24
21345	Treat nose/jaw fracture	Y		A2	$995.00	23.9765	$992.65	$994.41
21355	Treat cheek bone fracture	Y		A2	$510.00	39.8776	$1,650.97	$795.24
21356	Treat cheek bone fracture	Y		A2	$510.00	23.9765	$992.65	$630.66
21360	Treat cheek bone fracture	Y	CH	G2		23.9765	$992.65	$992.65
21390	Treat eye socket fracture	Y		G2		39.8776	$1,650.97	$1,650.97
21400	Treat eye socket fracture	Y		A2	$446.00	7.4474	$308.33	$411.58
21401	Treat eye socket fracture	Y		A2	$510.00	16.3288	$676.03	$551.51
21406	Treat eye socket fracture	Y		G2		39.8776	$1,650.97	$1,650.97
21407	Treat eye socket fracture	Y		G2		39.8776	$1,650.97	$1,650.97
21421	Treat mouth roof fracture	Y		A2	$630.00	23.9765	$992.65	$720.66
21440	Treat dental ridge fracture	Y		P3		7.0605	$292.31	$292.31
21445	Treat dental ridge fracture	Y		A2	$630.00	23.9765	$992.65	$720.66
21450	Treat lower jaw fracture	Y		A2	$150.72	2.5002	$103.51	$138.92
21451	Treat lower jaw fracture	Y		A2	$464.15	7.4474	$308.33	$425.20
21452	Treat lower jaw fracture	Y		A2	$446.00	16.3288	$676.03	$503.51
21453	Treat lower jaw fracture	Y		A2	$510.00	39.8776	$1,650.97	$795.24
21454	Treat lower jaw fracture	Y		A2	$717.00	23.9765	$992.65	$785.91
21461	Treat lower jaw fracture	Y		A2	$630.00	39.8776	$1,650.97	$885.24
21462	Treat lower jaw fracture	Y		A2	$717.00	39.8776	$1,650.97	$950.49
21465	Treat lower jaw fracture	Y		A2	$630.00	39.8776	$1,650.97	$885.24
21480	Reset dislocated jaw	Y		A2	$150.72	2.5002	$103.51	$138.92
21485	Reset dislocated jaw	Y		A2	$446.00	16.3288	$676.03	$503.51
21490	Repair dislocated jaw	Y		A2	$510.00	39.8776	$1,650.97	$795.24
21495	Treat hyoid bone fracture	Y		G2		16.3288	$676.03	$676.03
21497	Interdental wiring	Y		A2	$446.00	16.3288	$676.03	$503.51
21501	Drain neck/chest lesion	Y		A2	$446.00	18.3197	$758.45	$524.11
21502	Drain chest lesion	Y		A2	$446.00	21.2689	$880.55	$554.64
21550	Biopsy of neck/chest	Y		G2		8.685	$359.57	$359.57
21555	Remove lesion, neck/chest	Y		A2	$446.00	21.1098	$873.97	$552.99
21556	Remove lesion, neck/chest	Y		A2	$446.00	21.1098	$873.97	$552.99
21557	Remove tumor, neck/chest	Y		G2		21.1098	$873.97	$873.97
21600	Partial removal of rib	Y		A2	$446.00	29.19	$1,208.50	$636.63
21610	Partial removal of rib	Y		A2	$446.00	29.19	$1,208.50	$636.63
21685	Hyoid myotomy & suspension	Y		G2		7.4474	$308.33	$308.33
21700	Revision of neck muscle	Y		A2	$446.00	21.2689	$880.55	$554.64

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
21720	Revision of neck muscle	Y		A2	$510.00	21.2689	$880.55	$602.64
21725	Revision of neck muscle	Y		A2	$88.46	1.4066	$58.23	$80.90
21800	Treatment of rib fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
21805	Treatment of rib fracture	Y		A2	$446.00	26.1592	$1,083.02	$605.26
21820	Treat sternum fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
21920	Biopsy soft tissue of back	Y		P3		3.1763	$131.50	$131.50
21925	Biopsy soft tissue of back	Y		A2	$446.00	21.1098	$873.97	$552.99
21930	Remove lesion, back or flank	Y		A2	$446.00	21.1098	$873.97	$552.99
21935	Remove tumor, back	Y		A2	$510.00	21.1098	$873.97	$600.99
22102	Remove part, lumbar vertebra	Y		G2		46.7724	$1,936.42	$1,936.42
22103	Remove extra spine segment	Y		G2		46.7724	$1,936.42	$1,936.42
22305	Treat spine process fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
22310	Treat spine fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
22315	Treat spine fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
22505	Manipulation of spine	Y		A2	$446.00	14.7658	$611.32	$487.33
22520	Percut vertebroplasty thor	Y		A2	$1,339.00	29.19	$1,208.50	$1,306.38
22521	Percut vertebroplasty lumb	Y		A2	$1,339.00	29.19	$1,208.50	$1,306.38
22522	Percut vertebroplasty add 1	Y		A2	$1,339.00	29.19	$1,208.50	$1,306.38
22523	Percut kyphoplasty, thor	Y		G2		79.4244	$3,288.25	$3,288.25
22524	Percut kyphoplasty, lumbar	Y		G2		79.4244	$3,288.25	$3,288.25
22525	Percut kyphoplasty, add-on	Y		G2		79.4244	$3,288.25	$3,288.25
22526	Idet, single level	Y	CH	G2		29.19	$1,208.50	$1,208.50
22527	Idet, 1 or more levels	Y	CH	G2		29.19	$1,208.50	$1,208.50
22900	Remove abdominal wall lesion	Y		A2	$630.00	21.1098	$873.97	$690.99
23000	Removal of calcium deposits	Y		A2	$446.00	16.1001	$666.56	$501.14
23020	Release shoulder joint	Y		A2	$446.00	42.985	$1,779.62	$779.41
23030	Drain shoulder lesion	Y		A2	$333.00	18.3197	$758.45	$439.36
23031	Drain shoulder bursa	Y		A2	$510.00	18.3197	$758.45	$572.11
23035	Drain shoulder bone lesion	Y		A2	$510.00	21.2689	$880.55	$602.64
23040	Exploratory shoulder surgery	Y		A2	$510.00	29.19	$1,208.50	$684.63
23044	Exploratory shoulder surgery	Y		A2	$630.00	29.19	$1,208.50	$774.63
23065	Biopsy shoulder tissues	Y		P3		2.2384	$92.67	$92.67
23066	Biopsy shoulder tissues	Y		A2	$446.00	21.1098	$873.97	$552.99
23075	Removal of shoulder lesion	Y		A2	$446.00	16.1001	$666.56	$501.14
23076	Removal of shoulder lesion	Y		A2	$446.00	21.1098	$873.97	$552.99
23077	Remove tumor of shoulder	Y		A2	$510.00	21.1098	$873.97	$600.99
23100	Biopsy of shoulder joint	Y		A2	$446.00	21.2689	$880.55	$554.64
23101	Shoulder joint surgery	Y		A2	$995.00	29.19	$1,208.50	$1,048.38
23105	Remove shoulder joint lining	Y		A2	$630.00	29.19	$1,208.50	$774.63
23106	Incision of collarbone joint	Y		A2	$630.00	29.19	$1,208.50	$774.63
23107	Explore treat shoulder joint	Y		A2	$630.00	29.19	$1,208.50	$774.63
23120	Partial removal, collar bone	Y		A2	$717.00	29.19	$1,208.50	$839.88
23125	Removal of collar bone	Y		A2	$717.00	29.19	$1,208.50	$839.88
23130	Remove shoulder bone, part	Y		A2	$717.00	42.985	$1,779.62	$982.66
23140	Removal of bone lesion	Y		A2	$630.00	21.2689	$880.55	$692.64
23145	Removal of bone lesion	Y		A2	$717.00	29.19	$1,208.50	$839.88
23146	Removal of bone lesion	Y		A2	$717.00	29.19	$1,208.50	$839.88
23150	Removal of humerus lesion	Y		A2	$630.00	29.19	$1,208.50	$774.63
23155	Removal of humerus lesion	Y		A2	$717.00	29.19	$1,208.50	$839.88
23156	Removal of humerus lesion	Y		A2	$717.00	29.19	$1,208.50	$839.88
23170	Remove collar bone lesion	Y		A2	$446.00	29.19	$1,208.50	$636.63
23172	Remove shoulder blade lesion	Y		A2	$446.00	29.19	$1,208.50	$636.63
23174	Remove humerus lesion	Y		A2	$446.00	29.19	$1,208.50	$636.63
23180	Remove collar bone lesion	Y		A2	$630.00	29.19	$1,208.50	$774.63
23182	Remove shoulder blade lesion	Y		A2	$630.00	29.19	$1,208.50	$774.63
23184	Remove humerus lesion	Y		A2	$630.00	29.19	$1,208.50	$774.63
23190	Partial removal of scapula	Y		A2	$630.00	29.19	$1,208.50	$774.63
23195	Removal of head of humerus	Y		A2	$717.00	29.19	$1,208.50	$839.88
23330	Remove shoulder foreign body	Y		A2	$333.00	8.685	$359.57	$339.64
23331	Remove shoulder foreign body	Y		A2	$333.00	21.1098	$873.97	$468.24
23350	Injection for shoulder x-ray	N		N1				
23395	Muscle transfer,shoulder/arm	Y		A2	$717.00	42.985	$1,779.62	$982.66
23397	Muscle transfers	Y		A2	$995.00	79.4244	$3,288.25	$1,568.31
23400	Fixation of shoulder blade	Y		A2	$995.00	29.19	$1,208.50	$1,048.38
23405	Incision of tendon & muscle	Y		A2	$446.00	29.19	$1,208.50	$636.63
23406	Incise tendon(s) & muscle(s)	Y		A2	$446.00	29.19	$1,208.50	$636.63
23410	Repair rotator cuff, acute	Y		A2	$717.00	42.985	$1,779.62	$982.66
23412	Repair rotator cuff, chronic	Y		A2	$995.00	42.985	$1,779.62	$1,191.16
23415	Release of shoulder ligament	Y		A2	$717.00	42.985	$1,779.62	$982.66
23420	Repair of shoulder	Y		A2	$995.00	42.985	$1,779.62	$1,191.16
23430	Repair biceps tendon	Y		A2	$630.00	42.985	$1,779.62	$917.41
23440	Remove/transplant tendon	Y		A2	$630.00	42.985	$1,779.62	$917.41
23450	Repair shoulder capsule	Y		A2	$717.00	79.4244	$3,288.25	$1,359.81

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.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
23455	Repair shoulder capsule	Y		A2	$995.00	79.4244	$3,288.25	$1,568.31
23460	Repair shoulder capsule	Y		A2	$717.00	79.4244	$3,288.25	$1,359.81
23462	Repair shoulder capsule	Y		A2	$995.00	42.985	$1,779.62	$1,191.16
23465	Repair shoulder capsule	Y		A2	$717.00	79.4244	$3,288.25	$1,359.81
23466	Repair shoulder capsule	Y		A2	$995.00	42.985	$1,779.62	$1,191.16
23480	Revision of collar bone	Y		A2	$630.00	42.985	$1,779.62	$917.41
23485	Revision of collar bone	Y		A2	$995.00	79.4244	$3,288.25	$1,568.31
23490	Reinforce clavicle	Y		A2	$510.00	42.985	$1,779.62	$827.41
23491	Reinforce shoulder bones	Y		A2	$510.00	79.4244	$3,288.25	$1,204.56
23500	Treat clavicle fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
23505	Treat clavicle fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
23515	Treat clavicle fracture	Y		A2	$510.00	59.2233	$2,451.90	$995.48
23520	Treat clavicle dislocation	Y		A2	$103.62	1.7682	$73.21	$96.02
23525	Treat clavicle dislocation	Y		A2	$103.62	1.7682	$73.21	$96.02
23530	Treat clavicle dislocation	Y		A2	$510.00	41.1091	$1,701.96	$807.99
23532	Treat clavicle dislocation	Y		A2	$630.00	26.1592	$1,083.02	$743.26
23540	Treat clavicle dislocation	Y		A2	$103.62	1.7682	$73.21	$96.02
23545	Treat clavicle dislocation	Y		A2	$103.62	1.7682	$73.21	$96.02
23550	Treat clavicle dislocation	Y		A2	$510.00	41.1091	$1,701.96	$807.99
23552	Treat clavicle dislocation	Y		A2	$630.00	41.1091	$1,701.96	$897.99
23570	Treat shoulder blade fx	Y		A2	$103.62	1.7682	$73.21	$96.02
23575	Treat shoulder blade fx	Y		A2	$103.62	1.7682	$73.21	$96.02
23585	Treat scapula fracture	Y		A2	$510.00	59.2233	$2,451.90	$995.48
23600	Treat humerus fracture	Y		P2		1.7682	$73.21	$73.21
23605	Treat humerus fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
23615	Treat humerus fracture	Y		A2	$630.00	59.2233	$2,451.90	$1,085.48
23616	Treat humerus fracture	Y		A2	$630.00	59.2233	$2,451.90	$1,085.48
23620	Treat humerus fracture	Y		P2		1.7682	$73.21	$73.21
23625	Treat humerus fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
23630	Treat humerus fracture	Y		A2	$717.00	59.2233	$2,451.90	$1,150.73
23650	Treat shoulder dislocation	Y		A2	$103.62	1.7682	$73.21	$96.02
23655	Treat shoulder dislocation	Y		A2	$333.00	14.7658	$611.32	$402.58
23660	Treat shoulder dislocation	Y		A2	$510.00	41.1091	$1,701.96	$807.99
23665	Treat dislocation/fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
23670	Treat dislocation/fracture	Y		A2	$510.00	59.2233	$2,451.90	$995.48
23675	Treat dislocation/fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
23680	Treat dislocation/fracture	Y		A2	$510.00	41.1091	$1,701.96	$807.99
23700	Fixation of shoulder	Y		A2	$333.00	14.7658	$611.32	$402.58
23800	Fusion of shoulder joint	Y		A2	$630.00	79.4244	$3,288.25	$1,294.56
23802	Fusion of shoulder joint	Y		A2	$995.00	42.985	$1,779.62	$1,191.16
23921	Amputation follow-up surgery	Y		A2	$323.28	15.0458	$622.91	$398.19
23930	Drainage of arm lesion	Y		A2	$333.00	18.3197	$758.45	$439.36
23931	Drainage of arm bursa	Y		A2	$446.00	18.3197	$758.45	$524.11
23935	Drain arm/elbow bone lesion	Y		A2	$446.00	21.2689	$880.55	$554.64
24000	Exploratory elbow surgery	Y		A2	$630.00	29.19	$1,208.50	$774.63
24006	Release elbow joint	Y		A2	$630.00	29.19	$1,208.50	$774.63
24065	Biopsy arm/elbow soft tissue	Y		P3		3.0282	$125.37	$125.37
24066	Biopsy arm/elbow soft tissue	Y		A2	$446.00	16.1001	$666.56	$501.14
24075	Remove arm/elbow lesion	Y		A2	$446.00	16.1001	$666.56	$501.14
24076	Remove arm/elbow lesion	Y		A2	$446.00	21.1098	$873.97	$552.99
24077	Remove tumor of arm/elbow	Y		A2	$510.00	21.1098	$873.97	$600.99
24100	Biopsy elbow joint lining	Y		A2	$333.00	21.2689	$880.55	$469.89
24101	Explore/treat elbow joint	Y		A2	$630.00	29.19	$1,208.50	$774.63
24102	Remove elbow joint lining	Y		A2	$630.00	29.19	$1,208.50	$774.63
24105	Removal of elbow bursa	Y		A2	$510.00	21.2689	$880.55	$602.64
24110	Remove humerus lesion	Y		A2	$446.00	21.2689	$880.55	$554.64
24115	Remove/graft bone lesion	Y		A2	$510.00	29.19	$1,208.50	$684.63
24116	Remove/graft bone lesion	Y		A2	$510.00	29.19	$1,208.50	$684.63
24120	Remove elbow lesion	Y		A2	$510.00	21.2689	$880.55	$602.64
24125	Remove/graft bone lesion	Y		A2	$510.00	29.19	$1,208.50	$684.63
24126	Remove/graft bone lesion	Y		A2	$510.00	29.19	$1,208.50	$684.63
24130	Removal of head of radius	Y		A2	$510.00	29.19	$1,208.50	$684.63
24134	Removal of arm bone lesion	Y		A2	$446.00	29.19	$1,208.50	$636.63
24136	Remove radius bone lesion	Y		A2	$446.00	29.19	$1,208.50	$636.63
24138	Remove elbow bone lesion	Y		A2	$446.00	29.19	$1,208.50	$636.63
24140	Partial removal of arm bone	Y		A2	$510.00	29.19	$1,208.50	$684.63
24145	Partial removal of radius	Y		A2	$510.00	29.19	$1,208.50	$684.63
24147	Partial removal of elbow	Y		A2	$446.00	29.19	$1,208.50	$636.63
24149	Radical resection of elbow	Y		G2		29.19	$1,208.50	$1,208.50
24152	Extensive radius surgery	Y		G2		42.985	$1,779.62	$1,779.62
24153	Extensive radius surgery	Y		G2		79.4244	$3,288.25	$3,288.25
24155	Removal of elbow joint	Y		A2	$510.00	42.985	$1,779.62	$827.41
24160	Remove elbow joint implant	Y		A2	$446.00	29.19	$1,208.50	$636.63

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
24164	Remove radius head implant	Y		A2	$510.00	29.19	$1,208.50	$684.63
24200	Removal of arm foreign body	Y		P3		2.5263	$104.59	$104.59
24201	Removal of arm foreign body	Y		A2	$446.00	16.1001	$666.56	$501.14
24220	Injection for elbow x-ray	N		N1				
24300	Manipulate elbow w/anesth	Y		G2		14.7658	$611.32	$611.32
24301	Muscle/tendon transfer	Y		A2	$630.00	29.19	$1,208.50	$774.63
24305	Arm tendon lengthening	Y		A2	$630.00	29.19	$1,208.50	$774.63
24310	Revision of arm tendon	Y		A2	$510.00	21.2689	$880.55	$602.64
24320	Repair of arm tendon	Y		A2	$510.00	42.985	$1,779.62	$827.41
24330	Revision of arm muscles	Y		A2	$510.00	79.4244	$3,288.25	$1,204.56
24331	Revision of arm muscles	Y		A2	$510.00	42.985	$1,779.62	$827.41
24332	Tenolysis, triceps	Y		G2		21.2689	$880.55	$880.55
24340	Repair of biceps tendon	Y		A2	$510.00	42.985	$1,779.62	$827.41
24341	Repair arm tendon/muscle	Y		A2	$510.00	42.985	$1,779.62	$827.41
24342	Repair of ruptured tendon	Y		A2	$510.00	42.985	$1,779.62	$827.41
24343	Repr elbow lat ligmnt w/tiss	Y		G2		29.19	$1,208.50	$1,208.50
24344	Reconstruct elbow lat ligmnt	Y		G2		79.4244	$3,288.25	$3,288.25
24345	Repr elbw med ligmnt w/tissu	Y		A2	$446.00	29.19	$1,208.50	$636.63
24346	Reconstruct elbow med ligmnt	Y		G2		42.985	$1,779.62	$1,779.62
24350	Repair of tennis elbow	N	CH	D5				
24351	Repair of tennis elbow	N	CH	D5				
24352	Repair of tennis elbow	N	CH	D5				
24354	Repair of tennis elbow	N	CH	D5				
24356	Revision of tennis elbow	N	CH	D5				
24357	Repair elbow, perc	Y	NI	G2		29.19	$1,208.50	$1,208.50
24358	Repair elbow w/deb, open	Y	NI	G2		29.19	$1,208.50	$1,208.50
24359	Repair elbow deb/attch open	Y	NI	G2		29.19	$1,208.50	$1,208.50
24360	Reconstruct elbow joint	Y		A2	$717.00	35.904	$1,486.46	$909.37
24361	Reconstruct elbow joint	Y		A2	$717.00	122.2057	$5,059.44	$1,802.61
24362	Reconstruct elbow joint	Y		A2	$717.00	50.8876	$2,106.80	$1,064.45
24363	Replace elbow joint	Y		A2	$995.00	122.2057	$5,059.44	$2,011.11
24365	Reconstruct head of radius	Y		A2	$717.00	35.904	$1,486.46	$909.37
24366	Reconstruct head of radius	Y		A2	$717.00	122.2057	$5,059.44	$1,802.61
24400	Revision of humerus	Y		A2	$630.00	29.19	$1,208.50	$774.63
24410	Revision of humerus	Y		A2	$630.00	29.19	$1,208.50	$774.63
24420	Revision of humerus	Y		A2	$510.00	42.985	$1,779.62	$827.41
24430	Repair of humerus	Y		A2	$510.00	79.4244	$3,288.25	$1,204.56
24435	Repair humerus with graft	Y		A2	$630.00	79.4244	$3,288.25	$1,294.56
24470	Revision of elbow joint	Y		A2	$510.00	42.985	$1,779.62	$827.41
24495	Decompression of forearm	Y		A2	$446.00	29.19	$1,208.50	$636.63
24498	Reinforce humerus	Y		A2	$510.00	79.4244	$3,288.25	$1,204.56
24500	Treat humerus fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
24505	Treat humerus fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
24515	Treat humerus fracture	Y		A2	$630.00	59.2233	$2,451.90	$1,085.48
24516	Treat humerus fracture	Y		A2	$630.00	59.2233	$2,451.90	$1,085.48
24530	Treat humerus fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
24535	Treat humerus fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
24538	Treat humerus fracture	Y		A2	$446.00	26.1592	$1,083.02	$605.26
24545	Treat humerus fracture	Y		A2	$630.00	59.2233	$2,451.90	$1,085.48
24546	Treat humerus fracture	Y		A2	$717.00	59.2233	$2,451.90	$1,150.73
24560	Treat humerus fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
24565	Treat humerus fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
24566	Treat humerus fracture	Y		A2	$446.00	26.1592	$1,083.02	$605.26
24575	Treat humerus fracture	Y		A2	$510.00	59.2233	$2,451.90	$995.48
24576	Treat humerus fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
24577	Treat humerus fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
24579	Treat humerus fracture	Y		A2	$510.00	59.2233	$2,451.90	$995.48
24582	Treat humerus fracture	Y		A2	$446.00	26.1592	$1,083.02	$605.26
24586	Treat elbow fracture	Y		A2	$630.00	59.2233	$2,451.90	$1,085.48
24587	Treat elbow fracture	Y		A2	$717.00	59.2233	$2,451.90	$1,150.73
24600	Treat elbow dislocation	Y		A2	$103.62	1.7682	$73.21	$96.02
24605	Treat elbow dislocation	Y		A2	$446.00	14.7658	$611.32	$487.33
24615	Treat elbow dislocation	Y		A2	$510.00	59.2233	$2,451.90	$995.48
24620	Treat elbow fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
24635	Treat elbow fracture	Y		A2	$510.00	59.2233	$2,451.90	$995.48
24640	Treat elbow dislocation	Y	CH	P3		1.3823	$57.23	$57.23
24650	Treat radius fracture	Y		P2		1.7682	$73.21	$73.21
24655	Treat radius fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
24665	Treat radius fracture	Y		A2	$630.00	41.1091	$1,701.96	$897.99
24666	Treat radius fracture	Y		A2	$630.00	59.2233	$2,451.90	$1,085.48
24670	Treat ulnar fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
24675	Treat ulnar fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
24685	Treat ulnar fracture	Y		A2	$510.00	41.1091	$1,701.96	$807.99

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
24800	Fusion of elbow joint	Y		A2	$630.00	42.985	$1,779.62	$917.41
24802	Fusion/graft of elbow joint	Y		A2	$717.00	42.985	$1,779.62	$982.66
24925	Amputation follow-up surgery	Y		A2	$510.00	21.2689	$880.55	$602.64
25000	Incision of tendon sheath	Y		A2	$510.00	21.2689	$880.55	$602.64
25001	Incise flexor carpi radialis	Y		G2		21.2689	$880.55	$880.55
25020	Decompress forearm 1 space	Y		A2	$510.00	21.2689	$880.55	$602.64
25023	Decompress forearm 1 space	Y		A2	$510.00	29.19	$1,208.50	$684.63
25024	Decompress forearm 2 spaces	Y		A2	$510.00	29.19	$1,208.50	$684.63
25025	Decompress forearm 2 spaces	Y		A2	$510.00	29.19	$1,208.50	$684.63
25028	Drainage of forearm lesion	Y		A2	$333.00	21.2689	$880.55	$469.89
25031	Drainage of forearm bursa	Y		A2	$446.00	21.2689	$880.55	$554.64
25035	Treat forearm bone lesion	Y		A2	$446.00	21.2689	$880.55	$554.64
25040	Explore/treat wrist joint	Y		A2	$717.00	29.19	$1,208.50	$839.88
25065	Biopsy forearm soft tissues	Y		P3		3.1023	$128.44	$128.44
25066	Biopsy forearm soft tissues	Y		A2	$446.00	21.1098	$873.97	$552.99
25075	Removal forearm lesion subcu	Y		A2	$446.00	16.1001	$666.56	$501.14
25076	Removal forearm lesion deep	Y		A2	$510.00	21.1098	$873.97	$600.99
25077	Remove tumor, forearm/wrist	Y		A2	$510.00	21.1098	$873.97	$600.99
25085	Incision of wrist capsule	Y		A2	$510.00	21.2689	$880.55	$602.64
25100	Biopsy of wrist joint	Y		A2	$446.00	21.2689	$880.55	$554.64
25101	Explore/treat wrist joint	Y		A2	$510.00	29.19	$1,208.50	$684.63
25105	Remove wrist joint lining	Y		A2	$630.00	29.19	$1,208.50	$774.63
25107	Remove wrist joint cartilage	Y		A2	$510.00	29.19	$1,208.50	$684.63
25109	Excise tendon forearm/wrist	Y		G2		21.2689	$880.55	$880.55
25110	Remove wrist tendon lesion	Y		A2	$510.00	21.2689	$880.55	$602.64
25111	Remove wrist tendon lesion	Y		A2	$510.00	16.4637	$681.61	$552.90
25112	Reremove wrist tendon lesion	Y		A2	$630.00	16.4637	$681.61	$642.90
25115	Remove wrist/forearm lesion	Y		A2	$630.00	21.2689	$880.55	$692.64
25116	Remove wrist/forearm lesion	Y		A2	$630.00	21.2689	$880.55	$692.64
25118	Excise wrist tendon sheath	Y		A2	$446.00	29.19	$1,208.50	$636.63
25119	Partial removal of ulna	Y		A2	$510.00	29.19	$1,208.50	$684.63
25120	Removal of forearm lesion	Y		A2	$510.00	29.19	$1,208.50	$684.63
25125	Remove/graft forearm lesion	Y		A2	$510.00	29.19	$1,208.50	$684.63
25126	Remove/graft forearm lesion	Y		A2	$510.00	29.19	$1,208.50	$684.63
25130	Removal of wrist lesion	Y		A2	$510.00	29.19	$1,208.50	$684.63
25135	Remove & graft wrist lesion	Y		A2	$510.00	29.19	$1,208.50	$684.63
25136	Remove & graft wrist lesion	Y		A2	$510.00	29.19	$1,208.50	$684.63
25145	Remove forearm bone lesion	Y		A2	$446.00	29.19	$1,208.50	$636.63
25150	Partial removal of ulna	Y		A2	$446.00	29.19	$1,208.50	$636.63
25151	Partial removal of radius	Y		A2	$446.00	29.19	$1,208.50	$636.63
25210	Removal of wrist bone	Y		A2	$510.00	26.3105	$1,089.28	$654.82
25215	Removal of wrist bones	Y		A2	$630.00	26.3105	$1,089.28	$744.82
25230	Partial removal of radius	Y		A2	$630.00	29.19	$1,208.50	$774.63
25240	Partial removal of ulna	Y		A2	$630.00	29.19	$1,208.50	$774.63
25246	Injection for wrist x-ray	N		N1				
25248	Remove forearm foreign body	Y		A2	$446.00	21.2689	$880.55	$554.64
25250	Removal of wrist prosthesis	Y		A2	$333.00	29.19	$1,208.50	$551.88
25251	Removal of wrist prosthesis	Y		A2	$333.00	29.19	$1,208.50	$551.88
25259	Manipulate wrist w/anesthes	Y		G2		1.7682	$73.21	$73.21
25260	Repair forearm tendon/muscle	Y		A2	$630.00	29.19	$1,208.50	$774.63
25263	Repair forearm tendon/muscle	Y		A2	$446.00	29.19	$1,208.50	$636.63
25265	Repair forearm tendon/muscle	Y		A2	$510.00	29.19	$1,208.50	$684.63
25270	Repair forearm tendon/muscle	Y		A2	$630.00	29.19	$1,208.50	$774.63
25272	Repair forearm tendon/muscle	Y		A2	$510.00	29.19	$1,208.50	$684.63
25274	Repair forearm tendon/muscle	Y		A2	$630.00	29.19	$1,208.50	$774.63
25275	Repair forearm tendon sheath	Y		A2	$630.00	29.19	$1,208.50	$774.63
25280	Revise wrist/forearm tendon	Y		A2	$630.00	29.19	$1,208.50	$774.63
25290	Incise wrist/forearm tendon	Y		A2	$510.00	29.19	$1,208.50	$684.63
25295	Release wrist/forearm tendon	Y		A2	$510.00	21.2689	$880.55	$602.64
25300	Fusion of tendons at wrist	Y		A2	$510.00	29.19	$1,208.50	$684.63
25301	Fusion of tendons at wrist	Y		A2	$510.00	29.19	$1,208.50	$684.63
25310	Transplant forearm tendon	Y		A2	$510.00	42.985	$1,779.62	$827.41
25312	Transplant forearm tendon	Y		A2	$630.00	42.985	$1,779.62	$917.41
25315	Revise palsy hand tendon(s)	Y		A2	$510.00	42.985	$1,779.62	$827.41
25316	Revise palsy hand tendon(s)	Y		A2	$510.00	79.4244	$3,288.25	$1,204.56
25320	Repair/revise wrist joint	Y		A2	$510.00	42.985	$1,779.62	$827.41
25332	Revise wrist joint	Y		A2	$717.00	35.904	$1,486.46	$909.37
25335	Realignment of hand	Y		A2	$510.00	42.985	$1,779.62	$827.41
25337	Reconstruct ulna/radioulnar	Y		A2	$717.00	42.985	$1,779.62	$982.66
25350	Revision of radius	Y		A2	$510.00	79.4244	$3,288.25	$1,204.56
25355	Revision of radius	Y		A2	$510.00	42.985	$1,779.62	$827.41
25360	Revision of ulna	Y		A2	$510.00	29.19	$1,208.50	$684.63
25365	Revise radius & ulna	Y		A2	$510.00	29.19	$1,208.50	$684.63

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
25370	Revise radius or ulna	Y		A2	$510.00	42.985	$1,779.62	$827.41
25375	Revise radius & ulna	Y		A2	$630.00	42.985	$1,779.62	$917.41
25390	Shorten radius or ulna	Y		A2	$510.00	29.19	$1,208.50	$684.63
25391	Lengthen radius or ulna	Y		A2	$630.00	42.985	$1,779.62	$917.41
25392	Shorten radius & ulna	Y		A2	$510.00	29.19	$1,208.50	$684.63
25393	Lengthen radius & ulna	Y		A2	$630.00	42.985	$1,779.62	$917.41
25394	Repair carpal bone, shorten	Y		G2		16.4637	$681.61	$681.61
25400	Repair radius or ulna	Y		A2	$510.00	79.4244	$3,288.25	$1,204.56
25405	Repair/graft radius or ulna	Y		A2	$630.00	79.4244	$3,288.25	$1,294.56
25415	Repair radius & ulna	Y		A2	$510.00	79.4244	$3,288.25	$1,204.56
25420	Repair/graft radius & ulna	Y		A2	$630.00	79.4244	$3,288.25	$1,294.56
25425	Repair/graft radius or ulna	Y		A2	$510.00	42.985	$1,779.62	$827.41
25426	Repair/graft radius & ulna	Y		A2	$630.00	42.985	$1,779.62	$917.41
25430	Vasc graft into carpal bone	Y		G2		26.3105	$1,089.28	$1,089.28
25431	Repair nonunion carpal bone	Y		G2		26.3105	$1,089.28	$1,089.28
25440	Repair/graft wrist bone	Y		A2	$630.00	79.4244	$3,288.25	$1,294.56
25441	Reconstruct wrist joint	Y		A2	$717.00	122.2057	$5,059.44	$1,802.61
25442	Reconstruct wrist joint	Y		A2	$717.00	122.2057	$5,059.44	$1,802.61
25443	Reconstruct wrist joint	Y		A2	$717.00	50.8876	$2,106.80	$1,064.45
25444	Reconstruct wrist joint	Y		A2	$717.00	50.8876	$2,106.80	$1,064.45
25445	Reconstruct wrist joint	Y		A2	$717.00	50.8876	$2,106.80	$1,064.45
25446	Wrist replacement	Y		A2	$995.00	122.2057	$5,059.44	$2,011.11
25447	Repair wrist joint(s)	Y		A2	$717.00	35.904	$1,486.46	$909.37
25449	Remove wrist joint implant	Y		A2	$717.00	35.904	$1,486.46	$909.37
25450	Revision of wrist joint	Y		A2	$510.00	42.985	$1,779.62	$827.41
25455	Revision of wrist joint	Y		A2	$510.00	42.985	$1,779.62	$827.41
25490	Reinforce radius	Y		A2	$510.00	42.985	$1,779.62	$827.41
25491	Reinforce ulna	Y		A2	$510.00	42.985	$1,779.62	$827.41
25492	Reinforce radius and ulna	Y		A2	$510.00	42.985	$1,779.62	$827.41
25500	Treat fracture of radius	Y		P2		1.7682	$73.21	$73.21
25505	Treat fracture of radius	Y		A2	$103.62	1.7682	$73.21	$96.02
25515	Treat fracture of radius	Y		A2	$510.00	41.1091	$1,701.96	$807.99
25520	Treat fracture of radius	Y		A2	$103.62	1.7682	$73.21	$96.02
25525	Treat fracture of radius	Y		A2	$630.00	41.1091	$1,701.96	$897.99
25526	Treat fracture of radius	Y		A2	$717.00	41.1091	$1,701.96	$963.24
25530	Treat fracture of ulna	Y		P2		1.7682	$73.21	$73.21
25535	Treat fracture of ulna	Y		A2	$103.62	1.7682	$73.21	$96.02
25545	Treat fracture of ulna	Y		A2	$510.00	41.1091	$1,701.96	$807.99
25560	Treat fracture radius & ulna	Y		P2		1.7682	$73.21	$73.21
25565	Treat fracture radius & ulna	Y		A2	$103.62	1.7682	$73.21	$96.02
25574	Treat fracture radius & ulna	Y		A2	$510.00	59.2233	$2,451.90	$995.48
25575	Treat fracture radius/ulna	Y		A2	$510.00	59.2233	$2,451.90	$995.48
25600	Treat fracture radius/ulna	Y		P2		1.7682	$73.21	$73.21
25605	Treat fracture radius/ulna	Y		A2	$103.62	1.7682	$73.21	$96.02
25606	Treat fx distal radial	Y		A2	$510.00	26.1592	$1,083.02	$653.26
25607	Treat fx rad extra-articul	Y		A2	$717.00	59.2233	$2,451.90	$1,150.73
25608	Treat fx rad intra-articul	Y		A2	$717.00	59.2233	$2,451.90	$1,150.73
25609	Treat fx radial 3+ frag	Y		A2	$717.00	59.2233	$2,451.90	$1,150.73
25622	Treat wrist bone fracture	Y		P2		1.7682	$73.21	$73.21
25624	Treat wrist bone fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
25628	Treat wrist bone fracture	Y		A2	$510.00	41.1091	$1,701.96	$807.99
25630	Treat wrist bone fracture	Y		P2		1.7682	$73.21	$73.21
25635	Treat wrist bone fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
25645	Treat wrist bone fracture	Y		A2	$510.00	41.1091	$1,701.96	$807.99
25650	Treat wrist bone fracture	Y		P2		1.7682	$73.21	$73.21
25651	Pin ulnar styloid fracture	Y		G2		26.1592	$1,083.02	$1,083.02
25652	Treat fracture ulnar styloid	Y		G2		41.1091	$1,701.96	$1,701.96
25660	Treat wrist dislocation	Y		A2	$103.62	1.7682	$73.21	$96.02
25670	Treat wrist dislocation	Y		A2	$510.00	26.1592	$1,083.02	$653.26
25671	Pin radioulnar dislocation	Y		A2	$333.00	26.1592	$1,083.02	$520.51
25675	Treat wrist dislocation	Y		A2	$103.62	1.7682	$73.21	$96.02
25676	Treat wrist dislocation	Y		A2	$446.00	26.1592	$1,083.02	$605.26
25680	Treat wrist fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
25685	Treat wrist fracture	Y		A2	$510.00	26.1592	$1,083.02	$653.26
25690	Treat wrist dislocation	Y		A2	$103.62	1.7682	$73.21	$96.02
25695	Treat wrist dislocation	Y		A2	$446.00	26.1592	$1,083.02	$605.26
25800	Fusion of wrist joint	Y		A2	$630.00	79.4244	$3,288.25	$1,294.56
25805	Fusion/graft of wrist joint	Y		A2	$717.00	42.985	$1,779.62	$982.66
25810	Fusion/graft of wrist joint	Y		A2	$717.00	79.4244	$3,288.25	$1,359.81
25820	Fusion of hand bones	Y		A2	$630.00	16.4637	$681.61	$642.90
25825	Fuse hand bones with graft	Y		A2	$717.00	79.4244	$3,288.25	$1,359.81
25830	Fusion, radioulnar jnt/ulna	Y		A2	$717.00	79.4244	$3,288.25	$1,359.81
25907	Amputation follow-up surgery	Y		A2	$510.00	21.2689	$880.55	$602.64

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
25922	Amputate hand at wrist	Y		A2	$510.00	21.2689	$880.55	$602.64
25929	Amputation follow-up surgery	Y		A2	$510.00	15.0458	$622.91	$538.23
25931	Amputation follow-up surgery	Y	CH	G2		21.2689	$880.55	$880.55
26010	Drainage of finger abscess	Y		P2		1.4066	$58.23	$58.23
26011	Drainage of finger abscess	Y		A2	$333.00	11.5594	$478.57	$369.39
26020	Drain hand tendon sheath	Y		A2	$446.00	16.4637	$681.61	$504.90
26025	Drainage of palm bursa	Y		A2	$333.00	16.4637	$681.61	$420.15
26030	Drainage of palm bursa(s)	Y		A2	$446.00	16.4637	$681.61	$504.90
26034	Treat hand bone lesion	Y		A2	$446.00	16.4637	$681.61	$504.90
26035	Decompress fingers/hand	Y		G2		16.4637	$681.61	$681.61
26040	Release palm contracture	Y		A2	$630.00	26.3105	$1,089.28	$744.82
26045	Release palm contracture	Y		A2	$510.00	26.3105	$1,089.28	$654.82
26055	Incise finger tendon sheath	Y		A2	$446.00	16.4637	$681.61	$504.90
26060	Incision of finger tendon	Y		A2	$446.00	16.4637	$681.61	$504.90
26070	Explore/treat hand joint	Y		A2	$446.00	16.4637	$681.61	$504.90
26075	Explore/treat finger joint	Y		A2	$630.00	16.4637	$681.61	$642.90
26080	Explore/treat finger joint	Y		A2	$630.00	16.4637	$681.61	$642.90
26100	Biopsy hand joint lining	Y		A2	$446.00	16.4637	$681.61	$504.90
26105	Biopsy finger joint lining	Y		A2	$333.00	16.4637	$681.61	$420.15
26110	Biopsy finger joint lining	Y		A2	$333.00	16.4637	$681.61	$420.15
26115	Removal hand lesion subcut	Y		A2	$446.00	21.1098	$873.97	$552.99
26116	Removal hand lesion, deep	Y		A2	$446.00	21.1098	$873.97	$552.99
26117	Remove tumor, hand/finger	Y		A2	$510.00	21.1098	$873.97	$600.99
26121	Release palm contracture	Y		A2	$630.00	26.3105	$1,089.28	$744.82
26123	Release palm contracture	Y		A2	$630.00	26.3105	$1,089.28	$744.82
26125	Release palm contracture	Y		A2	$630.00	16.4637	$681.61	$642.90
26130	Remove wrist joint lining	Y		A2	$510.00	16.4637	$681.61	$552.90
26135	Revise finger joint, each	Y		A2	$630.00	26.3105	$1,089.28	$744.82
26140	Revise finger joint, each	Y		A2	$446.00	16.4637	$681.61	$504.90
26145	Tendon excision, palm/finger	Y		A2	$510.00	16.4637	$681.61	$552.90
26160	Remove tendon sheath lesion	Y		A2	$510.00	16.4637	$681.61	$552.90
26170	Removal of palm tendon, each	Y		A2	$510.00	16.4637	$681.61	$552.90
26180	Removal of finger tendon	Y		A2	$510.00	16.4637	$681.61	$552.90
26185	Remove finger bone	Y		A2	$630.00	16.4637	$681.61	$642.90
26200	Remove hand bone lesion	Y		A2	$446.00	16.4637	$681.61	$504.90
26205	Remove/graft bone lesion	Y		A2	$510.00	26.3105	$1,089.28	$654.82
26210	Removal of finger lesion	Y		A2	$446.00	16.4637	$681.61	$504.90
26215	Remove/graft finger lesion	Y		A2	$510.00	16.4637	$681.61	$552.90
26230	Partial removal of hand bone	Y		A2	$992.95	16.4637	$681.61	$915.12
26235	Partial removal, finger bone	Y		A2	$510.00	16.4637	$681.61	$552.90
26236	Partial removal, finger bone	Y		A2	$510.00	16.4637	$681.61	$552.90
26250	Extensive hand surgery	Y		A2	$510.00	16.4637	$681.61	$552.90
26255	Extensive hand surgery	Y		A2	$510.00	26.3105	$1,089.28	$654.82
26260	Extensive finger surgery	Y		A2	$510.00	16.4637	$681.61	$552.90
26261	Extensive finger surgery	Y		A2	$510.00	16.4637	$681.61	$552.90
26262	Partial removal of finger	Y		A2	$446.00	16.4637	$681.61	$504.90
26320	Removal of implant from hand	Y		A2	$446.00	16.1001	$666.56	$501.14
26340	Manipulate finger w/anesth	Y		G2		1.7682	$73.21	$73.21
26350	Repair finger/hand tendon	Y		A2	$333.00	26.3105	$1,089.28	$522.07
26352	Repair/graft hand tendon	Y		A2	$630.00	26.3105	$1,089.28	$744.82
26356	Repair finger/hand tendon	Y		A2	$630.00	26.3105	$1,089.28	$744.82
26357	Repair finger/hand tendon	Y		A2	$630.00	26.3105	$1,089.28	$744.82
26358	Repair/graft hand tendon	Y		A2	$630.00	26.3105	$1,089.28	$744.82
26370	Repair finger/hand tendon	Y		A2	$630.00	26.3105	$1,089.28	$744.82
26372	Repair/graft hand tendon	Y		A2	$630.00	26.3105	$1,089.28	$744.82
26373	Repair finger/hand tendon	Y		A2	$510.00	26.3105	$1,089.28	$654.82
26390	Revise hand/finger tendon	Y		A2	$630.00	26.3105	$1,089.28	$744.82
26392	Repair/graft hand tendon	Y		A2	$510.00	26.3105	$1,089.28	$654.82
26410	Repair hand tendon	Y		A2	$510.00	16.4637	$681.61	$552.90
26412	Repair/graft hand tendon	Y		A2	$510.00	26.3105	$1,089.28	$654.82
26415	Excision, hand/finger tendon	Y		A2	$630.00	26.3105	$1,089.28	$744.82
26416	Graft hand or finger tendon	Y		A2	$510.00	26.3105	$1,089.28	$654.82
26418	Repair finger tendon	Y		A2	$630.00	16.4637	$681.61	$642.90
26420	Repair/graft finger tendon	Y		A2	$630.00	26.3105	$1,089.28	$744.82
26426	Repair finger/hand tendon	Y		A2	$510.00	26.3105	$1,089.28	$654.82
26428	Repair/graft finger tendon	Y		A2	$510.00	26.3105	$1,089.28	$654.82
26432	Repair finger tendon	Y		A2	$510.00	16.4637	$681.61	$552.90
26433	Repair finger tendon	Y		A2	$510.00	16.4637	$681.61	$552.90
26434	Repair/graft finger tendon	Y		A2	$510.00	26.3105	$1,089.28	$654.82
26437	Realignment of tendons	Y		A2	$510.00	16.4637	$681.61	$552.90
26440	Release palm/finger tendon	Y		A2	$510.00	16.4637	$681.61	$552.90
26442	Release palm & finger tendon	Y		A2	$510.00	26.3105	$1,089.28	$654.82
26445	Release hand/finger tendon	Y		A2	$510.00	16.4637	$681.61	$552.90

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
26449	Release forearm/hand tendon	Y		A2	$510.00	26.3105	$1,089.28	$654.82
26450	Incision of palm tendon	Y		A2	$510.00	16.4637	$681.61	$552.90
26455	Incision of finger tendon	Y		A2	$510.00	16.4637	$681.61	$552.90
26460	Incise hand/finger tendon	Y		A2	$510.00	16.4637	$681.61	$552.90
26471	Fusion of finger tendons	Y		A2	$446.00	16.4637	$681.61	$504.90
26474	Fusion of finger tendons	Y		A2	$446.00	16.4637	$681.61	$504.90
26476	Tendon lengthening	Y		A2	$333.00	16.4637	$681.61	$420.15
26477	Tendon shortening	Y		A2	$333.00	16.4637	$681.61	$420.15
26478	Lengthening of hand tendon	Y		A2	$333.00	16.4637	$681.61	$420.15
26479	Shortening of hand tendon	Y		A2	$333.00	16.4637	$681.61	$420.15
26480	Transplant hand tendon	Y		A2	$510.00	26.3105	$1,089.28	$654.82
26483	Transplant/graft hand tendon	Y		A2	$510.00	26.3105	$1,089.28	$654.82
26485	Transplant palm tendon	Y		A2	$446.00	26.3105	$1,089.28	$606.82
26489	Transplant/graft palm tendon	Y		A2	$510.00	26.3105	$1,089.28	$654.82
26490	Revise thumb tendon	Y		A2	$510.00	26.3105	$1,089.28	$654.82
26492	Tendon transfer with graft	Y		A2	$510.00	26.3105	$1,089.28	$654.82
26494	Hand tendon/muscle transfer	Y		A2	$510.00	26.3105	$1,089.28	$654.82
26496	Revise thumb tendon	Y		A2	$510.00	26.3105	$1,089.28	$654.82
26497	Finger tendon transfer	Y		A2	$510.00	26.3105	$1,089.28	$654.82
26498	Finger tendon transfer	Y		A2	$630.00	26.3105	$1,089.28	$744.82
26499	Revision of finger	Y		A2	$510.00	26.3105	$1,089.28	$654.82
26500	Hand tendon reconstruction	Y		A2	$630.00	16.4637	$681.61	$642.90
26502	Hand tendon reconstruction	Y		A2	$630.00	26.3105	$1,089.28	$744.82
26508	Release thumb contracture	Y		A2	$510.00	16.4637	$681.61	$552.90
26510	Thumb tendon transfer	Y		A2	$510.00	26.3105	$1,089.28	$654.82
26516	Fusion of knuckle joint	Y		A2	$333.00	26.3105	$1,089.28	$522.07
26517	Fusion of knuckle joints	Y		A2	$510.00	26.3105	$1,089.28	$654.82
26518	Fusion of knuckle joints	Y		A2	$510.00	26.3105	$1,089.28	$654.82
26520	Release knuckle contracture	Y		A2	$510.00	16.4637	$681.61	$552.90
26525	Release finger contracture	Y		A2	$510.00	16.4637	$681.61	$552.90
26530	Revise knuckle joint	Y		A2	$510.00	35.904	$1,486.46	$754.12
26531	Revise knuckle with implant	Y		A2	$995.00	50.8876	$2,106.80	$1,272.95
26535	Revise finger joint	Y		A2	$717.00	35.904	$1,486.46	$909.37
26536	Revise/implant finger joint	Y		A2	$717.00	50.8876	$2,106.80	$1,064.45
26540	Repair hand joint	Y		A2	$630.00	16.4637	$681.61	$642.90
26541	Repair hand joint with graft	Y		A2	$995.00	26.3105	$1,089.28	$1,018.57
26542	Repair hand joint with graft	Y		A2	$630.00	16.4637	$681.61	$642.90
26545	Reconstruct finger joint	Y		A2	$630.00	26.3105	$1,089.28	$744.82
26546	Repair nonunion hand	Y		A2	$630.00	26.3105	$1,089.28	$744.82
26548	Reconstruct finger joint	Y		A2	$630.00	26.3105	$1,089.28	$744.82
26550	Construct thumb replacement	Y		A2	$446.00	26.3105	$1,089.28	$606.82
26555	Positional change of finger	Y		A2	$510.00	26.3105	$1,089.28	$654.82
26560	Repair of web finger	Y		A2	$446.00	16.4637	$681.61	$504.90
26561	Repair of web finger	Y		A2	$510.00	26.3105	$1,089.28	$654.82
26562	Repair of web finger	Y		A2	$630.00	26.3105	$1,089.28	$744.82
26565	Correct metacarpal flaw	Y		A2	$717.00	26.3105	$1,089.28	$810.07
26567	Correct finger deformity	Y		A2	$717.00	26.3105	$1,089.28	$810.07
26568	Lengthen metacarpal/finger	Y		A2	$510.00	26.3105	$1,089.28	$654.82
26580	Repair hand deformity	Y		A2	$717.00	16.4637	$681.61	$708.15
26587	Reconstruct extra finger	Y		A2	$717.00	16.4637	$681.61	$708.15
26590	Repair finger deformity	Y		A2	$717.00	16.4637	$681.61	$708.15
26591	Repair muscles of hand	Y		A2	$510.00	26.3105	$1,089.28	$654.82
26593	Release muscles of hand	Y		A2	$510.00	16.4637	$681.61	$552.90
26596	Excision constricting tissue	Y		A2	$446.00	16.4637	$681.61	$504.90
26600	Treat metacarpal fracture	Y		P2		1.7682	$73.21	$73.21
26605	Treat metacarpal fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
26607	Treat metacarpal fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
26608	Treat metacarpal fracture	Y		A2	$630.00	26.1592	$1,083.02	$743.26
26615	Treat metacarpal fracture	Y		A2	$630.00	41.1091	$1,701.96	$897.99
26641	Treat thumb dislocation	Y	CH	P2		1.7682	$73.21	$73.21
26645	Treat thumb fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
26650	Treat thumb fracture	Y		A2	$446.00	26.1592	$1,083.02	$605.26
26665	Treat thumb fracture	Y		A2	$630.00	41.1091	$1,701.96	$897.99
26670	Treat hand dislocation	Y	CH	P2		1.7682	$73.21	$73.21
26675	Treat hand dislocation	Y		A2	$103.62	1.7682	$73.21	$96.02
26676	Pin hand dislocation	Y		A2	$446.00	26.1592	$1,083.02	$605.26
26685	Treat hand dislocation	Y		A2	$510.00	26.1592	$1,083.02	$653.26
26686	Treat hand dislocation	Y		A2	$510.00	59.2233	$2,451.90	$995.48
26700	Treat knuckle dislocation	Y	CH	P2		1.7682	$73.21	$73.21
26705	Treat knuckle dislocation	Y		A2	$103.62	1.7682	$73.21	$96.02
26706	Pin knuckle dislocation	Y		A2	$103.62	1.7682	$73.21	$96.02
26715	Treat knuckle dislocation	Y		A2	$630.00	26.1592	$1,083.02	$743.26
26720	Treat finger fracture, each	Y		P2		1.7682	$73.21	$73.21

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.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
26725	Treat finger fracture, each	Y		P2		1.7682	$73.21	$73.21
26727	Treat finger fracture, each	Y		A2	$995.00	26.1592	$1,083.02	$1,017.01
26735	Treat finger fracture, each	Y		A2	$630.00	26.1592	$1,083.02	$743.26
26740	Treat finger fracture, each	Y		P2		1.7682	$73.21	$73.21
26742	Treat finger fracture, each	Y		A2	$103.62	1.7682	$73.21	$96.02
26746	Treat finger fracture, each	Y		A2	$717.00	26.1592	$1,083.02	$808.51
26750	Treat finger fracture, each	Y		P2		1.7682	$73.21	$73.21
26755	Treat finger fracture, each	Y		G2		1.7682	$73.21	$73.21
26756	Pin finger fracture, each	Y		A2	$446.00	26.1592	$1,083.02	$605.26
26765	Treat finger fracture, each	Y		A2	$630.00	26.1592	$1,083.02	$743.26
26770	Treat finger dislocation	Y		G2		1.7682	$73.21	$73.21
26775	Treat finger dislocation	Y	CH	P3		4.032	$166.93	$166.93
26776	Pin finger dislocation	Y		A2	$446.00	26.1592	$1,083.02	$605.26
26785	Treat finger dislocation	Y		A2	$446.00	26.1592	$1,083.02	$605.26
26820	Thumb fusion with graft	Y		A2	$717.00	26.3105	$1,089.28	$810.07
26841	Fusion of thumb	Y		A2	$630.00	26.3105	$1,089.28	$744.82
26842	Thumb fusion with graft	Y		A2	$630.00	26.3105	$1,089.28	$744.82
26843	Fusion of hand joint	Y		A2	$510.00	26.3105	$1,089.28	$654.82
26844	Fusion/graft of hand joint	Y		A2	$510.00	26.3105	$1,089.28	$654.82
26850	Fusion of knuckle	Y		A2	$630.00	26.3105	$1,089.28	$744.82
26852	Fusion of knuckle with graft	Y		A2	$630.00	26.3105	$1,089.28	$744.82
26860	Fusion of finger joint	Y		A2	$510.00	26.3105	$1,089.28	$654.82
26861	Fusion of finger jnt, add-on	Y		A2	$446.00	26.3105	$1,089.28	$606.82
26862	Fusion/graft of finger joint	Y		A2	$630.00	26.3105	$1,089.28	$744.82
26863	Fuse/graft added joint	Y		A2	$510.00	26.3105	$1,089.28	$654.82
26910	Amputate metacarpal bone	Y		A2	$510.00	26.3105	$1,089.28	$654.82
26951	Amputation of finger/thumb	Y		A2	$446.00	16.4637	$681.61	$504.90
26952	Amputation of finger/thumb	Y		A2	$630.00	16.4637	$681.61	$642.90
26990	Drainage of pelvis lesion	Y		A2	$333.00	21.2689	$880.55	$469.89
26991	Drainage of pelvis bursa	Y		A2	$333.00	21.2689	$880.55	$469.89
27000	Incision of hip tendon	Y		A2	$446.00	21.2689	$880.55	$554.64
27001	Incision of hip tendon	Y		A2	$510.00	29.19	$1,208.50	$684.63
27003	Incision of hip tendon	Y		A2	$510.00	29.19	$1,208.50	$684.63
27033	Exploration of hip joint	Y		A2	$510.00	42.985	$1,779.62	$827.41
27035	Denervation of hip joint	Y		A2	$630.00	42.985	$1,779.62	$917.41
27040	Biopsy of soft tissues	Y		A2	$333.00	8.685	$359.57	$339.64
27041	Biopsy of soft tissues	Y		A2	$418.49	8.685	$359.57	$403.76
27047	Remove hip/pelvis lesion	Y		A2	$446.00	21.1098	$873.97	$552.99
27048	Remove hip/pelvis lesion	Y		A2	$510.00	21.1098	$873.97	$600.99
27049	Remove tumor, hip/pelvis	Y		A2	$510.00	21.1098	$873.97	$600.99
27050	Biopsy of sacroiliac joint	Y		A2	$510.00	21.2689	$880.55	$602.64
27052	Biopsy of hip joint	Y		A2	$510.00	21.2689	$880.55	$602.64
27060	Removal of ischial bursa	Y		A2	$717.00	21.2689	$880.55	$757.89
27062	Remove femur lesion/bursa	Y		A2	$717.00	21.2689	$880.55	$757.89
27065	Removal of hip bone lesion	Y		A2	$717.00	21.2689	$880.55	$757.89
27066	Removal of hip bone lesion	Y		A2	$717.00	29.19	$1,208.50	$839.88
27067	Remove/graft hip bone lesion	Y		A2	$717.00	29.19	$1,208.50	$839.88
27080	Removal of tail bone	Y		A2	$446.00	29.19	$1,208.50	$636.63
27086	Remove hip foreign body	Y		A2	$333.00	8.685	$359.57	$339.64
27087	Remove hip foreign body	Y		A2	$510.00	21.2689	$880.55	$602.64
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	29.19	$1,208.50	$684.63
27098	Transfer tendon to pelvis	Y		A2	$510.00	29.19	$1,208.50	$684.63
27100	Transfer of abdominal muscle	Y		A2	$630.00	42.985	$1,779.62	$917.41
27105	Transfer of spinal muscle	Y		A2	$630.00	42.985	$1,779.62	$917.41
27110	Transfer of iliopsoas muscle	Y		A2	$630.00	42.985	$1,779.62	$917.41
27111	Transfer of iliopsoas muscle	Y		A2	$630.00	42.985	$1,779.62	$917.41
27193	Treat pelvic ring fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
27194	Treat pelvic ring fracture	Y		A2	$446.00	14.7658	$611.32	$487.33
27200	Treat tail bone fracture	Y	CH	P3		1.7693	$73.25	$73.25
27202	Treat tail bone fracture	Y		A2	$446.00	41.1091	$1,701.96	$759.99
27220	Treat hip socket fracture	Y		G2		1.7682	$73.21	$73.21
27230	Treat thigh fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
27238	Treat thigh fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
27246	Treat thigh fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
27250	Treat hip dislocation	Y		A2	$103.62	1.7682	$73.21	$96.02
27252	Treat hip dislocation	Y		A2	$446.00	14.7658	$611.32	$487.33
27256	Treat hip dislocation	Y		G2		1.7682	$73.21	$73.21
27257	Treat hip dislocation	Y		A2	$510.00	14.7658	$611.32	$535.33
27265	Treat hip dislocation	Y		A2	$103.62	1.7682	$73.21	$96.02
27266	Treat hip dislocation	Y		A2	$446.00	14.7658	$611.32	$487.33
27267	Cltx thigh fx	Y	NI	G2		1.7682	$73.21	$73.21

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
27275	Manipulation of hip joint	Y		A2	$446.00	14.7658	$611.32	$487.33
27301	Drain thigh/knee lesion	Y		A2	$510.00	18.3197	$758.45	$572.11
27305	Incise thigh tendon & fascia	Y		A2	$446.00	21.2689	$880.55	$554.64
27306	Incision of thigh tendon	Y		A2	$510.00	21.2689	$880.55	$602.64
27307	Incision of thigh tendons	Y		A2	$510.00	21.2689	$880.55	$602.64
27310	Exploration of knee joint	Y		A2	$630.00	29.19	$1,208.50	$774.63
27323	Biopsy, thigh soft tissues	Y		A2	$333.00	8.685	$359.57	$339.64
27324	Biopsy, thigh soft tissues	Y		A2	$333.00	21.1098	$873.97	$468.24
27325	Neurectomy, hamstring	Y		A2	$446.00	18.0518	$747.36	$521.34
27326	Neurectomy, popliteal	Y		A2	$446.00	18.0518	$747.36	$521.34
27327	Removal of thigh lesion	Y		A2	$446.00	21.1098	$873.97	$552.99
27328	Removal of thigh lesion	Y		A2	$510.00	21.1098	$873.97	$600.99
27329	Remove tumor, thigh/knee	Y		A2	$630.00	21.1098	$873.97	$690.99
27330	Biopsy, knee joint lining	Y		A2	$630.00	29.19	$1,208.50	$774.63
27331	Explore/treat knee joint	Y		A2	$630.00	29.19	$1,208.50	$774.63
27332	Removal of knee cartilage	Y		A2	$630.00	29.19	$1,208.50	$774.63
27333	Removal of knee cartilage	Y		A2	$630.00	29.19	$1,208.50	$774.63
27334	Remove knee joint lining	Y		A2	$630.00	29.19	$1,208.50	$774.63
27335	Remove knee joint lining	Y		A2	$630.00	29.19	$1,208.50	$774.63
27340	Removal of kneecap bursa	Y		A2	$510.00	21.2689	$880.55	$602.64
27345	Removal of knee cyst	Y		A2	$630.00	21.2689	$880.55	$692.64
27347	Remove knee cyst	Y		A2	$630.00	21.2689	$880.55	$692.64
27350	Removal of kneecap	Y		A2	$630.00	29.19	$1,208.50	$774.63
27355	Remove femur lesion	Y		A2	$510.00	29.19	$1,208.50	$684.63
27356	Remove femur lesion/graft	Y		A2	$630.00	29.19	$1,208.50	$774.63
27357	Remove femur lesion/graft	Y		A2	$717.00	29.19	$1,208.50	$839.88
27358	Remove femur lesion/fixation	Y		A2	$717.00	29.19	$1,208.50	$839.88
27360	Partial removal, leg bone(s)	Y		A2	$717.00	29.19	$1,208.50	$839.88
27370	Injection for knee x-ray	N		N1				
27372	Removal of foreign body	Y		A2	$995.00	21.1098	$873.97	$964.74
27380	Repair of kneecap tendon	Y		A2	$333.00	21.2689	$880.55	$469.89
27381	Repair/graft kneecap tendon	Y		A2	$510.00	21.2689	$880.55	$602.64
27385	Repair of thigh muscle	Y		A2	$510.00	21.2689	$880.55	$602.64
27386	Repair/graft of thigh muscle	Y		A2	$510.00	21.2689	$880.55	$602.64
27390	Incision of thigh tendon	Y		A2	$333.00	21.2689	$880.55	$469.89
27391	Incision of thigh tendons	Y		A2	$446.00	21.2689	$880.55	$554.64
27392	Incision of thigh tendons	Y		A2	$510.00	21.2689	$880.55	$602.64
27393	Lengthening of thigh tendon	Y		A2	$446.00	29.19	$1,208.50	$636.63
27394	Lengthening of thigh tendons	Y		A2	$510.00	29.19	$1,208.50	$684.63
27395	Lengthening of thigh tendons	Y		A2	$510.00	42.985	$1,779.62	$827.41
27396	Transplant of thigh tendon	Y		A2	$510.00	29.19	$1,208.50	$684.63
27397	Transplants of thigh tendons	Y		A2	$510.00	42.985	$1,779.62	$827.41
27400	Revise thigh muscles/tendons	Y		A2	$510.00	42.985	$1,779.62	$827.41
27403	Repair of knee cartilage	Y		A2	$630.00	29.19	$1,208.50	$774.63
27405	Repair of knee ligament	Y		A2	$630.00	42.985	$1,779.62	$917.41
27407	Repair of knee ligament	Y		A2	$630.00	79.4244	$3,288.25	$1,294.56
27409	Repair of knee ligaments	Y		A2	$630.00	42.985	$1,779.62	$917.41
27416	Osteochondral knee autograft	Y	NI	G2		42.985	$1,779.62	$1,779.62
27418	Repair degenerated kneecap	Y		A2	$510.00	42.985	$1,779.62	$827.41
27420	Revision of unstable kneecap	Y		A2	$510.00	42.985	$1,779.62	$827.41
27422	Revision of unstable kneecap	Y		A2	$995.00	42.985	$1,779.62	$1,191.16
27424	Revision/removal of kneecap	Y		A2	$510.00	42.985	$1,779.62	$827.41
27425	Lat retinacular release open	Y		A2	$995.00	29.19	$1,208.50	$1,048.38
27427	Reconstruction, knee	Y		A2	$510.00	42.985	$1,779.62	$827.41
27428	Reconstruction, knee	Y		A2	$630.00	79.4244	$3,288.25	$1,294.56
27429	Reconstruction, knee	Y		A2	$630.00	79.4244	$3,288.25	$1,294.56
27430	Revision of thigh muscles	Y		A2	$630.00	42.985	$1,779.62	$917.41
27435	Incision of knee joint	Y		A2	$630.00	42.985	$1,779.62	$917.41
27437	Revise kneecap	Y		A2	$630.00	35.904	$1,486.46	$844.12
27438	Revise kneecap with implant	Y		A2	$717.00	50.8876	$2,106.80	$1,064.45
27440	Revision of knee joint	Y		G2		35.904	$1,486.46	$1,486.46
27441	Revision of knee joint	Y		A2	$717.00	35.904	$1,486.46	$909.37
27442	Revision of knee joint	Y		A2	$717.00	35.904	$1,486.46	$909.37
27443	Revision of knee joint	Y		A2	$717.00	35.904	$1,486.46	$909.37
27446	Revision of knee joint	Y		G2		274.6715	$11,371.67	$11,371.67
27496	Decompression of thigh/knee	Y		A2	$717.00	21.2689	$880.55	$757.89
27497	Decompression of thigh/knee	Y		A2	$510.00	21.2689	$880.55	$602.64
27498	Decompression of thigh/knee	Y		A2	$510.00	21.2689	$880.55	$602.64
27499	Decompression of thigh/knee	Y		A2	$510.00	21.2689	$880.55	$602.64
27500	Treatment of thigh fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
27501	Treatment of thigh fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
27502	Treatment of thigh fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
27503	Treatment of thigh fracture	Y		A2	$103.62	1.7682	$73.21	$96.02

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
27508	Treatment of thigh fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
27509	Treatment of thigh fracture	Y		A2	$510.00	26.1592	$1,083.02	$653.26
27510	Treatment of thigh fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
27516	Treat thigh fx growth plate	Y		A2	$103.62	1.7682	$73.21	$96.02
27517	Treat thigh fx growth plate	Y		A2	$103.62	1.7682	$73.21	$96.02
27520	Treat kneecap fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
27530	Treat knee fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
27532	Treat knee fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
27538	Treat knee fracture(s)	Y		A2	$103.62	1.7682	$73.21	$96.02
27550	Treat knee dislocation	Y		A2	$103.62	1.7682	$73.21	$96.02
27552	Treat knee dislocation	Y		A2	$333.00	14.7658	$611.32	$402.58
27560	Treat kneecap dislocation	Y		A2	$103.62	1.7682	$73.21	$96.02
27562	Treat kneecap dislocation	Y		A2	$333.00	14.7658	$611.32	$402.58
27566	Treat kneecap dislocation	Y		A2	$446.00	41.1091	$1,701.96	$759.99
27570	Fixation of knee joint	Y		A2	$333.00	14.7658	$611.32	$402.58
27594	Amputation follow-up surgery	Y		A2	$510.00	21.2689	$880.55	$602.64
27600	Decompression of lower leg	Y		A2	$510.00	21.2689	$880.55	$602.64
27601	Decompression of lower leg	Y		A2	$510.00	21.2689	$880.55	$602.64
27602	Decompression of lower leg	Y		A2	$510.00	21.2689	$880.55	$602.64
27603	Drain lower leg lesion	Y		A2	$446.00	18.3197	$758.45	$524.11
27604	Drain lower leg bursa	Y		A2	$446.00	21.2689	$880.55	$554.64
27605	Incision of achilles tendon	Y		A2	$333.00	20.8284	$862.32	$465.33
27606	Incision of achilles tendon	Y		A2	$333.00	21.2689	$880.55	$469.89
27607	Treat lower leg bone lesion	Y		A2	$446.00	21.2689	$880.55	$554.64
27610	Explore/treat ankle joint	Y		A2	$446.00	29.19	$1,208.50	$636.63
27612	Exploration of ankle joint	Y		A2	$510.00	29.19	$1,208.50	$684.63
27613	Biopsy lower leg soft tissue	Y		P3		2.9376	$121.62	$121.62
27614	Biopsy lower leg soft tissue	Y		A2	$446.00	21.1098	$873.97	$552.99
27615	Remove tumor, lower leg	Y		A2	$510.00	29.19	$1,208.50	$684.63
27618	Remove lower leg lesion	Y		A2	$446.00	16.1001	$666.56	$501.14
27619	Remove lower leg lesion	Y		A2	$510.00	21.1098	$873.97	$600.99
27620	Explore/treat ankle joint	Y		A2	$630.00	29.19	$1,208.50	$774.63
27625	Remove ankle joint lining	Y		A2	$630.00	29.19	$1,208.50	$774.63
27626	Remove ankle joint lining	Y		A2	$630.00	29.19	$1,208.50	$774.63
27630	Removal of tendon lesion	Y		A2	$510.00	21.2689	$880.55	$602.64
27635	Remove lower leg bone lesion	Y		A2	$510.00	29.19	$1,208.50	$684.63
27637	Remove/graft leg bone lesion	Y		A2	$510.00	29.19	$1,208.50	$684.63
27638	Remove/graft leg bone lesion	Y		A2	$510.00	29.19	$1,208.50	$684.63
27640	Partial removal of tibia	Y		A2	$446.00	42.985	$1,779.62	$779.41
27641	Partial removal of fibula	Y		A2	$446.00	29.19	$1,208.50	$636.63
27647	Extensive ankle/heel surgery	Y		A2	$510.00	42.985	$1,779.62	$827.41
27648	Injection for ankle x-ray	N		N1				
27650	Repair achilles tendon	Y		A2	$510.00	42.985	$1,779.62	$827.41
27652	Repair/graft achilles tendon	Y		A2	$510.00	79.4244	$3,288.25	$1,204.56
27654	Repair of achilles tendon	Y		A2	$510.00	42.985	$1,779.62	$827.41
27656	Repair leg fascia defect	Y		A2	$446.00	21.2689	$880.55	$554.64
27658	Repair of leg tendon, each	Y		A2	$333.00	21.2689	$880.55	$469.89
27659	Repair of leg tendon, each	Y		A2	$446.00	21.2689	$880.55	$554.64
27664	Repair of leg tendon, each	Y		A2	$446.00	21.2689	$880.55	$554.64
27665	Repair of leg tendon, each	Y		A2	$446.00	29.19	$1,208.50	$636.63
27675	Repair lower leg tendons	Y		A2	$446.00	21.2689	$880.55	$554.64
27676	Repair lower leg tendons	Y		A2	$510.00	29.19	$1,208.50	$684.63
27680	Release of lower leg tendon	Y		A2	$510.00	29.19	$1,208.50	$684.63
27681	Release of lower leg tendons	Y		A2	$446.00	29.19	$1,208.50	$636.63
27685	Revision of lower leg tendon	Y		A2	$510.00	29.19	$1,208.50	$684.63
27686	Revise lower leg tendons	Y		A2	$510.00	29.19	$1,208.50	$684.63
27687	Revision of calf tendon	Y		A2	$510.00	29.19	$1,208.50	$684.63
27690	Revise lower leg tendon	Y		A2	$630.00	42.985	$1,779.62	$917.41
27691	Revise lower leg tendon	Y		A2	$630.00	42.985	$1,779.62	$917.41
27692	Revise additional leg tendon	Y		A2	$510.00	42.985	$1,779.62	$827.41
27695	Repair of ankle ligament	Y		A2	$446.00	29.19	$1,208.50	$636.63
27696	Repair of ankle ligaments	Y		A2	$446.00	29.19	$1,208.50	$636.63
27698	Repair of ankle ligament	Y		A2	$446.00	29.19	$1,208.50	$636.63
27700	Revision of ankle joint	Y		A2	$717.00	35.904	$1,486.46	$909.37
27704	Removal of ankle implant	Y		A2	$446.00	21.2689	$880.55	$554.64
27705	Incision of tibia	Y		A2	$446.00	42.985	$1,779.62	$779.41
27707	Incision of fibula	Y		A2	$446.00	21.2689	$880.55	$554.64
27709	Incision of tibia & fibula	Y		A2	$446.00	29.19	$1,208.50	$636.63
27726	Repair fibula nonunion	Y	NI	G2		26.1592	$1,083.02	$1,083.02
27730	Repair of tibia epiphysis	Y		A2	$446.00	29.19	$1,208.50	$636.63
27732	Repair of fibula epiphysis	Y		A2	$446.00	29.19	$1,208.50	$636.63
27734	Repair lower leg epiphyses	Y		A2	$446.00	29.19	$1,208.50	$636.63
27740	Repair of leg epiphyses	Y		A2	$446.00	29.19	$1,208.50	$636.63

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
27742	Repair of leg epiphyses	Y		A2	$446.00	42.985	$1,779.62	$779.41
27745	Reinforce tibia	Y		A2	$510.00	79.4244	$3,288.25	$1,204.56
27750	Treatment of tibia fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
27752	Treatment of tibia fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
27756	Treatment of tibia fracture	Y		A2	$510.00	26.1592	$1,083.02	$653.26
27758	Treatment of tibia fracture	Y		A2	$630.00	41.1091	$1,701.96	$897.99
27759	Treatment of tibia fracture	Y		A2	$630.00	59.2233	$2,451.90	$1,085.48
27760	Cltx medial ankle fx	Y		A2	$103.62	1.7682	$73.21	$96.02
27762	Cltx med ankle fx w/mnpj	Y		A2	$103.62	1.7682	$73.21	$96.02
27766	Optx medial ankle fx	Y		A2	$510.00	41.1091	$1,701.96	$807.99
27767	Cltx post ankle fx	Y	NI	G2		1.7682	$73.21	$73.21
27768	Cltx post ankle fx w/mnpj	Y	NI	G2		1.7682	$73.21	$73.21
27769	Optx post ankle fx	Y	NI	G2		41.1091	$1,701.96	$1,701.96
27780	Treatment of fibula fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
27781	Treatment of fibula fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
27784	Treatment of fibula fracture	Y		A2	$510.00	41.1091	$1,701.96	$807.99
27786	Treatment of ankle fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
27788	Treatment of ankle fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
27792	Treatment of ankle fracture	Y		A2	$510.00	41.1091	$1,701.96	$807.99
27808	Treatment of ankle fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
27810	Treatment of ankle fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
27814	Treatment of ankle fracture	Y		A2	$510.00	41.1091	$1,701.96	$807.99
27816	Treatment of ankle fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
27818	Treatment of ankle fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
27822	Treatment of ankle fracture	Y		A2	$510.00	41.1091	$1,701.96	$807.99
27823	Treatment of ankle fracture	Y		A2	$510.00	59.2233	$2,451.90	$995.48
27824	Treat lower leg fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
27825	Treat lower leg fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
27826	Treat lower leg fracture	Y		A2	$510.00	41.1091	$1,701.96	$807.99
27827	Treat lower leg fracture	Y		A2	$510.00	59.2233	$2,451.90	$995.48
27828	Treat lower leg fracture	Y		A2	$630.00	59.2233	$2,451.90	$1,085.48
27829	Treat lower leg joint	Y		A2	$446.00	41.1091	$1,701.96	$759.99
27830	Treat lower leg dislocation	Y		A2	$103.62	1.7682	$73.21	$96.02
27831	Treat lower leg dislocation	Y		A2	$103.62	1.7682	$73.21	$96.02
27832	Treat lower leg dislocation	Y		A2	$446.00	41.1091	$1,701.96	$759.99
27840	Treat ankle dislocation	Y		A2	$103.62	1.7682	$73.21	$96.02
27842	Treat ankle dislocation	Y		A2	$333.00	14.7658	$611.32	$402.58
27846	Treat ankle dislocation	Y		A2	$510.00	41.1091	$1,701.96	$807.99
27848	Treat ankle dislocation	Y		A2	$510.00	41.1091	$1,701.96	$807.99
27860	Fixation of ankle joint	Y		A2	$333.00	14.7658	$611.32	$402.58
27870	Fusion of ankle joint, open	Y		A2	$630.00	79.4244	$3,288.25	$1,294.56
27871	Fusion of tibiofibular joint	Y		A2	$630.00	79.4244	$3,288.25	$1,294.56
27884	Amputation follow-up surgery	Y		A2	$510.00	21.2689	$880.55	$602.64
27889	Amputation of foot at ankle	Y		A2	$510.00	29.19	$1,208.50	$684.63
27892	Decompression of leg	Y		A2	$510.00	21.2689	$880.55	$602.64
27893	Decompression of leg	Y		A2	$510.00	21.2689	$880.55	$602.64
27894	Decompression of leg	Y		A2	$510.00	21.2689	$880.55	$602.64
28001	Drainage of bursa of foot	Y		P3		2.8719	$118.90	$118.90
28002	Treatment of foot infection	Y		A2	$510.00	21.2689	$880.55	$602.64
28003	Treatment of foot infection	Y		A2	$510.00	21.2689	$880.55	$602.64
28005	Treat foot bone lesion	Y		A2	$510.00	20.8284	$862.32	$598.08
28008	Incision of foot fascia	Y		A2	$510.00	20.8284	$862.32	$598.08
28010	Incision of toe tendon	Y		P3		2.156	$89.26	$89.26
28011	Incision of toe tendons	Y		A2	$510.00	20.8284	$862.32	$598.08
28020	Exploration of foot joint	Y		A2	$446.00	20.8284	$862.32	$550.08
28022	Exploration of foot joint	Y		A2	$446.00	20.8284	$862.32	$550.08
28024	Exploration of toe joint	Y		A2	$446.00	20.8284	$862.32	$550.08
28035	Decompression of tibia nerve	Y		A2	$630.00	18.0518	$747.36	$659.34
28043	Excision of foot lesion	Y		A2	$446.00	21.1098	$873.97	$552.99
28045	Excision of foot lesion	Y		A2	$510.00	20.8284	$862.32	$598.08
28046	Resection of tumor, foot	Y		A2	$510.00	20.8284	$862.32	$598.08
28050	Biopsy of foot joint lining	Y		A2	$446.00	20.8284	$862.32	$550.08
28052	Biopsy of foot joint lining	Y		A2	$446.00	20.8284	$862.32	$550.08
28054	Biopsy of toe joint lining	Y		A2	$446.00	20.8284	$862.32	$550.08
28055	Neurectomy, foot	Y		A2	$630.00	18.0518	$747.36	$659.34
28060	Partial removal, foot fascia	Y		A2	$446.00	20.8284	$862.32	$550.08
28062	Removal of foot fascia	Y		A2	$510.00	20.8284	$862.32	$598.08
28070	Removal of foot joint lining	Y		A2	$510.00	20.8284	$862.32	$598.08
28072	Removal of foot joint lining	Y		A2	$510.00	20.8284	$862.32	$598.08
28080	Removal of foot lesion	Y		A2	$510.00	20.8284	$862.32	$598.08
28086	Excise foot tendon sheath	Y		A2	$446.00	20.8284	$862.32	$550.08
28088	Excise foot tendon sheath	Y		A2	$446.00	20.8284	$862.32	$550.08
28090	Removal of foot lesion	Y		A2	$510.00	20.8284	$862.32	$598.08

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
28092	Removal of toe lesions	Y		A2	$510.00	20.8284	$862.32	$598.08
28100	Removal of ankle/heel lesion	Y		A2	$446.00	20.8284	$862.32	$550.08
28102	Remove/graft foot lesion	Y		A2	$510.00	44.2687	$1,832.77	$840.69
28103	Remove/graft foot lesion	Y		A2	$510.00	44.2687	$1,832.77	$840.69
28104	Removal of foot lesion	Y		A2	$446.00	20.8284	$862.32	$550.08
28106	Remove/graft foot lesion	Y		A2	$510.00	44.2687	$1,832.77	$840.69
28107	Remove/graft foot lesion	Y		A2	$510.00	44.2687	$1,832.77	$840.69
28108	Removal of toe lesions	Y		A2	$446.00	20.8284	$862.32	$550.08
28110	Part removal of metatarsal	Y		A2	$510.00	20.8284	$862.32	$598.08
28111	Part removal of metatarsal	Y		A2	$510.00	20.8284	$862.32	$598.08
28112	Part removal of metatarsal	Y		A2	$510.00	20.8284	$862.32	$598.08
28113	Part removal of metatarsal	Y		A2	$510.00	20.8284	$862.32	$598.08
28114	Removal of metatarsal heads	Y		A2	$510.00	20.8284	$862.32	$598.08
28116	Revision of foot	Y		A2	$510.00	20.8284	$862.32	$598.08
28118	Removal of heel bone	Y		A2	$630.00	20.8284	$862.32	$688.08
28119	Removal of heel spur	Y		A2	$630.00	20.8284	$862.32	$688.08
28120	Part removal of ankle/heel	Y		A2	$995.00	20.8284	$862.32	$961.83
28122	Partial removal of foot bone	Y		A2	$510.00	20.8284	$862.32	$598.08
28124	Partial removal of toe	Y		P3		4.8385	$200.32	$200.32
28126	Partial removal of toe	Y		A2	$510.00	20.8284	$862.32	$598.08
28130	Removal of ankle bone	Y		A2	$510.00	20.8284	$862.32	$598.08
28140	Removal of metatarsal	Y		A2	$510.00	20.8284	$862.32	$598.08
28150	Removal of toe	Y		A2	$510.00	20.8284	$862.32	$598.08
28153	Partial removal of toe	Y		A2	$510.00	20.8284	$862.32	$598.08
28160	Partial removal of toe	Y		A2	$510.00	20.8284	$862.32	$598.08
28171	Extensive foot surgery	Y		A2	$510.00	20.8284	$862.32	$598.08
28173	Extensive foot surgery	Y		A2	$510.00	20.8284	$862.32	$598.08
28175	Extensive foot surgery	Y		A2	$510.00	20.8284	$862.32	$598.08
28190	Removal of foot foreign body	Y		P3		3.0446	$126.05	$126.05
28192	Removal of foot foreign body	Y		A2	$446.00	16.1001	$666.56	$501.14
28193	Removal of foot foreign body	Y		A2	$418.49	8.685	$359.57	$403.76
28200	Repair of foot tendon	Y		A2	$510.00	20.8284	$862.32	$598.08
28202	Repair/graft of foot tendon	Y		A2	$510.00	20.8284	$862.32	$598.08
28208	Repair of foot tendon	Y		A2	$510.00	20.8284	$862.32	$598.08
28210	Repair/graft of foot tendon	Y		A2	$510.00	44.2687	$1,832.77	$840.69
28220	Release of foot tendon	Y		P3		4.5588	$188.74	$188.74
28222	Release of foot tendons	Y		A2	$333.00	20.8284	$862.32	$465.33
28225	Release of foot tendon	Y		A2	$333.00	20.8284	$862.32	$465.33
28226	Release of foot tendons	Y		A2	$333.00	20.8284	$862.32	$465.33
28230	Incision of foot tendon(s)	Y		P3		4.4929	$186.01	$186.01
28232	Incision of toe tendon	Y		P3		4.2955	$177.84	$177.84
28234	Incision of foot tendon	Y		A2	$446.00	20.8284	$862.32	$550.08
28238	Revision of foot tendon	Y		A2	$510.00	44.2687	$1,832.77	$840.69
28240	Release of big toe	Y		A2	$446.00	20.8284	$862.32	$550.08
28250	Revision of foot fascia	Y		A2	$510.00	20.8284	$862.32	$598.08
28260	Release of midfoot joint	Y		A2	$510.00	20.8284	$862.32	$598.08
28261	Revision of foot tendon	Y		A2	$510.00	20.8284	$862.32	$598.08
28262	Revision of foot and ankle	Y		A2	$630.00	20.8284	$862.32	$688.08
28264	Release of midfoot joint	Y		A2	$333.00	44.2687	$1,832.77	$707.94
28270	Release of foot contracture	Y		A2	$510.00	20.8284	$862.32	$598.08
28272	Release of toe joint, each	Y		P3		4.1144	$170.34	$170.34
28280	Fusion of toes	Y		A2	$446.00	20.8284	$862.32	$550.08
28285	Repair of hammertoe	Y		A2	$510.00	20.8284	$862.32	$598.08
28286	Repair of hammertoe	Y		A2	$630.00	20.8284	$862.32	$688.08
28288	Partial removal of foot bone	Y		A2	$510.00	20.8284	$862.32	$598.08
28289	Repair hallux rigidus	Y		A2	$510.00	20.8284	$862.32	$598.08
28290	Correction of bunion	Y		A2	$446.00	29.4167	$1,217.88	$638.97
28292	Correction of bunion	Y		A2	$446.00	29.4167	$1,217.88	$638.97
28293	Correction of bunion	Y		A2	$510.00	29.4167	$1,217.88	$686.97
28294	Correction of bunion	Y		A2	$510.00	29.4167	$1,217.88	$686.97
28296	Correction of bunion	Y		A2	$510.00	29.4167	$1,217.88	$686.97
28297	Correction of bunion	Y		A2	$510.00	29.4167	$1,217.88	$686.97
28298	Correction of bunion	Y		A2	$510.00	29.4167	$1,217.88	$686.97
28299	Correction of bunion	Y		A2	$717.00	29.4167	$1,217.88	$842.22
28300	Incision of heel bone	Y		A2	$446.00	44.2687	$1,832.77	$792.69
28302	Incision of ankle bone	Y		A2	$446.00	20.8284	$862.32	$550.08
28304	Incision of midfoot bones	Y		A2	$446.00	44.2687	$1,832.77	$792.69
28305	Incise/graft midfoot bones	Y		A2	$510.00	44.2687	$1,832.77	$840.69
28306	Incision of metatarsal	Y		A2	$630.00	20.8284	$862.32	$688.08
28307	Incision of metatarsal	Y		A2	$630.00	20.8284	$862.32	$688.08
28308	Incision of metatarsal	Y		A2	$446.00	20.8284	$862.32	$550.08
28309	Incision of metatarsals	Y		A2	$630.00	44.2687	$1,832.77	$930.69
28310	Revision of big toe	Y		A2	$510.00	20.8284	$862.32	$598.08

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
28312	Revision of toe	Y		A2	$510.00	20.8284	$862.32	$598.08
28313	Repair deformity of toe	Y		A2	$446.00	20.8284	$862.32	$550.08
28315	Removal of sesamoid bone	Y		A2	$630.00	20.8284	$862.32	$688.08
28320	Repair of foot bones	Y		A2	$630.00	44.2687	$1,832.77	$930.69
28322	Repair of metatarsals	Y		A2	$630.00	44.2687	$1,832.77	$930.69
28340	Resect enlarged toe tissue	Y		A2	$630.00	20.8284	$862.32	$688.08
28341	Resect enlarged toe	Y		A2	$630.00	20.8284	$862.32	$688.08
28344	Repair extra toe(s)	Y		A2	$630.00	20.8284	$862.32	$688.08
28345	Repair webbed toe(s)	Y		A2	$630.00	20.8284	$862.32	$688.08
28400	Treatment of heel fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
28405	Treatment of heel fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
28406	Treatment of heel fracture	Y		A2	$446.00	26.1592	$1,083.02	$605.26
28415	Treat heel fracture	Y		A2	$510.00	59.2233	$2,451.90	$995.48
28420	Treat/graft heel fracture	Y		A2	$630.00	41.1091	$1,701.96	$897.99
28430	Treatment of ankle fracture	Y		P2		1.7682	$73.21	$73.21
28435	Treatment of ankle fracture	Y		A2	$103.62	1.7682	$73.21	$96.02
28436	Treatment of ankle fracture	Y		A2	$446.00	26.1592	$1,083.02	$605.26
28445	Treat ankle fracture	Y		A2	$510.00	41.1091	$1,701.96	$807.99
28446	Osteochondral talus autogrft	Y	NI	G2		44.2687	$1,832.77	$1,832.77
28450	Treat midfoot fracture, each	Y		P2		1.7682	$73.21	$73.21
28455	Treat midfoot fracture, each	Y		P2		1.7682	$73.21	$73.21
28456	Treat midfoot fracture	Y		A2	$446.00	26.1592	$1,083.02	$605.26
28465	Treat midfoot fracture, each	Y		A2	$510.00	41.1091	$1,701.96	$807.99
28470	Treat metatarsal fracture	Y		P2		1.7682	$73.21	$73.21
28475	Treat metatarsal fracture	Y		P2		1.7682	$73.21	$73.21
28476	Treat metatarsal fracture	Y		A2	$446.00	26.1592	$1,083.02	$605.26
28485	Treat metatarsal fracture	Y		A2	$630.00	41.1091	$1,701.96	$897.99
28490	Treat big toe fracture	Y		P3		1.6869	$69.84	$69.84
28495	Treat big toe fracture	Y		P2		1.7682	$73.21	$73.21
28496	Treat big toe fracture	Y		A2	$446.00	26.1592	$1,083.02	$605.26
28505	Treat big toe fracture	Y		A2	$510.00	26.1592	$1,083.02	$653.26
28510	Treatment of toe fracture	Y		P3		1.3166	$54.51	$54.51
28515	Treatment of toe fracture	Y		P3		1.6951	$70.18	$70.18
28525	Treat toe fracture	Y		A2	$510.00	26.1592	$1,083.02	$653.26
28530	Treat sesamoid bone fracture	Y		P3		1.2589	$52.12	$52.12
28531	Treat sesamoid bone fracture	Y		A2	$510.00	26.1592	$1,083.02	$653.26
28540	Treat foot dislocation	Y		P2		1.7682	$73.21	$73.21
28545	Treat foot dislocation	Y		A2	$333.00	26.1592	$1,083.02	$520.51
28546	Treat foot dislocation	Y		A2	$446.00	26.1592	$1,083.02	$605.26
28555	Repair foot dislocation	Y		A2	$446.00	41.1091	$1,701.96	$759.99
28570	Treat foot dislocation	Y		P2		1.7682	$73.21	$73.21
28575	Treat foot dislocation	Y		A2	$103.62	1.7682	$73.21	$96.02
28576	Treat foot dislocation	Y		A2	$510.00	26.1592	$1,083.02	$653.26
28585	Repair foot dislocation	Y		A2	$510.00	26.1592	$1,083.02	$653.26
28600	Treat foot dislocation	Y		P2		1.7682	$73.21	$73.21
28605	Treat foot dislocation	Y		A2	$103.62	1.7682	$73.21	$96.02
28606	Treat foot dislocation	Y		A2	$446.00	26.1592	$1,083.02	$605.26
28615	Repair foot dislocation	Y		A2	$510.00	41.1091	$1,701.96	$807.99
28630	Treat toe dislocation	Y	CH	P3		1.399	$57.92	$57.92
28635	Treat toe dislocation	Y		A2	$333.00	14.7658	$611.32	$402.58
28636	Treat toe dislocation	Y		A2	$510.00	26.1592	$1,083.02	$653.26
28645	Repair toe dislocation	Y		A2	$510.00	26.1592	$1,083.02	$653.26
28660	Treat toe dislocation	Y	CH	P3		1.0534	$43.61	$43.61
28665	Treat toe dislocation	Y		A2	$333.00	14.7658	$611.32	$402.58
28666	Treat toe dislocation	Y		A2	$510.00	26.1592	$1,083.02	$653.26
28675	Repair of toe dislocation	Y		A2	$510.00	26.1592	$1,083.02	$653.26
28705	Fusion of foot bones	Y		A2	$630.00	44.2687	$1,832.77	$930.69
28715	Fusion of foot bones	Y		A2	$630.00	79.4244	$3,288.25	$1,294.56
28725	Fusion of foot bones	Y		A2	$630.00	44.2687	$1,832.77	$930.69
28730	Fusion of foot bones	Y		A2	$630.00	44.2687	$1,832.77	$930.69
28735	Fusion of foot bones	Y		A2	$630.00	44.2687	$1,832.77	$930.69
28737	Revision of foot bones	Y		A2	$717.00	44.2687	$1,832.77	$995.94
28740	Fusion of foot bones	Y		A2	$630.00	44.2687	$1,832.77	$930.69
28750	Fusion of big toe joint	Y		A2	$630.00	44.2687	$1,832.77	$930.69
28755	Fusion of big toe joint	Y		A2	$630.00	20.8284	$862.32	$688.08
28760	Fusion of big toe joint	Y		A2	$630.00	44.2687	$1,832.77	$930.69
28810	Amputation toe & metatarsal	Y		A2	$446.00	20.8284	$862.32	$550.08
28820	Amputation of toe	Y		A2	$446.00	20.8284	$862.32	$550.08
28825	Partial amputation of toe	Y		A2	$446.00	20.8284	$862.32	$550.08
28890*	High energy eswt, plantar f	Y	CH	P3		4.2296	$175.11	$175.11
29000	Application of body cast	N		G2		1.0931	$45.26	$45.26
29010	Application of body cast	N		P2		2.291	$94.85	$94.85
29015	Application of body cast	N		P2		2.291	$94.85	$94.85

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
29020	Application of body cast	N		G2		1.0931	$45.26	$45.26
29025	Application of body cast	N		P2		1.0931	$45.26	$45.26
29035	Application of body cast	N	CH	P2		2.291	$94.85	$94.85
29040	Application of body cast	N		G2		1.0931	$45.26	$45.26
29044	Application of body cast	N		P2		2.291	$94.85	$94.85
29046	Application of body cast	N		G2		2.291	$94.85	$94.85
29049	Application of figure eight	N		P3		0.9956	$41.22	$41.22
29055	Application of shoulder cast	N		P2		2.291	$94.85	$94.85
29058	Application of shoulder cast	N		P2		1.0931	$45.26	$45.26
29065	Application of long arm cast	N		P3		1.0698	$44.29	$44.29
29075	Application of forearm cast	N		P3		1.0203	$42.24	$42.24
29085	Apply hand/wrist cast	N		P3		1.0451	$43.27	$43.27
29086	Apply finger cast	N		P3		0.8394	$34.75	$34.75
29105	Apply long arm splint	N		P3		0.9546	$39.52	$39.52
29125	Apply forearm splint	N		P3		0.8147	$33.73	$33.73
29126	Apply forearm splint	N		P3		0.9135	$37.82	$37.82
29130	Application of finger splint	N		P3		0.3703	$15.33	$15.33
29131	Application of finger splint	N		P3		0.5432	$22.49	$22.49
29200	Strapping of chest	N		P3		0.5432	$22.49	$22.49
29220	Strapping of low back	N		P3		0.5596	$23.17	$23.17
29240	Strapping of shoulder	N		P3		0.6253	$25.89	$25.89
29260	Strapping of elbow or wrist	N		P3		0.5761	$23.85	$23.85
29280	Strapping of hand or finger	N		P3		0.6007	$24.87	$24.87
29305	Application of hip cast	N	CH	P2		2.291	$94.85	$94.85
29325	Application of hip casts	N	CH	P2		2.291	$94.85	$94.85
29345	Application of long leg cast	N		P3		1.4072	$58.26	$58.26
29355	Application of long leg cast	N		P3		1.3659	$56.55	$56.55
29358	Apply long leg cast brace	N		P3		1.6705	$69.16	$69.16
29365	Application of long leg cast	N		P3		1.3331	$55.19	$55.19
29405	Apply short leg cast	N		P3		0.9874	$40.88	$40.88
29425	Apply short leg cast	N		P3		1.0038	$41.56	$41.56
29435	Apply short leg cast	N		P3		1.2674	$52.47	$52.47
29440	Addition of walker to cast	N		P3		0.5514	$22.83	$22.83
29445	Apply rigid leg cast	N		P3		1.3823	$57.23	$57.23
29450	Application of leg cast	N		P2		1.0931	$45.26	$45.26
29505	Application, long leg splint	N	CH	P3		0.9217	$38.16	$38.16
29515	Application lower leg splint	N	CH	P3		0.7488	$31.00	$31.00
29520	Strapping of hip	N		P3		0.6171	$25.55	$25.55
29530	Strapping of knee	N		P3		0.5925	$24.53	$24.53
29540	Strapping of ankle and/or ft	N		P3		0.3949	$16.35	$16.35
29550	Strapping of toes	N		P3		0.4031	$16.69	$16.69
29580	Application of paste boot	N		P3		0.5596	$23.17	$23.17
29590	Application of foot splint	N		P3		0.4526	$18.74	$18.74
29700	Removal/revision of cast	N		P3		0.757	$31.34	$31.34
29705	Removal/revision of cast	N		P3		0.65	$26.91	$26.91
29710	Removal/revision of cast	N		P3		1.1686	$48.38	$48.38
29715	Removal/revision of cast	N		P3		0.971	$40.20	$40.20
29720	Repair of body cast	N		P3		0.9546	$39.52	$39.52
29730	Windowing of cast	N		P3		0.6336	$26.23	$26.23
29740	Wedging of cast	N		P3		0.8968	$37.13	$37.13
29750	Wedging of clubfoot cast	N		P3		0.8722	$36.11	$36.11
29800	Jaw arthroscopy/surgery	Y		A2	$510.00	28.7803	$1,191.53	$680.38
29804	Jaw arthroscopy/surgery	Y		A2	$510.00	28.7803	$1,191.53	$680.38
29805	Shoulder arthroscopy, dx	Y		A2	$510.00	28.7803	$1,191.53	$680.38
29806	Shoulder arthroscopy/surgery	Y		A2	$510.00	45.7072	$1,892.32	$855.58
29807	Shoulder arthroscopy/surgery	Y		A2	$510.00	45.7072	$1,892.32	$855.58
29819	Shoulder arthroscopy/surgery	Y		A2	$510.00	45.7072	$1,892.32	$855.58
29820	Shoulder arthroscopy/surgery	Y		A2	$510.00	45.7072	$1,892.32	$855.58
29821	Shoulder arthroscopy/surgery	Y		A2	$510.00	45.7072	$1,892.32	$855.58
29822	Shoulder arthroscopy/surgery	Y		A2	$510.00	28.7803	$1,191.53	$680.38
29823	Shoulder arthroscopy/surgery	Y		A2	$510.00	45.7072	$1,892.32	$855.58
29824	Shoulder arthroscopy/surgery	Y		A2	$717.00	28.7803	$1,191.53	$835.63
29825	Shoulder arthroscopy/surgery	Y		A2	$510.00	45.7072	$1,892.32	$855.58
29826	Shoulder arthroscopy/surgery	Y		A2	$510.00	45.7072	$1,892.32	$855.58
29827	Arthroscop rotator cuff repr	Y		A2	$717.00	45.7072	$1,892.32	$1,010.83
29828	Arthroscopy biceps tenodesis	Y	NI	G2		45.7072	$1,892.32	$1,892.32
29830	Elbow arthroscopy	Y		A2	$510.00	28.7803	$1,191.53	$680.38
29834	Elbow arthroscopy/surgery	Y		A2	$510.00	28.7803	$1,191.53	$680.38
29835	Elbow arthroscopy/surgery	Y		A2	$510.00	28.7803	$1,191.53	$680.38
29836	Elbow arthroscopy/surgery	Y		A2	$510.00	28.7803	$1,191.53	$680.38
29837	Elbow arthroscopy/surgery	Y		A2	$510.00	28.7803	$1,191.53	$680.38
29838	Elbow arthroscopy/surgery	Y		A2	$510.00	28.7803	$1,191.53	$680.38
29840	Wrist arthroscopy	Y		A2	$510.00	28.7803	$1,191.53	$680.38

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
29843	Wrist arthroscopy/surgery	Y		A2	$510.00	28.7803	$1,191.53	$680.38
29844	Wrist arthroscopy/surgery	Y		A2	$510.00	28.7803	$1,191.53	$680.38
29845	Wrist arthroscopy/surgery	Y		A2	$510.00	28.7803	$1,191.53	$680.38
29846	Wrist arthroscopy/surgery	Y		A2	$510.00	28.7803	$1,191.53	$680.38
29847	Wrist arthroscopy/surgery	Y		A2	$510.00	45.7072	$1,892.32	$855.58
29848	Wrist endoscopy/surgery	Y		A2	$1,339.00	28.7803	$1,191.53	$1,302.13
29850	Knee arthroscopy/surgery	Y		A2	$630.00	28.7803	$1,191.53	$770.38
29851	Knee arthroscopy/surgery	Y		A2	$630.00	45.7072	$1,892.32	$945.58
29855	Tibial arthroscopy/surgery	Y		A2	$630.00	45.7072	$1,892.32	$945.58
29856	Tibial arthroscopy/surgery	Y		A2	$630.00	45.7072	$1,892.32	$945.58
29860	Hip arthroscopy, dx	Y		A2	$630.00	45.7072	$1,892.32	$945.58
29861	Hip arthroscopy/surgery	Y		A2	$630.00	45.7072	$1,892.32	$945.58
29862	Hip arthroscopy/surgery	Y		A2	$1,339.00	45.7072	$1,892.32	$1,477.33
29863	Hip arthroscopy/surgery	Y		A2	$630.00	45.7072	$1,892.32	$945.58
29866	Autgrft implnt, knee w/scope	Y	CH	G2		45.7072	$1,892.32	$1,892.32
29870	Knee arthroscopy, dx	Y		A2	$510.00	28.7803	$1,191.53	$680.38
29871	Knee arthroscopy/drainage	Y		A2	$510.00	28.7803	$1,191.53	$680.38
29873	Knee arthroscopy/surgery	Y		A2	$510.00	28.7803	$1,191.53	$680.38
29874	Knee arthroscopy/surgery	Y		A2	$510.00	28.7803	$1,191.53	$680.38
29875	Knee arthroscopy/surgery	Y		A2	$630.00	28.7803	$1,191.53	$770.38
29876	Knee arthroscopy/surgery	Y		A2	$630.00	28.7803	$1,191.53	$770.38
29877	Knee arthroscopy/surgery	Y		A2	$630.00	28.7803	$1,191.53	$770.38
29879	Knee arthroscopy/surgery	Y		A2	$510.00	28.7803	$1,191.53	$680.38
29880	Knee arthroscopy/surgery	Y		A2	$630.00	28.7803	$1,191.53	$770.38
29881	Knee arthroscopy/surgery	Y		A2	$630.00	28.7803	$1,191.53	$770.38
29882	Knee arthroscopy/surgery	Y		A2	$510.00	28.7803	$1,191.53	$680.38
29883	Knee arthroscopy/surgery	Y		A2	$510.00	28.7803	$1,191.53	$680.38
29884	Knee arthroscopy/surgery	Y		A2	$510.00	28.7803	$1,191.53	$680.38
29885	Knee arthroscopy/surgery	Y		A2	$510.00	45.7072	$1,892.32	$855.58
29886	Knee arthroscopy/surgery	Y		A2	$510.00	28.7803	$1,191.53	$680.38
29887	Knee arthroscopy/surgery	Y		A2	$510.00	28.7803	$1,191.53	$680.38
29888	Knee arthroscopy/surgery	Y		A2	$510.00	45.7072	$1,892.32	$855.58
29889	Knee arthroscopy/surgery	Y		A2	$510.00	45.7072	$1,892.32	$855.58
29891	Ankle arthroscopy/surgery	Y		A2	$510.00	45.7072	$1,892.32	$855.58
29892	Ankle arthroscopy/surgery	Y		A2	$510.00	45.7072	$1,892.32	$855.58
29893	Scope, plantar fasciotomy	Y		A2	$1,255.56	20.8284	$862.32	$1,157.25
29894	Ankle arthroscopy/surgery	Y		A2	$510.00	28.7803	$1,191.53	$680.38
29895	Ankle arthroscopy/surgery	Y		A2	$510.00	28.7803	$1,191.53	$680.38
29897	Ankle arthroscopy/surgery	Y		A2	$510.00	28.7803	$1,191.53	$680.38
29898	Ankle arthroscopy/surgery	Y		A2	$510.00	28.7803	$1,191.53	$680.38
29899	Ankle arthroscopy/surgery	Y		A2	$510.00	45.7072	$1,892.32	$855.58
29900	Mcp joint arthroscopy, dx	Y		A2	$510.00	28.7803	$1,191.53	$680.38
29901	Mcp joint arthroscopy, surg	Y		A2	$510.00	28.7803	$1,191.53	$680.38
29902	Mcp joint arthroscopy, surg	Y		A2	$510.00	28.7803	$1,191.53	$680.38
29904	Subtalar arthro w/fb rmvl	Y	NI	G2		28.7803	$1,191.53	$1,191.53
29905	Subtalar arthro w/exc	Y	NI	G2		28.7803	$1,191.53	$1,191.53
29906	Subtalar arthro w/deb	Y	NI	G2		28.7803	$1,191.53	$1,191.53
29907	Subtalar arthro w/fusion	Y	NI	G2		45.7072	$1,892.32	$1,892.32
30000	Drainage of nose lesion	Y		P2		2.5002	$103.51	$103.51
30020	Drainage of nose lesion	Y		P2		2.5002	$103.51	$103.51
30100	Intranasal biopsy	Y		P3		1.8763	$77.68	$77.68
30110	Removal of nose polyp(s)	Y		P3		2.9376	$121.62	$121.62
30115	Removal of nose polyp(s)	Y		A2	$446.00	16.3288	$676.03	$503.51
30117	Removal of intranasal lesion	Y		A2	$510.00	16.3288	$676.03	$551.51
30118	Removal of intranasal lesion	Y		A2	$510.00	23.9765	$992.65	$630.66
30120	Revision of nose	Y		A2	$333.00	16.3288	$676.03	$418.76
30124	Removal of nose lesion	Y		R2		7.4474	$308.33	$308.33
30125	Removal of nose lesion	Y		A2	$446.00	39.8776	$1,650.97	$747.24
30130	Excise inferior turbinate	Y		A2	$510.00	16.3288	$676.03	$551.51
30140	Resect inferior turbinate	Y		A2	$446.00	23.9765	$992.65	$582.66
30150	Partial removal of nose	Y		A2	$510.00	39.8776	$1,650.97	$795.24
30160	Removal of nose	Y		A2	$630.00	39.8776	$1,650.97	$885.24
30200	Injection treatment of nose	Y		P3		1.4975	$62.00	$62.00
30210	Nasal sinus therapy	Y		P3		1.8927	$78.36	$78.36
30220	Insert nasal septal button	Y		A2	$464.15	7.4474	$308.33	$425.20
30300	Remove nasal foreign body	N		P2		0.631	$26.12	$26.12
30310	Remove nasal foreign body	Y		A2	$333.00	16.3288	$676.03	$418.76
30320	Remove nasal foreign body	Y		A2	$446.00	16.3288	$676.03	$503.51
30400	Reconstruction of nose	Y		A2	$630.00	39.8776	$1,650.97	$885.24
30410	Reconstruction of nose	Y		A2	$717.00	39.8776	$1,650.97	$950.49
30420	Reconstruction of nose	Y		A2	$717.00	39.8776	$1,650.97	$950.49
30430	Revision of nose	Y		A2	$510.00	23.9765	$992.65	$630.66
30435	Revision of nose	Y		A2	$717.00	39.8776	$1,650.97	$950.49

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
30450	Revision of nose	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
30460	Revision of nose	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
30462	Revision of nose	Y		A2	$1,339.00	39.8776	$1,650.97	$1,416.99
30465	Repair nasal stenosis	Y		A2	$1,339.00	39.8776	$1,650.97	$1,416.99
30520	Repair of nasal septum	Y		A2	$630.00	23.9765	$992.65	$720.66
30540	Repair nasal defect	Y		A2	$717.00	39.8776	$1,650.97	$950.49
30545	Repair nasal defect	Y		A2	$717.00	39.8776	$1,650.97	$950.49
30560	Release of nasal adhesions	Y		A2	$150.72	2.5002	$103.51	$138.92
30580	Repair upper jaw fistula	Y		A2	$630.00	39.8776	$1,650.97	$885.24
30600	Repair mouth/nose fistula	Y		A2	$630.00	39.8776	$1,650.97	$885.24
30620	Intranasal reconstruction	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
30630	Repair nasal septum defect	Y		A2	$995.00	23.9765	$992.65	$994.41
30801	Ablate inf turbinate, superf	Y		A2	$333.00	7.4474	$308.33	$326.83
30802	Cauterization, inner nose	Y		A2	$333.00	7.4474	$308.33	$326.83
30901	Control of nosebleed	Y		P3		1.078	$44.63	$44.63
30903	Control of nosebleed	Y		A2	$72.48	1.1251	$46.58	$66.01
30905	Control of nosebleed	Y		A2	$72.48	1.1251	$46.58	$66.01
30906	Repeat control of nosebleed	Y		A2	$72.48	1.1251	$46.58	$66.01
30915	Ligation, nasal sinus artery	Y		A2	$446.00	25.841	$1,069.84	$601.96
30920	Ligation, upper jaw artery	Y		A2	$510.00	25.841	$1,069.84	$649.96
30930	Ther fx, nasal inf turbinate	Y		A2	$630.00	16.3288	$676.03	$641.51
31000	Irrigation, maxillary sinus	Y		P3		2.4934	$103.23	$103.23
31002	Irrigation, sphenoid sinus	Y		R2		7.4474	$308.33	$308.33
31020	Exploration, maxillary sinus	Y		A2	$446.00	23.9765	$992.65	$582.66
31030	Exploration, maxillary sinus	Y		A2	$510.00	39.8776	$1,650.97	$795.24
31032	Explore sinus, remove polyps	Y		A2	$630.00	39.8776	$1,650.97	$885.24
31040	Exploration behind upper jaw	Y		R2		23.9765	$992.65	$992.65
31050	Exploration, sphenoid sinus	Y		A2	$446.00	39.8776	$1,650.97	$747.24
31051	Sphenoid sinus surgery	Y		A2	$630.00	39.8776	$1,650.97	$885.24
31070	Exploration of frontal sinus	Y		A2	$446.00	23.9765	$992.65	$582.66
31075	Exploration of frontal sinus	Y		A2	$630.00	39.8776	$1,650.97	$885.24
31080	Removal of frontal sinus	Y		A2	$630.00	39.8776	$1,650.97	$885.24
31081	Removal of frontal sinus	Y		A2	$630.00	39.8776	$1,650.97	$885.24
31084	Removal of frontal sinus	Y		A2	$630.00	39.8776	$1,650.97	$885.24
31085	Removal of frontal sinus	Y		A2	$630.00	39.8776	$1,650.97	$885.24
31086	Removal of frontal sinus	Y		A2	$630.00	39.8776	$1,650.97	$885.24
31087	Removal of frontal sinus	Y		A2	$630.00	39.8776	$1,650.97	$885.24
31090	Exploration of sinuses	Y		A2	$717.00	39.8776	$1,650.97	$950.49
31200	Removal of ethmoid sinus	Y		A2	$446.00	39.8776	$1,650.97	$747.24
31201	Removal of ethmoid sinus	Y		A2	$717.00	39.8776	$1,650.97	$950.49
31205	Removal of ethmoid sinus	Y		A2	$510.00	39.8776	$1,650.97	$795.24
31231	Nasal endoscopy, dx	Y		P2		1.6115	$66.72	$66.72
31233	Nasal/sinus endoscopy, dx	Y		A2	$86.39	1.6115	$66.72	$81.47
31235	Nasal/sinus endoscopy, dx	Y		A2	$333.00	17.016	$704.48	$425.87
31237	Nasal/sinus endoscopy, surg	Y		A2	$446.00	17.016	$704.48	$510.62
31238	Nasal/sinus endoscopy, surg	Y		A2	$333.00	17.016	$704.48	$425.87
31239	Nasal/sinus endoscopy, surg	Y		A2	$630.00	22.7191	$940.59	$707.65
31240	Nasal/sinus endoscopy, surg	Y		A2	$446.00	17.016	$704.48	$510.62
31254	Revision of ethmoid sinus	Y		A2	$510.00	22.7191	$940.59	$617.65
31255	Removal of ethmoid sinus	Y		A2	$717.00	22.7191	$940.59	$772.90
31256	Exploration maxillary sinus	Y		A2	$510.00	22.7191	$940.59	$617.65
31267	Endoscopy, maxillary sinus	Y		A2	$510.00	22.7191	$940.59	$617.65
31276	Sinus endoscopy, surgical	Y		A2	$510.00	22.7191	$940.59	$617.65
31287	Nasal/sinus endoscopy, surg	Y		A2	$510.00	22.7191	$940.59	$617.65
31288	Nasal/sinus endoscopy, surg	Y		A2	$510.00	22.7191	$940.59	$617.65
31300	Removal of larynx lesion	Y		A2	$717.00	23.9765	$992.65	$785.91
31320	Diagnostic incision, larynx	Y		A2	$446.00	39.8776	$1,650.97	$747.24
31400	Revision of larynx	Y		A2	$446.00	39.8776	$1,650.97	$747.24
31420	Removal of epiglottis	Y		A2	$446.00	39.8776	$1,650.97	$747.24
31500	Insert emergency airway	N		G2		2.459	$101.81	$101.81
31502	Change of windpipe airway	N		G2		1.3362	$55.32	$55.32
31505	Diagnostic laryngoscopy	Y		P2		0.8224	$34.05	$34.05
31510	Laryngoscopy with biopsy	Y		A2	$446.00	17.016	$704.48	$510.62
31511	Remove foreign body, larynx	Y		A2	$86.39	1.6115	$66.72	$81.47
31512	Removal of larynx lesion	Y		A2	$446.00	17.016	$704.48	$510.62
31513	Injection into vocal cord	Y		A2	$86.39	1.6115	$66.72	$81.47
31515	Laryngoscopy for aspiration	Y		A2	$333.00	17.016	$704.48	$425.87
31520	Dx laryngoscopy, newborn	Y		G2		1.6115	$66.72	$66.72
31525	Dx laryngoscopy excl nb	Y		A2	$333.00	17.016	$704.48	$425.87
31526	Dx laryngoscopy w/oper scope	Y		A2	$446.00	22.7191	$940.59	$569.65
31527	Laryngoscopy for treatment	Y		A2	$333.00	22.7191	$940.59	$484.90
31528	Laryngoscopy and dilation	Y		A2	$446.00	17.016	$704.48	$510.62
31529	Laryngoscopy and dilation	Y		A2	$446.00	17.016	$704.48	$510.62

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
31530	Laryngoscopy w/fb removal	Y		A2	$446.00	22.7191	$940.59	$569.65
31531	Laryngoscopy w/fb & op scope	Y		A2	$510.00	22.7191	$940.59	$617.65
31535	Laryngoscopy w/biopsy	Y		A2	$446.00	22.7191	$940.59	$569.65
31536	Laryngoscopy w/bx & op scope	Y		A2	$510.00	22.7191	$940.59	$617.65
31540	Laryngoscopy w/exc of tumor	Y		A2	$510.00	22.7191	$940.59	$617.65
31541	Larynscop w/tumr exc + scope	Y		A2	$630.00	22.7191	$940.59	$707.65
31545	Remove vc lesion w/scope	Y		A2	$630.00	22.7191	$940.59	$707.65
31546	Remove vc lesion scope/graft	Y		A2	$630.00	22.7191	$940.59	$707.65
31560	Laryngoscop w/arytenoidectom	Y		A2	$717.00	22.7191	$940.59	$772.90
31561	Larynscop, remve cart + scop	Y		A2	$717.00	22.7191	$940.59	$772.90
31570	Laryngoscope w/vc inj	Y		A2	$446.00	17.016	$704.48	$510.62
31571	Laryngoscop w/vc inj + scope	Y		A2	$446.00	22.7191	$940.59	$569.65
31575	Diagnostic laryngoscopy	Y		P3		1.4811	$61.32	$61.32
31576	Laryngoscopy with biopsy	Y		A2	$446.00	22.7191	$940.59	$569.65
31577	Remove foreign body, larynx	Y		A2	$236.42	3.994	$165.36	$218.66
31578	Removal of larynx lesion	Y		A2	$446.00	22.7191	$940.59	$569.65
31579	Diagnostic laryngoscopy	Y		P3		2.7321	$113.11	$113.11
31580	Revision of larynx	Y		A2	$717.00	39.8776	$1,650.97	$950.49
31582	Revision of larynx	Y		A2	$717.00	39.8776	$1,650.97	$950.49
31588	Revision of larynx	Y		A2	$717.00	39.8776	$1,650.97	$950.49
31590	Reinnervate larynx	Y		A2	$717.00	39.8776	$1,650.97	$950.49
31595	Larynx nerve surgery	Y		A2	$446.00	39.8776	$1,650.97	$747.24
31603	Incision of windpipe	Y		A2	$333.00	7.4474	$308.33	$326.83
31605	Incision of windpipe	Y		G2		7.4474	$308.33	$308.33
31611	Surgery/speech prosthesis	Y		A2	$510.00	23.9765	$992.65	$630.66
31612	Puncture/clear windpipe	Y		A2	$333.00	23.9765	$992.65	$497.91
31613	Repair windpipe opening	Y		A2	$446.00	23.9765	$992.65	$582.66
31614	Repair windpipe opening	Y		A2	$446.00	39.8776	$1,650.97	$747.24
31615	Visualization of windpipe	Y		A2	$333.00	9.9575	$412.25	$352.81
31620	Endobronchial us add-on	N	CH	N1				
31622	Dx bronchoscope/wash	Y		A2	$333.00	9.9575	$412.25	$352.81
31623	Dx bronchoscope/brush	Y		A2	$446.00	9.9575	$412.25	$437.56
31624	Dx bronchoscope/lavage	Y		A2	$446.00	9.9575	$412.25	$437.56
31625	Bronchoscopy w/biopsy(s)	Y		A2	$446.00	9.9575	$412.25	$437.56
31628	Bronchoscopy/lung bx, each	Y		A2	$446.00	9.9575	$412.25	$437.56
31629	Bronchoscopy/needle bx, each	Y		A2	$446.00	9.9575	$412.25	$437.56
31630	Bronchoscopy dilate/fx repr	Y		A2	$446.00	24.0654	$996.33	$583.58
31631	Bronchoscopy, dilate w/stent	Y		A2	$446.00	24.0654	$996.33	$583.58
31632	Bronchoscopy/lung bx, add?l	Y		G2		9.9575	$412.25	$412.25
31633	Bronchoscopy/needle bx add?l	Y		G2		9.9575	$412.25	$412.25
31635	Bronchoscopy w/fb removal	Y		A2	$446.00	9.9575	$412.25	$437.56
31636	Bronchoscopy, bronch stents	Y		A2	$446.00	24.0654	$996.33	$583.58
31637	Bronchoscopy, stent add-on	Y		A2	$333.00	9.9575	$412.25	$352.81
31638	Bronchoscopy, revise stent	Y		A2	$446.00	24.0654	$996.33	$583.58
31640	Bronchoscopy w/tumor excise	Y		A2	$446.00	24.0654	$996.33	$583.58
31641	Bronchoscopy, treat blockage	Y		A2	$446.00	24.0654	$996.33	$583.58
31643	Diag bronchoscope/catheter	Y		A2	$446.00	9.9575	$412.25	$437.56
31645	Bronchoscopy, clear airways	Y		A2	$333.00	9.9575	$412.25	$352.81
31646	Bronchoscopy, reclear airway	Y		A2	$333.00	9.9575	$412.25	$352.81
31656	Bronchoscopy, inj for x-ray	Y		A2	$333.00	9.9575	$412.25	$352.81
31715	Injection for bronchus x-ray	N		N1				
31717	Bronchial brush biopsy	Y		A2	$236.42	3.994	$165.36	$218.66
31720	Clearance of airways	N		A2	$47.32	0.3877	$16.05	$39.50
31730	Intro, windpipe wire/tube	Y		A2	$236.42	3.994	$165.36	$218.66
31750	Repair of windpipe	Y		A2	$717.00	39.8776	$1,650.97	$950.49
31755	Repair of windpipe	Y		A2	$446.00	39.8776	$1,650.97	$747.24
31820	Closure of windpipe lesion	Y		A2	$333.00	16.3288	$676.03	$418.76
31825	Repair of windpipe defect	Y		A2	$446.00	23.9765	$992.65	$582.66
31830	Revise windpipe scar	Y		A2	$446.00	23.9765	$992.65	$582.66
32000	Drainage of chest	N	CH	D5				
32002	Treatment of collapsed lung	N	CH	D5				
32019	Insert pleural catheter	N	CH	D5				
32400	Needle biopsy chest lining	Y		A2	$333.00	9.3354	$386.49	$346.37
32405	Biopsy, lung or mediastinum	Y		A2	$333.00	9.3354	$386.49	$346.37
32420	Puncture/clear lung	Y		A2	$222.78	5.2024	$215.38	$220.93
32421	Thoracentesis for aspiration	Y	NI	A2	$222.78	5.2024	$215.38	$220.93
32422	Thoracentesis w/tube insert	Y	NI	G2		5.2024	$215.38	$215.38
32550	Insert pleural cath	Y	NI	G2		30.7096	$1,271.41	$1,271.41
32960	Therapeutic pneumothorax	Y		G2		5.2024	$215.38	$215.38
32998	Perq rf ablate tx, pul tumor	Y	CH	G2		42.998	$1,780.16	$1,780.16
33010	Drainage of heart sac	Y		A2	$222.78	5.2024	$215.38	$220.93
33011	Repeat drainage of heart sac	Y		A2	$222.78	5.2024	$215.38	$220.93
33206	Insertion of heart pacemaker	Y		J8		169.4628	$7,015.93	$7,015.93

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
33207	Insertion of heart pacemaker	Y		J8		169.4628	$7,015.93	$7,015.93
33208	Insertion of heart pacemaker	Y		J8		196.2967	$8,126.88	$8,126.88
33210	Insertion of heart electrode	Y	CH	J8		90.579	$3,750.06	$3,750.06
33211	Insertion of heart electrode	Y	CH	J8		90.579	$3,750.06	$3,750.06
33212	Insertion of pulse generator	Y		H8	$510.00	142.1043	$5,883.26	$5,514.64
33213	Insertion of pulse generator	Y		H8	$510.00	154.6733	$6,403.63	$6,010.06
33214	Upgrade of pacemaker system	Y		J8		196.2967	$8,126.88	$8,126.88
33215	Reposition pacing-defib lead	Y		G2		23.9802	$992.80	$992.80
33216	Insert lead pace-defib, one	Y	CH	J8		90.579	$3,750.06	$3,750.06
33217	Insert lead pace-defib, dual	Y	CH	J8		90.579	$3,750.06	$3,750.06
33218	Repair lead pace-defib, one	Y		G2		23.9802	$992.80	$992.80
33220	Repair lead pace-defib, dual	Y		G2		23.9802	$992.80	$992.80
33222	Revise pocket, pacemaker	Y		A2	$446.00	15.0458	$622.91	$490.23
33223	Revise pocket, pacing-defib	Y		A2	$446.00	15.0458	$622.91	$490.23
33224	Insert pacing lead & connect	Y		J8		375.1658	$15,532.24	$15,532.24
33225	L ventric pacing lead add-on	Y		J8		375.1658	$15,532.24	$15,532.24
33226	Reposition l ventric lead	Y		G2		23.9802	$992.80	$992.80
33233	Removal of pacemaker system	Y		A2	$446.00	23.9802	$992.80	$582.70
33234	Removal of pacemaker system	Y		G2		23.9802	$992.80	$992.80
33235	Removal pacemaker electrode	Y		G2		23.9802	$992.80	$992.80
33240	Insert pulse generator	Y	CH	J8		493.9803	$20,451.28	$20,451.28
33241	Remove pulse generator	Y		G2		23.9802	$992.80	$992.80
33249	Eltrd/insert pace-defib	Y	CH	J8		599.3974	$24,815.65	$24,815.65
33282	Implant pat-active ht record	N		J8		98.4186	$4,074.63	$4,074.63
33284	Remove pat-active ht record	Y		G2		8.685	$359.57	$359.57
33508	Endoscopic vein harvest	N		N1				
35188	Repair blood vessel lesion	Y		A2	$630.00	38.7673	$1,605.00	$873.75
35207	Repair blood vessel lesion	Y		A2	$630.00	38.7673	$1,605.00	$873.75
35473	Repair arterial blockage	Y		G2		45.3845	$1,878.96	$1,878.96
35476	Repair venous blockage	Y		G2		45.3845	$1,878.96	$1,878.96
35492	Atherectomy, percutaneous	Y		G2		87.5137	$3,623.15	$3,623.15
35572	Harvest femoropopliteal vein	N		N1				
35761	Exploration of artery/vein	Y		G2		29.6965	$1,229.46	$1,229.46
35875	Removal of clot in graft	Y		A2	$1,339.00	38.7673	$1,605.00	$1,405.50
35876	Removal of clot in graft	Y		A2	$1,339.00	38.7673	$1,605.00	$1,405.50
36000	Place needle in vein	N		N1				
36002	Pseudoaneurysm injection trt	N		G2		2.3792	$98.50	$98.50
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	28.8743	$1,195.42	$681.36
36261	Revision of infusion pump	Y		A2	$446.00	23.9802	$992.80	$582.70
36262	Removal of infusion pump	Y		A2	$333.00	23.9802	$992.80	$497.95
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		0.2143	$8.87	$8.87
36425	Vein access cutdown > 1 yr	Y		R2		0.2143	$8.87	$8.87
36430	Blood transfusion service	N		P3		0.7983	$33.05	$33.05
36440	Bl push transfuse, 2 yr or <	N		R2		3.3967	$140.63	$140.63
36450	Bl exchange/transfuse, nb	N		R2		3.3967	$140.63	$140.63
36468	Injection(s), spider veins	Y		R2		0.793	$32.83	$32.83
36469	Injection(s), spider veins	Y	CH	R2		0.793	$32.83	$32.83

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
36470	Injection therapy of vein	Y		P2		0.793	$32.83	$32.83
36471	Injection therapy of veins	Y		P2		0.793	$32.83	$32.83
36475	Endovenous rf, 1st vein	Y		A2	$1,339.00	42.6114	$1,764.15	$1,445.29
36476	Endovenous rf, vein add-on	Y		A2	$1,339.00	25.841	$1,069.84	$1,271.71
36478	Endovenous laser, 1st vein	Y		A2	$1,339.00	25.841	$1,069.84	$1,271.71
36479	Endovenous laser vein addon	Y		A2	$1,339.00	25.841	$1,069.84	$1,271.71
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		11.5058	$476.35	$476.35
36512	Apheresis rbc	N		G2		11.5058	$476.35	$476.35
36513	Apheresis platelets	N		G2		11.5058	$476.35	$476.35
36514	Apheresis plasma	N		G2		11.5058	$476.35	$476.35
36515	Apheresis, adsorp/reinfuse	N		G2		30.6035	$1,267.02	$1,267.02
36516	Apheresis, selective	N		G2		30.6035	$1,267.02	$1,267.02
36522	Photopheresis	N		G2		30.6035	$1,267.02	$1,267.02
36540	Collect blood venous device	N	CH	D5				
36550	Declot vascular device	N	CH	D5				
36555	Insert non-tunnel cv cath	Y		A2	$333.00	10.9092	$451.65	$362.66
36556	Insert non-tunnel cv cath	Y		A2	$333.00	10.9092	$451.65	$362.66
36557	Insert tunneled cv cath	Y		A2	$446.00	24.1069	$998.05	$584.01
36558	Insert tunneled cv cath	Y		A2	$446.00	24.1069	$998.05	$584.01
36560	Insert tunneled cv cath	Y		A2	$510.00	28.8743	$1,195.42	$681.36
36561	Insert tunneled cv cath	Y		A2	$510.00	28.8743	$1,195.42	$681.36
36563	Insert tunneled cv cath	Y		A2	$510.00	28.8743	$1,195.42	$681.36
36565	Insert tunneled cv cath	Y		A2	$510.00	28.8743	$1,195.42	$681.36
36566	Insert tunneled cv cath	Y		H8	$510.00	107.6665	$4,457.50	$3,796.23
36568	Insert picc cath	Y		A2	$333.00	10.9092	$451.65	$362.66
36569	Insert picc cath	Y		A2	$333.00	10.9092	$451.65	$362.66
36570	Insert picvad cath	Y		A2	$510.00	24.1069	$998.05	$632.01
36571	Insert picvad cath	Y		A2	$510.00	24.1069	$998.05	$632.01
36575	Repair tunneled cv cath	Y		A2	$446.00	5.6614	$234.39	$393.10
36576	Repair tunneled cv cath	Y		A2	$446.00	10.9092	$451.65	$447.41
36578	Replace tunneled cv cath	Y		A2	$446.00	24.1069	$998.05	$584.01
36580	Replace cvad cath	Y		A2	$333.00	10.9092	$451.65	$362.66
36581	Replace tunneled cv cath	Y		A2	$446.00	24.1069	$998.05	$584.01
36582	Replace tunneled cv cath	Y		A2	$510.00	28.8743	$1,195.42	$681.36
36583	Replace tunneled cv cath	Y		A2	$510.00	28.8743	$1,195.42	$681.36
36584	Replace picc cath	Y		A2	$333.00	10.9092	$451.65	$362.66
36585	Replace picvad cath	Y		A2	$510.00	24.1069	$998.05	$632.01
36589	Removal tunneled cv cath	Y		A2	$333.00	5.6614	$234.39	$308.35
36590	Removal tunneled cv cath	Y		A2	$333.00	10.9092	$451.65	$362.66
36591	Draw blood off venous device	N	NI	N1				
36592	Collect blood from picc	N	NI	N1				
36593	Declot vascular device	Y	NI	P3		0.4937	$20.44	$20.44
36595	Mech remov tunneled cv cath	Y		G2		24.1069	$998.05	$998.05
36596	Mech remov tunneled cv cath	Y		G2		10.9092	$451.65	$451.65
36597	Reposition venous catheter	Y		G2		10.9092	$451.65	$451.65
36598	Inj w/fluor, eval cv device	Y	CH	P3		1.9997	$82.79	$82.79
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	28.8743	$1,195.42	$548.61
36680	Insert needle, bone cavity	Y		G2		1.1097	$45.94	$45.94
36800	Insertion of cannula	Y		A2	$510.00	29.6965	$1,229.46	$689.87
36810	Insertion of cannula	Y		A2	$510.00	29.6965	$1,229.46	$689.87
36815	Insertion of cannula	Y		A2	$510.00	29.6965	$1,229.46	$689.87
36818	Av fuse, uppr arm, cephalic	Y		A2	$510.00	38.7673	$1,605.00	$783.75
36819	Av fuse, uppr arm, basilic	Y		A2	$510.00	38.7673	$1,605.00	$783.75
36820	Av fusion/forearm vein	Y		A2	$510.00	38.7673	$1,605.00	$783.75
36821	Av fusion direct any site	Y		A2	$510.00	38.7673	$1,605.00	$783.75
36825	Artery-vein autograft	Y		A2	$630.00	38.7673	$1,605.00	$873.75
36830	Artery-vein nonautograft	Y		A2	$630.00	38.7673	$1,605.00	$873.75
36831	Open thrombect av fistula	Y		A2	$1,339.00	38.7673	$1,605.00	$1,405.50
36832	Av fistula revision, open	Y		A2	$630.00	38.7673	$1,605.00	$873.75
36833	Av fistula revision	Y		A2	$630.00	38.7673	$1,605.00	$873.75
36834	Repair a-v aneurysm	Y		A2	$510.00	38.7673	$1,605.00	$783.75
36835	Artery to vein shunt	Y		A2	$630.00	29.6965	$1,229.46	$779.87
36860	External cannula declotting	Y		A2	$127.40	2.4824	$102.77	$121.24
36861	Cannula declotting	Y		A2	$510.00	29.6965	$1,229.46	$689.87
36870	Percut thrombect av fistula	Y		A2	$1,339.00	40.4667	$1,675.36	$1,423.09
37184	Prim art mech thrombectomy	Y		G2		38.7673	$1,605.00	$1,605.00
37185	Prim art m-thrombect add-on	Y		G2		38.7673	$1,605.00	$1,605.00

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
37186	Sec art m-thrombect add-on	Y		G2		38.7673	$1,605.00	$1,605.00
37187	Venous mech thrombectomy	Y		G2		38.7673	$1,605.00	$1,605.00
37188	Venous m-thrombectomy add-on	Y		G2		38.7673	$1,605.00	$1,605.00
37200	Transcatheter biopsy	Y		G2		28.8743	$1,195.42	$1,195.42
37203	Transcatheter retrieval	Y		G2		28.8743	$1,195.42	$1,195.42
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	42.6114	$1,764.15	$823.54
37607	Ligation of a-v fistula	Y		A2	$510.00	25.841	$1,069.84	$649.96
37609	Temporal artery procedure	Y		A2	$446.00	16.1001	$666.56	$501.14
37650	Revision of major vein	Y		A2	$446.00	25.841	$1,069.84	$601.96
37700	Revise leg vein	Y		A2	$446.00	25.841	$1,069.84	$601.96
37718	Ligate/strip short leg vein	Y		A2	$510.00	25.841	$1,069.84	$649.96
37722	Ligate/strip long leg vein	Y		A2	$510.00	42.6114	$1,764.15	$823.54
37735	Removal of leg veins/lesion	Y		A2	$510.00	42.6114	$1,764.15	$823.54
37760	Ligation, leg veins, open	Y		A2	$510.00	25.841	$1,069.84	$649.96
37765	Phleb veins extrem 10-20	Y		R2		25.841	$1,069.84	$1,069.84
37766	Phleb veins extrem 20+	Y		R2		25.841	$1,069.84	$1,069.84
37780	Revision of leg vein	Y		A2	$510.00	25.841	$1,069.84	$649.96
37785	Ligate/divide/excise vein	Y		A2	$510.00	25.841	$1,069.84	$649.96
37790	Penile venous occlusion	Y		A2	$510.00	33.9306	$1,404.76	$733.69
38200	Injection for spleen x-ray	N		N1				
38204	Bl donor search management	N		N1				
38205	Harvest allogenic stem cells	N		G2		11.5058	$476.35	$476.35
38206	Harvest auto stem cells	N		G2		11.5058	$476.35	$476.35
38220	Bone marrow aspiration	Y	CH	P3		2.6333	$109.02	$109.02
38221	Bone marrow biopsy	Y	CH	P3		2.7649	$114.47	$114.47
38230	Bone marrow collection	N		G2		30.6035	$1,267.02	$1,267.02
38241	Bone marrow/stem transplant	N		G2		30.6035	$1,267.02	$1,267.02
38242	Lymphocyte infuse transplant	N		R2		11.5058	$476.35	$476.35
38300	Drainage, lymph node lesion	Y		A2	$333.00	11.5594	$478.57	$369.39
38305	Drainage, lymph node lesion	Y		A2	$446.00	18.3197	$758.45	$524.11
38308	Incision of lymph channels	Y		A2	$446.00	22.9584	$950.50	$572.13
38500	Biopsy/removal, lymph nodes	Y		A2	$446.00	22.9584	$950.50	$572.13
38505	Needle biopsy, lymph nodes	Y		A2	$240.00	7.1147	$294.56	$253.64
38510	Biopsy/removal, lymph nodes	Y		A2	$446.00	22.9584	$950.50	$572.13
38520	Biopsy/removal, lymph nodes	Y		A2	$446.00	22.9584	$950.50	$572.13
38525	Biopsy/removal, lymph nodes	Y		A2	$446.00	22.9584	$950.50	$572.13
38530	Biopsy/removal, lymph nodes	Y		A2	$446.00	22.9584	$950.50	$572.13
38542	Explore deep node(s), neck	Y		A2	$446.00	44.324	$1,835.06	$793.27
38550	Removal, neck/armpit lesion	Y		A2	$510.00	22.9584	$950.50	$620.13
38555	Removal, neck/armpit lesion	Y		A2	$630.00	22.9584	$950.50	$710.13
38570	Laparoscopy, lymph node biop	Y		A2	$1,339.00	45.5317	$1,885.06	$1,475.52
38571	Laparoscopy, lymphadenectomy	Y		A2	$1,339.00	69.6652	$2,884.21	$1,725.30
38572	Laparoscopy, lymphadenectomy	Y		A2	$1,339.00	45.5317	$1,885.06	$1,475.52
38700	Removal of lymph nodes, neck	Y		G2		22.9584	$950.50	$950.50
38740	Remove armpit lymph nodes	Y		A2	$446.00	44.324	$1,835.06	$793.27
38745	Remove armpit lymph nodes	Y		A2	$630.00	44.324	$1,835.06	$931.27
38760	Remove groin lymph nodes	Y		A2	$446.00	22.9584	$950.50	$572.13
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		1.5224	$63.03	$63.03
40500	Partial excision of lip	Y		A2	$446.00	16.3288	$676.03	$503.51
40510	Partial excision of lip	Y		A2	$446.00	23.9765	$992.65	$582.66
40520	Partial excision of lip	Y		A2	$446.00	16.3288	$676.03	$503.51
40525	Reconstruct lip with flap	Y		A2	$446.00	23.9765	$992.65	$582.66
40527	Reconstruct lip with flap	Y		A2	$446.00	23.9765	$992.65	$582.66
40530	Partial removal of lip	Y		A2	$446.00	23.9765	$992.65	$582.66
40650	Repair lip	Y		A2	$464.15	7.4474	$308.33	$425.20
40652	Repair lip	Y		A2	$464.15	7.4474	$308.33	$425.20
40654	Repair lip	Y		A2	$464.15	7.4474	$308.33	$425.20
40700	Repair cleft lip/nasal	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
40701	Repair cleft lip/nasal	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
40702	Repair cleft lip/nasal	Y		R2		39.8776	$1,650.97	$1,650.97
40720	Repair cleft lip/nasal	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
40761	Repair cleft lip/nasal	Y		A2	$510.00	39.8776	$1,650.97	$795.24
40800	Drainage of mouth lesion	Y		P2		1.4066	$58.23	$58.23
40801	Drainage of mouth lesion	Y		A2	$446.00	7.4474	$308.33	$411.58
40804	Removal, foreign body, mouth	N		P2		0.631	$26.12	$26.12
40805	Removal, foreign body, mouth	Y		P3		3.9499	$163.53	$163.53
40806	Incision of lip fold	Y		P3		1.7529	$72.57	$72.57
40808	Biopsy of mouth lesion	Y		P2		2.5002	$103.51	$103.51

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
40810	Excision of mouth lesion	Y		P3		2.699	$111.74	$111.74
40812	Excise/repair mouth lesion	Y		P3		3.3985	$140.70	$140.70
40814	Excise/repair mouth lesion	Y		A2	$446.00	16.3288	$676.03	$503.51
40816	Excision of mouth lesion	Y		A2	$446.00	23.9765	$992.65	$582.66
40818	Excise oral mucosa for graft	Y		A2	$150.72	2.5002	$103.51	$138.92
40819	Excise lip or cheek fold	Y		A2	$333.00	7.4474	$308.33	$326.83
40820	Treatment of mouth lesion	Y		P3		3.7934	$157.05	$157.05
40830	Repair mouth laceration	Y		G2		2.5002	$103.51	$103.51
40831	Repair mouth laceration	Y		A2	$333.00	7.4474	$308.33	$326.83
40840	Reconstruction of mouth	Y		A2	$446.00	23.9765	$992.65	$582.66
40842	Reconstruction of mouth	Y		A2	$510.00	23.9765	$992.65	$630.66
40843	Reconstruction of mouth	Y		A2	$510.00	23.9765	$992.65	$630.66
40844	Reconstruction of mouth	Y		A2	$717.00	39.8776	$1,650.97	$950.49
40845	Reconstruction of mouth	Y		A2	$717.00	39.8776	$1,650.97	$950.49
41000	Drainage of mouth lesion	Y		P3		1.9997	$82.79	$82.79
41005	Drainage of mouth lesion	Y		A2	$150.72	2.5002	$103.51	$138.92
41006	Drainage of mouth lesion	Y		A2	$333.00	23.9765	$992.65	$497.91
41007	Drainage of mouth lesion	Y		A2	$333.00	16.3288	$676.03	$418.76
41008	Drainage of mouth lesion	Y		A2	$333.00	16.3288	$676.03	$418.76
41009	Drainage of mouth lesion	Y		A2	$150.72	2.5002	$103.51	$138.92
41010	Incision of tongue fold	Y		A2	$333.00	7.4474	$308.33	$326.83
41015	Drainage of mouth lesion	Y		A2	$150.72	2.5002	$103.51	$138.92
41016	Drainage of mouth lesion	Y		A2	$333.00	7.4474	$308.33	$326.83
41017	Drainage of mouth lesion	Y		A2	$333.00	7.4474	$308.33	$326.83
41018	Drainage of mouth lesion	Y		A2	$333.00	7.4474	$308.33	$326.83
41019	Place needles h&n for rt	Y	NI	G2		23.9765	$992.65	$992.65
41100	Biopsy of tongue	Y		P3		2.0983	$86.87	$86.87
41105	Biopsy of tongue	Y		P3		2.049	$84.83	$84.83
41108	Biopsy of floor of mouth	Y		P3		1.8927	$78.36	$78.36
41110	Excision of tongue lesion	Y		P3		2.7321	$113.11	$113.11
41112	Excision of tongue lesion	Y		A2	$446.00	16.3288	$676.03	$503.51
41113	Excision of tongue lesion	Y		A2	$446.00	16.3288	$676.03	$503.51
41114	Excision of tongue lesion	Y		A2	$446.00	23.9765	$992.65	$582.66
41115	Excision of tongue fold	Y		P3		3.0777	$127.42	$127.42
41116	Excision of mouth lesion	Y		A2	$333.00	16.3288	$676.03	$418.76
41120	Partial removal of tongue	Y		A2	$717.00	23.9765	$992.65	$785.91
41250	Repair tongue laceration	Y		A2	$150.72	2.5002	$103.51	$138.92
41251	Repair tongue laceration	Y		A2	$150.72	2.5002	$103.51	$138.92
41252	Repair tongue laceration	Y		A2	$446.00	7.4474	$308.33	$411.58
41500	Fixation of tongue	Y		A2	$333.00	23.9765	$992.65	$497.91
41510	Tongue to lip surgery	Y		A2	$333.00	16.3288	$676.03	$418.76
41520	Reconstruction, tongue fold	Y		A2	$446.00	7.4474	$308.33	$411.58
41800	Drainage of gum lesion	Y		A2	$88.46	1.4066	$58.23	$80.90
41805	Removal foreign body, gum	Y		P3		3.0036	$124.35	$124.35
41806	Removal foreign body,jawbone	Y		P3		3.8675	$160.12	$160.12
41820	Excision, gum, each quadrant	Y		R2		7.4474	$308.33	$308.33
41821	Excision of gum flap	Y		G2		7.4474	$308.33	$308.33
41822	Excision of gum lesion	Y		P3		3.5714	$147.86	$147.86
41823	Excision of gum lesion	Y		P3		4.9455	$204.75	$204.75
41825	Excision of gum lesion	Y		P3		2.7731	$114.81	$114.81
41826	Excision of gum lesion	Y		P3		3.0941	$128.10	$128.10
41827	Excision of gum lesion	Y		A2	$446.00	23.9765	$992.65	$582.66
41828	Excision of gum lesion	Y		P3		3.2422	$134.23	$134.23
41830	Removal of gum tissue	Y		P3		4.5011	$186.35	$186.35
41850	Treatment of gum lesion	Y		R2		16.3288	$676.03	$676.03
41870	Gum graft	Y		G2		23.9765	$992.65	$992.65
41872	Repair gum	Y		P3		4.5506	$188.40	$188.40
41874	Repair tooth socket	Y		P3		4.3202	$178.86	$178.86
42000	Drainage mouth roof lesion	Y		A2	$150.72	2.5002	$103.51	$138.92
42100	Biopsy roof of mouth	Y		P3		1.7939	$74.27	$74.27
42104	Excision lesion, mouth roof	Y		P3		2.5181	$104.25	$104.25
42106	Excision lesion, mouth roof	Y		P3		3.1516	$130.48	$130.48
42107	Excision lesion, mouth roof	Y		A2	$446.00	23.9765	$992.65	$582.66
42120	Remove palate/lesion	Y		A2	$630.00	39.8776	$1,650.97	$885.24
42140	Excision of uvula	Y		A2	$446.00	7.4474	$308.33	$411.58
42145	Repair palate, pharynx/uvula	Y		A2	$717.00	23.9765	$992.65	$785.91
42160	Treatment mouth roof lesion	Y		P3		3.2997	$136.61	$136.61
42180	Repair palate	Y		A2	$150.72	2.5002	$103.51	$138.92
42182	Repair palate	Y		A2	$446.00	39.8776	$1,650.97	$747.24
42200	Reconstruct cleft palate	Y		A2	$717.00	39.8776	$1,650.97	$950.49
42205	Reconstruct cleft palate	Y		A2	$717.00	39.8776	$1,650.97	$950.49
42210	Reconstruct cleft palate	Y		A2	$717.00	39.8776	$1,650.97	$950.49
42215	Reconstruct cleft palate	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99

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.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
42220	Reconstruct cleft palate	Y		A2	$717.00	39.8776	$1,650.97	$950.49
42226	Lengthening of palate	Y		A2	$717.00	39.8776	$1,650.97	$950.49
42235	Repair palate	Y		A2	$717.00	16.3288	$676.03	$706.76
42260	Repair nose to lip fistula	Y		A2	$630.00	23.9765	$992.65	$720.66
42280	Preparation, palate mold	Y		P3		1.728	$71.54	$71.54
42281	Insertion, palate prosthesis	Y		G2		16.3288	$676.03	$676.03
42300	Drainage of salivary gland	Y		A2	$333.00	16.3288	$676.03	$418.76
42305	Drainage of salivary gland	Y		A2	$446.00	16.3288	$676.03	$503.51
42310	Drainage of salivary gland	Y		A2	$150.72	2.5002	$103.51	$138.92
42320	Drainage of salivary gland	Y		A2	$150.72	2.5002	$103.51	$138.92
42330	Removal of salivary stone	Y		P3		2.6908	$111.40	$111.40
42335	Removal of salivary stone	Y		P3		4.3859	$181.58	$181.58
42340	Removal of salivary stone	Y		A2	$446.00	16.3288	$676.03	$503.51
42400	Biopsy of salivary gland	Y		P3		1.4975	$62.00	$62.00
42405	Biopsy of salivary gland	Y		A2	$446.00	16.3288	$676.03	$503.51
42408	Excision of salivary cyst	Y		A2	$510.00	16.3288	$676.03	$551.51
42409	Drainage of salivary cyst	Y		A2	$510.00	16.3288	$676.03	$551.51
42410	Excise parotid gland/lesion	Y		A2	$510.00	39.8776	$1,650.97	$795.24
42415	Excise parotid gland/lesion	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
42420	Excise parotid gland/lesion	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
42425	Excise parotid gland/lesion	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
42440	Excise submaxillary gland	Y		A2	$510.00	39.8776	$1,650.97	$795.24
42450	Excise sublingual gland	Y		A2	$446.00	23.9765	$992.65	$582.66
42500	Repair salivary duct	Y		A2	$510.00	23.9765	$992.65	$630.66
42505	Repair salivary duct	Y		A2	$630.00	39.8776	$1,650.97	$885.24
42507	Parotid duct diversion	Y		A2	$510.00	39.8776	$1,650.97	$795.24
42508	Parotid duct diversion	Y		A2	$630.00	39.8776	$1,650.97	$885.24
42509	Parotid duct diversion	Y		A2	$630.00	39.8776	$1,650.97	$885.24
42510	Parotid duct diversion	Y		A2	$630.00	39.8776	$1,650.97	$885.24
42550	Injection for salivary x-ray	N		N1				
42600	Closure of salivary fistula	Y		A2	$333.00	16.3288	$676.03	$418.76
42650	Dilation of salivary duct	Y		P3		0.9792	$40.54	$40.54
42660	Dilation of salivary duct	Y		P3		1.1521	$47.70	$47.70
42665	Ligation of salivary duct	Y		A2	$995.00	23.9765	$992.65	$994.41
42700	Drainage of tonsil abscess	Y		A2	$150.72	2.5002	$103.51	$138.92
42720	Drainage of throat abscess	Y		A2	$333.00	16.3288	$676.03	$418.76
42725	Drainage of throat abscess	Y		A2	$446.00	39.8776	$1,650.97	$747.24
42800	Biopsy of throat	Y		P3		1.9091	$79.04	$79.04
42802	Biopsy of throat	Y		A2	$333.00	16.3288	$676.03	$418.76
42804	Biopsy of upper nose/throat	Y		A2	$333.00	16.3288	$676.03	$418.76
42806	Biopsy of upper nose/throat	Y		A2	$446.00	23.9765	$992.65	$582.66
42808	Excise pharynx lesion	Y		A2	$446.00	16.3288	$676.03	$503.51
42809	Remove pharynx foreign body	N		G2		0.631	$26.12	$26.12
42810	Excision of neck cyst	Y		A2	$510.00	23.9765	$992.65	$630.66
42815	Excision of neck cyst	Y		A2	$717.00	39.8776	$1,650.97	$950.49
42820	Remove tonsils and adenoids	Y		A2	$510.00	22.2557	$921.41	$612.85
42821	Remove tonsils and adenoids	Y		A2	$717.00	22.2557	$921.41	$768.10
42825	Removal of tonsils	Y		A2	$630.00	22.2557	$921.41	$702.85
42826	Removal of tonsils	Y		A2	$630.00	22.2557	$921.41	$702.85
42830	Removal of adenoids	Y		A2	$630.00	22.2557	$921.41	$702.85
42831	Removal of adenoids	Y		A2	$630.00	22.2557	$921.41	$702.85
42835	Removal of adenoids	Y		A2	$630.00	22.2557	$921.41	$702.85
42836	Removal of adenoids	Y		A2	$630.00	22.2557	$921.41	$702.85
42860	Excision of tonsil tags	Y		A2	$510.00	22.2557	$921.41	$612.85
42870	Excision of lingual tonsil	Y		A2	$510.00	22.2557	$921.41	$612.85
42890	Partial removal of pharynx	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
42892	Revision of pharyngeal walls	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
42900	Repair throat wound	Y		A2	$333.00	7.4474	$308.33	$326.83
42950	Reconstruction of throat	Y		A2	$446.00	23.9765	$992.65	$582.66
42955	Surgical opening of throat	Y		A2	$446.00	23.9765	$992.65	$582.66
42960	Control throat bleeding	Y		A2	$72.48	1.1251	$46.58	$66.01
42962	Control throat bleeding	Y		A2	$446.00	39.8776	$1,650.97	$747.24
42970	Control nose/throat bleeding	Y		R2		1.1251	$46.58	$46.58
42972	Control nose/throat bleeding	Y		A2	$510.00	16.3288	$676.03	$551.51
43030	Throat muscle surgery	Y		G2		16.3288	$676.03	$676.03
43200	Esophagus endoscopy	Y		A2	$333.00	8.503	$352.03	$337.76
43201	Esoph scope w/submucous inj	Y		A2	$333.00	8.503	$352.03	$337.76
43202	Esophagus endoscopy, biopsy	Y		A2	$333.00	8.503	$352.03	$337.76
43204	Esoph scope w/sclerosis inj	Y		A2	$333.00	8.503	$352.03	$337.76
43205	Esophagus endoscopy/ligation	Y		A2	$333.00	8.503	$352.03	$337.76
43215	Esophagus endoscopy	Y		A2	$333.00	8.503	$352.03	$337.76
43216	Esophagus endoscopy/lesion	Y		A2	$333.00	8.503	$352.03	$337.76
43217	Esophagus endoscopy	Y		A2	$333.00	8.503	$352.03	$337.76

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
43219	Esophagus endoscopy	Y		A2	$333.00	24.9814	$1,034.25	$508.31
43220	Esoph endoscopy, dilation	Y		A2	$333.00	8.503	$352.03	$337.76
43226	Esoph endoscopy, dilation	Y		A2	$333.00	8.503	$352.03	$337.76
43227	Esoph endoscopy, repair	Y		A2	$446.00	8.503	$352.03	$422.51
43228	Esoph endoscopy, ablation	Y		A2	$446.00	25.3233	$1,048.41	$596.60
43231	Esoph endoscopy w/us exam	Y		A2	$446.00	8.503	$352.03	$422.51
43232	Esoph endoscopy w/us fn bx	Y		A2	$446.00	8.503	$352.03	$422.51
43234	Upper gi endoscopy, exam	Y		A2	$333.00	8.503	$352.03	$337.76
43235	Uppr gi endoscopy, diagnosis	Y		A2	$333.00	8.503	$352.03	$337.76
43236	Uppr gi scope w/submuc inj	Y		A2	$446.00	8.503	$352.03	$422.51
43237	Endoscopic us exam, esoph	Y		A2	$446.00	8.503	$352.03	$422.51
43238	Uppr gi endoscopy w/us fn bx	Y		A2	$446.00	8.503	$352.03	$422.51
43239	Upper gi endoscopy, biopsy	Y		A2	$446.00	8.503	$352.03	$422.51
43240	Esoph endoscope w/drain cyst	Y		A2	$446.00	8.503	$352.03	$422.51
43241	Upper gi endoscopy with tube	Y		A2	$446.00	8.503	$352.03	$422.51
43242	Uppr gi endoscopy w/us fn bx	Y		A2	$446.00	8.503	$352.03	$422.51
43243	Upper gi endoscopy & inject	Y		A2	$446.00	8.503	$352.03	$422.51
43244	Upper gi endoscopy/ligation	Y		A2	$446.00	8.503	$352.03	$422.51
43245	Uppr gi scope dilate strictr	Y		A2	$446.00	8.503	$352.03	$422.51
43246	Place gastrostomy tube	Y		A2	$446.00	8.503	$352.03	$422.51
43247	Operative upper gi endoscopy	Y		A2	$446.00	8.503	$352.03	$422.51
43248	Uppr gi endoscopy/guide wire	Y		A2	$446.00	8.503	$352.03	$422.51
43249	Esoph endoscopy, dilation	Y		A2	$446.00	8.503	$352.03	$422.51
43250	Upper gi endoscopy/tumor	Y		A2	$446.00	8.503	$352.03	$422.51
43251	Operative upper gi endoscopy	Y		A2	$446.00	8.503	$352.03	$422.51
43255	Operative upper gi endoscopy	Y		A2	$446.00	8.503	$352.03	$422.51
43256	Uppr gi endoscopy w/stent	Y		A2	$510.00	24.9814	$1,034.25	$641.06
43257	Uppr gi scope w/thrml txmnt	Y		A2	$510.00	25.3233	$1,048.41	$644.60
43258	Operative upper gi endoscopy	Y		A2	$510.00	8.503	$352.03	$470.51
43259	Endoscopic ultrasound exam	Y		A2	$510.00	8.503	$352.03	$470.51
43260	Endo cholangiopancreatograph	Y		A2	$446.00	20.951	$867.39	$551.35
43261	Endo cholangiopancreatograph	Y		A2	$446.00	20.951	$867.39	$551.35
43262	Endo cholangiopancreatograph	Y		A2	$446.00	20.951	$867.39	$551.35
43263	Endo cholangiopancreatograph	Y		A2	$446.00	20.951	$867.39	$551.35
43264	Endo cholangiopancreatograph	Y		A2	$446.00	20.951	$867.39	$551.35
43265	Endo cholangiopancreatograph	Y		A2	$446.00	20.951	$867.39	$551.35
43267	Endo cholangiopancreatograph	Y		A2	$446.00	20.951	$867.39	$551.35
43268	Endo cholangiopancreatograph	Y		A2	$446.00	24.9814	$1,034.25	$593.06
43269	Endo cholangiopancreatograph	Y		A2	$446.00	24.9814	$1,034.25	$593.06
43271	Endo cholangiopancreatograph	Y		A2	$446.00	20.951	$867.39	$551.35
43272	Endo cholangiopancreatograph	Y		A2	$446.00	20.951	$867.39	$551.35
43450	Dilate esophagus	Y		A2	$333.00	5.8431	$241.91	$310.23
43453	Dilate esophagus	Y		A2	$333.00	5.8431	$241.91	$310.23
43456	Dilate esophagus	Y		A2	$335.41	5.8431	$241.91	$312.04
43458	Dilate esophagus	Y		A2	$335.41	8.503	$352.03	$339.57
43600	Biopsy of stomach	Y		A2	$333.00	8.503	$352.03	$337.76
43653	Laparoscopy, gastrostomy	Y		A2	$1,339.00	45.5317	$1,885.06	$1,475.52
43750	Place gastrostomy tube	N	CH	D5				
43760	Change gastrostomy tube	Y		A2	$144.98	3.2383	$134.07	$142.25
43761	Reposition gastrostomy tube	Y		A2	$333.00	8.503	$352.03	$337.76
43870	Repair stomach opening	Y		A2	$333.00	8.503	$352.03	$337.76
43886	Revise gastric port, open	Y		G2		20.2069	$836.59	$836.59
43887	Remove gastric port, open	Y		G2		4.5263	$187.39	$187.39
43888	Change gastric port, open	Y		G2		20.2069	$836.59	$836.59
44100	Biopsy of bowel	Y		A2	$333.00	8.503	$352.03	$337.76
44312	Revision of ileostomy	Y		A2	$333.00	20.2069	$836.59	$458.90
44340	Revision of colostomy	Y		A2	$510.00	20.2069	$836.59	$591.65
44360	Small bowel endoscopy	Y		A2	$446.00	9.5292	$394.52	$433.13
44361	Small bowel endoscopy/biopsy	Y		A2	$446.00	9.5292	$394.52	$433.13
44363	Small bowel endoscopy	Y		A2	$446.00	9.5292	$394.52	$433.13
44364	Small bowel endoscopy	Y		A2	$446.00	9.5292	$394.52	$433.13
44365	Small bowel endoscopy	Y		A2	$446.00	9.5292	$394.52	$433.13
44366	Small bowel endoscopy	Y		A2	$446.00	9.5292	$394.52	$433.13
44369	Small bowel endoscopy	Y		A2	$446.00	9.5292	$394.52	$433.13
44370	Small bowel endoscopy/stent	Y		A2	$1,339.00	24.9814	$1,034.25	$1,262.81
44372	Small bowel endoscopy	Y		A2	$446.00	9.5292	$394.52	$433.13
44373	Small bowel endoscopy	Y		A2	$446.00	9.5292	$394.52	$433.13
44376	Small bowel endoscopy	Y		A2	$446.00	9.5292	$394.52	$433.13
44377	Small bowel endoscopy/biopsy	Y		A2	$446.00	9.5292	$394.52	$433.13
44378	Small bowel endoscopy	Y		A2	$446.00	9.5292	$394.52	$433.13
44379	S bowel endoscope w/stent	Y		A2	$1,339.00	24.9814	$1,034.25	$1,262.81
44380	Small bowel endoscopy	Y		A2	$333.00	9.5292	$394.52	$348.38
44382	Small bowel endoscopy	Y		A2	$333.00	9.5292	$394.52	$348.38

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
44383	Ileoscopy w/stent	Y		A2	$1,339.00	24.9814	$1,034.25	$1,262.81
44385	Endoscopy of bowel pouch	Y		A2	$333.00	8.8486	$366.34	$341.34
44386	Endoscopy, bowel pouch/biop	Y		A2	$333.00	8.8486	$366.34	$341.34
44388	Colonoscopy	Y		A2	$333.00	8.8486	$366.34	$341.34
44389	Colonoscopy with biopsy	Y		A2	$333.00	8.8486	$366.34	$341.34
44390	Colonoscopy for foreign body	Y		A2	$333.00	8.8486	$366.34	$341.34
44391	Colonoscopy for bleeding	Y		A2	$333.00	8.8486	$366.34	$341.34
44392	Colonoscopy & polypectomy	Y		A2	$333.00	8.8486	$366.34	$341.34
44393	Colonoscopy, lesion removal	Y		A2	$333.00	8.8486	$366.34	$341.34
44394	Colonoscopy w/snare	Y		A2	$333.00	8.8486	$366.34	$341.34
44397	Colonoscopy w/stent	Y		A2	$333.00	24.9814	$1,034.25	$508.31
44500	Intro, gastrointestinal tube	Y	CH	G2		3.2383	$134.07	$134.07
44701	Intraop colon lavage add-on	N		N1				
45000	Drainage of pelvic abscess	Y		A2	$312.07	10.9132	$451.82	$347.01
45005	Drainage of rectal abscess	Y		A2	$446.00	10.9132	$451.82	$447.46
45020	Drainage of rectal abscess	Y		A2	$446.00	10.9132	$451.82	$447.46
45100	Biopsy of rectum	Y		A2	$333.00	22.7451	$941.67	$485.17
45108	Removal of anorectal lesion	Y		A2	$446.00	22.7451	$941.67	$569.92
45150	Excision of rectal stricture	Y		A2	$446.00	22.7451	$941.67	$569.92
45160	Excision of rectal lesion	Y		A2	$446.00	22.7451	$941.67	$569.92
45170	Excision of rectal lesion	Y		A2	$446.00	22.7451	$941.67	$569.92
45190	Destruction, rectal tumor	Y		A2	$1,339.00	22.7451	$941.67	$1,239.67
45300	Proctosigmoidoscopy dx	Y		P3		1.4318	$59.28	$59.28
45303	Proctosigmoidoscopy dilate	Y		P2		8.7031	$360.32	$360.32
45305	Proctosigmoidoscopy w/bx	Y		A2	$333.00	8.7031	$360.32	$339.83
45307	Proctosigmoidoscopy fb	Y		A2	$333.00	21.4632	$888.60	$471.90
45308	Proctosigmoidoscopy removal	Y		A2	$333.00	8.7031	$360.32	$339.83
45309	Proctosigmoidoscopy removal	Y		A2	$333.00	8.7031	$360.32	$339.83
45315	Proctosigmoidoscopy removal	Y		A2	$333.00	8.7031	$360.32	$339.83
45317	Proctosigmoidoscopy bleed	Y		A2	$333.00	8.7031	$360.32	$339.83
45320	Proctosigmoidoscopy ablate	Y		A2	$333.00	21.4632	$888.60	$471.90
45321	Proctosigmoidoscopy volvul	Y		A2	$333.00	21.4632	$888.60	$471.90
45327	Proctosigmoidoscopy w/stent	Y		A2	$333.00	24.9814	$1,034.25	$508.31
45330	Diagnostic sigmoidoscopy	Y		P3		1.9748	$81.76	$81.76
45331	Sigmoidoscopy and biopsy	Y		A2	$299.24	5.0972	$211.03	$277.19
45332	Sigmoidoscopy w/fb removal	Y		A2	$299.24	5.0972	$211.03	$277.19
45333	Sigmoidoscopy & polypectomy	Y		A2	$333.00	8.7031	$360.32	$339.83
45334	Sigmoidoscopy for bleeding	Y		A2	$333.00	8.7031	$360.32	$339.83
45335	Sigmoidoscopy w/submuc inj	Y		A2	$299.24	5.0972	$211.03	$277.19
45337	Sigmoidoscopy & decompress	Y		A2	$299.24	5.0972	$211.03	$277.19
45338	Sigmoidoscopy w/tumr remove	Y		A2	$333.00	8.7031	$360.32	$339.83
45339	Sigmoidoscopy w/ablate tumr	Y		A2	$333.00	8.7031	$360.32	$339.83
45340	Sig w/balloon dilation	Y		A2	$333.00	8.7031	$360.32	$339.83
45341	Sigmoidoscopy w/ultrasound	Y		A2	$333.00	8.7031	$360.32	$339.83
45342	Sigmoidoscopy w/us guide bx	Y		A2	$333.00	8.7031	$360.32	$339.83
45345	Sigmoidoscopy w/stent	Y		A2	$333.00	24.9814	$1,034.25	$508.31
45355	Surgical colonoscopy	Y		A2	$333.00	8.8486	$366.34	$341.34
45378	Diagnostic colonoscopy	Y		A2	$446.00	8.8486	$366.34	$426.09
45379	Colonoscopy w/fb removal	Y		A2	$446.00	8.8486	$366.34	$426.09
45380	Colonoscopy and biopsy	Y		A2	$446.00	8.8486	$366.34	$426.09
45381	Colonoscopy, submucous inj	Y		A2	$446.00	8.8486	$366.34	$426.09
45382	Colonoscopy/control bleeding	Y		A2	$446.00	8.8486	$366.34	$426.09
45383	Lesion removal colonoscopy	Y		A2	$446.00	8.8486	$366.34	$426.09
45384	Lesion remove colonoscopy	Y		A2	$446.00	8.8486	$366.34	$426.09
45385	Lesion removal colonoscopy	Y		A2	$446.00	8.8486	$366.34	$426.09
45386	Colonoscopy dilate stricture	Y		A2	$446.00	8.8486	$366.34	$426.09
45387	Colonoscopy w/stent	Y		A2	$333.00	24.9814	$1,034.25	$508.31
45391	Colonoscopy w/endoscope us	Y		A2	$446.00	8.8486	$366.34	$426.09
45392	Colonoscopy w/endoscopic fnb	Y		A2	$446.00	8.8486	$366.34	$426.09
45500	Repair of rectum	Y		A2	$446.00	22.7451	$941.67	$569.92
45505	Repair of rectum	Y		A2	$446.00	30.1606	$1,248.68	$646.67
45520	Treatment of rectal prolapse	Y		P2		0.793	$32.83	$32.83
45560	Repair of rectocele	Y		A2	$446.00	30.1606	$1,248.68	$646.67
45900	Reduction of rectal prolapse	Y		A2	$312.07	4.7935	$198.46	$283.67
45905	Dilation of anal sphincter	Y		A2	$333.00	22.7451	$941.67	$485.17
45910	Dilation of rectal narrowing	Y		A2	$333.00	22.7451	$941.67	$485.17
45915	Remove rectal obstruction	Y		A2	$312.07	10.9132	$451.82	$347.01
45990	Surg dx exam, anorectal	Y		A2	$312.07	22.7451	$941.67	$469.47
46020	Placement of seton	Y		A2	$510.00	22.7451	$941.67	$617.92
46030	Removal of rectal marker	Y		A2	$312.07	4.7935	$198.46	$283.67
46040	Incision of rectal abscess	Y		A2	$510.00	22.7451	$941.67	$617.92
46045	Incision of rectal abscess	Y		A2	$446.00	22.7451	$941.67	$569.92
46050	Incision of anal abscess	Y		A2	$312.07	10.9132	$451.82	$347.01

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
46060	Incision of rectal abscess	Y		A2	$446.00	22.7451	$941.67	$569.92
46070	Incision of anal septum	Y		G2		10.9132	$451.82	$451.82
46080	Incision of anal sphincter	Y		A2	$510.00	22.7451	$941.67	$617.92
46083	Incise external hemorrhoid	Y		P3		2.0079	$83.13	$83.13
46200	Removal of anal fissure	Y		A2	$446.00	22.7451	$941.67	$569.92
46210	Removal of anal crypt	Y		A2	$446.00	22.7451	$941.67	$569.92
46211	Removal of anal crypts	Y		A2	$446.00	22.7451	$941.67	$569.92
46220	Removal of anal tag	Y		A2	$333.00	22.7451	$941.67	$485.17
46221	Ligation of hemorrhoid(s)	Y		P3		2.6251	$108.68	$108.68
46230	Removal of anal tags	Y		A2	$333.00	22.7451	$941.67	$485.17
46250	Hemorrhoidectomy	Y		A2	$510.00	22.7451	$941.67	$617.92
46255	Hemorrhoidectomy	Y		A2	$510.00	22.7451	$941.67	$617.92
46257	Remove hemorrhoids & fissure	Y		A2	$510.00	22.7451	$941.67	$617.92
46258	Remove hemorrhoids & fistula	Y		A2	$510.00	22.7451	$941.67	$617.92
46260	Hemorrhoidectomy	Y		A2	$510.00	22.7451	$941.67	$617.92
46261	Remove hemorrhoids & fissure	Y		A2	$630.00	22.7451	$941.67	$707.92
46262	Remove hemorrhoids & fistula	Y		A2	$630.00	22.7451	$941.67	$707.92
46270	Removal of anal fistula	Y		A2	$510.00	22.7451	$941.67	$617.92
46275	Removal of anal fistula	Y		A2	$510.00	22.7451	$941.67	$617.92
46280	Removal of anal fistula	Y		A2	$630.00	22.7451	$941.67	$707.92
46285	Removal of anal fistula	Y		A2	$333.00	22.7451	$941.67	$485.17
46288	Repair anal fistula	Y		A2	$630.00	22.7451	$941.67	$707.92
46320	Removal of hemorrhoid clot	Y		P3		1.8596	$76.99	$76.99
46500	Injection into hemorrhoid(s)	Y		P3		2.3536	$97.44	$97.44
46505	Chemodenervation anal musc	Y		G2		4.7935	$198.46	$198.46
46600	Diagnostic anoscopy	N		P2		0.631	$26.12	$26.12
46604	Anoscopy and dilation	Y		P2		8.7031	$360.32	$360.32
46606	Anoscopy and biopsy	Y		P3		3.1434	$130.14	$130.14
46608	Anoscopy, remove for body	Y		A2	$333.00	8.7031	$360.32	$339.83
46610	Anoscopy, remove lesion	Y		A2	$333.00	21.4632	$888.60	$471.90
46611	Anoscopy	Y		A2	$333.00	8.7031	$360.32	$339.83
46612	Anoscopy, remove lesions	Y		A2	$333.00	21.4632	$888.60	$471.90
46614	Anoscopy, control bleeding	Y		P3		1.7529	$72.57	$72.57
46615	Anoscopy	Y		A2	$446.00	21.4632	$888.60	$556.65
46700	Repair of anal stricture	Y		A2	$510.00	22.7451	$941.67	$617.92
46706	Repr of anal fistula w/glue	Y		A2	$333.00	30.1606	$1,248.68	$561.92
46750	Repair of anal sphincter	Y		A2	$510.00	30.1606	$1,248.68	$694.67
46753	Reconstruction of anus	Y		A2	$510.00	22.7451	$941.67	$617.92
46754	Removal of suture from anus	Y		A2	$446.00	22.7451	$941.67	$569.92
46760	Repair of anal sphincter	Y		A2	$446.00	30.1606	$1,248.68	$646.67
46761	Repair of anal sphincter	Y		A2	$510.00	30.1606	$1,248.68	$694.67
46762	Implant artificial sphincter	Y		A2	$995.00	30.1606	$1,248.68	$1,058.42
46900	Destruction, anal lesion(s)	Y		P3		2.5673	$106.29	$106.29
46910	Destruction, anal lesion(s)	Y		P3		2.7895	$115.49	$115.49
46916	Cryosurgery, anal lesion(s)	Y		P2		1.4595	$60.42	$60.42
46917	Laser surgery, anal lesions	Y		A2	$333.00	19.9041	$824.05	$455.76
46922	Excision of anal lesion(s)	Y		A2	$333.00	19.9041	$824.05	$455.76
46924	Destruction, anal lesion(s)	Y		A2	$333.00	19.9041	$824.05	$455.76
46934	Destruction of hemorrhoids	Y		P3		4.3695	$180.90	$180.90
46935	Destruction of hemorrhoids	Y		P3		3.0118	$124.69	$124.69
46936	Destruction of hemorrhoids	Y		P3		4.567	$189.08	$189.08
46937	Cryotherapy of rectal lesion	Y		A2	$446.00	22.7451	$941.67	$569.92
46938	Cryotherapy of rectal lesion	Y		A2	$446.00	30.1606	$1,248.68	$646.67
46940	Treatment of anal fissure	Y		P3		1.9915	$82.45	$82.45
46942	Treatment of anal fissure	Y		P3		1.9091	$79.04	$79.04
46945	Ligation of hemorrhoids	Y		P3		3.3161	$137.29	$137.29
46946	Ligation of hemorrhoids	Y		A2	$333.00	10.9132	$451.82	$362.71
46947	Hemorrhoidopexy by stapling	Y		A2	$995.00	30.1606	$1,248.68	$1,058.42
47000	Needle biopsy of liver	Y		A2	$333.00	9.3354	$386.49	$346.37
47001	Needle biopsy, liver add-on	N		N1				
47382	Percut ablate liver rf	Y		G2		42.998	$1,780.16	$1,780.16
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	28.6884	$1,187.73	$631.43
47511	Insert bile duct drain	Y		A2	$1,245.85	28.6884	$1,187.73	$1,231.32
47525	Change bile duct catheter	Y		A2	$333.00	15.3545	$635.69	$408.67
47530	Revise/reinsert bile tube	Y		A2	$333.00	15.3545	$635.69	$408.67
47552	Biliary endoscopy thru skin	Y		A2	$446.00	28.6884	$1,187.73	$631.43
47553	Biliary endoscopy thru skin	Y		A2	$510.00	28.6884	$1,187.73	$679.43
47554	Biliary endoscopy thru skin	Y		A2	$510.00	28.6884	$1,187.73	$679.43
47555	Biliary endoscopy thru skin	Y		A2	$510.00	28.6884	$1,187.73	$679.43
47556	Biliary endoscopy thru skin	Y		A2	$1,245.85	28.6884	$1,187.73	$1,231.32
47560	Laparoscopy w/cholangio	Y		A2	$510.00	34.3958	$1,424.02	$738.51

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
47561	Laparo w/cholangio/biopsy	Y		A2	$510.00	34.3958	$1,424.02	$738.51
47562	Laparoscopic cholecystectomy	Y		G2		45.5317	$1,885.06	$1,885.06
47563	Laparo cholecystectomy/graph	Y		G2		45.5317	$1,885.06	$1,885.06
47564	Laparo cholecystectomy/explr	Y		G2		45.5317	$1,885.06	$1,885.06
47630	Remove bile duct stone	Y		A2	$510.00	28.6884	$1,187.73	$679.43
48102	Needle biopsy, pancreas	Y		A2	$333.00	9.3354	$386.49	$346.37
49080	Puncture, peritoneal cavity	Y		A2	$222.78	5.2024	$215.38	$220.93
49081	Removal of abdominal fluid	Y		A2	$222.78	5.2024	$215.38	$220.93
49180	Biopsy, abdominal mass	Y		A2	$333.00	9.3354	$386.49	$346.37
49250	Excision of umbilicus	Y		A2	$630.00	25.6947	$1,063.79	$738.45
49320	Diag laparo separate proc	Y		A2	$510.00	34.3958	$1,424.02	$738.51
49321	Laparoscopy, biopsy	Y		A2	$630.00	34.3958	$1,424.02	$828.51
49322	Laparoscopy, aspiration	Y		A2	$630.00	34.3958	$1,424.02	$828.51
49400	Air injection into abdomen	N		N1				
49402	Remove foreign body, adbomen	Y		A2	$446.00	25.6947	$1,063.79	$600.45
49419	Insrt abdom cath for chemotx	Y		A2	$333.00	29.6965	$1,229.46	$557.12
49420	Insert abdom drain, temp	Y		A2	$333.00	30.7096	$1,271.41	$567.60
49421	Insert abdom drain, perm	Y		A2	$333.00	30.7096	$1,271.41	$567.60
49422	Remove perm cannula/catheter	Y		A2	$333.00	23.9802	$992.80	$497.95
49423	Exchange drainage catheter	Y		G2		15.3545	$635.69	$635.69
49424	Assess cyst, contrast inject	N		N1				
49426	Revise abdomen-venous shunt	Y		A2	$446.00	25.6947	$1,063.79	$600.45
49427	Injection, abdominal shunt	N		N1				
49429	Removal of shunt	Y		G2		23.9802	$992.80	$992.80
49440	Place gastrostomy tube perc	Y	NI	G2		8.503	$352.03	$352.03
49441	Place duod/jej tube perc	Y	NI	G2		8.503	$352.03	$352.03
49446	Change g-tube to g-j perc	Y	NI	G2		8.503	$352.03	$352.03
49450	Replace g/c tube perc	Y	NI	G2		3.2383	$134.07	$134.07
49451	Replace duod/jej tube perc	Y	NI	G2		3.2383	$134.07	$134.07
49452	Replace g-j tube perc	Y	NI	G2		3.2383	$134.07	$134.07
49460	Fix g/colon tube w/device	Y	NI	G2		3.2383	$134.07	$134.07
49465	Fluoro exam of g/colon tube	N	NI	N1				
49495	Rpr ing hernia baby, reduc	Y		A2	$630.00	30.6788	$1,270.13	$790.03
49496	Rpr ing hernia baby, blocked	Y		A2	$630.00	30.6788	$1,270.13	$790.03
49500	Rpr ing hernia, init, reduce	Y		A2	$630.00	30.6788	$1,270.13	$790.03
49501	Rpr ing hernia, init blocked	Y		A2	$1,339.00	30.6788	$1,270.13	$1,321.78
49505	Prp i/hern init reduc >5 yr	Y		A2	$630.00	30.6788	$1,270.13	$790.03
49507	Prp i/hern init block >5 yr	Y		A2	$1,339.00	30.6788	$1,270.13	$1,321.78
49520	Rerepair ing hernia, reduce	Y		A2	$995.00	30.6788	$1,270.13	$1,063.78
49521	Rerepair ing hernia, blocked	Y		A2	$1,339.00	30.6788	$1,270.13	$1,321.78
49525	Repair ing hernia, sliding	Y		A2	$630.00	30.6788	$1,270.13	$790.03
49540	Repair lumbar hernia	Y		A2	$446.00	30.6788	$1,270.13	$652.03
49550	Rpr rem hernia, init, reduce	Y		A2	$717.00	30.6788	$1,270.13	$855.28
49553	Rpr fem hernia, init blocked	Y		A2	$1,339.00	30.6788	$1,270.13	$1,321.78
49555	Rerepair fem hernia, reduce	Y		A2	$717.00	30.6788	$1,270.13	$855.28
49557	Rerepair fem hernia, blocked	Y		A2	$1,339.00	30.6788	$1,270.13	$1,321.78
49560	Rpr ventral hern init, reduc	Y		A2	$630.00	30.6788	$1,270.13	$790.03
49561	Rpr ventral hern init, block	Y		A2	$1,339.00	30.6788	$1,270.13	$1,321.78
49565	Rerepair ventrl hern, reduce	Y		A2	$630.00	30.6788	$1,270.13	$790.03
49566	Rerepair ventrl hern, block	Y		A2	$1,339.00	30.6788	$1,270.13	$1,321.78
49568	Hernia repair w/mesh	Y		A2	$995.00	30.6788	$1,270.13	$1,063.78
49570	Rpr epigastric hern, reduce	Y		A2	$630.00	30.6788	$1,270.13	$790.03
49572	Rpr epigastric hern, blocked	Y		A2	$1,339.00	30.6788	$1,270.13	$1,321.78
49580	Rpr umbil hern, reduc < 5 yr	Y		A2	$630.00	30.6788	$1,270.13	$790.03
49582	Rpr umbil hern, block < 5 yr	Y		A2	$1,339.00	30.6788	$1,270.13	$1,321.78
49585	Rpr umbil hern, reduc > 5 yr	Y		A2	$630.00	30.6788	$1,270.13	$790.03
49587	Rpr umbil hern, block > 5 yr	Y		A2	$1,339.00	30.6788	$1,270.13	$1,321.78
49590	Repair spigelian hernia	Y		A2	$510.00	30.6788	$1,270.13	$700.03
49600	Repair umbilical lesion	Y		A2	$630.00	30.6788	$1,270.13	$790.03
49650	Laparo hernia repair initial	Y		A2	$630.00	45.5317	$1,885.06	$943.77
49651	Laparo hernia repair recur	Y		A2	$995.00	45.5317	$1,885.06	$1,217.52
50200	Biopsy of kidney	Y		A2	$333.00	9.3354	$386.49	$346.37
50382	Change ureter stent, percut	Y		G2		24.7749	$1,025.71	$1,025.71
50384	Remove ureter stent, percut	Y		G2		17.942	$742.82	$742.82
50385	Change stent via transureth	Y	NI	G2		17.942	$742.82	$742.82
50386	Remove stent via transureth	Y	NI	G2		5.9735	$247.31	$247.31
50387	Change ext/int ureter stent	Y		G2		15.3545	$635.69	$635.69
50389	Remove renal tube w/fluoro	Y		G2		5.9735	$247.31	$247.31
50390	Drainage of kidney lesion	Y		A2	$333.00	9.3354	$386.49	$346.37
50391	Instll rx agnt into rnal tub	Y		P2		1.0356	$42.87	$42.87
50392	Insert kidney drain	Y		A2	$333.00	17.942	$742.82	$435.46
50393	Insert ureteral tube	Y		A2	$333.00	24.7749	$1,025.71	$506.18
50394	Injection for kidney x-ray	N		N1				

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
50395	Create passage to kidney	Y		A2	$333.00	17.942	$742.82	$435.46
50396	Measure kidney pressure	Y		A2	$131.50	2.0077	$83.12	$119.41
50398	Change kidney tube	Y		A2	$333.00	15.3545	$635.69	$408.67
50551	Kidney endoscopy	Y		A2	$333.00	5.9735	$247.31	$311.58
50553	Kidney endoscopy	Y		A2	$333.00	24.7749	$1,025.71	$506.18
50555	Kidney endoscopy & biopsy	Y		A2	$333.00	5.9735	$247.31	$311.58
50557	Kidney endoscopy & treatment	Y		A2	$333.00	24.7749	$1,025.71	$506.18
50561	Kidney endoscopy & treatment	Y		A2	$333.00	24.7749	$1,025.71	$506.18
50562	Renal scope w/tumor resect	Y		G2		5.9735	$247.31	$247.31
50570	Kidney endoscopy	Y		G2		5.9735	$247.31	$247.31
50572	Kidney endoscopy	Y		G2		5.9735	$247.31	$247.31
50574	Kidney endoscopy & biopsy	Y		G2		5.9735	$247.31	$247.31
50575	Kidney endoscopy	Y		G2		36.0774	$1,493.64	$1,493.64
50576	Kidney endoscopy & treatment	Y		G2		17.942	$742.82	$742.82
50580	Kidney endoscopy & treatment	Y	CH	G2		17.942	$742.82	$742.82
50590	Fragmenting of kidney stone	Y		G2		41.5299	$1,719.38	$1,719.38
50592	Perc rf ablate renal tumor	Y		G2		42.998	$1,780.16	$1,780.16
50684	Injection for ureter x-ray	N		N1				
50686	Measure ureter pressure	Y		P2		1.0356	$42.87	$42.87
50688	Change of ureter tube/stent	Y		A2	$333.00	15.3545	$635.69	$408.67
50690	Injection for ureter x-ray	N		N1				
50947	Laparo new ureter/bladder	Y		A2	$1,339.00	45.5317	$1,885.06	$1,475.52
50948	Laparo new ureter/bladder	Y		A2	$1,339.00	45.5317	$1,885.06	$1,475.52
50951	Endoscopy of ureter	Y		A2	$333.00	5.9735	$247.31	$311.58
50953	Endoscopy of ureter	Y		A2	$333.00	5.9735	$247.31	$311.58
50955	Ureter endoscopy & biopsy	Y		A2	$333.00	24.7749	$1,025.71	$506.18
50957	Ureter endoscopy & treatment	Y		A2	$333.00	24.7749	$1,025.71	$506.18
50961	Ureter endoscopy & treatment	Y		A2	$333.00	24.7749	$1,025.71	$506.18
50970	Ureter endoscopy	Y		A2	$333.00	5.9735	$247.31	$311.58
50972	Ureter endoscopy & catheter	Y		A2	$333.00	5.9735	$247.31	$311.58
50974	Ureter endoscopy & biopsy	Y		A2	$333.00	17.942	$742.82	$435.46
50976	Ureter endoscopy & treatment	Y		A2	$333.00	17.942	$742.82	$435.46
50980	Ureter endoscopy & treatment	Y		A2	$333.00	24.7749	$1,025.71	$506.18
51000	Drainage of bladder	N	CH	D5				
51005	Drainage of bladder	N	CH	D5				
51010	Drainage of bladder	N	CH	D5				
51020	Incise & treat bladder	Y		A2	$630.00	24.7749	$1,025.71	$728.93
51030	Incise & treat bladder	Y		A2	$630.00	24.7749	$1,025.71	$728.93
51040	Incise & drain bladder	Y		A2	$630.00	24.7749	$1,025.71	$728.93
51045	Incise bladder/drain ureter	Y		A2	$399.24	5.9735	$247.31	$361.26
51050	Removal of bladder stone	Y		A2	$630.00	24.7749	$1,025.71	$728.93
51065	Remove ureter calculus	Y		A2	$630.00	24.7749	$1,025.71	$728.93
51080	Drainage of bladder abscess	Y		A2	$333.00	18.3197	$758.45	$439.36
51100	Drain bladder by needle	Y	NI	P3		0.757	$31.34	$31.34
51101	Drain bladder by trocar/cath	Y	NI	P2		1.0356	$42.87	$42.87
51102	Drain bl w/cath insertion	Y	NI	A2	$333.00	19.3414	$800.75	$449.94
51500	Removal of bladder cyst	Y		A2	$630.00	30.6788	$1,270.13	$790.03
51520	Removal of bladder lesion	Y		A2	$630.00	24.7749	$1,025.71	$728.93
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		1.2756	$52.81	$52.81
51701	Insert bladder catheter	N		P2		0.631	$26.12	$26.12
51702	Insert temp bladder cath	N		P2		0.631	$26.12	$26.12
51703	Insert bladder cath, complex	Y		P2		1.0356	$42.87	$42.87
51705	Change of bladder tube	Y		P3		1.7693	$73.25	$73.25
51710	Change of bladder tube	Y		A2	$333.00	15.3545	$635.69	$408.67
51715	Endoscopic injection/implant	Y		A2	$510.00	29.7864	$1,233.19	$690.80
51720	Treatment of bladder lesion	Y		P3		1.3823	$57.23	$57.23
51725	Simple cystometrogram	Y		P2		3.0469	$126.14	$126.14
51726	Complex cystometrogram	Y		A2	$209.48	3.0469	$126.14	$188.65
51736	Urine flow measurement	Y		P3		0.4444	$18.40	$18.40
51741	Electro-uroflowmetry, first	Y		P3		0.5101	$21.12	$21.12
51772	Urethra pressure profile	Y		A2	$131.50	2.0077	$83.12	$119.41
51784	Anal/urinary muscle study	Y		P2		1.0356	$42.87	$42.87
51785	Anal/urinary muscle study	Y		A2	$66.92	2.0077	$83.12	$70.97
51792	Urinary reflex study	Y		P2		1.0356	$42.87	$42.87
51795	Urine voiding pressure study	Y		P2		2.0077	$83.12	$83.12
51797	Intraabdominal pressure test	Y		P2		2.0077	$83.12	$83.12
51798	Us urine capacity measure	N		P3		0.3867	$16.01	$16.01
51880	Repair of bladder opening	Y		A2	$333.00	24.7749	$1,025.71	$506.18
51992	Laparo sling operation	Y		A2	$717.00	45.5317	$1,885.06	$1,009.02
52000	Cystoscopy	Y		A2	$333.00	5.9735	$247.31	$311.58

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
52001	Cystoscopy, removal of clots	Y		A2	$399.24	17.942	$742.82	$485.14
52005	Cystoscopy & ureter catheter	Y		A2	$446.00	17.942	$742.82	$520.21
52007	Cystoscopy and biopsy	Y		A2	$446.00	24.7749	$1,025.71	$590.93
52010	Cystoscopy & duct catheter	Y		A2	$399.24	5.9735	$247.31	$361.26
52204	Cystoscopy w/biopsy(s)	Y		A2	$446.00	17.942	$742.82	$520.21
52214	Cystoscopy and treatment	Y		A2	$446.00	24.7749	$1,025.71	$590.93
52224	Cystoscopy and treatment	Y		A2	$446.00	24.7749	$1,025.71	$590.93
52234	Cystoscopy and treatment	Y		A2	$446.00	24.7749	$1,025.71	$590.93
52235	Cystoscopy and treatment	Y		A2	$510.00	24.7749	$1,025.71	$638.93
52240	Cystoscopy and treatment	Y		A2	$510.00	24.7749	$1,025.71	$638.93
52250	Cystoscopy and radiotracer	Y		A2	$630.00	24.7749	$1,025.71	$728.93
52260	Cystoscopy and treatment	Y		A2	$446.00	17.942	$742.82	$520.21
52265	Cystoscopy and treatment	Y		P2		5.9735	$247.31	$247.31
52270	Cystoscopy & revise urethra	Y		A2	$446.00	17.942	$742.82	$520.21
52275	Cystoscopy & revise urethra	Y		A2	$446.00	24.7749	$1,025.71	$590.93
52276	Cystoscopy and treatment	Y		A2	$510.00	24.7749	$1,025.71	$638.93
52277	Cystoscopy and treatment	Y		A2	$446.00	24.7749	$1,025.71	$590.93
52281	Cystoscopy and treatment	Y		A2	$446.00	17.942	$742.82	$520.21
52282	Cystoscopy, implant stent	Y		A2	$1,339.00	36.0774	$1,493.64	$1,377.66
52283	Cystoscopy and treatment	Y		A2	$446.00	24.7749	$1,025.71	$590.93
52285	Cystoscopy and treatment	Y		A2	$446.00	17.942	$742.82	$520.21
52290	Cystoscopy and treatment	Y		A2	$446.00	17.942	$742.82	$520.21
52300	Cystoscopy and treatment	Y		A2	$446.00	24.7749	$1,025.71	$590.93
52301	Cystoscopy and treatment	Y		A2	$510.00	24.7749	$1,025.71	$638.93
52305	Cystoscopy and treatment	Y		A2	$446.00	24.7749	$1,025.71	$590.93
52310	Cystoscopy and treatment	Y		A2	$399.24	17.942	$742.82	$485.14
52315	Cystoscopy and treatment	Y		A2	$446.00	24.7749	$1,025.71	$590.93
52317	Remove bladder stone	Y		A2	$333.00	24.7749	$1,025.71	$506.18
52318	Remove bladder stone	Y		A2	$446.00	24.7749	$1,025.71	$590.93
52320	Cystoscopy and treatment	Y		A2	$717.00	24.7749	$1,025.71	$794.18
52325	Cystoscopy, stone removal	Y		A2	$630.00	24.7749	$1,025.71	$728.93
52327	Cystoscopy, inject material	Y		A2	$446.00	24.7749	$1,025.71	$590.93
52330	Cystoscopy and treatment	Y		A2	$446.00	24.7749	$1,025.71	$590.93
52332	Cystoscopy and treatment	Y		A2	$446.00	24.7749	$1,025.71	$590.93
52334	Create passage to kidney	Y		A2	$510.00	24.7749	$1,025.71	$638.93
52341	Cysto w/ureter stricture tx	Y		A2	$510.00	24.7749	$1,025.71	$638.93
52342	Cysto w/up stricture tx	Y		A2	$510.00	24.7749	$1,025.71	$638.93
52343	Cysto w/renal stricture tx	Y		A2	$510.00	24.7749	$1,025.71	$638.93
52344	Cysto/uretero, stricture tx	Y		A2	$510.00	24.7749	$1,025.71	$638.93
52345	Cysto/uretero w/up stricture	Y		A2	$510.00	24.7749	$1,025.71	$638.93
52346	Cystouretero w/renal strict	Y		A2	$510.00	24.7749	$1,025.71	$638.93
52351	Cystouretero & or pyeloscope	Y		A2	$510.00	24.7749	$1,025.71	$638.93
52352	Cystouretero w/stone remove	Y		A2	$630.00	24.7749	$1,025.71	$728.93
52353	Cystouretero w/lithotripsy	Y		A2	$630.00	36.0774	$1,493.64	$845.91
52354	Cystouretero w/biopsy	Y		A2	$630.00	24.7749	$1,025.71	$728.93
52355	Cystouretero w/excise tumor	Y		A2	$630.00	24.7749	$1,025.71	$728.93
52400	Cystouretero w/congen repr	Y		A2	$510.00	24.7749	$1,025.71	$638.93
52402	Cystourethro cut ejacul duct	Y		A2	$510.00	24.7749	$1,025.71	$638.93
52450	Incision of prostate	Y		A2	$510.00	24.7749	$1,025.71	$638.93
52500	Revision of bladder neck	Y		A2	$510.00	24.7749	$1,025.71	$638.93
52510	Dilation prostatic urethra	N	CH	D5				
52601	Prostatectomy (turp)	Y		A2	$630.00	36.0774	$1,493.64	$845.91
52606	Control postop bleeding	Y		A2	$333.00	24.7749	$1,025.71	$506.18
52612	Prostatectomy, first stage	Y		A2	$446.00	36.0774	$1,493.64	$707.91
52614	Prostatectomy, second stage	Y		A2	$333.00	36.0774	$1,493.64	$623.16
52620	Remove residual prostate	Y		A2	$333.00	36.0774	$1,493.64	$623.16
52630	Remove prostate regrowth	Y		A2	$446.00	36.0774	$1,493.64	$707.91
52640	Relieve bladder contracture	Y		A2	$446.00	24.7749	$1,025.71	$590.93
52647	Laser surgery of prostate	Y		A2	$1,339.00	45.2042	$1,871.50	$1,472.13
52648	Laser surgery of prostate	Y		A2	$1,339.00	45.2042	$1,871.50	$1,472.13
52700	Drainage of prostate abscess	Y		A2	$446.00	24.7749	$1,025.71	$590.93
53000	Incision of urethra	Y		A2	$333.00	19.1505	$792.85	$447.96
53010	Incision of urethra	Y		A2	$333.00	19.1505	$792.85	$447.96
53020	Incision of urethra	Y		A2	$333.00	19.1505	$792.85	$447.96
53025	Incision of urethra	Y		R2		19.1505	$792.85	$792.85
53040	Drainage of urethra abscess	Y		A2	$446.00	19.1505	$792.85	$532.71
53060	Drainage of urethra abscess	Y		P3		1.7198	$71.20	$71.20
53080	Drainage of urinary leakage	Y		A2	$510.00	19.1505	$792.85	$580.71
53085	Drainage of urinary leakage	Y		G2		19.1505	$792.85	$792.85
53200	Biopsy of urethra	Y		A2	$333.00	19.1505	$792.85	$447.96
53210	Removal of urethra	Y		A2	$717.00	29.7864	$1,233.19	$846.05
53215	Removal of urethra	Y		A2	$717.00	19.1505	$792.85	$735.96
53220	Treatment of urethra lesion	Y		A2	$446.00	29.7864	$1,233.19	$642.80

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
53230	Removal of urethra lesion	Y		A2	$446.00	29.7864	$1,233.19	$642.80
53235	Removal of urethra lesion	Y		A2	$510.00	19.1505	$792.85	$580.71
53240	Surgery for urethra pouch	Y		A2	$446.00	29.7864	$1,233.19	$642.80
53250	Removal of urethra gland	Y		A2	$446.00	19.1505	$792.85	$532.71
53260	Treatment of urethra lesion	Y		A2	$446.00	19.1505	$792.85	$532.71
53265	Treatment of urethra lesion	Y		A2	$446.00	19.1505	$792.85	$532.71
53270	Removal of urethra gland	Y		A2	$446.00	19.1505	$792.85	$532.71
53275	Repair of urethra defect	Y		A2	$446.00	19.1505	$792.85	$532.71
53400	Revise urethra, stage 1	Y		A2	$510.00	29.7864	$1,233.19	$690.80
53405	Revise urethra, stage 2	Y		A2	$446.00	29.7864	$1,233.19	$642.80
53410	Reconstruction of urethra	Y		A2	$446.00	29.7864	$1,233.19	$642.80
53420	Reconstruct urethra, stage 1	Y		A2	$510.00	29.7864	$1,233.19	$690.80
53425	Reconstruct urethra, stage 2	Y		A2	$446.00	29.7864	$1,233.19	$642.80
53430	Reconstruction of urethra	Y		A2	$446.00	29.7864	$1,233.19	$642.80
53431	Reconstruct urethra/bladder	Y		A2	$446.00	29.7864	$1,233.19	$642.80
53440	Male sling procedure	N	CH	H8	$446.00	106.8568	$4,423.98	$3,500.50
53442	Remove/revise male sling	Y		A2	$333.00	29.7864	$1,233.19	$558.05
53444	Insert tandem cuff	N	CH	H8	$446.00	106.8568	$4,423.98	$3,500.50
53445	Insert uro/ves nck sphincter	N		H8	$333.00	193.4277	$8,008.10	$6,625.75
53446	Remove uro sphincter	Y		A2	$333.00	29.7864	$1,233.19	$558.05
53447	Remove/replace ur sphincter	N		H8	$333.00	193.4277	$8,008.10	$6,625.75
53449	Repair uro sphincter	Y		A2	$333.00	29.7864	$1,233.19	$558.05
53450	Revision of urethra	Y		A2	$333.00	29.7864	$1,233.19	$558.05
53460	Revision of urethra	Y		A2	$333.00	19.1505	$792.85	$447.96
53502	Repair of urethra injury	Y		A2	$446.00	19.1505	$792.85	$532.71
53505	Repair of urethra injury	Y		A2	$446.00	29.7864	$1,233.19	$642.80
53510	Repair of urethra injury	Y		A2	$446.00	19.1505	$792.85	$532.71
53515	Repair of urethra injury	Y		A2	$446.00	29.7864	$1,233.19	$642.80
53520	Repair of urethra defect	Y		A2	$446.00	29.7864	$1,233.19	$642.80
53600	Dilate urethra stricture	Y		P3		0.9381	$38.84	$38.84
53601	Dilate urethra stricture	Y	CH	P2		1.0356	$42.87	$42.87
53605	Dilate urethra stricture	Y		A2	$446.00	17.942	$742.82	$520.21
53620	Dilate urethra stricture	Y		P3		1.5142	$62.69	$62.69
53621	Dilate urethra stricture	Y		P3		1.5963	$66.09	$66.09
53660	Dilation of urethra	Y	CH	P2		1.0356	$42.87	$42.87
53661	Dilation of urethra	Y	CH	P2		1.0356	$42.87	$42.87
53665	Dilation of urethra	Y		A2	$333.00	19.1505	$792.85	$447.96
53850	Prostatic microwave thermotx	Y		P2		45.2042	$1,871.50	$1,871.50
53852	Prostatic rf thermotx	Y		P2		45.2042	$1,871.50	$1,871.50
53853	Prostatic water thermother	Y		P2		24.7749	$1,025.71	$1,025.71
54000	Slitting of prepuce	Y		A2	$446.00	19.1505	$792.85	$532.71
54001	Slitting of prepuce	Y		A2	$446.00	19.1505	$792.85	$532.71
54015	Drain penis lesion	Y		A2	$630.00	18.3197	$758.45	$662.11
54050	Destruction, penis lesion(s)	Y		P2		1.4595	$60.42	$60.42
54055	Destruction, penis lesion(s)	Y		P3		1.4565	$60.30	$60.30
54056	Cryosurgery, penis lesion(s)	Y		P2		0.793	$32.83	$32.83
54057	Laser surg, penis lesion(s)	Y		A2	$333.00	19.9041	$824.05	$455.76
54060	Excision of penis lesion(s)	Y		A2	$333.00	19.9041	$824.05	$455.76
54065	Destruction, penis lesion(s)	Y		A2	$333.00	19.9041	$824.05	$455.76
54100	Biopsy of penis	Y		A2	$333.00	16.1001	$666.56	$416.39
54105	Biopsy of penis	Y		A2	$333.00	21.1098	$873.97	$468.24
54110	Treatment of penis lesion	Y		A2	$446.00	33.9306	$1,404.76	$685.69
54111	Treat penis lesion, graft	Y		A2	$446.00	33.9306	$1,404.76	$685.69
54112	Treat penis lesion, graft	Y		A2	$446.00	33.9306	$1,404.76	$685.69
54115	Treatment of penis lesion	Y		A2	$333.00	18.3197	$758.45	$439.36
54120	Partial removal of penis	Y		A2	$446.00	33.9306	$1,404.76	$685.69
54150	Circumcision w/regionl block	Y		A2	$333.00	22.3251	$924.28	$480.82
54160	Circumcision, neonate	Y		A2	$446.00	22.3251	$924.28	$565.57
54161	Circum 28 days or older	Y		A2	$446.00	22.3251	$924.28	$565.57
54162	Lysis penil circumic lesion	Y		A2	$446.00	22.3251	$924.28	$565.57
54163	Repair of circumcision	Y		A2	$446.00	22.3251	$924.28	$565.57
54164	Frenulotomy of penis	Y		A2	$446.00	22.3251	$924.28	$565.57
54200	Treatment of penis lesion	Y		P3		1.5635	$64.73	$64.73
54205	Treatment of penis lesion	Y		A2	$630.00	33.9306	$1,404.76	$823.69
54220	Treatment of penis lesion	Y		A2	$131.50	2.0077	$83.12	$119.41
54230	Prepare penis study	N		N1				
54231	Dynamic cavernosometry	Y		P3		1.3741	$56.89	$56.89
54235	Penile injection	Y		P3		0.9628	$39.86	$39.86
54240	Penis study	Y		P3		0.6667	$27.60	$27.60
54250	Penis study	Y		P3		0.2304	$9.54	$9.54
54300	Revision of penis	Y		A2	$510.00	33.9306	$1,404.76	$733.69
54304	Revision of penis	Y		A2	$510.00	33.9306	$1,404.76	$733.69
54308	Reconstruction of urethra	Y		A2	$510.00	33.9306	$1,404.76	$733.69

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
54312	Reconstruction of urethra	Y		A2	$510.00	33.9306	$1,404.76	$733.69
54316	Reconstruction of urethra	Y		A2	$510.00	33.9306	$1,404.76	$733.69
54318	Reconstruction of urethra	Y		A2	$510.00	33.9306	$1,404.76	$733.69
54322	Reconstruction of urethra	Y		A2	$510.00	33.9306	$1,404.76	$733.69
54324	Reconstruction of urethra	Y		A2	$510.00	33.9306	$1,404.76	$733.69
54326	Reconstruction of urethra	Y		A2	$510.00	33.9306	$1,404.76	$733.69
54328	Revise penis/urethra	Y		A2	$510.00	33.9306	$1,404.76	$733.69
54340	Secondary urethral surgery	Y		A2	$510.00	33.9306	$1,404.76	$733.69
54344	Secondary urethral surgery	Y		A2	$510.00	33.9306	$1,404.76	$733.69
54348	Secondary urethral surgery	Y		A2	$510.00	33.9306	$1,404.76	$733.69
54352	Reconstruct urethra/penis	Y		A2	$510.00	33.9306	$1,404.76	$733.69
54360	Penis plastic surgery	Y		A2	$510.00	33.9306	$1,404.76	$733.69
54380	Repair penis	Y		A2	$510.00	33.9306	$1,404.76	$733.69
54385	Repair penis	Y		A2	$510.00	33.9306	$1,404.76	$733.69
54400	Insert semi-rigid prosthesis	N	CH	H8	$510.00	106.8568	$4,423.98	$3,548.50
54401	Insert self-contd prosthesis	N		H8	$510.00	193.4277	$8,008.10	$6,758.50
54405	Insert multi-comp penis pros	N		H8	$510.00	193.4277	$8,008.10	$6,758.50
54406	Remove muti-comp penis pros	Y		A2	$510.00	33.9306	$1,404.76	$733.69
54408	Repair multi-comp penis pros	Y		A2	$510.00	33.9306	$1,404.76	$733.69
54410	Remove/replace penis prosth	N		H8	$510.00	193.4277	$8,008.10	$6,758.50
54415	Remove self-contd penis pros	Y		A2	$510.00	33.9306	$1,404.76	$733.69
54416	Remv/repl penis contain pros	N		H8	$510.00	193.4277	$8,008.10	$6,758.50
54420	Revision of penis	Y		A2	$630.00	33.9306	$1,404.76	$823.69
54435	Revision of penis	Y		A2	$630.00	33.9306	$1,404.76	$823.69
54440	Repair of penis	Y		A2	$630.00	33.9306	$1,404.76	$823.69
54450	Preputial stretching	Y		A2	$209.48	3.0469	$126.14	$188.65
54500	Biopsy of testis	Y		A2	$333.00	13.5764	$562.08	$390.27
54505	Biopsy of testis	Y		A2	$333.00	22.3251	$924.28	$480.82
54512	Excise lesion testis	Y		A2	$446.00	22.3251	$924.28	$565.57
54520	Removal of testis	Y		A2	$510.00	22.3251	$924.28	$613.57
54522	Orchiectomy, partial	Y		A2	$510.00	22.3251	$924.28	$613.57
54530	Removal of testis	Y		A2	$630.00	30.6788	$1,270.13	$790.03
54550	Exploration for testis	Y		A2	$630.00	30.6788	$1,270.13	$790.03
54560	Exploration for testis	Y		G2		22.3251	$924.28	$924.28
54600	Reduce testis torsion	Y		A2	$630.00	22.3251	$924.28	$703.57
54620	Suspension of testis	Y		A2	$510.00	22.3251	$924.28	$613.57
54640	Suspension of testis	Y		A2	$630.00	30.6788	$1,270.13	$790.03
54660	Revision of testis	Y		A2	$446.00	22.3251	$924.28	$565.57
54670	Repair testis injury	Y		A2	$510.00	22.3251	$924.28	$613.57
54680	Relocation of testis(es)	Y		A2	$510.00	22.3251	$924.28	$613.57
54690	Laparoscopy, orchiectomy	Y		A2	$1,339.00	45.5317	$1,885.06	$1,475.52
54692	Laparoscopy, orchiopexy	Y		G2		69.6652	$2,884.21	$2,884.21
54700	Drainage of scrotum	Y		A2	$446.00	22.3251	$924.28	$565.57
54800	Biopsy of epididymis	Y		A2	$127.16	4.327	$179.14	$140.16
54830	Remove epididymis lesion	Y		A2	$510.00	22.3251	$924.28	$613.57
54840	Remove epididymis lesion	Y		A2	$630.00	22.3251	$924.28	$703.57
54860	Removal of epididymis	Y		A2	$510.00	22.3251	$924.28	$613.57
54861	Removal of epididymis	Y		A2	$630.00	22.3251	$924.28	$703.57
54865	Explore epididymis	Y		A2	$333.00	22.3251	$924.28	$480.82
54900	Fusion of spermatic ducts	Y		A2	$630.00	22.3251	$924.28	$703.57
54901	Fusion of spermatic ducts	Y		A2	$630.00	22.3251	$924.28	$703.57
55000	Drainage of hydrocele	Y		P3		1.6128	$66.77	$66.77
55040	Removal of hydrocele	Y		A2	$510.00	30.6788	$1,270.13	$700.03
55041	Removal of hydroceles	Y		A2	$717.00	30.6788	$1,270.13	$855.28
55060	Repair of hydrocele	Y		A2	$630.00	22.3251	$924.28	$703.57
55100	Drainage of scrotum abscess	Y		A2	$333.00	11.5594	$478.57	$369.39
55110	Explore scrotum	Y		A2	$446.00	22.3251	$924.28	$565.57
55120	Removal of scrotum lesion	Y		A2	$446.00	22.3251	$924.28	$565.57
55150	Removal of scrotum	Y		A2	$333.00	22.3251	$924.28	$480.82
55175	Revision of scrotum	Y		A2	$333.00	22.3251	$924.28	$480.82
55180	Revision of scrotum	Y		A2	$446.00	22.3251	$924.28	$565.57
55200	Incision of sperm duct	Y		A2	$446.00	22.3251	$924.28	$565.57
55250	Removal of sperm duct(s)	Y		A2	$446.00	22.3251	$924.28	$565.57
55300	Prepare, sperm duct x-ray	N		N1				
55400	Repair of sperm duct	Y		A2	$333.00	22.3251	$924.28	$480.82
55450	Ligation of sperm duct	Y		P3		5.1182	$211.90	$211.90
55500	Removal of hydrocele	Y		A2	$510.00	22.3251	$924.28	$613.57
55520	Removal of sperm cord lesion	Y		A2	$630.00	22.3251	$924.28	$703.57
55530	Revise spermatic cord veins	Y		A2	$630.00	22.3251	$924.28	$703.57
55535	Revise spermatic cord veins	Y		A2	$630.00	30.6788	$1,270.13	$790.03
55540	Revise hernia & sperm veins	Y		A2	$717.00	30.6788	$1,270.13	$855.28
55550	Laparo ligate spermatic vein	Y		A2	$1,339.00	45.5317	$1,885.06	$1,475.52
55600	Incise sperm duct pouch	Y		R2		22.3251	$924.28	$924.28

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
55680	Remove sperm pouch lesion	Y		A2	$333.00	22.3251	$924.28	$480.82
55700	Biopsy of prostate	Y		A2	$345.83	11.0338	$456.81	$373.58
55705	Biopsy of prostate	Y		A2	$345.83	11.0338	$456.81	$373.58
55720	Drainage of prostate abscess	Y		A2	$333.00	24.7749	$1,025.71	$506.18
55725	Drainage of prostate abscess	Y		A2	$446.00	24.7749	$1,025.71	$590.93
55860	Surgical exposure, prostate	Y		G2		19.3414	$800.75	$800.75
55870	Electroejaculation	Y		P3		1.6541	$68.48	$68.48
55873	Cryoablate prostate	Y		H8	$1,339.00	162.5379	$6,729.23	$6,219.63
55875	Transperi needle place, pros	N		A2	$1,339.00	36.0774	$1,493.64	$1,377.66
55876*	Place rt device/marker, pros	Y		P3		1.7033	$70.52	$70.52
55920	Place needles pelvic for rt	Y	NI	G2		25.6947	$1,063.79	$1,063.79
56405	I & d of vulva/perineum	Y		P3		1.0287	$42.59	$42.59
56420	Drainage of gland abscess	Y		P2		1.352	$55.97	$55.97
56440	Surgery for vulva lesion	Y		A2	$446.00	19.0203	$787.46	$531.37
56441	Lysis of labial lesion(s)	Y		A2	$333.00	19.0203	$787.46	$446.62
56442	Hymenotomy	Y		A2	$333.00	19.0203	$787.46	$446.62
56501	Destroy, vulva lesions, sim	Y		P3		1.4072	$58.26	$58.26
56515	Destroy vulva lesion/s compl	Y		A2	$510.00	19.9041	$824.05	$588.51
56605	Biopsy of vulva/perineum	Y		P3		0.8229	$34.07	$34.07
56606	Biopsy of vulva/perineum	Y		P3		0.3456	$14.31	$14.31
56620	Partial removal of vulva	Y		A2	$717.00	19.0203	$787.46	$734.62
56625	Complete removal of vulva	Y		A2	$995.00	19.0203	$787.46	$943.12
56700	Partial removal of hymen	Y		A2	$333.00	19.0203	$787.46	$446.62
56740	Remove vagina gland lesion	Y		A2	$510.00	19.0203	$787.46	$579.37
56800	Repair of vagina	Y		A2	$510.00	19.0203	$787.46	$579.37
56805	Repair clitoris	Y		G2		19.0203	$787.46	$787.46
56810	Repair of perineum	Y		A2	$717.00	19.0203	$787.46	$734.62
56820	Exam of vulva w/scope	Y		P3		1.0287	$42.59	$42.59
56821	Exam/biopsy of vulva w/scope	Y		P3		1.3495	$55.87	$55.87
57000	Exploration of vagina	Y		A2	$333.00	19.0203	$787.46	$446.62
57010	Drainage of pelvic abscess	Y		A2	$446.00	19.0203	$787.46	$531.37
57020	Drainage of pelvic fluid	Y		A2	$409.33	6.0783	$251.65	$369.91
57022	I & d vaginal hematoma, pp	Y		G2		11.5594	$478.57	$478.57
57023	I & d vag hematoma, non-ob	Y		A2	$333.00	18.3197	$758.45	$439.36
57061	Destroy vag lesions, simple	Y		P3		1.3002	$53.83	$53.83
57065	Destroy vag lesions, complex	Y		A2	$333.00	19.0203	$787.46	$446.62
57100	Biopsy of vagina	Y		P3		0.8311	$34.41	$34.41
57105	Biopsy of vagina	Y		A2	$446.00	19.0203	$787.46	$531.37
57130	Remove vagina lesion	Y		A2	$446.00	19.0203	$787.46	$531.37
57135	Remove vagina lesion	Y		A2	$446.00	19.0203	$787.46	$531.37
57150	Treat vagina infection	Y	CH	P3		0.6913	$28.62	$28.62
57155	Insert uteri tandems/ovoids	Y		A2	$409.33	6.0783	$251.65	$369.91
57160	Insert pessary/other device	Y		P3		0.8476	$35.09	$35.09
57170	Fitting of diaphragm/cap	Y		P2		0.1309	$5.42	$5.42
57180	Treat vaginal bleeding	Y		A2	$178.05	1.352	$55.97	$147.53
57200	Repair of vagina	Y		A2	$333.00	19.0203	$787.46	$446.62
57210	Repair vagina/perineum	Y		A2	$446.00	19.0203	$787.46	$531.37
57220	Revision of urethra	Y		A2	$510.00	42.7099	$1,768.23	$824.56
57230	Repair of urethral lesion	Y		A2	$510.00	32.4237	$1,342.37	$718.09
57240	Repair bladder & vagina	Y		A2	$717.00	32.4237	$1,342.37	$873.34
57250	Repair rectum & vagina	Y		A2	$717.00	32.4237	$1,342.37	$873.34
57260	Repair of vagina	Y		A2	$717.00	32.4237	$1,342.37	$873.34
57265	Extensive repair of vagina	Y		A2	$995.00	42.7099	$1,768.23	$1,188.31
57267	Insert mesh/pelvic flr addon	Y		A2	$995.00	32.4237	$1,342.37	$1,081.84
57268	Repair of bowel bulge	Y		A2	$510.00	32.4237	$1,342.37	$718.09
57287	Revise/remove sling repair	Y		G2		32.4237	$1,342.37	$1,342.37
57288	Repair bladder defect	Y		A2	$717.00	42.7099	$1,768.23	$979.81
57289	Repair bladder & vagina	Y		A2	$717.00	32.4237	$1,342.37	$873.34
57291	Construction of vagina	Y		A2	$717.00	32.4237	$1,342.37	$873.34
57300	Repair rectum-vagina fistula	Y		A2	$510.00	32.4237	$1,342.37	$718.09
57320	Repair bladder-vagina lesion	Y		G2		32.4237	$1,342.37	$1,342.37
57400	Dilation of vagina	Y		A2	$446.00	19.0203	$787.46	$531.37
57410	Pelvic examination	Y		A2	$446.00	19.0203	$787.46	$531.37
57415	Remove vaginal foreign body	Y		A2	$446.00	19.0203	$787.46	$531.37
57420	Exam of vagina w/scope	Y		P3		1.0616	$43.95	$43.95
57421	Exam/biopsy of vag w/scope	Y		P3		1.4154	$58.60	$58.60
57452	Exam of cervix w/scope	Y		P3		1.0121	$41.90	$41.90
57454	Bx/curett of cervix w/scope	Y		P3		1.2425	$51.44	$51.44
57455	Biopsy of cervix w/scope	Y		P3		1.3248	$54.85	$54.85
57456	Endocerv curettage w/scope	Y		P3		1.2756	$52.81	$52.81
57460	Bx of cervix w/scope, leep	Y		P3		4.1639	$172.39	$172.39
57461	Conz of cervix w/scope, leep	Y		P3		4.3859	$181.58	$181.58
57500	Biopsy of cervix	Y		P3		1.8763	$77.68	$77.68

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ADDENDUM AA.—ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

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57505	Endocervical curettage	Y		P3		1.1437	$47.35	$47.35
57510	Cauterization of cervix	Y		P3		1.1768	$48.72	$48.72
57511	Cryocautery of cervix	Y		P2		1.352	$55.97	$55.97
57513	Laser surgery of cervix	Y		A2	$446.00	19.0203	$787.46	$531.37
57520	Conization of cervix	Y		A2	$446.00	19.0203	$787.46	$531.37
57522	Conization of cervix	Y		A2	$446.00	19.0203	$787.46	$531.37
57530	Removal of cervix	Y		A2	$510.00	32.4237	$1,342.37	$718.09
57550	Removal of residual cervix	Y		A2	$510.00	32.4237	$1,342.37	$718.09
57556	Remove cervix, repair bowel	Y		A2	$717.00	42.7099	$1,768.23	$979.81
57558	D&c of cervical stump	Y		A2	$510.00	19.0203	$787.46	$579.37
57700	Revision of cervix	Y		A2	$333.00	19.0203	$787.46	$446.62
57720	Revision of cervix	Y		A2	$510.00	19.0203	$787.46	$579.37
57800	Dilation of cervical canal	Y		P3		0.6089	$25.21	$25.21
58100	Biopsy of uterus lining	Y		P3		1.0121	$41.90	$41.90
58110	Bx done w/colposcopy add-on	N	CH	N1				
58120	Dilation and curettage	Y		A2	$446.00	19.0203	$787.46	$531.37
58145	Myomectomy vag method	Y		A2	$717.00	32.4237	$1,342.37	$873.34
58301	Remove intrauterine device	Y		P3		0.971	$40.20	$40.20
58321	Artificial insemination	Y		P3		0.8558	$35.43	$35.43
58322	Artificial insemination	Y		P3		0.9135	$37.82	$37.82
58323	Sperm washing	Y		P3		0.2797	$11.58	$11.58
58340	Catheter for hysterography	N		N1				
58345	Reopen fallopian tube	Y		R2		19.0203	$787.46	$787.46
58346	Insert heyman uteri capsule	Y		A2	$446.00	19.0203	$787.46	$531.37
58350	Reopen fallopian tube	Y		A2	$510.00	32.4237	$1,342.37	$718.09
58353	Endometr ablate, thermal	Y		A2	$995.00	32.4237	$1,342.37	$1,081.84
58356	Endometrial cryoablation	Y		P3		43.0862	$1,783.81	$1,783.81
58545	Laparoscopic myomectomy	Y		A2	$1,339.00	34.3958	$1,424.02	$1,360.26
58546	Laparo-myomectomy, complex	Y		A2	$1,339.00	45.5317	$1,885.06	$1,475.52
58550	Laparo-asst vag hysterectomy	Y		A2	$1,339.00	69.6652	$2,884.21	$1,725.30
58552	Laparo-vag hyst incl t/o	Y		G2		45.5317	$1,885.06	$1,885.06
58555	Hysteroscopy, dx, sep proc	Y		A2	$333.00	21.6576	$896.65	$473.91
58558	Hysteroscopy, biopsy	Y		A2	$510.00	21.6576	$896.65	$606.66
58559	Hysteroscopy, lysis	Y		A2	$446.00	21.6576	$896.65	$558.66
58560	Hysteroscopy, resect septum	Y		A2	$510.00	34.2048	$1,416.11	$736.53
58561	Hysteroscopy, remove myoma	Y		A2	$510.00	34.2048	$1,416.11	$736.53
58562	Hysteroscopy, remove fb	Y		A2	$510.00	21.6576	$896.65	$606.66
58563	Hysteroscopy, ablation	Y		A2	$1,339.00	34.2048	$1,416.11	$1,358.28
58565	Hysteroscopy, sterilization	Y		A2	$1,339.00	42.7099	$1,768.23	$1,446.31
58600	Division of fallopian tube	Y		G2		32.4237	$1,342.37	$1,342.37
58615	Occlude fallopian tube(s)	Y		G2		19.0203	$787.46	$787.46
58660	Laparoscopy, lysis	Y		A2	$717.00	45.5317	$1,885.06	$1,009.02
58661	Laparoscopy, remove adnexa	Y		A2	$717.00	45.5317	$1,885.06	$1,009.02
58662	Laparoscopy, excise lesions	Y		A2	$717.00	45.5317	$1,885.06	$1,009.02
58670	Laparoscopy, tubal cautery	Y		A2	$510.00	45.5317	$1,885.06	$853.77
58671	Laparoscopy, tubal block	Y		A2	$510.00	45.5317	$1,885.06	$853.77
58672	Laparoscopy, fimbrioplasty	Y		A2	$717.00	45.5317	$1,885.06	$1,009.02
58673	Laparoscopy, salpingostomy	Y		A2	$717.00	45.5317	$1,885.06	$1,009.02
58800	Drainage of ovarian cyst(s)	Y		A2	$510.00	19.0203	$787.46	$579.37
58805	Drainage of ovarian cyst(s)	Y	CH	G2		32.4237	$1,342.37	$1,342.37
58820	Drain ovary abscess, open	Y		A2	$510.00	32.4237	$1,342.37	$718.09
58900	Biopsy of ovary(s)	Y		A2	$510.00	19.0203	$787.46	$579.37
58970	Retrieval of oocyte	Y		A2	$245.92	2.7584	$114.20	$212.99
58974	Transfer of embryo	Y		A2	$245.92	2.7584	$114.20	$212.99
58976	Transfer of embryo	Y		A2	$245.92	2.7584	$114.20	$212.99
59000	Amniocentesis, diagnostic	Y	CH	P3		1.5717	$65.07	$65.07
59001	Amniocentesis, therapeutic	Y		R2		6.0783	$251.65	$251.65
59012	Fetal cord puncture,prenatal	Y		G2		2.7584	$114.20	$114.20
59015	Chorion biopsy	Y		P3		1.2178	$50.42	$50.42
59020	Fetal contract stress test	Y		P3		0.5761	$23.85	$23.85
59025	Fetal non-stress test	Y		P3		0.2961	$12.26	$12.26
59070	Transabdom amnioinfus w/us	Y		G2		2.7584	$114.20	$114.20
59072	Umbilical cord occlud w/us	Y		G2		2.7584	$114.20	$114.20
59076	Fetal shunt placement, w/us	Y		G2		2.7584	$114.20	$114.20
59100	Remove uterus lesion	Y		R2		32.4237	$1,342.37	$1,342.37
59150	Treat ectopic pregnancy	Y		G2		45.5317	$1,885.06	$1,885.06
59151	Treat ectopic pregnancy	Y		G2		45.5317	$1,885.06	$1,885.06
59160	D & c after delivery	Y		A2	$510.00	19.0203	$787.46	$579.37
59200	Insert cervical dilator	Y		P3		0.8722	$36.11	$36.11
59300	Episiotomy or vaginal repair	Y		P3		1.7939	$74.27	$74.27
59320	Revision of cervix	Y		A2	$333.00	19.0203	$787.46	$446.62
59412	Antepartum manipulation	Y		G2		19.0203	$787.46	$787.46
59414	Deliver placenta	Y		G2		19.0203	$787.46	$787.46

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
59812	Treatment of miscarriage	Y		A2	$717.00	19.0203	$787.46	$734.62
59820	Care of miscarriage	Y		A2	$717.00	19.0203	$787.46	$734.62
59821	Treatment of miscarriage	Y		A2	$717.00	19.0203	$787.46	$734.62
59840	Abortion	Y		A2	$717.00	19.0203	$787.46	$734.62
59841	Abortion	Y		A2	$717.00	19.0203	$787.46	$734.62
59866	Abortion (mpr)	Y		G2		2.7584	$114.20	$114.20
59870	Evacuate mole of uterus	Y		A2	$717.00	19.0203	$787.46	$734.62
59871	Remove cerclage suture	Y		A2	$717.00	19.0203	$787.46	$734.62
60000	Drain thyroid/tongue cyst	Y		A2	$333.00	7.4474	$308.33	$326.83
60001	Aspirate/inject thyriod cyst	N	CH	D5				
60100	Biopsy of thyroid	Y		P3		1.1108	$45.99	$45.99
60200	Remove thyroid lesion	Y		A2	$446.00	44.324	$1,835.06	$793.27
60280	Remove thyroid duct lesion	Y		A2	$630.00	44.324	$1,835.06	$931.27
60281	Remove thyroid duct lesion	Y		A2	$630.00	44.324	$1,835.06	$931.27
60300	Aspir/inj thyroid cyst	Y	NI	P3		1.3741	$56.89	$56.89
61000	Remove cranial cavity fluid	Y		R2		8.5263	$353.00	$353.00
61001	Remove cranial cavity fluid	Y		R2		8.5263	$353.00	$353.00
61020	Remove brain cavity fluid	Y		A2	$183.83	8.5263	$353.00	$226.12
61026	Injection into brain canal	Y		A2	$183.83	8.5263	$353.00	$226.12
61050	Remove brain canal fluid	Y		A2	$183.83	8.5263	$353.00	$226.12
61055	Injection into brain canal	Y		A2	$183.83	8.5263	$353.00	$226.12
61070	Brain canal shunt procedure	Y		A2	$183.83	3.2383	$134.07	$171.39
61215	Insert brain-fluid device	Y		A2	$510.00	36.2768	$1,501.90	$757.98
61330	Decompress eye socket	Y		G2		39.8776	$1,650.97	$1,650.97
61334	Explore orbit/remove object	Y		G2		39.8776	$1,650.97	$1,650.97
61790	Treat trigeminal nerve	Y		A2	$510.00	18.0518	$747.36	$569.34
61791	Treat trigeminal tract	Y		A2	$351.92	14.4879	$599.81	$413.89
61795	Brain surgery using computer	N	CH	N1				
61880	Revise/remove neuroelectrode	Y		G2		22.4734	$930.42	$930.42
61885	Insrt/redo neurostim 1 array	N		H8	$446.00	269.543	$11,159.35	$10,493.89
61886	Implant neurostim arrays	N		H8	$510.00	395.2777	$16,364.89	$15,586.16
61888	Revise/remove neuroreceiver	Y		A2	$333.00	34.4166	$1,424.88	$605.97
62194	Replace/irrigate catheter	Y		A2	$333.00	8.5263	$353.00	$338.00
62225	Replace/irrigate catheter	Y		A2	$333.00	15.3545	$635.69	$408.67
62230	Replace/revise brain shunt	Y		A2	$446.00	36.2768	$1,501.90	$709.98
62252	Csf shunt reprogram	N		P3		1.0698	$44.29	$44.29
62263	Epidural lysis mult sessions	Y		A2	$333.00	14.4879	$599.81	$399.70
62264	Epidural lysis on single day	Y		A2	$333.00	14.4879	$599.81	$399.70
62268	Drain spinal cord cyst	Y		A2	$183.83	8.5263	$353.00	$226.12
62269	Needle biopsy, spinal cord	Y		A2	$333.00	9.3354	$386.49	$346.37
62270	Spinal fluid tap, diagnostic	Y		A2	$139.00	4.0964	$169.60	$146.65
62272	Drain cerebro spinal fluid	Y		A2	$139.00	4.0964	$169.60	$146.65
62273	Inject epidural patch	Y		A2	$333.00	4.0964	$169.60	$292.15
62280	Treat spinal cord lesion	Y		A2	$333.00	7.0546	$292.07	$322.77
62281	Treat spinal cord lesion	Y		A2	$333.00	7.0546	$292.07	$322.77
62282	Treat spinal canal lesion	Y		A2	$333.00	7.0546	$292.07	$322.77
62284	Injection for myelogram	N		N1				
62287	Percutaneous diskectomy	Y		A2	$1,339.00	33.2707	$1,377.44	$1,348.61
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		8.5263	$353.00	$353.00
62294	Injection into spinal artery	Y		A2	$183.83	8.5263	$353.00	$226.12
62310	Inject spine c/t	Y		A2	$333.00	7.0546	$292.07	$322.77
62311	Inject spine l/s (cd)	Y		A2	$333.00	7.0546	$292.07	$322.77
62318	Inject spine w/cath, c/t	Y		A2	$333.00	7.0546	$292.07	$322.77
62319	Inject spine w/cath l/s (cd)	Y		A2	$333.00	7.0546	$292.07	$322.77
62350	Implant spinal canal cath	Y		A2	$446.00	36.2768	$1,501.90	$709.98
62355	Remove spinal canal catheter	Y		A2	$446.00	14.4879	$599.81	$484.45
62360	Insert spine infusion device	Y		A2	$446.00	36.2768	$1,501.90	$709.98
62361	Implant spine infusion pump	Y		H8	$446.00	263.8315	$10,922.89	$10,157.07
62362	Implant spine infusion pump	Y		H8	$446.00	263.8315	$10,922.89	$10,157.07
62365	Remove spine infusion device	Y		A2	$446.00	33.2707	$1,377.44	$678.86
62367	Analyze spine infusion pump	N		P3		0.428	$17.72	$17.72
62368	Analyze spine infusion pump	N		P3		0.5183	$21.46	$21.46
63600	Remove spinal cord lesion	Y		A2	$446.00	18.0518	$747.36	$521.34
63610	Stimulation of spinal cord	Y		A2	$333.00	18.0518	$747.36	$436.59
63615	Remove lesion of spinal cord	Y		R2		18.0518	$747.36	$747.36
63650	Implant neuroelectrodes	N		H8	$446.00	83.1135	$3,440.98	$2,909.36
63655	Implant neuroelectrodes	N		J8		109.8976	$4,549.87	$4,549.87
63660	Revise/remove neuroelectrode	Y		A2	$333.00	22.4734	$930.42	$482.36
63685	Insrt/redo spine n generator	N		H8	$446.00	350.8302	$14,524.72	$13,727.20
63688	Revise/remove neuroreceiver	Y		A2	$333.00	34.4166	$1,424.88	$605.97
63744	Revision of spinal shunt	Y		A2	$510.00	36.2768	$1,501.90	$757.98

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
63746	Removal of spinal shunt	Y		A2	$446.00	5.6614	$234.39	$393.10
64400	N block inj, trigeminal	Y		P3		1.3577	$56.21	$56.21
64402	N block inj, facial	Y		P3		1.2425	$51.44	$51.44
64405	N block inj, occipital	Y		P3		1.078	$44.63	$44.63
64408	N block inj, vagus	Y		P3		1.2425	$51.44	$51.44
64410	N block inj, phrenic	Y		A2	$333.00	7.0546	$292.07	$322.77
64412	N block inj, spinal accessor	Y		P3		1.9666	$81.42	$81.42
64413	N block inj, cervical plexus	Y		P3		1.292	$53.49	$53.49
64415	N block inj, brachial plexus	Y		A2	$139.00	4.0964	$169.60	$146.65
64416	N block cont infuse, b plex	Y		G2		7.0546	$292.07	$292.07
64417	N block inj, axillary	Y		A2	$139.00	4.0964	$169.60	$146.65
64418	N block inj, suprascapular	Y		P3		1.8596	$76.99	$76.99
64420	N block inj, intercost, sng	Y		A2	$139.00	4.0964	$169.60	$146.65
64421	N block inj, intercost, mlt	Y		A2	$333.00	4.0964	$169.60	$292.15
64425	N block inj, ilio-ing/hypogi	Y		P3		1.2096	$50.08	$50.08
64430	N block inj, pudendal	Y		A2	$139.00	7.0546	$292.07	$177.27
64435	N block inj, paracervical	Y		P3		1.8596	$76.99	$76.99
64445	N block inj, sciatic, sng	Y		P3		1.7693	$73.25	$73.25
64446	N blk inj, sciatic, cont inf	Y		G2		14.4879	$599.81	$599.81
64447	N block inj fem, single	Y	CH	R2		4.0964	$169.60	$169.60
64450	N block, other peripheral	Y		P3		1.0287	$42.59	$42.59
64470	Inj paravertebral c/t	Y		A2	$333.00	7.0546	$292.07	$322.77
64472	Inj paravertebral c/t add-on	Y		A2	$333.00	4.0964	$169.60	$292.15
64475	Inj paravertebral l/s	Y		A2	$333.00	7.0546	$292.07	$322.77
64476	Inj paravertebral l/s add-on	Y		A2	$333.00	2.3213	$96.10	$273.78
64479	Inj foramen epidural c/t	Y		A2	$333.00	7.0546	$292.07	$322.77
64480	Inj foramen epidural add-on	Y		A2	$333.00	4.0964	$169.60	$292.15
64483	Inj foramen epidural l/s	Y		A2	$333.00	7.0546	$292.07	$322.77
64484	Inj foramen epidural add-on	Y		A2	$333.00	4.0964	$169.60	$292.15
64505	N block, spenopalatine gangl	Y		P3		0.971	$40.20	$40.20
64508	N block, carotid sinus s/p	Y		P3		2.2053	$91.30	$91.30
64510	N block, stellate ganglion	Y		A2	$333.00	7.0546	$292.07	$322.77
64517	N block inj, hypogas plxs	Y		A2	$139.00	7.0546	$292.07	$177.27
64520	N block, lumbar/thoracic	Y		A2	$333.00	7.0546	$292.07	$322.77
64530	N block inj, celiac pelus	Y		A2	$333.00	7.0546	$292.07	$322.77
64553	Implant neuroelectrodes	N		H8	$333.00	316.5407	$13,105.10	$12,022.95
64555	Implant neuroelectrodes	N		J8		83.1135	$3,440.98	$3,440.98
64560	Implant neuroelectrodes	N		J8		83.1135	$3,440.98	$3,440.98
64561	Implant neuroelectrodes	N		H8	$510.00	83.1135	$3,440.98	$2,957.36
64565	Implant neuroelectrodes	N		J8		83.1135	$3,440.98	$3,440.98
64573	Implant neuroelectrodes	N		H8	$333.00	316.5407	$13,105.10	$12,022.95
64575	Implant neuroelectrodes	N		H8	$333.00	109.8976	$4,549.87	$3,785.92
64577	Implant neuroelectrodes	N		H8	$333.00	109.8976	$4,549.87	$3,785.92
64580	Implant neuroelectrodes	N		H8	$333.00	109.8976	$4,549.87	$3,785.92
64581	Implant neuroelectrodes	N		H8	$510.00	109.8976	$4,549.87	$3,918.67
64585	Revise/remove neuroelectrode	Y		A2	$333.00	22.4734	$930.42	$482.36
64590	Insrt/redo pn/gastr stimul	N		H8	$446.00	269.543	$11,159.35	$10,493.89
64595	Revise/rmv pn/gastr stimul	Y		A2	$333.00	34.4166	$1,424.88	$605.97
64600	Injection treatment of nerve	Y		A2	$333.00	14.4879	$599.81	$399.70
64605	Injection treatment of nerve	Y		A2	$333.00	14.4879	$599.81	$399.70
64610	Injection treatment of nerve	Y		A2	$333.00	14.4879	$599.81	$399.70
64612	Destroy nerve, face muscle	Y		P3		1.6705	$69.16	$69.16
64613	Destroy nerve, neck muscle	Y		P3		1.7693	$73.25	$73.25
64614	Destroy nerve, extrem musc	Y		P3		1.9915	$82.45	$82.45
64620	Injection treatment of nerve	Y		A2	$333.00	7.0546	$292.07	$322.77
64622	Destr paravertebrl nerve l/s	Y		A2	$333.00	14.4879	$599.81	$399.70
64623	Destr paravertebral n add-on	Y		A2	$333.00	7.0546	$292.07	$322.77
64626	Destr paravertebrl nerve c/t	Y		A2	$333.00	14.4879	$599.81	$399.70
64627	Destr paravertebral n add-on	Y		A2	$333.00	2.3213	$96.10	$273.78
64630	Injection treatment of nerve	Y		A2	$351.92	7.0546	$292.07	$336.96
64640	Injection treatment of nerve	Y		P3		2.7156	$112.43	$112.43
64650	Chemodenerv eccrine glands	Y	CH	P3		0.65	$26.91	$26.91
64653	Chemodenerv eccrine glands	Y	CH	P3		0.6831	$28.28	$28.28
64680	Injection treatment of nerve	Y		A2	$390.95	14.4879	$599.81	$443.17
64681	Injection treatment of nerve	Y		A2	$446.00	14.4879	$599.81	$484.45
64702	Revise finger/toe nerve	Y		A2	$333.00	18.0518	$747.36	$436.59
64704	Revise hand/foot nerve	Y		A2	$333.00	18.0518	$747.36	$436.59
64708	Revise arm/leg nerve	Y		A2	$446.00	18.0518	$747.36	$521.34
64712	Revision of sciatic nerve	Y		A2	$446.00	18.0518	$747.36	$521.34
64713	Revision of arm nerve(s)	Y		A2	$446.00	18.0518	$747.36	$521.34
64714	Revise low back nerve(s)	Y		A2	$446.00	18.0518	$747.36	$521.34
64716	Revision of cranial nerve	Y		A2	$510.00	18.0518	$747.36	$569.34
64718	Revise ulnar nerve at elbow	Y		A2	$446.00	18.0518	$747.36	$521.34

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[Including surgical procedures for which payment is packaged]

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64719	Revise ulnar nerve at wrist	Y		A2	$446.00	18.0518	$747.36	$521.34
64721	Carpal tunnel surgery	Y		A2	$446.00	18.0518	$747.36	$521.34
64722	Relieve pressure on nerve(s)	Y		A2	$333.00	18.0518	$747.36	$436.59
64726	Release foot/toe nerve	Y		A2	$333.00	18.0518	$747.36	$436.59
64727	Internal nerve revision	Y		A2	$333.00	18.0518	$747.36	$436.59
64732	Incision of brow nerve	Y		A2	$446.00	18.0518	$747.36	$521.34
64734	Incision of cheek nerve	Y		A2	$446.00	18.0518	$747.36	$521.34
64736	Incision of chin nerve	Y		A2	$446.00	18.0518	$747.36	$521.34
64738	Incision of jaw nerve	Y		A2	$446.00	18.0518	$747.36	$521.34
64740	Incision of tongue nerve	Y		A2	$446.00	18.0518	$747.36	$521.34
64742	Incision of facial nerve	Y		A2	$446.00	18.0518	$747.36	$521.34
64744	Incise nerve, back of head	Y		A2	$446.00	18.0518	$747.36	$521.34
64746	Incise diaphragm nerve	Y		A2	$446.00	18.0518	$747.36	$521.34
64761	Incision of pelvis nerve	Y		G2		18.0518	$747.36	$747.36
64763	Incise hip/thigh nerve	Y		G2		18.0518	$747.36	$747.36
64766	Incise hip/thigh nerve	Y		G2		33.2707	$1,377.44	$1,377.44
64771	Sever cranial nerve	Y		A2	$446.00	18.0518	$747.36	$521.34
64772	Incision of spinal nerve	Y		A2	$446.00	18.0518	$747.36	$521.34
64774	Remove skin nerve lesion	Y		A2	$446.00	18.0518	$747.36	$521.34
64776	Remove digit nerve lesion	Y		A2	$510.00	18.0518	$747.36	$569.34
64778	Digit nerve surgery add-on	Y		A2	$446.00	18.0518	$747.36	$521.34
64782	Remove limb nerve lesion	Y		A2	$510.00	18.0518	$747.36	$569.34
64783	Limb nerve surgery add-on	Y		A2	$446.00	18.0518	$747.36	$521.34
64784	Remove nerve lesion	Y		A2	$510.00	18.0518	$747.36	$569.34
64786	Remove sciatic nerve lesion	Y		A2	$510.00	33.2707	$1,377.44	$726.86
64787	Implant nerve end	Y		A2	$446.00	18.0518	$747.36	$521.34
64788	Remove skin nerve lesion	Y		A2	$510.00	18.0518	$747.36	$569.34
64790	Removal of nerve lesion	Y		A2	$510.00	18.0518	$747.36	$569.34
64792	Removal of nerve lesion	Y		A2	$510.00	33.2707	$1,377.44	$726.86
64795	Biopsy of nerve	Y		A2	$446.00	18.0518	$747.36	$521.34
64802	Remove sympathetic nerves	Y		A2	$446.00	18.0518	$747.36	$521.34
64820	Remove sympathetic nerves	Y		G2		18.0518	$747.36	$747.36
64821	Remove sympathetic nerves	Y		A2	$630.00	26.3105	$1,089.28	$744.82
64822	Remove sympathetic nerves	Y		G2		26.3105	$1,089.28	$1,089.28
64823	Remove sympathetic nerves	Y		G2		26.3105	$1,089.28	$1,089.28
64831	Repair of digit nerve	Y		A2	$630.00	33.2707	$1,377.44	$816.86
64832	Repair nerve add-on	Y		A2	$333.00	33.2707	$1,377.44	$594.11
64834	Repair of hand or foot nerve	Y		A2	$446.00	33.2707	$1,377.44	$678.86
64835	Repair of hand or foot nerve	Y		A2	$510.00	33.2707	$1,377.44	$726.86
64836	Repair of hand or foot nerve	Y		A2	$510.00	33.2707	$1,377.44	$726.86
64837	Repair nerve add-on	Y		A2	$333.00	33.2707	$1,377.44	$594.11
64840	Repair of leg nerve	Y		A2	$446.00	33.2707	$1,377.44	$678.86
64856	Repair/transpose nerve	Y		A2	$446.00	33.2707	$1,377.44	$678.86
64857	Repair arm/leg nerve	Y		A2	$446.00	33.2707	$1,377.44	$678.86
64858	Repair sciatic nerve	Y		A2	$446.00	33.2707	$1,377.44	$678.86
64859	Nerve surgery	Y		A2	$333.00	33.2707	$1,377.44	$594.11
64861	Repair of arm nerves	Y		A2	$510.00	33.2707	$1,377.44	$726.86
64862	Repair of low back nerves	Y		A2	$510.00	33.2707	$1,377.44	$726.86
64864	Repair of facial nerve	Y		A2	$510.00	33.2707	$1,377.44	$726.86
64865	Repair of facial nerve	Y		A2	$630.00	33.2707	$1,377.44	$816.86
64870	Fusion of facial/other nerve	Y		A2	$630.00	33.2707	$1,377.44	$816.86
64872	Subsequent repair of nerve	Y		A2	$446.00	33.2707	$1,377.44	$678.86
64874	Repair & revise nerve add-on	Y		A2	$510.00	33.2707	$1,377.44	$726.86
64876	Repair nerve/shorten bone	Y		A2	$510.00	33.2707	$1,377.44	$726.86
64885	Nerve graft, head or neck	Y		A2	$446.00	33.2707	$1,377.44	$678.86
64886	Nerve graft, head or neck	Y		A2	$446.00	33.2707	$1,377.44	$678.86
64890	Nerve graft, hand or foot	Y		A2	$446.00	33.2707	$1,377.44	$678.86
64891	Nerve graft, hand or foot	Y		A2	$446.00	33.2707	$1,377.44	$678.86
64892	Nerve graft, arm or leg	Y		A2	$446.00	33.2707	$1,377.44	$678.86
64893	Nerve graft, arm or leg	Y		A2	$446.00	33.2707	$1,377.44	$678.86
64895	Nerve graft, hand or foot	Y		A2	$510.00	33.2707	$1,377.44	$726.86
64896	Nerve graft, hand or foot	Y		A2	$510.00	33.2707	$1,377.44	$726.86
64897	Nerve graft, arm or leg	Y		A2	$510.00	33.2707	$1,377.44	$726.86
64898	Nerve graft, arm or leg	Y		A2	$510.00	33.2707	$1,377.44	$726.86
64901	Nerve graft add-on	Y		A2	$446.00	33.2707	$1,377.44	$678.86
64902	Nerve graft add-on	Y		A2	$446.00	33.2707	$1,377.44	$678.86
64905	Nerve pedicle transfer	Y		A2	$446.00	33.2707	$1,377.44	$678.86
64907	Nerve pedicle transfer	Y		A2	$333.00	33.2707	$1,377.44	$594.11
64910	Nerve repair w/allograft	Y	CH	G2		18.0518	$747.36	$747.36
65091	Revise eye	Y		A2	$510.00	37.7243	$1,561.82	$772.96
65093	Revise eye with implant	Y		A2	$510.00	37.7243	$1,561.82	$772.96
65101	Removal of eye	Y		A2	$510.00	37.7243	$1,561.82	$772.96
65103	Remove eye/insert implant	Y		A2	$510.00	37.7243	$1,561.82	$772.96

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
65105	Remove eye/attach implant	Y		A2	$630.00	37.7243	$1,561.82	$862.96
65110	Removal of eye	Y		A2	$717.00	37.7243	$1,561.82	$928.21
65112	Remove eye/revise socket	Y		A2	$995.00	37.7243	$1,561.82	$1,136.71
65114	Remove eye/revise socket	Y		A2	$995.00	37.7243	$1,561.82	$1,136.71
65125	Revise ocular implant	Y		G2		18.7307	$775.47	$775.47
65130	Insert ocular implant	Y		A2	$510.00	24.3077	$1,006.36	$634.09
65135	Insert ocular implant	Y		A2	$446.00	24.3077	$1,006.36	$586.09
65140	Attach ocular implant	Y		A2	$510.00	37.7243	$1,561.82	$772.96
65150	Revise ocular implant	Y		A2	$446.00	24.3077	$1,006.36	$586.09
65155	Reinsert ocular implant	Y		A2	$510.00	37.7243	$1,561.82	$772.96
65175	Removal of ocular implant	Y		A2	$333.00	18.7307	$775.47	$443.62
65205	Remove foreign body from eye	N		P3		0.4937	$20.44	$20.44
65210	Remove foreign body from eye	N		P3		0.6253	$25.89	$25.89
65220	Remove foreign body from eye	N		G2		0.8696	$36.00	$36.00
65222	Remove foreign body from eye	N		P3		0.6831	$28.28	$28.28
65235	Remove foreign body from eye	Y		A2	$446.00	16.171	$669.50	$501.88
65260	Remove foreign body from eye	Y		A2	$510.00	18.235	$754.95	$571.24
65265	Remove foreign body from eye	Y		A2	$630.00	27.845	$1,152.81	$760.70
65270	Repair of eye wound	Y		A2	$446.00	18.7307	$775.47	$528.37
65272	Repair of eye wound	Y		A2	$446.00	23.1758	$959.50	$574.38
65275	Repair of eye wound	Y		A2	$630.00	23.1758	$959.50	$712.38
65280	Repair of eye wound	Y		A2	$630.00	18.235	$754.95	$661.24
65285	Repair of eye wound	Y		A2	$630.00	37.2078	$1,540.44	$857.61
65286	Repair of eye wound	Y		P2		5.1169	$211.84	$211.84
65290	Repair of eye socket wound	Y		A2	$510.00	24.1291	$998.97	$632.24
65400	Removal of eye lesion	Y		A2	$333.00	16.171	$669.50	$417.13
65410	Biopsy of cornea	Y		A2	$446.00	16.171	$669.50	$501.88
65420	Removal of eye lesion	Y		A2	$446.00	16.171	$669.50	$501.88
65426	Removal of eye lesion	Y		A2	$717.00	23.1758	$959.50	$777.63
65430	Corneal smear	N	CH	P2		0.8696	$36.00	$36.00
65435	Curette/treat cornea	Y		P3		0.7652	$31.68	$31.68
65436	Curette/treat cornea	Y		G2		16.171	$669.50	$669.50
65450	Treatment of corneal lesion	N		G2		2.179	$90.21	$90.21
65600	Revision of cornea	Y		P3		3.8758	$160.46	$160.46
65710	Corneal transplant	Y		A2	$995.00	37.4896	$1,552.11	$1,134.28
65730	Corneal transplant	Y		A2	$995.00	37.4896	$1,552.11	$1,134.28
65750	Corneal transplant	Y		A2	$995.00	37.4896	$1,552.11	$1,134.28
65755	Corneal transplant	Y		A2	$995.00	37.4896	$1,552.11	$1,134.28
65770	Revise cornea with implant	Y		A2	$995.00	84.8039	$3,510.97	$1,623.99
65772	Correction of astigmatism	Y		A2	$630.00	16.171	$669.50	$639.88
65775	Correction of astigmatism	Y		A2	$630.00	16.171	$669.50	$639.88
65780	Ocular reconst, transplant	Y		A2	$717.00	37.4896	$1,552.11	$925.78
65781	Ocular reconst, transplant	Y		A2	$717.00	37.4896	$1,552.11	$925.78
65782	Ocular reconst, transplant	Y		A2	$717.00	37.4896	$1,552.11	$925.78
65800	Drainage of eye	Y		A2	$333.00	16.171	$669.50	$417.13
65805	Drainage of eye	Y		A2	$333.00	16.171	$669.50	$417.13
65810	Drainage of eye	Y		A2	$510.00	23.1758	$959.50	$622.38
65815	Drainage of eye	Y		A2	$446.00	23.1758	$959.50	$574.38
65820	Relieve inner eye pressure	Y		A2	$333.00	5.1169	$211.84	$302.71
65850	Incision of eye	Y		A2	$630.00	23.1758	$959.50	$712.38
65855	Laser surgery of eye	Y		P3		3.2011	$132.53	$132.53
65860	Incise inner eye adhesions	Y		P3		2.9953	$124.01	$124.01
65865	Incise inner eye adhesions	Y		A2	$333.00	16.171	$669.50	$417.13
65870	Incise inner eye adhesions	Y		A2	$630.00	23.1758	$959.50	$712.38
65875	Incise inner eye adhesions	Y		A2	$630.00	23.1758	$959.50	$712.38
65880	Incise inner eye adhesions	Y		A2	$630.00	16.171	$669.50	$639.88
65900	Remove eye lesion	Y		A2	$717.00	16.171	$669.50	$705.13
65920	Remove implant of eye	Y		A2	$995.00	23.1758	$959.50	$986.13
65930	Remove blood clot from eye	Y		A2	$717.00	23.1758	$959.50	$777.63
66020	Injection treatment of eye	Y		A2	$333.00	16.171	$669.50	$417.13
66030	Injection treatment of eye	Y		A2	$333.00	5.1169	$211.84	$302.71
66130	Remove eye lesion	Y		A2	$995.00	23.1758	$959.50	$986.13
66150	Glaucoma surgery	Y		A2	$630.00	23.1758	$959.50	$712.38
66155	Glaucoma surgery	Y		A2	$630.00	23.1758	$959.50	$712.38
66160	Glaucoma surgery	Y		A2	$446.00	23.1758	$959.50	$574.38
66165	Glaucoma surgery	Y		A2	$630.00	23.1758	$959.50	$712.38
66170	Glaucoma surgery	Y		A2	$630.00	23.1758	$959.50	$712.38
66172	Incision of eye	Y		A2	$630.00	23.1758	$959.50	$712.38
66180	Implant eye shunt	Y		A2	$717.00	39.7101	$1,644.04	$948.76
66185	Revise eye shunt	Y		A2	$446.00	39.7101	$1,644.04	$745.51
66220	Repair eye lesion	Y		A2	$510.00	37.2078	$1,540.44	$767.61
66225	Repair/graft eye lesion	Y		A2	$630.00	39.7101	$1,644.04	$883.51
66250	Follow-up surgery of eye	Y		A2	$446.00	16.171	$669.50	$501.88

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
66500	Incision of iris	Y		A2	$333.00	5.1169	$211.84	$302.71
66505	Incision of iris	Y		A2	$333.00	5.1169	$211.84	$302.71
66600	Remove iris and lesion	Y		A2	$510.00	23.1758	$959.50	$622.38
66605	Removal of iris	Y		A2	$510.00	23.1758	$959.50	$622.38
66625	Removal of iris	Y		A2	$372.94	5.1169	$211.84	$332.67
66630	Removal of iris	Y		A2	$510.00	23.1758	$959.50	$622.38
66635	Removal of iris	Y		A2	$510.00	23.1758	$959.50	$622.38
66680	Repair iris & ciliary body	Y		A2	$510.00	23.1758	$959.50	$622.38
66682	Repair iris & ciliary body	Y		A2	$446.00	23.1758	$959.50	$574.38
66700	Destruction, ciliary body	Y		A2	$446.00	16.171	$669.50	$501.88
66710	Ciliary transsleral therapy	Y		A2	$446.00	16.171	$669.50	$501.88
66711	Ciliary endoscopic ablation	Y		A2	$446.00	16.171	$669.50	$501.88
66720	Destruction, ciliary body	Y		A2	$446.00	16.171	$669.50	$501.88
66740	Destruction, ciliary body	Y		A2	$446.00	23.1758	$959.50	$574.38
66761	Revision of iris	Y		P3		4.3612	$180.56	$180.56
66762	Revision of iris	Y		P3		4.419	$182.95	$182.95
66770	Removal of inner eye lesion	Y		P3		4.7728	$197.60	$197.60
66820	Incision, secondary cataract	Y		G2		5.1169	$211.84	$211.84
66821	After cataract laser surgery	Y		A2	$312.50	5.2001	$215.29	$288.20
66825	Reposition intraocular lens	Y		A2	$630.00	23.1758	$959.50	$712.38
66830	Removal of lens lesion	Y		A2	$372.94	5.1169	$211.84	$332.67
66840	Removal of lens material	Y		A2	$630.00	14.9171	$617.58	$626.90
66850	Removal of lens material	Y		A2	$995.00	28.7035	$1,188.35	$1,043.34
66852	Removal of lens material	Y		A2	$630.00	28.7035	$1,188.35	$769.59
66920	Extraction of lens	Y		A2	$630.00	28.7035	$1,188.35	$769.59
66930	Extraction of lens	Y		A2	$717.00	28.7035	$1,188.35	$834.84
66940	Extraction of lens	Y		A2	$717.00	14.9171	$617.58	$692.15
66982	Cataract surgery, complex	Y		A2	$973.00	23.8649	$988.03	$976.76
66983	Cataract surg w/iol, 1 stage	Y		A2	$973.00	23.8649	$988.03	$976.76
66984	Cataract surg w/iol, 1 stage	Y		A2	$973.00	23.8649	$988.03	$976.76
66985	Insert lens prosthesis	Y		A2	$826.00	23.8649	$988.03	$866.51
66986	Exchange lens prosthesis	Y		A2	$826.00	23.8649	$988.03	$866.51
66990	Ophthalmic endoscope add-on	N		N1				
67005	Partial removal of eye fluid	Y		A2	$630.00	27.845	$1,152.81	$760.70
67010	Partial removal of eye fluid	Y		A2	$630.00	27.845	$1,152.81	$760.70
67015	Release of eye fluid	Y		A2	$333.00	27.845	$1,152.81	$537.95
67025	Replace eye fluid	Y		A2	$333.00	27.845	$1,152.81	$537.95
67027	Implant eye drug system	Y		A2	$630.00	37.2078	$1,540.44	$857.61
67028	Injection eye drug	N		P3		1.9915	$82.45	$82.45
67030	Incise inner eye strands	Y		A2	$333.00	18.235	$754.95	$438.49
67031	Laser surgery, eye strands	Y		A2	$312.50	5.2001	$215.29	$288.20
67036	Removal of inner eye fluid	Y		A2	$630.00	37.2078	$1,540.44	$857.61
67038	Strip retinal membrane	N	CH	D5				
67039	Laser treatment of retina	Y		A2	$995.00	37.2078	$1,540.44	$1,131.36
67040	Laser treatment of retina	Y		A2	$995.00	37.2078	$1,540.44	$1,131.36
67041	Vit for macular pucker	Y	NI	G2		37.2078	$1,540.44	$1,540.44
67042	Vit for macular hole	Y	NI	G2		37.2078	$1,540.44	$1,540.44
67043	Vit for membrane dissect	Y	NI	G2		37.2078	$1,540.44	$1,540.44
67101	Repair detached retina	Y		P3		7.2414	$299.80	$299.80
67105	Repair detached retina	Y		P2		5.2001	$215.29	$215.29
67107	Repair detached retina	Y		A2	$717.00	37.2078	$1,540.44	$922.86
67108	Repair detached retina	Y		A2	$995.00	37.2078	$1,540.44	$1,131.36
67110	Repair detached retina	Y		P3		7.8749	$326.03	$326.03
67112	Rerepair detached retina	Y		A2	$995.00	37.2078	$1,540.44	$1,131.36
67113	Repair retinal detach, cplx	Y	NI	G2		37.2078	$1,540.44	$1,540.44
67115	Release encircling material	Y		A2	$446.00	18.235	$754.95	$523.24
67120	Remove eye implant material	Y		A2	$446.00	18.235	$754.95	$523.24
67121	Remove eye implant material	Y		A2	$446.00	27.845	$1,152.81	$622.70
67141	Treatment of retina	Y		A2	$241.77	4.1331	$171.11	$224.11
67145	Treatment of retina	Y		P3		4.5506	$188.40	$188.40
67208	Treatment of retinal lesion	Y		P3		4.8385	$200.32	$200.32
67210	Treatment of retinal lesion	Y	CH	P3		5.1349	$212.59	$212.59
67218	Treatment of retinal lesion	Y		A2	$717.00	18.235	$754.95	$726.49
67220	Treatment of choroid lesion	Y		P2		4.1331	$171.11	$171.11
67221	Ocular photodynamic ther	Y		P3		2.9789	$123.33	$123.33
67225	Eye photodynamic ther add-on	Y		P3		0.1976	$8.18	$8.18
67227	Treatment of retinal lesion	Y		A2	$333.00	27.845	$1,152.81	$537.95
67228	Treatment of retinal lesion	Y		P2		5.2001	$215.29	$215.29
67229*	Tr retinal les preterm inf	Y	NI	R2		5.2001	$215.29	$215.29
67250	Reinforce eye wall	Y		A2	$510.00	18.7307	$775.47	$576.37
67255	Reinforce/graft eye wall	Y		A2	$510.00	27.845	$1,152.81	$670.70
67311	Revise eye muscle	Y		A2	$510.00	24.1291	$998.97	$632.24
67312	Revise two eye muscles	Y		A2	$630.00	24.1291	$998.97	$722.24

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
67314	Revise eye muscle	Y		A2	$630.00	24.1291	$998.97	$722.24
67316	Revise two eye muscles	Y		A2	$630.00	24.1291	$998.97	$722.24
67318	Revise eye muscle(s)	Y		A2	$630.00	24.1291	$998.97	$722.24
67320	Revise eye muscle(s) add-on	Y		A2	$630.00	24.1291	$998.97	$722.24
67331	Eye surgery follow-up add-on	Y		A2	$630.00	24.1291	$998.97	$722.24
67332	Rerevise eye muscles add-on	Y		A2	$630.00	24.1291	$998.97	$722.24
67334	Revise eye muscle w/suture	Y		A2	$630.00	24.1291	$998.97	$722.24
67335	Eye suture during surgery	Y		A2	$630.00	24.1291	$998.97	$722.24
67340	Revise eye muscle add-on	Y		A2	$630.00	24.1291	$998.97	$722.24
67343	Release eye tissue	Y		A2	$995.00	24.1291	$998.97	$995.99
67345	Destroy nerve of eye muscle	Y		P3		1.9584	$81.08	$81.08
67346	Biopsy, eye muscle	Y		A2	$333.00	13.7453	$569.07	$392.02
67400	Explore/biopsy eye socket	Y		A2	$510.00	24.3077	$1,006.36	$634.09
67405	Explore/drain eye socket	Y		A2	$630.00	24.3077	$1,006.36	$724.09
67412	Explore/treat eye socket	Y		A2	$717.00	24.3077	$1,006.36	$789.34
67413	Explore/treat eye socket	Y		A2	$717.00	24.3077	$1,006.36	$789.34
67414	Explr/decompress eye socket	Y		G2		37.7243	$1,561.82	$1,561.82
67415	Aspiration, orbital contents	Y		A2	$333.00	18.7307	$775.47	$443.62
67420	Explore/treat eye socket	Y		A2	$717.00	37.7243	$1,561.82	$928.21
67430	Explore/treat eye socket	Y		A2	$717.00	37.7243	$1,561.82	$928.21
67440	Explore/drain eye socket	Y		A2	$717.00	37.7243	$1,561.82	$928.21
67445	Explr/decompress eye socket	Y		A2	$717.00	37.7243	$1,561.82	$928.21
67450	Explore/biopsy eye socket	Y		A2	$717.00	37.7243	$1,561.82	$928.21
67500	Inject/treat eye socket	N		G2		2.179	$90.21	$90.21
67505	Inject/treat eye socket	Y		G2		2.9022	$120.15	$120.15
67515	Inject/treat eye socket	Y		P3		0.5596	$23.17	$23.17
67550	Insert eye socket implant	Y		A2	$630.00	37.7243	$1,561.82	$862.96
67560	Revise eye socket implant	Y		A2	$446.00	24.3077	$1,006.36	$586.09
67570	Decompress optic nerve	Y		A2	$630.00	37.7243	$1,561.82	$862.96
67700	Drainage of eyelid abscess	Y		P2		2.9022	$120.15	$120.15
67710	Incision of eyelid	Y		P3		3.7277	$154.33	$154.33
67715	Incision of eyelid fold	Y		A2	$333.00	18.7307	$775.47	$443.62
67800	Remove eyelid lesion	Y		P3		1.2343	$51.10	$51.10
67801	Remove eyelid lesions	Y		P3		1.4975	$62.00	$62.00
67805	Remove eyelid lesions	Y		P3		1.9338	$80.06	$80.06
67808	Remove eyelid lesion(s)	Y		A2	$446.00	18.7307	$775.47	$528.37
67810	Biopsy of eyelid	Y		P2		2.9022	$120.15	$120.15
67820	Revise eyelashes	N		P3		0.428	$17.72	$17.72
67825	Revise eyelashes	Y		P3		1.292	$53.49	$53.49
67830	Revise eyelashes	Y		A2	$446.00	7.2847	$301.59	$409.90
67835	Revise eyelashes	Y		A2	$446.00	18.7307	$775.47	$528.37
67840	Remove eyelid lesion	Y		P3		3.8593	$159.78	$159.78
67850	Treat eyelid lesion	Y		P3		2.7403	$113.45	$113.45
67875	Closure of eyelid by suture	Y		G2		7.2847	$301.59	$301.59
67880	Revision of eyelid	Y		A2	$510.00	16.171	$669.50	$549.88
67882	Revision of eyelid	Y		A2	$510.00	18.7307	$775.47	$576.37
67900	Repair brow defect	Y		A2	$630.00	18.7307	$775.47	$666.37
67901	Repair eyelid defect	Y		A2	$717.00	18.7307	$775.47	$731.62
67902	Repair eyelid defect	Y		A2	$717.00	18.7307	$775.47	$731.62
67903	Repair eyelid defect	Y		A2	$630.00	18.7307	$775.47	$666.37
67904	Repair eyelid defect	Y		A2	$630.00	18.7307	$775.47	$666.37
67906	Repair eyelid defect	Y		A2	$717.00	18.7307	$775.47	$731.62
67908	Repair eyelid defect	Y		A2	$630.00	18.7307	$775.47	$666.37
67909	Revise eyelid defect	Y		A2	$630.00	18.7307	$775.47	$666.37
67911	Revise eyelid defect	Y		A2	$510.00	18.7307	$775.47	$576.37
67912	Correction eyelid w/implant	Y		A2	$510.00	18.7307	$775.47	$576.37
67914	Repair eyelid defect	Y		A2	$510.00	18.7307	$775.47	$576.37
67915	Repair eyelid defect	Y		P3		4.2378	$175.45	$175.45
67916	Repair eyelid defect	Y		A2	$630.00	18.7307	$775.47	$666.37
67917	Repair eyelid defect	Y		A2	$630.00	18.7307	$775.47	$666.37
67921	Repair eyelid defect	Y		A2	$510.00	18.7307	$775.47	$576.37
67922	Repair eyelid defect	Y		P3		4.139	$171.36	$171.36
67923	Repair eyelid defect	Y		A2	$630.00	18.7307	$775.47	$666.37
67924	Repair eyelid defect	Y		A2	$630.00	18.7307	$775.47	$666.37
67930	Repair eyelid wound	Y		P3		4.1472	$171.70	$171.70
67935	Repair eyelid wound	Y		A2	$446.00	18.7307	$775.47	$528.37
67938	Remove eyelid foreign body	N		P2		2.179	$90.21	$90.21
67950	Revision of eyelid	Y		A2	$446.00	18.7307	$775.47	$528.37
67961	Revision of eyelid	Y		A2	$510.00	18.7307	$775.47	$576.37
67966	Revision of eyelid	Y		A2	$510.00	18.7307	$775.47	$576.37
67971	Reconstruction of eyelid	Y		A2	$510.00	24.3077	$1,006.36	$634.09
67973	Reconstruction of eyelid	Y		A2	$510.00	24.3077	$1,006.36	$634.09
67974	Reconstruction of eyelid	Y		A2	$510.00	24.3077	$1,006.36	$634.09

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.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
67975	Reconstruction of eyelid	Y		A2	$510.00	18.7307	$775.47	$576.37
68020	Incise/drain eyelid lining	Y		P3		1.0862	$44.97	$44.97
68040	Treatment of eyelid lesions	N		P3		0.5348	$22.14	$22.14
68100	Biopsy of eyelid lining	Y		P3		2.3041	$95.39	$95.39
68110	Remove eyelid lining lesion	Y		P3		2.9458	$121.96	$121.96
68115	Remove eyelid lining lesion	Y		A2	$446.00	18.7307	$775.47	$528.37
68130	Remove eyelid lining lesion	Y		A2	$446.00	16.171	$669.50	$501.88
68135	Remove eyelid lining lesion	Y		P3		1.399	$57.92	$57.92
68200	Treat eyelid by injection	N		P3		0.4031	$16.69	$16.69
68320	Revise/graft eyelid lining	Y		A2	$630.00	18.7307	$775.47	$666.37
68325	Revise/graft eyelid lining	Y		A2	$630.00	24.3077	$1,006.36	$724.09
68326	Revise/graft eyelid lining	Y		A2	$630.00	24.3077	$1,006.36	$724.09
68328	Revise/graft eyelid lining	Y		A2	$630.00	24.3077	$1,006.36	$724.09
68330	Revise eyelid lining	Y		A2	$630.00	23.1758	$959.50	$712.38
68335	Revise/graft eyelid lining	Y		A2	$630.00	24.3077	$1,006.36	$724.09
68340	Separate eyelid adhesions	Y		A2	$630.00	18.7307	$775.47	$666.37
68360	Revise eyelid lining	Y		A2	$446.00	23.1758	$959.50	$574.38
68362	Revise eyelid lining	Y		A2	$446.00	23.1758	$959.50	$574.38
68371	Harvest eye tissue, alograft	Y		A2	$446.00	16.171	$669.50	$501.88
68400	Incise/drain tear gland	Y		P2		2.9022	$120.15	$120.15
68420	Incise/drain tear sac	Y		P3		4.4354	$183.63	$183.63
68440	Incise tear duct opening	Y		P3		1.3741	$56.89	$56.89
68500	Removal of tear gland	Y		A2	$510.00	24.3077	$1,006.36	$634.09
68505	Partial removal, tear gland	Y		A2	$510.00	24.3077	$1,006.36	$634.09
68510	Biopsy of tear gland	Y		A2	$333.00	18.7307	$775.47	$443.62
68520	Removal of tear sac	Y		A2	$510.00	24.3077	$1,006.36	$634.09
68525	Biopsy of tear sac	Y		A2	$333.00	18.7307	$775.47	$443.62
68530	Clearance of tear duct	Y		P3		5.6615	$234.39	$234.39
68540	Remove tear gland lesion	Y		A2	$510.00	24.3077	$1,006.36	$634.09
68550	Remove tear gland lesion	Y		A2	$510.00	24.3077	$1,006.36	$634.09
68700	Repair tear ducts	Y		A2	$446.00	24.3077	$1,006.36	$586.09
68705	Revise tear duct opening	Y		P2		2.9022	$120.15	$120.15
68720	Create tear sac drain	Y		A2	$630.00	24.3077	$1,006.36	$724.09
68745	Create tear duct drain	Y		A2	$630.00	24.3077	$1,006.36	$724.09
68750	Create tear duct drain	Y		A2	$630.00	24.3077	$1,006.36	$724.09
68760	Close tear duct opening	N		P2		2.179	$90.21	$90.21
68761	Close tear duct opening	N		P3		1.6869	$69.84	$69.84
68770	Close tear system fistula	Y		A2	$630.00	18.7307	$775.47	$666.37
68801	Dilate tear duct opening	N		P2		0.8696	$36.00	$36.00
68810	Probe nasolacrimal duct	N		A2	$131.86	2.179	$90.21	$121.45
68811	Probe nasolacrimal duct	Y		A2	$446.00	18.7307	$775.47	$528.37
68815	Probe nasolacrimal duct	Y		A2	$446.00	18.7307	$775.47	$528.37
68816*	Probe nl duct w/balloon	Y	NI	P3		10.4754	$433.69	$433.69
68840	Explore/irrigate tear ducts	N	CH	P3		1.2756	$52.81	$52.81
68850	Injection for tear sac x-ray	N		N1				
69000	Drain external ear lesion	Y		P2		1.4066	$58.23	$58.23
69005	Drain external ear lesion	Y		P3		2.4357	$100.84	$100.84
69020	Drain outer ear canal lesion	Y		P2		1.4066	$58.23	$58.23
69100	Biopsy of external ear	Y		P3		1.4647	$60.64	$60.64
69105	Biopsy of external ear canal	Y		P3		2.049	$84.83	$84.83
69110	Remove external ear, partial	Y		A2	$333.00	16.1001	$666.56	$416.39
69120	Removal of external ear	Y		A2	$446.00	23.9765	$992.65	$582.66
69140	Remove ear canal lesion(s)	Y		A2	$446.00	23.9765	$992.65	$582.66
69145	Remove ear canal lesion(s)	Y		A2	$446.00	16.1001	$666.56	$501.14
69150	Extensive ear canal surgery	Y		A2	$464.15	7.4474	$308.33	$425.20
69200	Clear outer ear canal	N		P2		0.631	$26.12	$26.12
69205	Clear outer ear canal	Y		A2	$333.00	21.1098	$873.97	$468.24
69210	Remove impacted ear wax	N		P3		0.4937	$20.44	$20.44
69220	Clean out mastoid cavity	Y		P2		0.793	$32.83	$32.83
69222	Clean out mastoid cavity	Y		P3		3.2176	$133.21	$133.21
69300	Revise external ear	Y		A2	$510.00	23.9765	$992.65	$630.66
69310	Rebuild outer ear canal	Y		A2	$510.00	39.8776	$1,650.97	$795.24
69320	Rebuild outer ear canal	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
69400	Inflate middle ear canal	Y		P3		2.049	$84.83	$84.83
69401	Inflate middle ear canal	Y		P3		1.1355	$47.01	$47.01
69405	Catheterize middle ear canal	Y		P3		2.9458	$121.96	$121.96
69420	Incision of eardrum	Y		P2		2.5002	$103.51	$103.51
69421	Incision of eardrum	Y		A2	$510.00	16.3288	$676.03	$551.51
69424	Remove ventilating tube	Y		P3		1.8596	$76.99	$76.99
69433	Create eardrum opening	Y		P3		2.6333	$109.02	$109.02
69436	Create eardrum opening	Y		A2	$510.00	16.3288	$676.03	$551.51
69440	Exploration of middle ear	Y		A2	$510.00	23.9765	$992.65	$630.66
69450	Eardrum revision	Y		A2	$333.00	39.8776	$1,650.97	$662.49

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
69501	Mastoidectomy	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
69502	Mastoidectomy	Y		A2	$995.00	23.9765	$992.65	$994.41
69505	Remove mastoid structures	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
69511	Extensive mastoid surgery	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
69530	Extensive mastoid surgery	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
69540	Remove ear lesion	Y		P3		3.1434	$130.14	$130.14
69550	Remove ear lesion	Y		A2	$717.00	39.8776	$1,650.97	$950.49
69552	Remove ear lesion	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
69601	Mastoid surgery revision	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
69602	Mastoid surgery revision	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
69603	Mastoid surgery revision	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
69604	Mastoid surgery revision	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
69605	Mastoid surgery revision	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
69610	Repair of eardrum	Y		P3		4.3038	$178.18	$178.18
69620	Repair of eardrum	Y		A2	$446.00	23.9765	$992.65	$582.66
69631	Repair eardrum structures	Y		A2	$717.00	39.8776	$1,650.97	$950.49
69632	Rebuild eardrum structures	Y		A2	$717.00	39.8776	$1,650.97	$950.49
69633	Rebuild eardrum structures	Y		A2	$717.00	39.8776	$1,650.97	$950.49
69635	Repair eardrum structures	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
69636	Rebuild eardrum structures	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
69637	Rebuild eardrum structures	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
69641	Revise middle ear & mastoid	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
69642	Revise middle ear & mastoid	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
69643	Revise middle ear & mastoid	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
69644	Revise middle ear & mastoid	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
69645	Revise middle ear & mastoid	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
69646	Revise middle ear & mastoid	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
69650	Release middle ear bone	Y		A2	$995.00	23.9765	$992.65	$994.41
69660	Revise middle ear bone	Y		A2	$717.00	39.8776	$1,650.97	$950.49
69661	Revise middle ear bone	Y		A2	$717.00	39.8776	$1,650.97	$950.49
69662	Revise middle ear bone	Y		A2	$717.00	39.8776	$1,650.97	$950.49
69666	Repair middle ear structures	Y		A2	$630.00	39.8776	$1,650.97	$885.24
69667	Repair middle ear structures	Y		A2	$630.00	39.8776	$1,650.97	$885.24
69670	Remove mastoid air cells	Y		A2	$510.00	39.8776	$1,650.97	$795.24
69676	Remove middle ear nerve	Y		A2	$510.00	39.8776	$1,650.97	$795.24
69700	Close mastoid fistula	Y		A2	$510.00	39.8776	$1,650.97	$795.24
69711	Remove/repair hearing aid	Y		A2	$333.00	39.8776	$1,650.97	$662.49
69714	Implant temple bone w/stimul	Y		A2	$1,339.00	39.8776	$1,650.97	$1,416.99
69715	Temple bne implnt w/stimulat	Y		A2	$1,339.00	39.8776	$1,650.97	$1,416.99
69717	Temple bone implant revision	Y		A2	$1,339.00	39.8776	$1,650.97	$1,416.99
69718	Revise temple bone implant	Y		A2	$1,339.00	39.8776	$1,650.97	$1,416.99
69720	Release facial nerve	Y		A2	$717.00	39.8776	$1,650.97	$950.49
69740	Repair facial nerve	Y		A2	$717.00	39.8776	$1,650.97	$950.49
69745	Repair facial nerve	Y		A2	$717.00	39.8776	$1,650.97	$950.49
69801	Incise inner ear	Y		A2	$717.00	39.8776	$1,650.97	$950.49
69802	Incise inner ear	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
69805	Explore inner ear	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
69806	Explore inner ear	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
69820	Establish inner ear window	Y		A2	$717.00	39.8776	$1,650.97	$950.49
69840	Revise inner ear window	Y		A2	$717.00	39.8776	$1,650.97	$950.49
69905	Remove inner ear	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
69910	Remove inner ear & mastoid	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
69915	Incise inner ear nerve	Y		A2	$995.00	39.8776	$1,650.97	$1,158.99
69930	Implant cochlear device	Y		H8	$995.00	568.8394	$23,550.52	$22,213.76
69990	Microsurgery add-on	N		N1				
C9716	Radiofrequency energy to anu	Y		G2		30.1606	$1,248.68	$1,248.68
C9724	EPS gast cardia plic	Y		G2		25.3233	$1,048.41	$1,048.41
C9725	Place endorectal app	N		G2		8.6351	$357.50	$357.50
C9726	Rxt breast appl place/remov	N		G2		10.2051	$422.50	$422.50
C9727	Insert palate implants	N		G2		13.3451	$552.50	$552.50
C9728	Place device/marker, non pro	Y	CH	R2		3.0469	$126.14	$126.14
G0104	CA screen;flexi sigmoidscope	N		P3		1.9748	$81.76	$81.76
G0105	Colorectal scrn; hi risk ind	Y		A2	$446.00	7.8504	$325.01	$415.75
G0121	Colon ca scrn not hi rsk ind	Y		A2	$446.00	7.8504	$325.01	$415.75
G0127	Trim nail(s)	Y		P3		0.2633	$10.90	$10.90
G0186	Dstry eye lesn,fdr vssl tech	Y		R2		4.1331	$171.11	$171.11
G0247	Routine footcare pt w lops	Y		P3		0.4937	$20.44	$20.44
G0259	Inject for sacroiliac joint	N		N1				
G0260	Inj for sacroiliac jt anesth	Y		A2	$333.00	7.0546	$292.07	$322.77
G0268	Removal of impacted wax md	N	CH	N1				
G0269	Occlusive device in vein art	N		N1				
G0289	Arthro, loose body + chondro	N		N1				
G0364	Bone marrow aspirate &biopsy	Y		P3		0.1234	$5.11	$5.11

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ADDENDUM AA.—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	Comment indicator	Payment indicator	CY 2007 ASC payment rate	CY 2008 fully implemented payment weight	CY 2008 fully implemented payment	CY 2008 first transition year payment
G0392	AV fistula or graft arterial	Y		A2	$1,339.00	45.3845	$1,878.96	$1,473.99
G0393	AV fistula or graft venous	Y		A2	$1,339.00	45.3845	$1,878.96	$1,473.99

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ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0001F	Heart failure composite		M					
0005F	Osteoarthritis composite		M					
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					
0014F	Comp preop assess cat surg	NI	M					
0015F	Melan follow-up complete	NI	M					
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	4.1331	$263.25	$58.93	$52.65
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	4.1331	$263.25	$58.93	$52.65
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					
0026T	Measure remnant lipoproteins		A					
0027T	Endoscopic epidural lysis		T	0220	18.0518	$1,149.79		$229.96
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0046T	Cath lavage, mammary duct(s)		T	0021	16.1001	$1,025.48	$219.48	$205.10
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	16.1001	$1,025.48	$219.48	$205.10
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					
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	D					
00550	Anesth, sternal debridement		N					
0055T	Bone surgery using computer	CH	D					
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	D					
00580	Anesth, heart/lung transplnt		C					
0058T	Cryopreservation, ovary tiss	CH	X	0344	0.8167	$52.02	$15.66	$10.40
0059T	Cryopreservation, oocyte	CH	X	0344	0.8167	$52.02	$15.66	$10.40
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	29.1900	$1,859.23		$371.85
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	29.1900	$1,859.23		$371.85
00640	Anesth, spine manipulation		N					
0064T	Spectroscop eval expired gas		X	0367	0.5677	$36.16	$13.76	$7.23
0065T	Ocular photoscreen bilat	CH	D					
0066T	Ct colonography;screen		E					
00670	Anesth, spine, cord surgery		C					
0067T	Ct colonography;dx	CH	S	0332	3.0109	$191.78	$75.24	$38.36
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	61.6965	$3,929.70		$785.94
0072T	U/s leiomyomata ablate >200	CH	S	0067	61.6965	$3,929.70		$785.94
00730	Anesth, abdominal wall surg		N					
0073T	Delivery, comp imrt		S	0412	5.4582	$347.65		$69.53
00740	Anesth, upper gi visualize		N					
0074T	Online physician e/m	CH	D					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
00848	Anesth, pelvic organ surg		C					
0084T	Temp prostate urethral stent		T	0164	2.0077	$127.88		$25.58
00851	Anesth, tubal ligation		N					
0085T	Breath test heart reject		X	0340	0.6310	$40.19		$8.04
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	0.8167	$52.02	$15.66	$10.40
00880	Anesth, abdomen vessel surg		N					
00882	Anesth, major vein ligation		C					
0088T	Rf tongue base vol reduxn		T	0253	16.3288	$1,040.05	$282.29	$208.01
0089T	Actigraphy testing, 3-day		S	0218	1.1550	$73.57		$14.71
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	16.1710	$1,030.00	$266.33	$206.00
0100T	Prosth retina receive&gen		T	0672	37.2078	$2,369.91		$473.98
0101T	Extracorp shockwv tx,hi enrg		T	0050	29.1900	$1,859.23		$371.85
0102T	Extracorp shockwv tx,anesth		T	0050	29.1900	$1,859.23		$371.85
0103T	Holotranscobalamin		A					
0104T	At rest cardio gas rebreathe		A					
0105T	Exerc cardio gas rebreathe		A					
0106T	Touch quant sensory test		X	0341	0.0844	$5.38	$2.14	$1.08
0107T	Vibrate quant sensory test		X	0341	0.0844	$5.38	$2.14	$1.08
0108T	Cool quant sensory test		X	0341	0.0844	$5.38	$2.14	$1.08

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0109T	Heat quant sensory test		X	0341	0.0844	$5.38	$2.14	$1.08
0110T	Nos quant sensory test		X	0341	0.0844	$5.38	$2.14	$1.08
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	CH	D					
01160	Anesth, pelvis procedure		N					
0116T	Med tx mngmt subsqt	CH	D					
01170	Anesth, pelvis surgery		N					
01173	Anesth, fx repair, pelvis		N					
0117T	Med tx mngmt addl 15 min	CH	D					
01180	Anesth, pelvis nerve removal		N					
01190	Anesth, pelvis nerve removal		N					
01200	Anesth, hip joint procedure		N					
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	23.1758	$1,476.16	$511.31	$295.23
0124T	Conjunctival drug placement		T	0232	5.1169	$325.92	$81.65	$65.18
01250	Anesth, upper leg surgery		N					
01260	Anesth, upper leg veins surg		N					
0126T	Chd risk imt study	CH	Q	0340	0.6310	$40.19		$8.04
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					
01340	Anesth, knee area procedure		N					
0135T	Perq cryoablate renal tumor	CH	D					
01360	Anesth, knee area surgery		N					
0137T	Prostate saturation sampling		T	0184	11.0338	$702.79		$140.56
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	1.5839	$100.88	$37.81	$20.18
0145T	CT heart w/wo dye funct	CH	S	0383	4.7005	$299.39	$117.06	$59.88
01462	Anesth, lower leg procedure		N					
01464	Anesth, ankle/ft arthroscopy		N					
0146T	CCTA w/wo dye	CH	S	0383	4.7005	$299.39	$117.06	$59.88
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	4.7005	$299.39	$117.06	$59.88
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	4.7005	$299.39	$117.06	$59.88
01490	Anesth, lower leg casting		N					
0149T	CCTA w/wo, strxr quan calc	CH	S	0383	4.7005	$299.39	$117.06	$59.88
01500	Anesth, leg arteries surg		N					
01502	Anesth, lwr leg embolectomy		C					
0150T	CCTA w/wo, disease strxr	CH	S	0383	4.7005	$299.39	$117.06	$59.88
0151T	CT heart funct add-on		S	0282	1.5839	$100.88	$37.81	$20.18
01520	Anesth, lower leg vein surg		N					
01522	Anesth, lower leg vein surg		N					
0153T	Tcath sensor aneurysm sac	CH	D					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0154T	Study sensor aneurysm sac	CH	D					
0155T	Lap impl gast curve electrd		T	0130	34.3958	$2,190.81	$659.53	$438.16
0156T	Lap remv gast curve electrd		T	0130	34.3958	$2,190.81	$659.53	$438.16
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	2.6846	$170.99		$34.20
01610	Anesth, surgery of shoulder		N					
0161T	Tcranial magn stim tx deliv		S	0216	2.6846	$170.99		$34.20
01620	Anesth, shoulder procedure		N					
01622	Anes dx shoulder arthroscopy		N					
0162T	Anal program gast neurostim		S	0692	1.8376	$117.04	$29.72	$23.41
01630	Anesth, surgery of shoulder		N					
01632	Anesth, surgery of shoulder		C					
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	2.5002	$159.25		$31.85
0169T	Place stereo cath brain		C					
0170T	Anorectal fistula plug rpr		T	0150	30.1606	$1,921.05	$437.12	$384.21
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	29.1900	$1,859.23		$371.85
0172T	Lumbar spine process addl		T	0050	29.1900	$1,859.23		$371.85
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	39.7101	$2,529.30	$649.56	$505.86
01770	Anesth, uppr arm artery surg		N					
01772	Anesth, uppr arm embolectomy		N					
0177T	Aqu canal dilat w retent		T	0673	39.7101	$2,529.30	$649.56	$505.86
01780	Anesth, upper arm vein surg		N					
01782	Anesth, uppr arm vein repair		N					
0178T	64 lead ecg w i&r	NF	B					
0179T	64 lead ecg w tracing	NF	X	0100	2.5547	$162.72	$41.44	$32.54
0180T	64 lead ecg w i&r only	NF	B					
01810	Anesth, lower arm surgery		N					
0181T	Corneal hysteresis	NF	S	0230	0.5903	$37.60		$7.52
01820	Anesth, lower arm procedure		N					
01829	Anesth, dx wrist arthroscopy		N					
0182T	Hdr elect brachytherapy	NF	S	1519		$1,750.00		$350.00
01830	Anesth, lower arm surgery		N					
01832	Anesth, wrist replacement		N					
0183T	Wound ultrasound	NI	T	0015	1.4595	$92.96		$18.59
01840	Anesth, lwr arm artery surg		N					
01842	Anesth, lwr arm embolectomy		N					
01844	Anesth, vascular shunt surg		N					
0184T	Exc rectal tumor endoscopic	NI	C					
01850	Anesth, lower arm vein surg		N					
01852	Anesth, lwr arm vein repair		N					
0185T	Comptr probability analysis	NI	N					
01860	Anesth, lower arm casting		N					
0186T	Suprachoroidal drug delivery	NI	T	0236	18.2350	$1,161.46		$232.29
0187T	Ophthalmic dx image anterior	NI	S	0230	0.5903	$37.60		$7.52
01905	Anes, spine inject, x-ray/re	CH	D					
01916	Anesth, dx arteriography		N					
01920	Anesth, catheterize heart		N					
01922	Anesth, cat or MRI scan		N					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
01935	Anesth, perc img dx sp proc	NI	N					
01936	Anesth, perc img tx sp proc	NI	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					
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'd		M					
0513F	Elev BP plan of care doc'd	NI	M					
0514F	Care plan Hgb doc'd ESA pt	NI	M					
0516F	Anemia plan of care doc'd	NI	M					
0517F	Glaucoma plan of care doc'd	NI	M					
0518F	Fall plan of care doc'd	NI	M					
0519F	Plan'd chemo doc'd b/4 txmnt	NI	M					
0520F	Tissue dose done w/in 5 days	NI	M					
0521F	Plan of care 4 pain doc'd	NI	M					
1000F	Tobacco use assessed		M					
10021	Fna w/o image		T	0002	1.1097	$70.68		$14.14
10022	Fna w/image	CH	T	0004	4.3270	$275.60		$55.12
1002F	Assess anginal symptom/level		M					
1003F	Level of activity assess		M					
10040	Acne surgery	CH	T	0013	0.7930	$50.51		$10.10
1004F	Clin symp vol ovrld assess		M					
1005F	Asthma symptoms evaluate		M					
10060	Drainage of skin abscess		T	0006	1.4066	$89.59		$17.92
10061	Drainage of skin abscess		T	0006	1.4066	$89.59		$17.92
1006F	Osteoarthritis assess		M					
1007F	Anti-inflm/anlgsc otc assess		M					
10080	Drainage of pilonidal cyst		T	0006	1.4066	$89.59		$17.92
10081	Drainage of pilonidal cyst		T	0007	11.5594	$736.26		$147.25
1008F	Gi/renal risk assess		M					
10120	Remove foreign body		T	0006	1.4066	$89.59		$17.92
10121	Remove foreign body		T	0021	16.1001	$1,025.48	$219.48	$205.10
10140	Drainage of hematoma/fluid		T	0007	11.5594	$736.26		$147.25
1015F	Copd symptoms assess		M					
10160	Puncture drainage of lesion	CH	T	0006	1.4066	$89.59		$17.92
10180	Complex drainage, wound		T	0008	18.3197	$1,166.85		$233.37
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 lt3 hrsb/4		M					
1066F	Ischm stroke symp ge3 hrsb/4		M					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
1070F	Alarm symp assessed-absent		M					
1071F	Alarm symp assessed-1+ prsnt		M					
1080F	Decis mkr/advncd plan doc'd	CH	D					
1090F	Pres/absn urine incon assess		M					
1091F	Urine incon characterized		M					
11000	Debride infected skin		T	0013	0.7930	$50.51		$10.10
11001	Debride infected skin add-on	CH	T	0013	0.7930	$50.51		$10.10
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	Ptfalls assess-doc'd ge2+/yr		M					
11010	Debride skin, fx		T	0019	4.3039	$274.13	$71.87	$54.83
11011	Debride skin/muscle, fx		T	0019	4.3039	$274.13	$71.87	$54.83
11012	Debride skin/muscle/bone, fx		T	0019	4.3039	$274.13	$71.87	$54.83
1101F	Pt falls assess-doc'd le1/yr		M					
11040	Debride skin, partial		T	0015	1.4595	$92.96		$18.59
11041	Debride skin, full		T	0015	1.4595	$92.96		$18.59
11042	Debride skin/tissue		T	0016	2.6604	$169.45		$33.89
11043	Debride tissue/muscle		T	0016	2.6604	$169.45		$33.89
11044	Debride tissue/muscle/bone		T	0682	6.8816	$438.32	$158.65	$87.66
11055	Trim skin lesion	CH	T	0013	0.7930	$50.51		$10.10
11056	Trim skin lesions, 2 to 4	CH	T	0013	0.7930	$50.51		$10.10
11057	Trim skin lesions, over 4	CH	T	0015	1.4595	$92.96		$18.59
11100	Biopsy, skin lesion	CH	T	0013	0.7930	$50.51		$10.10
11101	Biopsy, skin add-on	CH	T	0013	0.7930	$50.51		$10.10
1110F	Pt lft inpt fac w/in 60 days		M					
1111F	Dschrg med/current med merge		M					
1116F	Auric/peri pain assessed		M					
1118F	GERD symps assessed 12 month	NI	M					
1119F	Init. Eval for condition	NI	M					
11200	Removal of skin tags		T	0013	0.7930	$50.51		$10.10
11201	Remove skin tags add-on		T	0015	1.4595	$92.96		$18.59
1121F	Subs. Eval for condition	NI	M					
1123F	ACP discuss/dscn mkr doc'd	NI	M					
1124F	ACP discuss-no dscnmkr doc'd	NI	M					
1125F	Amnt Pain noted; pain prsnt	NI	M					
1126F	Amnt Pain noted; none prsnt	NI	M					
1127F	New episode for condition	NI	M					
1128F	Subs. episode for condition	NI	M					
11300	Shave skin lesion	CH	T	0013	0.7930	$50.51		$10.10
11301	Shave skin lesion	CH	T	0013	0.7930	$50.51		$10.10
11302	Shave skin lesion		T	0013	0.7930	$50.51		$10.10
11303	Shave skin lesion		T	0015	1.4595	$92.96		$18.59
11305	Shave skin lesion		T	0013	0.7930	$50.51		$10.10
11306	Shave skin lesion		T	0013	0.7930	$50.51		$10.10
11307	Shave skin lesion		T	0013	0.7930	$50.51		$10.10
11308	Shave skin lesion		T	0013	0.7930	$50.51		$10.10
11310	Shave skin lesion		T	0013	0.7930	$50.51		$10.10
11311	Shave skin lesion		T	0013	0.7930	$50.51		$10.10
11312	Shave skin lesion		T	0013	0.7930	$50.51		$10.10
11313	Shave skin lesion	CH	T	0013	0.7930	$50.51		$10.10
11400	Exc tr-ext b9+marg 0.5 < cm		T	0019	4.3039	$274.13	$71.87	$54.83
11401	Exc tr-ext b9+marg 0.6–1 cm		T	0019	4.3039	$274.13	$71.87	$54.83
11402	Exc tr-ext b9+marg 1.1–2 cm		T	0019	4.3039	$274.13	$71.87	$54.83
11403	Exc tr-ext b9+marg 2.1–3 cm		T	0020	8.6850	$553.18		$110.64
11404	Exc tr-ext b9+marg 3.1–4 cm		T	0021	16.1001	$1,025.48	$219.48	$205.10
11406	Exc tr-ext b9+marg > 4.0 cm		T	0021	16.1001	$1,025.48	$219.48	$205.10
11420	Exc h-f-nk-sp b9+marg 0.5 <		T	0020	8.6850	$553.18		$110.64
11421	Exc h-f-nk-sp b9+marg 0.6–1		T	0020	8.6850	$553.18		$110.64
11422	Exc h-f-nk-sp b9+marg 1.1–2		T	0020	8.6850	$553.18		$110.64
11423	Exc h-f-nk-sp b9+marg 2.1–3		T	0021	16.1001	$1,025.48	$219.48	$205.10
11424	Exc h-f-nk-sp b9+marg 3.1–4		T	0021	16.1001	$1,025.48	$219.48	$205.10
11426	Exc h-f-nk-sp b9+marg > 4 cm		T	0022	21.1098	$1,344.57	$354.45	$268.91
11440	Exc face-mm b9+marg 0.5 < cm		T	0019	4.3039	$274.13	$71.87	$54.83
11441	Exc face-mm b9+marg 0.6–1 cm		T	0019	4.3039	$274.13	$71.87	$54.83
11442	Exc face-mm b9+marg 1.1–2 cm		T	0020	8.6850	$553.18		$110.64
11443	Exc face-mm b9+marg 2.1–3 cm		T	0020	8.6850	$553.18		$110.64
11444	Exc face-mm b9+marg 3.1–4 cm		T	0020	8.6850	$553.18		$110.64
11446	Exc face-mm b9+marg > 4 cm		T	0022	21.1098	$1,344.57	$354.45	$268.91
11450	Removal, sweat gland lesion		T	0022	21.1098	$1,344.57	$354.45	$268.91
11451	Removal, sweat gland lesion		T	0022	21.1098	$1,344.57	$354.45	$268.91
11462	Removal, sweat gland lesion		T	0022	21.1098	$1,344.57	$354.45	$268.91
11463	Removal, sweat gland lesion		T	0022	21.1098	$1,344.57	$354.45	$268.91
11470	Removal, sweat gland lesion		T	0022	21.1098	$1,344.57	$354.45	$268.91
11471	Removal, sweat gland lesion		T	0022	21.1098	$1,344.57	$354.45	$268.91
11600	Exc tr-ext mlg+marg 0.5 < cm		T	0019	4.3039	$274.13	$71.87	$54.83
11601	Exc tr-ext mlg+marg 0.6–1 cm		T	0019	4.3039	$274.13	$71.87	$54.83
11602	Exc tr-ext mlg+marg 1.1–2 cm		T	0019	4.3039	$274.13	$71.87	$54.83
11603	Exc tr-ext mlg+marg 2.1–3 cm		T	0020	8.6850	$553.18		$110.64

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
11604	Exc tr-ext mlg+marg 3.1–4 cm		T	0020	8.6850	$553.18		$110.64
11606	Exc tr-ext mlg+marg > 4 cm		T	0021	16.1001	$1,025.48	$219.48	$205.10
11620	Exc h-f-nk-sp mlg+marg 0.5 <		T	0020	8.6850	$553.18		$110.64
11621	Exc h-f-nk-sp mlg+marg 0.6–1		T	0019	4.3039	$274.13	$71.87	$54.83
11622	Exc h-f-nk-sp mlg+marg 1.1–2		T	0020	8.6850	$553.18		$110.64
11623	Exc h-f-nk-sp mlg+marg 2.1–3	CH	T	0020	8.6850	$553.18		$110.64
11624	Exc h-f-nk-sp mlg+marg 3.1–4		T	0021	16.1001	$1,025.48	$219.48	$205.10
11626	Exc h-f-nk-sp mlg+mar > 4 cm		T	0022	21.1098	$1,344.57	$354.45	$268.91
11640	Exc face-mm malig+marg 0.5 <	CH	T	0019	4.3039	$274.13	$71.87	$54.83
11641	Exc face-mm malig+marg 0.6–1	CH	T	0019	4.3039	$274.13	$71.87	$54.83
11642	Exc face-mm malig+marg 1.1–2		T	0020	8.6850	$553.18		$110.64
11643	Exc face-mm malig+marg 2.1–3		T	0020	8.6850	$553.18		$110.64
11644	Exc face-mm malig+marg 3.1–4		T	0021	16.1001	$1,025.48	$219.48	$205.10
11646	Exc face-mm mlg+marg > 4 cm		T	0022	21.1098	$1,344.57	$354.45	$268.91
11719	Trim nail(s)	CH	T	0013	0.7930	$50.51		$10.10
11720	Debride nail, 1–5	CH	T	0013	0.7930	$50.51		$10.10
11721	Debride nail, 6 or more	CH	T	0013	0.7930	$50.51		$10.10
11730	Removal of nail plate		T	0013	0.7930	$50.51		$10.10
11732	Remove nail plate, add-on	CH	T	0013	0.7930	$50.51		$10.10
11740	Drain blood from under nail	CH	T	0012	0.2963	$18.87		$3.77
11750	Removal of nail bed		T	0019	4.3039	$274.13	$71.87	$54.83
11752	Remove nail bed/finger tip		T	0022	21.1098	$1,344.57	$354.45	$268.91
11755	Biopsy, nail unit		T	0019	4.3039	$274.13	$71.87	$54.83
11760	Repair of nail bed	CH	T	0134	2.1051	$134.08	$42.24	$26.82
11762	Reconstruction of nail bed	CH	T	0136	15.0458	$958.33		$191.67
11765	Excision of nail fold, toe		T	0015	1.4595	$92.96		$18.59
11770	Removal of pilonidal lesion		T	0022	21.1098	$1,344.57	$354.45	$268.91
11771	Removal of pilonidal lesion		T	0022	21.1098	$1,344.57	$354.45	$268.91
11772	Removal of pilonidal lesion		T	0022	21.1098	$1,344.57	$354.45	$268.91
11900	Injection into skin lesions	CH	T	0013	0.7930	$50.51		$10.10
11901	Added skin lesions injection	CH	T	0013	0.7930	$50.51		$10.10
11920	Correct skin color defects	CH	T	0134	2.1051	$134.08	$42.24	$26.82
11921	Correct skin color defects	CH	T	0134	2.1051	$134.08	$42.24	$26.82
11922	Correct skin color defects	CH	T	0134	2.1051	$134.08	$42.24	$26.82
11950	Therapy for contour defects	CH	T	0133	1.2792	$81.48	$25.67	$16.30
11951	Therapy for contour defects	CH	T	0133	1.2792	$81.48	$25.67	$16.30
11952	Therapy for contour defects	CH	T	0133	1.2792	$81.48	$25.67	$16.30
11954	Therapy for contour defects	CH	T	0133	1.2792	$81.48	$25.67	$16.30
11960	Insert tissue expander(s)	CH	T	0137	20.2069	$1,287.06		$257.41
11970	Replace tissue expander		T	0051	42.9850	$2,737.89		$547.58
11971	Remove tissue expander(s)		T	0022	21.1098	$1,344.57	$354.45	$268.91
11975	Insert contraceptive cap		E					
11976	Removal of contraceptive cap		T	0019	4.3039	$274.13	$71.87	$54.83
11977	Removal/reinsert contra cap		E					
11980	Implant hormone pellet(s)		X	0340	0.6310	$40.19		$8.04
11981	Insert drug implant device		X	0340	0.6310	$40.19		$8.04
11982	Remove drug implant device		X	0340	0.6310	$40.19		$8.04
11983	Remove/insert drug implant		X	0340	0.6310	$40.19		$8.04
12001	Repair superficial wound(s)	CH	T	0133	1.2792	$81.48	$25.67	$16.30
12002	Repair superficial wound(s)	CH	T	0133	1.2792	$81.48	$25.67	$16.30
12004	Repair superficial wound(s)	CH	T	0133	1.2792	$81.48	$25.67	$16.30
12005	Repair superficial wound(s)	CH	T	0133	1.2792	$81.48	$25.67	$16.30
12006	Repair superficial wound(s)	CH	T	0133	1.2792	$81.48	$25.67	$16.30
12007	Repair superficial wound(s)	CH	T	0133	1.2792	$81.48	$25.67	$16.30
12011	Repair superficial wound(s)	CH	T	0133	1.2792	$81.48	$25.67	$16.30
12013	Repair superficial wound(s)	CH	T	0133	1.2792	$81.48	$25.67	$16.30
12014	Repair superficial wound(s)	CH	T	0133	1.2792	$81.48	$25.67	$16.30
12015	Repair superficial wound(s)	CH	T	0133	1.2792	$81.48	$25.67	$16.30
12016	Repair superficial wound(s)	CH	T	0133	1.2792	$81.48	$25.67	$16.30
12017	Repair superficial wound(s)	CH	T	0133	1.2792	$81.48	$25.67	$16.30
12018	Repair superficial wound(s)	CH	T	0133	1.2792	$81.48	$25.67	$16.30
12020	Closure of split wound	CH	T	0135	4.5263	$288.30		$57.66
12021	Closure of split wound	CH	T	0135	4.5263	$288.30		$57.66
12031	Layer closure of wound(s)	CH	T	0134	2.1051	$134.08	$42.24	$26.82
12032	Layer closure of wound(s)	CH	T	0134	2.1051	$134.08	$42.24	$26.82
12034	Layer closure of wound(s)	CH	T	0134	2.1051	$134.08	$42.24	$26.82
12035	Layer closure of wound(s)	CH	T	0134	2.1051	$134.08	$42.24	$26.82
12036	Layer closure of wound(s)	CH	T	0134	2.1051	$134.08	$42.24	$26.82
12037	Layer closure of wound(s)	CH	T	0134	2.1051	$134.08	$42.24	$26.82
12041	Layer closure of wound(s)	CH	T	0134	2.1051	$134.08	$42.24	$26.82
12042	Layer closure of wound(s)	CH	T	0134	2.1051	$134.08	$42.24	$26.82
12044	Layer closure of wound(s)	CH	T	0134	2.1051	$134.08	$42.24	$26.82
12045	Layer closure of wound(s)	CH	T	0134	2.1051	$134.08	$42.24	$26.82
12046	Layer closure of wound(s)	CH	T	0134	2.1051	$134.08	$42.24	$26.82
12047	Layer closure of wound(s)	CH	T	0134	2.1051	$134.08	$42.24	$26.82
12051	Layer closure of wound(s)	CH	T	0134	2.1051	$134.08	$42.24	$26.82
12052	Layer closure of wound(s)	CH	T	0134	2.1051	$134.08	$42.24	$26.82
12053	Layer closure of wound(s)	CH	T	0134	2.1051	$134.08	$42.24	$26.82
12054	Layer closure of wound(s)	CH	T	0134	2.1051	$134.08	$42.24	$26.82
12055	Layer closure of wound(s)	CH	T	0134	2.1051	$134.08	$42.24	$26.82

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
12056	Layer closure of wound(s)	CH	T	0134	2.1051	$134.08	$42.24	$26.82
12057	Layer closure of wound(s)	CH	T	0134	2.1051	$134.08	$42.24	$26.82
13100	Repair of wound or lesion	CH	T	0135	4.5263	$288.30		$57.66
13101	Repair of wound or lesion	CH	T	0135	4.5263	$288.30		$57.66
13102	Repair wound/lesion add-on	CH	T	0135	4.5263	$288.30		$57.66
13120	Repair of wound or lesion	CH	T	0134	2.1051	$134.08	$42.24	$26.82
13121	Repair of wound or lesion	CH	T	0135	4.5263	$288.30		$57.66
13122	Repair wound/lesion add-on	CH	T	0134	2.1051	$134.08	$42.24	$26.82
13131	Repair of wound or lesion	CH	T	0135	4.5263	$288.30		$57.66
13132	Repair of wound or lesion	CH	T	0135	4.5263	$288.30		$57.66
13133	Repair wound/lesion add-on	CH	T	0135	4.5263	$288.30		$57.66
13150	Repair of wound or lesion	CH	T	0135	4.5263	$288.30		$57.66
13151	Repair of wound or lesion	CH	T	0135	4.5263	$288.30		$57.66
13152	Repair of wound or lesion	CH	T	0135	4.5263	$288.30		$57.66
13153	Repair wound/lesion add-on	CH	T	0134	2.1051	$134.08	$42.24	$26.82
13160	Late closure of wound	CH	T	0137	20.2069	$1,287.06		$257.41
14000	Skin tissue rearrangement	CH	T	0136	15.0458	$958.33		$191.67
14001	Skin tissue rearrangement	CH	T	0136	15.0458	$958.33		$191.67
14020	Skin tissue rearrangement	CH	T	0136	15.0458	$958.33		$191.67
14021	Skin tissue rearrangement	CH	T	0136	15.0458	$958.33		$191.67
14040	Skin tissue rearrangement	CH	T	0136	15.0458	$958.33		$191.67
14041	Skin tissue rearrangement	CH	T	0136	15.0458	$958.33		$191.67
14060	Skin tissue rearrangement	CH	T	0136	15.0458	$958.33		$191.67
14061	Skin tissue rearrangement	CH	T	0136	15.0458	$958.33		$191.67
14300	Skin tissue rearrangement	CH	T	0137	20.2069	$1,287.06		$257.41
14350	Skin tissue rearrangement	CH	T	0137	20.2069	$1,287.06		$257.41
15002	Wnd prep, ch/inf, trk/arm/lg	CH	T	0135	4.5263	$288.30		$57.66
15003	Wnd prep, ch/inf addl 100 cm	CH	T	0135	4.5263	$288.30		$57.66
15004	Wnd prep ch/inf, f/n/hf/g	CH	T	0135	4.5263	$288.30		$57.66
15005	Wnd prep, f/n/hf/g, addl cm	CH	T	0135	4.5263	$288.30		$57.66
15040	Harvest cultured skin graft	CH	T	0134	2.1051	$134.08	$42.24	$26.82
15050	Skin pinch graft	CH	T	0135	4.5263	$288.30		$57.66
15100	Skin splt grft, trnk/arm/leg	CH	T	0137	20.2069	$1,287.06		$257.41
15101	Skin splt grft t/a/l, add-on	CH	T	0137	20.2069	$1,287.06		$257.41
15110	Epidrm autogrft trnk/arm/leg	CH	T	0135	4.5263	$288.30		$57.66
15111	Epidrm autogrft t/a/l add-on	CH	T	0135	4.5263	$288.30		$57.66
15115	Epidrm a-grft face/nck/hf/g	CH	T	0135	4.5263	$288.30		$57.66
15116	Epidrm a-grft f/n/hf/g addl	CH	T	0135	4.5263	$288.30		$57.66
15120	Skn splt a-grft fac/nck/hf/g	CH	T	0137	20.2069	$1,287.06		$257.41
15121	Skn splt a-grft f/n/hf/g add	CH	T	0137	20.2069	$1,287.06		$257.41
15130	Derm autograft, trnk/arm/leg	CH	T	0136	15.0458	$958.33		$191.67
15131	Derm autograft t/a/l add-on	CH	T	0136	15.0458	$958.33		$191.67
15135	Derm autograft face/nck/hf/g	CH	T	0136	15.0458	$958.33		$191.67
15136	Derm autograft, f/n/hf/g add	CH	T	0136	15.0458	$958.33		$191.67
15150	Cult epiderm grft t/arm/leg	CH	T	0135	4.5263	$288.30		$57.66
15151	Cult epiderm grft t/a/l addl	CH	T	0135	4.5263	$288.30		$57.66
15152	Cult epiderm graft t/a/l +%	CH	T	0135	4.5263	$288.30		$57.66
15155	Cult epiderm graft, f/n/hf/g	CH	T	0135	4.5263	$288.30		$57.66
15156	Cult epidrm grft f/n/hfg add	CH	T	0135	4.5263	$288.30		$57.66
15157	Cult epiderm grft f/n/hfg +%	CH	T	0135	4.5263	$288.30		$57.66
15170	Acell graft trunk/arms/legs	CH	T	0134	2.1051	$134.08	$42.24	$26.82
15171	Acell graft t/arm/leg add-on	CH	T	0134	2.1051	$134.08	$42.24	$26.82
15175	Acellular graft, f/n/hf/g	CH	T	0135	4.5263	$288.30		$57.66
15176	Acell graft, f/n/hf/g add-on	CH	T	0135	4.5263	$288.30		$57.66
15200	Skin full graft, trunk	CH	T	0136	15.0458	$958.33		$191.67
15201	Skin full graft trunk add-on	CH	T	0136	15.0458	$958.33		$191.67
15220	Skin full graft sclp/arm/leg	CH	T	0136	15.0458	$958.33		$191.67
15221	Skin full graft add-on	CH	T	0135	4.5263	$288.30		$57.66
15240	Skin full grft face/genit/hf	CH	T	0136	15.0458	$958.33		$191.67
15241	Skin full graft add-on	CH	T	0135	4.5263	$288.30		$57.66
15260	Skin full graft een & lips	CH	T	0136	15.0458	$958.33		$191.67
15261	Skin full graft add-on	CH	T	0136	15.0458	$958.33		$191.67
15300	Apply skinallogrft, t/arm/lg	CH	T	0135	4.5263	$288.30		$57.66
15301	Apply sknallogrft t/a/l addl	CH	T	0135	4.5263	$288.30		$57.66
15320	Apply skin allogrft f/n/hf/g	CH	T	0135	4.5263	$288.30		$57.66
15321	Aply sknallogrft f/n/hfg add	CH	T	0135	4.5263	$288.30		$57.66
15330	Aply acell alogrft t/arm/leg	CH	T	0135	4.5263	$288.30		$57.66
15331	Aply acell grft t/a/l add-on	CH	T	0135	4.5263	$288.30		$57.66
15335	Apply acell graft, f/n/hf/g	CH	T	0135	4.5263	$288.30		$57.66
15336	Aply acell grft f/n/hf/g add	CH	T	0135	4.5263	$288.30		$57.66
15340	Apply cult skin substitute	CH	T	0134	2.1051	$134.08	$42.24	$26.82
15341	Apply cult skin sub add-on	CH	T	0134	2.1051	$134.08	$42.24	$26.82
15360	Apply cult derm sub, t/a/l	CH	T	0134	2.1051	$134.08	$42.24	$26.82
15361	Aply cult derm sub t/a/l add	CH	T	0134	2.1051	$134.08	$42.24	$26.82
15365	Apply cult derm sub f/n/hf/g	CH	T	0134	2.1051	$134.08	$42.24	$26.82
15366	Apply cult derm f/hf/g add	CH	T	0134	2.1051	$134.08	$42.24	$26.82
15400	Apply skin xenograft, t/a/l	CH	T	0135	4.5263	$288.30		$57.66
15401	Apply skn xenogrft t/a/l add	CH	T	0135	4.5263	$288.30		$57.66
15420	Apply skin xgraft, f/n/hf/g	CH	T	0135	4.5263	$288.30		$57.66
15421	Apply skn xgrft f/n/hf/g add	CH	T	0135	4.5263	$288.30		$57.66

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
15430	Apply acellular xenograft	CH	T	0135	4.5263	$288.30		$57.66
15431	Apply acellular xgraft add	CH	T	0135	4.5263	$288.30		$57.66
15570	Form skin pedicle flap	CH	T	0137	20.2069	$1,287.06		$257.41
15572	Form skin pedicle flap	CH	T	0137	20.2069	$1,287.06		$257.41
15574	Form skin pedicle flap	CH	T	0137	20.2069	$1,287.06		$257.41
15576	Form skin pedicle flap	CH	T	0137	20.2069	$1,287.06		$257.41
15600	Skin graft	CH	T	0137	20.2069	$1,287.06		$257.41
15610	Skin graft	CH	T	0137	20.2069	$1,287.06		$257.41
15620	Skin graft	CH	T	0137	20.2069	$1,287.06		$257.41
15630	Skin graft	CH	T	0137	20.2069	$1,287.06		$257.41
15650	Transfer skin pedicle flap	CH	T	0137	20.2069	$1,287.06		$257.41
15731	Forehead flap w/vasc pedicle	CH	T	0137	20.2069	$1,287.06		$257.41
15732	Muscle-skin graft, head/neck	CH	T	0137	20.2069	$1,287.06		$257.41
15734	Muscle-skin graft, trunk	CH	T	0137	20.2069	$1,287.06		$257.41
15736	Muscle-skin graft, arm	CH	T	0137	20.2069	$1,287.06		$257.41
15738	Muscle-skin graft, leg	CH	T	0137	20.2069	$1,287.06		$257.41
15740	Island pedicle flap graft	CH	T	0136	15.0458	$958.33		$191.67
15750	Neurovascular pedicle graft	CH	T	0137	20.2069	$1,287.06		$257.41
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	20.2069	$1,287.06		$257.41
15770	Derma-fat-fascia graft	CH	T	0137	20.2069	$1,287.06		$257.41
15775	Hair transplant punch grafts	CH	T	0133	1.2792	$81.48	$25.67	$16.30
15776	Hair transplant punch grafts	CH	T	0133	1.2792	$81.48	$25.67	$16.30
15780	Abrasion treatment of skin		T	0022	21.1098	$1,344.57	$354.45	$268.91
15781	Abrasion treatment of skin		T	0019	4.3039	$274.13	$71.87	$54.83
15782	Abrasion treatment of skin		T	0019	4.3039	$274.13	$71.87	$54.83
15783	Abrasion treatment of skin		T	0016	2.6604	$169.45		$33.89
15786	Abrasion, lesion, single		T	0013	0.7930	$50.51		$10.10
15787	Abrasion, lesions, add-on		T	0013	0.7930	$50.51		$10.10
15788	Chemical peel, face, epiderm	CH	T	0013	0.7930	$50.51		$10.10
15789	Chemical peel, face, dermal		T	0015	1.4595	$92.96		$18.59
15792	Chemical peel, nonfacial	CH	T	0015	1.4595	$92.96		$18.59
15793	Chemical peel, nonfacial	CH	T	0013	0.7930	$50.51		$10.10
15819	Plastic surgery, neck	CH	T	0134	2.1051	$134.08	$42.24	$26.82
15820	Revision of lower eyelid	CH	T	0137	20.2069	$1,287.06		$257.41
15821	Revision of lower eyelid	CH	T	0137	20.2069	$1,287.06		$257.41
15822	Revision of upper eyelid	CH	T	0137	20.2069	$1,287.06		$257.41
15823	Revision of upper eyelid	CH	T	0137	20.2069	$1,287.06		$257.41
15824	Removal of forehead wrinkles	CH	T	0137	20.2069	$1,287.06		$257.41
15825	Removal of neck wrinkles	CH	T	0137	20.2069	$1,287.06		$257.41
15826	Removal of brow wrinkles	CH	T	0137	20.2069	$1,287.06		$257.41
15828	Removal of face wrinkles	CH	T	0137	20.2069	$1,287.06		$257.41
15829	Removal of skin wrinkles	CH	T	0137	20.2069	$1,287.06		$257.41
15830	Exc skin abd		T	0022	21.1098	$1,344.57	$354.45	$268.91
15832	Excise excessive skin tissue		T	0022	21.1098	$1,344.57	$354.45	$268.91
15833	Excise excessive skin tissue		T	0022	21.1098	$1,344.57	$354.45	$268.91
15834	Excise excessive skin tissue		T	0022	21.1098	$1,344.57	$354.45	$268.91
15835	Excise excessive skin tissue	CH	T	0022	21.1098	$1,344.57	$354.45	$268.91
15836	Excise excessive skin tissue		T	0021	16.1001	$1,025.48	$219.48	$205.10
15837	Excise excessive skin tissue		T	0021	16.1001	$1,025.48	$219.48	$205.10
15838	Excise excessive skin tissue		T	0021	16.1001	$1,025.48	$219.48	$205.10
15839	Excise excessive skin tissue		T	0021	16.1001	$1,025.48	$219.48	$205.10
15840	Graft for face nerve palsy	CH	T	0137	20.2069	$1,287.06		$257.41
15841	Graft for face nerve palsy	CH	T	0137	20.2069	$1,287.06		$257.41
15842	Flap for face nerve palsy	CH	T	0137	20.2069	$1,287.06		$257.41
15845	Skin and muscle repair, face	CH	T	0137	20.2069	$1,287.06		$257.41
15847	Exc skin abd add-on		T	0022	21.1098	$1,344.57	$354.45	$268.91
15850	Removal of sutures		T	0016	2.6604	$169.45		$33.89
15851	Removal of sutures		T	0016	2.6604	$169.45		$33.89
15852	Dressing change not for burn		X	0340	0.6310	$40.19		$8.04
15860	Test for blood flow in graft		X	0340	0.6310	$40.19		$8.04
15876	Suction assisted lipectomy	CH	T	0137	20.2069	$1,287.06		$257.41
15877	Suction assisted lipectomy	CH	T	0137	20.2069	$1,287.06		$257.41
15878	Suction assisted lipectomy	CH	T	0137	20.2069	$1,287.06		$257.41
15879	Suction assisted lipectomy	CH	T	0137	20.2069	$1,287.06		$257.41
15920	Removal of tail bone ulcer		T	0019	4.3039	$274.13	$71.87	$54.83
15922	Removal of tail bone ulcer	CH	T	0137	20.2069	$1,287.06		$257.41
15931	Remove sacrum pressure sore		T	0022	21.1098	$1,344.57	$354.45	$268.91
15933	Remove sacrum pressure sore		T	0022	21.1098	$1,344.57	$354.45	$268.91
15934	Remove sacrum pressure sore	CH	T	0137	20.2069	$1,287.06		$257.41
15935	Remove sacrum pressure sore	CH	T	0137	20.2069	$1,287.06		$257.41
15936	Remove sacrum pressure sore	CH	T	0136	15.0458	$958.33		$191.67
15937	Remove sacrum pressure sore	CH	T	0137	20.2069	$1,287.06		$257.41
15940	Remove hip pressure sore		T	0022	21.1098	$1,344.57	$354.45	$268.91
15941	Remove hip pressure sore		T	0022	21.1098	$1,344.57	$354.45	$268.91
15944	Remove hip pressure sore	CH	T	0137	20.2069	$1,287.06		$257.41
15945	Remove hip pressure sore	CH	T	0137	20.2069	$1,287.06		$257.41
15946	Remove hip pressure sore	CH	T	0137	20.2069	$1,287.06		$257.41

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
15950	Remove thigh pressure sore		T	0022	21.1098	$1,344.57	$354.45	$268.91
15951	Remove thigh pressure sore		T	0022	21.1098	$1,344.57	$354.45	$268.91
15952	Remove thigh pressure sore	CH	T	0136	15.0458	$958.33		$191.67
15953	Remove thigh pressure sore	CH	T	0136	15.0458	$958.33		$191.67
15956	Remove thigh pressure sore	CH	T	0136	15.0458	$958.33		$191.67
15958	Remove thigh pressure sore	CH	T	0136	15.0458	$958.33		$191.67
15999	Removal of pressure sore		T	0019	4.3039	$274.13	$71.87	$54.83
16000	Initial treatment of burn(s)	CH	T	0013	0.7930	$50.51		$10.10
16020	Dress/debrid p-thick burn, s	CH	T	0015	1.4595	$92.96		$18.59
16025	Dress/debrid p-thick burn, m	CH	T	0016	2.6604	$169.45		$33.89
16030	Dress/debrid p-thick burn, l	CH	T	0016	2.6604	$169.45		$33.89
16035	Incision of burn scab, initi		T	0016	2.6604	$169.45		$33.89
16036	Escharotomy; add'l incision		C					
17000	Destruct premalg lesion	CH	T	0013	0.7930	$50.51		$10.10
17003	Destruct premalg les, 2–14	CH	T	0012	0.2963	$18.87		$3.77
17004	Destroy premlg lesions 15+	CH	T	0016	2.6604	$169.45		$33.89
17106	Destruction of skin lesions	CH	T	0016	2.6604	$169.45		$33.89
17107	Destruction of skin lesions	CH	T	0016	2.6604	$169.45		$33.89
17108	Destruction of skin lesions	CH	T	0016	2.6604	$169.45		$33.89
17110	Destruct b9 lesion, 1–14	CH	T	0013	0.7930	$50.51		$10.10
17111	Destruct lesion, 15 or more	CH	T	0015	1.4595	$92.96		$18.59
17250	Chemical cautery, tissue	CH	T	0015	1.4595	$92.96		$18.59
17260	Destruction of skin lesions		T	0015	1.4595	$92.96		$18.59
17261	Destruction of skin lesions		T	0015	1.4595	$92.96		$18.59
17262	Destruction of skin lesions		T	0015	1.4595	$92.96		$18.59
17263	Destruction of skin lesions		T	0015	1.4595	$92.96		$18.59
17264	Destruction of skin lesions		T	0015	1.4595	$92.96		$18.59
17266	Destruction of skin lesions		T	0016	2.6604	$169.45		$33.89
17270	Destruction of skin lesions		T	0015	1.4595	$92.96		$18.59
17271	Destruction of skin lesions	CH	T	0015	1.4595	$92.96		$18.59
17272	Destruction of skin lesions		T	0015	1.4595	$92.96		$18.59
17273	Destruction of skin lesions	CH	T	0016	2.6604	$169.45		$33.89
17274	Destruction of skin lesions		T	0016	2.6604	$169.45		$33.89
17276	Destruction of skin lesions		T	0016	2.6604	$169.45		$33.89
17280	Destruction of skin lesions		T	0015	1.4595	$92.96		$18.59
17281	Destruction of skin lesions	CH	T	0016	2.6604	$169.45		$33.89
17282	Destruction of skin lesions	CH	T	0016	2.6604	$169.45		$33.89
17283	Destruction of skin lesions	CH	T	0016	2.6604	$169.45		$33.89
17284	Destruction of skin lesions		T	0016	2.6604	$169.45		$33.89
17286	Destruction of skin lesions	CH	T	0016	2.6604	$169.45		$33.89
17311	Mohs, 1 stage, h/n/hf/g		T	0694	3.6321	$231.34	$91.69	$46.27
17312	Mohs addl stage		T	0694	3.6321	$231.34	$91.69	$46.27
17313	Mohs, 1 stage, t/a/l		T	0694	3.6321	$231.34	$91.69	$46.27
17314	Mohs, addl stage, t/a/l		T	0694	3.6321	$231.34	$91.69	$46.27
17315	Mohs surg, addl block		T	0694	3.6321	$231.34	$91.69	$46.27
17340	Cryotherapy of skin	CH	T	0013	0.7930	$50.51		$10.10
17360	Skin peel therapy		T	0013	0.7930	$50.51		$10.10
17380	Hair removal by electrolysis		T	0013	0.7930	$50.51		$10.10
17999	Skin tissue procedure		T	0012	0.2963	$18.87		$3.77
19000	Drainage of breast lesion		T	0004	4.3270	$275.60		$55.12
19001	Drain breast lesion add-on		T	0002	1.1097	$70.68		$14.14
19020	Incision of breast lesion		T	0008	18.3197	$1,166.85		$233.37
19030	Injection for breast x-ray		N					
19100	Bx breast percut w/o image	CH	T	0004	4.3270	$275.60		$55.12
19101	Biopsy of breast, open		T	0028	20.6417	$1,314.75	$303.74	$262.95
19102	Bx breast percut w/image		T	0005	7.1147	$453.16		$90.63
19103	Bx breast percut w/device	CH	T	0037	13.5764	$864.74	$228.76	$172.95
19105	Cryosurg ablate fa, each		T	0029	31.7134	$2,019.95	$581.52	$403.99
19110	Nipple exploration		T	0028	20.6417	$1,314.75	$303.74	$262.95
19112	Excise breast duct fistula		T	0028	20.6417	$1,314.75	$303.74	$262.95
19120	Removal of breast lesion		T	0028	20.6417	$1,314.75	$303.74	$262.95
19125	Excision, breast lesion		T	0028	20.6417	$1,314.75	$303.74	$262.95
19126	Excision, addl breast lesion		T	0028	20.6417	$1,314.75	$303.74	$262.95
19260	Removal of chest wall lesion		T	0021	16.1001	$1,025.48	$219.48	$205.10
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	56.5774	$3,603.64		$720.73
19297	Place breast cath for rad		T	0648	56.5774	$3,603.64		$720.73
19298	Place breast rad tube/caths	CH	T	0648	56.5774	$3,603.64		$720.73
19300	Removal of breast tissue		T	0028	20.6417	$1,314.75	$303.74	$262.95
19301	Partical mastectomy		T	0028	20.6417	$1,314.75	$303.74	$262.95
19302	P-mastectomy w/ln removal	CH	T	0030	39.8191	$2,536.24	$747.07	$507.25
19303	Mast, simple, complete		T	0029	31.7134	$2,019.95	$581.52	$403.99
19304	Mast, subq		T	0029	31.7134	$2,019.95	$581.52	$403.99
19305	Mast, radical		C					
19306	Mast, rad, urban type		C					
19307	Mast, mod rad		T	0030	39.8191	$2,536.24	$747.07	$507.25

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
19316	Suspension of breast		T	0029	31.7134	$2,019.95	$581.52	$403.99
19318	Reduction of large breast	CH	T	0030	39.8191	$2,536.24	$747.07	$507.25
19324	Enlarge breast	CH	T	0030	39.8191	$2,536.24	$747.07	$507.25
19325	Enlarge breast with implant		T	0648	56.5774	$3,603.64		$720.73
19328	Removal of breast implant		T	0029	31.7134	$2,019.95	$581.52	$403.99
19330	Removal of implant material		T	0029	31.7134	$2,019.95	$581.52	$403.99
19340	Immediate breast prosthesis		T	0030	39.8191	$2,536.24	$747.07	$507.25
19342	Delayed breast prosthesis		T	0648	56.5774	$3,603.64		$720.73
19350	Breast reconstruction		T	0028	20.6417	$1,314.75	$303.74	$262.95
19355	Correct inverted nipple(s)		T	0029	31.7134	$2,019.95	$581.52	$403.99
19357	Breast reconstruction		T	0648	56.5774	$3,603.64		$720.73
19361	Breast reconstr w/lat flap		C					
19364	Breast reconstruction		C					
19366	Breast reconstruction		T	0029	31.7134	$2,019.95	$581.52	$403.99
19367	Breast reconstruction		C					
19368	Breast reconstruction		C					
19369	Breast reconstruction		C					
19370	Surgery of breast capsule		T	0029	31.7134	$2,019.95	$581.52	$403.99
19371	Removal of breast capsule		T	0029	31.7134	$2,019.95	$581.52	$403.99
19380	Revise breast reconstruction		T	0030	39.8191	$2,536.24	$747.07	$507.25
19396	Design custom breast implant		T	0029	31.7134	$2,019.95	$581.52	$403.99
19499	Breast surgery procedure		T	0028	20.6417	$1,314.75	$303.74	$262.95
20000	Incision of abscess		T	0006	1.4066	$89.59		$17.92
20005	Incision of deep abscess		T	0049	21.2689	$1,354.70		$270.94
2000F	Blood pressure measure		M					
2001F	Weight recorded		M					
2002F	Clin sign vol ovrld assess		M					
2004F	Initial exam involved joints		M					
20100	Explore wound, neck		T	0023	9.6341	$613.63		$122.73
20101	Explore wound, chest	CH	T	0137	20.2069	$1,287.06		$257.41
20102	Explore wound, abdomen	CH	T	0137	20.2069	$1,287.06		$257.41
20103	Explore wound, extremity		T	0023	9.6341	$613.63		$122.73
2010F	Vital signs recorded		M					
2014F	Mental status assess		M					
20150	Excise epiphyseal bar		T	0051	42.9850	$2,737.89		$547.58
2018F	Hydration status assess		M					
2019F	Dilated macul exam done		M					
20200	Muscle biopsy		T	0021	16.1001	$1,025.48	$219.48	$205.10
20205	Deep muscle biopsy		T	0021	16.1001	$1,025.48	$219.48	$205.10
20206	Needle biopsy, muscle		T	0005	7.1147	$453.16		$90.63
2020F	Dilated fundus eval done		M					
2021F	Dilat macul+ exam done		M					
20220	Bone biopsy, trocar/needle	CH	T	0020	8.6850	$553.18		$110.64
20225	Bone biopsy, trocar/needle		T	0020	8.6850	$553.18		$110.64
2022F	Dil retina exam interp rev		M					
20240	Bone biopsy, excisional		T	0022	21.1098	$1,344.57	$354.45	$268.91
20245	Bone biopsy, excisional		T	0022	21.1098	$1,344.57	$354.45	$268.91
2024F	7 field photo interp doc rev		M					
20250	Open bone biopsy		T	0049	21.2689	$1,354.70		$270.94
20251	Open bone biopsy		T	0049	21.2689	$1,354.70		$270.94
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					
2035F	Tymp memb motion exam'd		M					
20500	Injection of sinus tract		T	0251	2.5002	$159.25		$31.85
20501	Inject sinus tract for x-ray		N					
20520	Removal of foreign body		T	0019	4.3039	$274.13	$71.87	$54.83
20525	Removal of foreign body		T	0022	21.1098	$1,344.57	$354.45	$268.91
20526	Ther injection, carp tunnel		T	0204	2.3213	$147.85	$40.13	$29.57
20550	Inj tendon sheath/ligament		T	0204	2.3213	$147.85	$40.13	$29.57
20551	Inj tendon origin/insertion		T	0204	2.3213	$147.85	$40.13	$29.57
20552	Inj trigger point, 1/2 muscl		T	0204	2.3213	$147.85	$40.13	$29.57
20553	Inject trigger points, =/> 3		T	0204	2.3213	$147.85	$40.13	$29.57
20555	Place ndl musc/tis for rt	NI	T	0050	29.1900	$1,859.23		$371.85
20600	Drain/inject, joint/bursa		T	0204	2.3213	$147.85	$40.13	$29.57
20605	Drain/inject, joint/bursa		T	0204	2.3213	$147.85	$40.13	$29.57
20610	Drain/inject, joint/bursa		T	0204	2.3213	$147.85	$40.13	$29.57
20612	Aspirate/inj ganglion cyst		T	0204	2.3213	$147.85	$40.13	$29.57
20615	Treatment of bone cyst		T	0004	4.3270	$275.60		$55.12
20650	Insert and remove bone pin		T	0049	21.2689	$1,354.70		$270.94
20660	Apply, rem fixation device		C					
20661	Application of head brace		C					
20662	Application of pelvis brace		T	0049	21.2689	$1,354.70		$270.94
20663	Application of thigh brace		T	0049	21.2689	$1,354.70		$270.94
20664	Halo brace application		C					
20665	Removal of fixation device		X	0340	0.6310	$40.19		$8.04
20670	Removal of support implant		T	0021	16.1001	$1,025.48	$219.48	$205.10

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
20680	Removal of support implant		T	0022	21.1098	$1,344.57	$354.45	$268.91
20690	Apply bone fixation device		T	0050	29.1900	$1,859.23		$371.85
20692	Apply bone fixation device		T	0050	29.1900	$1,859.23		$371.85
20693	Adjust bone fixation device		T	0049	21.2689	$1,354.70		$270.94
20694	Remove bone fixation device		T	0049	21.2689	$1,354.70		$270.94
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	26.3105	$1,675.82		$335.16
20824	Replantation thumb, complete		C					
20827	Replantation thumb, complete		C					
20838	Replantation foot, complete		C					
20900	Removal of bone for graft		T	0050	29.1900	$1,859.23		$371.85
20902	Removal of bone for graft		T	0050	29.1900	$1,859.23		$371.85
20910	Remove cartilage for graft	CH	T	0137	20.2069	$1,287.06		$257.41
20912	Remove cartilage for graft	CH	T	0137	20.2069	$1,287.06		$257.41
20920	Removal of fascia for graft	CH	T	0136	15.0458	$958.33		$191.67
20922	Removal of fascia for graft	CH	T	0136	15.0458	$958.33		$191.67
20924	Removal of tendon for graft		T	0050	29.1900	$1,859.23		$371.85
20926	Removal of tissue for graft	CH	T	0135	4.5263	$288.30		$57.66
20930	Sp bone algrft morsel add-on		C					
20931	Sp bone algrft struct add-on		C					
20936	Sp bone agrft local add-on		C					
20937	Sp bone agrft morsel add-on		C					
20938	Sp bone agrft struct add-on		C					
20950	Fluid pressure, muscle		T	0006	1.4066	$89.59		$17.92
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					
20972	Bone/skin graft, metatarsal		T	0056	44.2687	$2,819.65		$563.93
20973	Bone/skin graft, great toe		T	0056	44.2687	$2,819.65		$563.93
20974	Electrical bone stimulation		A					
20975	Electrical bone stimulation	CH	N					
20979	Us bone stimulation		X	0340	0.6310	$40.19		$8.04
20982	Ablate, bone tumor(s) perq		T	0051	42.9850	$2,737.89		$547.58
20985	Cptr-asst dir ms px	NI	N					
20986	Cptr-asst dir ms px io img	NI	N					
20987	Cptr-asst dir ms px pre img	NI	N					
20999	Musculoskeletal surgery		T	0049	21.2689	$1,354.70		$270.94
21010	Incision of jaw joint		T	0254	23.9765	$1,527.16	$321.35	$305.43
21015	Resection of facial tumor		T	0253	16.3288	$1,040.05	$282.29	$208.01
21025	Excision of bone, lower jaw		T	0256	39.8776	$2,539.96		$507.99
21026	Excision of facial bone(s)		T	0256	39.8776	$2,539.96		$507.99
21029	Contour of face bone lesion		T	0256	39.8776	$2,539.96		$507.99
21030	Excise max/zygoma b9 tumor		T	0254	23.9765	$1,527.16	$321.35	$305.43
21031	Remove exostosis, mandible		T	0254	23.9765	$1,527.16	$321.35	$305.43
21032	Remove exostosis, maxilla		T	0254	23.9765	$1,527.16	$321.35	$305.43
21034	Excise max/zygoma mlg tumor		T	0256	39.8776	$2,539.96		$507.99
21040	Excise mandible lesion		T	0254	23.9765	$1,527.16	$321.35	$305.43
21044	Removal of jaw bone lesion		T	0256	39.8776	$2,539.96		$507.99
21045	Extensive jaw surgery		C					
21046	Remove mandible cyst complex		T	0256	39.8776	$2,539.96		$507.99
21047	Excise lwr jaw cyst w/repair		T	0256	39.8776	$2,539.96		$507.99
21048	Remove maxilla cyst complex		T	0256	39.8776	$2,539.96		$507.99
21049	Excis uppr jaw cyst w/repair		T	0256	39.8776	$2,539.96		$507.99
21050	Removal of jaw joint		T	0256	39.8776	$2,539.96		$507.99
21060	Remove jaw joint cartilage		T	0256	39.8776	$2,539.96		$507.99
21070	Remove coronoid process		T	0256	39.8776	$2,539.96		$507.99
21073	Mnpj of tmj w/anesth	NI	T	0252	7.4474	$474.35	$109.16	$94.87
21076	Prepare face/oral prosthesis		T	0254	23.9765	$1,527.16	$321.35	$305.43
21077	Prepare face/oral prosthesis		T	0256	39.8776	$2,539.96		$507.99
21079	Prepare face/oral prosthesis		T	0256	39.8776	$2,539.96		$507.99
21080	Prepare face/oral prosthesis		T	0256	39.8776	$2,539.96		$507.99
21081	Prepare face/oral prosthesis		T	0256	39.8776	$2,539.96		$507.99
21082	Prepare face/oral prosthesis		T	0256	39.8776	$2,539.96		$507.99
21083	Prepare face/oral prosthesis		T	0256	39.8776	$2,539.96		$507.99
21084	Prepare face/oral prosthesis		T	0256	39.8776	$2,539.96		$507.99
21085	Prepare face/oral prosthesis		T	0253	16.3288	$1,040.05	$282.29	$208.01
21086	Prepare face/oral prosthesis		T	0256	39.8776	$2,539.96		$507.99
21087	Prepare face/oral prosthesis		T	0256	39.8776	$2,539.96		$507.99
21088	Prepare face/oral prosthesis		T	0256	39.8776	$2,539.96		$507.99
21089	Prepare face/oral prosthesis		T	0251	2.5002	$159.25		$31.85
21100	Maxillofacial fixation		T	0256	39.8776	$2,539.96		$507.99
21110	Interdental fixation		T	0252	7.4474	$474.35	$109.16	$94.87
21116	Injection, jaw joint x-ray		N					
21120	Reconstruction of chin		T	0254	23.9765	$1,527.16	$321.35	$305.43

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
21121	Reconstruction of chin		T	0254	23.9765	$1,527.16	$321.35	$305.43
21122	Reconstruction of chin		T	0254	23.9765	$1,527.16	$321.35	$305.43
21123	Reconstruction of chin		T	0254	23.9765	$1,527.16	$321.35	$305.43
21125	Augmentation, lower jaw bone		T	0254	23.9765	$1,527.16	$321.35	$305.43
21127	Augmentation, lower jaw bone		T	0256	39.8776	$2,539.96		$507.99
21137	Reduction of forehead		T	0254	23.9765	$1,527.16	$321.35	$305.43
21138	Reduction of forehead		T	0256	39.8776	$2,539.96		$507.99
21139	Reduction of forehead		T	0256	39.8776	$2,539.96		$507.99
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	39.8776	$2,539.96		$507.99
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	39.8776	$2,539.96		$507.99
21179	Reconstruct entire forehead		C					
21180	Reconstruct entire forehead		C					
21181	Contour cranial bone lesion		T	0254	23.9765	$1,527.16	$321.35	$305.43
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	39.8776	$2,539.96		$507.99
21196	Reconst lwr jaw w/fixation		C					
21198	Reconstr lwr jaw segment		T	0256	39.8776	$2,539.96		$507.99
21199	Reconstr lwr jaw w/advance		T	0256	39.8776	$2,539.96		$507.99
21206	Reconstruct upper jaw bone		T	0256	39.8776	$2,539.96		$507.99
21208	Augmentation of facial bones		T	0256	39.8776	$2,539.96		$507.99
21209	Reduction of facial bones		T	0256	39.8776	$2,539.96		$507.99
21210	Face bone graft		T	0256	39.8776	$2,539.96		$507.99
21215	Lower jaw bone graft		T	0256	39.8776	$2,539.96		$507.99
21230	Rib cartilage graft		T	0256	39.8776	$2,539.96		$507.99
21235	Ear cartilage graft		T	0254	23.9765	$1,527.16	$321.35	$305.43
21240	Reconstruction of jaw joint		T	0256	39.8776	$2,539.96		$507.99
21242	Reconstruction of jaw joint		T	0256	39.8776	$2,539.96		$507.99
21243	Reconstruction of jaw joint		T	0256	39.8776	$2,539.96		$507.99
21244	Reconstruction of lower jaw		T	0256	39.8776	$2,539.96		$507.99
21245	Reconstruction of jaw		T	0256	39.8776	$2,539.96		$507.99
21246	Reconstruction of jaw		T	0256	39.8776	$2,539.96		$507.99
21247	Reconstruct lower jaw bone		C					
21248	Reconstruction of jaw		T	0256	39.8776	$2,539.96		$507.99
21249	Reconstruction of jaw		T	0256	39.8776	$2,539.96		$507.99
21255	Reconstruct lower jaw bone		C					
21256	Reconstruction of orbit		C					
21260	Revise eye sockets		T	0256	39.8776	$2,539.96		$507.99
21261	Revise eye sockets		T	0256	39.8776	$2,539.96		$507.99
21263	Revise eye sockets		T	0256	39.8776	$2,539.96		$507.99
21267	Revise eye sockets		T	0256	39.8776	$2,539.96		$507.99
21268	Revise eye sockets		C					
21270	Augmentation, cheek bone		T	0256	39.8776	$2,539.96		$507.99
21275	Revision, orbitofacial bones		T	0256	39.8776	$2,539.96		$507.99
21280	Revision of eyelid		T	0256	39.8776	$2,539.96		$507.99
21282	Revision of eyelid		T	0253	16.3288	$1,040.05	$282.29	$208.01
21295	Revision of jaw muscle/bone		T	0252	7.4474	$474.35	$109.16	$94.87
21296	Revision of jaw muscle/bone		T	0254	23.9765	$1,527.16	$321.35	$305.43
21299	Cranio/maxillofacial surgery		T	0251	2.5002	$159.25		$31.85
21310	Treatment of nose fracture		T	0251	2.5002	$159.25		$31.85
21315	Treatment of nose fracture		T	0251	2.5002	$159.25		$31.85
21320	Treatment of nose fracture	CH	T	0253	16.3288	$1,040.05	$282.29	$208.01
21325	Treatment of nose fracture		T	0254	23.9765	$1,527.16	$321.35	$305.43
21330	Treatment of nose fracture		T	0254	23.9765	$1,527.16	$321.35	$305.43
21335	Treatment of nose fracture		T	0254	23.9765	$1,527.16	$321.35	$305.43
21336	Treat nasal septal fracture	CH	T	0062	26.1592	$1,666.18	$372.87	$333.24
21337	Treat nasal septal fracture		T	0253	16.3288	$1,040.05	$282.29	$208.01
21338	Treat nasoethmoid fracture		T	0254	23.9765	$1,527.16	$321.35	$305.43
21339	Treat nasoethmoid fracture		T	0254	23.9765	$1,527.16	$321.35	$305.43
21340	Treatment of nose fracture		T	0256	39.8776	$2,539.96		$507.99
21343	Treatment of sinus fracture		C					
21344	Treatment of sinus fracture		C					
21345	Treat nose/jaw fracture		T	0254	23.9765	$1,527.16	$321.35	$305.43
21346	Treat nose/jaw fracture		C					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
21347	Treat nose/jaw fracture		C					
21348	Treat nose/jaw fracture		C					
21355	Treat cheek bone fracture		T	0256	39.8776	$2,539.96		$507.99
21356	Treat cheek bone fracture		T	0254	23.9765	$1,527.16	$321.35	$305.43
21360	Treat cheek bone fracture	CH	T	0254	23.9765	$1,527.16	$321.35	$305.43
21365	Treat cheek bone fracture	CH	T	0256	39.8776	$2,539.96		$507.99
21366	Treat cheek bone fracture		C					
21385	Treat eye socket fracture	CH	T	0256	39.8776	$2,539.96		$507.99
21386	Treat eye socket fracture		C					
21387	Treat eye socket fracture		C					
21390	Treat eye socket fracture		T	0256	39.8776	$2,539.96		$507.99
21395	Treat eye socket fracture		C					
21400	Treat eye socket fracture		T	0252	7.4474	$474.35	$109.16	$94.87
21401	Treat eye socket fracture		T	0253	16.3288	$1,040.05	$282.29	$208.01
21406	Treat eye socket fracture		T	0256	39.8776	$2,539.96		$507.99
21407	Treat eye socket fracture		T	0256	39.8776	$2,539.96		$507.99
21408	Treat eye socket fracture		T	0256	39.8776	$2,539.96		$507.99
21421	Treat mouth roof fracture		T	0254	23.9765	$1,527.16	$321.35	$305.43
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	23.9765	$1,527.16	$321.35	$305.43
21445	Treat dental ridge fracture		T	0254	23.9765	$1,527.16	$321.35	$305.43
21450	Treat lower jaw fracture		T	0251	2.5002	$159.25		$31.85
21451	Treat lower jaw fracture		T	0252	7.4474	$474.35	$109.16	$94.87
21452	Treat lower jaw fracture		T	0253	16.3288	$1,040.05	$282.29	$208.01
21453	Treat lower jaw fracture		T	0256	39.8776	$2,539.96		$507.99
21454	Treat lower jaw fracture		T	0254	23.9765	$1,527.16	$321.35	$305.43
21461	Treat lower jaw fracture		T	0256	39.8776	$2,539.96		$507.99
21462	Treat lower jaw fracture		T	0256	39.8776	$2,539.96		$507.99
21465	Treat lower jaw fracture		T	0256	39.8776	$2,539.96		$507.99
21470	Treat lower jaw fracture		T	0256	39.8776	$2,539.96		$507.99
21480	Reset dislocated jaw		T	0251	2.5002	$159.25		$31.85
21485	Reset dislocated jaw		T	0253	16.3288	$1,040.05	$282.29	$208.01
21490	Repair dislocated jaw		T	0256	39.8776	$2,539.96		$507.99
21495	Treat hyoid bone fracture		T	0253	16.3288	$1,040.05	$282.29	$208.01
21497	Interdental wiring		T	0253	16.3288	$1,040.05	$282.29	$208.01
21499	Head surgery procedure		T	0251	2.5002	$159.25		$31.85
21501	Drain neck/chest lesion		T	0008	18.3197	$1,166.85		$233.37
21502	Drain chest lesion		T	0049	21.2689	$1,354.70		$270.94
21510	Drainage of bone lesion		C					
21550	Biopsy of neck/chest		T	0020	8.6850	$553.18		$110.64
21555	Remove lesion, neck/chest		T	0022	21.1098	$1,344.57	$354.45	$268.91
21556	Remove lesion, neck/chest		T	0022	21.1098	$1,344.57	$354.45	$268.91
21557	Remove tumor, neck/chest		T	0022	21.1098	$1,344.57	$354.45	$268.91
21600	Partial removal of rib		T	0050	29.1900	$1,859.23		$371.85
21610	Partial removal of rib		T	0050	29.1900	$1,859.23		$371.85
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	7.4474	$474.35	$109.16	$94.87
21700	Revision of neck muscle		T	0049	21.2689	$1,354.70		$270.94
21705	Revision of neck muscle/rib		C					
21720	Revision of neck muscle		T	0049	21.2689	$1,354.70		$270.94
21725	Revision of neck muscle		T	0006	1.4066	$89.59		$17.92
21740	Reconstruction of sternum		C					
21742	Repair stern/nuss w/o scope		T	0051	42.9850	$2,737.89		$547.58
21743	Repair sternum/nuss w/scope		T	0051	42.9850	$2,737.89		$547.58
21750	Repair of sternum separation		C					
21800	Treatment of rib fracture		T	0043	1.7682	$112.62		$22.52
21805	Treatment of rib fracture		T	0062	26.1592	$1,666.18	$372.87	$333.24
21810	Treatment of rib fracture(s)		C					
21820	Treat sternum fracture		T	0043	1.7682	$112.62		$22.52
21825	Treat sternum fracture		C					
21899	Neck/chest surgery procedure		T	0251	2.5002	$159.25		$31.85
21920	Biopsy soft tissue of back		T	0020	8.6850	$553.18		$110.64
21925	Biopsy soft tissue of back		T	0022	21.1098	$1,344.57	$354.45	$268.91
21930	Remove lesion, back or flank		T	0022	21.1098	$1,344.57	$354.45	$268.91
21935	Remove tumor, back		T	0022	21.1098	$1,344.57	$354.45	$268.91
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	46.7724	$2,979.12		$595.82
22101	Remove part, thorax vertebra		T	0208	46.7724	$2,979.12		$595.82

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
22102	Remove part, lumbar vertebra		T	0208	46.7724	$2,979.12		$595.82
22103	Remove extra spine segment		T	0208	46.7724	$2,979.12		$595.82
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					
22206	Cut spine 3 col, thor	NI	C					
22207	Cut spine 3 col, lumb	NI	C					
22208	Cut spine 3 col, addl seg	NI	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	46.7724	$2,979.12		$595.82
22224	Revision of lumbar spine		C					
22226	Revise, extra spine segment		C					
22305	Treat spine process fracture		T	0043	1.7682	$112.62		$22.52
22310	Treat spine fracture		T	0043	1.7682	$112.62		$22.52
22315	Treat spine fracture		T	0043	1.7682	$112.62		$22.52
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	14.7658	$940.49	$268.47	$188.10
22520	Percut vertebroplasty thor		T	0050	29.1900	$1,859.23		$371.85
22521	Percut vertebroplasty lumb		T	0050	29.1900	$1,859.23		$371.85
22522	Percut vertebroplasty add'l		T	0050	29.1900	$1,859.23		$371.85
22523	Percut kyphoplasty, thor		T	0052	79.4244	$5,058.86		$1,011.77
22524	Percut kyphoplasty, lumbar		T	0052	79.4244	$5,058.86		$1,011.77
22525	Percut kyphoplasty, add-on		T	0052	79.4244	$5,058.86		$1,011.77
22526	Idet, single level		T	0050	29.1900	$1,859.23		$371.85
22527	Idet, 1 or more levels		T	0050	29.1900	$1,859.23		$371.85
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	46.7724	$2,979.12		$595.82
22614	Spine fusion, extra segment		T	0208	46.7724	$2,979.12		$595.82
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	21.2689	$1,354.70		$270.94
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	21.2689	$1,354.70		$270.94
22900	Remove abdominal wall lesion		T	0022	21.1098	$1,344.57	$354.45	$268.91
22999	Abdomen surgery procedure		T	0049	21.2689	$1,354.70		$270.94

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
23000	Removal of calcium deposits		T	0021	16.1001	$1,025.48	$219.48	$205.10
23020	Release shoulder joint		T	0051	42.9850	$2,737.89		$547.58
23030	Drain shoulder lesion		T	0008	18.3197	$1,166.85		$233.37
23031	Drain shoulder bursa		T	0008	18.3197	$1,166.85		$233.37
23035	Drain shoulder bone lesion		T	0049	21.2689	$1,354.70		$270.94
23040	Exploratory shoulder surgery		T	0050	29.1900	$1,859.23		$371.85
23044	Exploratory shoulder surgery		T	0050	29.1900	$1,859.23		$371.85
23065	Biopsy shoulder tissues		T	0020	8.6850	$553.18		$110.64
23066	Biopsy shoulder tissues		T	0022	21.1098	$1,344.57	$354.45	$268.91
23075	Removal of shoulder lesion		T	0021	16.1001	$1,025.48	$219.48	$205.10
23076	Removal of shoulder lesion		T	0022	21.1098	$1,344.57	$354.45	$268.91
23077	Remove tumor of shoulder		T	0022	21.1098	$1,344.57	$354.45	$268.91
23100	Biopsy of shoulder joint		T	0049	21.2689	$1,354.70		$270.94
23101	Shoulder joint surgery		T	0050	29.1900	$1,859.23		$371.85
23105	Remove shoulder joint lining		T	0050	29.1900	$1,859.23		$371.85
23106	Incision of collarbone joint		T	0050	29.1900	$1,859.23		$371.85
23107	Explore treat shoulder joint		T	0050	29.1900	$1,859.23		$371.85
23120	Partial removal, collar bone	CH	T	0050	29.1900	$1,859.23		$371.85
23125	Removal of collar bone	CH	T	0050	29.1900	$1,859.23		$371.85
23130	Remove shoulder bone, part		T	0051	42.9850	$2,737.89		$547.58
23140	Removal of bone lesion		T	0049	21.2689	$1,354.70		$270.94
23145	Removal of bone lesion		T	0050	29.1900	$1,859.23		$371.85
23146	Removal of bone lesion		T	0050	29.1900	$1,859.23		$371.85
23150	Removal of humerus lesion		T	0050	29.1900	$1,859.23		$371.85
23155	Removal of humerus lesion		T	0050	29.1900	$1,859.23		$371.85
23156	Removal of humerus lesion		T	0050	29.1900	$1,859.23		$371.85
23170	Remove collar bone lesion		T	0050	29.1900	$1,859.23		$371.85
23172	Remove shoulder blade lesion		T	0050	29.1900	$1,859.23		$371.85
23174	Remove humerus lesion		T	0050	29.1900	$1,859.23		$371.85
23180	Remove collar bone lesion		T	0050	29.1900	$1,859.23		$371.85
23182	Remove shoulder blade lesion		T	0050	29.1900	$1,859.23		$371.85
23184	Remove humerus lesion		T	0050	29.1900	$1,859.23		$371.85
23190	Partial removal of scapula		T	0050	29.1900	$1,859.23		$371.85
23195	Removal of head of humerus		T	0050	29.1900	$1,859.23		$371.85
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	8.6850	$553.18		$110.64
23331	Remove shoulder foreign body		T	0022	21.1098	$1,344.57	$354.45	$268.91
23332	Remove shoulder foreign body		C					
23350	Injection for shoulder x-ray		N					
23395	Muscle transfer,shoulder/arm		T	0051	42.9850	$2,737.89		$547.58
23397	Muscle transfers		T	0052	79.4244	$5,058.86		$1,011.77
23400	Fixation of shoulder blade		T	0050	29.1900	$1,859.23		$371.85
23405	Incision of tendon & muscle		T	0050	29.1900	$1,859.23		$371.85
23406	Incise tendon(s) & muscle(s)		T	0050	29.1900	$1,859.23		$371.85
23410	Repair rotator cuff, acute		T	0051	42.9850	$2,737.89		$547.58
23412	Repair rotator cuff, chronic		T	0051	42.9850	$2,737.89		$547.58
23415	Release of shoulder ligament		T	0051	42.9850	$2,737.89		$547.58
23420	Repair of shoulder		T	0051	42.9850	$2,737.89		$547.58
23430	Repair biceps tendon		T	0051	42.9850	$2,737.89		$547.58
23440	Remove/transplant tendon		T	0051	42.9850	$2,737.89		$547.58
23450	Repair shoulder capsule		T	0052	79.4244	$5,058.86		$1,011.77
23455	Repair shoulder capsule		T	0052	79.4244	$5,058.86		$1,011.77
23460	Repair shoulder capsule		T	0052	79.4244	$5,058.86		$1,011.77
23462	Repair shoulder capsule		T	0051	42.9850	$2,737.89		$547.58
23465	Repair shoulder capsule		T	0052	79.4244	$5,058.86		$1,011.77
23466	Repair shoulder capsule		T	0051	42.9850	$2,737.89		$547.58
23470	Reconstruct shoulder joint		T	0425	122.2057	$7,783.77		$1,556.75
23472	Reconstruct shoulder joint		C					
23480	Revision of collar bone		T	0051	42.9850	$2,737.89		$547.58
23485	Revision of collar bone		T	0052	79.4244	$5,058.86		$1,011.77
23490	Reinforce clavicle		T	0051	42.9850	$2,737.89		$547.58
23491	Reinforce shoulder bones		T	0052	79.4244	$5,058.86		$1,011.77
23500	Treat clavicle fracture		T	0043	1.7682	$112.62		$22.52
23505	Treat clavicle fracture		T	0043	1.7682	$112.62		$22.52
23515	Treat clavicle fracture		T	0064	59.2233	$3,772.17	$835.79	$754.43
23520	Treat clavicle dislocation		T	0043	1.7682	$112.62		$22.52
23525	Treat clavicle dislocation		T	0043	1.7682	$112.62		$22.52
23530	Treat clavicle dislocation		T	0063	41.1091	$2,618.40	$548.33	$523.68
23532	Treat clavicle dislocation		T	0062	26.1592	$1,666.18	$372.87	$333.24
23540	Treat clavicle dislocation		T	0043	1.7682	$112.62		$22.52
23545	Treat clavicle dislocation		T	0043	1.7682	$112.62		$22.52
23550	Treat clavicle dislocation		T	0063	41.1091	$2,618.40	$548.33	$523.68
23552	Treat clavicle dislocation		T	0063	41.1091	$2,618.40	$548.33	$523.68
23570	Treat shoulder blade fx		T	0043	1.7682	$112.62		$22.52
23575	Treat shoulder blade fx		T	0043	1.7682	$112.62		$22.52
23585	Treat scapula fracture		T	0064	59.2233	$3,772.17	$835.79	$754.43

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
23600	Treat humerus fracture		T	0043	1.7682	$112.62		$22.52
23605	Treat humerus fracture		T	0043	1.7682	$112.62		$22.52
23615	Treat humerus fracture		T	0064	59.2233	$3,772.17	$835.79	$754.43
23616	Treat humerus fracture		T	0064	59.2233	$3,772.17	$835.79	$754.43
23620	Treat humerus fracture		T	0043	1.7682	$112.62		$22.52
23625	Treat humerus fracture		T	0043	1.7682	$112.62		$22.52
23630	Treat humerus fracture		T	0064	59.2233	$3,772.17	$835.79	$754.43
23650	Treat shoulder dislocation		T	0043	1.7682	$112.62		$22.52
23655	Treat shoulder dislocation		T	0045	14.7658	$940.49	$268.47	$188.10
23660	Treat shoulder dislocation		T	0063	41.1091	$2,618.40	$548.33	$523.68
23665	Treat dislocation/fracture		T	0043	1.7682	$112.62		$22.52
23670	Treat dislocation/fracture		T	0064	59.2233	$3,772.17	$835.79	$754.43
23675	Treat dislocation/fracture		T	0043	1.7682	$112.62		$22.52
23680	Treat dislocation/fracture		T	0063	41.1091	$2,618.40	$548.33	$523.68
23700	Fixation of shoulder		T	0045	14.7658	$940.49	$268.47	$188.10
23800	Fusion of shoulder joint		T	0052	79.4244	$5,058.86		$1,011.77
23802	Fusion of shoulder joint		T	0051	42.9850	$2,737.89		$547.58
23900	Amputation of arm & girdle		C					
23920	Amputation at shoulder joint		C					
23921	Amputation follow-up surgery	CH	T	0136	15.0458	$958.33		$191.67
23929	Shoulder surgery procedure		T	0043	1.7682	$112.62		$22.52
23930	Drainage of arm lesion		T	0008	18.3197	$1,166.85		$233.37
23931	Drainage of arm bursa		T	0008	18.3197	$1,166.85		$233.37
23935	Drain arm/elbow bone lesion		T	0049	21.2689	$1,354.70		$270.94
24000	Exploratory elbow surgery		T	0050	29.1900	$1,859.23		$371.85
24006	Release elbow joint		T	0050	29.1900	$1,859.23		$371.85
24065	Biopsy arm/elbow soft tissue		T	0021	16.1001	$1,025.48	$219.48	$205.10
24066	Biopsy arm/elbow soft tissue		T	0021	16.1001	$1,025.48	$219.48	$205.10
24075	Remove arm/elbow lesion		T	0021	16.1001	$1,025.48	$219.48	$205.10
24076	Remove arm/elbow lesion		T	0022	21.1098	$1,344.57	$354.45	$268.91
24077	Remove tumor of arm/elbow		T	0022	21.1098	$1,344.57	$354.45	$268.91
24100	Biopsy elbow joint lining		T	0049	21.2689	$1,354.70		$270.94
24101	Explore/treat elbow joint		T	0050	29.1900	$1,859.23		$371.85
24102	Remove elbow joint lining		T	0050	29.1900	$1,859.23		$371.85
24105	Removal of elbow bursa		T	0049	21.2689	$1,354.70		$270.94
24110	Remove humerus lesion		T	0049	21.2689	$1,354.70		$270.94
24115	Remove/graft bone lesion		T	0050	29.1900	$1,859.23		$371.85
24116	Remove/graft bone lesion		T	0050	29.1900	$1,859.23		$371.85
24120	Remove elbow lesion		T	0049	21.2689	$1,354.70		$270.94
24125	Remove/graft bone lesion		T	0050	29.1900	$1,859.23		$371.85
24126	Remove/graft bone lesion		T	0050	29.1900	$1,859.23		$371.85
24130	Removal of head of radius		T	0050	29.1900	$1,859.23		$371.85
24134	Removal of arm bone lesion		T	0050	29.1900	$1,859.23		$371.85
24136	Remove radius bone lesion		T	0050	29.1900	$1,859.23		$371.85
24138	Remove elbow bone lesion		T	0050	29.1900	$1,859.23		$371.85
24140	Partial removal of arm bone		T	0050	29.1900	$1,859.23		$371.85
24145	Partial removal of radius		T	0050	29.1900	$1,859.23		$371.85
24147	Partial removal of elbow		T	0050	29.1900	$1,859.23		$371.85
24149	Radical resection of elbow		T	0050	29.1900	$1,859.23		$371.85
24150	Extensive humerus surgery		T	0051	42.9850	$2,737.89		$547.58
24151	Extensive humerus surgery		T	0052	79.4244	$5,058.86		$1,011.77
24152	Extensive radius surgery		T	0051	42.9850	$2,737.89		$547.58
24153	Extensive radius surgery		T	0052	79.4244	$5,058.86		$1,011.77
24155	Removal of elbow joint		T	0051	42.9850	$2,737.89		$547.58
24160	Remove elbow joint implant		T	0050	29.1900	$1,859.23		$371.85
24164	Remove radius head implant		T	0050	29.1900	$1,859.23		$371.85
24200	Removal of arm foreign body		T	0019	4.3039	$274.13	$71.87	$54.83
24201	Removal of arm foreign body		T	0021	16.1001	$1,025.48	$219.48	$205.10
24220	Injection for elbow x-ray		N					
24300	Manipulate elbow w/anesth		T	0045	14.7658	$940.49	$268.47	$188.10
24301	Muscle/tendon transfer		T	0050	29.1900	$1,859.23		$371.85
24305	Arm tendon lengthening		T	0050	29.1900	$1,859.23		$371.85
24310	Revision of arm tendon		T	0049	21.2689	$1,354.70		$270.94
24320	Repair of arm tendon		T	0051	42.9850	$2,737.89		$547.58
24330	Revision of arm muscles		T	0052	79.4244	$5,058.86		$1,011.77
24331	Revision of arm muscles		T	0051	42.9850	$2,737.89		$547.58
24332	Tenolysis, triceps		T	0049	21.2689	$1,354.70		$270.94
24340	Repair of biceps tendon		T	0051	42.9850	$2,737.89		$547.58
24341	Repair arm tendon/muscle		T	0051	42.9850	$2,737.89		$547.58
24342	Repair of ruptured tendon		T	0051	42.9850	$2,737.89		$547.58
24343	Repr elbow lat ligmnt w/tiss		T	0050	29.1900	$1,859.23		$371.85
24344	Reconstruct elbow lat ligmnt		T	0052	79.4244	$5,058.86		$1,011.77
24345	Repr elbw med ligmnt w/tissu		T	0050	29.1900	$1,859.23		$371.85
24346	Reconstruct elbow med ligmnt		T	0051	42.9850	$2,737.89		$547.58
24350	Repair of tennis elbow	CH	D					
24351	Repair of tennis elbow	CH	D					
24352	Repair of tennis elbow	CH	D					
24354	Repair of tennis elbow	CH	D					
24356	Revision of tennis elbow	CH	D					
24357	Repair elbow, perc	NI	T	0050	29.1900	$1,859.23		$371.85

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
24358	Repair elbow w/deb, open	NI	T	0050	29.1900	$1,859.23		$371.85
24359	Repair elbow deb/attch open	NI	T	0050	29.1900	$1,859.23		$371.85
24360	Reconstruct elbow joint		T	0047	35.9040	$2,286.87	$537.03	$457.37
24361	Reconstruct elbow joint		T	0425	122.2057	$7,783.77		$1,556.75
24362	Reconstruct elbow joint		T	0048	50.8876	$3,241.23		$648.25
24363	Replace elbow joint		T	0425	122.2057	$7,783.77		$1,556.75
24365	Reconstruct head of radius		T	0047	35.9040	$2,286.87	$537.03	$457.37
24366	Reconstruct head of radius		T	0425	122.2057	$7,783.77		$1,556.75
24400	Revision of humerus		T	0050	29.1900	$1,859.23		$371.85
24410	Revision of humerus		T	0050	29.1900	$1,859.23		$371.85
24420	Revision of humerus		T	0051	42.9850	$2,737.89		$547.58
24430	Repair of humerus		T	0052	79.4244	$5,058.86		$1,011.77
24435	Repair humerus with graft		T	0052	79.4244	$5,058.86		$1,011.77
24470	Revision of elbow joint		T	0051	42.9850	$2,737.89		$547.58
24495	Decompression of forearm		T	0050	29.1900	$1,859.23		$371.85
24498	Reinforce humerus		T	0052	79.4244	$5,058.86		$1,011.77
24500	Treat humerus fracture		T	0043	1.7682	$112.62		$22.52
24505	Treat humerus fracture		T	0043	1.7682	$112.62		$22.52
24515	Treat humerus fracture		T	0064	59.2233	$3,772.17	$835.79	$754.43
24516	Treat humerus fracture		T	0064	59.2233	$3,772.17	$835.79	$754.43
24530	Treat humerus fracture		T	0043	1.7682	$112.62		$22.52
24535	Treat humerus fracture		T	0043	1.7682	$112.62		$22.52
24538	Treat humerus fracture		T	0062	26.1592	$1,666.18	$372.87	$333.24
24545	Treat humerus fracture		T	0064	59.2233	$3,772.17	$835.79	$754.43
24546	Treat humerus fracture		T	0064	59.2233	$3,772.17	$835.79	$754.43
24560	Treat humerus fracture		T	0043	1.7682	$112.62		$22.52
24565	Treat humerus fracture		T	0043	1.7682	$112.62		$22.52
24566	Treat humerus fracture		T	0062	26.1592	$1,666.18	$372.87	$333.24
24575	Treat humerus fracture		T	0064	59.2233	$3,772.17	$835.79	$754.43
24576	Treat humerus fracture		T	0043	1.7682	$112.62		$22.52
24577	Treat humerus fracture		T	0043	1.7682	$112.62		$22.52
24579	Treat humerus fracture		T	0064	59.2233	$3,772.17	$835.79	$754.43
24582	Treat humerus fracture		T	0062	26.1592	$1,666.18	$372.87	$333.24
24586	Treat elbow fracture		T	0064	59.2233	$3,772.17	$835.79	$754.43
24587	Treat elbow fracture		T	0064	59.2233	$3,772.17	$835.79	$754.43
24600	Treat elbow dislocation		T	0043	1.7682	$112.62		$22.52
24605	Treat elbow dislocation		T	0045	14.7658	$940.49	$268.47	$188.10
24615	Treat elbow dislocation		T	0064	59.2233	$3,772.17	$835.79	$754.43
24620	Treat elbow fracture		T	0043	1.7682	$112.62		$22.52
24635	Treat elbow fracture		T	0064	59.2233	$3,772.17	$835.79	$754.43
24640	Treat elbow dislocation		T	0043	1.7682	$112.62		$22.52
24650	Treat radius fracture		T	0043	1.7682	$112.62		$22.52
24655	Treat radius fracture		T	0043	1.7682	$112.62		$22.52
24665	Treat radius fracture		T	0063	41.1091	$2,618.40	$548.33	$523.68
24666	Treat radius fracture		T	0064	59.2233	$3,772.17	$835.79	$754.43
24670	Treat ulnar fracture		T	0043	1.7682	$112.62		$22.52
24675	Treat ulnar fracture		T	0043	1.7682	$112.62		$22.52
24685	Treat ulnar fracture		T	0063	41.1091	$2,618.40	$548.33	$523.68
24800	Fusion of elbow joint		T	0051	42.9850	$2,737.89		$547.58
24802	Fusion/graft of elbow joint		T	0051	42.9850	$2,737.89		$547.58
24900	Amputation of upper arm		C					
24920	Amputation of upper arm		C					
24925	Amputation follow-up surgery		T	0049	21.2689	$1,354.70		$270.94
24930	Amputation follow-up surgery		C					
24931	Amputate upper arm & implant		C					
24935	Revision of amputation		T	0052	79.4244	$5,058.86		$1,011.77
24940	Revision of upper arm		C					
24999	Upper arm/elbow surgery		T	0043	1.7682	$112.62		$22.52
25000	Incision of tendon sheath		T	0049	21.2689	$1,354.70		$270.94
25001	Incise flexor carpi radialis		T	0049	21.2689	$1,354.70		$270.94
25020	Decompress forearm 1 space		T	0049	21.2689	$1,354.70		$270.94
25023	Decompress forearm 1 space		T	0050	29.1900	$1,859.23		$371.85
25024	Decompress forearm 2 spaces		T	0050	29.1900	$1,859.23		$371.85
25025	Decompress forearm 2 spaces		T	0050	29.1900	$1,859.23		$371.85
25028	Drainage of forearm lesion		T	0049	21.2689	$1,354.70		$270.94
25031	Drainage of forearm bursa		T	0049	21.2689	$1,354.70		$270.94
25035	Treat forearm bone lesion		T	0049	21.2689	$1,354.70		$270.94
25040	Explore/treat wrist joint		T	0050	29.1900	$1,859.23		$371.85
25065	Biopsy forearm soft tissues		T	0020	8.6850	$553.18		$110.64
25066	Biopsy forearm soft tissues		T	0022	21.1098	$1,344.57	$354.45	$268.91
25075	Removal forearm lesion subcu		T	0021	16.1001	$1,025.48	$219.48	$205.10
25076	Removal forearm lesion deep		T	0022	21.1098	$1,344.57	$354.45	$268.91
25077	Remove tumor, forearm/wrist		T	0022	21.1098	$1,344.57	$354.45	$268.91
25085	Incision of wrist capsule		T	0049	21.2689	$1,354.70		$270.94
25100	Biopsy of wrist joint		T	0049	21.2689	$1,354.70		$270.94
25101	Explore/treat wrist joint		T	0050	29.1900	$1,859.23		$371.85
25105	Remove wrist joint lining		T	0050	29.1900	$1,859.23		$371.85
25107	Remove wrist joint cartilage		T	0050	29.1900	$1,859.23		$371.85
25109	Excise tendon forearm/wrist		T	0049	21.2689	$1,354.70		$270.94
25110	Remove wrist tendon lesion		T	0049	21.2689	$1,354.70		$270.94

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
25111	Remove wrist tendon lesion		T	0053	16.4637	$1,048.64	$253.49	$209.73
25112	Reremove wrist tendon lesion		T	0053	16.4637	$1,048.64	$253.49	$209.73
25115	Remove wrist/forearm lesion		T	0049	21.2689	$1,354.70		$270.94
25116	Remove wrist/forearm lesion		T	0049	21.2689	$1,354.70		$270.94
25118	Excise wrist tendon sheath		T	0050	29.1900	$1,859.23		$371.85
25119	Partial removal of ulna		T	0050	29.1900	$1,859.23		$371.85
25120	Removal of forearm lesion		T	0050	29.1900	$1,859.23		$371.85
25125	Remove/graft forearm lesion		T	0050	29.1900	$1,859.23		$371.85
25126	Remove/graft forearm lesion		T	0050	29.1900	$1,859.23		$371.85
25130	Removal of wrist lesion		T	0050	29.1900	$1,859.23		$371.85
25135	Remove & graft wrist lesion		T	0050	29.1900	$1,859.23		$371.85
25136	Remove & graft wrist lesion		T	0050	29.1900	$1,859.23		$371.85
25145	Remove forearm bone lesion		T	0050	29.1900	$1,859.23		$371.85
25150	Partial removal of ulna		T	0050	29.1900	$1,859.23		$371.85
25151	Partial removal of radius		T	0050	29.1900	$1,859.23		$371.85
25170	Extensive forearm surgery		T	0051	42.9850	$2,737.89		$547.58
25210	Removal of wrist bone		T	0054	26.3105	$1,675.82		$335.16
25215	Removal of wrist bones		T	0054	26.3105	$1,675.82		$335.16
25230	Partial removal of radius		T	0050	29.1900	$1,859.23		$371.85
25240	Partial removal of ulna		T	0050	29.1900	$1,859.23		$371.85
25246	Injection for wrist x-ray		N					
25248	Remove forearm foreign body		T	0049	21.2689	$1,354.70		$270.94
25250	Removal of wrist prosthesis		T	0050	29.1900	$1,859.23		$371.85
25251	Removal of wrist prosthesis		T	0050	29.1900	$1,859.23		$371.85
25259	Manipulate wrist w/anesthes		T	0043	1.7682	$112.62		$22.52
25260	Repair forearm tendon/muscle		T	0050	29.1900	$1,859.23		$371.85
25263	Repair forearm tendon/muscle		T	0050	29.1900	$1,859.23		$371.85
25265	Repair forearm tendon/muscle		T	0050	29.1900	$1,859.23		$371.85
25270	Repair forearm tendon/muscle		T	0050	29.1900	$1,859.23		$371.85
25272	Repair forearm tendon/muscle		T	0050	29.1900	$1,859.23		$371.85
25274	Repair forearm tendon/muscle		T	0050	29.1900	$1,859.23		$371.85
25275	Repair forearm tendon sheath		T	0050	29.1900	$1,859.23		$371.85
25280	Revise wrist/forearm tendon		T	0050	29.1900	$1,859.23		$371.85
25290	Incise wrist/forearm tendon		T	0050	29.1900	$1,859.23		$371.85
25295	Release wrist/forearm tendon		T	0049	21.2689	$1,354.70		$270.94
25300	Fusion of tendons at wrist		T	0050	29.1900	$1,859.23		$371.85
25301	Fusion of tendons at wrist		T	0050	29.1900	$1,859.23		$371.85
25310	Transplant forearm tendon		T	0051	42.9850	$2,737.89		$547.58
25312	Transplant forearm tendon		T	0051	42.9850	$2,737.89		$547.58
25315	Revise palsy hand tendon(s)		T	0051	42.9850	$2,737.89		$547.58
25316	Revise palsy hand tendon(s)		T	0052	79.4244	$5,058.86		$1,011.77
25320	Repair/revise wrist joint		T	0051	42.9850	$2,737.89		$547.58
25332	Revise wrist joint		T	0047	35.9040	$2,286.87	$537.03	$457.37
25335	Realignment of hand		T	0051	42.9850	$2,737.89		$547.58
25337	Reconstruct ulna/radioulnar		T	0051	42.9850	$2,737.89		$547.58
25350	Revision of radius		T	0052	79.4244	$5,058.86		$1,011.77
25355	Revision of radius		T	0051	42.9850	$2,737.89		$547.58
25360	Revision of ulna		T	0050	29.1900	$1,859.23		$371.85
25365	Revise radius & ulna		T	0050	29.1900	$1,859.23		$371.85
25370	Revise radius or ulna		T	0051	42.9850	$2,737.89		$547.58
25375	Revise radius & ulna		T	0051	42.9850	$2,737.89		$547.58
25390	Shorten radius or ulna		T	0050	29.1900	$1,859.23		$371.85
25391	Lengthen radius or ulna		T	0051	42.9850	$2,737.89		$547.58
25392	Shorten radius & ulna		T	0050	29.1900	$1,859.23		$371.85
25393	Lengthen radius & ulna		T	0051	42.9850	$2,737.89		$547.58
25394	Repair carpal bone, shorten		T	0053	16.4637	$1,048.64	$253.49	$209.73
25400	Repair radius or ulna	CH	T	0052	79.4244	$5,058.86		$1,011.77
25405	Repair/graft radius or ulna	CH	T	0052	79.4244	$5,058.86		$1,011.77
25415	Repair radius & ulna	CH	T	0052	79.4244	$5,058.86		$1,011.77
25420	Repair/graft radius & ulna		T	0052	79.4244	$5,058.86		$1,011.77
25425	Repair/graft radius or ulna		T	0051	42.9850	$2,737.89		$547.58
25426	Repair/graft radius & ulna		T	0051	42.9850	$2,737.89		$547.58
25430	Vasc graft into carpal bone		T	0054	26.3105	$1,675.82		$335.16
25431	Repair nonunion carpal bone		T	0054	26.3105	$1,675.82		$335.16
25440	Repair/graft wrist bone		T	0052	79.4244	$5,058.86		$1,011.77
25441	Reconstruct wrist joint		T	0425	122.2057	$7,783.77		$1,556.75
25442	Reconstruct wrist joint		T	0425	122.2057	$7,783.77		$1,556.75
25443	Reconstruct wrist joint		T	0048	50.8876	$3,241.23		$648.25
25444	Reconstruct wrist joint		T	0048	50.8876	$3,241.23		$648.25
25445	Reconstruct wrist joint		T	0048	50.8876	$3,241.23		$648.25
25446	Wrist replacement		T	0425	122.2057	$7,783.77		$1,556.75
25447	Repair wrist joint(s)		T	0047	35.9040	$2,286.87	$537.03	$457.37
25449	Remove wrist joint implant		T	0047	35.9040	$2,286.87	$537.03	$457.37
25450	Revision of wrist joint		T	0051	42.9850	$2,737.89		$547.58
25455	Revision of wrist joint		T	0051	42.9850	$2,737.89		$547.58
25490	Reinforce radius		T	0051	42.9850	$2,737.89		$547.58
25491	Reinforce ulna		T	0051	42.9850	$2,737.89		$547.58
25492	Reinforce radius and ulna		T	0051	42.9850	$2,737.89		$547.58
25500	Treat fracture of radius		T	0043	1.7682	$112.62		$22.52
25505	Treat fracture of radius		T	0043	1.7682	$112.62		$22.52

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
25515	Treat fracture of radius		T	0063	41.1091	$2,618.40	$548.33	$523.68
25520	Treat fracture of radius		T	0043	1.7682	$112.62		$22.52
25525	Treat fracture of radius		T	0063	41.1091	$2,618.40	$548.33	$523.68
25526	Treat fracture of radius		T	0063	41.1091	$2,618.40	$548.33	$523.68
25530	Treat fracture of ulna		T	0043	1.7682	$112.62		$22.52
25535	Treat fracture of ulna		T	0043	1.7682	$112.62		$22.52
25545	Treat fracture of ulna		T	0063	41.1091	$2,618.40	$548.33	$523.68
25560	Treat fracture radius & ulna		T	0043	1.7682	$112.62		$22.52
25565	Treat fracture radius & ulna		T	0043	1.7682	$112.62		$22.52
25574	Treat fracture radius & ulna		T	0064	59.2233	$3,772.17	$835.79	$754.43
25575	Treat fracture radius/ulna		T	0064	59.2233	$3,772.17	$835.79	$754.43
25600	Treat fracture radius/ulna		T	0043	1.7682	$112.62		$22.52
25605	Treat fracture radius/ulna		T	0043	1.7682	$112.62		$22.52
25606	Treat fx distal radial		T	0062	26.1592	$1,666.18	$372.87	$333.24
25607	Treat fx rad extra-articul		T	0064	59.2233	$3,772.17	$835.79	$754.43
25608	Treat fx rad intra-articul		T	0064	59.2233	$3,772.17	$835.79	$754.43
25609	Treat fx radial 3+ frag		T	0064	59.2233	$3,772.17	$835.79	$754.43
25622	Treat wrist bone fracture		T	0043	1.7682	$112.62		$22.52
25624	Treat wrist bone fracture		T	0043	1.7682	$112.62		$22.52
25628	Treat wrist bone fracture		T	0063	41.1091	$2,618.40	$548.33	$523.68
25630	Treat wrist bone fracture		T	0043	1.7682	$112.62		$22.52
25635	Treat wrist bone fracture		T	0043	1.7682	$112.62		$22.52
25645	Treat wrist bone fracture		T	0063	41.1091	$2,618.40	$548.33	$523.68
25650	Treat wrist bone fracture		T	0043	1.7682	$112.62		$22.52
25651	Pin ulnar styloid fracture		T	0062	26.1592	$1,666.18	$372.87	$333.24
25652	Treat fracture ulnar styloid		T	0063	41.1091	$2,618.40	$548.33	$523.68
25660	Treat wrist dislocation		T	0043	1.7682	$112.62		$22.52
25670	Treat wrist dislocation		T	0062	26.1592	$1,666.18	$372.87	$333.24
25671	Pin radioulnar dislocation		T	0062	26.1592	$1,666.18	$372.87	$333.24
25675	Treat wrist dislocation		T	0043	1.7682	$112.62		$22.52
25676	Treat wrist dislocation		T	0062	26.1592	$1,666.18	$372.87	$333.24
25680	Treat wrist fracture		T	0043	1.7682	$112.62		$22.52
25685	Treat wrist fracture		T	0062	26.1592	$1,666.18	$372.87	$333.24
25690	Treat wrist dislocation		T	0043	1.7682	$112.62		$22.52
25695	Treat wrist dislocation		T	0062	26.1592	$1,666.18	$372.87	$333.24
25800	Fusion of wrist joint		T	0052	79.4244	$5,058.86		$1,011.77
25805	Fusion/graft of wrist joint		T	0051	42.9850	$2,737.89		$547.58
25810	Fusion/graft of wrist joint		T	0052	79.4244	$5,058.86		$1,011.77
25820	Fusion of hand bones		T	0053	16.4637	$1,048.64	$253.49	$209.73
25825	Fuse hand bones with graft	CH	T	0052	79.4244	$5,058.86		$1,011.77
25830	Fusion, radioulnar jnt/ulna		T	0052	79.4244	$5,058.86		$1,011.77
25900	Amputation of forearm		C					
25905	Amputation of forearm		C					
25907	Amputation follow-up surgery		T	0049	21.2689	$1,354.70		$270.94
25909	Amputation follow-up surgery		C					
25915	Amputation of forearm		C					
25920	Amputate hand at wrist		C					
25922	Amputate hand at wrist		T	0049	21.2689	$1,354.70		$270.94
25924	Amputation follow-up surgery		C					
25927	Amputation of hand		C					
25929	Amputation follow-up surgery	CH	T	0136	15.0458	$958.33		$191.67
25931	Amputation follow-up surgery	CH	T	0049	21.2689	$1,354.70		$270.94
25999	Forearm or wrist surgery		T	0043	1.7682	$112.62		$22.52
26010	Drainage of finger abscess		T	0006	1.4066	$89.59		$17.92
26011	Drainage of finger abscess		T	0007	11.5594	$736.26		$147.25
26020	Drain hand tendon sheath		T	0053	16.4637	$1,048.64	$253.49	$209.73
26025	Drainage of palm bursa		T	0053	16.4637	$1,048.64	$253.49	$209.73
26030	Drainage of palm bursa(s)		T	0053	16.4637	$1,048.64	$253.49	$209.73
26034	Treat hand bone lesion		T	0053	16.4637	$1,048.64	$253.49	$209.73
26035	Decompress fingers/hand		T	0053	16.4637	$1,048.64	$253.49	$209.73
26037	Decompress fingers/hand		T	0053	16.4637	$1,048.64	$253.49	$209.73
26040	Release palm contracture		T	0054	26.3105	$1,675.82		$335.16
26045	Release palm contracture		T	0054	26.3105	$1,675.82		$335.16
26055	Incise finger tendon sheath		T	0053	16.4637	$1,048.64	$253.49	$209.73
26060	Incision of finger tendon		T	0053	16.4637	$1,048.64	$253.49	$209.73
26070	Explore/treat hand joint		T	0053	16.4637	$1,048.64	$253.49	$209.73
26075	Explore/treat finger joint		T	0053	16.4637	$1,048.64	$253.49	$209.73
26080	Explore/treat finger joint		T	0053	16.4637	$1,048.64	$253.49	$209.73
26100	Biopsy hand joint lining		T	0053	16.4637	$1,048.64	$253.49	$209.73
26105	Biopsy finger joint lining		T	0053	16.4637	$1,048.64	$253.49	$209.73
26110	Biopsy finger joint lining		T	0053	16.4637	$1,048.64	$253.49	$209.73
26115	Removal hand lesion subcut		T	0022	21.1098	$1,344.57	$354.45	$268.91
26116	Removal hand lesion, deep		T	0022	21.1098	$1,344.57	$354.45	$268.91
26117	Remove tumor, hand/finger		T	0022	21.1098	$1,344.57	$354.45	$268.91
26121	Release palm contracture		T	0054	26.3105	$1,675.82		$335.16
26123	Release palm contracture		T	0054	26.3105	$1,675.82		$335.16
26125	Release palm contracture		T	0053	16.4637	$1,048.64	$253.49	$209.73
26130	Remove wrist joint lining		T	0053	16.4637	$1,048.64	$253.49	$209.73
26135	Revise finger joint, each		T	0054	26.3105	$1,675.82		$335.16
26140	Revise finger joint, each		T	0053	16.4637	$1,048.64	$253.49	$209.73

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
26145	Tendon excision, palm/finger		T	0053	16.4637	$1,048.64	$253.49	$209.73
26160	Remove tendon sheath lesion		T	0053	16.4637	$1,048.64	$253.49	$209.73
26170	Removal of palm tendon, each		T	0053	16.4637	$1,048.64	$253.49	$209.73
26180	Removal of finger tendon		T	0053	16.4637	$1,048.64	$253.49	$209.73
26185	Remove finger bone		T	0053	16.4637	$1,048.64	$253.49	$209.73
26200	Remove hand bone lesion		T	0053	16.4637	$1,048.64	$253.49	$209.73
26205	Remove/graft bone lesion		T	0054	26.3105	$1,675.82		$335.16
26210	Removal of finger lesion		T	0053	16.4637	$1,048.64	$253.49	$209.73
26215	Remove/graft finger lesion		T	0053	16.4637	$1,048.64	$253.49	$209.73
26230	Partial removal of hand bone		T	0053	16.4637	$1,048.64	$253.49	$209.73
26235	Partial removal, finger bone		T	0053	16.4637	$1,048.64	$253.49	$209.73
26236	Partial removal, finger bone		T	0053	16.4637	$1,048.64	$253.49	$209.73
26250	Extensive hand surgery		T	0053	16.4637	$1,048.64	$253.49	$209.73
26255	Extensive hand surgery		T	0054	26.3105	$1,675.82		$335.16
26260	Extensive finger surgery		T	0053	16.4637	$1,048.64	$253.49	$209.73
26261	Extensive finger surgery		T	0053	16.4637	$1,048.64	$253.49	$209.73
26262	Partial removal of finger		T	0053	16.4637	$1,048.64	$253.49	$209.73
26320	Removal of implant from hand		T	0021	16.1001	$1,025.48	$219.48	$205.10
26340	Manipulate finger w/anesth		T	0043	1.7682	$112.62		$22.52
26350	Repair finger/hand tendon		T	0054	26.3105	$1,675.82		$335.16
26352	Repair/graft hand tendon		T	0054	26.3105	$1,675.82		$335.16
26356	Repair finger/hand tendon		T	0054	26.3105	$1,675.82		$335.16
26357	Repair finger/hand tendon		T	0054	26.3105	$1,675.82		$335.16
26358	Repair/graft hand tendon		T	0054	26.3105	$1,675.82		$335.16
26370	Repair finger/hand tendon		T	0054	26.3105	$1,675.82		$335.16
26372	Repair/graft hand tendon		T	0054	26.3105	$1,675.82		$335.16
26373	Repair finger/hand tendon		T	0054	26.3105	$1,675.82		$335.16
26390	Revise hand/finger tendon		T	0054	26.3105	$1,675.82		$335.16
26392	Repair/graft hand tendon		T	0054	26.3105	$1,675.82		$335.16
26410	Repair hand tendon		T	0053	16.4637	$1,048.64	$253.49	$209.73
26412	Repair/graft hand tendon		T	0054	26.3105	$1,675.82		$335.16
26415	Excision, hand/finger tendon		T	0054	26.3105	$1,675.82		$335.16
26416	Graft hand or finger tendon		T	0054	26.3105	$1,675.82		$335.16
26418	Repair finger tendon		T	0053	16.4637	$1,048.64	$253.49	$209.73
26420	Repair/graft finger tendon		T	0054	26.3105	$1,675.82		$335.16
26426	Repair finger/hand tendon		T	0054	26.3105	$1,675.82		$335.16
26428	Repair/graft finger tendon		T	0054	26.3105	$1,675.82		$335.16
26432	Repair finger tendon		T	0053	16.4637	$1,048.64	$253.49	$209.73
26433	Repair finger tendon		T	0053	16.4637	$1,048.64	$253.49	$209.73
26434	Repair/graft finger tendon		T	0054	26.3105	$1,675.82		$335.16
26437	Realignment of tendons		T	0053	16.4637	$1,048.64	$253.49	$209.73
26440	Release palm/finger tendon		T	0053	16.4637	$1,048.64	$253.49	$209.73
26442	Release palm & finger tendon		T	0054	26.3105	$1,675.82		$335.16
26445	Release hand/finger tendon		T	0053	16.4637	$1,048.64	$253.49	$209.73
26449	Release forearm/hand tendon		T	0054	26.3105	$1,675.82		$335.16
26450	Incision of palm tendon		T	0053	16.4637	$1,048.64	$253.49	$209.73
26455	Incision of finger tendon		T	0053	16.4637	$1,048.64	$253.49	$209.73
26460	Incise hand/finger tendon		T	0053	16.4637	$1,048.64	$253.49	$209.73
26471	Fusion of finger tendons		T	0053	16.4637	$1,048.64	$253.49	$209.73
26474	Fusion of finger tendons		T	0053	16.4637	$1,048.64	$253.49	$209.73
26476	Tendon lengthening		T	0053	16.4637	$1,048.64	$253.49	$209.73
26477	Tendon shortening		T	0053	16.4637	$1,048.64	$253.49	$209.73
26478	Lengthening of hand tendon		T	0053	16.4637	$1,048.64	$253.49	$209.73
26479	Shortening of hand tendon		T	0053	16.4637	$1,048.64	$253.49	$209.73
26480	Transplant hand tendon		T	0054	26.3105	$1,675.82		$335.16
26483	Transplant/graft hand tendon		T	0054	26.3105	$1,675.82		$335.16
26485	Transplant palm tendon		T	0054	26.3105	$1,675.82		$335.16
26489	Transplant/graft palm tendon		T	0054	26.3105	$1,675.82		$335.16
26490	Revise thumb tendon		T	0054	26.3105	$1,675.82		$335.16
26492	Tendon transfer with graft		T	0054	26.3105	$1,675.82		$335.16
26494	Hand tendon/muscle transfer		T	0054	26.3105	$1,675.82		$335.16
26496	Revise thumb tendon		T	0054	26.3105	$1,675.82		$335.16
26497	Finger tendon transfer		T	0054	26.3105	$1,675.82		$335.16
26498	Finger tendon transfer		T	0054	26.3105	$1,675.82		$335.16
26499	Revision of finger		T	0054	26.3105	$1,675.82		$335.16
26500	Hand tendon reconstruction		T	0053	16.4637	$1,048.64	$253.49	$209.73
26502	Hand tendon reconstruction		T	0054	26.3105	$1,675.82		$335.16
26508	Release thumb contracture		T	0053	16.4637	$1,048.64	$253.49	$209.73
26510	Thumb tendon transfer		T	0054	26.3105	$1,675.82		$335.16
26516	Fusion of knuckle joint		T	0054	26.3105	$1,675.82		$335.16
26517	Fusion of knuckle joints		T	0054	26.3105	$1,675.82		$335.16
26518	Fusion of knuckle joints		T	0054	26.3105	$1,675.82		$335.16
26520	Release knuckle contracture		T	0053	16.4637	$1,048.64	$253.49	$209.73
26525	Release finger contracture		T	0053	16.4637	$1,048.64	$253.49	$209.73
26530	Revise knuckle joint		T	0047	35.9040	$2,286.87	$537.03	$457.37
26531	Revise knuckle with implant		T	0048	50.8876	$3,241.23		$648.25
26535	Revise finger joint		T	0047	35.9040	$2,286.87	$537.03	$457.37
26536	Revise/implant finger joint		T	0048	50.8876	$3,241.23		$648.25
26540	Repair hand joint		T	0053	16.4637	$1,048.64	$253.49	$209.73
26541	Repair hand joint with graft		T	0054	26.3105	$1,675.82		$335.16

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
26542	Repair hand joint with graft		T	0053	16.4637	$1,048.64	$253.49	$209.73
26545	Reconstruct finger joint		T	0054	26.3105	$1,675.82		$335.16
26546	Repair nonunion hand		T	0054	26.3105	$1,675.82		$335.16
26548	Reconstruct finger joint		T	0054	26.3105	$1,675.82		$335.16
26550	Construct thumb replacement		T	0054	26.3105	$1,675.82		$335.16
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	26.3105	$1,675.82		$335.16
26556	Toe joint transfer		C					
26560	Repair of web finger		T	0053	16.4637	$1,048.64	$253.49	$209.73
26561	Repair of web finger		T	0054	26.3105	$1,675.82		$335.16
26562	Repair of web finger		T	0054	26.3105	$1,675.82		$335.16
26565	Correct metacarpal flaw		T	0054	26.3105	$1,675.82		$335.16
26567	Correct finger deformity		T	0054	26.3105	$1,675.82		$335.16
26568	Lengthen metacarpal/finger		T	0054	26.3105	$1,675.82		$335.16
26580	Repair hand deformity		T	0053	16.4637	$1,048.64	$253.49	$209.73
26587	Reconstruct extra finger		T	0053	16.4637	$1,048.64	$253.49	$209.73
26590	Repair finger deformity		T	0053	16.4637	$1,048.64	$253.49	$209.73
26591	Repair muscles of hand		T	0054	26.3105	$1,675.82		$335.16
26593	Release muscles of hand		T	0053	16.4637	$1,048.64	$253.49	$209.73
26596	Excision constricting tissue		T	0053	16.4637	$1,048.64	$253.49	$209.73
26600	Treat metacarpal fracture		T	0043	1.7682	$112.62		$22.52
26605	Treat metacarpal fracture		T	0043	1.7682	$112.62		$22.52
26607	Treat metacarpal fracture		T	0043	1.7682	$112.62		$22.52
26608	Treat metacarpal fracture		T	0062	26.1592	$1,666.18	$372.87	$333.24
26615	Treat metacarpal fracture		T	0063	41.1091	$2,618.40	$548.33	$523.68
26641	Treat thumb dislocation		T	0043	1.7682	$112.62		$22.52
26645	Treat thumb fracture		T	0043	1.7682	$112.62		$22.52
26650	Treat thumb fracture		T	0062	26.1592	$1,666.18	$372.87	$333.24
26665	Treat thumb fracture		T	0063	41.1091	$2,618.40	$548.33	$523.68
26670	Treat hand dislocation		T	0043	1.7682	$112.62		$22.52
26675	Treat hand dislocation		T	0043	1.7682	$112.62		$22.52
26676	Pin hand dislocation		T	0062	26.1592	$1,666.18	$372.87	$333.24
26685	Treat hand dislocation	CH	T	0062	26.1592	$1,666.18	$372.87	$333.24
26686	Treat hand dislocation		T	0064	59.2233	$3,772.17	$835.79	$754.43
26700	Treat knuckle dislocation		T	0043	1.7682	$112.62		$22.52
26705	Treat knuckle dislocation		T	0043	1.7682	$112.62		$22.52
26706	Pin knuckle dislocation		T	0043	1.7682	$112.62		$22.52
26715	Treat knuckle dislocation	CH	T	0062	26.1592	$1,666.18	$372.87	$333.24
26720	Treat finger fracture, each		T	0043	1.7682	$112.62		$22.52
26725	Treat finger fracture, each		T	0043	1.7682	$112.62		$22.52
26727	Treat finger fracture, each		T	0062	26.1592	$1,666.18	$372.87	$333.24
26735	Treat finger fracture, each	CH	T	0062	26.1592	$1,666.18	$372.87	$333.24
26740	Treat finger fracture, each		T	0043	1.7682	$112.62		$22.52
26742	Treat finger fracture, each		T	0043	1.7682	$112.62		$22.52
26746	Treat finger fracture, each	CH	T	0062	26.1592	$1,666.18	$372.87	$333.24
26750	Treat finger fracture, each		T	0043	1.7682	$112.62		$22.52
26755	Treat finger fracture, each		T	0043	1.7682	$112.62		$22.52
26756	Pin finger fracture, each		T	0062	26.1592	$1,666.18	$372.87	$333.24
26765	Treat finger fracture, each	CH	T	0062	26.1592	$1,666.18	$372.87	$333.24
26770	Treat finger dislocation		T	0043	1.7682	$112.62		$22.52
26775	Treat finger dislocation		T	0045	14.7658	$940.49	$268.47	$188.10
26776	Pin finger dislocation		T	0062	26.1592	$1,666.18	$372.87	$333.24
26785	Treat finger dislocation		T	0062	26.1592	$1,666.18	$372.87	$333.24
26820	Thumb fusion with graft		T	0054	26.3105	$1,675.82		$335.16
26841	Fusion of thumb		T	0054	26.3105	$1,675.82		$335.16
26842	Thumb fusion with graft		T	0054	26.3105	$1,675.82		$335.16
26843	Fusion of hand joint		T	0054	26.3105	$1,675.82		$335.16
26844	Fusion/graft of hand joint		T	0054	26.3105	$1,675.82		$335.16
26850	Fusion of knuckle		T	0054	26.3105	$1,675.82		$335.16
26852	Fusion of knuckle with graft		T	0054	26.3105	$1,675.82		$335.16
26860	Fusion of finger joint		T	0054	26.3105	$1,675.82		$335.16
26861	Fusion of finger jnt, add-on		T	0054	26.3105	$1,675.82		$335.16
26862	Fusion/graft of finger joint		T	0054	26.3105	$1,675.82		$335.16
26863	Fuse/graft added joint		T	0054	26.3105	$1,675.82		$335.16
26910	Amputate metacarpal bone		T	0054	26.3105	$1,675.82		$335.16
26951	Amputation of finger/thumb		T	0053	16.4637	$1,048.64	$253.49	$209.73
26952	Amputation of finger/thumb		T	0053	16.4637	$1,048.64	$253.49	$209.73
26989	Hand/finger surgery		T	0043	1.7682	$112.62		$22.52
26990	Drainage of pelvis lesion		T	0049	21.2689	$1,354.70		$270.94
26991	Drainage of pelvis bursa		T	0049	21.2689	$1,354.70		$270.94
26992	Drainage of bone lesion		C					
27000	Incision of hip tendon		T	0049	21.2689	$1,354.70		$270.94
27001	Incision of hip tendon		T	0050	29.1900	$1,859.23		$371.85
27003	Incision of hip tendon		T	0050	29.1900	$1,859.23		$371.85
27005	Incision of hip tendon		C					
27006	Incision of hip tendons	CH	T	0050	29.1900	$1,859.23		$371.85
27025	Incision of hip/thigh fascia		C					
27030	Drainage of hip joint		C					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27033	Exploration of hip joint		T	0051	42.9850	$2,737.89		$547.58
27035	Denervation of hip joint		T	0051	42.9850	$2,737.89		$547.58
27036	Excision of hip joint/muscle		C					
27040	Biopsy of soft tissues		T	0020	8.6850	$553.18		$110.64
27041	Biopsy of soft tissues		T	0020	8.6850	$553.18		$110.64
27047	Remove hip/pelvis lesion		T	0022	21.1098	$1,344.57	$354.45	$268.91
27048	Remove hip/pelvis lesion		T	0022	21.1098	$1,344.57	$354.45	$268.91
27049	Remove tumor, hip/pelvis		T	0022	21.1098	$1,344.57	$354.45	$268.91
27050	Biopsy of sacroiliac joint		T	0049	21.2689	$1,354.70		$270.94
27052	Biopsy of hip joint		T	0049	21.2689	$1,354.70		$270.94
27054	Removal of hip joint lining		C					
27060	Removal of ischial bursa		T	0049	21.2689	$1,354.70		$270.94
27062	Remove femur lesion/bursa		T	0049	21.2689	$1,354.70		$270.94
27065	Removal of hip bone lesion		T	0049	21.2689	$1,354.70		$270.94
27066	Removal of hip bone lesion		T	0050	29.1900	$1,859.23		$371.85
27067	Remove/graft hip bone lesion		T	0050	29.1900	$1,859.23		$371.85
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					
27080	Removal of tail bone		T	0050	29.1900	$1,859.23		$371.85
27086	Remove hip foreign body		T	0020	8.6850	$553.18		$110.64
27087	Remove hip foreign body		T	0049	21.2689	$1,354.70		$270.94
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	29.1900	$1,859.23		$371.85
27098	Transfer tendon to pelvis		T	0050	29.1900	$1,859.23		$371.85
27100	Transfer of abdominal muscle		T	0051	42.9850	$2,737.89		$547.58
27105	Transfer of spinal muscle		T	0051	42.9850	$2,737.89		$547.58
27110	Transfer of iliopsoas muscle		T	0051	42.9850	$2,737.89		$547.58
27111	Transfer of iliopsoas muscle		T	0051	42.9850	$2,737.89		$547.58
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	1.7682	$112.62		$22.52
27194	Treat pelvic ring fracture		T	0045	14.7658	$940.49	$268.47	$188.10
27200	Treat tail bone fracture		T	0043	1.7682	$112.62		$22.52
27202	Treat tail bone fracture		T	0063	41.1091	$2,618.40	$548.33	$523.68
27215	Treat pelvic fracture(s)		C					
27216	Treat pelvic ring fracture		T	0050	29.1900	$1,859.23		$371.85
27217	Treat pelvic ring fracture		C					
27218	Treat pelvic ring fracture		C					
27220	Treat hip socket fracture		T	0043	1.7682	$112.62		$22.52
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	1.7682	$112.62		$22.52
27232	Treat thigh fracture		C					
27235	Treat thigh fracture		T	0050	29.1900	$1,859.23		$371.85
27236	Treat thigh fracture		C					
27238	Treat thigh fracture		T	0043	1.7682	$112.62		$22.52

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27240	Treat thigh fracture		C					
27244	Treat thigh fracture		C					
27245	Treat thigh fracture		C					
27246	Treat thigh fracture		T	0043	1.7682	$112.62		$22.52
27248	Treat thigh fracture		C					
27250	Treat hip dislocation		T	0043	1.7682	$112.62		$22.52
27252	Treat hip dislocation		T	0045	14.7658	$940.49	$268.47	$188.10
27253	Treat hip dislocation		C					
27254	Treat hip dislocation		C					
27256	Treat hip dislocation		T	0043	1.7682	$112.62		$22.52
27257	Treat hip dislocation		T	0045	14.7658	$940.49	$268.47	$188.10
27258	Treat hip dislocation		C					
27259	Treat hip dislocation		C					
27265	Treat hip dislocation		T	0043	1.7682	$112.62		$22.52
27266	Treat hip dislocation		T	0045	14.7658	$940.49	$268.47	$188.10
27267	Cltx thigh fx	NI	T	0043	1.7682	$112.62		$22.52
27268	Cltx thigh fx w/mnpj	NI	C					
27269	Optx thigh fx	NI	C					
27275	Manipulation of hip joint		T	0045	14.7658	$940.49	$268.47	$188.10
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	1.7682	$112.62		$22.52
27301	Drain thigh/knee lesion		T	0008	18.3197	$1,166.85		$233.37
27303	Drainage of bone lesion		C					
27305	Incise thigh tendon & fascia		T	0049	21.2689	$1,354.70		$270.94
27306	Incision of thigh tendon		T	0049	21.2689	$1,354.70		$270.94
27307	Incision of thigh tendons		T	0049	21.2689	$1,354.70		$270.94
27310	Exploration of knee joint		T	0050	29.1900	$1,859.23		$371.85
27323	Biopsy, thigh soft tissues		T	0020	8.6850	$553.18		$110.64
27324	Biopsy, thigh soft tissues		T	0022	21.1098	$1,344.57	$354.45	$268.91
27325	Neurectomy, hamstring		T	0220	18.0518	$1,149.79		$229.96
27326	Neurectomy, popliteal		T	0220	18.0518	$1,149.79		$229.96
27327	Removal of thigh lesion		T	0022	21.1098	$1,344.57	$354.45	$268.91
27328	Removal of thigh lesion		T	0022	21.1098	$1,344.57	$354.45	$268.91
27329	Remove tumor, thigh/knee		T	0022	21.1098	$1,344.57	$354.45	$268.91
27330	Biopsy, knee joint lining		T	0050	29.1900	$1,859.23		$371.85
27331	Explore/treat knee joint		T	0050	29.1900	$1,859.23		$371.85
27332	Removal of knee cartilage		T	0050	29.1900	$1,859.23		$371.85
27333	Removal of knee cartilage		T	0050	29.1900	$1,859.23		$371.85
27334	Remove knee joint lining		T	0050	29.1900	$1,859.23		$371.85
27335	Remove knee joint lining		T	0050	29.1900	$1,859.23		$371.85
27340	Removal of kneecap bursa		T	0049	21.2689	$1,354.70		$270.94
27345	Removal of knee cyst		T	0049	21.2689	$1,354.70		$270.94
27347	Remove knee cyst		T	0049	21.2689	$1,354.70		$270.94
27350	Removal of kneecap		T	0050	29.1900	$1,859.23		$371.85
27355	Remove femur lesion		T	0050	29.1900	$1,859.23		$371.85
27356	Remove femur lesion/graft		T	0050	29.1900	$1,859.23		$371.85
27357	Remove femur lesion/graft		T	0050	29.1900	$1,859.23		$371.85
27358	Remove femur lesion/fixation		T	0050	29.1900	$1,859.23		$371.85
27360	Partial removal, leg bone(s)		T	0050	29.1900	$1,859.23		$371.85
27365	Extensive leg surgery		C					
27370	Injection for knee x-ray		N					
27372	Removal of foreign body		T	0022	21.1098	$1,344.57	$354.45	$268.91
27380	Repair of kneecap tendon		T	0049	21.2689	$1,354.70		$270.94
27381	Repair/graft kneecap tendon		T	0049	21.2689	$1,354.70		$270.94
27385	Repair of thigh muscle		T	0049	21.2689	$1,354.70		$270.94
27386	Repair/graft of thigh muscle		T	0049	21.2689	$1,354.70		$270.94
27390	Incision of thigh tendon		T	0049	21.2689	$1,354.70		$270.94
27391	Incision of thigh tendons		T	0049	21.2689	$1,354.70		$270.94
27392	Incision of thigh tendons		T	0049	21.2689	$1,354.70		$270.94
27393	Lengthening of thigh tendon		T	0050	29.1900	$1,859.23		$371.85
27394	Lengthening of thigh tendons		T	0050	29.1900	$1,859.23		$371.85
27395	Lengthening of thigh tendons		T	0051	42.9850	$2,737.89		$547.58
27396	Transplant of thigh tendon		T	0050	29.1900	$1,859.23		$371.85
27397	Transplants of thigh tendons		T	0051	42.9850	$2,737.89		$547.58
27400	Revise thigh muscles/tendons		T	0051	42.9850	$2,737.89		$547.58
27403	Repair of knee cartilage		T	0050	29.1900	$1,859.23		$371.85
27405	Repair of knee ligament		T	0051	42.9850	$2,737.89		$547.58
27407	Repair of knee ligament		T	0052	79.4244	$5,058.86		$1,011.77
27409	Repair of knee ligaments		T	0051	42.9850	$2,737.89		$547.58
27412	Autochondrocyte implant knee		T	0042	45.7072	$2,911.27	$804.74	$582.25
27415	Osteochondral knee allograft		T	0042	45.7072	$2,911.27	$804.74	$582.25
27416	Osteochondral knee autograft	NI	T	0051	42.9850	$2,737.89		$547.58
27418	Repair degenerated kneecap		T	0051	42.9850	$2,737.89		$547.58
27420	Revision of unstable kneecap		T	0051	42.9850	$2,737.89		$547.58
27422	Revision of unstable kneecap		T	0051	42.9850	$2,737.89		$547.58

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27424	Revision/removal of kneecap		T	0051	42.9850	$2,737.89		$547.58
27425	Lat retinacular release open		T	0050	29.1900	$1,859.23		$371.85
27427	Reconstruction, knee		T	0051	42.9850	$2,737.89		$547.58
27428	Reconstruction, knee		T	0052	79.4244	$5,058.86		$1,011.77
27429	Reconstruction, knee		T	0052	79.4244	$5,058.86		$1,011.77
27430	Revision of thigh muscles		T	0051	42.9850	$2,737.89		$547.58
27435	Incision of knee joint		T	0051	42.9850	$2,737.89		$547.58
27437	Revise kneecap		T	0047	35.9040	$2,286.87	$537.03	$457.37
27438	Revise kneecap with implant		T	0048	50.8876	$3,241.23		$648.25
27440	Revision of knee joint		T	0047	35.9040	$2,286.87	$537.03	$457.37
27441	Revision of knee joint		T	0047	35.9040	$2,286.87	$537.03	$457.37
27442	Revision of knee joint		T	0047	35.9040	$2,286.87	$537.03	$457.37
27443	Revision of knee joint		T	0047	35.9040	$2,286.87	$537.03	$457.37
27445	Revision of knee joint		C					
27446	Revision of knee joint		T	0681	274.6715	$17,494.93		$3,498.99
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					
27475	Surgery to stop leg growth		T	0050	29.1900	$1,859.23		$371.85
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	21.2689	$1,354.70		$270.94
27497	Decompression of thigh/knee		T	0049	21.2689	$1,354.70		$270.94
27498	Decompression of thigh/knee		T	0049	21.2689	$1,354.70		$270.94
27499	Decompression of thigh/knee		T	0049	21.2689	$1,354.70		$270.94
27500	Treatment of thigh fracture		T	0043	1.7682	$112.62		$22.52
27501	Treatment of thigh fracture		T	0043	1.7682	$112.62		$22.52
27502	Treatment of thigh fracture		T	0043	1.7682	$112.62		$22.52
27503	Treatment of thigh fracture		T	0043	1.7682	$112.62		$22.52
27506	Treatment of thigh fracture		C					
27507	Treatment of thigh fracture		C					
27508	Treatment of thigh fracture		T	0043	1.7682	$112.62		$22.52
27509	Treatment of thigh fracture		T	0062	26.1592	$1,666.18	$372.87	$333.24
27510	Treatment of thigh fracture		T	0043	1.7682	$112.62		$22.52
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	1.7682	$112.62		$22.52
27517	Treat thigh fx growth plate		T	0043	1.7682	$112.62		$22.52
27519	Treat thigh fx growth plate		C					
27520	Treat kneecap fracture		T	0043	1.7682	$112.62		$22.52
27524	Treat kneecap fracture		T	0063	41.1091	$2,618.40	$548.33	$523.68
27530	Treat knee fracture		T	0043	1.7682	$112.62		$22.52
27532	Treat knee fracture		T	0043	1.7682	$112.62		$22.52
27535	Treat knee fracture		C					
27536	Treat knee fracture		C					
27538	Treat knee fracture(s)		T	0043	1.7682	$112.62		$22.52
27540	Treat knee fracture		C					
27550	Treat knee dislocation		T	0043	1.7682	$112.62		$22.52
27552	Treat knee dislocation		T	0045	14.7658	$940.49	$268.47	$188.10
27556	Treat knee dislocation		C					
27557	Treat knee dislocation		C					
27558	Treat knee dislocation		C					
27560	Treat kneecap dislocation		T	0043	1.7682	$112.62		$22.52
27562	Treat kneecap dislocation		T	0045	14.7658	$940.49	$268.47	$188.10
27566	Treat kneecap dislocation		T	0063	41.1091	$2,618.40	$548.33	$523.68
27570	Fixation of knee joint		T	0045	14.7658	$940.49	$268.47	$188.10
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	21.2689	$1,354.70		$270.94
27596	Amputation follow-up surgery		C					
27598	Amputate lower leg at knee		C					
27599	Leg surgery procedure		T	0043	1.7682	$112.62		$22.52
27600	Decompression of lower leg		T	0049	21.2689	$1,354.70		$270.94
27601	Decompression of lower leg		T	0049	21.2689	$1,354.70		$270.94

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27602	Decompression of lower leg		T	0049	21.2689	$1,354.70		$270.94
27603	Drain lower leg lesion		T	0008	18.3197	$1,166.85		$233.37
27604	Drain lower leg bursa		T	0049	21.2689	$1,354.70		$270.94
27605	Incision of achilles tendon		T	0055	20.8284	$1,326.64	$355.34	$265.33
27606	Incision of achilles tendon		T	0049	21.2689	$1,354.70		$270.94
27607	Treat lower leg bone lesion		T	0049	21.2689	$1,354.70		$270.94
27610	Explore/treat ankle joint		T	0050	29.1900	$1,859.23		$371.85
27612	Exploration of ankle joint		T	0050	29.1900	$1,859.23		$371.85
27613	Biopsy lower leg soft tissue		T	0020	8.6850	$553.18		$110.64
27614	Biopsy lower leg soft tissue		T	0022	21.1098	$1,344.57	$354.45	$268.91
27615	Remove tumor, lower leg		T	0050	29.1900	$1,859.23		$371.85
27618	Remove lower leg lesion		T	0021	16.1001	$1,025.48	$219.48	$205.10
27619	Remove lower leg lesion		T	0022	21.1098	$1,344.57	$354.45	$268.91
27620	Explore/treat ankle joint		T	0050	29.1900	$1,859.23		$371.85
27625	Remove ankle joint lining		T	0050	29.1900	$1,859.23		$371.85
27626	Remove ankle joint lining		T	0050	29.1900	$1,859.23		$371.85
27630	Removal of tendon lesion		T	0049	21.2689	$1,354.70		$270.94
27635	Remove lower leg bone lesion		T	0050	29.1900	$1,859.23		$371.85
27637	Remove/graft leg bone lesion		T	0050	29.1900	$1,859.23		$371.85
27638	Remove/graft leg bone lesion		T	0050	29.1900	$1,859.23		$371.85
27640	Partial removal of tibia		T	0051	42.9850	$2,737.89		$547.58
27641	Partial removal of fibula		T	0050	29.1900	$1,859.23		$371.85
27645	Extensive lower leg surgery		C					
27646	Extensive lower leg surgery		C					
27647	Extensive ankle/heel surgery		T	0051	42.9850	$2,737.89		$547.58
27648	Injection for ankle x-ray		N					
27650	Repair achilles tendon		T	0051	42.9850	$2,737.89		$547.58
27652	Repair/graft achilles tendon		T	0052	79.4244	$5,058.86		$1,011.77
27654	Repair of achilles tendon		T	0051	42.9850	$2,737.89		$547.58
27656	Repair leg fascia defect		T	0049	21.2689	$1,354.70		$270.94
27658	Repair of leg tendon, each		T	0049	21.2689	$1,354.70		$270.94
27659	Repair of leg tendon, each		T	0049	21.2689	$1,354.70		$270.94
27664	Repair of leg tendon, each		T	0049	21.2689	$1,354.70		$270.94
27665	Repair of leg tendon, each		T	0050	29.1900	$1,859.23		$371.85
27675	Repair lower leg tendons		T	0049	21.2689	$1,354.70		$270.94
27676	Repair lower leg tendons		T	0050	29.1900	$1,859.23		$371.85
27680	Release of lower leg tendon		T	0050	29.1900	$1,859.23		$371.85
27681	Release of lower leg tendons		T	0050	29.1900	$1,859.23		$371.85
27685	Revision of lower leg tendon		T	0050	29.1900	$1,859.23		$371.85
27686	Revise lower leg tendons		T	0050	29.1900	$1,859.23		$371.85
27687	Revision of calf tendon		T	0050	29.1900	$1,859.23		$371.85
27690	Revise lower leg tendon		T	0051	42.9850	$2,737.89		$547.58
27691	Revise lower leg tendon		T	0051	42.9850	$2,737.89		$547.58
27692	Revise additional leg tendon		T	0051	42.9850	$2,737.89		$547.58
27695	Repair of ankle ligament		T	0050	29.1900	$1,859.23		$371.85
27696	Repair of ankle ligaments		T	0050	29.1900	$1,859.23		$371.85
27698	Repair of ankle ligament		T	0050	29.1900	$1,859.23		$371.85
27700	Revision of ankle joint		T	0047	35.9040	$2,286.87	$537.03	$457.37
27702	Reconstruct ankle joint		C					
27703	Reconstruction, ankle joint		C					
27704	Removal of ankle implant		T	0049	21.2689	$1,354.70		$270.94
27705	Incision of tibia		T	0051	42.9850	$2,737.89		$547.58
27707	Incision of fibula		T	0049	21.2689	$1,354.70		$270.94
27709	Incision of tibia & fibula		T	0050	29.1900	$1,859.23		$371.85
27712	Realignment of lower leg		C					
27715	Revision of lower leg		C					
27720	Repair of tibia	CH	T	0063	41.1091	$2,618.40	$548.33	$523.68
27722	Repair/graft of tibia	CH	T	0064	59.2233	$3,772.17	$835.79	$754.43
27724	Repair/graft of tibia		C					
27725	Repair of lower leg		C					
27726	Repair fibula nonunion	NI	T	0062	26.1592	$1,666.18	$372.87	$333.24
27727	Repair of lower leg		C					
27730	Repair of tibia epiphysis		T	0050	29.1900	$1,859.23		$371.85
27732	Repair of fibula epiphysis		T	0050	29.1900	$1,859.23		$371.85
27734	Repair lower leg epiphyses		T	0050	29.1900	$1,859.23		$371.85
27740	Repair of leg epiphyses		T	0050	29.1900	$1,859.23		$371.85
27742	Repair of leg epiphyses		T	0051	42.9850	$2,737.89		$547.58
27745	Reinforce tibia		T	0052	79.4244	$5,058.86		$1,011.77
27750	Treatment of tibia fracture		T	0043	1.7682	$112.62		$22.52
27752	Treatment of tibia fracture		T	0043	1.7682	$112.62		$22.52
27756	Treatment of tibia fracture		T	0062	26.1592	$1,666.18	$372.87	$333.24
27758	Treatment of tibia fracture		T	0063	41.1091	$2,618.40	$548.33	$523.68
27759	Treatment of tibia fracture		T	0064	59.2233	$3,772.17	$835.79	$754.43
27760	Cltx medial ankle fx		T	0043	1.7682	$112.62		$22.52
27762	Cltx med ankle fx w/mnpj		T	0043	1.7682	$112.62		$22.52
27766	Optx medial ankle fx		T	0063	41.1091	$2,618.40	$548.33	$523.68
27767	Cltx post ankle fx	NI	T	0043	1.7682	$112.62		$22.52
27768	Cltx post ankle fx w/mnpj	NI	T	0043	1.7682	$112.62		$22.52
27769	Optx post ankle fx	NI	T	0063	41.1091	$2,618.40	$548.33	$523.68
27780	Treatment of fibula fracture		T	0043	1.7682	$112.62		$22.52

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27781	Treatment of fibula fracture		T	0043	1.7682	$112.62		$22.52
27784	Treatment of fibula fracture		T	0063	41.1091	$2,618.40	$548.33	$523.68
27786	Treatment of ankle fracture		T	0043	1.7682	$112.62		$22.52
27788	Treatment of ankle fracture		T	0043	1.7682	$112.62		$22.52
27792	Treatment of ankle fracture		T	0063	41.1091	$2,618.40	$548.33	$523.68
27808	Treatment of ankle fracture		T	0043	1.7682	$112.62		$22.52
27810	Treatment of ankle fracture		T	0043	1.7682	$112.62		$22.52
27814	Treatment of ankle fracture		T	0063	41.1091	$2,618.40	$548.33	$523.68
27816	Treatment of ankle fracture		T	0043	1.7682	$112.62		$22.52
27818	Treatment of ankle fracture		T	0043	1.7682	$112.62		$22.52
27822	Treatment of ankle fracture		T	0063	41.1091	$2,618.40	$548.33	$523.68
27823	Treatment of ankle fracture		T	0064	59.2233	$3,772.17	$835.79	$754.43
27824	Treat lower leg fracture		T	0043	1.7682	$112.62		$22.52
27825	Treat lower leg fracture		T	0043	1.7682	$112.62		$22.52
27826	Treat lower leg fracture		T	0063	41.1091	$2,618.40	$548.33	$523.68
27827	Treat lower leg fracture		T	0064	59.2233	$3,772.17	$835.79	$754.43
27828	Treat lower leg fracture		T	0064	59.2233	$3,772.17	$835.79	$754.43
27829	Treat lower leg joint		T	0063	41.1091	$2,618.40	$548.33	$523.68
27830	Treat lower leg dislocation		T	0043	1.7682	$112.62		$22.52
27831	Treat lower leg dislocation		T	0043	1.7682	$112.62		$22.52
27832	Treat lower leg dislocation		T	0063	41.1091	$2,618.40	$548.33	$523.68
27840	Treat ankle dislocation		T	0043	1.7682	$112.62		$22.52
27842	Treat ankle dislocation		T	0045	14.7658	$940.49	$268.47	$188.10
27846	Treat ankle dislocation		T	0063	41.1091	$2,618.40	$548.33	$523.68
27848	Treat ankle dislocation		T	0063	41.1091	$2,618.40	$548.33	$523.68
27860	Fixation of ankle joint		T	0045	14.7658	$940.49	$268.47	$188.10
27870	Fusion of ankle joint, open		T	0052	79.4244	$5,058.86		$1,011.77
27871	Fusion of tibiofibular joint		T	0052	79.4244	$5,058.86		$1,011.77
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	21.2689	$1,354.70		$270.94
27886	Amputation follow-up surgery		C					
27888	Amputation of foot at ankle		C					
27889	Amputation of foot at ankle		T	0050	29.1900	$1,859.23		$371.85
27892	Decompression of leg		T	0049	21.2689	$1,354.70		$270.94
27893	Decompression of leg		T	0049	21.2689	$1,354.70		$270.94
27894	Decompression of leg		T	0049	21.2689	$1,354.70		$270.94
27899	Leg/ankle surgery procedure		T	0043	1.7682	$112.62		$22.52
28001	Drainage of bursa of foot		T	0007	11.5594	$736.26		$147.25
28002	Treatment of foot infection		T	0049	21.2689	$1,354.70		$270.94
28003	Treatment of foot infection		T	0049	21.2689	$1,354.70		$270.94
28005	Treat foot bone lesion		T	0055	20.8284	$1,326.64	$355.34	$265.33
28008	Incision of foot fascia		T	0055	20.8284	$1,326.64	$355.34	$265.33
28010	Incision of toe tendon		T	0055	20.8284	$1,326.64	$355.34	$265.33
28011	Incision of toe tendons		T	0055	20.8284	$1,326.64	$355.34	$265.33
28020	Exploration of foot joint		T	0055	20.8284	$1,326.64	$355.34	$265.33
28022	Exploration of foot joint		T	0055	20.8284	$1,326.64	$355.34	$265.33
28024	Exploration of toe joint		T	0055	20.8284	$1,326.64	$355.34	$265.33
28035	Decompression of tibia nerve		T	0220	18.0518	$1,149.79		$229.96
28043	Excision of foot lesion		T	0022	21.1098	$1,344.57	$354.45	$268.91
28045	Excision of foot lesion		T	0055	20.8284	$1,326.64	$355.34	$265.33
28046	Resection of tumor, foot		T	0055	20.8284	$1,326.64	$355.34	$265.33
28050	Biopsy of foot joint lining		T	0055	20.8284	$1,326.64	$355.34	$265.33
28052	Biopsy of foot joint lining		T	0055	20.8284	$1,326.64	$355.34	$265.33
28054	Biopsy of toe joint lining		T	0055	20.8284	$1,326.64	$355.34	$265.33
28055	Neurectomy, foot		T	0220	18.0518	$1,149.79		$229.96
28060	Partial removal, foot fascia		T	0055	20.8284	$1,326.64	$355.34	$265.33
28062	Removal of foot fascia		T	0055	20.8284	$1,326.64	$355.34	$265.33
28070	Removal of foot joint lining		T	0055	20.8284	$1,326.64	$355.34	$265.33
28072	Removal of foot joint lining		T	0055	20.8284	$1,326.64	$355.34	$265.33
28080	Removal of foot lesion		T	0055	20.8284	$1,326.64	$355.34	$265.33
28086	Excise foot tendon sheath		T	0055	20.8284	$1,326.64	$355.34	$265.33
28088	Excise foot tendon sheath		T	0055	20.8284	$1,326.64	$355.34	$265.33
28090	Removal of foot lesion		T	0055	20.8284	$1,326.64	$355.34	$265.33
28092	Removal of toe lesions		T	0055	20.8284	$1,326.64	$355.34	$265.33
28100	Removal of ankle/heel lesion		T	0055	20.8284	$1,326.64	$355.34	$265.33
28102	Remove/graft foot lesion		T	0056	44.2687	$2,819.65		$563.93
28103	Remove/graft foot lesion		T	0056	44.2687	$2,819.65		$563.93
28104	Removal of foot lesion		T	0055	20.8284	$1,326.64	$355.34	$265.33
28106	Remove/graft foot lesion		T	0056	44.2687	$2,819.65		$563.93
28107	Remove/graft foot lesion		T	0056	44.2687	$2,819.65		$563.93
28108	Removal of toe lesions		T	0055	20.8284	$1,326.64	$355.34	$265.33
28110	Part removal of metatarsal		T	0055	20.8284	$1,326.64	$355.34	$265.33
28111	Part removal of metatarsal		T	0055	20.8284	$1,326.64	$355.34	$265.33
28112	Part removal of metatarsal		T	0055	20.8284	$1,326.64	$355.34	$265.33
28113	Part removal of metatarsal		T	0055	20.8284	$1,326.64	$355.34	$265.33
28114	Removal of metatarsal heads		T	0055	20.8284	$1,326.64	$355.34	$265.33
28116	Revision of foot		T	0055	20.8284	$1,326.64	$355.34	$265.33
28118	Removal of heel bone		T	0055	20.8284	$1,326.64	$355.34	$265.33

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
28119	Removal of heel spur		T	0055	20.8284	$1,326.64	$355.34	$265.33
28120	Part removal of ankle/heel		T	0055	20.8284	$1,326.64	$355.34	$265.33
28122	Partial removal of foot bone		T	0055	20.8284	$1,326.64	$355.34	$265.33
28124	Partial removal of toe		T	0055	20.8284	$1,326.64	$355.34	$265.33
28126	Partial removal of toe		T	0055	20.8284	$1,326.64	$355.34	$265.33
28130	Removal of ankle bone		T	0055	20.8284	$1,326.64	$355.34	$265.33
28140	Removal of metatarsal		T	0055	20.8284	$1,326.64	$355.34	$265.33
28150	Removal of toe		T	0055	20.8284	$1,326.64	$355.34	$265.33
28153	Partial removal of toe		T	0055	20.8284	$1,326.64	$355.34	$265.33
28160	Partial removal of toe		T	0055	20.8284	$1,326.64	$355.34	$265.33
28171	Extensive foot surgery		T	0055	20.8284	$1,326.64	$355.34	$265.33
28173	Extensive foot surgery		T	0055	20.8284	$1,326.64	$355.34	$265.33
28175	Extensive foot surgery		T	0055	20.8284	$1,326.64	$355.34	$265.33
28190	Removal of foot foreign body		T	0019	4.3039	$274.13	$71.87	$54.83
28192	Removal of foot foreign body		T	0021	16.1001	$1,025.48	$219.48	$205.10
28193	Removal of foot foreign body		T	0020	8.6850	$553.18		$110.64
28200	Repair of foot tendon		T	0055	20.8284	$1,326.64	$355.34	$265.33
28202	Repair/graft of foot tendon		T	0055	20.8284	$1,326.64	$355.34	$265.33
28208	Repair of foot tendon		T	0055	20.8284	$1,326.64	$355.34	$265.33
28210	Repair/graft of foot tendon		T	0056	44.2687	$2,819.65		$563.93
28220	Release of foot tendon		T	0055	20.8284	$1,326.64	$355.34	$265.33
28222	Release of foot tendons		T	0055	20.8284	$1,326.64	$355.34	$265.33
28225	Release of foot tendon		T	0055	20.8284	$1,326.64	$355.34	$265.33
28226	Release of foot tendons		T	0055	20.8284	$1,326.64	$355.34	$265.33
28230	Incision of foot tendon(s)		T	0055	20.8284	$1,326.64	$355.34	$265.33
28232	Incision of toe tendon		T	0055	20.8284	$1,326.64	$355.34	$265.33
28234	Incision of foot tendon		T	0055	20.8284	$1,326.64	$355.34	$265.33
28238	Revision of foot tendon		T	0056	44.2687	$2,819.65		$563.93
28240	Release of big toe		T	0055	20.8284	$1,326.64	$355.34	$265.33
28250	Revision of foot fascia		T	0055	20.8284	$1,326.64	$355.34	$265.33
28260	Release of midfoot joint		T	0055	20.8284	$1,326.64	$355.34	$265.33
28261	Revision of foot tendon		T	0055	20.8284	$1,326.64	$355.34	$265.33
28262	Revision of foot and ankle		T	0055	20.8284	$1,326.64	$355.34	$265.33
28264	Release of midfoot joint		T	0056	44.2687	$2,819.65		$563.93
28270	Release of foot contracture		T	0055	20.8284	$1,326.64	$355.34	$265.33
28272	Release of toe joint, each		T	0055	20.8284	$1,326.64	$355.34	$265.33
28280	Fusion of toes		T	0055	20.8284	$1,326.64	$355.34	$265.33
28285	Repair of hammertoe		T	0055	20.8284	$1,326.64	$355.34	$265.33
28286	Repair of hammertoe		T	0055	20.8284	$1,326.64	$355.34	$265.33
28288	Partial removal of foot bone		T	0055	20.8284	$1,326.64	$355.34	$265.33
28289	Repair hallux rigidus		T	0055	20.8284	$1,326.64	$355.34	$265.33
28290	Correction of bunion		T	0057	29.4167	$1,873.67	$475.91	$374.73
28292	Correction of bunion		T	0057	29.4167	$1,873.67	$475.91	$374.73
28293	Correction of bunion		T	0057	29.4167	$1,873.67	$475.91	$374.73
28294	Correction of bunion		T	0057	29.4167	$1,873.67	$475.91	$374.73
28296	Correction of bunion		T	0057	29.4167	$1,873.67	$475.91	$374.73
28297	Correction of bunion		T	0057	29.4167	$1,873.67	$475.91	$374.73
28298	Correction of bunion		T	0057	29.4167	$1,873.67	$475.91	$374.73
28299	Correction of bunion		T	0057	29.4167	$1,873.67	$475.91	$374.73
28300	Incision of heel bone		T	0056	44.2687	$2,819.65		$563.93
28302	Incision of ankle bone		T	0055	20.8284	$1,326.64	$355.34	$265.33
28304	Incision of midfoot bones		T	0056	44.2687	$2,819.65		$563.93
28305	Incise/graft midfoot bones		T	0056	44.2687	$2,819.65		$563.93
28306	Incision of metatarsal		T	0055	20.8284	$1,326.64	$355.34	$265.33
28307	Incision of metatarsal		T	0055	20.8284	$1,326.64	$355.34	$265.33
28308	Incision of metatarsal		T	0055	20.8284	$1,326.64	$355.34	$265.33
28309	Incision of metatarsals		T	0056	44.2687	$2,819.65		$563.93
28310	Revision of big toe		T	0055	20.8284	$1,326.64	$355.34	$265.33
28312	Revision of toe		T	0055	20.8284	$1,326.64	$355.34	$265.33
28313	Repair deformity of toe		T	0055	20.8284	$1,326.64	$355.34	$265.33
28315	Removal of sesamoid bone		T	0055	20.8284	$1,326.64	$355.34	$265.33
28320	Repair of foot bones		T	0056	44.2687	$2,819.65		$563.93
28322	Repair of metatarsals		T	0056	44.2687	$2,819.65		$563.93
28340	Resect enlarged toe tissue		T	0055	20.8284	$1,326.64	$355.34	$265.33
28341	Resect enlarged toe		T	0055	20.8284	$1,326.64	$355.34	$265.33
28344	Repair extra toe(s)		T	0055	20.8284	$1,326.64	$355.34	$265.33
28345	Repair webbed toe(s)		T	0055	20.8284	$1,326.64	$355.34	$265.33
28360	Reconstruct cleft foot		T	0056	44.2687	$2,819.65		$563.93
28400	Treatment of heel fracture		T	0043	1.7682	$112.62		$22.52
28405	Treatment of heel fracture		T	0043	1.7682	$112.62		$22.52
28406	Treatment of heel fracture		T	0062	26.1592	$1,666.18	$372.87	$333.24
28415	Treat heel fracture	CH	T	0064	59.2233	$3,772.17	$835.79	$754.43
28420	Treat/graft heel fracture		T	0063	41.1091	$2,618.40	$548.33	$523.68
28430	Treatment of ankle fracture		T	0043	1.7682	$112.62		$22.52
28435	Treatment of ankle fracture		T	0043	1.7682	$112.62		$22.52
28436	Treatment of ankle fracture		T	0062	26.1592	$1,666.18	$372.87	$333.24
28445	Treat ankle fracture		T	0063	41.1091	$2,618.40	$548.33	$523.68
28446	Osteochondral talus autogrft	NI	T	0056	44.2687	$2,819.65		$563.93
28450	Treat midfoot fracture, each		T	0043	1.7682	$112.62		$22.52
28455	Treat midfoot fracture, each		T	0043	1.7682	$112.62		$22.52

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
28456	Treat midfoot fracture		T	0062	26.1592	$1,666.18	$372.87	$333.24
28465	Treat midfoot fracture, each		T	0063	41.1091	$2,618.40	$548.33	$523.68
28470	Treat metatarsal fracture		T	0043	1.7682	$112.62		$22.52
28475	Treat metatarsal fracture		T	0043	1.7682	$112.62		$22.52
28476	Treat metatarsal fracture		T	0062	26.1592	$1,666.18	$372.87	$333.24
28485	Treat metatarsal fracture		T	0063	41.1091	$2,618.40	$548.33	$523.68
28490	Treat big toe fracture		T	0043	1.7682	$112.62		$22.52
28495	Treat big toe fracture		T	0043	1.7682	$112.62		$22.52
28496	Treat big toe fracture		T	0062	26.1592	$1,666.18	$372.87	$333.24
28505	Treat big toe fracture	CH	T	0062	26.1592	$1,666.18	$372.87	$333.24
28510	Treatment of toe fracture		T	0043	1.7682	$112.62		$22.52
28515	Treatment of toe fracture		T	0043	1.7682	$112.62		$22.52
28525	Treat toe fracture	CH	T	0062	26.1592	$1,666.18	$372.87	$333.24
28530	Treat sesamoid bone fracture		T	0043	1.7682	$112.62		$22.52
28531	Treat sesamoid bone fracture	CH	T	0062	26.1592	$1,666.18	$372.87	$333.24
28540	Treat foot dislocation		T	0043	1.7682	$112.62		$22.52
28545	Treat foot dislocation		T	0062	26.1592	$1,666.18	$372.87	$333.24
28546	Treat foot dislocation		T	0062	26.1592	$1,666.18	$372.87	$333.24
28555	Repair foot dislocation		T	0063	41.1091	$2,618.40	$548.33	$523.68
28570	Treat foot dislocation		T	0043	1.7682	$112.62		$22.52
28575	Treat foot dislocation		T	0043	1.7682	$112.62		$22.52
28576	Treat foot dislocation		T	0062	26.1592	$1,666.18	$372.87	$333.24
28585	Repair foot dislocation	CH	T	0062	26.1592	$1,666.18	$372.87	$333.24
28600	Treat foot dislocation		T	0043	1.7682	$112.62		$22.52
28605	Treat foot dislocation		T	0043	1.7682	$112.62		$22.52
28606	Treat foot dislocation		T	0062	26.1592	$1,666.18	$372.87	$333.24
28615	Repair foot dislocation		T	0063	41.1091	$2,618.40	$548.33	$523.68
28630	Treat toe dislocation		T	0043	1.7682	$112.62		$22.52
28635	Treat toe dislocation		T	0045	14.7658	$940.49	$268.47	$188.10
28636	Treat toe dislocation		T	0062	26.1592	$1,666.18	$372.87	$333.24
28645	Repair toe dislocation	CH	T	0062	26.1592	$1,666.18	$372.87	$333.24
28660	Treat toe dislocation		T	0043	1.7682	$112.62		$22.52
28665	Treat toe dislocation		T	0045	14.7658	$940.49	$268.47	$188.10
28666	Treat toe dislocation		T	0062	26.1592	$1,666.18	$372.87	$333.24
28675	Repair of toe dislocation	CH	T	0062	26.1592	$1,666.18	$372.87	$333.24
28705	Fusion of foot bones		T	0056	44.2687	$2,819.65		$563.93
28715	Fusion of foot bones	CH	T	0052	79.4244	$5,058.86		$1,011.77
28725	Fusion of foot bones		T	0056	44.2687	$2,819.65		$563.93
28730	Fusion of foot bones		T	0056	44.2687	$2,819.65		$563.93
28735	Fusion of foot bones		T	0056	44.2687	$2,819.65		$563.93
28737	Revision of foot bones		T	0056	44.2687	$2,819.65		$563.93
28740	Fusion of foot bones		T	0056	44.2687	$2,819.65		$563.93
28750	Fusion of big toe joint		T	0056	44.2687	$2,819.65		$563.93
28755	Fusion of big toe joint		T	0055	20.8284	$1,326.64	$355.34	$265.33
28760	Fusion of big toe joint		T	0056	44.2687	$2,819.65		$563.93
28800	Amputation of midfoot		C					
28805	Amputation thru metatarsal		C					
28810	Amputation toe & metatarsal		T	0055	20.8284	$1,326.64	$355.34	$265.33
28820	Amputation of toe		T	0055	20.8284	$1,326.64	$355.34	$265.33
28825	Partial amputation of toe		T	0055	20.8284	$1,326.64	$355.34	$265.33
28890	High energy eswt, plantar f		T	0050	29.1900	$1,859.23		$371.85
28899	Foot/toes surgery procedure		T	0043	1.7682	$112.62		$22.52
29000	Application of body cast		S	0058	1.0931	$69.62		$13.92
29010	Application of body cast		S	0426	2.2910	$145.92		$29.18
29015	Application of body cast		S	0426	2.2910	$145.92		$29.18
29020	Application of body cast		S	0058	1.0931	$69.62		$13.92
29025	Application of body cast		S	0058	1.0931	$69.62		$13.92
29035	Application of body cast		S	0426	2.2910	$145.92		$29.18
29040	Application of body cast		S	0058	1.0931	$69.62		$13.92
29044	Application of body cast		S	0426	2.2910	$145.92		$29.18
29046	Application of body cast		S	0426	2.2910	$145.92		$29.18
29049	Application of figure eight		S	0058	1.0931	$69.62		$13.92
29055	Application of shoulder cast		S	0426	2.2910	$145.92		$29.18
29058	Application of shoulder cast		S	0058	1.0931	$69.62		$13.92
29065	Application of long arm cast		S	0426	2.2910	$145.92		$29.18
29075	Application of forearm cast		S	0426	2.2910	$145.92		$29.18
29085	Apply hand/wrist cast		S	0058	1.0931	$69.62		$13.92
29086	Apply finger cast		S	0058	1.0931	$69.62		$13.92
29105	Apply long arm splint		S	0058	1.0931	$69.62		$13.92
29125	Apply forearm splint		S	0058	1.0931	$69.62		$13.92
29126	Apply forearm splint		S	0058	1.0931	$69.62		$13.92
29130	Application of finger splint		S	0058	1.0931	$69.62		$13.92
29131	Application of finger splint		S	0058	1.0931	$69.62		$13.92
29200	Strapping of chest		S	0058	1.0931	$69.62		$13.92
29220	Strapping of low back		S	0058	1.0931	$69.62		$13.92
29240	Strapping of shoulder		S	0058	1.0931	$69.62		$13.92
29260	Strapping of elbow or wrist		S	0058	1.0931	$69.62		$13.92
29280	Strapping of hand or finger		S	0058	1.0931	$69.62		$13.92
29305	Application of hip cast		S	0426	2.2910	$145.92		$29.18
29325	Application of hip casts		S	0426	2.2910	$145.92		$29.18

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
29345	Application of long leg cast		S	0426	2.2910	$145.92		$29.18
29355	Application of long leg cast		S	0426	2.2910	$145.92		$29.18
29358	Apply long leg cast brace		S	0426	2.2910	$145.92		$29.18
29365	Application of long leg cast		S	0426	2.2910	$145.92		$29.18
29405	Apply short leg cast		S	0426	2.2910	$145.92		$29.18
29425	Apply short leg cast		S	0426	2.2910	$145.92		$29.18
29435	Apply short leg cast		S	0426	2.2910	$145.92		$29.18
29440	Addition of walker to cast		S	0058	1.0931	$69.62		$13.92
29445	Apply rigid leg cast		S	0426	2.2910	$145.92		$29.18
29450	Application of leg cast		S	0058	1.0931	$69.62		$13.92
29505	Application, long leg splint		S	0058	1.0931	$69.62		$13.92
29515	Application lower leg splint		S	0058	1.0931	$69.62		$13.92
29520	Strapping of hip		S	0058	1.0931	$69.62		$13.92
29530	Strapping of knee		S	0058	1.0931	$69.62		$13.92
29540	Strapping of ankle and/or ft		S	0058	1.0931	$69.62		$13.92
29550	Strapping of toes		S	0058	1.0931	$69.62		$13.92
29580	Application of paste boot		S	0058	1.0931	$69.62		$13.92
29590	Application of foot splint		S	0058	1.0931	$69.62		$13.92
29700	Removal/revision of cast		S	0058	1.0931	$69.62		$13.92
29705	Removal/revision of cast		S	0058	1.0931	$69.62		$13.92
29710	Removal/revision of cast		S	0426	2.2910	$145.92		$29.18
29715	Removal/revision of cast		S	0058	1.0931	$69.62		$13.92
29720	Repair of body cast		S	0058	1.0931	$69.62		$13.92
29730	Windowing of cast		S	0058	1.0931	$69.62		$13.92
29740	Wedging of cast		S	0058	1.0931	$69.62		$13.92
29750	Wedging of clubfoot cast		S	0058	1.0931	$69.62		$13.92
29799	Casting/strapping procedure		S	0058	1.0931	$69.62		$13.92
29800	Jaw arthroscopy/surgery		T	0041	28.7803	$1,833.13		$366.63
29804	Jaw arthroscopy/surgery		T	0041	28.7803	$1,833.13		$366.63
29805	Shoulder arthroscopy, dx		T	0041	28.7803	$1,833.13		$366.63
29806	Shoulder arthroscopy/surgery		T	0042	45.7072	$2,911.27	$804.74	$582.25
29807	Shoulder arthroscopy/surgery		T	0042	45.7072	$2,911.27	$804.74	$582.25
29819	Shoulder arthroscopy/surgery	CH	T	0042	45.7072	$2,911.27	$804.74	$582.25
29820	Shoulder arthroscopy/surgery	CH	T	0042	45.7072	$2,911.27	$804.74	$582.25
29821	Shoulder arthroscopy/surgery	CH	T	0042	45.7072	$2,911.27	$804.74	$582.25
29822	Shoulder arthroscopy/surgery		T	0041	28.7803	$1,833.13		$366.63
29823	Shoulder arthroscopy/surgery	CH	T	0042	45.7072	$2,911.27	$804.74	$582.25
29824	Shoulder arthroscopy/surgery		T	0041	28.7803	$1,833.13		$366.63
29825	Shoulder arthroscopy/surgery	CH	T	0042	45.7072	$2,911.27	$804.74	$582.25
29826	Shoulder arthroscopy/surgery		T	0042	45.7072	$2,911.27	$804.74	$582.25
29827	Arthroscop rotator cuff repr		T	0042	45.7072	$2,911.27	$804.74	$582.25
29828	Arthroscopy biceps tenodesis	NI	T	0042	45.7072	$2,911.27	$804.74	$582.25
29830	Elbow arthroscopy		T	0041	28.7803	$1,833.13		$366.63
29834	Elbow arthroscopy/surgery		T	0041	28.7803	$1,833.13		$366.63
29835	Elbow arthroscopy/surgery		T	0041	28.7803	$1,833.13		$366.63
29836	Elbow arthroscopy/surgery		T	0041	28.7803	$1,833.13		$366.63
29837	Elbow arthroscopy/surgery		T	0041	28.7803	$1,833.13		$366.63
29838	Elbow arthroscopy/surgery		T	0041	28.7803	$1,833.13		$366.63
29840	Wrist arthroscopy		T	0041	28.7803	$1,833.13		$366.63
29843	Wrist arthroscopy/surgery		T	0041	28.7803	$1,833.13		$366.63
29844	Wrist arthroscopy/surgery		T	0041	28.7803	$1,833.13		$366.63
29845	Wrist arthroscopy/surgery		T	0041	28.7803	$1,833.13		$366.63
29846	Wrist arthroscopy/surgery		T	0041	28.7803	$1,833.13		$366.63
29847	Wrist arthroscopy/surgery	CH	T	0042	45.7072	$2,911.27	$804.74	$582.25
29848	Wrist endoscopy/surgery		T	0041	28.7803	$1,833.13		$366.63
29850	Knee arthroscopy/surgery		T	0041	28.7803	$1,833.13		$366.63
29851	Knee arthroscopy/surgery		T	0042	45.7072	$2,911.27	$804.74	$582.25
29855	Tibial arthroscopy/surgery		T	0042	45.7072	$2,911.27	$804.74	$582.25
29856	Tibial arthroscopy/surgery	CH	T	0042	45.7072	$2,911.27	$804.74	$582.25
29860	Hip arthroscopy, dx	CH	T	0042	45.7072	$2,911.27	$804.74	$582.25
29861	Hip arthroscopy/surgery	CH	T	0042	45.7072	$2,911.27	$804.74	$582.25
29862	Hip arthroscopy/surgery		T	0042	45.7072	$2,911.27	$804.74	$582.25
29863	Hip arthroscopy/surgery		T	0042	45.7072	$2,911.27	$804.74	$582.25
29866	Autgrft implnt, knee w/scope		T	0042	45.7072	$2,911.27	$804.74	$582.25
29867	Allgrft implnt, knee w/scope		T	0042	45.7072	$2,911.27	$804.74	$582.25
29868	Meniscal trnspl, knee w/scpe		T	0042	45.7072	$2,911.27	$804.74	$582.25
29870	Knee arthroscopy, dx		T	0041	28.7803	$1,833.13		$366.63
29871	Knee arthroscopy/drainage		T	0041	28.7803	$1,833.13		$366.63
29873	Knee arthroscopy/surgery		T	0041	28.7803	$1,833.13		$366.63
29874	Knee arthroscopy/surgery		T	0041	28.7803	$1,833.13		$366.63
29875	Knee arthroscopy/surgery		T	0041	28.7803	$1,833.13		$366.63
29876	Knee arthroscopy/surgery		T	0041	28.7803	$1,833.13		$366.63
29877	Knee arthroscopy/surgery		T	0041	28.7803	$1,833.13		$366.63
29879	Knee arthroscopy/surgery		T	0041	28.7803	$1,833.13		$366.63
29880	Knee arthroscopy/surgery		T	0041	28.7803	$1,833.13		$366.63
29881	Knee arthroscopy/surgery		T	0041	28.7803	$1,833.13		$366.63
29882	Knee arthroscopy/surgery		T	0041	28.7803	$1,833.13		$366.63
29883	Knee arthroscopy/surgery		T	0041	28.7803	$1,833.13		$366.63
29884	Knee arthroscopy/surgery		T	0041	28.7803	$1,833.13		$366.63
29885	Knee arthroscopy/surgery		T	0042	45.7072	$2,911.27	$804.74	$582.25

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
29886	Knee arthroscopy/surgery		T	0041	28.7803	$1,833.13		$366.63
29887	Knee arthroscopy/surgery		T	0041	28.7803	$1,833.13		$366.63
29888	Knee arthroscopy/surgery		T	0042	45.7072	$2,911.27	$804.74	$582.25
29889	Knee arthroscopy/surgery		T	0042	45.7072	$2,911.27	$804.74	$582.25
29891	Ankle arthroscopy/surgery	CH	T	0042	45.7072	$2,911.27	$804.74	$582.25
29892	Ankle arthroscopy/surgery	CH	T	0042	45.7072	$2,911.27	$804.74	$582.25
29893	Scope, plantar fasciotomy		T	0055	20.8284	$1,326.64	$355.34	$265.33
29894	Ankle arthroscopy/surgery		T	0041	28.7803	$1,833.13		$366.63
29895	Ankle arthroscopy/surgery		T	0041	28.7803	$1,833.13		$366.63
29897	Ankle arthroscopy/surgery		T	0041	28.7803	$1,833.13		$366.63
29898	Ankle arthroscopy/surgery		T	0041	28.7803	$1,833.13		$366.63
29899	Ankle arthroscopy/surgery		T	0042	45.7072	$2,911.27	$804.74	$582.25
29900	Mcp joint arthroscopy, dx	CH	T	0041	28.7803	$1,833.13		$366.63
29901	Mcp joint arthroscopy, surg	CH	T	0041	28.7803	$1,833.13		$366.63
29902	Mcp joint arthroscopy, surg	CH	T	0041	28.7803	$1,833.13		$366.63
29904	Subtalar arthro w/fb rmvl	NI	T	0041	28.7803	$1,833.13		$366.63
29905	Subtalar arthro w/exc	NI	T	0041	28.7803	$1,833.13		$366.63
29906	Subtalar arthro w/deb	NI	T	0041	28.7803	$1,833.13		$366.63
29907	Subtalar arthro w/fusion	NI	T	0042	45.7072	$2,911.27	$804.74	$582.25
29999	Arthroscopy of joint		T	0041	28.7803	$1,833.13		$366.63
30000	Drainage of nose lesion		T	0251	2.5002	$159.25		$31.85
30020	Drainage of nose lesion		T	0251	2.5002	$159.25		$31.85
3006F	Cxr doc rev		M					
30100	Intranasal biopsy		T	0252	7.4474	$474.35	$109.16	$94.87
30110	Removal of nose polyp(s)		T	0253	16.3288	$1,040.05	$282.29	$208.01
30115	Removal of nose polyp(s)		T	0253	16.3288	$1,040.05	$282.29	$208.01
30117	Removal of intranasal lesion		T	0253	16.3288	$1,040.05	$282.29	$208.01
30118	Removal of intranasal lesion		T	0254	23.9765	$1,527.16	$321.35	$305.43
3011F	Lipid panel doc rev		M					
30120	Revision of nose		T	0253	16.3288	$1,040.05	$282.29	$208.01
30124	Removal of nose lesion		T	0252	7.4474	$474.35	$109.16	$94.87
30125	Removal of nose lesion		T	0256	39.8776	$2,539.96		$507.99
30130	Excise inferior turbinate		T	0253	16.3288	$1,040.05	$282.29	$208.01
30140	Resect inferior turbinate		T	0254	23.9765	$1,527.16	$321.35	$305.43
3014F	Screen mammo doc rev		M					
30150	Partial removal of nose		T	0256	39.8776	$2,539.96		$507.99
30160	Removal of nose		T	0256	39.8776	$2,539.96		$507.99
3017F	Colorectal ca screen doc rev		M					
30200	Injection treatment of nose		T	0252	7.4474	$474.35	$109.16	$94.87
3020F	Lvf assess		M					
30210	Nasal sinus therapy		T	0252	7.4474	$474.35	$109.16	$94.87
3021F	Lvef mod/sever deprs syst		M					
30220	Insert nasal septal button		T	0252	7.4474	$474.35	$109.16	$94.87
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	0.6310	$40.19		$8.04
30310	Remove nasal foreign body		T	0253	16.3288	$1,040.05	$282.29	$208.01
30320	Remove nasal foreign body		T	0253	16.3288	$1,040.05	$282.29	$208.01
3035F	O2 saturation<=88% /pao<=55		M					
3037F	O2 saturation >88% /pao>55		M					
30400	Reconstruction of nose		T	0256	39.8776	$2,539.96		$507.99
3040F	Fev<40% predicted value		M					
30410	Reconstruction of nose		T	0256	39.8776	$2,539.96		$507.99
30420	Reconstruction of nose		T	0256	39.8776	$2,539.96		$507.99
3042F	Fev>= 40% predicted value		M					
30430	Revision of nose		T	0254	23.9765	$1,527.16	$321.35	$305.43
30435	Revision of nose		T	0256	39.8776	$2,539.96		$507.99
3044F	Hg a1c level lt 7.0%		M					
30450	Revision of nose		T	0256	39.8776	$2,539.96		$507.99
3045F	HG a1c level 7.0–9.0%		M					
30460	Revision of nose		T	0256	39.8776	$2,539.96		$507.99
30462	Revision of nose		T	0256	39.8776	$2,539.96		$507.99
30465	Repair nasal stenosis		T	0256	39.8776	$2,539.96		$507.99
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	23.9765	$1,527.16	$321.35	$305.43
30540	Repair nasal defect		T	0256	39.8776	$2,539.96		$507.99
30545	Repair nasal defect		T	0256	39.8776	$2,539.96		$507.99
30560	Release of nasal adhesions		T	0251	2.5002	$159.25		$31.85
30580	Repair upper jaw fistula		T	0256	39.8776	$2,539.96		$507.99
30600	Repair mouth/nose fistula		T	0256	39.8776	$2,539.96		$507.99
3060F	Pos microalbuminuria rev		M					
3061F	Neg microalbuminuria rev		M					
30620	Intranasal reconstruction		T	0256	39.8776	$2,539.96		$507.99
3062F	Pos macroalbuminuria rev		M					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
30630	Repair nasal septum defect		T	0254	23.9765	$1,527.16	$321.35	$305.43
3066F	Nephropathy doc tx		M					
3072F	Low risk for retinopathy		M					
3073F	Pre-surg eye measures doc'd		M					
3074F	Syst bp lt 130 mm hg		M					
3075F	Syst bp ge 130 - 139mm hg		M					
3077F	Syst bp >= 140 mm hg6 it		M					
3078F	Diast bp < 80 mm hg		M					
3079F	Diast bp 80–89 mm hg		M					
30801	Ablate inf turbinate, superf		T	0252	7.4474	$474.35	$109.16	$94.87
30802	Cauterization, inner nose		T	0252	7.4474	$474.35	$109.16	$94.87
3080F	Diast bp >= 90 mm hg		M					
3082F	Kt/v lt 1.2		M					
3083F	Kt/v ge 1.2 and <1.7		M					
3084F	Kt/v ge 1.7		M					
3085F	Suicide risk assessed		M					
3088F	MDD, mild		M					
3089F	MDD, moderate		M					
30901	Control of nosebleed		T	0250	1.1251	$71.66	$25.10	$14.33
30903	Control of nosebleed		T	0250	1.1251	$71.66	$25.10	$14.33
30905	Control of nosebleed		T	0250	1.1251	$71.66	$25.10	$14.33
30906	Repeat control of nosebleed		T	0250	1.1251	$71.66	$25.10	$14.33
3090F	MDD, severe; w/o psych		M					
30915	Ligation, nasal sinus artery		T	0092	25.8410	$1,645.92		$329.18
3091F	Mdd, severe; w/ psych		M					
30920	Ligation, upper jaw artery		T	0092	25.8410	$1,645.92		$329.18
3092F	MDD, in remission		M					
30930	Ther fx, nasal inf turbinate		T	0253	16.3288	$1,040.05	$282.29	$208.01
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	2.5002	$159.25		$31.85
31000	Irrigation, maxillary sinus		T	0251	2.5002	$159.25		$31.85
31002	Irrigation, sphenoid sinus		T	0252	7.4474	$474.35	$109.16	$94.87
3100F	Image test ref carot diam		M					
31020	Exploration, maxillary sinus		T	0254	23.9765	$1,527.16	$321.35	$305.43
31030	Exploration, maxillary sinus		T	0256	39.8776	$2,539.96		$507.99
31032	Explore sinus, remove polyps		T	0256	39.8776	$2,539.96		$507.99
31040	Exploration behind upper jaw		T	0254	23.9765	$1,527.16	$321.35	$305.43
31050	Exploration, sphenoid sinus		T	0256	39.8776	$2,539.96		$507.99
31051	Sphenoid sinus surgery		T	0256	39.8776	$2,539.96		$507.99
31070	Exploration of frontal sinus		T	0254	23.9765	$1,527.16	$321.35	$305.43
31075	Exploration of frontal sinus		T	0256	39.8776	$2,539.96		$507.99
31080	Removal of frontal sinus		T	0256	39.8776	$2,539.96		$507.99
31081	Removal of frontal sinus		T	0256	39.8776	$2,539.96		$507.99
31084	Removal of frontal sinus		T	0256	39.8776	$2,539.96		$507.99
31085	Removal of frontal sinus		T	0256	39.8776	$2,539.96		$507.99
31086	Removal of frontal sinus		T	0256	39.8776	$2,539.96		$507.99
31087	Removal of frontal sinus		T	0256	39.8776	$2,539.96		$507.99
31090	Exploration of sinuses		T	0256	39.8776	$2,539.96		$507.99
3110F	Pres/absn hmrhg/lesion doc'd		M					
3111F	Ct/mri brain done w/in 24hrs		M					
3112F	Ct/mri brain done gt 24 hrs		M					
31200	Removal of ethmoid sinus		T	0256	39.8776	$2,539.96		$507.99
31201	Removal of ethmoid sinus		T	0256	39.8776	$2,539.96		$507.99
31205	Removal of ethmoid sinus		T	0256	39.8776	$2,539.96		$507.99
3120F	12-lead ecg performed		M					
31225	Removal of upper jaw		C					
31230	Removal of upper jaw		C					
31231	Nasal endoscopy, dx		T	0072	1.6115	$102.64	$21.27	$20.53
31233	Nasal/sinus endoscopy, dx		T	0072	1.6115	$102.64	$21.27	$20.53
31235	Nasal/sinus endoscopy, dx		T	0074	17.0160	$1,083.82	$292.25	$216.76
31237	Nasal/sinus endoscopy, surg		T	0074	17.0160	$1,083.82	$292.25	$216.76
31238	Nasal/sinus endoscopy, surg		T	0074	17.0160	$1,083.82	$292.25	$216.76
31239	Nasal/sinus endoscopy, surg		T	0075	22.7191	$1,447.07	$445.92	$289.41
31240	Nasal/sinus endoscopy, surg		T	0074	17.0160	$1,083.82	$292.25	$216.76
31254	Revision of ethmoid sinus		T	0075	22.7191	$1,447.07	$445.92	$289.41
31255	Removal of ethmoid sinus		T	0075	22.7191	$1,447.07	$445.92	$289.41
31256	Exploration maxillary sinus		T	0075	22.7191	$1,447.07	$445.92	$289.41
31267	Endoscopy, maxillary sinus		T	0075	22.7191	$1,447.07	$445.92	$289.41
31276	Sinus endoscopy, surgical		T	0075	22.7191	$1,447.07	$445.92	$289.41
31287	Nasal/sinus endoscopy, surg		T	0075	22.7191	$1,447.07	$445.92	$289.41
31288	Nasal/sinus endoscopy, surg		T	0075	22.7191	$1,447.07	$445.92	$289.41
31290	Nasal/sinus endoscopy, surg		C					
31291	Nasal/sinus endoscopy, surg		C					
31292	Nasal/sinus endoscopy, surg		T	0075	22.7191	$1,447.07	$445.92	$289.41
31293	Nasal/sinus endoscopy, surg		T	0075	22.7191	$1,447.07	$445.92	$289.41
31294	Nasal/sinus endoscopy, surg		T	0075	22.7191	$1,447.07	$445.92	$289.41
31299	Sinus surgery procedure		T	0251	2.5002	$159.25		$31.85
31300	Removal of larynx lesion		T	0254	23.9765	$1,527.16	$321.35	$305.43

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
3130F	Upper gi endoscopy performed		M					
31320	Diagnostic incision, larynx		T	0256	39.8776	$2,539.96		$507.99
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					
31382	Partial removal of larynx		C					
31390	Removal of larynx & pharynx		C					
31395	Reconstruct larynx & pharynx		C					
31400	Revision of larynx		T	0256	39.8776	$2,539.96		$507.99
3140F	Upper gi endo shows barrtt's		M					
3141F	Upper gi endo not barrtt's		M					
31420	Removal of epiglottis		T	0256	39.8776	$2,539.96		$507.99
3142F	Barium swallow test ordered		M					
31500	Insert emergency airway		S	0094	2.4590	$156.62	$46.29	$31.32
31502	Change of windpipe airway	CH	S	0078	1.3362	$85.11		$17.02
31505	Diagnostic laryngoscopy		T	0071	0.8224	$52.38	$11.20	$10.48
3150F	Forceps esoph biopsy done		M					
31510	Laryngoscopy with biopsy		T	0074	17.0160	$1,083.82	$292.25	$216.76
31511	Remove foreign body, larynx		T	0072	1.6115	$102.64	$21.27	$20.53
31512	Removal of larynx lesion		T	0074	17.0160	$1,083.82	$292.25	$216.76
31513	Injection into vocal cord		T	0072	1.6115	$102.64	$21.27	$20.53
31515	Laryngoscopy for aspiration		T	0074	17.0160	$1,083.82	$292.25	$216.76
31520	Dx laryngoscopy, newborn		T	0072	1.6115	$102.64	$21.27	$20.53
31525	Dx laryngoscopy excl nb		T	0074	17.0160	$1,083.82	$292.25	$216.76
31526	Dx laryngoscopy w/oper scope		T	0075	22.7191	$1,447.07	$445.92	$289.41
31527	Laryngoscopy for treatment		T	0075	22.7191	$1,447.07	$445.92	$289.41
31528	Laryngoscopy and dilation		T	0074	17.0160	$1,083.82	$292.25	$216.76
31529	Laryngoscopy and dilation		T	0074	17.0160	$1,083.82	$292.25	$216.76
31530	Laryngoscopy w/fb removal		T	0075	22.7191	$1,447.07	$445.92	$289.41
31531	Laryngoscopy w/fb & op scope		T	0075	22.7191	$1,447.07	$445.92	$289.41
31535	Laryngoscopy w/biopsy		T	0075	22.7191	$1,447.07	$445.92	$289.41
31536	Laryngoscopy w/bx & op scope		T	0075	22.7191	$1,447.07	$445.92	$289.41
31540	Laryngoscopy w/exc of tumor		T	0075	22.7191	$1,447.07	$445.92	$289.41
31541	Larynscop w/tumr exc + scope		T	0075	22.7191	$1,447.07	$445.92	$289.41
31545	Remove vc lesion w/scope		T	0075	22.7191	$1,447.07	$445.92	$289.41
31546	Remove vc lesion scope/graft		T	0075	22.7191	$1,447.07	$445.92	$289.41
3155F	Cytogen test marrow b/4 tx		M					
31560	Laryngoscop w/arytenoidectom		T	0075	22.7191	$1,447.07	$445.92	$289.41
31561	Larynscop, remve cart + scop		T	0075	22.7191	$1,447.07	$445.92	$289.41
31570	Laryngoscope w/vc inj		T	0074	17.0160	$1,083.82	$292.25	$216.76
31571	Laryngoscop w/vc inj + scope		T	0075	22.7191	$1,447.07	$445.92	$289.41
31575	Diagnostic laryngoscopy		T	0072	1.6115	$102.64	$21.27	$20.53
31576	Laryngoscopy with biopsy		T	0075	22.7191	$1,447.07	$445.92	$289.41
31577	Remove foreign body, larynx		T	0073	3.9940	$254.39	$69.15	$50.88
31578	Removal of larynx lesion		T	0075	22.7191	$1,447.07	$445.92	$289.41
31579	Diagnostic laryngoscopy		T	0073	3.9940	$254.39	$69.15	$50.88
31580	Revision of larynx		T	0256	39.8776	$2,539.96		$507.99
31582	Revision of larynx		T	0256	39.8776	$2,539.96		$507.99
31584	Treat larynx fracture		C					
31587	Revision of larynx		C					
31588	Revision of larynx		T	0256	39.8776	$2,539.96		$507.99
31590	Reinnervate larynx		T	0256	39.8776	$2,539.96		$507.99
31595	Larynx nerve surgery		T	0256	39.8776	$2,539.96		$507.99
31599	Larynx surgery procedure		T	0251	2.5002	$159.25		$31.85
31600	Incision of windpipe		T	0254	23.9765	$1,527.16	$321.35	$305.43
31601	Incision of windpipe		T	0254	23.9765	$1,527.16	$321.35	$305.43
31603	Incision of windpipe		T	0252	7.4474	$474.35	$109.16	$94.87
31605	Incision of windpipe		T	0252	7.4474	$474.35	$109.16	$94.87
3160F	Doc fe+ stores b/4 epo thx		M					
31610	Incision of windpipe		T	0254	23.9765	$1,527.16	$321.35	$305.43
31611	Surgery/speech prosthesis		T	0254	23.9765	$1,527.16	$321.35	$305.43
31612	Puncture/clear windpipe		T	0254	23.9765	$1,527.16	$321.35	$305.43
31613	Repair windpipe opening		T	0254	23.9765	$1,527.16	$321.35	$305.43
31614	Repair windpipe opening		T	0256	39.8776	$2,539.96		$507.99
31615	Visualization of windpipe		T	0076	9.9575	$634.23	$189.82	$126.85
31620	Endobronchial us add-on	CH	N					
31622	Dx bronchoscope/wash		T	0076	9.9575	$634.23	$189.82	$126.85
31623	Dx bronchoscope/brush		T	0076	9.9575	$634.23	$189.82	$126.85
31624	Dx bronchoscope/lavage		T	0076	9.9575	$634.23	$189.82	$126.85
31625	Bronchoscopy w/biopsy(s)		T	0076	9.9575	$634.23	$189.82	$126.85
31628	Bronchoscopy/lung bx, each		T	0076	9.9575	$634.23	$189.82	$126.85
31629	Bronchoscopy/needle bx, each		T	0076	9.9575	$634.23	$189.82	$126.85
31630	Bronchoscopy dilate/fx repr		T	0415	24.0654	$1,532.82	$459.92	$306.56
31631	Bronchoscopy, dilate w/stent		T	0415	24.0654	$1,532.82	$459.92	$306.56
31632	Bronchoscopy/lung bx, add'l		T	0076	9.9575	$634.23	$189.82	$126.85

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
31633	Bronchoscopy/needle bx add'l		T	0076	9.9575	$634.23	$189.82	$126.85
31635	Bronchoscopy w/fb removal		T	0076	9.9575	$634.23	$189.82	$126.85
31636	Bronchoscopy, bronch stents		T	0415	24.0654	$1,532.82	$459.92	$306.56
31637	Bronchoscopy, stent add-on		T	0076	9.9575	$634.23	$189.82	$126.85
31638	Bronchoscopy, revise stent		T	0415	24.0654	$1,532.82	$459.92	$306.56
31640	Bronchoscopy w/tumor excise		T	0415	24.0654	$1,532.82	$459.92	$306.56
31641	Bronchoscopy, treat blockage		T	0415	24.0654	$1,532.82	$459.92	$306.56
31643	Diag bronchoscope/catheter		T	0076	9.9575	$634.23	$189.82	$126.85
31645	Bronchoscopy, clear airways		T	0076	9.9575	$634.23	$189.82	$126.85
31646	Bronchoscopy, reclear airway		T	0076	9.9575	$634.23	$189.82	$126.85
31656	Bronchoscopy, inj for x-ray		T	0076	9.9575	$634.23	$189.82	$126.85
3170F	Flow cyto done b/4 tx		M					
31715	Injection for bronchus x-ray		N					
31717	Bronchial brush biopsy		T	0073	3.9940	$254.39	$69.15	$50.88
31720	Clearance of airways	CH	S	0077	0.3877	$24.69	$7.74	$4.94
31725	Clearance of airways		C					
31730	Intro, windpipe wire/tube		T	0073	3.9940	$254.39	$69.15	$50.88
31750	Repair of windpipe		T	0256	39.8776	$2,539.96		$507.99
31755	Repair of windpipe		T	0256	39.8776	$2,539.96		$507.99
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	23.9765	$1,527.16	$321.35	$305.43
31786	Remove windpipe lesion		C					
31800	Repair of windpipe injury		C					
31805	Repair of windpipe injury		C					
31820	Closure of windpipe lesion		T	0253	16.3288	$1,040.05	$282.29	$208.01
31825	Repair of windpipe defect		T	0254	23.9765	$1,527.16	$321.35	$305.43
31830	Revise windpipe scar		T	0254	23.9765	$1,527.16	$321.35	$305.43
31899	Airways surgical procedure		T	0076	9.9575	$634.23	$189.82	$126.85
32000	Drainage of chest	CH	D					
32002	Treatment of collapsed lung	CH	D					
32005	Treat lung lining chemically	CH	D					
3200F	Barium swallow test not req		M					
32019	Insert pleural catheter	CH	D					
32020	Insertion of chest tube	CH	D					
32035	Exploration of chest		C					
32036	Exploration of chest		C					
32095	Biopsy through chest wall		C					
32100	Exploration/biopsy of chest		C					
3210F	Grp a strep test performed		M					
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					
3215F	Pt immunity to hep A doc'd		M					
32160	Open chest heart massage		C					
3216F	Pt immunity to hep B doc'd		M					
3218F	Rna tstng hep c doc'd-done		M					
32200	Drain, open, lung lesion		C					
32201	Drain, percut, lung lesion		T	0070	5.2024	$331.36		$66.27
3220F	Hep C quant rna tstng doc'd		M					
32215	Treat chest lining		C					
32220	Release of lung		C					
32225	Partial release of lung		C					
3230F	Note hring tst w/in 6 mon		M					
32310	Removal of chest lining		C					
32320	Free/remove chest lining		C					
32400	Needle biopsy chest lining		T	0685	9.3354	$594.61		$118.92
32402	Open biopsy chest lining		C					
32405	Biopsy, lung or mediastinum		T	0685	9.3354	$594.61		$118.92
32420	Puncture/clear lung		T	0070	5.2024	$331.36		$66.27
32421	Thoracentesis for aspiration	NI	T	0070	5.2024	$331.36		$66.27
32422	Thoracentesis w/tube insert	NI	T	0070	5.2024	$331.36		$66.27
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
32550	Insert pleural cath	NI	T	0652	30.7096	$1,956.02		$391.20
32551	Insertion of chest tube	NI	T	0070	5.2024	$331.36		$66.27
32560	Treat lung lining chemically	NI	T	0070	5.2024	$331.36		$66.27
32601	Thoracoscopy, diagnostic		T	0069	32.5666	$2,074.30	$591.64	$414.86
32602	Thoracoscopy, diagnostic		T	0069	32.5666	$2,074.30	$591.64	$414.86
32603	Thoracoscopy, diagnostic		T	0069	32.5666	$2,074.30	$591.64	$414.86
32604	Thoracoscopy, diagnostic		T	0069	32.5666	$2,074.30	$591.64	$414.86
32605	Thoracoscopy, diagnostic		T	0069	32.5666	$2,074.30	$591.64	$414.86
32606	Thoracoscopy, diagnostic		T	0069	32.5666	$2,074.30	$591.64	$414.86
3260F	Pt cat/pn cat/hist grd doc'd		M					
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					
3265F	RNA tstng HepC vir ord/doc'd	NI	M					
32660	Thoracoscopy, surgical		C					
32661	Thoracoscopy, surgical		C					
32662	Thoracoscopy, surgical		C					
32663	Thoracoscopy, surgical		C					
32664	Thoracoscopy, surgical		C					
32665	Thoracoscopy, surgical		C					
3266F	HepC gn tstng doc'd b/4txmnt	NI	M					
3268F	PSA/T/G1Sc doc'd b/4 txmnt	NI	M					
3269F	Bone scn b/4 txmnt/aftr Dx	NI	M					
3270F	No bone scn b/4 txmnt/aftrDx	NI	M					
3271F	Low risk, prostate cancer	NI	M					
3272F	Med. risk, prostate cancer	NI	M					
3273F	High risk, prostate cancer	NI	M					
3274F	Prost Cncr rsk not lw/md/hgh	NI	M					
3278F	Serum lvls CA/iPTH/lpd ord	NI	M					
3279F	Hgb lvl >/=13 g/dL	NI	M					
32800	Repair lung hernia		C					
3280F	Hgb lvl 11–12.9 g/dL	NI	M					
32810	Close chest after drainage		C					
32815	Close bronchial fistula		C					
3281F	Hgb lvl <11 g/dL	NI	M					
32820	Reconstruct injured chest		C					
3284F	IOP down >15% of pre-svc lvl	NI	M					
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					
3285F	IOP down <15% of pre-svc lvl	NI	M					
3288F	Fall risk assessment doc'd	NI	M					
32900	Removal of rib(s)		C					
32905	Revise & repair chest wall		C					
32906	Revise & repair chest wall		C					
3290F	Pt=D(Rh)- and unsensitized	NI	M					
3291F	Pt=D(Rh)+or sensitized	NI	M					
3292F	HIV tstng asked/doc'd/revw'd	NI	M					
32940	Revision of lung		C					
32960	Therapeutic pneumothorax		T	0070	5.2024	$331.36		$66.27
32997	Total lung lavage		C					
32998	Perq rf ablate tx, pul tumor		T	0423	42.9980	$2,738.71		$547.74
32999	Chest surgery procedure		T	0070	5.2024	$331.36		$66.27
3300F	AJCC stage doc'd b/4 thxpy	NI	M					
33010	Drainage of heart sac		T	0070	5.2024	$331.36		$66.27
33011	Repeat drainage of heart sac		T	0070	5.2024	$331.36		$66.27
33015	Incision of heart sac		C					
3301F	Cancer stage doc'd, metast	NI	M					
33020	Incision of heart sac		C					
33025	Incision of heart sac		C					
3302F	AJCC stage 0 doc'd	NI	M					
33030	Partial removal of heart sac		C					
33031	Partial removal of heart sac		C					
3303F	AJCC stage IA doc'd	NI	M					
3304F	AJCC stage IB doc'd	NI	M					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
33050	Removal of heart sac lesion		C					
3305F	AJCC stage IC doc'd	NI	M					
3306F	AJCC stage IIA doc'd	NI	M					
3307F	AJCC stage IIB doc'd	NI	M					
3308F	AJCC stage IIC doc'd	NI	M					
3309F	AJCC stage IIIA doc'd	NI	M					
3310F	AJCC stage IIIB doc'd	NI	M					
3311F	AJCC stage IIIC doc'd	NI	M					
33120	Removal of heart lesion		C					
3312F	AJCC stage IVA doc'd	NI	M					
33130	Removal of heart lesion		C					
3313F	AJCC stage IVB doc'd	NI	M					
33140	Heart revascularize (tmr)		C					
33141	Heart tmr w/other procedure		C					
3314F	AJCC stage IVC doc'd	NI	M					
3315F	ER +or PR +breast cancer	NI	M					
3316F	ER- or PR- breast cancer	NI	M					
3317F	Path rpt malig cancer doc'd	NI	M					
3318F	Path rpt malig cancer doc'd	NI	M					
3319F	X-ray/CT/Ultrsnd et al ord'd	NI	M					
33202	Insert epicard eltrd, open		C					
33203	Insert epicard eltrd, endo		C					
33206	Insertion of heart pacemaker		T	0089	121.6508	$7,748.43	$1,682.28	$1,549.69
33207	Insertion of heart pacemaker		T	0089	121.6508	$7,748.43	$1,682.28	$1,549.69
33208	Insertion of heart pacemaker		T	0655	140.0317	$8,919.18		$1,783.84
3320F	No Xray/CT/ et al ord'd	NI	M					
33210	Insertion of heart electrode		T	0106	69.5217	$4,428.12		$885.62
33211	Insertion of heart electrode		T	0106	69.5217	$4,428.12		$885.62
33212	Insertion of pulse generator		T	0090	100.8341	$6,422.53	$1,612.80	$1,284.51
33213	Insertion of pulse generator		T	0654	109.2851	$6,960.81		$1,392.16
33214	Upgrade of pacemaker system		T	0655	140.0317	$8,919.18		$1,783.84
33215	Reposition pacing-defib lead		T	0105	23.9802	$1,527.39		$305.48
33216	Insert lead pace-defib, one		T	0106	69.5217	$4,428.12		$885.62
33217	Insert lead pace-defib, dual		T	0106	69.5217	$4,428.12		$885.62
33218	Repair lead pace-defib, one		T	0105	23.9802	$1,527.39		$305.48
33220	Repair lead pace-defib, dual		T	0105	23.9802	$1,527.39		$305.48
33222	Revise pocket, pacemaker	CH	T	0136	15.0458	$958.33		$191.67
33223	Revise pocket, pacing-defib	CH	T	0136	15.0458	$958.33		$191.67
33224	Insert pacing lead & connect		T	0418	259.7486	$16,544.43		$3,308.89
33225	L ventric pacing lead add-on		T	0418	259.7486	$16,544.43		$3,308.89
33226	Reposition l ventric lead		T	0105	23.9802	$1,527.39		$305.48
33233	Removal of pacemaker system		T	0105	23.9802	$1,527.39		$305.48
33234	Removal of pacemaker system		T	0105	23.9802	$1,527.39		$305.48
33235	Removal pacemaker electrode		T	0105	23.9802	$1,527.39		$305.48
33236	Remove electrode/thoracotomy		C					
33237	Remove electrode/thoracotomy		C					
33238	Remove electrode/thoracotomy		C					
33240	Insert pulse generator	CH	T	0107	333.8096	$21,261.67		$4,252.33
33241	Remove pulse generator		T	0105	23.9802	$1,527.39		$305.48
33243	Remove eltrd/thoracotomy		C					
33244	Remove eltrd, transven		T	0105	23.9802	$1,527.39		$305.48
33249	Eltrd/insert pace-defib	CH	T	0108	404.8543	$25,786.79		$5,157.36
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					
33257	Ablate atria, lmtd, add-on	NI	C					
33258	Ablate atria, x10sv, add-on	NI	C					
33259	Ablate atria w/bypass add-on	NI	C					
3325F	Preop asses 4 cataract surg	NI	M					
33261	Ablate heart dysrhythm focus		C					
33265	Ablate atria, lmtd, endo		C					
33266	Ablate atria, x10sv, endo		C					
33282	Implant pat-active ht record		S	0680	70.6073	$4,497.26		$899.45
33284	Remove pat-active ht record	CH	T	0020	8.6850	$553.18		$110.64
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
33864	Ascending aortic graft	NI	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					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	5.2024	$331.36		$66.27
34001	Removal of artery clot		C					
34051	Removal of artery clot		C					
34101	Removal of artery clot		T	0088	38.7673	$2,469.24	$655.22	$493.85
34111	Removal of arm artery clot		T	0088	38.7673	$2,469.24	$655.22	$493.85
34151	Removal of artery clot		C					
34201	Removal of artery clot		T	0088	38.7673	$2,469.24	$655.22	$493.85
34203	Removal of leg artery clot		T	0088	38.7673	$2,469.24	$655.22	$493.85
34401	Removal of vein clot		C					
34421	Removal of vein clot		T	0088	38.7673	$2,469.24	$655.22	$493.85
34451	Removal of vein clot		C					
34471	Removal of vein clot		T	0088	38.7673	$2,469.24	$655.22	$493.85
34490	Removal of vein clot		T	0088	38.7673	$2,469.24	$655.22	$493.85
34501	Repair valve, femoral vein		T	0088	38.7673	$2,469.24	$655.22	$493.85
34502	Reconstruct vena cava		C					
34510	Transposition of vein valve		T	0088	38.7673	$2,469.24	$655.22	$493.85
34520	Cross-over vein graft		T	0088	38.7673	$2,469.24	$655.22	$493.85
34530	Leg vein fusion		T	0088	38.7673	$2,469.24	$655.22	$493.85
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					
34806	Aneurysm press sensor add-on	NI	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	40.4667	$2,577.49		$515.50
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					
35180	Repair blood vessel lesion		T	0093	30.1294	$1,919.06		$383.81
35182	Repair blood vessel lesion		C					
35184	Repair blood vessel lesion		T	0093	30.1294	$1,919.06		$383.81
35188	Repair blood vessel lesion		T	0088	38.7673	$2,469.24	$655.22	$493.85
35189	Repair blood vessel lesion		C					
35190	Repair blood vessel lesion		T	0093	30.1294	$1,919.06		$383.81
35201	Repair blood vessel lesion		T	0093	30.1294	$1,919.06		$383.81
35206	Repair blood vessel lesion		T	0093	30.1294	$1,919.06		$383.81
35207	Repair blood vessel lesion		T	0088	38.7673	$2,469.24	$655.22	$493.85

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	30.1294	$1,919.06		$383.81
35231	Repair blood vessel lesion		T	0093	30.1294	$1,919.06		$383.81
35236	Repair blood vessel lesion		T	0093	30.1294	$1,919.06		$383.81
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	30.1294	$1,919.06		$383.81
35261	Repair blood vessel lesion		T	0653	40.4667	$2,577.49		$515.50
35266	Repair blood vessel lesion		T	0653	40.4667	$2,577.49		$515.50
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	40.4667	$2,577.49		$515.50
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	30.1294	$1,919.06		$383.81
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	45.3845	$2,890.72		$578.14
35459	Repair arterial blockage	CH	T	0083	45.3845	$2,890.72		$578.14
35460	Repair venous blockage	CH	T	0083	45.3845	$2,890.72		$578.14
35470	Repair arterial blockage	CH	T	0083	45.3845	$2,890.72		$578.14
35471	Repair arterial blockage	CH	T	0083	45.3845	$2,890.72		$578.14
35472	Repair arterial blockage	CH	T	0083	45.3845	$2,890.72		$578.14
35473	Repair arterial blockage	CH	T	0083	45.3845	$2,890.72		$578.14
35474	Repair arterial blockage	CH	T	0083	45.3845	$2,890.72		$578.14
35475	Repair arterial blockage	CH	T	0083	45.3845	$2,890.72		$578.14
35476	Repair venous blockage	CH	T	0083	45.3845	$2,890.72		$578.14
35480	Atherectomy, open		C					
35481	Atherectomy, open		C					
35482	Atherectomy, open		C					
35483	Atherectomy, open		C					
35484	Atherectomy, open	CH	T	0082	87.5137	$5,574.10		$1,114.82
35485	Atherectomy, open	CH	T	0082	87.5137	$5,574.10		$1,114.82
35490	Atherectomy, percutaneous	CH	T	0082	87.5137	$5,574.10		$1,114.82
35491	Atherectomy, percutaneous	CH	T	0082	87.5137	$5,574.10		$1,114.82
35492	Atherectomy, percutaneous	CH	T	0082	87.5137	$5,574.10		$1,114.82
35493	Atherectomy, percutaneous	CH	T	0082	87.5137	$5,574.10		$1,114.82
35494	Atherectomy, percutaneous	CH	T	0082	87.5137	$5,574.10		$1,114.82
35495	Atherectomy, percutaneous	CH	T	0082	87.5137	$5,574.10		$1,114.82
35500	Harvest vein for bypass	CH	T	0103	14.6576	$933.60		$186.72
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					
35523	Artery bypass graft	NI	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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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 art for cabg add-on		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	30.1294	$1,919.06		$383.81
35686	Bypass graft/av fist patency		T	0093	30.1294	$1,919.06		$383.81
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	29.6965	$1,891.49		$378.30
35800	Explore neck vessels		C					
35820	Explore chest vessels		C					
35840	Explore abdominal vessels		C					
35860	Explore limb vessels		T	0093	30.1294	$1,919.06		$383.81
35870	Repair vessel graft defect		C					
35875	Removal of clot in graft		T	0088	38.7673	$2,469.24	$655.22	$493.85
35876	Removal of clot in graft		T	0088	38.7673	$2,469.24	$655.22	$493.85
35879	Revise graft w/vein		T	0088	38.7673	$2,469.24	$655.22	$493.85
35881	Revise graft w/vein		T	0088	38.7673	$2,469.24	$655.22	$493.85
35883	Revise graft w/nonauto graft		T	0088	38.7673	$2,469.24	$655.22	$493.85
35884	Revise graft w/vein		T	0088	38.7673	$2,469.24	$655.22	$493.85
35901	Excision, graft, neck		C					
35903	Excision, graft, extremity		T	0115	29.6965	$1,891.49		$378.30
35905	Excision, graft, thorax		C					
35907	Excision, graft, abdomen		C					
36000	Place needle in vein		N					
36002	Pseudoaneurysm injection trt		S	0267	2.3792	$151.54	$60.50	$30.31
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	28.8743	$1,839.12		$367.82
36261	Revision of infusion pump	CH	T	0105	23.9802	$1,527.39		$305.48
36262	Removal of infusion pump	CH	T	0105	23.9802	$1,527.39		$305.48
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	0.2143	$13.65		$2.73
36425	Vein access cutdown > 1 yr		T	0035	0.2143	$13.65		$2.73
36430	Blood transfusion service		S	0110	3.3967	$216.35		$43.27
36440	Bl push transfuse, 2 yr or <		S	0110	3.3967	$216.35		$43.27
36450	Bl exchange/transfuse, nb		S	0110	3.3967	$216.35		$43.27
36455	Bl exchange/transfuse non-nb		S	0110	3.3967	$216.35		$43.27
36460	Transfusion service, fetal		S	0110	3.3967	$216.35		$43.27
36468	Injection(s), spider veins	CH	T	0013	0.7930	$50.51		$10.10
36469	Injection(s), spider veins	CH	T	0013	0.7930	$50.51		$10.10
36470	Injection therapy of vein	CH	T	0013	0.7930	$50.51		$10.10
36471	Injection therapy of veins	CH	T	0013	0.7930	$50.51		$10.10
36475	Endovenous rf, 1st vein		T	0091	42.6114	$2,714.09		$542.82
36476	Endovenous rf, vein add-on	CH	T	0092	25.8410	$1,645.92		$329.18
36478	Endovenous laser, 1st vein		T	0092	25.8410	$1,645.92		$329.18
36479	Endovenous laser vein add-on		T	0092	25.8410	$1,645.92		$329.18
36481	Insertion of catheter, vein		N					
36500	Insertion of catheter, vein		N					
36510	Insertion of catheter, vein		N					
36511	Apheresis wbc		S	0111	11.5058	$732.85	$198.40	$146.57
36512	Apheresis rbc		S	0111	11.5058	$732.85	$198.40	$146.57
36513	Apheresis platelets		S	0111	11.5058	$732.85	$198.40	$146.57
36514	Apheresis plasma		S	0111	11.5058	$732.85	$198.40	$146.57
36515	Apheresis, adsorp/reinfuse		S	0112	30.6035	$1,949.26	$433.29	$389.85
36516	Apheresis, selective		S	0112	30.6035	$1,949.26	$433.29	$389.85
36522	Photopheresis		S	0112	30.6035	$1,949.26	$433.29	$389.85
36540	Collect blood venous device	CH	D					
36550	Declot vascular device	CH	D					
36555	Insert non-tunnel cv cath		T	0621	10.9092	$694.85		$138.97
36556	Insert non-tunnel cv cath		T	0621	10.9092	$694.85		$138.97
36557	Insert tunneled cv cath		T	0622	24.1069	$1,535.46		$307.09
36558	Insert tunneled cv cath		T	0622	24.1069	$1,535.46		$307.09
36560	Insert tunneled cv cath		T	0623	28.8743	$1,839.12		$367.82
36561	Insert tunneled cv cath		T	0623	28.8743	$1,839.12		$367.82
36563	Insert tunneled cv cath		T	0623	28.8743	$1,839.12		$367.82
36565	Insert tunneled cv cath		T	0623	28.8743	$1,839.12		$367.82
36566	Insert tunneled cv cath		T	0625	81.7482	$5,206.87		$1,041.37
36568	Insert picc cath		T	0621	10.9092	$694.85		$138.97
36569	Insert picc cath		T	0621	10.9092	$694.85		$138.97
36570	Insert picvad cath		T	0622	24.1069	$1,535.46		$307.09
36571	Insert picvad cath		T	0622	24.1069	$1,535.46		$307.09
36575	Repair tunneled cv cath	CH	T	0109	5.6614	$360.60		$72.12
36576	Repair tunneled cv cath		T	0621	10.9092	$694.85		$138.97
36578	Replace tunneled cv cath		T	0622	24.1069	$1,535.46		$307.09
36580	Replace cvad cath		T	0621	10.9092	$694.85		$138.97
36581	Replace tunneled cv cath		T	0622	24.1069	$1,535.46		$307.09
36582	Replace tunneled cv cath		T	0623	28.8743	$1,839.12		$367.82
36583	Replace tunneled cv cath		T	0623	28.8743	$1,839.12		$367.82
36584	Replace picc cath		T	0621	10.9092	$694.85		$138.97
36585	Replace picvad cath		T	0622	24.1069	$1,535.46		$307.09
36589	Removal tunneled cv cath	CH	T	0109	5.6614	$360.60		$72.12
36590	Removal tunneled cv cath		T	0621	10.9092	$694.85		$138.97
36591	Draw blood off venous device	NI	Q	0624	0.5689	$36.24	$12.65	$7.25
36592	Collect blood from picc	NI	N					
36593	Declot vascular device	NI	T	0676	2.4824	$158.11		$31.62
36595	Mech remov tunneled cv cath		T	0622	24.1069	$1,535.46		$307.09

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
36596	Mech remov tunneled cv cath		T	0621	10.9092	$694.85		$138.97
36597	Reposition venous catheter		T	0621	10.9092	$694.85		$138.97
36598	Inj w/fluor, eval cv device	CH	T	0676	2.4824	$158.11		$31.62
36600	Withdrawal of arterial blood		Q	0035	0.2143	$13.65		$2.73
36620	Insertion catheter, artery		N					
36625	Insertion catheter, artery		N					
36640	Insertion catheter, artery		T	0623	28.8743	$1,839.12		$367.82
36660	Insertion catheter, artery		C					
36680	Insert needle, bone cavity		T	0002	1.1097	$70.68		$14.14
36800	Insertion of cannula		T	0115	29.6965	$1,891.49		$378.30
36810	Insertion of cannula		T	0115	29.6965	$1,891.49		$378.30
36815	Insertion of cannula		T	0115	29.6965	$1,891.49		$378.30
36818	Av fuse, uppr arm, cephalic		T	0088	38.7673	$2,469.24	$655.22	$493.85
36819	Av fuse, uppr arm, basilic		T	0088	38.7673	$2,469.24	$655.22	$493.85
36820	Av fusion/forearm vein		T	0088	38.7673	$2,469.24	$655.22	$493.85
36821	Av fusion direct any site		T	0088	38.7673	$2,469.24	$655.22	$493.85
36822	Insertion of cannula(s)		C					
36823	Insertion of cannula(s)		C					
36825	Artery-vein autograft		T	0088	38.7673	$2,469.24	$655.22	$493.85
36830	Artery-vein nonautograft		T	0088	38.7673	$2,469.24	$655.22	$493.85
36831	Open thrombect av fistula		T	0088	38.7673	$2,469.24	$655.22	$493.85
36832	Av fistula revision, open		T	0088	38.7673	$2,469.24	$655.22	$493.85
36833	Av fistula revision		T	0088	38.7673	$2,469.24	$655.22	$493.85
36834	Repair A-V aneurysm		T	0088	38.7673	$2,469.24	$655.22	$493.85
36835	Artery to vein shunt		T	0115	29.6965	$1,891.49		$378.30
36838	Dist revas ligation, hemo		T	0088	38.7673	$2,469.24	$655.22	$493.85
36860	External cannula declotting		T	0676	2.4824	$158.11		$31.62
36861	Cannula declotting		T	0115	29.6965	$1,891.49		$378.30
36870	Percut thrombect av fistula		T	0653	40.4667	$2,577.49		$515.50
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	88.5367	$5,639.26		$1,127.85
37184	Prim art mech thrombectomy		T	0088	38.7673	$2,469.24	$655.22	$493.85
37185	Prim art m-thrombect add-on		T	0088	38.7673	$2,469.24	$655.22	$493.85
37186	Sec art m-thrombect add-on		T	0088	38.7673	$2,469.24	$655.22	$493.85
37187	Venous mech thrombectomy		T	0088	38.7673	$2,469.24	$655.22	$493.85
37188	Venous m-thrombectomy add-on		T	0088	38.7673	$2,469.24	$655.22	$493.85
37195	Thrombolytic therapy, stroke		T	0676	2.4824	$158.11		$31.62
37200	Transcatheter biopsy	CH	T	0623	28.8743	$1,839.12		$367.82
37201	Transcatheter therapy infuse	CH	T	0103	14.6576	$933.60		$186.72
37202	Transcatheter therapy infuse	CH	T	0103	14.6576	$933.60		$186.72
37203	Transcatheter retrieval	CH	T	0623	28.8743	$1,839.12		$367.82
37204	Transcatheter occlusion	CH	T	0082	87.5137	$5,574.10		$1,114.82
37205	Transcath iv stent, percut		T	0229	88.5367	$5,639.26		$1,127.85
37206	Transcath iv stent/perc addl		T	0229	88.5367	$5,639.26		$1,127.85
37207	Transcath iv stent, open		T	0229	88.5367	$5,639.26		$1,127.85
37208	Transcath iv stent/open addl		T	0229	88.5367	$5,639.26		$1,127.85
37209	Change iv cath at thromb tx	CH	T	0623	28.8743	$1,839.12		$367.82
37210	Embolization uterine fibroid	CH	T	0229	88.5367	$5,639.26		$1,127.85
37215	Transcath stent, cca w/eps		C					
37216	Transcath stent, cca w/o eps		E					
37250	Iv us first vessel add-on	CH	N					
37251	Iv us each add vessel add-on	CH	N					
37500	Endoscopy ligate perf veins		T	0091	42.6114	$2,714.09		$542.82
37501	Vascular endoscopy procedure		T	0092	25.8410	$1,645.92		$329.18
37565	Ligation of neck vein		T	0093	30.1294	$1,919.06		$383.81
37600	Ligation of neck artery		T	0093	30.1294	$1,919.06		$383.81
37605	Ligation of neck artery		T	0091	42.6114	$2,714.09		$542.82
37606	Ligation of neck artery		T	0092	25.8410	$1,645.92		$329.18
37607	Ligation of a-v fistula		T	0092	25.8410	$1,645.92		$329.18
37609	Temporal artery procedure		T	0021	16.1001	$1,025.48	$219.48	$205.10
37615	Ligation of neck artery		T	0092	25.8410	$1,645.92		$329.18
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	42.6114	$2,714.09		$542.82
37650	Revision of major vein		T	0092	25.8410	$1,645.92		$329.18
37660	Revision of major vein		C					
37700	Revise leg vein	CH	T	0092	25.8410	$1,645.92		$329.18
37718	Ligate/strip short leg vein	CH	T	0092	25.8410	$1,645.92		$329.18
37722	Ligate/strip long leg vein		T	0091	42.6114	$2,714.09		$542.82
37735	Removal of leg veins/lesion		T	0091	42.6114	$2,714.09		$542.82
37760	Ligation, leg veins, open		T	0092	25.8410	$1,645.92		$329.18
37765	Phleb veins extrem 10–20		T	0092	25.8410	$1,645.92		$329.18
37766	Phleb veins extrem 20+		T	0092	25.8410	$1,645.92		$329.18
37780	Revision of leg vein		T	0092	25.8410	$1,645.92		$329.18

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
37785	Ligate/divide/excise vein		T	0092	25.8410	$1,645.92		$329.18
37788	Revascularization, penis		C					
37790	Penile venous occlusion		T	0181	33.9306	$2,161.18	$621.82	$432.24
37799	Vascular surgery procedure		T	0103	14.6576	$933.60		$186.72
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	45.5317	$2,900.10	$1,001.89	$580.02
38129	Laparoscope proc, spleen		T	0130	34.3958	$2,190.81	$659.53	$438.16
38200	Injection for spleen x-ray		N					
38204	Bl donor search management		N					
38205	Harvest allogenic stem cells		S	0111	11.5058	$732.85	$198.40	$146.57
38206	Harvest auto stem cells		S	0111	11.5058	$732.85	$198.40	$146.57
38207	Cryopreserve stem cells	CH	S	0110	3.3967	$216.35		$43.27
38208	Thaw preserved stem cells	CH	S	0110	3.3967	$216.35		$43.27
38209	Wash harvest stem cells	CH	S	0110	3.3967	$216.35		$43.27
38210	T-cell depletion of harvest	CH	S	0393	5.6921	$362.55	$82.04	$72.51
38211	Tumor cell deplete of harvest	CH	S	0393	5.6921	$362.55	$82.04	$72.51
38212	Rbc depletion of harvest	CH	S	0393	5.6921	$362.55	$82.04	$72.51
38213	Platelet deplete of harvest	CH	S	0393	5.6921	$362.55	$82.04	$72.51
38214	Volume deplete of harvest	CH	S	0393	5.6921	$362.55	$82.04	$72.51
38215	Harvest stem cell concentrate	CH	S	0393	5.6921	$362.55	$82.04	$72.51
38220	Bone marrow aspiration		T	0003	3.1008	$197.50		$39.50
38221	Bone marrow biopsy		T	0003	3.1008	$197.50		$39.50
38230	Bone marrow collection	CH	S	0112	30.6035	$1,949.26	$433.29	$389.85
38240	Bone marrow/stem transplant	CH	S	0112	30.6035	$1,949.26	$433.29	$389.85
38241	Bone marrow/stem transplant	CH	S	0112	30.6035	$1,949.26	$433.29	$389.85
38242	Lymphocyte infuse transplant		S	0111	11.5058	$732.85	$198.40	$146.57
38300	Drainage, lymph node lesion		T	0007	11.5594	$736.26		$147.25
38305	Drainage, lymph node lesion		T	0008	18.3197	$1,166.85		$233.37
38308	Incision of lymph channels		T	0113	22.9584	$1,462.31		$292.46
38380	Thoracic duct procedure		C					
38381	Thoracic duct procedure		C					
38382	Thoracic duct procedure		C					
38500	Biopsy/removal, lymph nodes		T	0113	22.9584	$1,462.31		$292.46
38505	Needle biopsy, lymph nodes		T	0005	7.1147	$453.16		$90.63
38510	Biopsy/removal, lymph nodes		T	0113	22.9584	$1,462.31		$292.46
38520	Biopsy/removal, lymph nodes		T	0113	22.9584	$1,462.31		$292.46
38525	Biopsy/removal, lymph nodes		T	0113	22.9584	$1,462.31		$292.46
38530	Biopsy/removal, lymph nodes		T	0113	22.9584	$1,462.31		$292.46
38542	Explore deep node(s), neck		T	0114	44.3240	$2,823.17		$564.63
38550	Removal, neck/armpit lesion		T	0113	22.9584	$1,462.31		$292.46
38555	Removal, neck/armpit lesion		T	0113	22.9584	$1,462.31		$292.46
38562	Removal, pelvic lymph nodes		C					
38564	Removal, abdomen lymph nodes		C					
38570	Laparoscopy, lymph node biop		T	0131	45.5317	$2,900.10	$1,001.89	$580.02
38571	Laparoscopy, lymphadenectomy		T	0132	69.6652	$4,437.26	$1,239.22	$887.45
38572	Laparoscopy, lymphadenectomy		T	0131	45.5317	$2,900.10	$1,001.89	$580.02
38589	Laparoscope proc, lymphatic		T	0130	34.3958	$2,190.81	$659.53	$438.16
38700	Removal of lymph nodes, neck		T	0113	22.9584	$1,462.31		$292.46
38720	Removal of lymph nodes, neck		T	0113	22.9584	$1,462.31		$292.46
38724	Removal of lymph nodes, neck		C					
38740	Remove armpit lymph nodes		T	0114	44.3240	$2,823.17		$564.63
38745	Remove armpit lymph nodes		T	0114	44.3240	$2,823.17		$564.63
38746	Remove thoracic lymph nodes		C					
38747	Remove abdominal lymph nodes		C					
38760	Remove groin lymph nodes		T	0113	22.9584	$1,462.31		$292.46
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	CH	Q	0392	2.9022	$184.85	$49.31	$36.97
38794	Access thoracic lymph duct		N					
38999	Blood/lymph system procedure		S	0110	3.3967	$216.35		$43.27
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	32.5666	$2,074.30	$591.64	$414.86
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	Areds/anitox vit/min rx'd	CH	D					
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 bronchodilator 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	2.5002	$159.25		$31.85
4049F	Doc order given stop antibio		M					
40500	Partial excision of lip		T	0253	16.3288	$1,040.05	$282.29	$208.01
4050F	Ht care plan doc		M					
40510	Partial excision of lip		T	0254	23.9765	$1,527.16	$321.35	$305.43
4051F	Referred for an AV fistula		M					
40520	Partial excision of lip		T	0253	16.3288	$1,040.05	$282.29	$208.01
40525	Reconstruct lip with flap		T	0254	23.9765	$1,527.16	$321.35	$305.43
40527	Reconstruct lip with flap		T	0254	23.9765	$1,527.16	$321.35	$305.43
4052F	Hemodialysis via AV fistula		M					
40530	Partial removal of lip		T	0254	23.9765	$1,527.16	$321.35	$305.43
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					
40650	Repair lip		T	0252	7.4474	$474.35	$109.16	$94.87
40652	Repair lip		T	0252	7.4474	$474.35	$109.16	$94.87
40654	Repair lip		T	0252	7.4474	$474.35	$109.16	$94.87
4065F	Antipsychotic rx		M					
4066F	ECT provided		M					
4067F	Pt referral for ECT doc'd		M					
40700	Repair cleft lip/nasal		T	0256	39.8776	$2,539.96		$507.99
40701	Repair cleft lip/nasal		T	0256	39.8776	$2,539.96		$507.99
40702	Repair cleft lip/nasal		T	0256	39.8776	$2,539.96		$507.99
4070F	Dvt prophylx recv'd day 2		M					
40720	Repair cleft lip/nasal		T	0256	39.8776	$2,539.96		$507.99
4073F	Oral antiplat thx rx dischrg		M					
4075F	Anticoag thx rx at dischrg		M					
40761	Repair cleft lip/nasal		T	0256	39.8776	$2,539.96		$507.99
4077F	Doc t-pa admin considered		M					
40799	Lip surgery procedure		T	0251	2.5002	$159.25		$31.85
4079F	Doc rehab svcs considered		M					
40800	Drainage of mouth lesion		T	0006	1.4066	$89.59		$17.92
40801	Drainage of mouth lesion		T	0252	7.4474	$474.35	$109.16	$94.87
40804	Removal, foreign body, mouth		X	0340	0.6310	$40.19		$8.04
40805	Removal, foreign body, mouth		T	0252	7.4474	$474.35	$109.16	$94.87
40806	Incision of lip fold		T	0251	2.5002	$159.25		$31.85
40808	Biopsy of mouth lesion		T	0251	2.5002	$159.25		$31.85
40810	Excision of mouth lesion		T	0253	16.3288	$1,040.05	$282.29	$208.01
40812	Excise/repair mouth lesion		T	0253	16.3288	$1,040.05	$282.29	$208.01
40814	Excise/repair mouth lesion		T	0253	16.3288	$1,040.05	$282.29	$208.01
40816	Excision of mouth lesion		T	0254	23.9765	$1,527.16	$321.35	$305.43
40818	Excise oral mucosa for graft		T	0251	2.5002	$159.25		$31.85

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
40819	Excise lip or cheek fold		T	0252	7.4474	$474.35	$109.16	$94.87
40820	Treatment of mouth lesion		T	0253	16.3288	$1,040.05	$282.29	$208.01
40830	Repair mouth laceration		T	0251	2.5002	$159.25		$31.85
40831	Repair mouth laceration		T	0252	7.4474	$474.35	$109.16	$94.87
40840	Reconstruction of mouth		T	0254	23.9765	$1,527.16	$321.35	$305.43
40842	Reconstruction of mouth		T	0254	23.9765	$1,527.16	$321.35	$305.43
40843	Reconstruction of mouth		T	0254	23.9765	$1,527.16	$321.35	$305.43
40844	Reconstruction of mouth		T	0256	39.8776	$2,539.96		$507.99
40845	Reconstruction of mouth		T	0256	39.8776	$2,539.96		$507.99
4084F	Aspirin recv'd w/in 24 hrs		M					
40899	Mouth surgery procedure		T	0251	2.5002	$159.25		$31.85
4090F	Pt rcvng epo thxpy		M					
4095F	Pt not rcvng epo thxpy		M					
41000	Drainage of mouth lesion		T	0253	16.3288	$1,040.05	$282.29	$208.01
41005	Drainage of mouth lesion		T	0251	2.5002	$159.25		$31.85
41006	Drainage of mouth lesion		T	0254	23.9765	$1,527.16	$321.35	$305.43
41007	Drainage of mouth lesion		T	0253	16.3288	$1,040.05	$282.29	$208.01
41008	Drainage of mouth lesion		T	0253	16.3288	$1,040.05	$282.29	$208.01
41009	Drainage of mouth lesion		T	0251	2.5002	$159.25		$31.85
4100F	Biphos thxpy vein ord/rec'vd		M					
41010	Incision of tongue fold		T	0252	7.4474	$474.35	$109.16	$94.87
41015	Drainage of mouth lesion		T	0251	2.5002	$159.25		$31.85
41016	Drainage of mouth lesion		T	0252	7.4474	$474.35	$109.16	$94.87
41017	Drainage of mouth lesion		T	0252	7.4474	$474.35	$109.16	$94.87
41018	Drainage of mouth lesion		T	0252	7.4474	$474.35	$109.16	$94.87
41019	Place needles h&n for rt	NI	T	0254	23.9765	$1,527.16	$321.35	$305.43
41100	Biopsy of tongue		T	0252	7.4474	$474.35	$109.16	$94.87
41105	Biopsy of tongue		T	0253	16.3288	$1,040.05	$282.29	$208.01
41108	Biopsy of floor of mouth		T	0252	7.4474	$474.35	$109.16	$94.87
4110F	Int mam art used for cabg		M					
41110	Excision of tongue lesion		T	0253	16.3288	$1,040.05	$282.29	$208.01
41112	Excision of tongue lesion		T	0253	16.3288	$1,040.05	$282.29	$208.01
41113	Excision of tongue lesion		T	0253	16.3288	$1,040.05	$282.29	$208.01
41114	Excision of tongue lesion		T	0254	23.9765	$1,527.16	$321.35	$305.43
41115	Excision of tongue fold		T	0252	7.4474	$474.35	$109.16	$94.87
41116	Excision of mouth lesion		T	0253	16.3288	$1,040.05	$282.29	$208.01
41120	Partial removal of tongue		T	0254	23.9765	$1,527.16	$321.35	$305.43
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					
4115F	Beta blckr admin w/in 24 hrs		M					
4120F	Antibiot rx'd/given		M					
4124F	Antibiot not rx'd/given		M					
41250	Repair tongue laceration		T	0251	2.5002	$159.25		$31.85
41251	Repair tongue laceration		T	0251	2.5002	$159.25		$31.85
41252	Repair tongue laceration		T	0252	7.4474	$474.35	$109.16	$94.87
4130F	Topical prep rx, AOE		M					
4131F	Syst antimicrobial thx rx		M					
4132F	No syst antimicrobial thx rx		M					
4133F	Antihist/decong rx/recom		M					
4134F	No antihist/decong rx/recom		M					
4135F	Systemic corticosteroids rx		M					
4136F	Syst corticosteroids not rx		M					
41500	Fixation of tongue		T	0254	23.9765	$1,527.16	$321.35	$305.43
4150F	Pt recvng antivir txmnt hepc		M					
41510	Tongue to lip surgery		T	0253	16.3288	$1,040.05	$282.29	$208.01
4151F	Pt not recvng antiv hep c		M					
41520	Reconstruction, tongue fold		T	0252	7.4474	$474.35	$109.16	$94.87
4152F	Doc'd pegintf/rib thxy consd		M					
4153F	Combo pegintf/rib rx		M					
4154F	Hep A vac series recommended		M					
4155F	Hep A vac series prev recvd		M					
4156F	Hep B vac series recommended		M					
4157F	Hep B vac series prev recvd		M					
4158F	Pt edu re: alcoh drnkng done		M					
41599	Tongue and mouth surgery		T	0251	2.5002	$159.25		$31.85
4159F	Contrcp talk b/4 antiv txmnt		M					
4163F	Pt couns. 4 txmnt opt, prost	NI	M					
4164F	Adjv hrmnl thxpy Rx'd	NI	M					
4165F	3D-CRT/IMRT received	NI	M					
4167F	Hd Bed tilted, 1st day vent	NI	M					
4168F	Pt care, ICU&vent w/in 24hrs	NI	M					
4169F	No pt care ICU/vent in 24hrs	NI	M					
4171F	Pt. rcvng ESA thxpy	NI	M					
4172F	Pt. not rcvng ESA thxpy	NI	M					
4174F	Couns., potent. Glauc impct	NI	M					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
4175F	Vis of >=20/40 w/in 90 days	NI	M					
4176F	Talk re UV light, pt/crgvr	NI	M					
4177F	Talk pt/crgvr re: AREDS,prev	NI	M					
4178F	AntiD glbln rcv'd w/in 26wks	NI	M					
4179F	Tamoxifen/AI prescribed	NI	M					
41800	Drainage of gum lesion		T	0006	1.4066	$89.59		$17.92
41805	Removal foreign body, gum		T	0254	23.9765	$1,527.16	$321.35	$305.43
41806	Removal foreign body, jawbone		T	0253	16.3288	$1,040.05	$282.29	$208.01
4180F	Adjv thxpyRx'd/rcv'd Stg3A-C	NI	M					
4181F	Conformal rad'n thxpy rcv'd	NI	M					
41820	Excision, gum, each quadrant		T	0252	7.4474	$474.35	$109.16	$94.87
41821	Excision of gum flap		T	0252	7.4474	$474.35	$109.16	$94.87
41822	Excision of gum lesion		T	0253	16.3288	$1,040.05	$282.29	$208.01
41823	Excision of gum lesion		T	0254	23.9765	$1,527.16	$321.35	$305.43
41825	Excision of gum lesion		T	0253	16.3288	$1,040.05	$282.29	$208.01
41826	Excision of gum lesion		T	0253	16.3288	$1,040.05	$282.29	$208.01
41827	Excision of gum lesion		T	0254	23.9765	$1,527.16	$321.35	$305.43
41828	Excision of gum lesion		T	0253	16.3288	$1,040.05	$282.29	$208.01
4182F	No conformal rad'n thxpy	NI	M					
41830	Removal of gum tissue		T	0253	16.3288	$1,040.05	$282.29	$208.01
41850	Treatment of gum lesion		T	0253	16.3288	$1,040.05	$282.29	$208.01
4185F	Continuous PPI or H2RA rcv'd	NI	M					
4186F	No Cont. PPI or H2RA rcv'd	NI	M					
41870	Gum graft		T	0254	23.9765	$1,527.16	$321.35	$305.43
41872	Repair gum		T	0253	16.3288	$1,040.05	$282.29	$208.01
41874	Repair tooth socket		T	0254	23.9765	$1,527.16	$321.35	$305.43
4187F	Anti rheum DrugthxpyRx'd/gvn	NI	M					
4188F	Approp ACE/ARB tstng done	NI	M					
41899	Dental surgery procedure		T	0251	2.5002	$159.25		$31.85
4189F	Approp dogoxin tstng done	NI	M					
4190F	Approp diuretic tstng done	NI	M					
4191F	Approp anticonvuls tstng	NI	M					
42000	Drainage mouth roof lesion		T	0251	2.5002	$159.25		$31.85
4200F	External beam to prost only	NI	M					
4201F	Extrnl beam other than prost	NI	M					
42100	Biopsy roof of mouth		T	0252	7.4474	$474.35	$109.16	$94.87
42104	Excision lesion, mouth roof		T	0253	16.3288	$1,040.05	$282.29	$208.01
42106	Excision lesion, mouth roof		T	0253	16.3288	$1,040.05	$282.29	$208.01
42107	Excision lesion, mouth roof		T	0254	23.9765	$1,527.16	$321.35	$305.43
4210F	ACE/ARB thxpy for >= 6 mons	NI	M					
42120	Remove palate/lesion		T	0256	39.8776	$2,539.96		$507.99
42140	Excision of uvula		T	0252	7.4474	$474.35	$109.16	$94.87
42145	Repair palate, pharynx/uvula		T	0254	23.9765	$1,527.16	$321.35	$305.43
42160	Treatment mouth roof lesion		T	0253	16.3288	$1,040.05	$282.29	$208.01
42180	Repair palate		T	0251	2.5002	$159.25		$31.85
42182	Repair palate		T	0256	39.8776	$2,539.96		$507.99
42200	Reconstruct cleft palate		T	0256	39.8776	$2,539.96		$507.99
42205	Reconstruct cleft palate		T	0256	39.8776	$2,539.96		$507.99
4220F	Digoxin thxpy for >= 6 mons	NI	M					
42210	Reconstruct cleft palate		T	0256	39.8776	$2,539.96		$507.99
42215	Reconstruct cleft palate		T	0256	39.8776	$2,539.96		$507.99
4221F	Diuretic thxpy for >= 6 mons	NI	M					
42220	Reconstruct cleft palate		T	0256	39.8776	$2,539.96		$507.99
42225	Reconstruct cleft palate		T	0256	39.8776	$2,539.96		$507.99
42226	Lengthening of palate		T	0256	39.8776	$2,539.96		$507.99
42227	Lengthening of palate		T	0256	39.8776	$2,539.96		$507.99
42235	Repair palate		T	0253	16.3288	$1,040.05	$282.29	$208.01
42260	Repair nose to lip fistula		T	0254	23.9765	$1,527.16	$321.35	$305.43
42280	Preparation, palate mold		T	0251	2.5002	$159.25		$31.85
42281	Insertion, palate prosthesis		T	0253	16.3288	$1,040.05	$282.29	$208.01
42299	Palate/uvula surgery		T	0251	2.5002	$159.25		$31.85
42300	Drainage of salivary gland		T	0253	16.3288	$1,040.05	$282.29	$208.01
42305	Drainage of salivary gland		T	0253	16.3288	$1,040.05	$282.29	$208.01
4230F	Anticonv thxpy for >= 6 mons	NI	M					
42310	Drainage of salivary gland		T	0251	2.5002	$159.25		$31.85
42320	Drainage of salivary gland		T	0251	2.5002	$159.25		$31.85
42330	Removal of salivary stone		T	0253	16.3288	$1,040.05	$282.29	$208.01
42335	Removal of salivary stone		T	0253	16.3288	$1,040.05	$282.29	$208.01
42340	Removal of salivary stone		T	0253	16.3288	$1,040.05	$282.29	$208.01
42400	Biopsy of salivary gland		T	0005	7.1147	$453.16		$90.63
42405	Biopsy of salivary gland		T	0253	16.3288	$1,040.05	$282.29	$208.01
42408	Excision of salivary cyst		T	0253	16.3288	$1,040.05	$282.29	$208.01
42409	Drainage of salivary cyst		T	0253	16.3288	$1,040.05	$282.29	$208.01
42410	Excise parotid gland/lesion		T	0256	39.8776	$2,539.96		$507.99
42415	Excise parotid gland/lesion		T	0256	39.8776	$2,539.96		$507.99
42420	Excise parotid gland/lesion		T	0256	39.8776	$2,539.96		$507.99
42425	Excise parotid gland/lesion		T	0256	39.8776	$2,539.96		$507.99
42426	Excise parotid gland/lesion		C					
42440	Excise submaxillary gland		T	0256	39.8776	$2,539.96		$507.99
42450	Excise sublingual gland		T	0254	23.9765	$1,527.16	$321.35	$305.43

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
42500	Repair salivary duct		T	0254	23.9765	$1,527.16	$321.35	$305.43
42505	Repair salivary duct		T	0256	39.8776	$2,539.96		$507.99
42507	Parotid duct diversion		T	0256	39.8776	$2,539.96		$507.99
42508	Parotid duct diversion		T	0256	39.8776	$2,539.96		$507.99
42509	Parotid duct diversion		T	0256	39.8776	$2,539.96		$507.99
42510	Parotid duct diversion		T	0256	39.8776	$2,539.96		$507.99
42550	Injection for salivary x-ray		N					
42600	Closure of salivary fistula		T	0253	16.3288	$1,040.05	$282.29	$208.01
42650	Dilation of salivary duct		T	0252	7.4474	$474.35	$109.16	$94.87
42660	Dilation of salivary duct		T	0251	2.5002	$159.25		$31.85
42665	Ligation of salivary duct		T	0254	23.9765	$1,527.16	$321.35	$305.43
42699	Salivary surgery procedure		T	0251	2.5002	$159.25		$31.85
42700	Drainage of tonsil abscess		T	0251	2.5002	$159.25		$31.85
42720	Drainage of throat abscess		T	0253	16.3288	$1,040.05	$282.29	$208.01
42725	Drainage of throat abscess		T	0256	39.8776	$2,539.96		$507.99
42800	Biopsy of throat		T	0252	7.4474	$474.35	$109.16	$94.87
42802	Biopsy of throat		T	0253	16.3288	$1,040.05	$282.29	$208.01
42804	Biopsy of upper nose/throat		T	0253	16.3288	$1,040.05	$282.29	$208.01
42806	Biopsy of upper nose/throat		T	0254	23.9765	$1,527.16	$321.35	$305.43
42808	Excise pharynx lesion		T	0253	16.3288	$1,040.05	$282.29	$208.01
42809	Remove pharynx foreign body		X	0340	0.6310	$40.19		$8.04
42810	Excision of neck cyst		T	0254	23.9765	$1,527.16	$321.35	$305.43
42815	Excision of neck cyst		T	0256	39.8776	$2,539.96		$507.99
42820	Remove tonsils and adenoids		T	0258	22.2557	$1,417.55	$437.25	$283.51
42821	Remove tonsils and adenoids		T	0258	22.2557	$1,417.55	$437.25	$283.51
42825	Removal of tonsils		T	0258	22.2557	$1,417.55	$437.25	$283.51
42826	Removal of tonsils		T	0258	22.2557	$1,417.55	$437.25	$283.51
42830	Removal of adenoids		T	0258	22.2557	$1,417.55	$437.25	$283.51
42831	Removal of adenoids		T	0258	22.2557	$1,417.55	$437.25	$283.51
42835	Removal of adenoids		T	0258	22.2557	$1,417.55	$437.25	$283.51
42836	Removal of adenoids		T	0258	22.2557	$1,417.55	$437.25	$283.51
42842	Extensive surgery of throat		T	0254	23.9765	$1,527.16	$321.35	$305.43
42844	Extensive surgery of throat		T	0256	39.8776	$2,539.96		$507.99
42845	Extensive surgery of throat		C					
42860	Excision of tonsil tags		T	0258	22.2557	$1,417.55	$437.25	$283.51
42870	Excision of lingual tonsil		T	0258	22.2557	$1,417.55	$437.25	$283.51
42890	Partial removal of pharynx		T	0256	39.8776	$2,539.96		$507.99
42892	Revision of pharyngeal walls		T	0256	39.8776	$2,539.96		$507.99
42894	Revision of pharyngeal walls		C					
42900	Repair throat wound		T	0252	7.4474	$474.35	$109.16	$94.87
42950	Reconstruction of throat		T	0254	23.9765	$1,527.16	$321.35	$305.43
42953	Repair throat, esophagus		C					
42955	Surgical opening of throat		T	0254	23.9765	$1,527.16	$321.35	$305.43
42960	Control throat bleeding		T	0250	1.1251	$71.66	$25.10	$14.33
42961	Control throat bleeding		C					
42962	Control throat bleeding		T	0256	39.8776	$2,539.96		$507.99
42970	Control nose/throat bleeding		T	0250	1.1251	$71.66	$25.10	$14.33
42971	Control nose/throat bleeding		C					
42972	Control nose/throat bleeding		T	0253	16.3288	$1,040.05	$282.29	$208.01
42999	Throat surgery procedure		T	0251	2.5002	$159.25		$31.85
43020	Incision of esophagus		T	0252	7.4474	$474.35	$109.16	$94.87
43030	Throat muscle surgery		T	0253	16.3288	$1,040.05	$282.29	$208.01
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	39.8776	$2,539.96		$507.99
43135	Removal of esophagus pouch		C					
43200	Esophagus endoscopy		T	0141	8.5030	$541.59	$143.38	$108.32
43201	Esoph scope w/submucous inj		T	0141	8.5030	$541.59	$143.38	$108.32
43202	Esophagus endoscopy, biopsy		T	0141	8.5030	$541.59	$143.38	$108.32
43204	Esoph scope w/sclerosis inj		T	0141	8.5030	$541.59	$143.38	$108.32
43205	Esophagus endoscopy/ligation		T	0141	8.5030	$541.59	$143.38	$108.32
43215	Esophagus endoscopy		T	0141	8.5030	$541.59	$143.38	$108.32
43216	Esophagus endoscopy/lesion		T	0141	8.5030	$541.59	$143.38	$108.32
43217	Esophagus endoscopy		T	0141	8.5030	$541.59	$143.38	$108.32
43219	Esophagus endoscopy		T	0384	24.9814	$1,591.17		$318.23
43220	Esoph endoscopy, dilation		T	0141	8.5030	$541.59	$143.38	$108.32
43226	Esoph endoscopy, dilation		T	0141	8.5030	$541.59	$143.38	$108.32
43227	Esoph endoscopy, repair		T	0141	8.5030	$541.59	$143.38	$108.32

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
43228	Esoph endoscopy, ablation		T	0422	25.3233	$1,612.94	$448.81	$322.59
43231	Esoph endoscopy w/us exam		T	0141	8.5030	$541.59	$143.38	$108.32
43232	Esoph endoscopy w/us fn bx		T	0141	8.5030	$541.59	$143.38	$108.32
43234	Upper GI endoscopy, exam		T	0141	8.5030	$541.59	$143.38	$108.32
43235	Uppr gi endoscopy, diagnosis		T	0141	8.5030	$541.59	$143.38	$108.32
43236	Uppr gi scope w/submuc inj		T	0141	8.5030	$541.59	$143.38	$108.32
43237	Endoscopic us exam, esoph		T	0141	8.5030	$541.59	$143.38	$108.32
43238	Uppr gi endoscopy w/us fn bx		T	0141	8.5030	$541.59	$143.38	$108.32
43239	Upper GI endoscopy, biopsy		T	0141	8.5030	$541.59	$143.38	$108.32
43240	Esoph endoscope w/drain cyst		T	0141	8.5030	$541.59	$143.38	$108.32
43241	Upper GI endoscopy with tube		T	0141	8.5030	$541.59	$143.38	$108.32
43242	Uppr gi endoscopy w/us fn bx		T	0141	8.5030	$541.59	$143.38	$108.32
43243	Upper gi endoscopy & inject		T	0141	8.5030	$541.59	$143.38	$108.32
43244	Upper GI endoscopy/ligation		T	0141	8.5030	$541.59	$143.38	$108.32
43245	Uppr gi scope dilate strictr		T	0141	8.5030	$541.59	$143.38	$108.32
43246	Place gastrostomy tube		T	0141	8.5030	$541.59	$143.38	$108.32
43247	Operative upper GI endoscopy		T	0141	8.5030	$541.59	$143.38	$108.32
43248	Uppr gi endoscopy/guide wire		T	0141	8.5030	$541.59	$143.38	$108.32
43249	Esoph endoscopy, dilation		T	0141	8.5030	$541.59	$143.38	$108.32
43250	Upper GI endoscopy/tumor		T	0141	8.5030	$541.59	$143.38	$108.32
43251	Operative upper GI endoscopy		T	0141	8.5030	$541.59	$143.38	$108.32
43255	Operative upper GI endoscopy		T	0141	8.5030	$541.59	$143.38	$108.32
43256	Uppr gi endoscopy w/stent		T	0384	24.9814	$1,591.17		$318.23
43257	Uppr gi scope w/thrml txmnt		T	0422	25.3233	$1,612.94	$448.81	$322.59
43258	Operative upper GI endoscopy		T	0141	8.5030	$541.59	$143.38	$108.32
43259	Endoscopic ultrasound exam		T	0141	8.5030	$541.59	$143.38	$108.32
43260	Endo cholangiopancreatograph		T	0151	20.9510	$1,334.45		$266.89
43261	Endo cholangiopancreatograph		T	0151	20.9510	$1,334.45		$266.89
43262	Endo cholangiopancreatograph		T	0151	20.9510	$1,334.45		$266.89
43263	Endo cholangiopancreatograph		T	0151	20.9510	$1,334.45		$266.89
43264	Endo cholangiopancreatograph		T	0151	20.9510	$1,334.45		$266.89
43265	Endo cholangiopancreatograph		T	0151	20.9510	$1,334.45		$266.89
43267	Endo cholangiopancreatograph		T	0151	20.9510	$1,334.45		$266.89
43268	Endo cholangiopancreatograph		T	0384	24.9814	$1,591.17		$318.23
43269	Endo cholangiopancreatograph		T	0384	24.9814	$1,591.17		$318.23
43271	Endo cholangiopancreatograph		T	0151	20.9510	$1,334.45		$266.89
43272	Endo cholangiopancreatograph		T	0151	20.9510	$1,334.45		$266.89
43280	Laparoscopy, fundoplasty		T	0132	69.6652	$4,437.26	$1,239.22	$887.45
43289	Laparoscope proc, esoph		T	0130	34.3958	$2,190.81	$659.53	$438.16
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	5.8431	$372.17	$91.40	$74.43
43453	Dilate esophagus		T	0140	5.8431	$372.17	$91.40	$74.43
43456	Dilate esophagus		T	0140	5.8431	$372.17	$91.40	$74.43
43458	Dilate esophagus	CH	T	0141	8.5030	$541.59	$143.38	$108.32
43460	Pressure treatment esophagus		C					
43496	Free jejunum flap, microvasc		C					
43499	Esophagus surgery procedure		T	0141	8.5030	$541.59	$143.38	$108.32
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	8.5030	$541.59	$143.38	$108.32
43520	Incision of pyloric muscle		C					
43600	Biopsy of stomach		T	0141	8.5030	$541.59	$143.38	$108.32
43605	Biopsy of stomach		C					
43610	Excision of stomach lesion		C					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	CH	S	0061	82.8597	$5,277.67		$1,055.53
43648	Lap revise/remv eltrd antrum		T	0130	34.3958	$2,190.81	$659.53	$438.16
43651	Laparoscopy, vagus nerve		T	0132	69.6652	$4,437.26	$1,239.22	$887.45
43652	Laparoscopy, vagus nerve		T	0132	69.6652	$4,437.26	$1,239.22	$887.45
43653	Laparoscopy, gastrostomy		T	0131	45.5317	$2,900.10	$1,001.89	$580.02
43659	Laparoscope proc, stom		T	0130	34.3958	$2,190.81	$659.53	$438.16
43750	Place gastrostomy tube	CH	D					
43752	Nasal/orogastric w/stent		X	0272	1.3271	$84.53	$31.64	$16.91
43760	Change gastrostomy tube		T	0121	3.2383	$206.26	$43.80	$41.25
43761	Reposition gastrostomy tube	CH	T	0141	8.5030	$541.59	$143.38	$108.32
43770	Lap place gastr adj device		C					
43771	Lap revise gastr adj device		C					
43772	Lap rmvl gastr adj device		C					
43773	Lap replace gastr adj device		C					
43774	Lap rmvl gastr adj all parts		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	25.3233	$1,612.94	$448.81	$322.59
43831	Place gastrostomy tube		T	0141	8.5030	$541.59	$143.38	$108.32
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	8.5030	$541.59	$143.38	$108.32
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	20.2069	$1,287.06		$257.41
43887	Remove gastric port, open	CH	T	0135	4.5263	$288.30		$57.66
43888	Change gastric port, open	CH	T	0137	20.2069	$1,287.06		$257.41
43999	Stomach surgery procedure		T	0141	8.5030	$541.59	$143.38	$108.32
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	8.5030	$541.59	$143.38	$108.32
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	45.5317	$2,900.10	$1,001.89	$580.02
44186	Lap, jejunostomy		T	0131	45.5317	$2,900.10	$1,001.89	$580.02
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					
44206	Lap part colectomy w/stoma		T	0132	69.6652	$4,437.26	$1,239.22	$887.45
44207	L colectomy/coloproctostomy		T	0132	69.6652	$4,437.26	$1,239.22	$887.45
44208	L colectomy/coloproctostomy		T	0132	69.6652	$4,437.26	$1,239.22	$887.45
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	34.3958	$2,190.81	$659.53	$438.16
44227	Lap, close enterostomy		C					
44238	Laparoscope proc, intestine		T	0130	34.3958	$2,190.81	$659.53	$438.16
44300	Open bowel to skin		C					
44310	Ileostomy/jejunostomy		C					
44312	Revision of ileostomy	CH	T	0137	20.2069	$1,287.06		$257.41
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	20.2069	$1,287.06		$257.41
44345	Revision of colostomy		C					
44346	Revision of colostomy		C					
44360	Small bowel endoscopy		T	0142	9.5292	$606.95	$152.78	$121.39
44361	Small bowel endoscopy/biopsy		T	0142	9.5292	$606.95	$152.78	$121.39
44363	Small bowel endoscopy		T	0142	9.5292	$606.95	$152.78	$121.39
44364	Small bowel endoscopy		T	0142	9.5292	$606.95	$152.78	$121.39
44365	Small bowel endoscopy		T	0142	9.5292	$606.95	$152.78	$121.39
44366	Small bowel endoscopy		T	0142	9.5292	$606.95	$152.78	$121.39
44369	Small bowel endoscopy		T	0142	9.5292	$606.95	$152.78	$121.39
44370	Small bowel endoscopy/stent		T	0384	24.9814	$1,591.17		$318.23
44372	Small bowel endoscopy		T	0142	9.5292	$606.95	$152.78	$121.39
44373	Small bowel endoscopy		T	0142	9.5292	$606.95	$152.78	$121.39
44376	Small bowel endoscopy		T	0142	9.5292	$606.95	$152.78	$121.39
44377	Small bowel endoscopy/biopsy		T	0142	9.5292	$606.95	$152.78	$121.39
44378	Small bowel endoscopy		T	0142	9.5292	$606.95	$152.78	$121.39
44379	S bowel endoscope w/stent		T	0384	24.9814	$1,591.17		$318.23
44380	Small bowel endoscopy		T	0142	9.5292	$606.95	$152.78	$121.39
44382	Small bowel endoscopy		T	0142	9.5292	$606.95	$152.78	$121.39
44383	Ileoscopy w/stent		T	0384	24.9814	$1,591.17		$318.23
44385	Endoscopy of bowel pouch		T	0143	8.8486	$563.60	$186.06	$112.72
44386	Endoscopy, bowel pouch/biop		T	0143	8.8486	$563.60	$186.06	$112.72
44388	Colonoscopy		T	0143	8.8486	$563.60	$186.06	$112.72
44389	Colonoscopy with biopsy		T	0143	8.8486	$563.60	$186.06	$112.72
44390	Colonoscopy for foreign body		T	0143	8.8486	$563.60	$186.06	$112.72
44391	Colonoscopy for bleeding		T	0143	8.8486	$563.60	$186.06	$112.72
44392	Colonoscopy & polypectomy		T	0143	8.8486	$563.60	$186.06	$112.72
44393	Colonoscopy, lesion removal		T	0143	8.8486	$563.60	$186.06	$112.72
44394	Colonoscopy w/snare		T	0143	8.8486	$563.60	$186.06	$112.72
44397	Colonoscopy w/stent		T	0384	24.9814	$1,591.17		$318.23
44500	Intro, gastrointestinal tube		T	0121	3.2383	$206.26	$43.80	$41.25
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	25.6947	$1,636.60	$397.95	$327.32
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	13.5764	$864.74	$228.76	$172.95
44950	Appendectomy		C					
44955	Appendectomy add-on		C					
44960	Appendectomy		C					
44970	Laparoscopy, appendectomy		T	0131	45.5317	$2,900.10	$1,001.89	$580.02
44979	Laparoscope proc, app		T	0130	34.3958	$2,190.81	$659.53	$438.16
45000	Drainage of pelvic abscess	CH	T	0155	10.9132	$695.11		$139.02
45005	Drainage of rectal abscess		T	0155	10.9132	$695.11		$139.02
45020	Drainage of rectal abscess		T	0155	10.9132	$695.11		$139.02
45100	Biopsy of rectum		T	0149	22.7451	$1,448.73	$293.06	$289.75
45108	Removal of anorectal lesion		T	0149	22.7451	$1,448.73	$293.06	$289.75
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	22.7451	$1,448.73	$293.06	$289.75
45160	Excision of rectal lesion		T	0149	22.7451	$1,448.73	$293.06	$289.75
45170	Excision of rectal lesion		T	0149	22.7451	$1,448.73	$293.06	$289.75
45190	Destruction, rectal tumor		T	0149	22.7451	$1,448.73	$293.06	$289.75
45300	Proctosigmoidoscopy dx		T	0146	5.0972	$324.66		$64.93
45303	Proctosigmoidoscopy dilate		T	0147	8.7031	$554.34		$110.87
45305	Proctosigmoidoscopy w/bx		T	0147	8.7031	$554.34		$110.87
45307	Proctosigmoidoscopy fb		T	0428	21.4632	$1,367.08		$273.42
45308	Proctosigmoidoscopy removal		T	0147	8.7031	$554.34		$110.87
45309	Proctosigmoidoscopy removal		T	0147	8.7031	$554.34		$110.87
45315	Proctosigmoidoscopy removal		T	0147	8.7031	$554.34		$110.87
45317	Proctosigmoidoscopy bleed		T	0147	8.7031	$554.34		$110.87
45320	Proctosigmoidoscopy ablate		T	0428	21.4632	$1,367.08		$273.42
45321	Proctosigmoidoscopy volvul		T	0428	21.4632	$1,367.08		$273.42
45327	Proctosigmoidoscopy w/stent		T	0384	24.9814	$1,591.17		$318.23
45330	Diagnostic sigmoidoscopy		T	0146	5.0972	$324.66		$64.93
45331	Sigmoidoscopy and biopsy		T	0146	5.0972	$324.66		$64.93
45332	Sigmoidoscopy w/fb removal		T	0146	5.0972	$324.66		$64.93
45333	Sigmoidoscopy & polypectomy		T	0147	8.7031	$554.34		$110.87
45334	Sigmoidoscopy for bleeding		T	0147	8.7031	$554.34		$110.87
45335	Sigmoidoscopy w/submuc inj		T	0146	5.0972	$324.66		$64.93
45337	Sigmoidoscopy & decompress		T	0146	5.0972	$324.66		$64.93
45338	Sigmoidoscopy w/tumr remove		T	0147	8.7031	$554.34		$110.87
45339	Sigmoidoscopy w/ablate tumr		T	0147	8.7031	$554.34		$110.87
45340	Sig w/balloon dilation		T	0147	8.7031	$554.34		$110.87
45341	Sigmoidoscopy w/ultrasound		T	0147	8.7031	$554.34		$110.87
45342	Sigmoidoscopy w/us guide bx		T	0147	8.7031	$554.34		$110.87
45345	Sigmoidoscopy w/stent		T	0384	24.9814	$1,591.17		$318.23
45355	Surgical colonoscopy		T	0143	8.8486	$563.60	$186.06	$112.72
45378	Diagnostic colonoscopy		T	0143	8.8486	$563.60	$186.06	$112.72
45379	Colonoscopy w/fb removal		T	0143	8.8486	$563.60	$186.06	$112.72
45380	Colonoscopy and biopsy		T	0143	8.8486	$563.60	$186.06	$112.72
45381	Colonoscopy, submucous inj		T	0143	8.8486	$563.60	$186.06	$112.72
45382	Colonoscopy/control bleeding		T	0143	8.8486	$563.60	$186.06	$112.72
45383	Lesion removal colonoscopy		T	0143	8.8486	$563.60	$186.06	$112.72
45384	Lesion remove colonoscopy		T	0143	8.8486	$563.60	$186.06	$112.72
45385	Lesion removal colonoscopy		T	0143	8.8486	$563.60	$186.06	$112.72
45386	Colonoscopy dilate stricture		T	0143	8.8486	$563.60	$186.06	$112.72
45387	Colonoscopy w/stent		T	0384	24.9814	$1,591.17		$318.23
45391	Colonoscopy w/endoscope us		T	0143	8.8486	$563.60	$186.06	$112.72
45392	Colonoscopy w/endoscopic fnb		T	0143	8.8486	$563.60	$186.06	$112.72
45395	Lap, removal of rectum		C					
45397	Lap, remove rectum w/pouch		C					
45400	Laparoscopic proc		C					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
45402	Lap proctopexy w/sig resect		C					
45499	Laparoscope proc, rectum		T	0130	34.3958	$2,190.81	$659.53	$438.16
45500	Repair of rectum		T	0149	22.7451	$1,448.73	$293.06	$289.75
45505	Repair of rectum		T	0150	30.1606	$1,921.05	$437.12	$384.21
45520	Treatment of rectal prolapse	CH	T	0013	0.7930	$50.51		$10.10
45540	Correct rectal prolapse		C					
45541	Correct rectal prolapse		T	0150	30.1606	$1,921.05	$437.12	$384.21
45550	Repair rectum/remove sigmoid		C					
45560	Repair of rectocele		T	0150	30.1606	$1,921.05	$437.12	$384.21
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					
45900	Reduction of rectal prolapse		T	0148	4.7935	$305.32		$61.06
45905	Dilation of anal sphincter		T	0149	22.7451	$1,448.73	$293.06	$289.75
45910	Dilation of rectal narrowing		T	0149	22.7451	$1,448.73	$293.06	$289.75
45915	Remove rectal obstruction	CH	T	0155	10.9132	$695.11		$139.02
45990	Surg dx exam, anorectal	CH	T	0149	22.7451	$1,448.73	$293.06	$289.75
45999	Rectum surgery procedure		T	0148	4.7935	$305.32		$61.06
46020	Placement of seton		T	0149	22.7451	$1,448.73	$293.06	$289.75
46030	Removal of rectal marker		T	0148	4.7935	$305.32		$61.06
46040	Incision of rectal abscess		T	0149	22.7451	$1,448.73	$293.06	$289.75
46045	Incision of rectal abscess		T	0149	22.7451	$1,448.73	$293.06	$289.75
46050	Incision of anal abscess	CH	T	0155	10.9132	$695.11		$139.02
46060	Incision of rectal abscess		T	0149	22.7451	$1,448.73	$293.06	$289.75
46070	Incision of anal septum		T	0155	10.9132	$695.11		$139.02
46080	Incision of anal sphincter		T	0149	22.7451	$1,448.73	$293.06	$289.75
46083	Incise external hemorrhoid		T	0164	2.0077	$127.88		$25.58
46200	Removal of anal fissure		T	0149	22.7451	$1,448.73	$293.06	$289.75
46210	Removal of anal crypt		T	0149	22.7451	$1,448.73	$293.06	$289.75
46211	Removal of anal crypts		T	0149	22.7451	$1,448.73	$293.06	$289.75
46220	Removal of anal tag		T	0149	22.7451	$1,448.73	$293.06	$289.75
46221	Ligation of hemorrhoid(s)		T	0148	4.7935	$305.32		$61.06
46230	Removal of anal tags		T	0149	22.7451	$1,448.73	$293.06	$289.75
46250	Hemorrhoidectomy		T	0149	22.7451	$1,448.73	$293.06	$289.75
46255	Hemorrhoidectomy		T	0149	22.7451	$1,448.73	$293.06	$289.75
46257	Remove hemorrhoids & fissure		T	0149	22.7451	$1,448.73	$293.06	$289.75
46258	Remove hemorrhoids & fistula		T	0149	22.7451	$1,448.73	$293.06	$289.75
46260	Hemorrhoidectomy		T	0149	22.7451	$1,448.73	$293.06	$289.75
46261	Remove hemorrhoids & fissure		T	0149	22.7451	$1,448.73	$293.06	$289.75
46262	Remove hemorrhoids & fistula		T	0149	22.7451	$1,448.73	$293.06	$289.75
46270	Removal of anal fistula		T	0149	22.7451	$1,448.73	$293.06	$289.75
46275	Removal of anal fistula		T	0149	22.7451	$1,448.73	$293.06	$289.75
46280	Removal of anal fistula		T	0149	22.7451	$1,448.73	$293.06	$289.75
46285	Removal of anal fistula		T	0149	22.7451	$1,448.73	$293.06	$289.75
46288	Repair anal fistula		T	0149	22.7451	$1,448.73	$293.06	$289.75
46320	Removal of hemorrhoid clot	CH	T	0149	22.7451	$1,448.73	$293.06	$289.75
46500	Injection into hemorrhoid(s)		T	0155	10.9132	$695.11		$139.02
46505	Chemodenervation anal musc		T	0148	4.7935	$305.32		$61.06
46600	Diagnostic anoscopy		X	0340	0.6310	$40.19		$8.04
46604	Anoscopy and dilation		T	0147	8.7031	$554.34		$110.87
46606	Anoscopy and biopsy		T	0146	5.0972	$324.66		$64.93
46608	Anoscopy, remove for body		T	0147	8.7031	$554.34		$110.87
46610	Anoscopy, remove lesion		T	0428	21.4632	$1,367.08		$273.42
46611	Anoscopy		T	0147	8.7031	$554.34		$110.87
46612	Anoscopy, remove lesions		T	0428	21.4632	$1,367.08		$273.42
46614	Anoscopy, control bleeding		T	0146	5.0972	$324.66		$64.93
46615	Anoscopy		T	0428	21.4632	$1,367.08		$273.42
46700	Repair of anal stricture		T	0149	22.7451	$1,448.73	$293.06	$289.75
46705	Repair of anal stricture		C					
46706	Repr of anal fistula w/glue		T	0150	30.1606	$1,921.05	$437.12	$384.21
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	30.1606	$1,921.05	$437.12	$384.21
46751	Repair of anal sphincter		C					
46753	Reconstruction of anus		T	0149	22.7451	$1,448.73	$293.06	$289.75
46754	Removal of suture from anus		T	0149	22.7451	$1,448.73	$293.06	$289.75
46760	Repair of anal sphincter	CH	T	0150	30.1606	$1,921.05	$437.12	$384.21
46761	Repair of anal sphincter	CH	T	0150	30.1606	$1,921.05	$437.12	$384.21

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
46762	Implant artificial sphincter	CH	T	0150	30.1606	$1,921.05	$437.12	$384.21
46900	Destruction, anal lesion(s)		T	0016	2.6604	$169.45		$33.89
46910	Destruction, anal lesion(s)		T	0017	19.9041	$1,267.77		$253.55
46916	Cryosurgery, anal lesion(s)	CH	T	0015	1.4595	$92.96		$18.59
46917	Laser surgery, anal lesions	CH	T	0017	19.9041	$1,267.77		$253.55
46922	Excision of anal lesion(s)	CH	T	0017	19.9041	$1,267.77		$253.55
46924	Destruction, anal lesion(s)	CH	T	0017	19.9041	$1,267.77		$253.55
46934	Destruction of hemorrhoids		T	0155	10.9132	$695.11		$139.02
46935	Destruction of hemorrhoids		T	0155	10.9132	$695.11		$139.02
46936	Destruction of hemorrhoids		T	0149	22.7451	$1,448.73	$293.06	$289.75
46937	Cryotherapy of rectal lesion		T	0149	22.7451	$1,448.73	$293.06	$289.75
46938	Cryotherapy of rectal lesion		T	0150	30.1606	$1,921.05	$437.12	$384.21
46940	Treatment of anal fissure		T	0149	22.7451	$1,448.73	$293.06	$289.75
46942	Treatment of anal fissure		T	0148	4.7935	$305.32		$61.06
46945	Ligation of hemorrhoids		T	0155	10.9132	$695.11		$139.02
46946	Ligation of hemorrhoids		T	0155	10.9132	$695.11		$139.02
46947	Hemorrhoidopexy by stapling		T	0150	30.1606	$1,921.05	$437.12	$384.21
46999	Anus surgery procedure		T	0148	4.7935	$305.32		$61.06
47000	Needle biopsy of liver		T	0685	9.3354	$594.61		$118.92
47001	Needle biopsy, liver add-on		N					
47010	Open drainage, liver lesion		C					
47011	Percut drain, liver lesion		T	0037	13.5764	$864.74	$228.76	$172.95
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	69.6652	$4,437.26	$1,239.22	$887.45
47371	Laparo ablate liver cryosurg		T	0131	45.5317	$2,900.10	$1,001.89	$580.02
47379	Laparoscope procedure, liver		T	0130	34.3958	$2,190.81	$659.53	$438.16
47380	Open ablate liver tumor rf		C					
47381	Open ablate liver tumor cryo		C					
47382	Percut ablate liver rf		T	0423	42.9980	$2,738.71		$547.74
47399	Liver surgery procedure		T	0004	4.3270	$275.60		$55.12
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	28.6884	$1,827.28		$365.46
47500	Injection for liver x-rays		N					
47505	Injection for liver x-rays		N					
47510	Insert catheter, bile duct		T	0152	28.6884	$1,827.28		$365.46
47511	Insert bile duct drain		T	0152	28.6884	$1,827.28		$365.46
47525	Change bile duct catheter		T	0427	15.3545	$977.99		$195.60
47530	Revise/reinsert bile tube		T	0427	15.3545	$977.99		$195.60
47550	Bile duct endoscopy add-on		C					
47552	Biliary endoscopy thru skin		T	0152	28.6884	$1,827.28		$365.46
47553	Biliary endoscopy thru skin		T	0152	28.6884	$1,827.28		$365.46
47554	Biliary endoscopy thru skin		T	0152	28.6884	$1,827.28		$365.46
47555	Biliary endoscopy thru skin		T	0152	28.6884	$1,827.28		$365.46
47556	Biliary endoscopy thru skin		T	0152	28.6884	$1,827.28		$365.46
47560	Laparoscopy w/cholangio		T	0130	34.3958	$2,190.81	$659.53	$438.16
47561	Laparo w/cholangio/biopsy		T	0130	34.3958	$2,190.81	$659.53	$438.16
47562	Laparoscopic cholecystectomy		T	0131	45.5317	$2,900.10	$1,001.89	$580.02
47563	Laparo cholecystectomy/graph		T	0131	45.5317	$2,900.10	$1,001.89	$580.02
47564	Laparo cholecystectomy/explr		T	0131	45.5317	$2,900.10	$1,001.89	$580.02
47570	Laparo cholecystoenterostomy		C					
47579	Laparoscope proc, biliary		T	0130	34.3958	$2,190.81	$659.53	$438.16
47600	Removal of gallbladder		C					
47605	Removal of gallbladder		C					
47610	Removal of gallbladder		C					
47612	Removal of gallbladder		C					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
47620	Removal of gallbladder		C					
47630	Remove bile duct stone		T	0152	28.6884	$1,827.28		$365.46
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	CH	D					
47720	Fuse gallbladder & bowel		C					
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	28.6884	$1,827.28		$365.46
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	9.3354	$594.61		$118.92
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	13.5764	$864.74	$228.76	$172.95
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	4.3270	$275.60		$55.12
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	13.5764	$864.74	$228.76	$172.95
49040	Drain, open, abdom abscess		C					
49041	Drain, percut, abdom abscess		T	0037	13.5764	$864.74	$228.76	$172.95
49060	Drain, open, retrop abscess		C					
49061	Drain, percut, retroper absc		T	0037	13.5764	$864.74	$228.76	$172.95
49062	Drain to peritoneal cavity		C					
49080	Puncture, peritoneal cavity		T	0070	5.2024	$331.36		$66.27
49081	Removal of abdominal fluid		T	0070	5.2024	$331.36		$66.27
49180	Biopsy, abdominal mass		T	0685	9.3354	$594.61		$118.92
49200	Removal of abdominal lesion	CH	D					
49201	Remove abdom lesion, complex	CH	D					
49203	Exc abd tum 5 cm or less	NI	C					
49204	Exc abd tum over 5 cm	NI	C					
49205	Exc abd tum over 10 cm	NI	C					
49215	Excise sacral spine tumor		C					
49220	Multiple surgery, abdomen		C					
49250	Excision of umbilicus		T	0153	25.6947	$1,636.60	$397.95	$327.32
49255	Removal of omentum		C					
49320	Diag laparo separate proc		T	0130	34.3958	$2,190.81	$659.53	$438.16
49321	Laparoscopy, biopsy		T	0130	34.3958	$2,190.81	$659.53	$438.16
49322	Laparoscopy, aspiration		T	0130	34.3958	$2,190.81	$659.53	$438.16
49323	Laparo drain lymphocele		T	0130	34.3958	$2,190.81	$659.53	$438.16
49324	Lap insertion perm ip cath		T	0130	34.3958	$2,190.81	$659.53	$438.16

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
49325	Lap revision perm ip cath		T	0130	34.3958	$2,190.81	$659.53	$438.16
49326	Lap w/omentopexy add-on		T	0130	34.3958	$2,190.81	$659.53	$438.16
49329	Laparo proc, abdm/per/oment		T	0130	34.3958	$2,190.81	$659.53	$438.16
49400	Air injection into abdomen		N					
49402	Remove foreign body, adbomen		T	0153	25.6947	$1,636.60	$397.95	$327.32
49419	Insrt abdom cath for chemotx		T	0115	29.6965	$1,891.49		$378.30
49420	Insert abdom drain, temp		T	0652	30.7096	$1,956.02		$391.20
49421	Insert abdom drain, perm		T	0652	30.7096	$1,956.02		$391.20
49422	Remove perm cannula/catheter		T	0105	23.9802	$1,527.39		$305.48
49423	Exchange drainage catheter		T	0427	15.3545	$977.99		$195.60
49424	Assess cyst, contrast inject		N					
49425	Insert abdomen-venous drain		C					
49426	Revise abdomen-venous shunt		T	0153	25.6947	$1,636.60	$397.95	$327.32
49427	Injection, abdominal shunt		N					
49428	Ligation of shunt		C					
49429	Removal of shunt		T	0105	23.9802	$1,527.39		$305.48
49435	Insert subq exten to ip cath		T	0427	15.3545	$977.99		$195.60
49436	Embedded ip cath exit-site		T	0427	15.3545	$977.99		$195.60
49440	Place gastrostomy tube perc	NI	T	0141	8.5030	$541.59	$143.38	$108.32
49441	Place duod/jej tube perc	NI	T	0141	8.5030	$541.59	$143.38	$108.32
49442	Place cecostomy tube perc	NI	T	0155	10.9132	$695.11		$139.02
49446	Change g-tube to g-j perc	NI	T	0141	8.5030	$541.59	$143.38	$108.32
49450	Replace g/c tube perc	NI	T	0121	3.2383	$206.26	$43.80	$41.25
49451	Replace duod/jej tube perc	NI	T	0121	3.2383	$206.26	$43.80	$41.25
49452	Replace g-j tube perc	NI	T	0121	3.2383	$206.26	$43.80	$41.25
49460	Fix g/colon tube w/device	NI	T	0121	3.2383	$206.26	$43.80	$41.25
49465	Fluoro exam of g/colon tube	NI	Q	0276	1.3834	$88.11	$34.97	$17.62
49491	Rpr hern preemie reduc		T	0154	30.6788	$1,954.06	$464.85	$390.81
49492	Rpr ing hern premie, blocked		T	0154	30.6788	$1,954.06	$464.85	$390.81
49495	Rpr ing hernia baby, reduc		T	0154	30.6788	$1,954.06	$464.85	$390.81
49496	Rpr ing hernia baby, blocked		T	0154	30.6788	$1,954.06	$464.85	$390.81
49500	Rpr ing hernia, init, reduce		T	0154	30.6788	$1,954.06	$464.85	$390.81
49501	Rpr ing hernia, init blocked		T	0154	30.6788	$1,954.06	$464.85	$390.81
49505	Prp i/hern init reduc >5 yr		T	0154	30.6788	$1,954.06	$464.85	$390.81
49507	Prp i/hern init block >5 yr		T	0154	30.6788	$1,954.06	$464.85	$390.81
49520	Rerepair ing hernia, reduce		T	0154	30.6788	$1,954.06	$464.85	$390.81
49521	Rerepair ing hernia, blocked		T	0154	30.6788	$1,954.06	$464.85	$390.81
49525	Repair ing hernia, sliding		T	0154	30.6788	$1,954.06	$464.85	$390.81
49540	Repair lumbar hernia		T	0154	30.6788	$1,954.06	$464.85	$390.81
49550	Rpr rem hernia, init, reduce		T	0154	30.6788	$1,954.06	$464.85	$390.81
49553	Rpr fem hernia, init blocked		T	0154	30.6788	$1,954.06	$464.85	$390.81
49555	Rerepair fem hernia, reduce		T	0154	30.6788	$1,954.06	$464.85	$390.81
49557	Rerepair fem hernia, blocked		T	0154	30.6788	$1,954.06	$464.85	$390.81
49560	Rpr ventral hern init, reduc		T	0154	30.6788	$1,954.06	$464.85	$390.81
49561	Rpr ventral hern init, block		T	0154	30.6788	$1,954.06	$464.85	$390.81
49565	Rerepair ventrl hern, reduce		T	0154	30.6788	$1,954.06	$464.85	$390.81
49566	Rerepair ventrl hern, block		T	0154	30.6788	$1,954.06	$464.85	$390.81
49568	Hernia repair w/mesh		T	0154	30.6788	$1,954.06	$464.85	$390.81
49570	Rpr epigastric hern, reduce		T	0154	30.6788	$1,954.06	$464.85	$390.81
49572	Rpr epigastric hern, blocked		T	0154	30.6788	$1,954.06	$464.85	$390.81
49580	Rpr umbil hern, reduc < 5 yr		T	0154	30.6788	$1,954.06	$464.85	$390.81
49582	Rpr umbil hern, block < 5 yr		T	0154	30.6788	$1,954.06	$464.85	$390.81
49585	Rpr umbil hern, reduc > 5 yr		T	0154	30.6788	$1,954.06	$464.85	$390.81
49587	Rpr umbil hern, block > 5 yr		T	0154	30.6788	$1,954.06	$464.85	$390.81
49590	Repair spigelian hernia		T	0154	30.6788	$1,954.06	$464.85	$390.81
49600	Repair umbilical lesion		T	0154	30.6788	$1,954.06	$464.85	$390.81
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	45.5317	$2,900.10	$1,001.89	$580.02
49651	Laparo hernia repair recur		T	0131	45.5317	$2,900.10	$1,001.89	$580.02
49659	Laparo proc, hernia repair		T	0130	34.3958	$2,190.81	$659.53	$438.16
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	25.6947	$1,636.60	$397.95	$327.32
50010	Exploration of kidney		C					
50020	Renal abscess, open drain		T	0162	24.7749	$1,578.01		$315.60
50021	Renal abscess, percut drain		T	0037	13.5764	$864.74	$228.76	$172.95
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	45.2042	$2,879.24		$575.85
50081	Removal of kidney stone		T	0429	45.2042	$2,879.24		$575.85

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	9.3354	$594.61		$118.92
50205	Biopsy of kidney		C					
5020F	Txmnts 2 main Dr by 1 mon	NI	M					
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					
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	24.7749	$1,578.01		$315.60
50384	Remove ureter stent, percut		T	0161	17.9420	$1,142.80	$241.15	$228.56
50385	Change stent via transureth	NI	T	0161	17.9420	$1,142.80	$241.15	$228.56
50386	Remove stent via transureth	NI	T	0160	5.9735	$380.48		$76.10
50387	Change ext/int ureter stent	CH	T	0427	15.3545	$977.99		$195.60
50389	Remove renal tube w/fluoro	CH	T	0160	5.9735	$380.48		$76.10
50390	Drainage of kidney lesion		T	0685	9.3354	$594.61		$118.92
50391	Instll rx agnt into rnal tub		T	0126	1.0356	$65.96	$16.21	$13.19
50392	Insert kidney drain		T	0161	17.9420	$1,142.80	$241.15	$228.56
50393	Insert ureteral tube	CH	T	0162	24.7749	$1,578.01		$315.60
50394	Injection for kidney x-ray		N					
50395	Create passage to kidney		T	0161	17.9420	$1,142.80	$241.15	$228.56
50396	Measure kidney pressure		T	0164	2.0077	$127.88		$25.58
50398	Change kidney tube	CH	T	0427	15.3545	$977.99		$195.60
50400	Revision of kidney/ureter		C					
50405	Revision of kidney/ureter		C					
50500	Repair of kidney wound		C					
5050F	Plan 2 main Dr. by 1 month	NI	M					
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	34.3958	$2,190.81	$659.53	$438.16
50542	Laparo ablate renal mass		T	0132	69.6652	$4,437.26	$1,239.22	$887.45
50543	Laparo partial nephrectomy		T	0131	45.5317	$2,900.10	$1,001.89	$580.02
50544	Laparoscopy, pyeloplasty		T	0130	34.3958	$2,190.81	$659.53	$438.16
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	34.3958	$2,190.81	$659.53	$438.16
50551	Kidney endoscopy		T	0160	5.9735	$380.48		$76.10
50553	Kidney endoscopy	CH	T	0162	24.7749	$1,578.01		$315.60
50555	Kidney endoscopy & biopsy		T	0160	5.9735	$380.48		$76.10
50557	Kidney endoscopy & treatment		T	0162	24.7749	$1,578.01		$315.60
50561	Kidney endoscopy & treatment	CH	T	0162	24.7749	$1,578.01		$315.60
50562	Renal scope w/tumor resect		T	0160	5.9735	$380.48		$76.10
50570	Kidney endoscopy		T	0160	5.9735	$380.48		$76.10
50572	Kidney endoscopy		T	0160	5.9735	$380.48		$76.10
50574	Kidney endoscopy & biopsy		T	0160	5.9735	$380.48		$76.10
50575	Kidney endoscopy		T	0163	36.0774	$2,297.91		$459.58
50576	Kidney endoscopy & treatment		T	0161	17.9420	$1,142.80	$241.15	$228.56
50580	Kidney endoscopy & treatment	CH	T	0161	17.9420	$1,142.80	$241.15	$228.56
50590	Fragmenting of kidney stone		T	0169	41.5299	$2,645.21	$997.74	$529.04
50592	Perc rf ablate renal tumor		T	0423	42.9980	$2,738.71		$547.74
50593	Perc cryo ablate renal tum	NI	T	0423	42.9980	$2,738.71		$547.74
50600	Exploration of ureter		C					
50605	Insert ureteral support		C					
50610	Removal of ureter stone		C					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	1.0356	$65.96	$16.21	$13.19
50688	Change of ureter tube/stent	CH	T	0427	15.3545	$977.99		$195.60
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					
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	45.5317	$2,900.10	$1,001.89	$580.02
50947	Laparo new ureter/bladder		T	0131	45.5317	$2,900.10	$1,001.89	$580.02
50948	Laparo new ureter/bladder		T	0131	45.5317	$2,900.10	$1,001.89	$580.02
50949	Laparoscope proc, ureter		T	0130	34.3958	$2,190.81	$659.53	$438.16
50951	Endoscopy of ureter		T	0160	5.9735	$380.48		$76.10
50953	Endoscopy of ureter		T	0160	5.9735	$380.48		$76.10
50955	Ureter endoscopy & biopsy	CH	T	0162	24.7749	$1,578.01		$315.60
50957	Ureter endoscopy & treatment	CH	T	0162	24.7749	$1,578.01		$315.60
50961	Ureter endoscopy & treatment	CH	T	0162	24.7749	$1,578.01		$315.60
50970	Ureter endoscopy		T	0160	5.9735	$380.48		$76.10
50972	Ureter endoscopy & catheter		T	0160	5.9735	$380.48		$76.10
50974	Ureter endoscopy & biopsy		T	0161	17.9420	$1,142.80	$241.15	$228.56
50976	Ureter endoscopy & treatment		T	0161	17.9420	$1,142.80	$241.15	$228.56
50980	Ureter endoscopy & treatment	CH	T	0162	24.7749	$1,578.01		$315.60
51000	Drainage of bladder	CH	D					
51005	Drainage of bladder	CH	D					
51010	Drainage of bladder	CH	D					
51020	Incise & treat bladder		T	0162	24.7749	$1,578.01		$315.60
51030	Incise & treat bladder		T	0162	24.7749	$1,578.01		$315.60
51040	Incise & drain bladder		T	0162	24.7749	$1,578.01		$315.60
51045	Incise bladder/drain ureter		T	0160	5.9735	$380.48		$76.10
51050	Removal of bladder stone		T	0162	24.7749	$1,578.01		$315.60
51060	Removal of ureter stone		C					
51065	Remove ureter calculus		T	0162	24.7749	$1,578.01		$315.60
51080	Drainage of bladder abscess		T	0008	18.3197	$1,166.85		$233.37
51100	Drain bladder by needle	NI	T	0164	2.0077	$127.88		$25.58
51101	Drain bladder by trocar/cath	NI	T	0126	1.0356	$65.96	$16.21	$13.19
51102	Drain bl w/cath insertion	NI	T	0165	19.3414	$1,231.93		$246.39
51500	Removal of bladder cyst		T	0154	30.6788	$1,954.06	$464.85	$390.81
51520	Removal of bladder lesion		T	0162	24.7749	$1,578.01		$315.60
51525	Removal of bladder lesion		C					
51530	Removal of bladder lesion		C					
51535	Repair of ureter lesion	CH	T	0162	24.7749	$1,578.01		$315.60
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
51605	Preparation for bladder xray		N					
51610	Injection for bladder x-ray		N					
51700	Irrigation of bladder		T	0164	2.0077	$127.88		$25.58
51701	Insert bladder catheter		X	0340	0.6310	$40.19		$8.04
51702	Insert temp bladder cath		X	0340	0.6310	$40.19		$8.04
51703	Insert bladder cath, complex		T	0126	1.0356	$65.96	$16.21	$13.19
51705	Change of bladder tube	CH	T	0164	2.0077	$127.88		$25.58
51710	Change of bladder tube	CH	T	0427	15.3545	$977.99		$195.60
51715	Endoscopic injection/implant		T	0168	29.7864	$1,897.21	$388.16	$379.44
51720	Treatment of bladder lesion		T	0164	2.0077	$127.88		$25.58
51725	Simple cystometrogram	CH	T	0156	3.0469	$194.07		$38.81
51726	Complex cystometrogram		T	0156	3.0469	$194.07		$38.81
51736	Urine flow measurement		T	0126	1.0356	$65.96	$16.21	$13.19
51741	Electro-uroflowmetry, first		T	0126	1.0356	$65.96	$16.21	$13.19
51772	Urethra pressure profile		T	0164	2.0077	$127.88		$25.58
51784	Anal/urinary muscle study		T	0126	1.0356	$65.96	$16.21	$13.19
51785	Anal/urinary muscle study	CH	T	0164	2.0077	$127.88		$25.58
51792	Urinary reflex study		T	0126	1.0356	$65.96	$16.21	$13.19
51795	Urine voiding pressure study		T	0164	2.0077	$127.88		$25.58
51797	Intraabdominal pressure test		T	0164	2.0077	$127.88		$25.58
51798	Us urine capacity measure		X	0340	0.6310	$40.19		$8.04
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	24.7749	$1,578.01		$315.60
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	45.5317	$2,900.10	$1,001.89	$580.02
51992	Laparo sling operation		T	0131	45.5317	$2,900.10	$1,001.89	$580.02
51999	Laparoscope proc, bla		T	0130	34.3958	$2,190.81	$659.53	$438.16
52000	Cystoscopy		T	0160	5.9735	$380.48		$76.10
52001	Cystoscopy, removal of clots	CH	T	0161	17.9420	$1,142.80	$241.15	$228.56
52005	Cystoscopy & ureter catheter		T	0161	17.9420	$1,142.80	$241.15	$228.56
52007	Cystoscopy and biopsy	CH	T	0162	24.7749	$1,578.01		$315.60
52010	Cystoscopy & duct catheter		T	0160	5.9735	$380.48		$76.10
52204	Cystoscopy w/biopsy(s)		T	0161	17.9420	$1,142.80	$241.15	$228.56
52214	Cystoscopy and treatment		T	0162	24.7749	$1,578.01		$315.60
52224	Cystoscopy and treatment		T	0162	24.7749	$1,578.01		$315.60
52234	Cystoscopy and treatment		T	0162	24.7749	$1,578.01		$315.60
52235	Cystoscopy and treatment		T	0162	24.7749	$1,578.01		$315.60
52240	Cystoscopy and treatment		T	0162	24.7749	$1,578.01		$315.60
52250	Cystoscopy and radiotracer		T	0162	24.7749	$1,578.01		$315.60
52260	Cystoscopy and treatment		T	0161	17.9420	$1,142.80	$241.15	$228.56
52265	Cystoscopy and treatment		T	0160	5.9735	$380.48		$76.10
52270	Cystoscopy & revise urethra		T	0161	17.9420	$1,142.80	$241.15	$228.56
52275	Cystoscopy & revise urethra	CH	T	0162	24.7749	$1,578.01		$315.60
52276	Cystoscopy and treatment	CH	T	0162	24.7749	$1,578.01		$315.60
52277	Cystoscopy and treatment		T	0162	24.7749	$1,578.01		$315.60
52281	Cystoscopy and treatment		T	0161	17.9420	$1,142.80	$241.15	$228.56
52282	Cystoscopy, implant stent		T	0163	36.0774	$2,297.91		$459.58
52283	Cystoscopy and treatment	CH	T	0162	24.7749	$1,578.01		$315.60
52285	Cystoscopy and treatment		T	0161	17.9420	$1,142.80	$241.15	$228.56
52290	Cystoscopy and treatment		T	0161	17.9420	$1,142.80	$241.15	$228.56
52300	Cystoscopy and treatment	CH	T	0162	24.7749	$1,578.01		$315.60
52301	Cystoscopy and treatment	CH	T	0162	24.7749	$1,578.01		$315.60
52305	Cystoscopy and treatment	CH	T	0162	24.7749	$1,578.01		$315.60
52310	Cystoscopy and treatment	CH	T	0161	17.9420	$1,142.80	$241.15	$228.56
52315	Cystoscopy and treatment	CH	T	0162	24.7749	$1,578.01		$315.60
52317	Remove bladder stone		T	0162	24.7749	$1,578.01		$315.60
52318	Remove bladder stone		T	0162	24.7749	$1,578.01		$315.60
52320	Cystoscopy and treatment		T	0162	24.7749	$1,578.01		$315.60
52325	Cystoscopy, stone removal		T	0162	24.7749	$1,578.01		$315.60
52327	Cystoscopy, inject material		T	0162	24.7749	$1,578.01		$315.60
52330	Cystoscopy and treatment		T	0162	24.7749	$1,578.01		$315.60
52332	Cystoscopy and treatment		T	0162	24.7749	$1,578.01		$315.60
52334	Create passage to kidney		T	0162	24.7749	$1,578.01		$315.60
52341	Cysto w/ureter stricture tx		T	0162	24.7749	$1,578.01		$315.60
52342	Cysto w/up stricture tx		T	0162	24.7749	$1,578.01		$315.60
52343	Cysto w/renal stricture tx		T	0162	24.7749	$1,578.01		$315.60
52344	Cysto/uretero, stricture tx		T	0162	24.7749	$1,578.01		$315.60
52345	Cysto/uretero w/up stricture		T	0162	24.7749	$1,578.01		$315.60
52346	Cystouretero w/renal strict		T	0162	24.7749	$1,578.01		$315.60

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
52351	Cystouretero & or pyeloscope	CH	T	0162	24.7749	$1,578.01		$315.60
52352	Cystouretero w/stone remove		T	0162	24.7749	$1,578.01		$315.60
52353	Cystouretero w/lithotripsy		T	0163	36.0774	$2,297.91		$459.58
52354	Cystouretero w/biopsy		T	0162	24.7749	$1,578.01		$315.60
52355	Cystouretero w/excise tumor		T	0162	24.7749	$1,578.01		$315.60
52400	Cystouretero w/congen repr		T	0162	24.7749	$1,578.01		$315.60
52402	Cystourethro cut ejacul duct		T	0162	24.7749	$1,578.01		$315.60
52450	Incision of prostate		T	0162	24.7749	$1,578.01		$315.60
52500	Revision of bladder neck		T	0162	24.7749	$1,578.01		$315.60
52510	Dilation prostatic urethra	CH	D					
52601	Prostatectomy (TURP)		T	0163	36.0774	$2,297.91		$459.58
52606	Control postop bleeding		T	0162	24.7749	$1,578.01		$315.60
52612	Prostatectomy, first stage		T	0163	36.0774	$2,297.91		$459.58
52614	Prostatectomy, second stage		T	0163	36.0774	$2,297.91		$459.58
52620	Remove residual prostate		T	0163	36.0774	$2,297.91		$459.58
52630	Remove prostate regrowth		T	0163	36.0774	$2,297.91		$459.58
52640	Relieve bladder contracture		T	0162	24.7749	$1,578.01		$315.60
52647	Laser surgery of prostate		T	0429	45.2042	$2,879.24		$575.85
52648	Laser surgery of prostate		T	0429	45.2042	$2,879.24		$575.85
52649	Prostate laser enucleation	NI	T	0429	45.2042	$2,879.24		$575.85
52700	Drainage of prostate abscess		T	0162	24.7749	$1,578.01		$315.60
53000	Incision of urethra		T	0166	19.1505	$1,219.77		$243.95
53010	Incision of urethra		T	0166	19.1505	$1,219.77		$243.95
53020	Incision of urethra		T	0166	19.1505	$1,219.77		$243.95
53025	Incision of urethra		T	0166	19.1505	$1,219.77		$243.95
53040	Drainage of urethra abscess		T	0166	19.1505	$1,219.77		$243.95
53060	Drainage of urethra abscess		T	0166	19.1505	$1,219.77		$243.95
53080	Drainage of urinary leakage		T	0166	19.1505	$1,219.77		$243.95
53085	Drainage of urinary leakage		T	0166	19.1505	$1,219.77		$243.95
53200	Biopsy of urethra		T	0166	19.1505	$1,219.77		$243.95
53210	Removal of urethra		T	0168	29.7864	$1,897.21	$388.16	$379.44
53215	Removal of urethra		T	0166	19.1505	$1,219.77		$243.95
53220	Treatment of urethra lesion		T	0168	29.7864	$1,897.21	$388.16	$379.44
53230	Removal of urethra lesion		T	0168	29.7864	$1,897.21	$388.16	$379.44
53235	Removal of urethra lesion		T	0166	19.1505	$1,219.77		$243.95
53240	Surgery for urethra pouch		T	0168	29.7864	$1,897.21	$388.16	$379.44
53250	Removal of urethra gland		T	0166	19.1505	$1,219.77		$243.95
53260	Treatment of urethra lesion		T	0166	19.1505	$1,219.77		$243.95
53265	Treatment of urethra lesion		T	0166	19.1505	$1,219.77		$243.95
53270	Removal of urethra gland		T	0166	19.1505	$1,219.77		$243.95
53275	Repair of urethra defect		T	0166	19.1505	$1,219.77		$243.95
53400	Revise urethra, stage 1		T	0168	29.7864	$1,897.21	$388.16	$379.44
53405	Revise urethra, stage 2		T	0168	29.7864	$1,897.21	$388.16	$379.44
53410	Reconstruction of urethra		T	0168	29.7864	$1,897.21	$388.16	$379.44
53415	Reconstruction of urethra		C					
53420	Reconstruct urethra, stage 1		T	0168	29.7864	$1,897.21	$388.16	$379.44
53425	Reconstruct urethra, stage 2		T	0168	29.7864	$1,897.21	$388.16	$379.44
53430	Reconstruction of urethra		T	0168	29.7864	$1,897.21	$388.16	$379.44
53431	Reconstruct urethra/bladder		T	0168	29.7864	$1,897.21	$388.16	$379.44
53440	Male sling procedure		S	0385	83.6366	$5,327.15		$1,065.43
53442	Remove/revise male sling		T	0168	29.7864	$1,897.21	$388.16	$379.44
53444	Insert tandem cuff		S	0385	83.6366	$5,327.15		$1,065.43
53445	Insert uro/ves nck sphincter		S	0386	144.1246	$9,179.87		$1,835.97
53446	Remove uro sphincter		T	0168	29.7864	$1,897.21	$388.16	$379.44
53447	Remove/replace ur sphincter		S	0386	144.1246	$9,179.87		$1,835.97
53448	Remov/replc ur sphinctr comp		C					
53449	Repair uro sphincter		T	0168	29.7864	$1,897.21	$388.16	$379.44
53450	Revision of urethra		T	0168	29.7864	$1,897.21	$388.16	$379.44
53460	Revision of urethra		T	0166	19.1505	$1,219.77		$243.95
53500	Urethrlys, transvag w/ scope		T	0168	29.7864	$1,897.21	$388.16	$379.44
53502	Repair of urethra injury		T	0166	19.1505	$1,219.77		$243.95
53505	Repair of urethra injury		T	0168	29.7864	$1,897.21	$388.16	$379.44
53510	Repair of urethra injury		T	0166	19.1505	$1,219.77		$243.95
53515	Repair of urethra injury		T	0168	29.7864	$1,897.21	$388.16	$379.44
53520	Repair of urethra defect		T	0168	29.7864	$1,897.21	$388.16	$379.44
53600	Dilate urethra stricture		T	0156	3.0469	$194.07		$38.81
53601	Dilate urethra stricture		T	0126	1.0356	$65.96	$16.21	$13.19
53605	Dilate urethra stricture		T	0161	17.9420	$1,142.80	$241.15	$228.56
53620	Dilate urethra stricture		T	0165	19.3414	$1,231.93		$246.39
53621	Dilate urethra stricture		T	0164	2.0077	$127.88		$25.58
53660	Dilation of urethra		T	0126	1.0356	$65.96	$16.21	$13.19
53661	Dilation of urethra		T	0126	1.0356	$65.96	$16.21	$13.19
53665	Dilation of urethra		T	0166	19.1505	$1,219.77		$243.95
53850	Prostatic microwave thermotx	CH	T	0429	45.2042	$2,879.24		$575.85
53852	Prostatic rf thermotx	CH	T	0429	45.2042	$2,879.24		$575.85
53853	Prostatic water thermother		T	0162	24.7749	$1,578.01		$315.60
53899	Urology surgery procedure		T	0126	1.0356	$65.96	$16.21	$13.19
54000	Slitting of prepuce		T	0166	19.1505	$1,219.77		$243.95
54001	Slitting of prepuce		T	0166	19.1505	$1,219.77		$243.95
54015	Drain penis lesion		T	0008	18.3197	$1,166.85		$233.37

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
54050	Destruction, penis lesion(s)	CH	T	0015	1.4595	$92.96		$18.59
54055	Destruction, penis lesion(s)		T	0017	19.9041	$1,267.77		$253.55
54056	Cryosurgery, penis lesion(s)	CH	T	0013	0.7930	$50.51		$10.10
54057	Laser surg, penis lesion(s)		T	0017	19.9041	$1,267.77		$253.55
54060	Excision of penis lesion(s)		T	0017	19.9041	$1,267.77		$253.55
54065	Destruction, penis lesion(s)	CH	T	0017	19.9041	$1,267.77		$253.55
54100	Biopsy of penis		T	0021	16.1001	$1,025.48	$219.48	$205.10
54105	Biopsy of penis		T	0022	21.1098	$1,344.57	$354.45	$268.91
54110	Treatment of penis lesion		T	0181	33.9306	$2,161.18	$621.82	$432.24
54111	Treat penis lesion, graft		T	0181	33.9306	$2,161.18	$621.82	$432.24
54112	Treat penis lesion, graft		T	0181	33.9306	$2,161.18	$621.82	$432.24
54115	Treatment of penis lesion		T	0008	18.3197	$1,166.85		$233.37
54120	Partial removal of penis		T	0181	33.9306	$2,161.18	$621.82	$432.24
54125	Removal of penis		C					
54130	Remove penis & nodes		C					
54135	Remove penis & nodes		C					
54150	Circumcision w/regionl block	CH	T	0183	22.3251	$1,421.97		$284.39
54160	Circumcision, neonate	CH	T	0183	22.3251	$1,421.97		$284.39
54161	Circum 28 days or older	CH	T	0183	22.3251	$1,421.97		$284.39
54162	Lysis penil circumic lesion	CH	T	0183	22.3251	$1,421.97		$284.39
54163	Repair of circumcision	CH	T	0183	22.3251	$1,421.97		$284.39
54164	Frenulotomy of penis	CH	T	0183	22.3251	$1,421.97		$284.39
54200	Treatment of penis lesion		T	0164	2.0077	$127.88		$25.58
54205	Treatment of penis lesion		T	0181	33.9306	$2,161.18	$621.82	$432.24
54220	Treatment of penis lesion		T	0164	2.0077	$127.88		$25.58
54230	Prepare penis study		N					
54231	Dynamic cavernosometry		T	0165	19.3414	$1,231.93		$246.39
54235	Penile injection		T	0164	2.0077	$127.88		$25.58
54240	Penis study		T	0126	1.0356	$65.96	$16.21	$13.19
54250	Penis study		T	0164	2.0077	$127.88		$25.58
54300	Revision of penis		T	0181	33.9306	$2,161.18	$621.82	$432.24
54304	Revision of penis		T	0181	33.9306	$2,161.18	$621.82	$432.24
54308	Reconstruction of urethra		T	0181	33.9306	$2,161.18	$621.82	$432.24
54312	Reconstruction of urethra		T	0181	33.9306	$2,161.18	$621.82	$432.24
54316	Reconstruction of urethra		T	0181	33.9306	$2,161.18	$621.82	$432.24
54318	Reconstruction of urethra		T	0181	33.9306	$2,161.18	$621.82	$432.24
54322	Reconstruction of urethra		T	0181	33.9306	$2,161.18	$621.82	$432.24
54324	Reconstruction of urethra		T	0181	33.9306	$2,161.18	$621.82	$432.24
54326	Reconstruction of urethra		T	0181	33.9306	$2,161.18	$621.82	$432.24
54328	Revise penis/urethra		T	0181	33.9306	$2,161.18	$621.82	$432.24
54332	Revise penis/urethra		C					
54336	Revise penis/urethra		C					
54340	Secondary urethral surgery		T	0181	33.9306	$2,161.18	$621.82	$432.24
54344	Secondary urethral surgery		T	0181	33.9306	$2,161.18	$621.82	$432.24
54348	Secondary urethral surgery		T	0181	33.9306	$2,161.18	$621.82	$432.24
54352	Reconstruct urethra/penis		T	0181	33.9306	$2,161.18	$621.82	$432.24
54360	Penis plastic surgery		T	0181	33.9306	$2,161.18	$621.82	$432.24
54380	Repair penis		T	0181	33.9306	$2,161.18	$621.82	$432.24
54385	Repair penis		T	0181	33.9306	$2,161.18	$621.82	$432.24
54390	Repair penis and bladder		C					
54400	Insert semi-rigid prosthesis		S	0385	83.6366	$5,327.15		$1,065.43
54401	Insert self-contd prosthesis		S	0386	144.1246	$9,179.87		$1,835.97
54405	Insert multi-comp penis pros		S	0386	144.1246	$9,179.87		$1,835.97
54406	Remove muti-comp penis pros		T	0181	33.9306	$2,161.18	$621.82	$432.24
54408	Repair multi-comp penis pros		T	0181	33.9306	$2,161.18	$621.82	$432.24
54410	Remove/replace penis prosth		S	0386	144.1246	$9,179.87		$1,835.97
54411	Remov/replc penis pros, comp		C					
54415	Remove self-contd penis pros		T	0181	33.9306	$2,161.18	$621.82	$432.24
54416	Remv/repl penis contain pros		S	0386	144.1246	$9,179.87		$1,835.97
54417	Remv/replc penis pros, compl		C					
54420	Revision of penis		T	0181	33.9306	$2,161.18	$621.82	$432.24
54430	Revision of penis		C					
54435	Revision of penis		T	0181	33.9306	$2,161.18	$621.82	$432.24
54440	Repair of penis		T	0181	33.9306	$2,161.18	$621.82	$432.24
54450	Preputial stretching		T	0156	3.0469	$194.07		$38.81
54500	Biopsy of testis		T	0037	13.5764	$864.74	$228.76	$172.95
54505	Biopsy of testis		T	0183	22.3251	$1,421.97		$284.39
54512	Excise lesion testis		T	0183	22.3251	$1,421.97		$284.39
54520	Removal of testis		T	0183	22.3251	$1,421.97		$284.39
54522	Orchiectomy, partial		T	0183	22.3251	$1,421.97		$284.39
54530	Removal of testis		T	0154	30.6788	$1,954.06	$464.85	$390.81
54535	Extensive testis surgery		C					
54550	Exploration for testis		T	0154	30.6788	$1,954.06	$464.85	$390.81
54560	Exploration for testis		T	0183	22.3251	$1,421.97		$284.39
54600	Reduce testis torsion		T	0183	22.3251	$1,421.97		$284.39
54620	Suspension of testis		T	0183	22.3251	$1,421.97		$284.39
54640	Suspension of testis		T	0154	30.6788	$1,954.06	$464.85	$390.81
54650	Orchiopexy (Fowler-Stephens)		C					
54660	Revision of testis		T	0183	22.3251	$1,421.97		$284.39
54670	Repair testis injury		T	0183	22.3251	$1,421.97		$284.39

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
54680	Relocation of testis(es)		T	0183	22.3251	$1,421.97		$284.39
54690	Laparoscopy, orchiectomy		T	0131	45.5317	$2,900.10	$1,001.89	$580.02
54692	Laparoscopy, orchiopexy		T	0132	69.6652	$4,437.26	$1,239.22	$887.45
54699	Laparoscope proc, testis		T	0130	34.3958	$2,190.81	$659.53	$438.16
54700	Drainage of scrotum		T	0183	22.3251	$1,421.97		$284.39
54800	Biopsy of epididymis		T	0004	4.3270	$275.60		$55.12
54830	Remove epididymis lesion		T	0183	22.3251	$1,421.97		$284.39
54840	Remove epididymis lesion		T	0183	22.3251	$1,421.97		$284.39
54860	Removal of epididymis		T	0183	22.3251	$1,421.97		$284.39
54861	Removal of epididymis		T	0183	22.3251	$1,421.97		$284.39
54865	Explore epididymis		T	0183	22.3251	$1,421.97		$284.39
54900	Fusion of spermatic ducts		T	0183	22.3251	$1,421.97		$284.39
54901	Fusion of spermatic ducts		T	0183	22.3251	$1,421.97		$284.39
55000	Drainage of hydrocele		T	0004	4.3270	$275.60		$55.12
55040	Removal of hydrocele		T	0154	30.6788	$1,954.06	$464.85	$390.81
55041	Removal of hydroceles		T	0154	30.6788	$1,954.06	$464.85	$390.81
55060	Repair of hydrocele		T	0183	22.3251	$1,421.97		$284.39
55100	Drainage of scrotum abscess		T	0007	11.5594	$736.26		$147.25
55110	Explore scrotum		T	0183	22.3251	$1,421.97		$284.39
55120	Removal of scrotum lesion		T	0183	22.3251	$1,421.97		$284.39
55150	Removal of scrotum		T	0183	22.3251	$1,421.97		$284.39
55175	Revision of scrotum		T	0183	22.3251	$1,421.97		$284.39
55180	Revision of scrotum		T	0183	22.3251	$1,421.97		$284.39
55200	Incision of sperm duct		T	0183	22.3251	$1,421.97		$284.39
55250	Removal of sperm duct(s)		T	0183	22.3251	$1,421.97		$284.39
55300	Prepare, sperm duct x-ray		N					
55400	Repair of sperm duct		T	0183	22.3251	$1,421.97		$284.39
55450	Ligation of sperm duct		T	0183	22.3251	$1,421.97		$284.39
55500	Removal of hydrocele		T	0183	22.3251	$1,421.97		$284.39
55520	Removal of sperm cord lesion		T	0183	22.3251	$1,421.97		$284.39
55530	Revise spermatic cord veins		T	0183	22.3251	$1,421.97		$284.39
55535	Revise spermatic cord veins		T	0154	30.6788	$1,954.06	$464.85	$390.81
55540	Revise hernia & sperm veins		T	0154	30.6788	$1,954.06	$464.85	$390.81
55550	Laparo ligate spermatic vein		T	0131	45.5317	$2,900.10	$1,001.89	$580.02
55559	Laparo proc, spermatic cord		T	0130	34.3958	$2,190.81	$659.53	$438.16
55600	Incise sperm duct pouch		T	0183	22.3251	$1,421.97		$284.39
55605	Incise sperm duct pouch		C					
55650	Remove sperm duct pouch		C					
55680	Remove sperm pouch lesion		T	0183	22.3251	$1,421.97		$284.39
55700	Biopsy of prostate		T	0184	11.0338	$702.79		$140.56
55705	Biopsy of prostate		T	0184	11.0338	$702.79		$140.56
55720	Drainage of prostate abscess		T	0162	24.7749	$1,578.01		$315.60
55725	Drainage of prostate abscess		T	0162	24.7749	$1,578.01		$315.60
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	19.3414	$1,231.93		$246.39
55862	Extensive prostate surgery		C					
55865	Extensive prostate surgery		C					
55866	Laparo radical prostatectomy		C					
55870	Electroejaculation	CH	T	0189	2.7584	$175.69		$35.14
55873	Cryoablate prostate		T	0674	122.7133	$7,816.10		$1,563.22
55875	Transperi needle place, pros	CH	Q	0163	36.0774	$2,297.91		$459.58
55876	Place rt device/marker, pros		T	0156	3.0469	$194.07		$38.81
55899	Genital surgery procedure		T	0126	1.0356	$65.96	$16.21	$13.19
55920	Place needles pelvic for rt	NI	T	0153	25.6947	$1,636.60	$397.95	$327.32
55970	Sex transformation, M to F		E					
55980	Sex transformation, F to M		E					
56405	I & D of vulva/perineum		T	0189	2.7584	$175.69		$35.14
56420	Drainage of gland abscess		T	0188	1.3520	$86.11		$17.22
56440	Surgery for vulva lesion	CH	T	0193	19.0203	$1,211.48		$242.30
56441	Lysis of labial lesion(s)		T	0193	19.0203	$1,211.48		$242.30
56442	Hymenotomy		T	0193	19.0203	$1,211.48		$242.30
56501	Destroy, vulva lesions, sim		T	0017	19.9041	$1,267.77		$253.55
56515	Destroy vulva lesion/s compl	CH	T	0017	19.9041	$1,267.77		$253.55
56605	Biopsy of vulva/perineum	CH	T	0189	2.7584	$175.69		$35.14
56606	Biopsy of vulva/perineum	CH	T	0188	1.3520	$86.11		$17.22
56620	Partial removal of vulva	CH	T	0193	19.0203	$1,211.48		$242.30
56625	Complete removal of vulva	CH	T	0193	19.0203	$1,211.48		$242.30
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
56637	Extensive vulva surgery		C					
56640	Extensive vulva surgery		C					
56700	Partial removal of hymen	CH	T	0193	19.0203	$1,211.48		$242.30
56740	Remove vagina gland lesion	CH	T	0193	19.0203	$1,211.48		$242.30
56800	Repair of vagina	CH	T	0193	19.0203	$1,211.48		$242.30
56805	Repair clitoris		T	0193	19.0203	$1,211.48		$242.30
56810	Repair of perineum	CH	T	0193	19.0203	$1,211.48		$242.30
56820	Exam of vulva w/scope		T	0188	1.3520	$86.11		$17.22
56821	Exam/biopsy of vulva w/scope	CH	T	0188	1.3520	$86.11		$17.22
57000	Exploration of vagina		T	0193	19.0203	$1,211.48		$242.30
57010	Drainage of pelvic abscess		T	0193	19.0203	$1,211.48		$242.30
57020	Drainage of pelvic fluid		T	0192	6.0783	$387.15		$77.43
57022	I & d vaginal hematoma, pp		T	0007	11.5594	$736.26		$147.25
57023	I & d vag hematoma, non-ob		T	0008	18.3197	$1,166.85		$233.37
57061	Destroy vag lesions, simple	CH	T	0193	19.0203	$1,211.48		$242.30
57065	Destroy vag lesions, complex	CH	T	0193	19.0203	$1,211.48		$242.30
57100	Biopsy of vagina		T	0192	6.0783	$387.15		$77.43
57105	Biopsy of vagina	CH	T	0193	19.0203	$1,211.48		$242.30
57106	Remove vagina wall, partial	CH	T	0193	19.0203	$1,211.48		$242.30
57107	Remove vagina tissue, part		T	0195	32.4237	$2,065.20	$483.80	$413.04
57109	Vaginectomy partial w/nodes		T	0195	32.4237	$2,065.20	$483.80	$413.04
57110	Remove vagina wall, complete		C					
57111	Remove vagina tissue, compl		C					
57112	Vaginectomy w/nodes, compl		C					
57120	Closure of vagina		T	0195	32.4237	$2,065.20	$483.80	$413.04
57130	Remove vagina lesion	CH	T	0193	19.0203	$1,211.48		$242.30
57135	Remove vagina lesion	CH	T	0193	19.0203	$1,211.48		$242.30
57150	Treat vagina infection	CH	T	0188	1.3520	$86.11		$17.22
57155	Insert uteri tandems/ovoids		T	0192	6.0783	$387.15		$77.43
57160	Insert pessary/other device		T	0188	1.3520	$86.11		$17.22
57170	Fitting of diaphragm/cap		T	0191	0.1309	$8.34	$2.36	$1.67
57180	Treat vaginal bleeding	CH	T	0188	1.3520	$86.11		$17.22
57200	Repair of vagina	CH	T	0193	19.0203	$1,211.48		$242.30
57210	Repair vagina/perineum	CH	T	0193	19.0203	$1,211.48		$242.30
57220	Revision of urethra		T	0202	42.7099	$2,720.36	$981.50	$544.07
57230	Repair of urethral lesion		T	0195	32.4237	$2,065.20	$483.80	$413.04
57240	Repair bladder & vagina		T	0195	32.4237	$2,065.20	$483.80	$413.04
57250	Repair rectum & vagina		T	0195	32.4237	$2,065.20	$483.80	$413.04
57260	Repair of vagina		T	0195	32.4237	$2,065.20	$483.80	$413.04
57265	Extensive repair of vagina		T	0202	42.7099	$2,720.36	$981.50	$544.07
57267	Insert mesh/pelvic flr addon		T	0195	32.4237	$2,065.20	$483.80	$413.04
57268	Repair of bowel bulge		T	0195	32.4237	$2,065.20	$483.80	$413.04
57270	Repair of bowel pouch		C					
57280	Suspension of vagina		C					
57282	Colpopexy, extraperitoneal		T	0202	42.7099	$2,720.36	$981.50	$544.07
57283	Colpopexy, intraperitoneal		T	0202	42.7099	$2,720.36	$981.50	$544.07
57284	Repair paravag defect, open		T	0202	42.7099	$2,720.36	$981.50	$544.07
57285	Repair paravag defect, vag	NI	T	0195	32.4237	$2,065.20	$483.80	$413.04
57287	Revise/remove sling repair		T	0195	32.4237	$2,065.20	$483.80	$413.04
57288	Repair bladder defect		T	0202	42.7099	$2,720.36	$981.50	$544.07
57289	Repair bladder & vagina		T	0195	32.4237	$2,065.20	$483.80	$413.04
57291	Construction of vagina		T	0195	32.4237	$2,065.20	$483.80	$413.04
57292	Construct vagina with graft		T	0195	32.4237	$2,065.20	$483.80	$413.04
57295	Revise vag graft via vagina	CH	T	0193	19.0203	$1,211.48		$242.30
57296	Revise vag graft, open abd		C					
57300	Repair rectum-vagina fistula		T	0195	32.4237	$2,065.20	$483.80	$413.04
57305	Repair rectum-vagina fistula		C					
57307	Fistula repair & colostomy		C					
57308	Fistula repair, transperine		C					
57310	Repair urethrovaginal lesion		T	0202	42.7099	$2,720.36	$981.50	$544.07
57311	Repair urethrovaginal lesion		C					
57320	Repair bladder-vagina lesion		T	0195	32.4237	$2,065.20	$483.80	$413.04
57330	Repair bladder-vagina lesion		T	0195	32.4237	$2,065.20	$483.80	$413.04
57335	Repair vagina		T	0195	32.4237	$2,065.20	$483.80	$413.04
57400	Dilation of vagina	CH	T	0193	19.0203	$1,211.48		$242.30
57410	Pelvic examination		T	0193	19.0203	$1,211.48		$242.30
57415	Remove vaginal foreign body	CH	T	0193	19.0203	$1,211.48		$242.30
57420	Exam of vagina w/scope		T	0189	2.7584	$175.69		$35.14
57421	Exam/biopsy of vag w/scope		T	0189	2.7584	$175.69		$35.14
57423	Repair paravag defect, lap	NI	T	0202	42.7099	$2,720.36	$981.50	$544.07
57425	Laparoscopy, surg, colpopexy		T	0130	34.3958	$2,190.81	$659.53	$438.16
57452	Exam of cervix w/scope	CH	T	0189	2.7584	$175.69		$35.14
57454	Bx/curett of cervix w/scope		T	0189	2.7584	$175.69		$35.14
57455	Biopsy of cervix w/scope		T	0189	2.7584	$175.69		$35.14
57456	Endocerv curettage w/scope		T	0189	2.7584	$175.69		$35.14
57460	Bx of cervix w/scope, leep		T	0193	19.0203	$1,211.48		$242.30
57461	Conz of cervix w/scope, leep	CH	T	0193	19.0203	$1,211.48		$242.30
57500	Biopsy of cervix	CH	T	0192	6.0783	$387.15		$77.43
57505	Endocervical curettage	CH	T	0192	6.0783	$387.15		$77.43
57510	Cauterization of cervix		T	0193	19.0203	$1,211.48		$242.30

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
57511	Cryocautery of cervix		T	0188	1.3520	$86.11		$17.22
57513	Laser surgery of cervix		T	0193	19.0203	$1,211.48		$242.30
57520	Conization of cervix	CH	T	0193	19.0203	$1,211.48		$242.30
57522	Conization of cervix	CH	T	0193	19.0203	$1,211.48		$242.30
57530	Removal of cervix		T	0195	32.4237	$2,065.20	$483.80	$413.04
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	32.4237	$2,065.20	$483.80	$413.04
57555	Remove cervix/repair vagina		T	0195	32.4237	$2,065.20	$483.80	$413.04
57556	Remove cervix, repair bowel		T	0202	42.7099	$2,720.36	$981.50	$544.07
57558	D&c of cervical stump	CH	T	0193	19.0203	$1,211.48		$242.30
57700	Revision of cervix	CH	T	0193	19.0203	$1,211.48		$242.30
57720	Revision of cervix	CH	T	0193	19.0203	$1,211.48		$242.30
57800	Dilation of cervical canal		T	0193	19.0203	$1,211.48		$242.30
58100	Biopsy of uterus lining		T	0188	1.3520	$86.11		$17.22
58110	Bx done w/colposcopy add-on	CH	N					
58120	Dilation and curettage	CH	T	0193	19.0203	$1,211.48		$242.30
58140	Myomectomy abdom method		C					
58145	Myomectomy vag method		T	0195	32.4237	$2,065.20	$483.80	$413.04
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	32.4237	$2,065.20	$483.80	$413.04
58262	Vag hyst including t/o		T	0195	32.4237	$2,065.20	$483.80	$413.04
58263	Vag hyst w/t/o & vag repair		T	0195	32.4237	$2,065.20	$483.80	$413.04
58267	Vag hyst w/urinary repair		C					
58270	Vag hyst w/enterocele repair		T	0195	32.4237	$2,065.20	$483.80	$413.04
58275	Hysterectomy/revise vagina		C					
58280	Hysterectomy/revise vagina		C					
58285	Extensive hysterectomy		C					
58290	Vag hyst complex		T	0202	42.7099	$2,720.36	$981.50	$544.07
58291	Vag hyst incl t/o, complex		T	0202	42.7099	$2,720.36	$981.50	$544.07
58292	Vag hyst t/o & repair, compl		T	0202	42.7099	$2,720.36	$981.50	$544.07
58293	Vag hyst w/uro repair, compl		C					
58294	Vag hyst w/enterocele, compl		T	0202	42.7099	$2,720.36	$981.50	$544.07
58300	Insert intrauterine device		E					
58301	Remove intrauterine device		T	0188	1.3520	$86.11		$17.22
58321	Artificial insemination	CH	T	0189	2.7584	$175.69		$35.14
58322	Artificial insemination	CH	T	0189	2.7584	$175.69		$35.14
58323	Sperm washing	CH	T	0189	2.7584	$175.69		$35.14
58340	Catheter for hysterography		N					
58345	Reopen fallopian tube		T	0193	19.0203	$1,211.48		$242.30
58346	Insert heyman uteri capsule		T	0193	19.0203	$1,211.48		$242.30
58350	Reopen fallopian tube		T	0195	32.4237	$2,065.20	$483.80	$413.04
58353	Endometr ablate, thermal		T	0195	32.4237	$2,065.20	$483.80	$413.04
58356	Endometrial cryoablation		T	0202	42.7099	$2,720.36	$981.50	$544.07
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	45.5317	$2,900.10	$1,001.89	$580.02
58542	Lsh w/t/o ut 250 g or less		T	0131	45.5317	$2,900.10	$1,001.89	$580.02
58543	Lsh uterus above 250 g		T	0131	45.5317	$2,900.10	$1,001.89	$580.02
58544	Lsh w/t/o uterus above 250 g		T	0131	45.5317	$2,900.10	$1,001.89	$580.02
58545	Laparoscopic myomectomy		T	0130	34.3958	$2,190.81	$659.53	$438.16
58546	Laparo-myomectomy, complex		T	0131	45.5317	$2,900.10	$1,001.89	$580.02
58548	Lap radical hyst		C					
58550	Laparo-asst vag hysterectomy		T	0132	69.6652	$4,437.26	$1,239.22	$887.45
58552	Laparo-vag hyst incl t/o		T	0131	45.5317	$2,900.10	$1,001.89	$580.02
58553	Laparo-vag hyst, complex		T	0131	45.5317	$2,900.10	$1,001.89	$580.02
58554	Laparo-vag hyst w/t/o, compl		T	0131	45.5317	$2,900.10	$1,001.89	$580.02
58555	Hysteroscopy, dx, sep proc		T	0190	21.6576	$1,379.46	$424.28	$275.89
58558	Hysteroscopy, biopsy		T	0190	21.6576	$1,379.46	$424.28	$275.89
58559	Hysteroscopy, lysis		T	0190	21.6576	$1,379.46	$424.28	$275.89
58560	Hysteroscopy, resect septum		T	0387	34.2048	$2,178.64	$655.55	$435.73
58561	Hysteroscopy, remove myoma		T	0387	34.2048	$2,178.64	$655.55	$435.73
58562	Hysteroscopy, remove fb		T	0190	21.6576	$1,379.46	$424.28	$275.89
58563	Hysteroscopy, ablation		T	0387	34.2048	$2,178.64	$655.55	$435.73
58565	Hysteroscopy, sterilization		T	0202	42.7099	$2,720.36	$981.50	$544.07
58570	Tlh, uterus 250 g or less	NI	T	0131	45.5317	$2,900.10	$1,001.89	$580.02
58571	Tlh w/t/o 250 g or less	NI	T	0131	45.5317	$2,900.10	$1,001.89	$580.02
58572	Tlh, uterus over 250 g	NI	T	0131	45.5317	$2,900.10	$1,001.89	$580.02
58573	Tlh w/t/o uterus over 250 g	NI	T	0131	45.5317	$2,900.10	$1,001.89	$580.02
58578	Laparo proc, uterus		T	0130	34.3958	$2,190.81	$659.53	$438.16
58579	Hysteroscope procedure		T	0190	21.6576	$1,379.46	$424.28	$275.89

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
58600	Division of fallopian tube		T	0195	32.4237	$2,065.20	$483.80	$413.04
58605	Division of fallopian tube		C					
58611	Ligate oviduct(s) add-on		C					
58615	Occlude fallopian tube(s)	CH	T	0193	19.0203	$1,211.48		$242.30
58660	Laparoscopy, lysis		T	0131	45.5317	$2,900.10	$1,001.89	$580.02
58661	Laparoscopy, remove adnexa		T	0131	45.5317	$2,900.10	$1,001.89	$580.02
58662	Laparoscopy, excise lesions		T	0131	45.5317	$2,900.10	$1,001.89	$580.02
58670	Laparoscopy, tubal cautery		T	0131	45.5317	$2,900.10	$1,001.89	$580.02
58671	Laparoscopy, tubal block		T	0131	45.5317	$2,900.10	$1,001.89	$580.02
58672	Laparoscopy, fimbrioplasty		T	0131	45.5317	$2,900.10	$1,001.89	$580.02
58673	Laparoscopy, salpingostomy		T	0131	45.5317	$2,900.10	$1,001.89	$580.02
58679	Laparo proc, oviduct-ovary		T	0130	34.3958	$2,190.81	$659.53	$438.16
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					
58770	Create new tubal opening		T	0195	32.4237	$2,065.20	$483.80	$413.04
58800	Drainage of ovarian cyst(s)		T	0193	19.0203	$1,211.48		$242.30
58805	Drainage of ovarian cyst(s)	CH	T	0195	32.4237	$2,065.20	$483.80	$413.04
58820	Drain ovary abscess, open		T	0195	32.4237	$2,065.20	$483.80	$413.04
58822	Drain ovary abscess, percut		C					
58823	Drain pelvic abscess, percut		T	0193	19.0203	$1,211.48		$242.30
58825	Transposition, ovary(s)		C					
58900	Biopsy of ovary(s)		T	0193	19.0203	$1,211.48		$242.30
58920	Partial removal of ovary(s)		T	0195	32.4237	$2,065.20	$483.80	$413.04
58925	Removal of ovarian cyst(s)		T	0195	32.4237	$2,065.20	$483.80	$413.04
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	2.7584	$175.69		$35.14
58974	Transfer of embryo	CH	T	0189	2.7584	$175.69		$35.14
58976	Transfer of embryo	CH	T	0189	2.7584	$175.69		$35.14
58999	Genital surgery procedure		T	0191	0.1309	$8.34	$2.36	$1.67
59000	Amniocentesis, diagnostic	CH	T	0189	2.7584	$175.69		$35.14
59001	Amniocentesis, therapeutic		T	0192	6.0783	$387.15		$77.43
59012	Fetal cord puncture,prenatal	CH	T	0189	2.7584	$175.69		$35.14
59015	Chorion biopsy	CH	T	0189	2.7584	$175.69		$35.14
59020	Fetal contract stress test	CH	T	0188	1.3520	$86.11		$17.22
59025	Fetal non-stress test	CH	T	0188	1.3520	$86.11		$17.22
59030	Fetal scalp blood sample	CH	T	0189	2.7584	$175.69		$35.14
59050	Fetal monitor w/report		M					
59051	Fetal monitor/interpret only		B					
59070	Transabdom amnioinfus w/us	CH	T	0189	2.7584	$175.69		$35.14
59072	Umbilical cord occlud w/us	CH	T	0189	2.7584	$175.69		$35.14
59074	Fetal fluid drainage w/us	CH	T	0189	2.7584	$175.69		$35.14
59076	Fetal shunt placement, w/us	CH	T	0189	2.7584	$175.69		$35.14
59100	Remove uterus lesion		T	0195	32.4237	$2,065.20	$483.80	$413.04
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	45.5317	$2,900.10	$1,001.89	$580.02
59151	Treat ectopic pregnancy		T	0131	45.5317	$2,900.10	$1,001.89	$580.02
59160	D & c after delivery	CH	T	0193	19.0203	$1,211.48		$242.30
59200	Insert cervical dilator		T	0189	2.7584	$175.69		$35.14
59300	Episiotomy or vaginal repair		T	0193	19.0203	$1,211.48		$242.30
59320	Revision of cervix	CH	T	0193	19.0203	$1,211.48		$242.30
59325	Revision of cervix		C					
59350	Repair of uterus		C					
59400	Obstetrical care		B					
59409	Obstetrical care	CH	T	0193	19.0203	$1,211.48		$242.30
59410	Obstetrical care		B					
59412	Antepartum manipulation	CH	T	0193	19.0203	$1,211.48		$242.30
59414	Deliver placenta		T	0193	19.0203	$1,211.48		$242.30
59425	Antepartum care only		B					
59426	Antepartum care only		B					
59430	Care after delivery		B					
59510	Cesarean delivery		B					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	19.0203	$1,211.48		$242.30
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	19.0203	$1,211.48		$242.30
59820	Care of miscarriage	CH	T	0193	19.0203	$1,211.48		$242.30
59821	Treatment of miscarriage	CH	T	0193	19.0203	$1,211.48		$242.30
59830	Treat uterus infection		C					
59840	Abortion	CH	T	0193	19.0203	$1,211.48		$242.30
59841	Abortion	CH	T	0193	19.0203	$1,211.48		$242.30
59850	Abortion		C					
59851	Abortion		C					
59852	Abortion		C					
59855	Abortion		C					
59856	Abortion		C					
59857	Abortion		C					
59866	Abortion (mpr)	CH	T	0189	2.7584	$175.69		$35.14
59870	Evacuate mole of uterus	CH	T	0193	19.0203	$1,211.48		$242.30
59871	Remove cerclage suture	CH	T	0193	19.0203	$1,211.48		$242.30
59897	Fetal invas px w/us	CH	T	0189	2.7584	$175.69		$35.14
59898	Laparo proc, ob care/deliver		T	0130	34.3958	$2,190.81	$659.53	$438.16
59899	Maternity care procedure	CH	T	0191	0.1309	$8.34	$2.36	$1.67
60000	Drain thyroid/tongue cyst		T	0252	7.4474	$474.35	$109.16	$94.87
60001	Aspirate/inject thyriod cyst	CH	D					
6005F	Care level rationale doc		M					
60100	Biopsy of thyroid		T	0004	4.3270	$275.60		$55.12
6010F	Dysphag test done b/4 eating		M					
6015F	Dysphag test done b/4 eating		M					
60200	Remove thyroid lesion		T	0114	44.3240	$2,823.17		$564.63
6020F	Npo (nothing-mouth) ordered		M					
60210	Partial thyroid excision		T	0114	44.3240	$2,823.17		$564.63
60212	Partial thyroid excision		T	0114	44.3240	$2,823.17		$564.63
60220	Partial removal of thyroid		T	0114	44.3240	$2,823.17		$564.63
60225	Partial removal of thyroid		T	0114	44.3240	$2,823.17		$564.63
60240	Removal of thyroid		T	0114	44.3240	$2,823.17		$564.63
60252	Removal of thyroid		T	0256	39.8776	$2,539.96		$507.99
60254	Extensive thyroid surgery		C					
60260	Repeat thyroid surgery		T	0256	39.8776	$2,539.96		$507.99
60270	Removal of thyroid		C					
60271	Removal of thyroid	CH	T	0256	39.8776	$2,539.96		$507.99
60280	Remove thyroid duct lesion		T	0114	44.3240	$2,823.17		$564.63
60281	Remove thyroid duct lesion		T	0114	44.3240	$2,823.17		$564.63
60300	Aspir/inj thyroid cyst	NI	T	0004	4.3270	$275.60		$55.12
6030F	Max sterile barriers follw'd	NI	M					
60500	Explore parathyroid glands		T	0256	39.8776	$2,539.96		$507.99
60502	Re-explore parathyroids		T	0256	39.8776	$2,539.96		$507.99
60505	Explore parathyroid glands		C					
60512	Autotransplant parathyroid		T	0022	21.1098	$1,344.57	$354.45	$268.91
60520	Removal of thymus gland		T	0256	39.8776	$2,539.96		$507.99
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	34.3958	$2,190.81	$659.53	$438.16
60699	Endocrine surgery procedure		T	0114	44.3240	$2,823.17		$564.63
61000	Remove cranial cavity fluid		T	0212	8.5263	$543.07		$108.61
61001	Remove cranial cavity fluid		T	0212	8.5263	$543.07		$108.61
61020	Remove brain cavity fluid		T	0212	8.5263	$543.07		$108.61
61026	Injection into brain canal		T	0212	8.5263	$543.07		$108.61
61050	Remove brain canal fluid		T	0212	8.5263	$543.07		$108.61
61055	Injection into brain canal		T	0212	8.5263	$543.07		$108.61
61070	Brain canal shunt procedure	CH	T	0121	3.2383	$206.26	$43.80	$41.25
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
61215	Insert brain-fluid device		T	0224	36.2768	$2,310.61		$462.12
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	39.8776	$2,539.96		$507.99
61332	Explore/biopsy eye socket		C					
61333	Explore orbit/remove lesion		C					
61334	Explore orbit/remove object		T	0256	39.8776	$2,539.96		$507.99
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
61623	Endovasc tempory vessel occl	CH	T	0082	87.5137	$5,574.10		$1,114.82
61624	Transcath occlusion, cns		C					
61626	Transcath occlusion, non-cns	CH	T	0082	87.5137	$5,574.10		$1,114.82
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	33.2707	$2,119.14	$463.62	$423.83
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	33.2707	$2,119.14	$463.62	$423.83
61790	Treat trigeminal nerve		T	0220	18.0518	$1,149.79		$229.96
61791	Treat trigeminal tract	CH	T	0203	14.4879	$922.79	$240.33	$184.56
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	22.4734	$1,431.42	$438.47	$286.28
61885	Insrt/redo neurostim 1 array		S	0039	186.4739	$11,877.27		$2,375.45
61886	Implant neurostim arrays	CH	S	0315	270.0190	$17,198.59		$3,439.72
61888	Revise/remove neuroreceiver		T	0688	34.4166	$2,192.13	$874.57	$438.43
62000	Treat skull fracture		T	0254	23.9765	$1,527.16	$321.35	$305.43
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
62190	Establish brain cavity shunt		C					
62192	Establish brain cavity shunt		C					
62194	Replace/irrigate catheter	CH	T	0212	8.5263	$543.07		$108.61
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	15.3545	$977.99		$195.60
62230	Replace/revise brain shunt		T	0224	36.2768	$2,310.61		$462.12
62252	Csf shunt reprogram		S	0691	2.3269	$148.21	$50.49	$29.64
62256	Remove brain cavity shunt		C					
62258	Replace brain cavity shunt		C					
62263	Epidural lysis mult sessions		T	0203	14.4879	$922.79	$240.33	$184.56
62264	Epidural lysis on single day		T	0203	14.4879	$922.79	$240.33	$184.56
62268	Drain spinal cord cyst		T	0212	8.5263	$543.07		$108.61
62269	Needle biopsy, spinal cord		T	0685	9.3354	$594.61		$118.92
62270	Spinal fluid tap, diagnostic	CH	T	0206	4.0964	$260.92	$56.01	$52.18
62272	Drain cerebro spinal fluid	CH	T	0206	4.0964	$260.92	$56.01	$52.18
62273	Inject epidural patch		T	0206	4.0964	$260.92	$56.01	$52.18
62280	Treat spinal cord lesion		T	0207	7.0546	$449.34		$89.87
62281	Treat spinal cord lesion		T	0207	7.0546	$449.34		$89.87
62282	Treat spinal canal lesion		T	0207	7.0546	$449.34		$89.87
62284	Injection for myelogram		N					
62287	Percutaneous diskectomy		T	0221	33.2707	$2,119.14	$463.62	$423.83
62290	Inject for spine disk x-ray		N					
62291	Inject for spine disk x-ray		N					
62292	Injection into disk lesion		T	0212	8.5263	$543.07		$108.61
62294	Injection into spinal artery		T	0212	8.5263	$543.07		$108.61
62310	Inject spine c/t		T	0207	7.0546	$449.34		$89.87
62311	Inject spine l/s (cd)		T	0207	7.0546	$449.34		$89.87
62318	Inject spine w/cath, c/t		T	0207	7.0546	$449.34		$89.87
62319	Inject spine w/cath l/s (cd)		T	0207	7.0546	$449.34		$89.87
62350	Implant spinal canal cath	CH	T	0224	36.2768	$2,310.61		$462.12
62351	Implant spinal canal cath		T	0208	46.7724	$2,979.12		$595.82
62355	Remove spinal canal catheter		T	0203	14.4879	$922.79	$240.33	$184.56
62360	Insert spine infusion device	CH	T	0224	36.2768	$2,310.61		$462.12
62361	Implant spine infusion pump		T	0227	183.8928	$11,712.87		$2,342.57
62362	Implant spine infusion pump		T	0227	183.8928	$11,712.87		$2,342.57
62365	Remove spine infusion device		T	0221	33.2707	$2,119.14	$463.62	$423.83
62367	Analyze spine infusion pump		S	0691	2.3269	$148.21	$50.49	$29.64
62368	Analyze spine infusion pump		S	0691	2.3269	$148.21	$50.49	$29.64
63001	Removal of spinal lamina		T	0208	46.7724	$2,979.12		$595.82
63003	Removal of spinal lamina		T	0208	46.7724	$2,979.12		$595.82
63005	Removal of spinal lamina		T	0208	46.7724	$2,979.12		$595.82
63011	Removal of spinal lamina		T	0208	46.7724	$2,979.12		$595.82
63012	Removal of spinal lamina		T	0208	46.7724	$2,979.12		$595.82
63015	Removal of spinal lamina		T	0208	46.7724	$2,979.12		$595.82
63016	Removal of spinal lamina		T	0208	46.7724	$2,979.12		$595.82
63017	Removal of spinal lamina		T	0208	46.7724	$2,979.12		$595.82
63020	Neck spine disk surgery		T	0208	46.7724	$2,979.12		$595.82
63030	Low back disk surgery		T	0208	46.7724	$2,979.12		$595.82
63035	Spinal disk surgery add-on		T	0208	46.7724	$2,979.12		$595.82
63040	Laminotomy, single cervical		T	0208	46.7724	$2,979.12		$595.82
63042	Laminotomy, single lumbar		T	0208	46.7724	$2,979.12		$595.82
63043	Laminotomy, add'l cervical		C					
63044	Laminotomy, add'l lumbar		C					
63045	Removal of spinal lamina		T	0208	46.7724	$2,979.12		$595.82
63046	Removal of spinal lamina		T	0208	46.7724	$2,979.12		$595.82
63047	Removal of spinal lamina		T	0208	46.7724	$2,979.12		$595.82
63048	Remove spinal lamina add-on		T	0208	46.7724	$2,979.12		$595.82
63050	Cervical laminoplasty		C					
63051	C-laminoplasty w/graft/plate		C					
63055	Decompress spinal cord		T	0208	46.7724	$2,979.12		$595.82
63056	Decompress spinal cord		T	0208	46.7724	$2,979.12		$595.82
63057	Decompress spine cord add-on		T	0208	46.7724	$2,979.12		$595.82
63064	Decompress spinal cord		T	0208	46.7724	$2,979.12		$595.82
63066	Decompress spine cord add-on		T	0208	46.7724	$2,979.12		$595.82
63075	Neck spine disk surgery		T	0208	46.7724	$2,979.12		$595.82
63076	Neck spine disk surgery		C					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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	18.0518	$1,149.79		$229.96
63610	Stimulation of spinal cord		T	0220	18.0518	$1,149.79		$229.96
63615	Remove lesion of spinal cord		T	0220	18.0518	$1,149.79		$229.96
63650	Implant neuroelectrodes		S	0040	63.7866	$4,062.82		$812.56
63655	Implant neuroelectrodes		S	0061	82.8597	$5,277.67		$1,055.53
63660	Revise/remove neuroelectrode		T	0687	22.4734	$1,431.42	$438.47	$286.28
63685	Insrt/redo spine n generator	CH	S	0222	240.7990	$15,337.45		$3,067.49
63688	Revise/remove neuroreceiver		T	0688	34.4166	$2,192.13	$874.57	$438.43
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	36.2768	$2,310.61		$462.12
63744	Revision of spinal shunt	CH	T	0224	36.2768	$2,310.61		$462.12
63746	Removal of spinal shunt		T	0109	5.6614	$360.60		$72.12

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
64400	N block inj, trigeminal		T	0204	2.3213	$147.85	$40.13	$29.57
64402	N block inj, facial		T	0204	2.3213	$147.85	$40.13	$29.57
64405	N block inj, occipital	CH	T	0206	4.0964	$260.92	$56.01	$52.18
64408	N block inj, vagus	CH	T	0206	4.0964	$260.92	$56.01	$52.18
64410	N block inj, phrenic	CH	T	0207	7.0546	$449.34		$89.87
64412	N block inj, spinal accessor	CH	T	0207	7.0546	$449.34		$89.87
64413	N block inj, cervical plexus	CH	T	0206	4.0964	$260.92	$56.01	$52.18
64415	N block inj, brachial plexus	CH	T	0206	4.0964	$260.92	$56.01	$52.18
64416	N block cont infuse, b plex	CH	T	0207	7.0546	$449.34		$89.87
64417	N block inj, axillary	CH	T	0206	4.0964	$260.92	$56.01	$52.18
64418	N block inj, suprascapular	CH	T	0206	4.0964	$260.92	$56.01	$52.18
64420	N block inj, intercost, sng	CH	T	0206	4.0964	$260.92	$56.01	$52.18
64421	N block inj, intercost, mlt		T	0206	4.0964	$260.92	$56.01	$52.18
64425	N block inj, ilio-ing/hypogi	CH	T	0206	4.0964	$260.92	$56.01	$52.18
64430	N block inj, pudendal	CH	T	0207	7.0546	$449.34		$89.87
64435	N block inj, paracervical	CH	T	0206	4.0964	$260.92	$56.01	$52.18
64445	N block inj, sciatic, sng	CH	T	0206	4.0964	$260.92	$56.01	$52.18
64446	N blk inj, sciatic, cont inf	CH	T	0203	14.4879	$922.79	$240.33	$184.56
64447	N block inj fem, single	CH	T	0206	4.0964	$260.92	$56.01	$52.18
64448	N block inj fem, cont inf	CH	T	0206	4.0964	$260.92	$56.01	$52.18
64449	N block inj, lumbar plexus	CH	T	0207	7.0546	$449.34		$89.87
64450	N block, other peripheral	CH	T	0206	4.0964	$260.92	$56.01	$52.18
64470	Inj paravertebral c/t		T	0207	7.0546	$449.34		$89.87
64472	Inj paravertebral c/t add-on		T	0206	4.0964	$260.92	$56.01	$52.18
64475	Inj paravertebral l/s		T	0207	7.0546	$449.34		$89.87
64476	Inj paravertebral l/s add-on	CH	T	0204	2.3213	$147.85	$40.13	$29.57
64479	Inj foramen epidural c/t		T	0207	7.0546	$449.34		$89.87
64480	Inj foramen epidural add-on	CH	T	0206	4.0964	$260.92	$56.01	$52.18
64483	Inj foramen epidural l/s		T	0207	7.0546	$449.34		$89.87
64484	Inj foramen epidural add-on	CH	T	0206	4.0964	$260.92	$56.01	$52.18
64505	N block, spenopalatine gangl		T	0204	2.3213	$147.85	$40.13	$29.57
64508	N block, carotid sinus s/p		T	0204	2.3213	$147.85	$40.13	$29.57
64510	N block, stellate ganglion		T	0207	7.0546	$449.34		$89.87
64517	N block inj, hypogas plxs	CH	T	0207	7.0546	$449.34		$89.87
64520	N block, lumbar/thoracic		T	0207	7.0546	$449.34		$89.87
64530	N block inj, celiac pelus		T	0207	7.0546	$449.34		$89.87
64550	Apply neurostimulator		A					
64553	Implant neuroelectrodes		S	0225	220.7642	$14,061.35		$2,812.27
64555	Implant neuroelectrodes		S	0040	63.7866	$4,062.82		$812.56
64560	Implant neuroelectrodes		S	0040	63.7866	$4,062.82		$812.56
64561	Implant neuroelectrodes		S	0040	63.7866	$4,062.82		$812.56
64565	Implant neuroelectrodes		S	0040	63.7866	$4,062.82		$812.56
64573	Implant neuroelectrodes		S	0225	220.7642	$14,061.35		$2,812.27
64575	Implant neuroelectrodes		S	0061	82.8597	$5,277.67		$1,055.53
64577	Implant neuroelectrodes		S	0061	82.8597	$5,277.67		$1,055.53
64580	Implant neuroelectrodes		S	0061	82.8597	$5,277.67		$1,055.53
64581	Implant neuroelectrodes		S	0061	82.8597	$5,277.67		$1,055.53
64585	Revise/remove neuroelectrode		T	0687	22.4734	$1,431.42	$438.47	$286.28
64590	Insrt/redo pn/gastr stimul	CH	S	0039	186.4739	$11,877.27		$2,375.45
64595	Revise/rmv pn/gastr stimul		T	0688	34.4166	$2,192.13	$874.57	$438.43
64600	Injection treatment of nerve		T	0203	14.4879	$922.79	$240.33	$184.56
64605	Injection treatment of nerve		T	0203	14.4879	$922.79	$240.33	$184.56
64610	Injection treatment of nerve		T	0203	14.4879	$922.79	$240.33	$184.56
64612	Destroy nerve, face muscle		T	0204	2.3213	$147.85	$40.13	$29.57
64613	Destroy nerve, neck muscle		T	0204	2.3213	$147.85	$40.13	$29.57
64614	Destroy nerve, extrem musc		T	0204	2.3213	$147.85	$40.13	$29.57
64620	Injection treatment of nerve	CH	T	0207	7.0546	$449.34		$89.87
64622	Destr paravertebrl nerve l/s		T	0203	14.4879	$922.79	$240.33	$184.56
64623	Destr paravertebral n add-on		T	0207	7.0546	$449.34		$89.87
64626	Destr paravertebrl nerve c/t		T	0203	14.4879	$922.79	$240.33	$184.56
64627	Destr paravertebral n add-on	CH	T	0204	2.3213	$147.85	$40.13	$29.57
64630	Injection treatment of nerve	CH	T	0207	7.0546	$449.34		$89.87
64640	Injection treatment of nerve	CH	T	0207	7.0546	$449.34		$89.87
64650	Chemodenerv eccrine glands		T	0204	2.3213	$147.85	$40.13	$29.57
64653	Chemodenerv eccrine glands		T	0204	2.3213	$147.85	$40.13	$29.57
64680	Injection treatment of nerve	CH	T	0203	14.4879	$922.79	$240.33	$184.56
64681	Injection treatment of nerve		T	0203	14.4879	$922.79	$240.33	$184.56
64702	Revise finger/toe nerve		T	0220	18.0518	$1,149.79		$229.96
64704	Revise hand/foot nerve		T	0220	18.0518	$1,149.79		$229.96
64708	Revise arm/leg nerve		T	0220	18.0518	$1,149.79		$229.96
64712	Revision of sciatic nerve		T	0220	18.0518	$1,149.79		$229.96
64713	Revision of arm nerve(s)		T	0220	18.0518	$1,149.79		$229.96
64714	Revise low back nerve(s)		T	0220	18.0518	$1,149.79		$229.96
64716	Revision of cranial nerve		T	0220	18.0518	$1,149.79		$229.96
64718	Revise ulnar nerve at elbow		T	0220	18.0518	$1,149.79		$229.96
64719	Revise ulnar nerve at wrist		T	0220	18.0518	$1,149.79		$229.96
64721	Carpal tunnel surgery		T	0220	18.0518	$1,149.79		$229.96
64722	Relieve pressure on nerve(s)		T	0220	18.0518	$1,149.79		$229.96
64726	Release foot/toe nerve		T	0220	18.0518	$1,149.79		$229.96
64727	Internal nerve revision		T	0220	18.0518	$1,149.79		$229.96

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
64732	Incision of brow nerve		T	0220	18.0518	$1,149.79		$229.96
64734	Incision of cheek nerve		T	0220	18.0518	$1,149.79		$229.96
64736	Incision of chin nerve		T	0220	18.0518	$1,149.79		$229.96
64738	Incision of jaw nerve		T	0220	18.0518	$1,149.79		$229.96
64740	Incision of tongue nerve		T	0220	18.0518	$1,149.79		$229.96
64742	Incision of facial nerve		T	0220	18.0518	$1,149.79		$229.96
64744	Incise nerve, back of head		T	0220	18.0518	$1,149.79		$229.96
64746	Incise diaphragm nerve		T	0220	18.0518	$1,149.79		$229.96
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	18.0518	$1,149.79		$229.96
64763	Incise hip/thigh nerve		T	0220	18.0518	$1,149.79		$229.96
64766	Incise hip/thigh nerve		T	0221	33.2707	$2,119.14	$463.62	$423.83
64771	Sever cranial nerve		T	0220	18.0518	$1,149.79		$229.96
64772	Incision of spinal nerve		T	0220	18.0518	$1,149.79		$229.96
64774	Remove skin nerve lesion		T	0220	18.0518	$1,149.79		$229.96
64776	Remove digit nerve lesion		T	0220	18.0518	$1,149.79		$229.96
64778	Digit nerve surgery add-on		T	0220	18.0518	$1,149.79		$229.96
64782	Remove limb nerve lesion		T	0220	18.0518	$1,149.79		$229.96
64783	Limb nerve surgery add-on		T	0220	18.0518	$1,149.79		$229.96
64784	Remove nerve lesion		T	0220	18.0518	$1,149.79		$229.96
64786	Remove sciatic nerve lesion		T	0221	33.2707	$2,119.14	$463.62	$423.83
64787	Implant nerve end		T	0220	18.0518	$1,149.79		$229.96
64788	Remove skin nerve lesion		T	0220	18.0518	$1,149.79		$229.96
64790	Removal of nerve lesion		T	0220	18.0518	$1,149.79		$229.96
64792	Removal of nerve lesion		T	0221	33.2707	$2,119.14	$463.62	$423.83
64795	Biopsy of nerve		T	0220	18.0518	$1,149.79		$229.96
64802	Remove sympathetic nerves		T	0220	18.0518	$1,149.79		$229.96
64804	Remove sympathetic nerves		T	0220	18.0518	$1,149.79		$229.96
64809	Remove sympathetic nerves		C					
64818	Remove sympathetic nerves		C					
64820	Remove sympathetic nerves		T	0220	18.0518	$1,149.79		$229.96
64821	Remove sympathetic nerves		T	0054	26.3105	$1,675.82		$335.16
64822	Remove sympathetic nerves		T	0054	26.3105	$1,675.82		$335.16
64823	Remove sympathetic nerves		T	0054	26.3105	$1,675.82		$335.16
64831	Repair of digit nerve		T	0221	33.2707	$2,119.14	$463.62	$423.83
64832	Repair nerve add-on		T	0221	33.2707	$2,119.14	$463.62	$423.83
64834	Repair of hand or foot nerve		T	0221	33.2707	$2,119.14	$463.62	$423.83
64835	Repair of hand or foot nerve		T	0221	33.2707	$2,119.14	$463.62	$423.83
64836	Repair of hand or foot nerve		T	0221	33.2707	$2,119.14	$463.62	$423.83
64837	Repair nerve add-on		T	0221	33.2707	$2,119.14	$463.62	$423.83
64840	Repair of leg nerve		T	0221	33.2707	$2,119.14	$463.62	$423.83
64856	Repair/transpose nerve		T	0221	33.2707	$2,119.14	$463.62	$423.83
64857	Repair arm/leg nerve		T	0221	33.2707	$2,119.14	$463.62	$423.83
64858	Repair sciatic nerve		T	0221	33.2707	$2,119.14	$463.62	$423.83
64859	Nerve surgery		T	0221	33.2707	$2,119.14	$463.62	$423.83
64861	Repair of arm nerves		T	0221	33.2707	$2,119.14	$463.62	$423.83
64862	Repair of low back nerves		T	0221	33.2707	$2,119.14	$463.62	$423.83
64864	Repair of facial nerve		T	0221	33.2707	$2,119.14	$463.62	$423.83
64865	Repair of facial nerve		T	0221	33.2707	$2,119.14	$463.62	$423.83
64866	Fusion of facial/other nerve		C					
64868	Fusion of facial/other nerve		C					
64870	Fusion of facial/other nerve		T	0221	33.2707	$2,119.14	$463.62	$423.83
64872	Subsequent repair of nerve		T	0221	33.2707	$2,119.14	$463.62	$423.83
64874	Repair & revise nerve add-on		T	0221	33.2707	$2,119.14	$463.62	$423.83
64876	Repair nerve/shorten bone		T	0221	33.2707	$2,119.14	$463.62	$423.83
64885	Nerve graft, head or neck		T	0221	33.2707	$2,119.14	$463.62	$423.83
64886	Nerve graft, head or neck		T	0221	33.2707	$2,119.14	$463.62	$423.83
64890	Nerve graft, hand or foot		T	0221	33.2707	$2,119.14	$463.62	$423.83
64891	Nerve graft, hand or foot		T	0221	33.2707	$2,119.14	$463.62	$423.83
64892	Nerve graft, arm or leg		T	0221	33.2707	$2,119.14	$463.62	$423.83
64893	Nerve graft, arm or leg		T	0221	33.2707	$2,119.14	$463.62	$423.83
64895	Nerve graft, hand or foot		T	0221	33.2707	$2,119.14	$463.62	$423.83
64896	Nerve graft, hand or foot		T	0221	33.2707	$2,119.14	$463.62	$423.83
64897	Nerve graft, arm or leg		T	0221	33.2707	$2,119.14	$463.62	$423.83
64898	Nerve graft, arm or leg		T	0221	33.2707	$2,119.14	$463.62	$423.83
64901	Nerve graft add-on		T	0221	33.2707	$2,119.14	$463.62	$423.83
64902	Nerve graft add-on		T	0221	33.2707	$2,119.14	$463.62	$423.83
64905	Nerve pedicle transfer		T	0221	33.2707	$2,119.14	$463.62	$423.83
64907	Nerve pedicle transfer		T	0221	33.2707	$2,119.14	$463.62	$423.83
64910	Nerve repair w/allograft		T	0220	18.0518	$1,149.79		$229.96
64911	Neurorraphy w/vein autograft		T	0220	18.0518	$1,149.79		$229.96
64999	Nervous system surgery		T	0204	2.3213	$147.85	$40.13	$29.57
65091	Revise eye		T	0242	37.7243	$2,402.81	$597.36	$480.56
65093	Revise eye with implant		T	0242	37.7243	$2,402.81	$597.36	$480.56
65101	Removal of eye		T	0242	37.7243	$2,402.81	$597.36	$480.56
65103	Remove eye/insert implant		T	0242	37.7243	$2,402.81	$597.36	$480.56
65105	Remove eye/attach implant		T	0242	37.7243	$2,402.81	$597.36	$480.56
65110	Removal of eye		T	0242	37.7243	$2,402.81	$597.36	$480.56

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
65112	Remove eye/revise socket		T	0242	37.7243	$2,402.81	$597.36	$480.56
65114	Remove eye/revise socket		T	0242	37.7243	$2,402.81	$597.36	$480.56
65125	Revise ocular implant		T	0240	18.7307	$1,193.03	$309.52	$238.61
65130	Insert ocular implant		T	0241	24.3077	$1,548.25	$383.45	$309.65
65135	Insert ocular implant		T	0241	24.3077	$1,548.25	$383.45	$309.65
65140	Attach ocular implant		T	0242	37.7243	$2,402.81	$597.36	$480.56
65150	Revise ocular implant		T	0241	24.3077	$1,548.25	$383.45	$309.65
65155	Reinsert ocular implant		T	0242	37.7243	$2,402.81	$597.36	$480.56
65175	Removal of ocular implant		T	0240	18.7307	$1,193.03	$309.52	$238.61
65205	Remove foreign body from eye		S	0698	0.8696	$55.39		$11.08
65210	Remove foreign body from eye		S	0698	0.8696	$55.39		$11.08
65220	Remove foreign body from eye		S	0698	0.8696	$55.39		$11.08
65222	Remove foreign body from eye		S	0698	0.8696	$55.39		$11.08
65235	Remove foreign body from eye		T	0233	16.1710	$1,030.00	$266.33	$206.00
65260	Remove foreign body from eye		T	0236	18.2350	$1,161.46		$232.29
65265	Remove foreign body from eye		T	0237	27.8450	$1,773.56		$354.71
65270	Repair of eye wound		T	0240	18.7307	$1,193.03	$309.52	$238.61
65272	Repair of eye wound		T	0234	23.1758	$1,476.16	$511.31	$295.23
65273	Repair of eye wound		C					
65275	Repair of eye wound		T	0234	23.1758	$1,476.16	$511.31	$295.23
65280	Repair of eye wound		T	0236	18.2350	$1,161.46		$232.29
65285	Repair of eye wound		T	0672	37.2078	$2,369.91		$473.98
65286	Repair of eye wound		T	0232	5.1169	$325.92	$81.65	$65.18
65290	Repair of eye socket wound		T	0243	24.1291	$1,536.88	$430.35	$307.38
65400	Removal of eye lesion		T	0233	16.1710	$1,030.00	$266.33	$206.00
65410	Biopsy of cornea		T	0233	16.1710	$1,030.00	$266.33	$206.00
65420	Removal of eye lesion		T	0233	16.1710	$1,030.00	$266.33	$206.00
65426	Removal of eye lesion		T	0234	23.1758	$1,476.16	$511.31	$295.23
65430	Corneal smear		S	0698	0.8696	$55.39		$11.08
65435	Curette/treat cornea		T	0239	7.2847	$463.99		$92.80
65436	Curette/treat cornea		T	0233	16.1710	$1,030.00	$266.33	$206.00
65450	Treatment of corneal lesion		S	0231	2.1790	$138.79		$27.76
65600	Revision of cornea		T	0240	18.7307	$1,193.03	$309.52	$238.61
65710	Corneal transplant		T	0244	37.4896	$2,387.86	$803.26	$477.57
65730	Corneal transplant		T	0244	37.4896	$2,387.86	$803.26	$477.57
65750	Corneal transplant		T	0244	37.4896	$2,387.86	$803.26	$477.57
65755	Corneal transplant		T	0244	37.4896	$2,387.86	$803.26	$477.57
65760	Revision of cornea		E					
65765	Revision of cornea		E					
65767	Corneal tissue transplant		E					
65770	Revise cornea with implant		T	0293	84.8039	$5,401.50	$1,128.29	$1,080.30
65771	Radial keratotomy		E					
65772	Correction of astigmatism		T	0233	16.1710	$1,030.00	$266.33	$206.00
65775	Correction of astigmatism		T	0233	16.1710	$1,030.00	$266.33	$206.00
65780	Ocular reconst, transplant		T	0244	37.4896	$2,387.86	$803.26	$477.57
65781	Ocular reconst, transplant		T	0244	37.4896	$2,387.86	$803.26	$477.57
65782	Ocular reconst, transplant		T	0244	37.4896	$2,387.86	$803.26	$477.57
65800	Drainage of eye		T	0233	16.1710	$1,030.00	$266.33	$206.00
65805	Drainage of eye		T	0233	16.1710	$1,030.00	$266.33	$206.00
65810	Drainage of eye		T	0234	23.1758	$1,476.16	$511.31	$295.23
65815	Drainage of eye		T	0234	23.1758	$1,476.16	$511.31	$295.23
65820	Relieve inner eye pressure		T	0232	5.1169	$325.92	$81.65	$65.18
65850	Incision of eye		T	0234	23.1758	$1,476.16	$511.31	$295.23
65855	Laser surgery of eye		T	0247	5.2001	$331.22	$104.31	$66.24
65860	Incise inner eye adhesions		T	0247	5.2001	$331.22	$104.31	$66.24
65865	Incise inner eye adhesions		T	0233	16.1710	$1,030.00	$266.33	$206.00
65870	Incise inner eye adhesions		T	0234	23.1758	$1,476.16	$511.31	$295.23
65875	Incise inner eye adhesions		T	0234	23.1758	$1,476.16	$511.31	$295.23
65880	Incise inner eye adhesions		T	0233	16.1710	$1,030.00	$266.33	$206.00
65900	Remove eye lesion		T	0233	16.1710	$1,030.00	$266.33	$206.00
65920	Remove implant of eye		T	0234	23.1758	$1,476.16	$511.31	$295.23
65930	Remove blood clot from eye		T	0234	23.1758	$1,476.16	$511.31	$295.23
66020	Injection treatment of eye		T	0233	16.1710	$1,030.00	$266.33	$206.00
66030	Injection treatment of eye		T	0232	5.1169	$325.92	$81.65	$65.18
66130	Remove eye lesion		T	0234	23.1758	$1,476.16	$511.31	$295.23
66150	Glaucoma surgery		T	0234	23.1758	$1,476.16	$511.31	$295.23
66155	Glaucoma surgery		T	0234	23.1758	$1,476.16	$511.31	$295.23
66160	Glaucoma surgery		T	0234	23.1758	$1,476.16	$511.31	$295.23
66165	Glaucoma surgery		T	0234	23.1758	$1,476.16	$511.31	$295.23
66170	Glaucoma surgery		T	0234	23.1758	$1,476.16	$511.31	$295.23
66172	Incision of eye		T	0234	23.1758	$1,476.16	$511.31	$295.23
66180	Implant eye shunt		T	0673	39.7101	$2,529.30	$649.56	$505.86
66185	Revise eye shunt		T	0673	39.7101	$2,529.30	$649.56	$505.86
66220	Repair eye lesion		T	0672	37.2078	$2,369.91		$473.98
66225	Repair/graft eye lesion		T	0673	39.7101	$2,529.30	$649.56	$505.86
66250	Follow-up surgery of eye		T	0233	16.1710	$1,030.00	$266.33	$206.00
66500	Incision of iris		T	0232	5.1169	$325.92	$81.65	$65.18
66505	Incision of iris		T	0232	5.1169	$325.92	$81.65	$65.18
66600	Remove iris and lesion		T	0234	23.1758	$1,476.16	$511.31	$295.23
66605	Removal of iris		T	0234	23.1758	$1,476.16	$511.31	$295.23

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
66625	Removal of iris		T	0232	5.1169	$325.92	$81.65	$65.18
66630	Removal of iris		T	0234	23.1758	$1,476.16	$511.31	$295.23
66635	Removal of iris		T	0234	23.1758	$1,476.16	$511.31	$295.23
66680	Repair iris & ciliary body		T	0234	23.1758	$1,476.16	$511.31	$295.23
66682	Repair iris & ciliary body		T	0234	23.1758	$1,476.16	$511.31	$295.23
66700	Destruction, ciliary body		T	0233	16.1710	$1,030.00	$266.33	$206.00
66710	Ciliary transsleral therapy		T	0233	16.1710	$1,030.00	$266.33	$206.00
66711	Ciliary endoscopic ablation		T	0233	16.1710	$1,030.00	$266.33	$206.00
66720	Destruction, ciliary body		T	0233	16.1710	$1,030.00	$266.33	$206.00
66740	Destruction, ciliary body		T	0234	23.1758	$1,476.16	$511.31	$295.23
66761	Revision of iris		T	0247	5.2001	$331.22	$104.31	$66.24
66762	Revision of iris		T	0247	5.2001	$331.22	$104.31	$66.24
66770	Removal of inner eye lesion		T	0247	5.2001	$331.22	$104.31	$66.24
66820	Incision, secondary cataract		T	0232	5.1169	$325.92	$81.65	$65.18
66821	After cataract laser surgery		T	0247	5.2001	$331.22	$104.31	$66.24
66825	Reposition intraocular lens		T	0234	23.1758	$1,476.16	$511.31	$295.23
66830	Removal of lens lesion		T	0232	5.1169	$325.92	$81.65	$65.18
66840	Removal of lens material		T	0245	14.9171	$950.13	$217.05	$190.03
66850	Removal of lens material		T	0249	28.7035	$1,828.24	$524.67	$365.65
66852	Removal of lens material		T	0249	28.7035	$1,828.24	$524.67	$365.65
66920	Extraction of lens		T	0249	28.7035	$1,828.24	$524.67	$365.65
66930	Extraction of lens		T	0249	28.7035	$1,828.24	$524.67	$365.65
66940	Extraction of lens		T	0245	14.9171	$950.13	$217.05	$190.03
66982	Cataract surgery, complex		T	0246	23.8649	$1,520.05	$495.96	$304.01
66983	Cataract surg w/iol, 1 stage		T	0246	23.8649	$1,520.05	$495.96	$304.01
66984	Cataract surg w/iol, 1 stage		T	0246	23.8649	$1,520.05	$495.96	$304.01
66985	Insert lens prosthesis		T	0246	23.8649	$1,520.05	$495.96	$304.01
66986	Exchange lens prosthesis		T	0246	23.8649	$1,520.05	$495.96	$304.01
66990	Ophthalmic endoscope add-on		N					
66999	Eye surgery procedure		T	0232	5.1169	$325.92	$81.65	$65.18
67005	Partial removal of eye fluid		T	0237	27.8450	$1,773.56		$354.71
67010	Partial removal of eye fluid		T	0237	27.8450	$1,773.56		$354.71
67015	Release of eye fluid		T	0237	27.8450	$1,773.56		$354.71
67025	Replace eye fluid		T	0237	27.8450	$1,773.56		$354.71
67027	Implant eye drug system		T	0672	37.2078	$2,369.91		$473.98
67028	Injection eye drug	CH	S	0231	2.1790	$138.79		$27.76
67030	Incise inner eye strands		T	0236	18.2350	$1,161.46		$232.29
67031	Laser surgery, eye strands		T	0247	5.2001	$331.22	$104.31	$66.24
67036	Removal of inner eye fluid		T	0672	37.2078	$2,369.91		$473.98
67038	Strip retinal membrane	CH	D					
67039	Laser treatment of retina		T	0672	37.2078	$2,369.91		$473.98
67040	Laser treatment of retina		T	0672	37.2078	$2,369.91		$473.98
67041	Vit for macular pucker	NI	T	0672	37.2078	$2,369.91		$473.98
67042	Vit for macular hole	NI	T	0672	37.2078	$2,369.91		$473.98
67043	Vit for membrane dissect	NI	T	0672	37.2078	$2,369.91		$473.98
67101	Repair detached retina		T	0236	18.2350	$1,161.46		$232.29
67105	Repair detached retina	CH	T	0247	5.2001	$331.22	$104.31	$66.24
67107	Repair detached retina		T	0672	37.2078	$2,369.91		$473.98
67108	Repair detached retina		T	0672	37.2078	$2,369.91		$473.98
67110	Repair detached retina		T	0236	18.2350	$1,161.46		$232.29
67112	Rerepair detached retina		T	0672	37.2078	$2,369.91		$473.98
67113	Repair retinal detach, cplx	NI	T	0672	37.2078	$2,369.91		$473.98
67115	Release encircling material		T	0236	18.2350	$1,161.46		$232.29
67120	Remove eye implant material		T	0236	18.2350	$1,161.46		$232.29
67121	Remove eye implant material		T	0237	27.8450	$1,773.56		$354.71
67141	Treatment of retina		T	0235	4.1331	$263.25	$58.93	$52.65
67145	Treatment of retina	CH	T	0247	5.2001	$331.22	$104.31	$66.24
67208	Treatment of retinal lesion		T	0236	18.2350	$1,161.46		$232.29
67210	Treatment of retinal lesion	CH	T	0247	5.2001	$331.22	$104.31	$66.24
67218	Treatment of retinal lesion		T	0236	18.2350	$1,161.46		$232.29
67220	Treatment of choroid lesion		T	0235	4.1331	$263.25	$58.93	$52.65
67221	Ocular photodynamic ther		T	0235	4.1331	$263.25	$58.93	$52.65
67225	Eye photodynamic ther add-on		T	0235	4.1331	$263.25	$58.93	$52.65
67227	Treatment of retinal lesion		T	0237	27.8450	$1,773.56		$354.71
67228	Treatment of retinal lesion	CH	T	0247	5.2001	$331.22	$104.31	$66.24
67229	Tr retinal les preterm inf	NI	T	0247	5.2001	$331.22	$104.31	$66.24
67250	Reinforce eye wall		T	0240	18.7307	$1,193.03	$309.52	$238.61
67255	Reinforce/graft eye wall		T	0237	27.8450	$1,773.56		$354.71
67299	Eye surgery procedure		T	0235	4.1331	$263.25	$58.93	$52.65
67311	Revise eye muscle		T	0243	24.1291	$1,536.88	$430.35	$307.38
67312	Revise two eye muscles		T	0243	24.1291	$1,536.88	$430.35	$307.38
67314	Revise eye muscle		T	0243	24.1291	$1,536.88	$430.35	$307.38
67316	Revise two eye muscles		T	0243	24.1291	$1,536.88	$430.35	$307.38
67318	Revise eye muscle(s)		T	0243	24.1291	$1,536.88	$430.35	$307.38
67320	Revise eye muscle(s) add-on		T	0243	24.1291	$1,536.88	$430.35	$307.38
67331	Eye surgery follow-up add-on		T	0243	24.1291	$1,536.88	$430.35	$307.38
67332	Rerevise eye muscles add-on		T	0243	24.1291	$1,536.88	$430.35	$307.38
67334	Revise eye muscle w/suture		T	0243	24.1291	$1,536.88	$430.35	$307.38
67335	Eye suture during surgery		T	0243	24.1291	$1,536.88	$430.35	$307.38
67340	Revise eye muscle add-on		T	0243	24.1291	$1,536.88	$430.35	$307.38

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
67343	Release eye tissue		T	0243	24.1291	$1,536.88	$430.35	$307.38
67345	Destroy nerve of eye muscle		T	0238	2.9022	$184.85		$36.97
67346	Biopsy, eye muscle		T	0699	13.7453	$875.49		$175.10
67399	Eye muscle surgery procedure		T	0243	24.1291	$1,536.88	$430.35	$307.38
67400	Explore/biopsy eye socket		T	0241	24.3077	$1,548.25	$383.45	$309.65
67405	Explore/drain eye socket		T	0241	24.3077	$1,548.25	$383.45	$309.65
67412	Explore/treat eye socket		T	0241	24.3077	$1,548.25	$383.45	$309.65
67413	Explore/treat eye socket		T	0241	24.3077	$1,548.25	$383.45	$309.65
67414	Explr/decompress eye socket		T	0242	37.7243	$2,402.81	$597.36	$480.56
67415	Aspiration, orbital contents		T	0240	18.7307	$1,193.03	$309.52	$238.61
67420	Explore/treat eye socket		T	0242	37.7243	$2,402.81	$597.36	$480.56
67430	Explore/treat eye socket		T	0242	37.7243	$2,402.81	$597.36	$480.56
67440	Explore/drain eye socket		T	0242	37.7243	$2,402.81	$597.36	$480.56
67445	Explr/decompress eye socket		T	0242	37.7243	$2,402.81	$597.36	$480.56
67450	Explore/biopsy eye socket		T	0242	37.7243	$2,402.81	$597.36	$480.56
67500	Inject/treat eye socket		S	0231	2.1790	$138.79		$27.76
67505	Inject/treat eye socket		T	0238	2.9022	$184.85		$36.97
67515	Inject/treat eye socket		T	0238	2.9022	$184.85		$36.97
67550	Insert eye socket implant		T	0242	37.7243	$2,402.81	$597.36	$480.56
67560	Revise eye socket implant		T	0241	24.3077	$1,548.25	$383.45	$309.65
67570	Decompress optic nerve		T	0242	37.7243	$2,402.81	$597.36	$480.56
67599	Orbit surgery procedure		T	0238	2.9022	$184.85		$36.97
67700	Drainage of eyelid abscess		T	0238	2.9022	$184.85		$36.97
67710	Incision of eyelid		T	0239	7.2847	$463.99		$92.80
67715	Incision of eyelid fold		T	0240	18.7307	$1,193.03	$309.52	$238.61
67800	Remove eyelid lesion		T	0238	2.9022	$184.85		$36.97
67801	Remove eyelid lesions		T	0239	7.2847	$463.99		$92.80
67805	Remove eyelid lesions		T	0238	2.9022	$184.85		$36.97
67808	Remove eyelid lesion(s)		T	0240	18.7307	$1,193.03	$309.52	$238.61
67810	Biopsy of eyelid		T	0238	2.9022	$184.85		$36.97
67820	Revise eyelashes		S	0698	0.8696	$55.39		$11.08
67825	Revise eyelashes		T	0238	2.9022	$184.85		$36.97
67830	Revise eyelashes		T	0239	7.2847	$463.99		$92.80
67835	Revise eyelashes		T	0240	18.7307	$1,193.03	$309.52	$238.61
67840	Remove eyelid lesion		T	0239	7.2847	$463.99		$92.80
67850	Treat eyelid lesion		T	0239	7.2847	$463.99		$92.80
67875	Closure of eyelid by suture		T	0239	7.2847	$463.99		$92.80
67880	Revision of eyelid		T	0233	16.1710	$1,030.00	$266.33	$206.00
67882	Revision of eyelid		T	0240	18.7307	$1,193.03	$309.52	$238.61
67900	Repair brow defect		T	0240	18.7307	$1,193.03	$309.52	$238.61
67901	Repair eyelid defect		T	0240	18.7307	$1,193.03	$309.52	$238.61
67902	Repair eyelid defect		T	0240	18.7307	$1,193.03	$309.52	$238.61
67903	Repair eyelid defect		T	0240	18.7307	$1,193.03	$309.52	$238.61
67904	Repair eyelid defect		T	0240	18.7307	$1,193.03	$309.52	$238.61
67906	Repair eyelid defect		T	0240	18.7307	$1,193.03	$309.52	$238.61
67908	Repair eyelid defect		T	0240	18.7307	$1,193.03	$309.52	$238.61
67909	Revise eyelid defect		T	0240	18.7307	$1,193.03	$309.52	$238.61
67911	Revise eyelid defect		T	0240	18.7307	$1,193.03	$309.52	$238.61
67912	Correction eyelid w/implant		T	0240	18.7307	$1,193.03	$309.52	$238.61
67914	Repair eyelid defect		T	0240	18.7307	$1,193.03	$309.52	$238.61
67915	Repair eyelid defect		T	0240	18.7307	$1,193.03	$309.52	$238.61
67916	Repair eyelid defect		T	0240	18.7307	$1,193.03	$309.52	$238.61
67917	Repair eyelid defect		T	0240	18.7307	$1,193.03	$309.52	$238.61
67921	Repair eyelid defect		T	0240	18.7307	$1,193.03	$309.52	$238.61
67922	Repair eyelid defect		T	0240	18.7307	$1,193.03	$309.52	$238.61
67923	Repair eyelid defect		T	0240	18.7307	$1,193.03	$309.52	$238.61
67924	Repair eyelid defect		T	0240	18.7307	$1,193.03	$309.52	$238.61
67930	Repair eyelid wound		T	0240	18.7307	$1,193.03	$309.52	$238.61
67935	Repair eyelid wound		T	0240	18.7307	$1,193.03	$309.52	$238.61
67938	Remove eyelid foreign body	CH	S	0231	2.1790	$138.79		$27.76
67950	Revision of eyelid		T	0240	18.7307	$1,193.03	$309.52	$238.61
67961	Revision of eyelid		T	0240	18.7307	$1,193.03	$309.52	$238.61
67966	Revision of eyelid		T	0240	18.7307	$1,193.03	$309.52	$238.61
67971	Reconstruction of eyelid		T	0241	24.3077	$1,548.25	$383.45	$309.65
67973	Reconstruction of eyelid		T	0241	24.3077	$1,548.25	$383.45	$309.65
67974	Reconstruction of eyelid		T	0241	24.3077	$1,548.25	$383.45	$309.65
67975	Reconstruction of eyelid		T	0240	18.7307	$1,193.03	$309.52	$238.61
67999	Revision of eyelid		T	0238	2.9022	$184.85		$36.97
68020	Incise/drain eyelid lining		T	0240	18.7307	$1,193.03	$309.52	$238.61
68040	Treatment of eyelid lesions		S	0698	0.8696	$55.39		$11.08
68100	Biopsy of eyelid lining		T	0232	5.1169	$325.92	$81.65	$65.18
68110	Remove eyelid lining lesion		T	0699	13.7453	$875.49		$175.10
68115	Remove eyelid lining lesion		T	0240	18.7307	$1,193.03	$309.52	$238.61
68130	Remove eyelid lining lesion		T	0233	16.1710	$1,030.00	$266.33	$206.00
68135	Remove eyelid lining lesion		T	0239	7.2847	$463.99		$92.80
68200	Treat eyelid by injection	CH	S	0698	0.8696	$55.39		$11.08
68320	Revise/graft eyelid lining		T	0240	18.7307	$1,193.03	$309.52	$238.61
68325	Revise/graft eyelid lining		T	0241	24.3077	$1,548.25	$383.45	$309.65
68326	Revise/graft eyelid lining		T	0241	24.3077	$1,548.25	$383.45	$309.65
68328	Revise/graft eyelid lining		T	0241	24.3077	$1,548.25	$383.45	$309.65

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
68330	Revise eyelid lining		T	0234	23.1758	$1,476.16	$511.31	$295.23
68335	Revise/graft eyelid lining		T	0241	24.3077	$1,548.25	$383.45	$309.65
68340	Separate eyelid adhesions		T	0240	18.7307	$1,193.03	$309.52	$238.61
68360	Revise eyelid lining		T	0234	23.1758	$1,476.16	$511.31	$295.23
68362	Revise eyelid lining		T	0234	23.1758	$1,476.16	$511.31	$295.23
68371	Harvest eye tissue, alograft		T	0233	16.1710	$1,030.00	$266.33	$206.00
68399	Eyelid lining surgery		T	0238	2.9022	$184.85		$36.97
68400	Incise/drain tear gland		T	0238	2.9022	$184.85		$36.97
68420	Incise/drain tear sac		T	0240	18.7307	$1,193.03	$309.52	$238.61
68440	Incise tear duct opening		T	0238	2.9022	$184.85		$36.97
68500	Removal of tear gland		T	0241	24.3077	$1,548.25	$383.45	$309.65
68505	Partial removal, tear gland		T	0241	24.3077	$1,548.25	$383.45	$309.65
68510	Biopsy of tear gland		T	0240	18.7307	$1,193.03	$309.52	$238.61
68520	Removal of tear sac		T	0241	24.3077	$1,548.25	$383.45	$309.65
68525	Biopsy of tear sac		T	0240	18.7307	$1,193.03	$309.52	$238.61
68530	Clearance of tear duct		T	0240	18.7307	$1,193.03	$309.52	$238.61
68540	Remove tear gland lesion		T	0241	24.3077	$1,548.25	$383.45	$309.65
68550	Remove tear gland lesion		T	0241	24.3077	$1,548.25	$383.45	$309.65
68700	Repair tear ducts		T	0241	24.3077	$1,548.25	$383.45	$309.65
68705	Revise tear duct opening		T	0238	2.9022	$184.85		$36.97
68720	Create tear sac drain		T	0241	24.3077	$1,548.25	$383.45	$309.65
68745	Create tear duct drain		T	0241	24.3077	$1,548.25	$383.45	$309.65
68750	Create tear duct drain		T	0241	24.3077	$1,548.25	$383.45	$309.65
68760	Close tear duct opening		S	0231	2.1790	$138.79		$27.76
68761	Close tear duct opening		S	0231	2.1790	$138.79		$27.76
68770	Close tear system fistula		T	0240	18.7307	$1,193.03	$309.52	$238.61
68801	Dilate tear duct opening		S	0698	0.8696	$55.39		$11.08
68810	Probe nasolacrimal duct		S	0231	2.1790	$138.79		$27.76
68811	Probe nasolacrimal duct		T	0240	18.7307	$1,193.03	$309.52	$238.61
68815	Probe nasolacrimal duct		T	0240	18.7307	$1,193.03	$309.52	$238.61
68816	Probe nl duct w/balloon	NI	T	0240	18.7307	$1,193.03	$309.52	$238.61
68840	Explore/irrigate tear ducts	CH	S	0231	2.1790	$138.79		$27.76
68850	Injection for tear sac x-ray		N					
68899	Tear duct system surgery		T	0238	2.9022	$184.85		$36.97
69000	Drain external ear lesion		T	0006	1.4066	$89.59		$17.92
69005	Drain external ear lesion		T	0008	18.3197	$1,166.85		$233.37
69020	Drain outer ear canal lesion		T	0006	1.4066	$89.59		$17.92
69090	Pierce earlobes		E					
69100	Biopsy of external ear	CH	T	0251	2.5002	$159.25		$31.85
69105	Biopsy of external ear canal		T	0253	16.3288	$1,040.05	$282.29	$208.01
69110	Remove external ear, partial		T	0021	16.1001	$1,025.48	$219.48	$205.10
69120	Removal of external ear		T	0254	23.9765	$1,527.16	$321.35	$305.43
69140	Remove ear canal lesion(s)		T	0254	23.9765	$1,527.16	$321.35	$305.43
69145	Remove ear canal lesion(s)		T	0021	16.1001	$1,025.48	$219.48	$205.10
69150	Extensive ear canal surgery		T	0252	7.4474	$474.35	$109.16	$94.87
69155	Extensive ear/neck surgery		C					
69200	Clear outer ear canal		X	0340	0.6310	$40.19		$8.04
69205	Clear outer ear canal		T	0022	21.1098	$1,344.57	$354.45	$268.91
69210	Remove impacted ear wax		X	0340	0.6310	$40.19		$8.04
69220	Clean out mastoid cavity	CH	T	0013	0.7930	$50.51		$10.10
69222	Clean out mastoid cavity	CH	T	0253	16.3288	$1,040.05	$282.29	$208.01
69300	Revise external ear		T	0254	23.9765	$1,527.16	$321.35	$305.43
69310	Rebuild outer ear canal		T	0256	39.8776	$2,539.96		$507.99
69320	Rebuild outer ear canal		T	0256	39.8776	$2,539.96		$507.99
69399	Outer ear surgery procedure		T	0251	2.5002	$159.25		$31.85
69400	Inflate middle ear canal		T	0251	2.5002	$159.25		$31.85
69401	Inflate middle ear canal		T	0251	2.5002	$159.25		$31.85
69405	Catheterize middle ear canal		T	0252	7.4474	$474.35	$109.16	$94.87
69420	Incision of eardrum		T	0251	2.5002	$159.25		$31.85
69421	Incision of eardrum		T	0253	16.3288	$1,040.05	$282.29	$208.01
69424	Remove ventilating tube	CH	T	0253	16.3288	$1,040.05	$282.29	$208.01
69433	Create eardrum opening		T	0252	7.4474	$474.35	$109.16	$94.87
69436	Create eardrum opening		T	0253	16.3288	$1,040.05	$282.29	$208.01
69440	Exploration of middle ear		T	0254	23.9765	$1,527.16	$321.35	$305.43
69450	Eardrum revision		T	0256	39.8776	$2,539.96		$507.99
69501	Mastoidectomy		T	0256	39.8776	$2,539.96		$507.99
69502	Mastoidectomy		T	0254	23.9765	$1,527.16	$321.35	$305.43
69505	Remove mastoid structures		T	0256	39.8776	$2,539.96		$507.99
69511	Extensive mastoid surgery		T	0256	39.8776	$2,539.96		$507.99
69530	Extensive mastoid surgery		T	0256	39.8776	$2,539.96		$507.99
69535	Remove part of temporal bone		C					
69540	Remove ear lesion		T	0253	16.3288	$1,040.05	$282.29	$208.01
69550	Remove ear lesion		T	0256	39.8776	$2,539.96		$507.99
69552	Remove ear lesion		T	0256	39.8776	$2,539.96		$507.99
69554	Remove ear lesion		C					
69601	Mastoid surgery revision		T	0256	39.8776	$2,539.96		$507.99
69602	Mastoid surgery revision		T	0256	39.8776	$2,539.96		$507.99
69603	Mastoid surgery revision		T	0256	39.8776	$2,539.96		$507.99
69604	Mastoid surgery revision		T	0256	39.8776	$2,539.96		$507.99
69605	Mastoid surgery revision		T	0256	39.8776	$2,539.96		$507.99

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
69610	Repair of eardrum		T	0254	23.9765	$1,527.16	$321.35	$305.43
69620	Repair of eardrum		T	0254	23.9765	$1,527.16	$321.35	$305.43
69631	Repair eardrum structures		T	0256	39.8776	$2,539.96		$507.99
69632	Rebuild eardrum structures		T	0256	39.8776	$2,539.96		$507.99
69633	Rebuild eardrum structures		T	0256	39.8776	$2,539.96		$507.99
69635	Repair eardrum structures		T	0256	39.8776	$2,539.96		$507.99
69636	Rebuild eardrum structures		T	0256	39.8776	$2,539.96		$507.99
69637	Rebuild eardrum structures		T	0256	39.8776	$2,539.96		$507.99
69641	Revise middle ear & mastoid		T	0256	39.8776	$2,539.96		$507.99
69642	Revise middle ear & mastoid		T	0256	39.8776	$2,539.96		$507.99
69643	Revise middle ear & mastoid		T	0256	39.8776	$2,539.96		$507.99
69644	Revise middle ear & mastoid		T	0256	39.8776	$2,539.96		$507.99
69645	Revise middle ear & mastoid		T	0256	39.8776	$2,539.96		$507.99
69646	Revise middle ear & mastoid		T	0256	39.8776	$2,539.96		$507.99
69650	Release middle ear bone		T	0254	23.9765	$1,527.16	$321.35	$305.43
69660	Revise middle ear bone		T	0256	39.8776	$2,539.96		$507.99
69661	Revise middle ear bone		T	0256	39.8776	$2,539.96		$507.99
69662	Revise middle ear bone		T	0256	39.8776	$2,539.96		$507.99
69666	Repair middle ear structures		T	0256	39.8776	$2,539.96		$507.99
69667	Repair middle ear structures		T	0256	39.8776	$2,539.96		$507.99
69670	Remove mastoid air cells		T	0256	39.8776	$2,539.96		$507.99
69676	Remove middle ear nerve		T	0256	39.8776	$2,539.96		$507.99
69700	Close mastoid fistula		T	0256	39.8776	$2,539.96		$507.99
69710	Implant/replace hearing aid		E					
69711	Remove/repair hearing aid		T	0256	39.8776	$2,539.96		$507.99
69714	Implant temple bone w/stimul		T	0256	39.8776	$2,539.96		$507.99
69715	Temple bne implnt w/stimulat		T	0256	39.8776	$2,539.96		$507.99
69717	Temple bone implant revision		T	0256	39.8776	$2,539.96		$507.99
69718	Revise temple bone implant		T	0256	39.8776	$2,539.96		$507.99
69720	Release facial nerve		T	0256	39.8776	$2,539.96		$507.99
69725	Release facial nerve		T	0256	39.8776	$2,539.96		$507.99
69740	Repair facial nerve		T	0256	39.8776	$2,539.96		$507.99
69745	Repair facial nerve		T	0256	39.8776	$2,539.96		$507.99
69799	Middle ear surgery procedure		T	0251	2.5002	$159.25		$31.85
69801	Incise inner ear		T	0256	39.8776	$2,539.96		$507.99
69802	Incise inner ear		T	0256	39.8776	$2,539.96		$507.99
69805	Explore inner ear		T	0256	39.8776	$2,539.96		$507.99
69806	Explore inner ear		T	0256	39.8776	$2,539.96		$507.99
69820	Establish inner ear window		T	0256	39.8776	$2,539.96		$507.99
69840	Revise inner ear window		T	0256	39.8776	$2,539.96		$507.99
69905	Remove inner ear		T	0256	39.8776	$2,539.96		$507.99
69910	Remove inner ear & mastoid		T	0256	39.8776	$2,539.96		$507.99
69915	Incise inner ear nerve		T	0256	39.8776	$2,539.96		$507.99
69930	Implant cochlear device		T	0259	393.2242	$25,046.02	$8,543.66	$5,009.20
69949	Inner ear surgery procedure		T	0251	2.5002	$159.25		$31.85
69950	Incise inner ear nerve		C					
69955	Release facial nerve		T	0256	39.8776	$2,539.96		$507.99
69960	Release inner ear canal		T	0256	39.8776	$2,539.96		$507.99
69970	Remove inner ear lesion	CH	T	0256	39.8776	$2,539.96		$507.99
69979	Temporal bone surgery		T	0251	2.5002	$159.25		$31.85
69990	Microsurgery add-on		N					
70010	Contrast x-ray of brain	CH	Q	0274	7.5589	$481.46		$96.29
70015	Contrast x-ray of brain	CH	Q	0274	7.5589	$481.46		$96.29
70030	X-ray eye for foreign body		X	0260	0.6954	$44.29		$8.86
70100	X-ray exam of jaw		X	0260	0.6954	$44.29		$8.86
7010F	Pt info into recall system	NI	M					
70110	X-ray exam of jaw		X	0260	0.6954	$44.29		$8.86
70120	X-ray exam of mastoids		X	0260	0.6954	$44.29		$8.86
70130	X-ray exam of mastoids		X	0260	0.6954	$44.29		$8.86
70134	X-ray exam of middle ear		X	0261	1.1570	$73.69		$14.74
70140	X-ray exam of facial bones		X	0260	0.6954	$44.29		$8.86
70150	X-ray exam of facial bones		X	0260	0.6954	$44.29		$8.86
70160	X-ray exam of nasal bones		X	0260	0.6954	$44.29		$8.86
70170	X-ray exam of tear duct	CH	Q	0317	5.3623	$341.55	$77.89	$68.31
70190	X-ray exam of eye sockets		X	0260	0.6954	$44.29		$8.86
70200	X-ray exam of eye sockets		X	0260	0.6954	$44.29		$8.86
70210	X-ray exam of sinuses		X	0260	0.6954	$44.29		$8.86
70220	X-ray exam of sinuses		X	0260	0.6954	$44.29		$8.86
70240	X-ray exam, pituitary saddle		X	0260	0.6954	$44.29		$8.86
70250	X-ray exam of skull		X	0260	0.6954	$44.29		$8.86
70260	X-ray exam of skull		X	0261	1.1570	$73.69		$14.74
70300	X-ray exam of teeth		X	0262	0.5749	$36.62		$7.32
70310	X-ray exam of teeth		X	0262	0.5749	$36.62		$7.32
70320	Full mouth x-ray of teeth		X	0262	0.5749	$36.62		$7.32
70328	X-ray exam of jaw joint		X	0260	0.6954	$44.29		$8.86
70330	X-ray exam of jaw joints		X	0260	0.6954	$44.29		$8.86
70332	X-ray exam of jaw joint	CH	Q	0275	4.0031	$254.97	$69.09	$50.99
70336	Magnetic image, jaw joint		S	0335	4.8830	$311.02	$111.92	$62.20
70350	X-ray head for orthodontia		X	0260	0.6954	$44.29		$8.86
70355	Panoramic x-ray of jaws		X	0260	0.6954	$44.29		$8.86

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE 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	0.6954	$44.29		$8.86
70370	Throat x-ray & fluoroscopy		X	0272	1.3271	$84.53	$31.64	$16.91
70371	Speech evaluation, complex		X	0272	1.3271	$84.53	$31.64	$16.91
70373	Contrast x-ray of larynx	CH	Q	0263	2.6838	$170.94		$34.19
70380	X-ray exam of salivary gland		X	0260	0.6954	$44.29		$8.86
70390	X-ray exam of salivary duct	CH	Q	0263	2.6838	$170.94		$34.19
70450	Ct head/brain w/o dye		S	0332	3.0109	$191.78	$75.24	$38.36
70460	Ct head/brain w/dye		S	0283	4.3564	$277.48	$100.37	$55.50
70470	Ct head/brain w/o & w/dye		S	0333	5.1125	$325.64	$119.01	$65.13
70480	Ct orbit/ear/fossa w/o dye		S	0332	3.0109	$191.78	$75.24	$38.36
70481	Ct orbit/ear/fossa w/dye		S	0283	4.3564	$277.48	$100.37	$55.50
70482	Ct orbit/ear/fossa w/o&w/dye		S	0333	5.1125	$325.64	$119.01	$65.13
70486	Ct maxillofacial w/o dye		S	0332	3.0109	$191.78	$75.24	$38.36
70487	Ct maxillofacial w/dye		S	0283	4.3564	$277.48	$100.37	$55.50
70488	Ct maxillofacial w/o & w/dye		S	0333	5.1125	$325.64	$119.01	$65.13
70490	Ct soft tissue neck w/o dye		S	0332	3.0109	$191.78	$75.24	$38.36
70491	Ct soft tissue neck w/dye		S	0283	4.3564	$277.48	$100.37	$55.50
70492	Ct sft tsue nck w/o & w/dye		S	0333	5.1125	$325.64	$119.01	$65.13
70496	Ct angiography, head		S	0662	5.1641	$328.92	$118.88	$65.78
70498	Ct angiography, neck		S	0662	5.1641	$328.92	$118.88	$65.78
70540	Mri orbit/face/neck w/o dye		S	0336	5.3933	$343.52	$137.40	$68.70
70542	Mri orbit/face/neck w/dye		S	0284	6.2350	$397.13	$148.40	$79.43
70543	Mri orbt/fac/nck w/o & w/dye		S	0337	8.2463	$525.24	$199.53	$105.05
70544	Mr angiography head w/o dye		S	0336	5.3933	$343.52	$137.40	$68.70
70545	Mr angiography head w/dye		S	0284	6.2350	$397.13	$148.40	$79.43
70546	Mr angiograph head w/o&w/dye		S	0337	8.2463	$525.24	$199.53	$105.05
70547	Mr angiography neck w/o dye		S	0336	5.3933	$343.52	$137.40	$68.70
70548	Mr angiography neck w/dye		S	0284	6.2350	$397.13	$148.40	$79.43
70549	Mr angiograph neck w/o&w/dye		S	0337	8.2463	$525.24	$199.53	$105.05
70551	Mri brain w/o dye		S	0336	5.3933	$343.52	$137.40	$68.70
70552	Mri brain w/dye		S	0284	6.2350	$397.13	$148.40	$79.43
70553	Mri brain w/o & w/dye		S	0337	8.2463	$525.24	$199.53	$105.05
70554	Fmri brain by tech		S	0336	5.3933	$343.52	$137.40	$68.70
70555	Fmri brain by phys/psych		S	0336	5.3933	$343.52	$137.40	$68.70
70557	Mri brain w/o dye		S	0336	5.3933	$343.52	$137.40	$68.70
70558	Mri brain w/dye		S	0284	6.2350	$397.13	$148.40	$79.43
70559	Mri brain w/o & w/dye		S	0337	8.2463	$525.24	$199.53	$105.05
71010	Chest x-ray		X	0260	0.6954	$44.29		$8.86
71015	Chest x-ray		X	0260	0.6954	$44.29		$8.86
71020	Chest x-ray		X	0260	0.6954	$44.29		$8.86
71021	Chest x-ray		X	0260	0.6954	$44.29		$8.86
71022	Chest x-ray		X	0260	0.6954	$44.29		$8.86
71023	Chest x-ray and fluoroscopy		X	0272	1.3271	$84.53	$31.64	$16.91
71030	Chest x-ray		X	0260	0.6954	$44.29		$8.86
71034	Chest x-ray and fluoroscopy		X	0272	1.3271	$84.53	$31.64	$16.91
71035	Chest x-ray		X	0260	0.6954	$44.29		$8.86
71040	Contrast x-ray of bronchi	CH	Q	0263	2.6838	$170.94		$34.19
71060	Contrast x-ray of bronchi	CH	Q	0317	5.3623	$341.55	$77.89	$68.31
71090	X-ray & pacemaker insertion	CH	N					
71100	X-ray exam of ribs		X	0260	0.6954	$44.29		$8.86
71101	X-ray exam of ribs/chest		X	0260	0.6954	$44.29		$8.86
71110	X-ray exam of ribs		X	0260	0.6954	$44.29		$8.86
71111	X-ray exam of ribs/chest		X	0261	1.1570	$73.69		$14.74
71120	X-ray exam of breastbone		X	0260	0.6954	$44.29		$8.86
71130	X-ray exam of breastbone		X	0260	0.6954	$44.29		$8.86
71250	Ct thorax w/o dye		S	0332	3.0109	$191.78	$75.24	$38.36
71260	Ct thorax w/dye		S	0283	4.3564	$277.48	$100.37	$55.50
71270	Ct thorax w/o & w/dye		S	0333	5.1125	$325.64	$119.01	$65.13
71275	Ct angiography, chest		S	0662	5.1641	$328.92	$118.88	$65.78
71550	Mri chest w/o dye		S	0336	5.3933	$343.52	$137.40	$68.70
71551	Mri chest w/dye		S	0284	6.2350	$397.13	$148.40	$79.43
71552	Mri chest w/o & w/dye		S	0337	8.2463	$525.24	$199.53	$105.05
71555	Mri angio chest w or w/o dye		B					
72010	X-ray exam of spine		X	0260	0.6954	$44.29		$8.86
72020	X-ray exam of spine		X	0260	0.6954	$44.29		$8.86
72040	X-ray exam of neck spine		X	0260	0.6954	$44.29		$8.86
72050	X-ray exam of neck spine		X	0261	1.1570	$73.69		$14.74
72052	X-ray exam of neck spine		X	0261	1.1570	$73.69		$14.74
72069	X-ray exam of trunk spine		X	0260	0.6954	$44.29		$8.86
72070	X-ray exam of thoracic spine		X	0260	0.6954	$44.29		$8.86
72072	X-ray exam of thoracic spine		X	0260	0.6954	$44.29		$8.86
72074	X-ray exam of thoracic spine		X	0260	0.6954	$44.29		$8.86
72080	X-ray exam of trunk spine		X	0260	0.6954	$44.29		$8.86
72090	X-ray exam of trunk spine		X	0261	1.1570	$73.69		$14.74
72100	X-ray exam of lower spine		X	0260	0.6954	$44.29		$8.86
72110	X-ray exam of lower spine		X	0261	1.1570	$73.69		$14.74
72114	X-ray exam of lower spine		X	0261	1.1570	$73.69		$14.74
72120	X-ray exam of lower spine		X	0261	1.1570	$73.69		$14.74
72125	Ct neck spine w/o dye		S	0332	3.0109	$191.78	$75.24	$38.36
72126	Ct neck spine w/dye		S	0283	4.3564	$277.48	$100.37	$55.50

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
72127	Ct neck spine w/o & w/dye		S	0333	5.1125	$325.64	$119.01	$65.13
72128	Ct chest spine w/o dye		S	0332	3.0109	$191.78	$75.24	$38.36
72129	Ct chest spine w/dye		S	0283	4.3564	$277.48	$100.37	$55.50
72130	Ct chest spine w/o & w/dye		S	0333	5.1125	$325.64	$119.01	$65.13
72131	Ct lumbar spine w/o dye		S	0332	3.0109	$191.78	$75.24	$38.36
72132	Ct lumbar spine w/dye		S	0283	4.3564	$277.48	$100.37	$55.50
72133	Ct lumbar spine w/o & w/dye		S	0333	5.1125	$325.64	$119.01	$65.13
72141	Mri neck spine w/o dye		S	0336	5.3933	$343.52	$137.40	$68.70
72142	Mri neck spine w/dye		S	0284	6.2350	$397.13	$148.40	$79.43
72146	Mri chest spine w/o dye		S	0336	5.3933	$343.52	$137.40	$68.70
72147	Mri chest spine w/dye		S	0284	6.2350	$397.13	$148.40	$79.43
72148	Mri lumbar spine w/o dye		S	0336	5.3933	$343.52	$137.40	$68.70
72149	Mri lumbar spine w/dye		S	0284	6.2350	$397.13	$148.40	$79.43
72156	Mri neck spine w/o & w/dye		S	0337	8.2463	$525.24	$199.53	$105.05
72157	Mri chest spine w/o & w/dye		S	0337	8.2463	$525.24	$199.53	$105.05
72158	Mri lumbar spine w/o & w/dye		S	0337	8.2463	$525.24	$199.53	$105.05
72159	Mr angio spine w/o&w/dye		E					
72170	X-ray exam of pelvis		X	0260	0.6954	$44.29		$8.86
72190	X-ray exam of pelvis		X	0260	0.6954	$44.29		$8.86
72191	Ct angiograph pelv w/o&w/dye		S	0662	5.1641	$328.92	$118.88	$65.78
72192	Ct pelvis w/o dye		S	0332	3.0109	$191.78	$75.24	$38.36
72193	Ct pelvis w/dye		S	0283	4.3564	$277.48	$100.37	$55.50
72194	Ct pelvis w/o & w/dye		S	0333	5.1125	$325.64	$119.01	$65.13
72195	Mri pelvis w/o dye		S	0336	5.3933	$343.52	$137.40	$68.70
72196	Mri pelvis w/dye		S	0284	6.2350	$397.13	$148.40	$79.43
72197	Mri pelvis w/o & w/dye		S	0337	8.2463	$525.24	$199.53	$105.05
72198	Mr angio pelvis w/o & w/dye		B					
72200	X-ray exam sacroiliac joints		X	0260	0.6954	$44.29		$8.86
72202	X-ray exam sacroiliac joints		X	0260	0.6954	$44.29		$8.86
72220	X-ray exam of tailbone		X	0260	0.6954	$44.29		$8.86
72240	Contrast x-ray of neck spine	CH	Q	0274	7.5589	$481.46		$96.29
72255	Contrast x-ray, thorax spine	CH	Q	0274	7.5589	$481.46		$96.29
72265	Contrast x-ray, lower spine	CH	Q	0274	7.5589	$481.46		$96.29
72270	Contrast x-ray, spine	CH	Q	0274	7.5589	$481.46		$96.29
72275	Epidurography	CH	N					
72285	X-ray c/t spine disk	CH	Q	0388	20.1823	$1,285.49	$289.72	$257.10
72291	Perq vertebroplasty, fluor	CH	N					
72292	Perq vertebroplasty, ct	CH	N					
72295	X-ray of lower spine disk	CH	Q	0388	20.1823	$1,285.49	$289.72	$257.10
73000	X-ray exam of collar bone		X	0260	0.6954	$44.29		$8.86
73010	X-ray exam of shoulder blade		X	0260	0.6954	$44.29		$8.86
73020	X-ray exam of shoulder		X	0260	0.6954	$44.29		$8.86
73030	X-ray exam of shoulder		X	0260	0.6954	$44.29		$8.86
73040	Contrast x-ray of shoulder	CH	Q	0275	4.0031	$254.97	$69.09	$50.99
73050	X-ray exam of shoulders		X	0260	0.6954	$44.29		$8.86
73060	X-ray exam of humerus		X	0260	0.6954	$44.29		$8.86
73070	X-ray exam of elbow		X	0260	0.6954	$44.29		$8.86
73080	X-ray exam of elbow		X	0260	0.6954	$44.29		$8.86
73085	Contrast x-ray of elbow	CH	Q	0275	4.0031	$254.97	$69.09	$50.99
73090	X-ray exam of forearm		X	0260	0.6954	$44.29		$8.86
73092	X-ray exam of arm, infant		X	0260	0.6954	$44.29		$8.86
73100	X-ray exam of wrist		X	0260	0.6954	$44.29		$8.86
73110	X-ray exam of wrist		X	0260	0.6954	$44.29		$8.86
73115	Contrast x-ray of wrist	CH	Q	0275	4.0031	$254.97	$69.09	$50.99
73120	X-ray exam of hand		X	0260	0.6954	$44.29		$8.86
73130	X-ray exam of hand		X	0260	0.6954	$44.29		$8.86
73140	X-ray exam of finger(s)		X	0260	0.6954	$44.29		$8.86
73200	Ct upper extremity w/o dye		S	0332	3.0109	$191.78	$75.24	$38.36
73201	Ct upper extremity w/dye		S	0283	4.3564	$277.48	$100.37	$55.50
73202	Ct uppr extremity w/o&w/dye		S	0333	5.1125	$325.64	$119.01	$65.13
73206	Ct angio upr extrm w/o&w/dye		S	0662	5.1641	$328.92	$118.88	$65.78
73218	Mri upper extremity w/o dye		S	0336	5.3933	$343.52	$137.40	$68.70
73219	Mri upper extremity w/dye		S	0284	6.2350	$397.13	$148.40	$79.43
73220	Mri uppr extremity w/o&w/dye		S	0337	8.2463	$525.24	$199.53	$105.05
73221	Mri joint upr extrem w/o dye		S	0336	5.3933	$343.52	$137.40	$68.70
73222	Mri joint upr extrem w/dye		S	0284	6.2350	$397.13	$148.40	$79.43
73223	Mri joint upr extr w/o&w/dye		S	0337	8.2463	$525.24	$199.53	$105.05
73225	Mr angio upr extr w/o&w/dye		E					
73500	X-ray exam of hip		X	0260	0.6954	$44.29		$8.86
73510	X-ray exam of hip		X	0260	0.6954	$44.29		$8.86
73520	X-ray exam of hips		X	0261	1.1570	$73.69		$14.74
73525	Contrast x-ray of hip	CH	Q	0275	4.0031	$254.97	$69.09	$50.99
73530	X-ray exam of hip	CH	N					
73540	X-ray exam of pelvis & hips		X	0260	0.6954	$44.29		$8.86
73542	X-ray exam, sacroiliac joint	CH	Q	0275	4.0031	$254.97	$69.09	$50.99
73550	X-ray exam of thigh		X	0260	0.6954	$44.29		$8.86
73560	X-ray exam of knee, 1 or 2		X	0260	0.6954	$44.29		$8.86
73562	X-ray exam of knee, 3		X	0260	0.6954	$44.29		$8.86
73564	X-ray exam, knee, 4 or more		X	0260	0.6954	$44.29		$8.86
73565	X-ray exam of knees		X	0260	0.6954	$44.29		$8.86

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
73580	Contrast x-ray of knee joint	CH	Q	0275	4.0031	$254.97	$69.09	$50.99
73590	X-ray exam of lower leg		X	0260	0.6954	$44.29		$8.86
73592	X-ray exam of leg, infant		X	0260	0.6954	$44.29		$8.86
73600	X-ray exam of ankle		X	0260	0.6954	$44.29		$8.86
73610	X-ray exam of ankle		X	0260	0.6954	$44.29		$8.86
73615	Contrast x-ray of ankle	CH	Q	0275	4.0031	$254.97	$69.09	$50.99
73620	X-ray exam of foot		X	0260	0.6954	$44.29		$8.86
73630	X-ray exam of foot		X	0260	0.6954	$44.29		$8.86
73650	X-ray exam of heel		X	0260	0.6954	$44.29		$8.86
73660	X-ray exam of toe(s)		X	0260	0.6954	$44.29		$8.86
73700	Ct lower extremity w/o dye		S	0332	3.0109	$191.78	$75.24	$38.36
73701	Ct lower extremity w/dye		S	0283	4.3564	$277.48	$100.37	$55.50
73702	Ct lwr extremity w/o&w/dye		S	0333	5.1125	$325.64	$119.01	$65.13
73706	Ct angio lwr extr w/o&w/dye		S	0662	5.1641	$328.92	$118.88	$65.78
73718	Mri lower extremity w/o dye		S	0336	5.3933	$343.52	$137.40	$68.70
73719	Mri lower extremity w/dye		S	0284	6.2350	$397.13	$148.40	$79.43
73720	Mri lwr extremity w/o&w/dye		S	0337	8.2463	$525.24	$199.53	$105.05
73721	Mri jnt of lwr extre w/o dye		S	0336	5.3933	$343.52	$137.40	$68.70
73722	Mri joint of lwr extr w/dye		S	0284	6.2350	$397.13	$148.40	$79.43
73723	Mri joint lwr extr w/o&w/dye		S	0337	8.2463	$525.24	$199.53	$105.05
73725	Mr ang lwr ext w or w/o dye		B					
74000	X-ray exam of abdomen		X	0260	0.6954	$44.29		$8.86
74010	X-ray exam of abdomen		X	0260	0.6954	$44.29		$8.86
74020	X-ray exam of abdomen		X	0260	0.6954	$44.29		$8.86
74022	X-ray exam series, abdomen		X	0261	1.1570	$73.69		$14.74
74150	Ct abdomen w/o dye		S	0332	3.0109	$191.78	$75.24	$38.36
74160	Ct abdomen w/dye		S	0283	4.3564	$277.48	$100.37	$55.50
74170	Ct abdomen w/o & w/dye		S	0333	5.1125	$325.64	$119.01	$65.13
74175	Ct angio abdom w/o & w/dye		S	0662	5.1641	$328.92	$118.88	$65.78
74181	Mri abdomen w/o dye		S	0336	5.3933	$343.52	$137.40	$68.70
74182	Mri abdomen w/dye		S	0284	6.2350	$397.13	$148.40	$79.43
74183	Mri abdomen w/o & w/dye		S	0337	8.2463	$525.24	$199.53	$105.05
74185	Mri angio, abdom w orw/o dye		B					
74190	X-ray exam of peritoneum	CH	Q	0317	5.3623	$341.55	$77.89	$68.31
74210	Contrst x-ray exam of throat		S	0276	1.3834	$88.11	$34.97	$17.62
74220	Contrast x-ray, esophagus		S	0276	1.3834	$88.11	$34.97	$17.62
74230	Cine/vid x-ray, throat/esoph		S	0276	1.3834	$88.11	$34.97	$17.62
74235	Remove esophagus obstruction	CH	N					
74240	X-ray exam, upper gi tract		S	0276	1.3834	$88.11	$34.97	$17.62
74241	X-ray exam, upper gi tract		S	0276	1.3834	$88.11	$34.97	$17.62
74245	X-ray exam, upper gi tract		S	0277	2.2222	$141.54	$54.52	$28.31
74246	Contrst x-ray uppr gi tract		S	0276	1.3834	$88.11	$34.97	$17.62
74247	Contrst x-ray uppr gi tract		S	0276	1.3834	$88.11	$34.97	$17.62
74249	Contrst x-ray uppr gi tract		S	0277	2.2222	$141.54	$54.52	$28.31
74250	X-ray exam of small bowel		S	0276	1.3834	$88.11	$34.97	$17.62
74251	X-ray exam of small bowel		S	0277	2.2222	$141.54	$54.52	$28.31
74260	X-ray exam of small bowel		S	0276	1.3834	$88.11	$34.97	$17.62
74270	Contrast x-ray exam of colon		S	0276	1.3834	$88.11	$34.97	$17.62
74280	Contrast x-ray exam of colon		S	0277	2.2222	$141.54	$54.52	$28.31
74283	Contrast x-ray exam of colon		S	0276	1.3834	$88.11	$34.97	$17.62
74290	Contrast x-ray, gallbladder		S	0276	1.3834	$88.11	$34.97	$17.62
74291	Contrast x-rays, gallbladder		S	0276	1.3834	$88.11	$34.97	$17.62
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	0317	5.3623	$341.55	$77.89	$68.31
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	D					
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	2.6121	$166.38	$59.40	$33.28
74410	Contrst x-ray, urinary tract		S	0278	2.6121	$166.38	$59.40	$33.28
74415	Contrst x-ray, urinary tract		S	0278	2.6121	$166.38	$59.40	$33.28
74420	Contrst x-ray, urinary tract		S	0278	2.6121	$166.38	$59.40	$33.28
74425	Contrst x-ray, urinary tract	CH	Q	0278	2.6121	$166.38	$59.40	$33.28
74430	Contrast x-ray, bladder	CH	Q	0278	2.6121	$166.38	$59.40	$33.28
74440	X-ray, male genital tract	CH	Q	0278	2.6121	$166.38	$59.40	$33.28
74445	X-ray exam of penis	CH	Q	0278	2.6121	$166.38	$59.40	$33.28
74450	X-ray, urethra/bladder	CH	Q	0278	2.6121	$166.38	$59.40	$33.28
74455	X-ray, urethra/bladder	CH	Q	0278	2.6121	$166.38	$59.40	$33.28
74470	X-ray exam of kidney lesion	CH	Q	0263	2.6838	$170.94		$34.19
74475	X-ray control, cath insert	CH	Q	0317	5.3623	$341.55	$77.89	$68.31
74480	X-ray control, cath insert	CH	Q	0317	5.3623	$341.55	$77.89	$68.31
74485	X-ray guide, GU dilation	CH	Q	0317	5.3623	$341.55	$77.89	$68.31
74710	X-ray measurement of pelvis		X	0261	1.1570	$73.69		$14.74

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
74740	X-ray, female genital tract	CH	Q	0263	2.6838	$170.94		$34.19
74742	X-ray, fallopian tube	CH	N					
74775	X-ray exam of perineum		S	0278	2.6121	$166.38	$59.40	$33.28
75552	Heart mri for morph w/o dye	CH	D					
75553	Heart mri for morph w/dye	CH	D					
75554	Cardiac MRI/function	CH	D					
75555	Cardiac MRI/limited study	CH	D					
75556	Cardiac MRI/flow mapping	CH	D					
75557	Cardiac mri for morph	NI	S	0336	5.3933	$343.52	$137.40	$68.70
75558	Cardiac mri flow/velocity	NI	E					
75559	Cardiac mri w/stress img	NI	S	0336	5.3933	$343.52	$137.40	$68.70
75560	Cardiac mri flow/vel/stress	NI	E					
75561	Cardiac mri for morph w/dye	NI	S	0337	8.2463	$525.24	$199.53	$105.05
75562	Card mri flow/vel w/dye	NI	E					
75563	Card mri w/stress img & dye	NI	S	0337	8.2463	$525.24	$199.53	$105.05
75564	Ht mri w/flo/vel/strs & dye	NI	E					
75600	Contrast x-ray exam of aorta	CH	Q	0279	28.8788	$1,839.41		$367.88
75605	Contrast x-ray exam of aorta	CH	Q	0279	28.8788	$1,839.41		$367.88
75625	Contrast x-ray exam of aorta	CH	Q	0279	28.8788	$1,839.41		$367.88
75630	X-ray aorta, leg arteries	CH	Q	0279	28.8788	$1,839.41		$367.88
75635	Ct angio abdominal arteries	CH	Q	0662	5.1641	$328.92	$118.88	$65.78
75650	Artery x-rays, head & neck	CH	Q	0280	44.7114	$2,847.85		$569.57
75658	Artery x-rays, arm	CH	Q	0279	28.8788	$1,839.41		$367.88
75660	Artery x-rays, head & neck	CH	Q	0280	44.7114	$2,847.85		$569.57
75662	Artery x-rays, head & neck	CH	Q	0280	44.7114	$2,847.85		$569.57
75665	Artery x-rays, head & neck	CH	Q	0279	28.8788	$1,839.41		$367.88
75671	Artery x-rays, head & neck	CH	Q	0280	44.7114	$2,847.85		$569.57
75676	Artery x-rays, neck	CH	Q	0279	28.8788	$1,839.41		$367.88
75680	Artery x-rays, neck	CH	Q	0279	28.8788	$1,839.41		$367.88
75685	Artery x-rays, spine	CH	Q	0279	28.8788	$1,839.41		$367.88
75705	Artery x-rays, spine	CH	Q	0279	28.8788	$1,839.41		$367.88
75710	Artery x-rays, arm/leg	CH	Q	0279	28.8788	$1,839.41		$367.88
75716	Artery x-rays, arms/legs	CH	Q	0279	28.8788	$1,839.41		$367.88
75722	Artery x-rays, kidney	CH	Q	0279	28.8788	$1,839.41		$367.88
75724	Artery x-rays, kidneys	CH	Q	0279	28.8788	$1,839.41		$367.88
75726	Artery x-rays, abdomen	CH	Q	0279	28.8788	$1,839.41		$367.88
75731	Artery x-rays, adrenal gland	CH	Q	0279	28.8788	$1,839.41		$367.88
75733	Artery x-rays, adrenals	CH	Q	0279	28.8788	$1,839.41		$367.88
75736	Artery x-rays, pelvis	CH	Q	0279	28.8788	$1,839.41		$367.88
75741	Artery x-rays, lung	CH	Q	0279	28.8788	$1,839.41		$367.88
75743	Artery x-rays, lungs	CH	Q	0279	28.8788	$1,839.41		$367.88
75746	Artery x-rays, lung	CH	Q	0668	9.3506	$595.58		$119.12
75756	Artery x-rays, chest	CH	Q	0668	9.3506	$595.58		$119.12
75774	Artery x-ray, each vessel	CH	N					
75790	Visualize A-V shunt	CH	Q	0668	9.3506	$595.58		$119.12
75801	Lymph vessel x-ray, arm/leg	CH	Q	0317	5.3623	$341.55	$77.89	$68.31
75803	Lymph vessel x-ray,arms/legs	CH	Q	0317	5.3623	$341.55	$77.89	$68.31
75805	Lymph vessel x-ray, trunk	CH	Q	0317	5.3623	$341.55	$77.89	$68.31
75807	Lymph vessel x-ray, trunk	CH	Q	0317	5.3623	$341.55	$77.89	$68.31
75809	Nonvascular shunt, x-ray	CH	Q	0263	2.6838	$170.94		$34.19
75810	Vein x-ray, spleen/liver	CH	Q	0279	28.8788	$1,839.41		$367.88
75820	Vein x-ray, arm/leg	CH	Q	0668	9.3506	$595.58		$119.12
75822	Vein x-ray, arms/legs	CH	Q	0668	9.3506	$595.58		$119.12
75825	Vein x-ray, trunk	CH	Q	0279	28.8788	$1,839.41		$367.88
75827	Vein x-ray, chest	CH	Q	0668	9.3506	$595.58		$119.12
75831	Vein x-ray, kidney	CH	Q	0279	28.8788	$1,839.41		$367.88
75833	Vein x-ray, kidneys	CH	Q	0279	28.8788	$1,839.41		$367.88
75840	Vein x-ray, adrenal gland	CH	Q	0279	28.8788	$1,839.41		$367.88
75842	Vein x-ray, adrenal glands	CH	Q	0279	28.8788	$1,839.41		$367.88
75860	Vein x-ray, neck	CH	Q	0668	9.3506	$595.58		$119.12
75870	Vein x-ray, skull	CH	Q	0668	9.3506	$595.58		$119.12
75872	Vein x-ray, skull	CH	Q	0668	9.3506	$595.58		$119.12
75880	Vein x-ray, eye socket	CH	Q	0668	9.3506	$595.58		$119.12
75885	Vein x-ray, liver	CH	Q	0279	28.8788	$1,839.41		$367.88
75887	Vein x-ray, liver	CH	Q	0668	9.3506	$595.58		$119.12
75889	Vein x-ray, liver	CH	Q	0279	28.8788	$1,839.41		$367.88
75891	Vein x-ray, liver	CH	Q	0279	28.8788	$1,839.41		$367.88
75893	Venous sampling by catheter	CH	Q	0279	28.8788	$1,839.41		$367.88
75894	X-rays, transcath therapy	CH	N					
75896	X-rays, transcath therapy	CH	N					
75898	Follow-up angiography	CH	Q	0263	2.6838	$170.94		$34.19
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	2.3792	$151.54	$60.50	$30.31
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.—OPPS PAYMENT BY HCPCS CODE 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	0083	45.3845	$2,890.72		$578.14
75964	Repair artery blockage, each	CH	N					
75966	Repair arterial blockage	CH	Q	0083	45.3845	$2,890.72		$578.14
75968	Repair artery blockage, each	CH	N					
75970	Vascular biopsy	CH	N					
75978	Repair venous blockage	CH	Q	0083	45.3845	$2,890.72		$578.14
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	1.3271	$84.53	$31.64	$16.91
76001	Fluoroscope exam, extensive		N					
76010	X-ray, nose to rectum		X	0260	0.6954	$44.29		$8.86
76080	X-ray exam of fistula	CH	Q	0263	2.6838	$170.94		$34.19
76098	X-ray exam, breast specimen		X	0260	0.6954	$44.29		$8.86
76100	X-ray exam of body section		X	0261	1.1570	$73.69		$14.74
76101	Complex body section x-ray		X	0263	2.6838	$170.94		$34.19
76102	Complex body section x-rays	CH	X	0263	2.6838	$170.94		$34.19
76120	Cine/video x-rays		X	0272	1.3271	$84.53	$31.64	$16.91
76125	Cine/video x-rays add-on	CH	N					
76140	X-ray consultation		E					
76150	X-ray exam, dry process		X	0260	0.6954	$44.29		$8.86
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	1.5839	$100.88	$37.81	$20.18
76390	Mr spectroscopy		E					
76496	Fluoroscopic procedure		X	0272	1.3271	$84.53	$31.64	$16.91
76497	Ct procedure		S	0282	1.5839	$100.88	$37.81	$20.18
76498	Mri procedure		S	0335	4.8830	$311.02	$111.92	$62.20
76499	Radiographic procedure		X	0260	0.6954	$44.29		$8.86
76506	Echo exam of head		S	0265	0.9570	$60.96	$22.35	$12.19
76510	Ophth us, b & quant a	CH	T	0232	5.1169	$325.92	$81.65	$65.18
76511	Ophth us, quant a only		S	0266	1.5094	$96.14	$37.80	$19.23
76512	Ophth us, b w/non-quant a		S	0266	1.5094	$96.14	$37.80	$19.23
76513	Echo exam of eye, water bath		S	0266	1.5094	$96.14	$37.80	$19.23
76514	Echo exam of eye, thickness	CH	S	0230	0.5903	$37.60		$7.52
76516	Echo exam of eye		S	0265	0.9570	$60.96	$22.35	$12.19
76519	Echo exam of eye		S	0266	1.5094	$96.14	$37.80	$19.23
76529	Echo exam of eye		S	0265	0.9570	$60.96	$22.35	$12.19
76536	Us exam of head and neck		S	0266	1.5094	$96.14	$37.80	$19.23
76604	Us exam, chest		S	0265	0.9570	$60.96	$22.35	$12.19
76645	Us exam, breast(s)		S	0265	0.9570	$60.96	$22.35	$12.19
76700	Us exam, abdom, complete		S	0266	1.5094	$96.14	$37.80	$19.23
76705	Echo exam of abdomen		S	0266	1.5094	$96.14	$37.80	$19.23
76770	Us exam abdo back wall, comp		S	0266	1.5094	$96.14	$37.80	$19.23
76775	Us exam abdo back wall, lim		S	0266	1.5094	$96.14	$37.80	$19.23
76776	Us exam k transpl w/doppler		S	0266	1.5094	$96.14	$37.80	$19.23
76800	Us exam, spinal canal		S	0266	1.5094	$96.14	$37.80	$19.23
76801	Ob us < 14 wks, single fetus		S	0266	1.5094	$96.14	$37.80	$19.23
76802	Ob us < 14 wks, add'l fetus		S	0265	0.9570	$60.96	$22.35	$12.19
76805	Ob us >/= 14 wks, sngl fetus		S	0266	1.5094	$96.14	$37.80	$19.23
76810	Ob us >/= 14 wks, addl fetus		S	0266	1.5094	$96.14	$37.80	$19.23
76811	Ob us, detailed, sngl fetus		S	0267	2.3792	$151.54	$60.50	$30.31
76812	Ob us, detailed, addl fetus		S	0265	0.9570	$60.96	$22.35	$12.19
76813	Ob us nuchal meas, 1 gest		S	0266	1.5094	$96.14	$37.80	$19.23
76814	Ob us nuchal meas, add-on		S	0265	0.9570	$60.96	$22.35	$12.19
76815	Ob us, limited, fetus(s)		S	0265	0.9570	$60.96	$22.35	$12.19
76816	Ob us, follow-up, per fetus		S	0265	0.9570	$60.96	$22.35	$12.19
76817	Transvaginal us, obstetric		S	0265	0.9570	$60.96	$22.35	$12.19
76818	Fetal biophys profile w/nst		S	0266	1.5094	$96.14	$37.80	$19.23
76819	Fetal biophys profil w/o nst		S	0266	1.5094	$96.14	$37.80	$19.23
76820	Umbilical artery echo		S	0096	1.4689	$93.56	$37.42	$18.71
76821	Middle cerebral artery echo		S	0096	1.4689	$93.56	$37.42	$18.71
76825	Echo exam of fetal heart	CH	S	0266	1.5094	$96.14	$37.80	$19.23
76826	Echo exam of fetal heart	CH	S	0265	0.9570	$60.96	$22.35	$12.19
76827	Echo exam of fetal heart	CH	S	0265	0.9570	$60.96	$22.35	$12.19
76828	Echo exam of fetal heart	CH	S	0265	0.9570	$60.96	$22.35	$12.19
76830	Transvaginal us, non-ob		S	0266	1.5094	$96.14	$37.80	$19.23

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
76831	Echo exam, uterus		S	0267	2.3792	$151.54	$60.50	$30.31
76856	Us exam, pelvic, complete		S	0266	1.5094	$96.14	$37.80	$19.23
76857	Us exam, pelvic, limited		S	0265	0.9570	$60.96	$22.35	$12.19
76870	Us exam, scrotum		S	0266	1.5094	$96.14	$37.80	$19.23
76872	Us, transrectal		S	0266	1.5094	$96.14	$37.80	$19.23
76873	Echograp trans r, pros study		S	0266	1.5094	$96.14	$37.80	$19.23
76880	Us exam, extremity		S	0266	1.5094	$96.14	$37.80	$19.23
76885	Us exam infant hips, dynamic		S	0265	0.9570	$60.96	$22.35	$12.19
76886	Us exam infant hips, static		S	0265	0.9570	$60.96	$22.35	$12.19
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	0.9570	$60.96	$22.35	$12.19
76975	GI endoscopic ultrasound	CH	Q	0267	2.3792	$151.54	$60.50	$30.31
76977	Us bone density measure		X	0340	0.6310	$40.19		$8.04
76998	Us guide, intraop	CH	N					
76999	Echo examination procedure		S	0265	0.9570	$60.96	$22.35	$12.19
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	2.6838	$170.94		$34.19
77054	X-ray of mammary ducts	CH	Q	0263	2.6838	$170.94		$34.19
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	0.6954	$44.29		$8.86
77072	X-rays for bone age		X	0260	0.6954	$44.29		$8.86
77073	X-rays, bone length studies		X	0260	0.6954	$44.29		$8.86
77074	X-rays, bone survey, limited		X	0261	1.1570	$73.69		$14.74
77075	X-rays, bone survey complete		X	0261	1.1570	$73.69		$14.74
77076	X-rays, bone survey, infant		X	0260	0.6954	$44.29		$8.86
77077	Joint survey, single view		X	0260	0.6954	$44.29		$8.86
77078	Ct bone density, axial		S	0288	1.1384	$72.51	$28.90	$14.50
77079	Ct bone density, peripheral		S	0282	1.5839	$100.88	$37.81	$20.18
77080	Dxa bone density, axial		S	0288	1.1384	$72.51	$28.90	$14.50
77081	Dxa bone density/peripheral		S	0665	0.5087	$32.40	$12.95	$6.48
77082	Dxa bone density, vert fx		X	0260	0.6954	$44.29		$8.86
77083	Radiographic absorptiometry		X	0261	1.1570	$73.69		$14.74
77084	Magnetic image, bone marrow		S	0335	4.8830	$311.02	$111.92	$62.20
77261	Radiation therapy planning		B					
77262	Radiation therapy planning		B					
77263	Radiation therapy planning		B					
77280	Set radiation therapy field		X	0304	1.5576	$99.21	$38.68	$19.84
77285	Set radiation therapy field		X	0305	3.9276	$250.16	$91.38	$50.03
77290	Set radiation therapy field		X	0305	3.9276	$250.16	$91.38	$50.03
77295	Set radiation therapy field		X	0310	13.5621	$863.82	$325.27	$172.76
77299	Radiation therapy planning		X	0304	1.5576	$99.21	$38.68	$19.84
77300	Radiation therapy dose plan		X	0304	1.5576	$99.21	$38.68	$19.84
77301	Radiotherapy dose plan, imrt		X	0310	13.5621	$863.82	$325.27	$172.76
77305	Teletx isodose plan simple		X	0304	1.5576	$99.21	$38.68	$19.84
77310	Teletx isodose plan intermed		X	0305	3.9276	$250.16	$91.38	$50.03
77315	Teletx isodose plan complex		X	0305	3.9276	$250.16	$91.38	$50.03
77321	Special teletx port plan		X	0305	3.9276	$250.16	$91.38	$50.03
77326	Brachytx isodose calc simp		X	0304	1.5576	$99.21	$38.68	$19.84
77327	Brachytx isodose calc interm		X	0305	3.9276	$250.16	$91.38	$50.03
77328	Brachytx isodose plan compl		X	0305	3.9276	$250.16	$91.38	$50.03
77331	Special radiation dosimetry		X	0304	1.5576	$99.21	$38.68	$19.84
77332	Radiation treatment aid(s)		X	0303	2.8878	$183.94	$66.95	$36.79
77333	Radiation treatment aid(s)		X	0303	2.8878	$183.94	$66.95	$36.79

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
77334	Radiation treatment aid(s)		X	0303	2.8878	$183.94	$66.95	$36.79
77336	Radiation physics consult		X	0304	1.5576	$99.21	$38.68	$19.84
77370	Radiation physics consult		X	0304	1.5576	$99.21	$38.68	$19.84
77371	Srs, multisource		S	0127	126.4653	$8,055.08		$1,611.02
77372	Srs, linear based		B					
77373	Sbrt delivery		B					
77399	External radiation dosimetry		X	0304	1.5576	$99.21	$38.68	$19.84
77401	Radiation treatment delivery		S	0300	1.4229	$90.63		$18.13
77402	Radiation treatment delivery		S	0300	1.4229	$90.63		$18.13
77403	Radiation treatment delivery		S	0300	1.4229	$90.63		$18.13
77404	Radiation treatment delivery		S	0300	1.4229	$90.63		$18.13
77406	Radiation treatment delivery		S	0300	1.4229	$90.63		$18.13
77407	Radiation treatment delivery		S	0300	1.4229	$90.63		$18.13
77408	Radiation treatment delivery		S	0300	1.4229	$90.63		$18.13
77409	Radiation treatment delivery		S	0300	1.4229	$90.63		$18.13
77411	Radiation treatment delivery		S	0301	2.2167	$141.19		$28.24
77412	Radiation treatment delivery		S	0301	2.2167	$141.19		$28.24
77413	Radiation treatment delivery		S	0301	2.2167	$141.19		$28.24
77414	Radiation treatment delivery		S	0301	2.2167	$141.19		$28.24
77416	Radiation treatment delivery		S	0301	2.2167	$141.19		$28.24
77417	Radiology port film(s)	CH	N					
77418	Radiation tx delivery, imrt		S	0412	5.4582	$347.65		$69.53
77421	Stereoscopic x-ray guidance	CH	N					
77422	Neutron beam tx, simple		S	0301	2.2167	$141.19		$28.24
77423	Neutron beam tx, complex		S	0301	2.2167	$141.19		$28.24
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	5.7996	$369.40		$73.88
77499	Radiation therapy management		B					
77520	Proton trmt, simple w/o comp		S	0664	12.8205	$816.59		$163.32
77522	Proton trmt, simple w/comp		S	0664	12.8205	$816.59		$163.32
77523	Proton trmt, intermediate		S	0667	15.3404	$977.09		$195.42
77525	Proton treatment, complex		S	0667	15.3404	$977.09		$195.42
77600	Hyperthermia treatment	CH	S	0299	5.7996	$369.40		$73.88
77605	Hyperthermia treatment	CH	S	0299	5.7996	$369.40		$73.88
77610	Hyperthermia treatment	CH	S	0299	5.7996	$369.40		$73.88
77615	Hyperthermia treatment	CH	S	0299	5.7996	$369.40		$73.88
77620	Hyperthermia treatment	CH	S	0299	5.7996	$369.40		$73.88
77750	Infuse radioactive materials		S	0301	2.2167	$141.19		$28.24
77761	Apply intrcav radiat simple		S	0312	8.5140	$542.29		$108.46
77762	Apply intrcav radiat interm		S	0312	8.5140	$542.29		$108.46
77763	Apply intrcav radiat compl		S	0312	8.5140	$542.29		$108.46
77776	Apply interstit radiat simpl		S	0312	8.5140	$542.29		$108.46
77777	Apply interstit radiat inter		S	0312	8.5140	$542.29		$108.46
77778	Apply interstit radiat compl	CH	Q	0651	18.1228	$1,154.31		$230.86
77781	High intensity brachytherapy		S	0313	11.6779	$743.81		$148.76
77782	High intensity brachytherapy		S	0313	11.6779	$743.81		$148.76
77783	High intensity brachytherapy		S	0313	11.6779	$743.81		$148.76
77784	High intensity brachytherapy		S	0313	11.6779	$743.81		$148.76
77789	Apply surface radiation		S	0300	1.4229	$90.63		$18.13
77790	Radiation handling		N					
77799	Radium/radioisotope therapy		S	0312	8.5140	$542.29		$108.46
78000	Thyroid, single uptake		S	0389	1.8190	$115.86	$33.81	$23.17
78001	Thyroid, multiple uptakes		S	0389	1.8190	$115.86	$33.81	$23.17
78003	Thyroid suppress/stimul		S	0392	2.9022	$184.85	$49.31	$36.97
78006	Thyroid imaging with uptake	CH	S	0391	3.4513	$219.83	$66.18	$43.97
78007	Thyroid image, mult uptakes		S	0391	3.4513	$219.83	$66.18	$43.97
78010	Thyroid imaging		S	0390	2.0471	$130.39	$52.15	$26.08
78011	Thyroid imaging with flow		S	0390	2.0471	$130.39	$52.15	$26.08
78015	Thyroid met imaging		S	0406	5.0681	$322.81	$98.18	$64.56
78016	Thyroid met imaging/studies		S	0406	5.0681	$322.81	$98.18	$64.56
78018	Thyroid met imaging, body		S	0406	5.0681	$322.81	$98.18	$64.56
78020	Thyroid met uptake	CH	N					
78070	Parathyroid nuclear imaging		S	0391	3.4513	$219.83	$66.18	$43.97
78075	Adrenal nuclear imaging	CH	S	0408	15.4033	$981.10		$196.22
78099	Endocrine nuclear procedure		S	0390	2.0471	$130.39	$52.15	$26.08
78102	Bone marrow imaging, ltd		S	0400	3.9293	$250.27	$93.22	$50.05
78103	Bone marrow imaging, mult		S	0400	3.9293	$250.27	$93.22	$50.05
78104	Bone marrow imaging, body		S	0400	3.9293	$250.27	$93.22	$50.05
78110	Plasma volume, single		S	0393	5.6921	$362.55	$82.04	$72.51
78111	Plasma volume, multiple		S	0393	5.6921	$362.55	$82.04	$72.51
78120	Red cell mass, single		S	0393	5.6921	$362.55	$82.04	$72.51
78121	Red cell mass, multiple		S	0393	5.6921	$362.55	$82.04	$72.51
78122	Blood volume		S	0393	5.6921	$362.55	$82.04	$72.51
78130	Red cell survival study		S	0393	5.6921	$362.55	$82.04	$72.51
78135	Red cell survival kinetics		S	0393	5.6921	$362.55	$82.04	$72.51
78140	Red cell sequestration		S	0393	5.6921	$362.55	$82.04	$72.51
78185	Spleen imaging		S	0400	3.9293	$250.27	$93.22	$50.05

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
78190	Platelet survival, kinetics		S	0392	2.9022	$184.85	$49.31	$36.97
78191	Platelet survival		S	0392	2.9022	$184.85	$49.31	$36.97
78195	Lymph system imaging		S	0400	3.9293	$250.27	$93.22	$50.05
78199	Blood/lymph nuclear exam		S	0400	3.9293	$250.27	$93.22	$50.05
78201	Liver imaging		S	0394	4.4603	$284.09	$102.61	$56.82
78202	Liver imaging with flow		S	0394	4.4603	$284.09	$102.61	$56.82
78205	Liver imaging (3D)		S	0394	4.4603	$284.09	$102.61	$56.82
78206	Liver image (3d) with flow		S	0394	4.4603	$284.09	$102.61	$56.82
78215	Liver and spleen imaging		S	0394	4.4603	$284.09	$102.61	$56.82
78216	Liver & spleen image/flow		S	0394	4.4603	$284.09	$102.61	$56.82
78220	Liver function study		S	0394	4.4603	$284.09	$102.61	$56.82
78223	Hepatobiliary imaging		S	0394	4.4603	$284.09	$102.61	$56.82
78230	Salivary gland imaging		S	0395	3.7911	$241.47	$89.73	$48.29
78231	Serial salivary imaging		S	0395	3.7911	$241.47	$89.73	$48.29
78232	Salivary gland function exam		S	0395	3.7911	$241.47	$89.73	$48.29
78258	Esophageal motility study		S	0395	3.7911	$241.47	$89.73	$48.29
78261	Gastric mucosa imaging		S	0395	3.7911	$241.47	$89.73	$48.29
78262	Gastroesophageal reflux exam		S	0395	3.7911	$241.47	$89.73	$48.29
78264	Gastric emptying study		S	0395	3.7911	$241.47	$89.73	$48.29
78267	Breath tst attain/anal c-14		A					
78268	Breath test analysis, c-14		A					
78270	Vit B-12 absorption exam		S	0392	2.9022	$184.85	$49.31	$36.97
78271	Vit b-12 absrp exam, int fac		S	0392	2.9022	$184.85	$49.31	$36.97
78272	Vit B-12 absorp, combined		S	0392	2.9022	$184.85	$49.31	$36.97
78278	Acute GI blood loss imaging		S	0395	3.7911	$241.47	$89.73	$48.29
78282	GI protein loss exam		S	0395	3.7911	$241.47	$89.73	$48.29
78290	Meckel's divert exam		S	0395	3.7911	$241.47	$89.73	$48.29
78291	Leveen/shunt patency exam		S	0395	3.7911	$241.47	$89.73	$48.29
78299	GI nuclear procedure		S	0395	3.7911	$241.47	$89.73	$48.29
78300	Bone imaging, limited area		S	0396	3.8039	$242.29	$95.02	$48.46
78305	Bone imaging, multiple areas		S	0396	3.8039	$242.29	$95.02	$48.46
78306	Bone imaging, whole body		S	0396	3.8039	$242.29	$95.02	$48.46
78315	Bone imaging, 3 phase		S	0396	3.8039	$242.29	$95.02	$48.46
78320	Bone imaging (3D)		S	0396	3.8039	$242.29	$95.02	$48.46
78350	Bone mineral, single photon		E					
78351	Bone mineral, dual photon		E					
78399	Musculoskeletal nuclear exam		S	0396	3.8039	$242.29	$95.02	$48.46
78414	Non-imaging heart function		S	0398	4.8620	$309.68	$100.06	$61.94
78428	Cardiac shunt imaging		S	0398	4.8620	$309.68	$100.06	$61.94
78445	Vascular flow imaging		S	0397	3.1433	$200.21	$49.58	$40.04
78456	Acute venous thrombus image		S	0397	3.1433	$200.21	$49.58	$40.04
78457	Venous thrombosis imaging		S	0397	3.1433	$200.21	$49.58	$40.04
78458	Ven thrombosis images, bilat		S	0397	3.1433	$200.21	$49.58	$40.04
78459	Heart muscle imaging (PET)		S	0307	21.9955	$1,400.98	$292.49	$280.20
78460	Heart muscle blood, single	CH	S	0377	11.8512	$754.85	$158.84	$150.97
78461	Heart muscle blood, multiple	CH	S	0377	11.8512	$754.85	$158.84	$150.97
78464	Heart image (3d), single	CH	S	0377	11.8512	$754.85	$158.84	$150.97
78465	Heart image (3d), multiple		S	0377	11.8512	$754.85	$158.84	$150.97
78466	Heart infarct image		S	0398	4.8620	$309.68	$100.06	$61.94
78468	Heart infarct image (ef)		S	0398	4.8620	$309.68	$100.06	$61.94
78469	Heart infarct image (3D)		S	0398	4.8620	$309.68	$100.06	$61.94
78472	Gated heart, planar, single		S	0398	4.8620	$309.68	$100.06	$61.94
78473	Gated heart, multiple	CH	S	0398	4.8620	$309.68	$100.06	$61.94
78478	Heart wall motion add-on	CH	N					
78480	Heart function add-on	CH	N					
78481	Heart first pass, single		S	0398	4.8620	$309.68	$100.06	$61.94
78483	Heart first pass, multiple	CH	S	0398	4.8620	$309.68	$100.06	$61.94
78491	Heart image (pet), single		S	0307	21.9955	$1,400.98	$292.49	$280.20
78492	Heart image (pet), multiple		S	0307	21.9955	$1,400.98	$292.49	$280.20
78494	Heart image, spect		S	0398	4.8620	$309.68	$100.06	$61.94
78496	Heart first pass add-on	CH	N					
78499	Cardiovascular nuclear exam		S	0398	4.8620	$309.68	$100.06	$61.94
78580	Lung perfusion imaging		S	0401	3.3954	$216.27	$78.19	$43.25
78584	Lung V/Q image single breath		S	0378	4.9509	$315.34	$125.33	$63.07
78585	Lung V/Q imaging		S	0378	4.9509	$315.34	$125.33	$63.07
78586	Aerosol lung image, single		S	0401	3.3954	$216.27	$78.19	$43.25
78587	Aerosol lung image, multiple		S	0401	3.3954	$216.27	$78.19	$43.25
78588	Perfusion lung image		S	0378	4.9509	$315.34	$125.33	$63.07
78591	Vent image, 1 breath, 1 proj		S	0401	3.3954	$216.27	$78.19	$43.25
78593	Vent image, 1 proj, gas		S	0401	3.3954	$216.27	$78.19	$43.25
78594	Vent image, mult proj, gas		S	0401	3.3954	$216.27	$78.19	$43.25
78596	Lung differential function		S	0378	4.9509	$315.34	$125.33	$63.07
78599	Respiratory nuclear exam		S	0401	3.3954	$216.27	$78.19	$43.25
78600	Brain image < 4 views	CH	S	0403	3.2295	$205.70	$79.87	$41.14
78601	Brain image w/flow < 4 views	CH	S	0403	3.2295	$205.70	$79.87	$41.14
78605	Brain image 4+ views	CH	S	0403	3.2295	$205.70	$79.87	$41.14
78606	Brain image w/flow 4 + views		S	0402	8.8235	$562.00	$114.12	$112.40
78607	Brain imaging (3D)		S	0402	8.8235	$562.00	$114.12	$112.40
78608	Brain imaging (PET)		S	0308	16.6001	$1,057.33		$211.47
78609	Brain imaging (PET)		E					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
78610	Brain flow imaging only		S	0402	8.8235	$562.00	$114.12	$112.40
78615	Cerebral vascular flow image	CH	D					
78630	Cerebrospinal fluid scan	CH	S	0402	8.8235	$562.00	$114.12	$112.40
78635	CSF ventriculography	CH	S	0402	8.8235	$562.00	$114.12	$112.40
78645	CSF shunt evaluation		S	0403	3.2295	$205.70	$79.87	$41.14
78647	Cerebrospinal fluid scan	CH	S	0402	8.8235	$562.00	$114.12	$112.40
78650	CSF leakage imaging	CH	S	0402	8.8235	$562.00	$114.12	$112.40
78660	Nuclear exam of tear flow		S	0403	3.2295	$205.70	$79.87	$41.14
78699	Nervous system nuclear exam	CH	S	0403	3.2295	$205.70	$79.87	$41.14
78700	Kidney imaging, morphol		S	0404	5.0824	$323.72	$84.11	$64.74
78701	Kidney imaging with flow		S	0404	5.0824	$323.72	$84.11	$64.74
78707	K flow/funct image w/o drug		S	0404	5.0824	$323.72	$84.11	$64.74
78708	K flow/funct image w/drug	CH	S	0404	5.0824	$323.72	$84.11	$64.74
78709	K flow/funct image, multiple	CH	S	0404	5.0824	$323.72	$84.11	$64.74
78710	Kidney imaging (3D)		S	0404	5.0824	$323.72	$84.11	$64.74
78725	Kidney function study	CH	S	0392	2.9022	$184.85	$49.31	$36.97
78730	Urinary bladder retention	CH	S	0389	1.8190	$115.86	$33.81	$23.17
78740	Ureteral reflux study		S	0404	5.0824	$323.72	$84.11	$64.74
78761	Testicular imaging w/flow		S	0404	5.0824	$323.72	$84.11	$64.74
78799	Genitourinary nuclear exam		S	0404	5.0824	$323.72	$84.11	$64.74
78800	Tumor imaging, limited area		S	0406	5.0681	$322.81	$98.18	$64.56
78801	Tumor imaging, mult areas		S	0406	5.0681	$322.81	$98.18	$64.56
78802	Tumor imaging, whole body	CH	S	0414	8.4176	$536.15	$214.44	$107.23
78803	Tumor imaging (3D)	CH	S	0408	15.4033	$981.10		$196.22
78804	Tumor imaging, whole body		S	0408	15.4033	$981.10		$196.22
78805	Abscess imaging, ltd area	CH	S	0414	8.4176	$536.15	$214.44	$107.23
78806	Abscess imaging, whole body	CH	S	0414	8.4176	$536.15	$214.44	$107.23
78807	Nuclear localization/abscess	CH	S	0414	8.4176	$536.15	$214.44	$107.23
78811	Pet image, ltd area		S	0308	16.6001	$1,057.33		$211.47
78812	Pet image, skull-thigh		S	0308	16.6001	$1,057.33		$211.47
78813	Pet image, full body		S	0308	16.6001	$1,057.33		$211.47
78814	Pet image w/ct, lmtd	CH	S	0308	16.6001	$1,057.33		$211.47
78815	Pet image w/ct, skull-thigh	CH	S	0308	16.6001	$1,057.33		$211.47
78816	Pet image w/ct, full body	CH	S	0308	16.6001	$1,057.33		$211.47
78890	Nuclear medicine data proc		N					
78891	Nuclear med data proc		N					
78999	Nuclear diagnostic exam		S	0389	1.8190	$115.86	$33.81	$23.17
79005	Nuclear rx, oral admin		S	0407	3.3020	$210.32	$78.13	$42.06
79101	Nuclear rx, iv admin		S	0407	3.3020	$210.32	$78.13	$42.06
79200	Nuclear rx, intracav admin		S	0413	5.2741	$335.93		$67.19
79300	Nuclr rx, interstit colloid		S	0407	3.3020	$210.32	$78.13	$42.06
79403	Hematopoietic nuclear tx		S	0413	5.2741	$335.93		$67.19
79440	Nuclear rx, intra-articular		S	0413	5.2741	$335.93		$67.19
79445	Nuclear rx, intra-arterial		S	0407	3.3020	$210.32	$78.13	$42.06
79999	Nuclear medicine therapy		S	0407	3.3020	$210.32	$78.13	$42.06
80047	Metabolic panel ionized ca	NI	A					
80048	Metabolic panel total ca		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					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	0.2397	$15.27	$5.17	$3.05
80502	Lab pathology consultation		X	0342	0.0969	$6.17	$2.02	$1.23
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					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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 bld feces, 1–3 tests		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					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
82610	Cystatin c	NI	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/o2 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					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
83993	Assay for calprotectin fecal	NI	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					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
84704	Hcg, free betachain test	NI	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	0.5142	$32.75	$10.84	$6.55
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					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	0.2397	$15.27	$5.17	$3.05
86078	Physician blood bank service		X	0343	0.5142	$32.75	$10.84	$6.55
86079	Physician blood bank service		X	0433	0.2397	$15.27	$5.17	$3.05
86140	C-reactive protein		A					
86141	C-reactive protein, hs		A					
86146	Glycoprotein antibody		A					
86147	Cardiolipin antibody		A					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
86356	Mononuclear cell antigen	NI	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	0.0844	$5.38	$2.14	$1.08
86486	Skin test, nos antigen	NI	A					
86490	Coccidioidomycosis skin test		X	0341	0.0844	$5.38	$2.14	$1.08
86510	Histoplasmosis skin test		X	0341	0.0844	$5.38	$2.14	$1.08
86580	TB intradermal test		X	0341	0.0844	$5.38	$2.14	$1.08
86586	Skin test, unlisted	CH	D					
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					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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	0.2140	$13.63	$2.87	$2.73
86860	RBC antibody elution		X	0346	0.3346	$21.31	$4.37	$4.26
86870	RBC antibody identification		X	0346	0.3346	$21.31	$4.37	$4.26
86880	Coombs test, direct		X	0409	0.1190	$7.58	$2.20	$1.52
86885	Coombs test, indirect, qual		X	0409	0.1190	$7.58	$2.20	$1.52
86886	Coombs test, indirect, titer		X	0409	0.1190	$7.58	$2.20	$1.52
86890	Autologous blood process		X	0347	0.7739	$49.29	$11.28	$9.86
86891	Autologous blood, op salvage		X	0346	0.3346	$21.31	$4.37	$4.26
86900	Blood typing, ABO		X	0409	0.1190	$7.58	$2.20	$1.52
86901	Blood typing, Rh (D)		X	0409	0.1190	$7.58	$2.20	$1.52
86903	Blood typing, antigen screen		X	0345	0.2140	$13.63	$2.87	$2.73
86904	Blood typing, patient serum		X	0346	0.3346	$21.31	$4.37	$4.26
86905	Blood typing, RBC antigens		X	0345	0.2140	$13.63	$2.87	$2.73
86906	Blood typing, Rh phenotype		X	0345	0.2140	$13.63	$2.87	$2.73

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
86910	Blood typing, paternity test		E					
86911	Blood typing, antigen system		E					
86920	Compatibility test, spin		X	0346	0.3346	$21.31	$4.37	$4.26
86921	Compatibility test, incubate		X	0345	0.2140	$13.63	$2.87	$2.73
86922	Compatibility test, antiglob		X	0346	0.3346	$21.31	$4.37	$4.26
86923	Compatibility test, electric		X	0345	0.2140	$13.63	$2.87	$2.73
86927	Plasma, fresh frozen		X	0345	0.2140	$13.63	$2.87	$2.73
86930	Frozen blood prep		X	0347	0.7739	$49.29	$11.28	$9.86
86931	Frozen blood thaw		X	0347	0.7739	$49.29	$11.28	$9.86
86932	Frozen blood freeze/thaw		X	0347	0.7739	$49.29	$11.28	$9.86
86940	Hemolysins/agglutinins, auto		A					
86941	Hemolysins/agglutinins		A					
86945	Blood product/irradiation		X	0345	0.2140	$13.63	$2.87	$2.73
86950	Leukacyte transfusion		X	0345	0.2140	$13.63	$2.87	$2.73
86960	Vol reduction of blood/prod		X	0345	0.2140	$13.63	$2.87	$2.73
86965	Pooling blood platelets		X	0346	0.3346	$21.31	$4.37	$4.26
86970	RBC pretreatment		X	0345	0.2140	$13.63	$2.87	$2.73
86971	RBC pretreatment		X	0345	0.2140	$13.63	$2.87	$2.73
86972	RBC pretreatment		X	0346	0.3346	$21.31	$4.37	$4.26
86975	RBC pretreatment, serum		X	0346	0.3346	$21.31	$4.37	$4.26
86976	RBC pretreatment, serum		X	0345	0.2140	$13.63	$2.87	$2.73
86977	RBC pretreatment, serum		X	0346	0.3346	$21.31	$4.37	$4.26
86978	RBC pretreatment, serum		X	0346	0.3346	$21.31	$4.37	$4.26
86985	Split blood or products		X	0345	0.2140	$13.63	$2.87	$2.73
86999	Transfusion procedure		X	0345	0.2140	$13.63	$2.87	$2.73
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					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	Cytomegalovirus dfa		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					
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					
87500	Vanomycin, dna, amp probe	NI	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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
87804	Influenza assay w/optic		A					
87807	Rsv assay w/optic		A					
87808	Trichomonas assay w/optic		A					
87809	Adenovirus assay w/optic	NI	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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
88099	Necropsy (autopsy) procedure		E					
88104	Cytopath fl nongyn, smears		X	0433	0.2397	$15.27	$5.17	$3.05
88106	Cytopath fl nongyn, filter		X	0433	0.2397	$15.27	$5.17	$3.05
88107	Cytopath fl nongyn, sm/fltr	CH	X	0343	0.5142	$32.75	$10.84	$6.55
88108	Cytopath, concentrate tech	CH	X	0343	0.5142	$32.75	$10.84	$6.55
88112	Cytopath, cell enhance tech		X	0343	0.5142	$32.75	$10.84	$6.55
88125	Forensic cytopathology		X	0433	0.2397	$15.27	$5.17	$3.05
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	0.2397	$15.27	$5.17	$3.05
88161	Cytopath smear, other source		X	0433	0.2397	$15.27	$5.17	$3.05
88162	Cytopath smear, other source	CH	X	0343	0.5142	$32.75	$10.84	$6.55
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	0.5142	$32.75	$10.84	$6.55
88173	Cytopath eval, fna, report		X	0343	0.5142	$32.75	$10.84	$6.55
88174	Cytopath, c/v auto, in fluid		A					
88175	Cytopath c/v auto fluid redo		A					
88182	Cell marker study		X	0343	0.5142	$32.75	$10.84	$6.55
88184	Flowcytometry/ tc, 1 marker		X	0433	0.2397	$15.27	$5.17	$3.05
88185	Flowcytometry/tc, add-on		X	0433	0.2397	$15.27	$5.17	$3.05
88187	Flowcytometry/read, 2–8		X	0433	0.2397	$15.27	$5.17	$3.05
88188	Flowcytometry/read, 9–15		X	0433	0.2397	$15.27	$5.17	$3.05
88189	Flowcytometry/read, 16 & >		X	0343	0.5142	$32.75	$10.84	$6.55
88199	Cytopathology procedure		X	0342	0.0969	$6.17	$2.02	$1.23
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					
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	0.0969	$6.17	$2.02	$1.23
88300	Surgical path, gross		X	0433	0.2397	$15.27	$5.17	$3.05
88302	Tissue exam by pathologist		X	0433	0.2397	$15.27	$5.17	$3.05
88304	Tissue exam by pathologist		X	0343	0.5142	$32.75	$10.84	$6.55
88305	Tissue exam by pathologist		X	0343	0.5142	$32.75	$10.84	$6.55
88307	Tissue exam by pathologist		X	0344	0.8167	$52.02	$15.66	$10.40
88309	Tissue exam by pathologist		X	0344	0.8167	$52.02	$15.66	$10.40
88311	Decalcify tissue		X	0433	0.2397	$15.27	$5.17	$3.05
88312	Special stains		X	0433	0.2397	$15.27	$5.17	$3.05
88313	Special stains		X	0433	0.2397	$15.27	$5.17	$3.05
88314	Histochemical stain	CH	X	0433	0.2397	$15.27	$5.17	$3.05
88318	Chemical histochemistry		X	0433	0.2397	$15.27	$5.17	$3.05
88319	Enzyme histochemistry	CH	X	0433	0.2397	$15.27	$5.17	$3.05
88321	Microslide consultation		X	0433	0.2397	$15.27	$5.17	$3.05
88323	Microslide consultation		X	0343	0.5142	$32.75	$10.84	$6.55
88325	Comprehensive review of data		X	0344	0.8167	$52.02	$15.66	$10.40
88329	Path consult introp		X	0433	0.2397	$15.27	$5.17	$3.05

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
88331	Path consult intraop, 1 bloc		X	0343	0.5142	$32.75	$10.84	$6.55
88332	Path consult intraop, add'l		X	0433	0.2397	$15.27	$5.17	$3.05
88333	Intraop cyto path consult, 1		X	0343	0.5142	$32.75	$10.84	$6.55
88334	Intraop cyto path consult, 2		X	0433	0.2397	$15.27	$5.17	$3.05
88342	Immunohistochemistry		X	0343	0.5142	$32.75	$10.84	$6.55
88346	Immunofluorescent study		X	0343	0.5142	$32.75	$10.84	$6.55
88347	Immunofluorescent study		X	0343	0.5142	$32.75	$10.84	$6.55
88348	Electron microscopy		X	0661	2.6949	$171.65	$62.09	$34.33
88349	Scanning electron microscopy		X	0661	2.6949	$171.65	$62.09	$34.33
88355	Analysis, skeletal muscle		X	0343	0.5142	$32.75	$10.84	$6.55
88356	Analysis, nerve		X	0344	0.8167	$52.02	$15.66	$10.40
88358	Analysis, tumor		X	0344	0.8167	$52.02	$15.66	$10.40
88360	Tumor immunohistochem/manual		X	0343	0.5142	$32.75	$10.84	$6.55
88361	Tumor immunohistochem/comput		X	0344	0.8167	$52.02	$15.66	$10.40
88362	Nerve teasing preparations		X	0344	0.8167	$52.02	$15.66	$10.40
88365	Insitu hybridization (fish)		X	0344	0.8167	$52.02	$15.66	$10.40
88367	Insitu hybridization, auto		X	0344	0.8167	$52.02	$15.66	$10.40
88368	Insitu hybridization, manual	CH	X	0343	0.5142	$32.75	$10.84	$6.55
88371	Protein, western blot tissue		A					
88372	Protein analysis w/probe		A					
88380	Microdissection, laser		N					
88381	Microdissection, manual	NI	N					
88384	Eval molecular probes, 11–50		X	0433	0.2397	$15.27	$5.17	$3.05
88385	Eval molecul probes, 51–250		X	0343	0.5142	$32.75	$10.84	$6.55
88386	Eval molecul probes, 251–500		X	0344	0.8167	$52.02	$15.66	$10.40
88399	Surgical pathology procedure		X	0342	0.0969	$6.17	$2.02	$1.23
88400	Bilirubin total transcut		A					
89049	Chct for mal hyperthermia		X	0343	0.5142	$32.75	$10.84	$6.55
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	1.5330	$97.64	$33.88	$19.53
89105	Sample intestinal contents		X	0360	1.5330	$97.64	$33.88	$19.53
89125	Specimen fat stain		A					
89130	Sample stomach contents		X	0360	1.5330	$97.64	$33.88	$19.53
89132	Sample stomach contents		X	0360	1.5330	$97.64	$33.88	$19.53
89135	Sample stomach contents		X	0360	1.5330	$97.64	$33.88	$19.53
89136	Sample stomach contents		X	0360	1.5330	$97.64	$33.88	$19.53
89140	Sample stomach contents		X	0360	1.5330	$97.64	$33.88	$19.53
89141	Sample stomach contents		X	0360	1.5330	$97.64	$33.88	$19.53
89160	Exam feces for meat fibers		A					
89190	Nasal smear for eosinophils		A					
89220	Sputum specimen collection		X	0343	0.5142	$32.75	$10.84	$6.55
89225	Starch granules, feces		A					
89230	Collect sweat for test	CH	X	0343	0.5142	$32.75	$10.84	$6.55
89235	Water load test		A					
89240	Pathology lab procedure		X	0342	0.0969	$6.17	$2.02	$1.23
89250	Cultr oocyte/embryo <4 days	CH	X	0344	0.8167	$52.02	$15.66	$10.40
89251	Cultr oocyte/embryo <4 days	CH	X	0344	0.8167	$52.02	$15.66	$10.40
89253	Embryo hatching	CH	X	0344	0.8167	$52.02	$15.66	$10.40
89254	Oocyte identification	CH	X	0344	0.8167	$52.02	$15.66	$10.40
89255	Prepare embryo for transfer	CH	X	0344	0.8167	$52.02	$15.66	$10.40
89257	Sperm identification	CH	X	0344	0.8167	$52.02	$15.66	$10.40
89258	Cryopreservation; embryo(s)	CH	X	0344	0.8167	$52.02	$15.66	$10.40
89259	Cryopreservation, sperm	CH	X	0344	0.8167	$52.02	$15.66	$10.40
89260	Sperm isolation, simple	CH	X	0344	0.8167	$52.02	$15.66	$10.40
89261	Sperm isolation, complex	CH	X	0344	0.8167	$52.02	$15.66	$10.40
89264	Identify sperm tissue	CH	X	0344	0.8167	$52.02	$15.66	$10.40
89268	Insemination of oocytes	CH	X	0344	0.8167	$52.02	$15.66	$10.40
89272	Extended culture of oocytes	CH	X	0344	0.8167	$52.02	$15.66	$10.40
89280	Assist oocyte fertilization	CH	X	0344	0.8167	$52.02	$15.66	$10.40
89281	Assist oocyte fertilization	CH	X	0344	0.8167	$52.02	$15.66	$10.40
89290	Biopsy, oocyte polar body	CH	X	0344	0.8167	$52.02	$15.66	$10.40
89291	Biopsy, oocyte polar body	CH	X	0344	0.8167	$52.02	$15.66	$10.40
89300	Semen analysis w/huhner		A					
89310	Semen analysis w/count		A					
89320	Semen anal vol/count/mot		A					
89321	Semen anal, sperm detection		A					
89322	Semen anal, strict criteria	NI	A					
89325	Sperm antibody test		A					
89329	Sperm evaluation test		A					
89330	Evaluation, cervical mucus		A					
89331	Retrograde ejaculation anal	NI	A					
89335	Cryopreserve testicular tiss	CH	X	0344	0.8167	$52.02	$15.66	$10.40
89342	Storage/year; embryo(s)	CH	X	0344	0.8167	$52.02	$15.66	$10.40
89343	Storage/year; sperm/semen	CH	X	0344	0.8167	$52.02	$15.66	$10.40
89344	Storage/year; reprod tissue	CH	X	0344	0.8167	$52.02	$15.66	$10.40
89346	Storage/year; oocyte(s)	CH	X	0344	0.8167	$52.02	$15.66	$10.40
89352	Thawing cryopresrved; embryo	CH	X	0344	0.8167	$52.02	$15.66	$10.40

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
89353	Thawing cryopresrved; sperm	CH	X	0344	0.8167	$52.02	$15.66	$10.40
89354	Thaw cryoprsvrd; reprod tiss	CH	X	0344	0.8167	$52.02	$15.66	$10.40
89356	Thawing cryopresrved; oocyte	CH	X	0344	0.8167	$52.02	$15.66	$10.40
90281	Human ig, im		E					
90283	Human ig, iv		E					
90284	Human ig, sc	NI	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		$122.02		$24.40
90375	Rabies ig, im/sc		K	9133		$68.22		$13.64
90376	Rabies ig, heat treated		K	9134		$71.69		$14.34
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		$122.74		$24.55
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	0.3945	$25.13		$5.03
90472	Immunization admin, each add		S	0436	0.2545	$16.21		$3.24
90473	Immune admin oral/nasal		S	0436	0.2545	$16.21		$3.24
90474	Immune admin oral/nasal addl		S	0436	0.2545	$16.21		$3.24
90476	Adenovirus vaccine, type 4		N					
90477	Adenovirus vaccine, type 7		N					
90581	Anthrax vaccine, sc		N					
90585	Bcg vaccine, percut		K	9137		$118.98		$23.80
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					
90661	Flu vacc cell cult prsv free	NI	L					
90662	Flu vacc prsv free inc antig	NI	L					
90663	Flu vacc pandemic	NI	L					
90665	Lyme disease vaccine, im		N					
90669	Pneumococcal vacc, ped <5	CH	L					
90675	Rabies vaccine, im		K	9139		$150.80		$30.16
90676	Rabies vaccine, id		K	9140		$119.86		$23.97
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		$45.53		$9.11
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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		$85.29		$17.06
90734	Meningococcal vaccine, im		K	9145		$82.00		$16.40
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	1.7998	$114.64		$22.93
90761	Hydrate iv infusion, add-on		S	0437	0.3945	$25.13		$5.03
90765	Ther/proph/diag iv inf, init		S	0440	1.7998	$114.64		$22.93
90766	Ther/proph/dg iv inf, add-on		S	0437	0.3945	$25.13		$5.03
90767	Tx/proph/dg addl seq iv inf		S	0437	0.3945	$25.13		$5.03
90768	Ther/diag concurrent inf		N					
90769	Sc ther infusion, up to 1 hr	NI	S	0440	1.7998	$114.64		$22.93
90770	Sc ther infusion, addl hr	NI	S	0437	0.3945	$25.13		$5.03
90771	Sc ther infusion, reset pump	NI	S	0438	0.8041	$51.22		$10.24
90772	Ther/proph/diag inj, sc/im		S	0437	0.3945	$25.13		$5.03
90773	Ther/proph/diag inj, ia		S	0438	0.8041	$51.22		$10.24
90774	Ther/proph/diag inj, iv push		S	0438	0.8041	$51.22		$10.24
90775	Tx/pro/dx inj new drug addon		S	0438	0.8041	$51.22		$10.24
90776	Tx/pro/dx inj same drug adon	NI	N					
90779	Ther/prop/diag inj/inf proc		S	0436	0.2545	$16.21		$3.24
90801	Psy dx interview	CH	Q	0323	1.6044	$102.19		$20.44
90802	Intac psy dx interview	CH	Q	0323	1.6044	$102.19		$20.44
90804	Psytx, office, 20–30 min	CH	Q	0322	1.1729	$74.71		$14.94
90805	Psytx, off, 20–30 min w/e&m	CH	Q	0322	1.1729	$74.71		$14.94
90806	Psytx, off, 45–50 min	CH	Q	0323	1.6044	$102.19		$20.44
90807	Psytx, off, 45–50 min w/e&m	CH	Q	0323	1.6044	$102.19		$20.44
90808	Psytx, office, 75–80 min	CH	Q	0323	1.6044	$102.19		$20.44
90809	Psytx, off, 75–80, w/e&m	CH	Q	0323	1.6044	$102.19		$20.44
90810	Intac psytx, off, 20–30 min	CH	Q	0322	1.1729	$74.71		$14.94
90811	Intac psytx, 20–30, w/e&m	CH	Q	0322	1.1729	$74.71		$14.94
90812	Intac psytx, off, 45–50 min	CH	Q	0323	1.6044	$102.19		$20.44
90813	Intac psytx, 45–50 min w/e&m	CH	Q	0323	1.6044	$102.19		$20.44
90814	Intac psytx, off, 75–80 min	CH	Q	0323	1.6044	$102.19		$20.44
90815	Intac psytx, 75–80 w/e&m	CH	Q	0323	1.6044	$102.19		$20.44
90816	Psytx, hosp, 20–30 min	CH	Q	0322	1.1729	$74.71		$14.94
90817	Psytx, hosp, 20–30 min w/e&m	CH	Q	0322	1.1729	$74.71		$14.94
90818	Psytx, hosp, 45–50 min	CH	Q	0323	1.6044	$102.19		$20.44
90819	Psytx, hosp, 45–50 min w/e&m	CH	Q	0323	1.6044	$102.19		$20.44
90821	Psytx, hosp, 75–80 min	CH	Q	0323	1.6044	$102.19		$20.44
90822	Psytx, hosp, 75–80 min w/e&m	CH	Q	0323	1.6044	$102.19		$20.44
90823	Intac psytx, hosp, 20–30 min	CH	Q	0322	1.1729	$74.71		$14.94
90824	Intac psytx, hsp 20–30 w/e&m	CH	Q	0322	1.1729	$74.71		$14.94
90826	Intac psytx, hosp, 45–50 min	CH	Q	0323	1.6044	$102.19		$20.44
90827	Intac psytx, hsp 45–50 w/e&m	CH	Q	0323	1.6044	$102.19		$20.44
90828	Intac psytx, hosp, 75–80 min	CH	Q	0323	1.6044	$102.19		$20.44
90829	Intac psytx, hsp 75–80 w/e&m	CH	Q	0323	1.6044	$102.19		$20.44
90845	Psychoanalysis	CH	Q	0323	1.6044	$102.19		$20.44
90846	Family psytx w/o patient	CH	Q	0324	2.3616	$150.42		$30.08
90847	Family psytx w/patient	CH	Q	0324	2.3616	$150.42		$30.08
90849	Multiple family group psytx	CH	Q	0325	0.9913	$63.14	$13.81	$12.63
90853	Group psychotherapy	CH	Q	0325	0.9913	$63.14	$13.81	$12.63
90857	Intac group psytx	CH	Q	0325	0.9913	$63.14	$13.81	$12.63
90862	Medication management	CH	Q	0606	1.3226	$84.24		$16.85
90865	Narcosynthesis	CH	Q	0323	1.6044	$102.19		$20.44
90870	Electroconvulsive therapy		S	0320	5.7299	$364.96	$80.06	$72.99
90875	Psychophysiological therapy		E					
90876	Psychophysiological therapy		E					
90880	Hypnotherapy	CH	Q	0323	1.6044	$102.19		$20.44
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	1.1729	$74.71		$14.94
90901	Biofeedback train, any meth		A					
90911	Biofeedback peri/uro/rectal	CH	T	0126	1.0356	$65.96	$16.21	$13.19
90918	ESRD related services, month		E					
90919	ESRD related services, month		E					
90920	ESRD related services, month		E					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	6.5383	$416.45		$83.29
90937	Hemodialysis, repeated eval		B					
90940	Hemodialysis access study		N					
90945	Dialysis, one evaluation		S	0170	6.5383	$416.45		$83.29
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	3.9276	$250.16	$83.23	$50.03
91010	Esophagus motility study		X	0361	3.9276	$250.16	$83.23	$50.03
91011	Esophagus motility study		X	0361	3.9276	$250.16	$83.23	$50.03
91012	Esophagus motility study		X	0361	3.9276	$250.16	$83.23	$50.03
91020	Gastric motility studies		X	0361	3.9276	$250.16	$83.23	$50.03
91022	Duodenal motility study		X	0361	3.9276	$250.16	$83.23	$50.03
91030	Acid perfusion of esophagus		X	0361	3.9276	$250.16	$83.23	$50.03
91034	Gastroesophageal reflux test		X	0361	3.9276	$250.16	$83.23	$50.03
91035	G-esoph reflx tst w/electrod		X	0361	3.9276	$250.16	$83.23	$50.03
91037	Esoph imped function test		X	0361	3.9276	$250.16	$83.23	$50.03
91038	Esoph imped funct test > 1h		X	0361	3.9276	$250.16	$83.23	$50.03
91040	Esoph balloon distension tst		X	0360	1.5330	$97.64	$33.88	$19.53
91052	Gastric analysis test		X	0361	3.9276	$250.16	$83.23	$50.03
91055	Gastric intubation for smear		X	0360	1.5330	$97.64	$33.88	$19.53
91065	Breath hydrogen test		X	0360	1.5330	$97.64	$33.88	$19.53
91100	Pass intestine bleeding tube		X	0360	1.5330	$97.64	$33.88	$19.53
91105	Gastric intubation treatment		X	0360	1.5330	$97.64	$33.88	$19.53
91110	Gi tract capsule endoscopy		T	0142	9.5292	$606.95	$152.78	$121.39
91111	Esophageal capsule endoscopy		T	0141	8.5030	$541.59	$143.38	$108.32
91120	Rectal sensation test		T	0126	1.0356	$65.96	$16.21	$13.19
91122	Anal pressure record		T	0164	2.0077	$127.88		$25.58
91123	Irrigate fecal impaction		N					
91132	Electrogastrography		X	0360	1.5330	$97.64	$33.88	$19.53
91133	Electrogastrography w/test		X	0360	1.5330	$97.64	$33.88	$19.53
91299	Gastroenterology procedure		X	0360	1.5330	$97.64	$33.88	$19.53
92002	Eye exam, new patient		V	0605	0.9964	$63.46		$12.69
92004	Eye exam, new patient		V	0606	1.3226	$84.24		$16.85
92012	Eye exam established pat		V	0604	0.8388	$53.43		$10.69
92014	Eye exam & treatment		V	0605	0.9964	$63.46		$12.69
92015	Refraction		E					
92018	New eye exam & treatment		T	0699	13.7453	$875.49		$175.10
92019	Eye exam & treatment		T	0699	13.7453	$875.49		$175.10
92020	Special eye evaluation		S	0230	0.5903	$37.60		$7.52
92025	Corneal topography		S	0698	0.8696	$55.39		$11.08
92060	Special eye evaluation	CH	S	0698	0.8696	$55.39		$11.08
92065	Orthoptic/pleoptic training	CH	S	0698	0.8696	$55.39		$11.08
92070	Fitting of contact lens		N					
92081	Visual field examination(s)		S	0230	0.5903	$37.60		$7.52
92082	Visual field examination(s)	CH	S	0698	0.8696	$55.39		$11.08
92083	Visual field examination(s)	CH	S	0698	0.8696	$55.39		$11.08
92100	Serial tonometry exam(s)		N					
92120	Tonography & eye evaluation	CH	S	0698	0.8696	$55.39		$11.08
92130	Water provocation tonography		S	0230	0.5903	$37.60		$7.52
92135	Ophth dx imaging post seg		S	0230	0.5903	$37.60		$7.52
92136	Ophthalmic biometry		S	0698	0.8696	$55.39		$11.08
92140	Glaucoma provocative tests		S	0230	0.5903	$37.60		$7.52
92225	Special eye exam, initial		S	0230	0.5903	$37.60		$7.52
92226	Special eye exam, subsequent	CH	S	0698	0.8696	$55.39		$11.08
92230	Eye exam with photos		S	0231	2.1790	$138.79		$27.76
92235	Eye exam with photos		S	0231	2.1790	$138.79		$27.76
92240	Icg angiography		S	0231	2.1790	$138.79		$27.76
92250	Eye exam with photos	CH	S	0698	0.8696	$55.39		$11.08
92260	Ophthalmoscopy/dynamometry		S	0230	0.5903	$37.60		$7.52
92265	Eye muscle evaluation	CH	S	0698	0.8696	$55.39		$11.08
92270	Electro-oculography		S	0230	0.5903	$37.60		$7.52
92275	Electroretinography		S	0231	2.1790	$138.79		$27.76
92283	Color vision examination		S	0230	0.5903	$37.60		$7.52
92284	Dark adaptation eye exam		S	0698	0.8696	$55.39		$11.08
92285	Eye photography	CH	S	0698	0.8696	$55.39		$11.08
92286	Internal eye photography	CH	S	0231	2.1790	$138.79		$27.76
92287	Internal eye photography	CH	S	0231	2.1790	$138.79		$27.76
92310	Contact lens fitting		E					
92311	Contact lens fitting	CH	S	0698	0.8696	$55.39		$11.08
92312	Contact lens fitting	CH	S	0698	0.8696	$55.39		$11.08
92313	Contact lens fitting	CH	S	0230	0.5903	$37.60		$7.52
92314	Prescription of contact lens		E					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
92315	Prescription of contact lens	CH	S	0230	0.5903	$37.60		$7.52
92316	Prescription of contact lens	CH	S	0698	0.8696	$55.39		$11.08
92317	Prescription of contact lens	CH	S	0230	0.5903	$37.60		$7.52
92325	Modification of contact lens	CH	S	0230	0.5903	$37.60		$7.52
92326	Replacement of contact lens	CH	S	0698	0.8696	$55.39		$11.08
92340	Fitting of spectacles		E					
92341	Fitting of spectacles		E					
92342	Fitting of spectacles		E					
92352	Special spectacles fitting	CH	S	0698	0.8696	$55.39		$11.08
92353	Special spectacles fitting	CH	S	0230	0.5903	$37.60		$7.52
92354	Special spectacles fitting	CH	S	0230	0.5903	$37.60		$7.52
92355	Special spectacles fitting	CH	S	0230	0.5903	$37.60		$7.52
92358	Eye prosthesis service	CH	S	0230	0.5903	$37.60		$7.52
92370	Repair & adjust spectacles		E					
92371	Repair & adjust spectacles	CH	S	0230	0.5903	$37.60		$7.52
92499	Eye service or procedure		S	0230	0.5903	$37.60		$7.52
92502	Ear and throat examination		T	0251	2.5002	$159.25		$31.85
92504	Ear microscopy examination		N					
92506	Speech/hearing evaluation		A					
92507	Speech/hearing therapy		A					
92508	Speech/hearing therapy		A					
92511	Nasopharyngoscopy		T	0071	0.8224	$52.38	$11.20	$10.48
92512	Nasal function studies		X	0363	0.8067	$51.38	$17.10	$10.28
92516	Facial nerve function test		X	0660	1.4312	$91.16	$28.06	$18.23
92520	Laryngeal function studies		X	0660	1.4312	$91.16	$28.06	$18.23
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	0.8067	$51.38	$17.10	$10.28
92542	Positional nystagmus test		X	0363	0.8067	$51.38	$17.10	$10.28
92543	Caloric vestibular test		X	0660	1.4312	$91.16	$28.06	$18.23
92544	Optokinetic nystagmus test		X	0363	0.8067	$51.38	$17.10	$10.28
92545	Oscillating tracking test		X	0363	0.8067	$51.38	$17.10	$10.28
92546	Sinusoidal rotational test		X	0660	1.4312	$91.16	$28.06	$18.23
92547	Supplemental electrical test	CH	N					
92548	Posturography		X	0660	1.4312	$91.16	$28.06	$18.23
92551	Pure tone hearing test, air		E					
92552	Pure tone audiometry, air		X	0364	0.4490	$28.60	$7.06	$5.72
92553	Audiometry, air & bone		X	0365	1.2549	$79.93	$18.52	$15.99
92555	Speech threshold audiometry		X	0364	0.4490	$28.60	$7.06	$5.72
92556	Speech audiometry, complete		X	0364	0.4490	$28.60	$7.06	$5.72
92557	Comprehensive hearing test		X	0365	1.2549	$79.93	$18.52	$15.99
92559	Group audiometric testing		E					
92560	Bekesy audiometry, screen		E					
92561	Bekesy audiometry, diagnosis		X	0364	0.4490	$28.60	$7.06	$5.72
92562	Loudness balance test		X	0364	0.4490	$28.60	$7.06	$5.72
92563	Tone decay hearing test		X	0364	0.4490	$28.60	$7.06	$5.72
92564	Sisi hearing test		X	0364	0.4490	$28.60	$7.06	$5.72
92565	Stenger test, pure tone		X	0364	0.4490	$28.60	$7.06	$5.72
92567	Tympanometry		X	0364	0.4490	$28.60	$7.06	$5.72
92568	Acoustic refl threshold tst		X	0364	0.4490	$28.60	$7.06	$5.72
92569	Acoustic reflex decay test		X	0364	0.4490	$28.60	$7.06	$5.72
92571	Filtered speech hearing test		X	0364	0.4490	$28.60	$7.06	$5.72
92572	Staggered spondaic word test		X	0366	1.7624	$112.25	$25.79	$22.45
92575	Sensorineural acuity test		X	0364	0.4490	$28.60	$7.06	$5.72
92576	Synthetic sentence test		X	0364	0.4490	$28.60	$7.06	$5.72
92577	Stenger test, speech		X	0366	1.7624	$112.25	$25.79	$22.45
92579	Visual audiometry (vra)		X	0365	1.2549	$79.93	$18.52	$15.99
92582	Conditioning play audiometry		X	0365	1.2549	$79.93	$18.52	$15.99
92583	Select picture audiometry		X	0364	0.4490	$28.60	$7.06	$5.72
92584	Electrocochleography	CH	S	0216	2.6846	$170.99		$34.20
92585	Auditor evoke potent, compre		S	0216	2.6846	$170.99		$34.20
92586	Auditor evoke potent, limit		S	0218	1.1550	$73.57		$14.71
92587	Evoked auditory test		X	0363	0.8067	$51.38	$17.10	$10.28
92588	Evoked auditory test		X	0660	1.4312	$91.16	$28.06	$18.23
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	0.4490	$28.60	$7.06	$5.72
92597	Oral speech device eval		A					
92601	Cochlear implt f/up exam < 7		X	0366	1.7624	$112.25	$25.79	$22.45
92602	Reprogram cochlear implt < 7		X	0366	1.7624	$112.25	$25.79	$22.45
92603	Cochlear implt f/up exam 7 >		X	0366	1.7624	$112.25	$25.79	$22.45
92604	Reprogram cochlear implt 7 >		X	0366	1.7624	$112.25	$25.79	$22.45
92605	Eval for nonspeech device rx		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	1.2549	$79.93	$18.52	$15.99
92621	Auditory function, + 15 min		N					
92625	Tinnitus assessment		X	0365	1.2549	$79.93	$18.52	$15.99
92626	Eval aud rehab status		X	0365	1.2549	$79.93	$18.52	$15.99
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	1.2549	$79.93	$18.52	$15.99
92700	Ent procedure/service		X	0364	0.4490	$28.60	$7.06	$5.72
92950	Heart/lung resuscitation cpr		S	0094	2.4590	$156.62	$46.29	$31.32
92953	Temporary external pacing		S	0094	2.4590	$156.62	$46.29	$31.32
92960	Cardioversion electric, ext		S	0679	5.4502	$347.15	$95.30	$69.43
92961	Cardioversion, electric, int		S	0679	5.4502	$347.15	$95.30	$69.43
92970	Cardioassist, internal		C					
92971	Cardioassist, external		C					
92973	Percut coronary thrombectomy		T	0088	38.7673	$2,469.24	$655.22	$493.85
92974	Cath place, cardio brachytx		T	0103	14.6576	$933.60		$186.72
92975	Dissolve clot, heart vessel		C					
92977	Dissolve clot, heart vessel		T	0676	2.4824	$158.11		$31.62
92978	Intravasc us, heart add-on	CH	N					
92979	Intravasc us, heart add-on	CH	N					
92980	Insert intracoronary stent		T	0104	89.0159	$5,669.78		$1,133.96
92981	Insert intracoronary stent		T	0104	89.0159	$5,669.78		$1,133.96
92982	Coronary artery dilation		T	0083	45.3845	$2,890.72		$578.14
92984	Coronary artery dilation		T	0083	45.3845	$2,890.72		$578.14
92986	Revision of aortic valve		T	0083	45.3845	$2,890.72		$578.14
92987	Revision of mitral valve		T	0083	45.3845	$2,890.72		$578.14
92990	Revision of pulmonary valve		T	0083	45.3845	$2,890.72		$578.14
92992	Revision of heart chamber		C					
92993	Revision of heart chamber		C					
92995	Coronary atherectomy		T	0082	87.5137	$5,574.10		$1,114.82
92996	Coronary atherectomy add-on		T	0082	87.5137	$5,574.10		$1,114.82
92997	Pul art balloon repr, percut	CH	T	0083	45.3845	$2,890.72		$578.14
92998	Pul art balloon repr, percut	CH	T	0083	45.3845	$2,890.72		$578.14
93000	Electrocardiogram, complete		B					
93005	Electrocardiogram, tracing		S	0099	0.3892	$24.79		$4.96
93010	Electrocardiogram report		B					
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	2.5547	$162.72	$41.44	$32.54
93018	Cardiovascular stress test		B					
93024	Cardiac drug stress test		X	0100	2.5547	$162.72	$41.44	$32.54
93025	Microvolt t-wave assess		X	0100	2.5547	$162.72	$41.44	$32.54
93040	Rhythm ECG with report		B					
93041	Rhythm ECG, tracing		S	0099	0.3892	$24.79		$4.96
93042	Rhythm ECG, report		B					
93224	ECG monitor/report, 24 hrs		B					
93225	ECG monitor/record, 24 hrs		X	0097	1.0015	$63.79	$23.79	$12.76
93226	ECG monitor/report, 24 hrs		X	0097	1.0015	$63.79	$23.79	$12.76
93227	ECG monitor/review, 24 hrs		B					
93230	ECG monitor/report, 24 hrs		B					
93231	Ecg monitor/record, 24 hrs		X	0097	1.0015	$63.79	$23.79	$12.76
93232	ECG monitor/report, 24 hrs		X	0097	1.0015	$63.79	$23.79	$12.76
93233	ECG monitor/review, 24 hrs		B					
93235	ECG monitor/report, 24 hrs		B					
93236	ECG monitor/report, 24 hrs		X	0097	1.0015	$63.79	$23.79	$12.76
93237	ECG monitor/review, 24 hrs		B					
93268	ECG record/review		B					
93270	ECG recording		X	0097	1.0015	$63.79	$23.79	$12.76
93271	Ecg/monitoring and analysis	CH	S	0663	1.5313	$97.53		$19.51
93272	Ecg/review, interpret only		B					
93278	ECG/signal-averaged	CH	X	0340	0.6310	$40.19		$8.04
93303	Echo transthoracic		S	0269	6.3751	$406.06		$81.21
93304	Echo transthoracic		S	0697	3.3401	$212.74		$42.55
93307	Echo exam of heart		S	0269	6.3751	$406.06		$81.21
93308	Echo exam of heart		S	0697	3.3401	$212.74		$42.55

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
93312	Echo transesophageal		S	0270	8.2165	$523.34	$141.32	$104.67
93313	Echo transesophageal		S	0270	8.2165	$523.34	$141.32	$104.67
93314	Echo transesophageal		N					
93315	Echo transesophageal		S	0270	8.2165	$523.34	$141.32	$104.67
93316	Echo transesophageal		S	0270	8.2165	$523.34	$141.32	$104.67
93317	Echo transesophageal		N					
93318	Echo transesophageal intraop		S	0270	8.2165	$523.34	$141.32	$104.67
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		S	0269	6.3751	$406.06		$81.21
93501	Right heart catheterization		T	0080	38.9204	$2,479.00	$838.92	$495.80
93503	Insert/place heart catheter		T	0103	14.6576	$933.60		$186.72
93505	Biopsy of heart lining		T	0103	14.6576	$933.60		$186.72
93508	Cath placement, angiography		T	0080	38.9204	$2,479.00	$838.92	$495.80
93510	Left heart catheterization		T	0080	38.9204	$2,479.00	$838.92	$495.80
93511	Left heart catheterization		T	0080	38.9204	$2,479.00	$838.92	$495.80
93514	Left heart catheterization		T	0080	38.9204	$2,479.00	$838.92	$495.80
93524	Left heart catheterization		T	0080	38.9204	$2,479.00	$838.92	$495.80
93526	Rt & Lt heart catheters		T	0080	38.9204	$2,479.00	$838.92	$495.80
93527	Rt & Lt heart catheters		T	0080	38.9204	$2,479.00	$838.92	$495.80
93528	Rt & Lt heart catheters		T	0080	38.9204	$2,479.00	$838.92	$495.80
93529	Rt, lt heart catheterization		T	0080	38.9204	$2,479.00	$838.92	$495.80
93530	Rt heart cath, congenital		T	0080	38.9204	$2,479.00	$838.92	$495.80
93531	R & l heart cath, congenital		T	0080	38.9204	$2,479.00	$838.92	$495.80
93532	R & l heart cath, congenital		T	0080	38.9204	$2,479.00	$838.92	$495.80
93533	R & l heart cath, congenital		T	0080	38.9204	$2,479.00	$838.92	$495.80
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	132.4129	$8,433.91		$1,686.78
93581	Transcath closure of vsd		T	0434	132.4129	$8,433.91		$1,686.78
93600	Bundle of His recording	CH	S	0084	9.5834	$610.41		$122.08
93602	Intra-atrial recording	CH	S	0084	9.5834	$610.41		$122.08
93603	Right ventricular recording	CH	S	0084	9.5834	$610.41		$122.08
93609	Map tachycardia, add-on	CH	N					
93610	Intra-atrial pacing	CH	S	0084	9.5834	$610.41		$122.08
93612	Intraventricular pacing	CH	S	0084	9.5834	$610.41		$122.08
93613	Electrophys map 3d, add-on	CH	N					
93615	Esophageal recording	CH	S	0084	9.5834	$610.41		$122.08
93616	Esophageal recording	CH	S	0084	9.5834	$610.41		$122.08
93618	Heart rhythm pacing	CH	S	0084	9.5834	$610.41		$122.08
93619	Electrophysiology evaluation	CH	Q	0085	47.2949	$3,012.40		$602.48
93620	Electrophysiology evaluation	CH	Q	0085	47.2949	$3,012.40		$602.48
93621	Electrophysiology evaluation	CH	N					
93622	Electrophysiology evaluation	CH	N					
93623	Stimulation, pacing heart	CH	N					
93624	Electrophysiologic study		T	0085	47.2949	$3,012.40		$602.48
93631	Heart pacing, mapping	CH	N					
93640	Evaluation heart device		N					
93641	Electrophysiology evaluation		N					
93642	Electrophysiology evaluation		S	0084	9.5834	$610.41		$122.08
93650	Ablate heart dysrhythm focus	CH	Q	0085	47.2949	$3,012.40		$602.48
93651	Ablate heart dysrhythm focus	CH	Q	0086	92.8564	$5,914.40		$1,182.88
93652	Ablate heart dysrhythm focus	CH	Q	0086	92.8564	$5,914.40		$1,182.88
93660	Tilt table evaluation		S	0101	4.1973	$267.34	$100.24	$53.47
93662	Intracardiac ecg (ice)	CH	N					
93668	Peripheral vascular rehab		E					
93701	Bioimpedance, thoracic		S	0099	0.3892	$24.79		$4.96
93720	Total body plethysmography		B					
93721	Plethysmography tracing		X	0368	0.9253	$58.94	$22.77	$11.79
93722	Plethysmography report		B					
93724	Analyze pacemaker system		S	0690	0.3504	$22.32	$8.67	$4.46
93727	Analyze ilr system		S	0690	0.3504	$22.32	$8.67	$4.46
93731	Analyze pacemaker system		S	0690	0.3504	$22.32	$8.67	$4.46
93732	Analyze pacemaker system		S	0690	0.3504	$22.32	$8.67	$4.46
93733	Telephone analy, pacemaker		S	0690	0.3504	$22.32	$8.67	$4.46
93734	Analyze pacemaker system		S	0690	0.3504	$22.32	$8.67	$4.46
93735	Analyze pacemaker system		S	0690	0.3504	$22.32	$8.67	$4.46
93736	Telephonic analy, pacemaker		S	0690	0.3504	$22.32	$8.67	$4.46

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
93740	Temperature gradient studies		X	0368	0.9253	$58.94	$22.77	$11.79
93741	Analyze ht pace device sngl		S	0689	0.5946	$37.87		$7.57
93742	Analyze ht pace device sngl		S	0689	0.5946	$37.87		$7.57
93743	Analyze ht pace device dual		S	0689	0.5946	$37.87		$7.57
93744	Analyze ht pace device dual		S	0689	0.5946	$37.87		$7.57
93745	Set-up cardiovert-defibrill		S	0689	0.5946	$37.87		$7.57
93760	Cephalic thermogram		E					
93762	Peripheral thermogram		E					
93770	Measure venous pressure		N					
93784	Ambulatory BP monitoring		E					
93786	Ambulatory BP recording		X	0097	1.0015	$63.79	$23.79	$12.76
93788	Ambulatory BP analysis		X	0097	1.0015	$63.79	$23.79	$12.76
93790	Review/report BP recording		B					
93797	Cardiac rehab		S	0095	0.5685	$36.21	$13.86	$7.24
93798	Cardiac rehab/monitor		S	0095	0.5685	$36.21	$13.86	$7.24
93799	Cardiovascular procedure		X	0097	1.0015	$63.79	$23.79	$12.76
93875	Extracranial study		S	0096	1.4689	$93.56	$37.42	$18.71
93880	Extracranial study		S	0267	2.3792	$151.54	$60.50	$30.31
93882	Extracranial study		S	0267	2.3792	$151.54	$60.50	$30.31
93886	Intracranial study		S	0267	2.3792	$151.54	$60.50	$30.31
93888	Intracranial study		S	0265	0.9570	$60.96	$22.35	$12.19
93890	Tcd, vasoreactivity study		S	0266	1.5094	$96.14	$37.80	$19.23
93892	Tcd, emboli detect w/o inj		S	0266	1.5094	$96.14	$37.80	$19.23
93893	Tcd, emboli detect w/inj		S	0266	1.5094	$96.14	$37.80	$19.23
93922	Extremity study		S	0096	1.4689	$93.56	$37.42	$18.71
93923	Extremity study		S	0096	1.4689	$93.56	$37.42	$18.71
93924	Extremity study		S	0096	1.4689	$93.56	$37.42	$18.71
93925	Lower extremity study		S	0267	2.3792	$151.54	$60.50	$30.31
93926	Lower extremity study		S	0266	1.5094	$96.14	$37.80	$19.23
93930	Upper extremity study		S	0267	2.3792	$151.54	$60.50	$30.31
93931	Upper extremity study		S	0266	1.5094	$96.14	$37.80	$19.23
93965	Extremity study		S	0096	1.4689	$93.56	$37.42	$18.71
93970	Extremity study		S	0267	2.3792	$151.54	$60.50	$30.31
93971	Extremity study		S	0266	1.5094	$96.14	$37.80	$19.23
93975	Vascular study		S	0267	2.3792	$151.54	$60.50	$30.31
93976	Vascular study		S	0267	2.3792	$151.54	$60.50	$30.31
93978	Vascular study	CH	S	0267	2.3792	$151.54	$60.50	$30.31
93979	Vascular study		S	0266	1.5094	$96.14	$37.80	$19.23
93980	Penile vascular study		S	0267	2.3792	$151.54	$60.50	$30.31
93981	Penile vascular study	CH	S	0267	2.3792	$151.54	$60.50	$30.31
93982	Aneurysm pressure sens study	NI	X	0097	1.0015	$63.79	$23.79	$12.76
93990	Doppler flow testing		S	0266	1.5094	$96.14	$37.80	$19.23
94002	Vent mgmt inpat, init day		S	0079	2.4783	$157.85		$31.57
94003	Vent mgmt inpat, subq day		S	0079	2.4783	$157.85		$31.57
94004	Vent mgmt nf per day		B					
94005	Home vent mgmt supervision		B					
94010	Breathing capacity test		X	0368	0.9253	$58.94	$22.77	$11.79
94014	Patient recorded spirometry		X	0367	0.5677	$36.16	$13.76	$7.23
94015	Patient recorded spirometry		X	0367	0.5677	$36.16	$13.76	$7.23
94016	Review patient spirometry		A					
94060	Evaluation of wheezing		X	0368	0.9253	$58.94	$22.77	$11.79
94070	Evaluation of wheezing		X	0369	2.7550	$175.48	$44.18	$35.10
94150	Vital capacity test		X	0367	0.5677	$36.16	$13.76	$7.23
94200	Lung function test (MBC/MVV)		X	0367	0.5677	$36.16	$13.76	$7.23
94240	Residual lung capacity		X	0368	0.9253	$58.94	$22.77	$11.79
94250	Expired gas collection		X	0367	0.5677	$36.16	$13.76	$7.23
94260	Thoracic gas volume		X	0368	0.9253	$58.94	$22.77	$11.79
94350	Lung nitrogen washout curve		X	0368	0.9253	$58.94	$22.77	$11.79
94360	Measure airflow resistance		X	0367	0.5677	$36.16	$13.76	$7.23
94370	Breath airway closing volume		X	0367	0.5677	$36.16	$13.76	$7.23
94375	Respiratory flow volume loop	CH	X	0368	0.9253	$58.94	$22.77	$11.79
94400	CO2 breathing response curve		X	0367	0.5677	$36.16	$13.76	$7.23
94450	Hypoxia response curve		X	0368	0.9253	$58.94	$22.77	$11.79
94452	Hast w/report		X	0368	0.9253	$58.94	$22.77	$11.79
94453	Hast w/oxygen titrate		X	0367	0.5677	$36.16	$13.76	$7.23
94610	Surfactant admin thru tube		S	0077	0.3877	$24.69	$7.74	$4.94
94620	Pulmonary stress test/simple		X	0368	0.9253	$58.94	$22.77	$11.79
94621	Pulm stress test/complex		X	0369	2.7550	$175.48	$44.18	$35.10
94640	Airway inhalation treatment		S	0077	0.3877	$24.69	$7.74	$4.94
94642	Aerosol inhalation treatment		S	0078	1.3362	$85.11		$17.02
94644	Cbt, 1st hour		S	0078	1.3362	$85.11		$17.02
94645	Cbt, each addl hour		S	0078	1.3362	$85.11		$17.02
94660	Pos airway pressure, CPAP	CH	S	0078	1.3362	$85.11		$17.02
94662	Neg press ventilation, cnp		S	0079	2.4783	$157.85		$31.57
94664	Evaluate pt use of inhaler		S	0077	0.3877	$24.69	$7.74	$4.94
94667	Chest wall manipulation		S	0077	0.3877	$24.69	$7.74	$4.94
94668	Chest wall manipulation		S	0077	0.3877	$24.69	$7.74	$4.94
94680	Exhaled air analysis, o2	CH	X	0368	0.9253	$58.94	$22.77	$11.79
94681	Exhaled air analysis, o2/co2		X	0368	0.9253	$58.94	$22.77	$11.79
94690	Exhaled air analysis		X	0367	0.5677	$36.16	$13.76	$7.23

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
94720	Monoxide diffusing capacity		X	0368	0.9253	$58.94	$22.77	$11.79
94725	Membrane diffusion capacity		X	0368	0.9253	$58.94	$22.77	$11.79
94750	Pulmonary compliance study	CH	X	0368	0.9253	$58.94	$22.77	$11.79
94760	Measure blood oxygen level		N					
94761	Measure blood oxygen level		N					
94762	Measure blood oxygen level	CH	Q	0097	1.0015	$63.79	$23.79	$12.76
94770	Exhaled carbon dioxide test		X	0367	0.5677	$36.16	$13.76	$7.23
94772	Breath recording, infant		X	0369	2.7550	$175.48	$44.18	$35.10
94774	Ped home apnea rec, compl		B					
94775	Ped home apnea rec, hk-up		X	0097	1.0015	$63.79	$23.79	$12.76
94776	Ped home apnea rec, downld		X	0097	1.0015	$63.79	$23.79	$12.76
94777	Ped home apnea rec, report		B					
94799	Pulmonary service/procedure		X	0367	0.5677	$36.16	$13.76	$7.23
95004	Percut allergy skin tests		X	0381	0.2773	$17.66		$3.53
95010	Percut allergy titrate test		X	0381	0.2773	$17.66		$3.53
95012	Exhaled nitric oxide meas		X	0367	0.5677	$36.16	$13.76	$7.23
95015	Id allergy titrate-drug/bug		X	0381	0.2773	$17.66		$3.53
95024	Id allergy test, drug/bug		X	0381	0.2773	$17.66		$3.53
95027	Id allergy titrate-airborne		X	0381	0.2773	$17.66		$3.53
95028	Id allergy test-delayed type		X	0381	0.2773	$17.66		$3.53
95044	Allergy patch tests		X	0381	0.2773	$17.66		$3.53
95052	Photo patch test		X	0381	0.2773	$17.66		$3.53
95056	Photosensitivity tests		X	0370	1.0430	$66.43		$13.29
95060	Eye allergy tests		X	0370	1.0430	$66.43		$13.29
95065	Nose allergy test		X	0381	0.2773	$17.66		$3.53
95070	Bronchial allergy tests		X	0369	2.7550	$175.48	$44.18	$35.10
95071	Bronchial allergy tests		X	0369	2.7550	$175.48	$44.18	$35.10
95075	Ingestion challenge test		X	0361	3.9276	$250.16	$83.23	$50.03
95115	Immunotherapy, one injection		S	0436	0.2545	$16.21		$3.24
95117	Immunotherapy injections		S	0437	0.3945	$25.13		$5.03
95120	Immunotherapy, one injection	CH	E					
95125	Immunotherapy, many antigens	CH	E					
95130	Immunotherapy, insect venom	CH	E					
95131	Immunotherapy, insect venoms	CH	E					
95132	Immunotherapy, insect venoms	CH	E					
95133	Immunotherapy, insect venoms	CH	E					
95134	Immunotherapy, insect venoms	CH	E					
95144	Antigen therapy services		S	0437	0.3945	$25.13		$5.03
95145	Antigen therapy services		S	0437	0.3945	$25.13		$5.03
95146	Antigen therapy services		S	0437	0.3945	$25.13		$5.03
95147	Antigen therapy services		S	0437	0.3945	$25.13		$5.03
95148	Antigen therapy services		S	0437	0.3945	$25.13		$5.03
95149	Antigen therapy services		S	0437	0.3945	$25.13		$5.03
95165	Antigen therapy services		S	0437	0.3945	$25.13		$5.03
95170	Antigen therapy services		S	0437	0.3945	$25.13		$5.03
95180	Rapid desensitization		X	0370	1.0430	$66.43		$13.29
95199	Allergy immunology services		X	0381	0.2773	$17.66		$3.53
95250	Glucose monitoring, cont	CH	V	0607	1.6604	$105.76		$21.15
95251	Gluc monitor, cont, phys i&r		B					
95805	Multiple sleep latency test		S	0209	11.2822	$718.61	$268.73	$143.72
95806	Sleep study, unattended		S	0213	2.2980	$146.37	$53.58	$29.27
95807	Sleep study, attended		S	0209	11.2822	$718.61	$268.73	$143.72
95808	Polysomnography, 1–3		S	0209	11.2822	$718.61	$268.73	$143.72
95810	Polysomnography, 4 or more		S	0209	11.2822	$718.61	$268.73	$143.72
95811	Polysomnography w/cpap		S	0209	11.2822	$718.61	$268.73	$143.72
95812	Eeg, 41–60 minutes		S	0213	2.2980	$146.37	$53.58	$29.27
95813	Eeg, over 1 hour		S	0213	2.2980	$146.37	$53.58	$29.27
95816	Eeg, awake and drowsy		S	0213	2.2980	$146.37	$53.58	$29.27
95819	Eeg, awake and asleep		S	0213	2.2980	$146.37	$53.58	$29.27
95822	Eeg, coma or sleep only		S	0213	2.2980	$146.37	$53.58	$29.27
95824	Eeg, cerebral death only	CH	S	0216	2.6846	$170.99		$34.20
95827	Eeg, all night recording		S	0213	2.2980	$146.37	$53.58	$29.27
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	1.1550	$73.57		$14.71
95860	Muscle test, one limb		S	0218	1.1550	$73.57		$14.71
95861	Muscle test, 2 limbs		S	0218	1.1550	$73.57		$14.71
95863	Muscle test, 3 limbs		S	0218	1.1550	$73.57		$14.71
95864	Muscle test, 4 limbs		S	0218	1.1550	$73.57		$14.71
95865	Muscle test, larynx		S	0218	1.1550	$73.57		$14.71
95866	Muscle test, hemidiaphragm		S	0218	1.1550	$73.57		$14.71
95867	Muscle test cran nerv unilat		S	0218	1.1550	$73.57		$14.71
95868	Muscle test cran nerve bilat		S	0218	1.1550	$73.57		$14.71
95869	Muscle test, thor paraspinal	CH	S	0218	1.1550	$73.57		$14.71

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
95870	Muscle test, nonparaspinal		S	0215	0.5804	$36.97		$7.39
95872	Muscle test, one fiber		S	0218	1.1550	$73.57		$14.71
95873	Guide nerv destr, elec stim	CH	N					
95874	Guide nerv destr, needle emg	CH	N					
95875	Limb exercise test		S	0215	0.5804	$36.97		$7.39
95900	Motor nerve conduction test		S	0215	0.5804	$36.97		$7.39
95903	Motor nerve conduction test		S	0215	0.5804	$36.97		$7.39
95904	Sense nerve conduction test		S	0215	0.5804	$36.97		$7.39
95920	Intraop nerve test add-on	CH	N					
95921	Autonomic nerv function test	CH	S	0218	1.1550	$73.57		$14.71
95922	Autonomic nerv function test	CH	S	0218	1.1550	$73.57		$14.71
95923	Autonomic nerv function test	CH	S	0218	1.1550	$73.57		$14.71
95925	Somatosensory testing		S	0216	2.6846	$170.99		$34.20
95926	Somatosensory testing		S	0216	2.6846	$170.99		$34.20
95927	Somatosensory testing		S	0216	2.6846	$170.99		$34.20
95928	C motor evoked, uppr limbs		S	0218	1.1550	$73.57		$14.71
95929	C motor evoked, lwr limbs		S	0218	1.1550	$73.57		$14.71
95930	Visual evoked potential test		S	0216	2.6846	$170.99		$34.20
95933	Blink reflex test		S	0215	0.5804	$36.97		$7.39
95934	H-reflex test		S	0215	0.5804	$36.97		$7.39
95936	H-reflex test		S	0215	0.5804	$36.97		$7.39
95937	Neuromuscular junction test	CH	S	0218	1.1550	$73.57		$14.71
95950	Ambulatory eeg monitoring		S	0209	11.2822	$718.61	$268.73	$143.72
95951	EEG monitoring/videorecord		S	0209	11.2822	$718.61	$268.73	$143.72
95953	EEG monitoring/computer		S	0209	11.2822	$718.61	$268.73	$143.72
95954	EEG monitoring/giving drugs	CH	S	0218	1.1550	$73.57		$14.71
95955	EEG during surgery	CH	N					
95956	Eeg monitoring, cable/radio		S	0209	11.2822	$718.61	$268.73	$143.72
95957	EEG digital analysis	CH	N					
95958	EEG monitoring/function test		S	0213	2.2980	$146.37	$53.58	$29.27
95961	Electrode stimulation, brain		S	0216	2.6846	$170.99		$34.20
95962	Electrode stim, brain add-on		S	0216	2.6846	$170.99		$34.20
95965	Meg, spontaneous	CH	S	0067	61.6965	$3,929.70		$785.94
95966	Meg, evoked, single	CH	S	0065	16.5911	$1,056.75		$211.35
95967	Meg, evoked, each add'l	CH	S	0065	16.5911	$1,056.75		$211.35
95970	Analyze neurostim, no prog		S	0218	1.1550	$73.57		$14.71
95971	Analyze neurostim, simple		S	0692	1.8376	$117.04	$29.72	$23.41
95972	Analyze neurostim, complex	CH	S	0663	1.5313	$97.53		$19.51
95973	Analyze neurostim, complex		S	0663	1.5313	$97.53		$19.51
95974	Cranial neurostim, complex	CH	S	0663	1.5313	$97.53		$19.51
95975	Cranial neurostim, complex		S	0692	1.8376	$117.04	$29.72	$23.41
95978	Analyze neurostim brain/1h		S	0692	1.8376	$117.04	$29.72	$23.41
95979	Analyz neurostim brain addon		S	0663	1.5313	$97.53		$19.51
95980	Io anal gast n-stim init	NI	N					
95981	Io anal gast n-stim subsq	NI	S	0218	1.1550	$73.57		$14.71
95982	Io ga n-stim subsq w/reprog	NI	S	0692	1.8376	$117.04	$29.72	$23.41
95990	Spin/brain pump refil & main		T	0125	2.3544	$149.96		$29.99
95991	Spin/brain pump refil & main		T	0125	2.3544	$149.96		$29.99
95999	Neurological procedure		S	0215	0.5804	$36.97		$7.39
96000	Motion analysis, video/3d		S	0216	2.6846	$170.99		$34.20
96001	Motion test w/ft press meas		S	0216	2.6846	$170.99		$34.20
96002	Dynamic surface emg		S	0218	1.1550	$73.57		$14.71
96003	Dynamic fine wire emg		S	0215	0.5804	$36.97		$7.39
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	2.6169	$166.68		$33.34
96102	Psycho testing by technician	CH	Q	0382	2.6169	$166.68		$33.34
96103	Psycho testing admin by comp	CH	Q	0373	1.2448	$79.29		$15.86
96105	Assessment of aphasia		A					
96110	Developmental test, lim	CH	Q	0373	1.2448	$79.29		$15.86
96111	Developmental test, extend	CH	Q	0382	2.6169	$166.68		$33.34
96116	Neurobehavioral status exam	CH	Q	0382	2.6169	$166.68		$33.34
96118	Neuropsych tst by psych/phys	CH	Q	0382	2.6169	$166.68		$33.34
96119	Neuropsych testing by tec	CH	Q	0382	2.6169	$166.68		$33.34
96120	Neuropsych tst admin w/comp	CH	Q	0373	1.2448	$79.29		$15.86
96125	Cognitive test by hc pro	NI	A					
96150	Assess hlth/behave, init	CH	Q	0432	0.3128	$19.92		$3.98
96151	Assess hlth/behave, subseq	CH	Q	0432	0.3128	$19.92		$3.98
96152	Intervene hlth/behave, indiv	CH	Q	0432	0.3128	$19.92		$3.98
96153	Intervene hlth/behave, group	CH	Q	0432	0.3128	$19.92		$3.98
96154	Interv hlth/behav, fam w/pt	CH	Q	0432	0.3128	$19.92		$3.98
96155	Interv hlth/behav fam no pt		E					
96401	Chemo, anti-neopl, sq/im		S	0438	0.8041	$51.22		$10.24
96402	Chemo hormon antineopl sq/im		S	0438	0.8041	$51.22		$10.24
96405	Chemo intralesional, up to 7		S	0438	0.8041	$51.22		$10.24
96406	Chemo intralesional over 7		S	0438	0.8041	$51.22		$10.24
96409	Chemo, iv push, sngl drug		S	0439	1.6544	$105.38		$21.08
96411	Chemo, iv push, addl drug		S	0439	1.6544	$105.38		$21.08
96413	Chemo, iv infusion, 1 hr		S	0441	2.3446	$149.34		$29.87

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
96415	Chemo, iv infusion, addl hr		S	0438	0.8041	$51.22		$10.24
96416	Chemo prolong infuse w/pump		S	0441	2.3446	$149.34		$29.87
96417	Chemo iv infus each addl seq		S	0438	0.8041	$51.22		$10.24
96420	Chemo, ia, push tecnique		S	0439	1.6544	$105.38		$21.08
96422	Chemo ia infusion up to 1 hr		S	0441	2.3446	$149.34		$29.87
96423	Chemo ia infuse each addl hr		S	0438	0.8041	$51.22		$10.24
96425	Chemotherapy,infusion method		S	0441	2.3446	$149.34		$29.87
96440	Chemotherapy, intracavitary		S	0441	2.3446	$149.34		$29.87
96445	Chemotherapy, intracavitary		S	0441	2.3446	$149.34		$29.87
96450	Chemotherapy, into CNS		S	0441	2.3446	$149.34		$29.87
96521	Refill/maint, portable pump		S	0440	1.7998	$114.64		$22.93
96522	Refill/maint pump/resvr syst		S	0440	1.7998	$114.64		$22.93
96523	Irrig drug delivery device		Q	0624	0.5689	$36.24	$12.65	$7.25
96542	Chemotherapy injection		S	0438	0.8041	$51.22		$10.24
96549	Chemotherapy, unspecified		S	0436	0.2545	$16.21		$3.24
96567	Photodynamic tx, skin	CH	T	0013	0.7930	$50.51		$10.10
96570	Photodynamic tx, 30 min		T	0015	1.4595	$92.96		$18.59
96571	Photodynamic tx, addl 15 min		T	0015	1.4595	$92.96		$18.59
96900	Ultraviolet light therapy		S	0001	0.4806	$30.61	$7.00	$6.12
96902	Trichogram		N					
96904	Whole body photography		N					
96910	Photochemotherapy with UV-B		S	0001	0.4806	$30.61	$7.00	$6.12
96912	Photochemotherapy with UV-A		S	0001	0.4806	$30.61	$7.00	$6.12
96913	Photochemotherapy, UV-A or B		S	0683	2.6045	$165.89		$33.18
96920	Laser tx, skin < 250 sq cm	CH	T	0015	1.4595	$92.96		$18.59
96921	Laser tx, skin 250–500 sq cm	CH	T	0015	1.4595	$92.96		$18.59
96922	Laser tx, skin > 500 sq cm	CH	T	0015	1.4595	$92.96		$18.59
96999	Dermatological procedure	CH	T	0012	0.2963	$18.87		$3.77
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					
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	1.4595	$92.96		$18.59
97598	Active wound care > 20 cm	CH	T	0015	1.4595	$92.96		$18.59
97602	Wound(s) care non-selective	CH	T	0015	1.4595	$92.96		$18.59
97605	Neg press wound tx, < 50 cm	CH	T	0013	0.7930	$50.51		$10.10
97606	Neg press wound tx, > 50 cm	CH	T	0015	1.4595	$92.96		$18.59
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	0.4482	$28.55		$5.71
98926	Osteopathic manipulation		S	0060	0.4482	$28.55		$5.71
98927	Osteopathic manipulation		S	0060	0.4482	$28.55		$5.71
98928	Osteopathic manipulation		S	0060	0.4482	$28.55		$5.71
98929	Osteopathic manipulation		S	0060	0.4482	$28.55		$5.71
98940	Chiropractic manipulation		S	0060	0.4482	$28.55		$5.71
98941	Chiropractic manipulation		S	0060	0.4482	$28.55		$5.71
98942	Chiropractic manipulation		S	0060	0.4482	$28.55		$5.71
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					
98966	Hc pro phone call 5–10 min	NI	E					
98967	Hc pro phone call 11–20 min	NI	E					
98968	Hc pro phone call 21–30 min	NI	E					
98969	Online service by hc pro	NI	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					
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	0.1309	$8.34	$2.36	$1.67
99172	Ocular function screen		E					
99173	Visual acuity screen		E					
99174	Ocular photoscreening	NI	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	0.5689	$36.24	$12.65	$7.25
99199	Special service/proc/report		B					
99201	Office/outpatient visit, new		V	0604	0.8388	$53.43		$10.69
99202	Office/outpatient visit, new		V	0605	0.9964	$63.46		$12.69
99203	Office/outpatient visit, new		V	0606	1.3226	$84.24		$16.85
99204	Office/outpatient visit, new		V	0607	1.6604	$105.76		$21.15
99205	Office/outpatient visit, new	CH	Q	0608	2.1740	$138.47		$27.69
99211	Office/outpatient visit, est		V	0604	0.8388	$53.43		$10.69
99212	Office/outpatient visit, est		V	0605	0.9964	$63.46		$12.69
99213	Office/outpatient visit, est		V	0605	0.9964	$63.46		$12.69
99214	Office/outpatient visit, est		V	0606	1.3226	$84.24		$16.85
99215	Office/outpatient visit, est	CH	Q	0607	1.6604	$105.76		$21.15
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	0.7970	$50.76	$12.70	$10.15
99282	Emergency dept visit		V	0613	1.3137	$83.67	$21.06	$16.73
99283	Emergency dept visit		V	0614	2.0750	$132.17	$34.50	$26.43
99284	Emergency dept visit	CH	Q	0615	3.3377	$212.59	$48.49	$42.52
99285	Emergency dept visit	CH	Q	0616	4.9535	$315.51	$72.86	$63.10
99288	Direct advanced life support		B					
99289	Ped crit care transport		N					
99290	Ped crit care transport addl		N					
99291	Critical care, first hour	CH	Q	0617	7.3166	$466.02	$111.59	$93.20
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					
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	CH	D					
99362	Physician/team conference	CH	D					
99363	Anticoag mgmt, init		B					
99364	Anticoag mgmt, subseq		B					
99366	Team conf w/pat by hc pro	NI	N					
99367	Team conf w/o pat by phys	NI	N					
99368	Team conf w/o pat by hc pro	NI	N					
99371	Physician phone consultation	CH	D					
99372	Physician phone consultation	CH	D					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
99373	Physician phone consultation	CH	D					
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					
99406	Behav chng smoking 3–10 min	NI	X	0031	0.1648	$10.50		$2.10
99407	Behav chng smoking < 10 min	NI	X	0031	0.1648	$10.50		$2.10
99408	Audit/dast, 15–30 min	NI	E					
99409	Audit/dast, over 30 min	NI	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	0.9964	$63.46		$12.69
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	2.4590	$156.62	$46.29	$31.32
99441	Phone e/m by phys 5–10 min	NI	E					
99442	Phone e/m by phys 11–20 min	NI	E					
99443	Phone e/m by phys 21–30 min	NI	E					
99444	Online e/m by phys	NI	E					
99450	Basic life disability exam		E					
99455	Work related disability exam		B					
99456	Disability examination		B					
99477	Init day hosp neonate care	NI	C					
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					
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					
99605	Mtms by pharm, np, 15 min	NI	E					
99606	Mtms by pharm, est, 15 min	NI	E					
99607	Mtms by pharm, addl 15 min	NI	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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A0225	Neonatal emergency transport	CH	E					
A0380	Basic life support mileage	CH	E					
A0382	Basic support routine suppls		A					
A0384	Bls defibrillation supplies		A					
A0390	Advanced life support mileag	CH	E					
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					
A4252	Blood ketone test or strip	NI	E					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
A4648	Implantable tissue marker	NI	N					
A4649	Surgical supplies		A					
A4650	Implant radiation dosimeter	NI	N					
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					
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					
A5083	Stoma absorptive cover	NI	A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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		E					
A6201	Compos drsg >16<=48 no bdr		E					
A6202	Compos drsg >48 no border		E					
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					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
A6413	Adhesive bandage, first-aid	NI	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÷ <÷/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					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
A7027	Combination oral/nasal mask	NI	Y					
A7028	Repl oral cushion combo mask	NI	Y					
A7029	Repl nasal pillow comb mask	NI	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					
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					
A9155	Artificial saliva	NI	B					
A9180	Lice treatment, topical		E					
A9270	Non-covered item or service		E					
A9274	Ext amb insulin delivery sys	NI	E					
A9275	Disp home glucose monitor		E					
A9276	Disposable sensor, CGM sys	NI	E					
A9277	External transmitter, CGM	NI	E					
A9278	External receiver, CGM sys	NI	E					
A9279	Monitoring feature/deviceNOC		E					
A9280	Alert device, noc		E					
A9281	Reaching/grabbing device		E					
A9282	Wig any type		E					
A9283	Foot press off load supp dev	NI	E					
A9300	Exercise equipment		E					
A9500	Tc99m sestamibi	CH	N					
A9501	Technetium TC-99m teboroxime	NI	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					
A9509	Iodine I-123 sod iodide mil	NI	N					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A9510	Tc99m disofenin		N					
A9512	Tc99m pertechnetate		N					
A9516	Iodine I-123 sod iodide mic	CH	N					
A9517	I131 iodide cap, rx	CH	K	1064	0.2393	$15.24		$3.05
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	0.4325	$27.55		$5.51
A9528	Iodine I-131 iodide cap, dx	CH	N					
A9529	I131 iodide sol, dx		N					
A9530	I131 iodide sol, rx	CH	K	1150	0.1762	$11.22		$2.24
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	235.8764	$15,023.91		$3,004.78
A9544	I131 tositumomab, dx	CH	N					
A9545	I131 tositumomab, rx	CH	K	1645	176.8495	$11,264.25		$2,252.85
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	1.7835	$113.60		$22.72
A9564	P32 chromic phosphate	CH	K	1676	1.8711	$119.18		$23.84
A9565	In111 pentetreotide	CH	D					
A9566	Tc99m fanolesomab	CH	N					
A9567	Technetium TC-99m aerosol	CH	N					
A9568	Technetium tc99m arcitumomab	CH	N					
A9569	Technetium TC-99m auto WBC	NI	N					
A9570	Indium In-111 auto WBC	NI	N					
A9571	Indium IN-111 auto platelet	NI	N					
A9572	Indium In-111 pentetreotide	NI	N					
A9576	Inj prohance multipack	NI	N					
A9577	Inj multihance	NI	N					
A9578	Inj multihance multipack	NI	N					
A9579	Gad-base MR contrast NOS,1ml	NI	N					
A9600	Sr89 strontium	CH	K	0701	9.6094	$612.06		$122.41
A9605	Sm 153 lexidronm	CH	K	0702	21.3689	$1,361.07		$272.21
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					
B4082	Enteral ng tubing w/o stylet		Y					
B4083	Enteral stomach tube levine		Y					
B4086	Gastrostomy/jejunostomy tube	CH	D					
B4087	Gastro/jejuno tube, std	NI	A					
B4088	Gastro/jejuno tube, low-pro	NI	A					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	1.5579	$99.23		$19.85
C1713	Anchor/screw bn/bn,tis/bn		N					
C1714	Cath, trans atherectomy, dir		N					
C1715	Brachytherapy needle		N					
C1716	Brachytx, non-str, Gold-198	CH	K	1716	0.5228	$33.30		$6.66
C1717	Brachytx, non-str,HDR Ir-192	CH	K	1717	2.7505	$175.19		$35.04
C1719	Brachytx, NS, Non-HDRIr-192	CH	K	1719	1.0226	$65.13		$13.03
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					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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, non-str,Yttrium-90	CH	K	2616	184.7105	$11,764.95		$2,352.99
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					
C2634	Brachytx, non-str, HA, I-125	CH	K	2634	0.4858	$30.94		$6.19
C2635	Brachytx, non-str, HA, P-103	CH	K	2635	0.7366	$46.92		$9.38
C2636	Brachy linear, non-str,P-103	CH	K	2636	0.6600	$42.04		$8.41
C2637	Brachy,non-str,Ytterbium-169	CH	B					
C2638	Brachytx, stranded, I-125	NF	K	2638	0.7113	$45.31		$9.06
C2639	Brachytx, non-stranded,I-125	NF	K	2639	0.5039	$32.10		$6.42
C2640	Brachytx, stranded, P-103	NF	K	2640	1.0308	$65.66		$13.13
C2641	Brachytx, non-stranded,P-103	NF	K	2641	0.8077	$51.45		$10.29
C2642	Brachytx, stranded, C-131	NF	K	2642	1.5342	$97.72		$19.54
C2643	Brachytx, non-stranded,C-131	NF	K	2643	1.0060	$64.08		$12.82
C2698	Brachytx, stranded, NOS	NF	K	2698	0.7113	$45.31		$9.06
C2699	Brachytx, non-stranded, NOS	NF	K	2699	0.4858	$30.94		$6.19
C8900	MRA w/cont, abd		S	0284	6.2350	$397.13	$148.40	$79.43
C8901	MRA w/o cont, abd		S	0336	5.3933	$343.52	$137.40	$68.70
C8902	MRA w/o fol w/cont, abd		S	0337	8.2463	$525.24	$199.53	$105.05
C8903	MRI w/cont, breast, uni		S	0284	6.2350	$397.13	$148.40	$79.43
C8904	MRI w/o cont, breast, uni		S	0336	5.3933	$343.52	$137.40	$68.70
C8905	MRI w/o fol w/cont, brst, un		S	0337	8.2463	$525.24	$199.53	$105.05
C8906	MRI w/cont, breast, bi		S	0284	6.2350	$397.13	$148.40	$79.43
C8907	MRI w/o cont, breast, bi		S	0336	5.3933	$343.52	$137.40	$68.70
C8908	MRI w/o fol w/cont, breast,		S	0337	8.2463	$525.24	$199.53	$105.05
C8909	MRA w/cont, chest		S	0284	6.2350	$397.13	$148.40	$79.43
C8910	MRA w/o cont, chest		S	0336	5.3933	$343.52	$137.40	$68.70
C8911	MRA w/o fol w/cont, chest		S	0337	8.2463	$525.24	$199.53	$105.05

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
C8912	MRA w/cont, lwr ext		S	0284	6.2350	$397.13	$148.40	$79.43
C8913	MRA w/o cont, lwr ext		S	0336	5.3933	$343.52	$137.40	$68.70
C8914	MRA w/o fol w/cont, lwr ext		S	0337	8.2463	$525.24	$199.53	$105.05
C8918	MRA w/cont, pelvis		S	0284	6.2350	$397.13	$148.40	$79.43
C8919	MRA w/o cont, pelvis		S	0336	5.3933	$343.52	$137.40	$68.70
C8920	MRA w/o fol w/cont, pelvis		S	0337	8.2463	$525.24	$199.53	$105.05
C8921	Comp transtho echo w/contr	NI	S	0128	8.4896	$540.74	$216.29	$108.15
C8922	Limit transtho echo w/contr	NI	S	0128	8.4896	$540.74	$216.29	$108.15
C8923	2D com transtho echo w/contr	NI	S	0128	8.4896	$540.74	$216.29	$108.15
C8924	2D lim transtho echo w/contr	NI	S	0128	8.4896	$540.74	$216.29	$108.15
C8925	2D TEE w/contrast, int/rept	NI	S	0128	8.4896	$540.74	$216.29	$108.15
C8926	Cong TEE w/contr, int/rept	NI	S	0128	8.4896	$540.74	$216.29	$108.15
C8927	TEE w/contrast; monitor	NI	S	0128	8.4896	$540.74	$216.29	$108.15
C8928	2D transtho w/contr; stress	NI	S	0128	8.4896	$540.74	$216.29	$108.15
C8957	Prolonged IV inf, req pump		S	0441	2.3446	$149.34		$29.87
C9003	Palivizumab, per 50 mg		K	9003		$810.67		$162.13
C9113	Inj pantoprazole sodium, via		N					
C9121	Injection, argatroban		K	9121		$18.96		$3.79
C9232	Injection, idursulfase	CH	D					
C9233	Injection, ranibizumab	CH	D					
C9234	Inj, alglucosidase alfa	CH	D					
C9235	Injection, panitumumab	CH	D					
C9236	Injection, eculizumab	CH	D					
C9238	Inj, levetiracetam	NI	K	9238		$6.30		$1.26
C9239	Inj, temsirolimus	NI	G	1168		$48.41		$9.68
C9350	Porous collagen tube per cm	CH	D					
C9351	Acellular derm tissue percm2	CH	D					
C9352	Neuragen nerve guide, per cm	NI	G	9350		$482.56		$96.51
C9353	Neurawrap nerve protector,cm	NI	G	1169		$482.56		$96.51
C9399	Unclassified drugs or biolog		A					
C9716	Radiofrequency energy to anu		T	0150	30.1606	$1,921.05	$437.12	$384.21
C9723	Dyn IR Perf Img		S	1502		$75.00		$15.00
C9724	EPS gast cardia plic		T	0422	25.3233	$1,612.94	$448.81	$322.59
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
C9728	Place device/marker, non pro	NF	T	0156	3.0469	$194.07		$38.81
D0120	Periodic oral evaluation		E					
D0140	Limit oral eval problm focus		E					
D0145	Oral evaluation, pt < 3yrs		E					
D0150	Comprehensve oral evaluation		S	0330	9.1677	$583.93		$116.79
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	9.1677	$583.93		$116.79
D0250	Extraoral first film		S	0330	9.1677	$583.93		$116.79
D0260	Extraoral ea additional film		S	0330	9.1677	$583.93		$116.79
D0270	Dental bitewing single film		S	0330	9.1677	$583.93		$116.79
D0272	Dental bitewings two films		S	0330	9.1677	$583.93		$116.79
D0273	Bitewings - three films		E					
D0274	Dental bitewings four films		S	0330	9.1677	$583.93		$116.79
D0277	Vert bitewings-sev to eight		S	0330	9.1677	$583.93		$116.79
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	9.1677	$583.93		$116.79
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D0479	Tissue in-situ hybridization		B					
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	9.1677	$583.93		$116.79
D1515	Fixed bilat space maintainer		S	0330	9.1677	$583.93		$116.79
D1520	Remove unilat space maintain		S	0330	9.1677	$583.93		$116.79
D1525	Remove bilat space maintain		S	0330	9.1677	$583.93		$116.79
D1550	Recement space maintainer		S	0330	9.1677	$583.93		$116.79
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					
D2920	Dental recement crown		E					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
D2970	Temp crown (fractured tooth)		E					
D2971	Add proc construct new crown		E					
D2975	Coping		E					
D2980	Crown repair		E					
D2999	Dental unspec restorative pr		S	0330	9.1677	$583.93		$116.79
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	9.1677	$583.93		$116.79
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	9.1677	$583.93		$116.79
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	9.1677	$583.93		$116.79
D4261	Osseous surgl-3teethperquad		E					
D4263	Bone replce graft first site		S	0330	9.1677	$583.93		$116.79
D4264	Bone replce graft each add		S	0330	9.1677	$583.93		$116.79
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	9.1677	$583.93		$116.79
D4270	Pedicle soft tissue graft pr		S	0330	9.1677	$583.93		$116.79
D4271	Free soft tissue graft proc		S	0330	9.1677	$583.93		$116.79
D4273	Subepithelial tissue graft		S	0330	9.1677	$583.93		$116.79
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	9.1677	$583.93		$116.79
D4381	Localized delivery antimicro		S	0330	9.1677	$583.93		$116.79
D4910	Periodontal maint procedures		E					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	9.1677	$583.93		$116.79
D5912	Facial moulage complete		S	0330	9.1677	$583.93		$116.79
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					
D5954	Superimposed prosthesis		E					
D5955	Palatal lift prosthesis		E					
D5958	Intraoral con def inter plt		E					
D5959	Intraoral con def mod palat		E					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D5960	Modify speech aid prosthesis		E					
D5982	Surgical stent		E					
D5983	Radiation applicator		S	0330	9.1677	$583.93		$116.79
D5984	Radiation shield		S	0330	9.1677	$583.93		$116.79
D5985	Radiation cone locator		S	0330	9.1677	$583.93		$116.79
D5986	Fluoride applicator		E					
D5987	Commissure splint		S	0330	9.1677	$583.93		$116.79
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					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	9.1677	$583.93		$116.79
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	9.1677	$583.93		$116.79
D7140	Extraction erupted tooth/exr		S	0330	9.1677	$583.93		$116.79
D7210	Rem imp tooth w mucoper flp		S	0330	9.1677	$583.93		$116.79
D7220	Impact tooth remov soft tiss		S	0330	9.1677	$583.93		$116.79
D7230	Impact tooth remov part bony		S	0330	9.1677	$583.93		$116.79
D7240	Impact tooth remov comp bony		S	0330	9.1677	$583.93		$116.79
D7241	Impact tooth rem bony w/comp		S	0330	9.1677	$583.93		$116.79
D7250	Tooth root removal		S	0330	9.1677	$583.93		$116.79
D7260	Oral antral fistula closure		S	0330	9.1677	$583.93		$116.79
D7261	Primary closure sinus perf		S	0330	9.1677	$583.93		$116.79
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	9.1677	$583.93		$116.79
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					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	9.1677	$583.93		$116.79
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					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	9.1677	$583.93		$116.79
D9910	Dent appl desensitizing med		E					
D9911	Appl desensitizing resin		E					
D9920	Behavior management		E					
D9930	Treatment of complications		S	0330	9.1677	$583.93		$116.79
D9940	Dental occlusal guard		S	0330	9.1677	$583.93		$116.79
D9941	Fabrication athletic guard		E					
D9942	Repair/reline occlusal guard		E					
D9950	Occlusion analysis		S	0330	9.1677	$583.93		$116.79
D9951	Limited occlusal adjustment		S	0330	9.1677	$583.93		$116.79
D9952	Complete occlusal adjustment		S	0330	9.1677	$583.93		$116.79
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					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	CH	E					
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					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
E0328	Ped hospital bed, manual	NI	Y					
E0329	Ped hospital bed semi/elect	NI	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					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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 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					
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					
E0856	Cervic collar w air bladder	NI	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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	CH	E					
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					
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	CH	E					
E1086	Hemi-wheelchair detachable a	CH	E					
E1087	Wheelchair lightwt fixed arm		A					
E1088	Wheelchair lightweight det a		A					
E1089	Wheelchair lightwt fixed arm	CH	E					
E1090	Wheelchair lightweight det a	CH	E					
E1092	Wheelchair wide w/ leg rests		A					
E1093	Wheelchair wide w/ foot rest		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E1100	Whchr s-recl fxd arm leg res		A					
E1110	Wheelchair semi-recl detach		A					
E1130	Whlchr stand fxd arm ft rest	CH	E					
E1140	Wheelchair standard detach a	CH	E					
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	CH	E					
E1260	Wheelchair lightwt foot rest	CH	E					
E1270	Wheelchair lightweight leg r		A					
E1280	Whchr h-duty det arm leg res		A					
E1285	Wheelchair heavy duty fixed	CH	E					
E1290	Wheelchair hvy duty detach a	CH	E					
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					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
E2227	Gear reduction drive wheel	NI	Y					
E2228	Mwc acc, wheelchair brake	NI	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					
E2301	Pwr standing		Y					
E2310	Electro connect btw control		Y					
E2311	Electro connect btw 2 sys		Y					
E2312	Mini-prop remote joystick	NI	Y					
E2313	PWC harness, expand control	NI	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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
E2397	Pwc acc, lith-based battery	NI	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					
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	CH	D					
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	0.3945	$25.13		
G0009	Admin pneumococcal vaccine		S	0350	0.3945	$25.13		
G0010	Admin hepatitis b vaccine		B					
G0027	Semen analysis		A					
G0101	CA screen;pelvic/breast exam		V	0604	0.8388	$53.43		$10.69
G0102	Prostate ca screening; dre		N					
G0103	PSA screening		A					
G0104	CA screen;flexi sigmoidscope		S	0159	4.7010	$299.43		$74.86

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G0105	Colorectal scrn; hi risk ind		T	0158	7.8504	$500.02		$125.01
G0106	Colon CA screen;barium enema		S	0157	2.0651	$131.53		$26.31
G0108	Diab manage trn per indiv		A					
G0109	Diab manage trn ind/group		A					
G0117	Glaucoma scrn hgh risk direc	CH	S	0698	0.8696	$55.39		$11.08
G0118	Glaucoma scrn hgh risk direc		S	0230	0.5903	$37.60		$7.52
G0120	Colon ca scrn; barium enema		S	0157	2.0651	$131.53		$26.31
G0121	Colon ca scrn not hi rsk ind		T	0158	7.8504	$500.02		$125.01
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	0.7930	$50.51		$10.10
G0128	CORF skilled nursing service		B					
G0129	Partial hosp prog service		P	0033				
G0130	Single energy x-ray study		X	0260	0.6954	$44.29		$8.86
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	1.7187	$109.47		$21.89
G0168	Wound closure by adhesive		B					
G0173	Linear acc stereo radsur com		S	0067	61.6965	$3,929.70		$785.94
G0175	OPPS Service,sched team conf		V	0608	2.1740	$138.47		$27.69
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	4.1331	$263.25	$58.93	$52.65
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	0.3877	$24.69	$7.74	$4.94
G0238	Oth resp proc, indiv	CH	S	0077	0.3877	$24.69	$7.74	$4.94
G0239	Oth resp proc, group	CH	S	0077	0.3877	$24.69	$7.74	$4.94
G0245	Initial foot exam pt lops		V	0604	0.8388	$53.43		$10.69
G0246	Followup eval of foot pt lop		V	0605	0.9964	$63.46		$12.69
G0247	Routine footcare pt w lops	CH	T	0013	0.7930	$50.51		$10.10
G0248	Demonstrate use home inr mon	CH	V	0607	1.6604	$105.76		$21.15
G0249	Provide test material,equipm	CH	V	0607	1.6604	$105.76		$21.15
G0250	MD review interpret of test		M					
G0251	Linear acc based stero radio		S	0065	16.5911	$1,056.75		$211.35
G0252	PET imaging initial dx		E					
G0255	Current percep threshold tst		E					
G0257	Unsched dialysis ESRD pt hos		S	0170	6.5383	$416.45		$83.29
G0259	Inject for sacroiliac joint		N					
G0260	Inj for sacroiliac jt anesth	CH	T	0207	7.0546	$449.34		$89.87
G0265	Cryopresevation Freeze+stora	CH	D					
G0266	Thawing + expansion froz cel	CH	D					
G0267	Bone marrow or psc harvest	CH	D					
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	N					
G0289	Arthro, loose body + chondro		N					
G0290	Drug-eluting stents, single		T	0656	118.4265	$7,543.06		$1,508.61
G0291	Drug-eluting stents,each add		T	0656	118.4265	$7,543.06		$1,508.61
G0293	Non-cov surg proc,clin trial		X	0340	0.6310	$40.19		$8.04
G0294	Non-cov proc, clinical trial		X	0340	0.6310	$40.19		$8.04
G0295	Electromagnetic therapy onc		E					
G0297	Insert single chamber/cd	CH	D					
G0298	Insert dual chamber/cd	CH	D					
G0299	Inser/repos single icd+leads	CH	D					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G0300	Insert reposit lead dual+gen	CH	D					
G0302	Pre-op service LVRS complete	CH	S	0209	11.2822	$718.61	$268.73	$143.72
G0303	Pre-op service LVRS 10–15dos	CH	S	0209	11.2822	$718.61	$268.73	$143.72
G0304	Pre-op service LVRS 1–9 dos	CH	S	0213	2.2980	$146.37	$53.58	$29.27
G0305	Post op service LVRS min 6	CH	S	0213	2.2980	$146.37	$53.58	$29.27
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	0.5921	$37.71		$7.54
G0333	Dispense fee initial 30 day		M					
G0337	Hospice evaluation preelecti		B					
G0339	Robot lin-radsurg com, first		S	0067	61.6965	$3,929.70		$785.94
G0340	Robt lin-radsurg fractx 2–5		S	0066	45.0693	$2,870.64		$574.13
G0341	Percutaneous islet celltrans		C					
G0342	Laparoscopy islet cell trans		C					
G0343	Laparotomy islet cell transp		C					
G0344	Initial preventive exam		V	0605	0.9964	$63.46		$12.69
G0364	Bone marrow aspirate &biopsy		T	0002	1.1097	$70.68		$14.14
G0365	Vessel mapping hemo access		S	0267	2.3792	$151.54	$60.50	$30.31
G0366	EKG for initial prevent exam		B					
G0367	EKG tracing for initial prev		S	0099	0.3892	$24.79		$4.96
G0368	EKG interpret & report preve		M					
G0372	MD service required for PMD		M					
G0375	Smoke/tobacco counselng 3–10	CH	D					
G0376	Smoke/tobacco counseling >10	CH	D					
G0377	Administra Part D vaccine		S	0437	0.3945	$25.13		$5.03
G0378	Hospital observation per hr	CH	N					
G0379	Direct admit hospital observ	CH	Q	0604	0.8388	$53.43		$10.69
G0380	Lev 1 hosp type B ED visit		V	0604	0.8388	$53.43		$10.69
G0381	Lev 2 hosp type B ED visit		V	0605	0.9964	$63.46		$12.69
G0382	Lev 3 hosp type B ED visit		V	0606	1.3226	$84.24		$16.85
G0383	Lev 4 hosp type B ED visit		V	0607	1.6604	$105.76		$21.15
G0384	Lev 5 hosp type B ED visit		V	0608	2.1740	$138.47		$27.69
G0389	Ultrasound exam AAA screen		S	0266	1.5094	$96.14	$37.80	$19.23
G0390	Trauma Respons w/hosp criti		S	0618	5.1854	$330.28	$132.11	$66.06
G0392	AV fistula or graft arterial	CH	T	0083	45.3845	$2,890.72		$578.14
G0393	AV fistula or graft venous	CH	T	0083	45.3845	$2,890.72		$578.14
G0394	Blood occult test,colorectal		A					
G0396	Alcohol/subs interv 15–30mn	NI	S	0432	0.3128	$19.92		$3.98
G0397	Alcohol/subs interv >30 min	NI	S	0432	0.3128	$19.92		$3.98
G3001	Admin + supply, tositumomab		S	0442	27.4298	$1,747.11		$349.42
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					
G8159	Pt w/CABG w/o IMA		M					
G8162	Iso CABG pt w/o preop Bblock		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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G8184	HF/atrial fib pt inelig warf		M					
G8185	Osteoarth pt w/ assess pain		M					
G8186	Osteoarth pt inelig assess		M					
G8193	Antibio not doc prior surg		M					
G8196	Antibio not docum prior surg		M					
G8200	Cefazolin not docum prophy		M					
G8204	MD not doc order to d/c anti		M					
G8209	Clinician did not doc		M					
G8214	Clini not doc order VTE		M					
G8217	Pt not received DVT proph		M					
G8219	Received DVT proph day 2		M					
G8220	Pt not rec DVT proph day 2		M					
G8221	Pt inelig for DVT proph		M					
G8223	Pt not doc for presc antipla		M					
G8226	Pt no prescr anticoa at D/C		M					
G8231	Pt not doc for admin t-PA		M					
G8234	Pt not doc dysphagia screen		M					
G8238	Pt not doc to rec rehab serv		M					
G8240	Inter carotid stenosis30–99%		M					
G8243	Pt not doc MRI/CT w/o lesion		M					
G8246	Pt inelig hx w new/chg mole		M					
G8248	Pt w/one alarm symp not doc		M					
G8251	Pt not doc w/Barretts, endo		M					
G8254	Pt w/no doc order for barium		M					
G8257	Pt not doc rev meds D/C		M					
G8260	Pt not doc to have dec maker		M					
G8263	Pt not doc assess urinary in		M					
G8266	Pt not doc charc urin incon		M					
G8268	Pt not doc rec care urin inc		M					
G8271	Pt no doc screen fall		M					
G8274	Clini not doc pres/abs alarm		M					
G8276	Pt not doc mole change		M					
G8279	Pt not doc rec PE		M					
G8282	Pt not doc to rec couns		M					
G8285	Pt did not rec pres osteo		M					
G8289	Pt not doc rec Ca/Vit D		M					
G8293	COPD pt w/o spir results		M					
G8296	COPD pt not doc bronch ther		M					
G8298	Pt doc optic nerve eval		M					
G8299	Pt not doc optic nerv eval		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					
G8310	Pt not doc rec antiox		M					
G8314	Pt not doc to rec mac exam		M					
G8318	Pt doc not have visual func		M					
G8322	Pt not doc pre axial leng		M					
G8326	Pt not doc rec fundus exam		M					
G8330	Pt not doc rec dilated mac		M					
G8334	Doc of macular not giv MD		M					
G8338	Clin not doc pt test osteo		M					
G8341	Pt not doc for DEXA		M					
G8345	Pt not doc have DEXA		M					
G8351	Pt not doc ECG		M					
G8354	Pt not rec aspirin prior ER		M					
G8357	Pt not doc to have ECG		M					
G8360	Pt not doc vital signs recor		M					
G8362	Pt not doc 02 SAT assess		M					
G8365	Pt not doc mental status		M					
G8367	Pt not doc have empiric AB		M					
G8370	Asthma pt w survey not docum		M					
G8371	Chemother not rec stg3 colon		M					
G8372	Chemother rec stg 3 colon ca		M					
G8373	Chemo plan docum prior chemo		M					
G8374	Chemo plan not doc prior che		M					
G8375	CLL pt w/o doc flow cytometr		M					
G8376	Brst ca pt inelig tamoxifen		M					
G8377	MD doc colon ca pt inelig ch		M					
G8378	MD doc pt inelig rad therapy		M					
G8379	Radiat tx recom doc12mo ov		M					
G8380	Pt w stgIC-3Brst ca w/o tam		M					
G8381	Pt w stgIC-3Brst ca rec tam		M					
G8382	MM pt w/o doc IV bisphophon		M					
G8383	Radiation rec not doc 12 mo		M					
G8384	MDS pt w/o base cytogen test		M					
G8385	Diab pt w nodoc Hgb A1c 12m		M					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G8386	Diab pt w nodoc LDL 12m		M					
G8387	ESRD pt w Hct/Hgb not docume		M					
G8388	ESRD pt w URR/Ktv not doc el		M					
G8389	MDS pt no doc Fe prior EPO		M					
G8390	Diabetic w/o document BP 12m		M					
G8391	Pt w asthma no doc med or tx		M					
G8395	LVEF>=40% doc normal or mild	NI	M					
G8396	LVEF not performed	NI	M					
G8397	Dil macula/fundus exam/w doc	NI	M					
G8398	Dil macular/fundus not perfo	NI	M					
G8399	Pt w/DXA document or order	NI	M					
G8400	Pt w/DXA no document or orde	NI	M					
G8401	Pt inelig osteo screen measu	NI	M					
G8402	Smoke preven interven counse	NI	M					
G8403	Smoke preven nocounsel	NI	M					
G8404	Low extemity neur exam docum	NI	M					
G8405	Low extemity neur not perfor	NI	M					
G8406	Pt inelig lower extrem neuro	NI	M					
G8407	ABI documented	NI	M					
G8408	ABI not documented	NI	M					
G8409	Pt inelig for ABI measure	NI	M					
G8410	Eval on foot documented	NI	M					
G8415	Eval on foot not performed	NI	M					
G8416	Pt inelig footwear evaluatio	NI	M					
G8417	BMI >=30 calcuate w/followup	NI	M					
G8418	BMI < 22 calcuate w/followup	NI	M					
G8419	BMI>=30or<22 cal no followup	NI	M					
G8420	BMI<30 and >=22 calc & docu	NI	M					
G8421	BMI not calculated	NI	M					
G8422	Pt inelig BMI calculation	NI	M					
G8423	Pt screen flu vac & counsel	NI	M					
G8424	Flu vaccine not screen	NI	M					
G8425	Flu vaccine screen not curre	NI	M					
G8426	Pt not approp screen & counc	NI	M					
G8427	Doc meds verified w/pt or re	NI	M					
G8428	Meds document w/o verifica	NI	M					
G8429	Incomplete doc pt on meds	NI	M					
G8430	Pt inelig med check	NI	M					
G8431	Clin depression screen doc	NI	M					
G8432	Clin depression screen not d	NI	M					
G8433	Pt inelig for depression scr	NI	M					
G8434	Cognitive impairment screen	NI	M					
G8435	Cognitive screen not documen	NI	M					
G8436	Pt inelig for cognitive impa	NI	M					
G8437	Tx plan develop & document	NI	M					
G8438	Tx plan develop & not docum	NI	M					
G8439	Pt inelig for co-develp tx p	NI	M					
G8440	Pain assessment document	NI	M					
G8441	No document of pain assess	NI	M					
G8442	Pt inelig pain assessment	NI	M					
G8443	Prescription by E-Prescrib s	NI	M					
G8445	Prescrip not gen at encounte	NI	M					
G8446	Some prescrib handwritten or	NI	M					
G8447	Pt visit doc using CCHIT cer	NI	M					
G8448	Pt visit docum w/non-CCHIT c	NI	M					
G8449	Pt not doc w/EMR due to syst	NI	M					
G8450	Beta-bloc rx pt w/abn lvef	NI	M					
G8451	Pt w/abn lvef inelig b-bloc	NI	M					
G8452	Pt w/abn lvef b-bloc no rx	NI	M					
G8453	Tob use cess int counsel	NI	M					
G8454	Tob use cess int no counsel	NI	M					
G8455	Current tobacco smoker	NI	M					
G8456	Smokeless tobacco user	NI	M					
G8457	Tobacco non-user	NI	M					
G8458	Pt inelig geno no antvir tx	NI	M					
G8459	Doc pt rec antivir treat	NI	M					
G8460	Pt inelig RNA no antvir tx	NI	M					
G8461	Pt rec antivir treat hep c	NI	M					
G8462	Pt inelig couns no antvir tx	NI	M					
G8463	Pt rec antiviral treat doc	NI	M					
G8464	Pt inelig; lo to no dter rsk	NI	M					
G8465	High risk recurrence pro ca	NI	M					
G8466	Pt inelig suic; MDD remis	NI	M					
G8467	New dx init/rec episode MDD	NI	M					
G8468	ACE/ARB rx pt w/abn lvef	NI	M					
G8469	Pt w/abn lvef inelig ACE/ARB	NI	M					
G8470	Pt w/ normal lvef	NI	M					
G8471	LVEF not performed/doc	NI	M					
G8472	ACE/ARB no rx pt w/abn lvef	NI	M					
G8473	ACE/ARB thxpy rx'd	NI	M					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G8474	ACE/ARB not rx'd; doc reas	NI	M					
G8475	ACE/ARB thxpy not rx'd	NI	M					
G8476	BP sys <130 and dias <80	NI	M					
G8477	BP sys>=130 and/or dias >=80	NI	M					
G8478	BP not performed/doc	NI	M					
G8479	MD rx'd ACE/ARB thxpy	NI	M					
G8480	Pt inelig ACE/ARB thxpy	NI	M					
G8481	MD not rx'd ACE/ARB thxpy	NI	M					
G8482	Flu immunize order/admin	NI	M					
G8483	Flu imm no ord/admin doc rea	NI	M					
G8484	Flu immunize no order/admin	NI	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					
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 unknwn 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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
G9139	Onc dx CML dx status unknown		M					
G9140	Frontier extended stay demo	NI	M					
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		$420.17		$84.03
J0132	Acetylcysteine injection	CH	N					
J0133	Acyclovir injection		N					
J0135	Adalimumab injection		K	1083		$329.58		$65.92
J0150	Injection adenosine 6 MG		K	0379		$25.10		$5.02
J0152	Adenosine injection		K	0917		$67.89		$13.58
J0170	Adrenalin epinephrin inject		N					
J0180	Agalsidase beta injection		K	9208		$126.00		$25.20
J0190	Inj biperiden lactate/5 mg	CH	K	0998		$88.15		$17.63
J0200	Alatrofloxacin mesylate		N					
J0205	Alglucerase injection		K	0900		$38.85		$7.77
J0207	Amifostine		K	7000		$490.93		$98.19
J0210	Methyldopate hcl injection		K	2210		$13.04		$2.61
J0215	Alefacept		K	1633		$26.47		$5.29
J0220	Aglucosidase alfa injection	NI	K	9234		$126.00		$25.20
J0256	Alpha 1 proteinase inhibitor		K	0901		$3.28		$0.66
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		$10.40		$2.08
J0288	Ampho b cholesteryl sulfate		K	0735		$11.89		$2.38
J0289	Amphotericin b liposome inj		K	0736		$16.21		$3.24
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		$2,693.80		$538.76
J0360	Hydralazine hcl injection		N					
J0364	Apomorphine hydrochloride	CH	N					
J0365	Aprotonin, 10,000 kiu		K	1682		$2.66		$0.53
J0380	Inj metaraminol bitartrate	CH	N					
J0390	Chloroquine injection		N					
J0395	Arbutamine HCl injection	CH	N					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J0400	Aripiprazole injection	NI	K	1165		$0.28		$0.06
J0456	Azithromycin		N					
J0460	Atropine sulfate injection		N					
J0470	Dimecaprol injection		N					
J0475	Baclofen 10 MG injection		K	9032		$193.29		$38.66
J0476	Baclofen intrathecal trial		K	1631		$69.73		$13.95
J0480	Basiliximab		K	1683		$1,541.03		$308.21
J0500	Dicyclomine injection		N					
J0515	Inj benztropine mesylate		N					
J0520	Bethanechol chloride inject		N					
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		$1.84		$0.37
J0585	Botulinum toxin a per unit		K	0902		$5.21		$1.04
J0587	Botulinum toxin type B		K	9018		$8.63		$1.73
J0592	Buprenorphine hydrochloride		N					
J0594	Busulfan injection		K	1178		$9.17		$1.83
J0595	Butorphanol tartrate 1 mg		N					
J0600	Edetate calcium disodium inj	CH	K	0999		$49.64		$9.93
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		$24.05		$4.81
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					
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		$62.78		$12.56
J0740	Cidofovir injection		K	9033		$754.39		$150.88
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		$4.43		$0.89
J0800	Corticotropin injection		K	1280		$169.77		$33.95
J0835	Inj cosyntropin per 0.25 MG		K	0835		$64.01		$12.80
J0850	Cytomegalovirus imm IV /vial		K	0903		$870.53		$174.11
J0878	Daptomycin injection		K	9124		$0.35		$0.07
J0881	Darbepoetin alfa, non-esrd		K	1685		$2.88		$0.58
J0882	Darbepoetin alfa, esrd use		A					
J0885	Epoetin alfa, non-esrd		K	1686		$8.97		$1.79
J0886	Epoetin alfa 1000 units ESRD		A					
J0894	Decitabine injection		G	9231		$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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J1160	Digoxin injection		N					
J1162	Digoxin immune fab (ovine)		K	1687		$478.88		$95.78
J1165	Phenytoin sodium injection		N					
J1170	Hydromorphone injection		N					
J1180	Dyphylline injection		N					
J1190	Dexrazoxane HCl injection		K	0726		$162.11		$32.42
J1200	Diphenhydramine hcl injectio		N					
J1205	Chlorothiazide sodium inj		K	0747		$141.07		$28.21
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		$4.66		$0.93
J1265	Dopamine injection		N					
J1270	Injection, doxercalciferol		N					
J1300	Eculizumab injection	NI	G	9236		$176.38		$35.28
J1320	Amitriptyline injection		N					
J1324	Enfuvirtide injection		K	0767		$0.40		$0.08
J1325	Epoprostenol injection		N					
J1327	Eptifibatide injection		K	1607		$17.67		$3.53
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		$66.64		$13.33
J1430	Ethanolamine oleate 100 mg		K	1688		$79.23		$15.85
J1435	Injection estrone per 1 MG		N					
J1436	Etidronate disodium inj		K	1436		$70.73		$14.15
J1438	Etanercept injection		K	1608		$167.12		$33.42
J1440	Filgrastim 300 mcg injection		K	0728		$193.79		$38.76
J1441	Filgrastim 480 mcg injection		K	7049		$298.39		$59.68
J1450	Fluconazole		N					
J1451	Fomepizole, 15 mg		K	1689		$12.80		$2.56
J1452	Intraocular Fomivirsen na	CH	N					
J1455	Foscarnet sodium injection	CH	N					
J1457	Gallium nitrate injection	CH	K	0878		$1.61		$0.32
J1458	Galsulfase injection		K	9224		$306.88		$61.38
J1460	Gamma globulin 1 CC inj		K	3043		$11.91		$2.38
J1470	Gamma globulin 2 CC inj	CH	K	0898		$23.82		$4.76
J1480	Gamma globulin 3 CC inj	CH	K	0899		$35.72		$7.14
J1490	Gamma globulin 4 CC inj	CH	K	0904		$47.64		$9.53
J1500	Gamma globulin 5 CC inj	CH	K	0919		$59.54		$11.91
J1510	Gamma globulin 6 CC inj	CH	K	0920		$71.50		$14.30
J1520	Gamma globulin 7 CC inj	CH	K	0921		$83.30		$16.66
J1530	Gamma globulin 8 CC inj	CH	K	0922		$95.27		$19.05
J1540	Gamma globulin 9 CC inj	CH	K	0923		$107.25		$21.45
J1550	Gamma globulin 10 CC inj	CH	K	0924		$119.09		$23.82
J1560	Gamma globulin > 10 CC inj	CH	K	0933		$119.09		$23.82
J1561	Gamunex injection	NI	K	0948		$32.06		$6.41
J1562	Vivaglobin, inj		K	0804		$7.01		$1.40
J1565	RSV-ivig		K	0906		$16.02		$3.20
J1566	Immune globulin, powder		K	2731		$26.89		$5.38
J1567	Immune globulin, liquid	CH	D					
J1568	Octagam injection	NI	K	0943		$33.19		$6.64
J1569	Gammagard liquid injection	NI	K	0944		$31.06		$6.21
J1570	Ganciclovir sodium injection		N					
J1571	HepaGam B IM injection	NI	K	0946		$63.51		$12.70
J1572	Flebogamma injection	NI	K	0947		$32.27		$6.45
J1573	Hepagam B intravenous, inj	NI	K	1138		$63.51		$12.70
J1580	Garamycin gentamicin inj		N					
J1590	Gatifloxacin injection		N					
J1595	Injection glatiramer acetate	CH	K	1015		$52.04		$10.41
J1600	Gold sodium thiomaleate inj		N					
J1610	Glucagon hydrochloride/1 MG		K	9042		$68.84		$13.77
J1620	Gonadorelin hydroch/ 100 mcg		K	7005		$178.59		$35.72
J1626	Granisetron HCl injection		K	0764		$5.74		$1.15
J1630	Haloperidol injection		N					
J1631	Haloperidol decanoate inj		N					
J1640	Hemin, 1 mg		K	1690		$7.08		$1.42
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		$5.92		$1.18
J1655	Tinzaparin sodium injection	CH	N					
J1670	Tetanus immune globulin inj		K	1670		$103.46		$20.69
J1675	Histrelin acetate		B					
J1700	Hydrocortisone acetate inj		N					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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		$138.96		$27.79
J1742	Ibutilide fumarate injection		K	9044		$287.15		$57.43
J1743	Idursulfase injection	NI	G	9232		$455.03		$91.01
J1745	Infliximab injection		K	7043		$54.42		$10.88
J1751	Iron dextran 165 injection		K	1691		$11.82		$2.36
J1752	Iron dextran 267 injection		K	1692		$10.30		$2.06
J1756	Iron sucrose injection		K	9046		$0.36		$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		$106.57		$21.31
J1835	Itraconazole injection		K	9047		$39.68		$7.94
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		$159.44		$31.89
J1950	Leuprolide acetate /3.75 MG		K	0800		$452.58		$90.52
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		$25.17		$5.03
J2060	Lorazepam injection		N					
J2150	Mannitol injection		N					
J2170	Mecasermin injection		K	0805		$15.62		$3.12
J2175	Meperidine hydrochl /100 MG		N					
J2180	Meperidine/promethazine inj		N					
J2185	Meropenem	CH	N					
J2210	Methylergonovin maleate inj		N					
J2248	Micafungin sodium injection		G	9227		$1.44		$0.29
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		$1.87		$0.37
J2320	Nandrolone decanoate 50 MG		N					
J2321	Nandrolone decanoate 100 MG		N					
J2322	Nandrolone decanoate 200 MG		N					
J2323	Natalizumab injection	NI	G	9126		$7.51		$1.50
J2325	Nesiritide injection		K	1695		$32.95		$6.59
J2353	Octreotide injection, depot		K	1207		$99.04		$19.81
J2354	Octreotide inj, non-depot		N					
J2355	Oprelvekin injection		K	7011		$247.02		$49.40
J2357	Omalizumab injection		K	9300		$17.12		$3.42
J2360	Orphenadrine injection		N					
J2370	Phenylephrine hcl injection		N					
J2400	Chloroprocaine hcl injection		N					
J2405	Ondansetron hcl injection		K	0768		$0.26		$0.06
J2410	Oxymorphone hcl injection		N					
J2425	Palifermin injection		K	1696		$11.24		$2.25
J2430	Pamidronate disodium /30 MG		K	0730		$28.31		$5.66
J2440	Papaverin hcl injection		N					
J2460	Oxytetracycline injection		N					
J2469	Palonosetron HCl		K	9210		$16.45		$3.29
J2501	Paricalcitol		N					
J2503	Pegaptanib sodium injection	CH	K	1697		$1,035.69		$207.14
J2504	Pegademase bovine, 25 iu		K	1739		$197.51		$39.50
J2505	Injection, pegfilgrastim 6mg		K	9119		$2,145.12		$429.02
J2510	Penicillin g procaine inj		N					
J2513	Pentastarch 10% solution	CH	K	0880		$21.98		$4.40
J2515	Pentobarbital sodium inj		N					
J2540	Penicillin g potassium inj		N					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J2543	Piperacillin/tazobactam		N					
J2545	Pentamidine non-comp unit		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					
J2724	Protein C concentrate	NI	K	1139		$12.08		$2.42
J2725	Inj protirelin per 250 mcg		N					
J2730	Pralidoxime chloride inj	CH	K	1023		$35.20		$7.04
J2760	Phentolaine mesylate inj		N					
J2765	Metoclopramide hcl injection		N					
J2770	Quinupristin/dalfopristin		K	2770		$126.44		$25.29
J2778	Ranibizumab injection	NI	G	9233		$2,030.23		$406.05
J2780	Ranitidine hydrochloride inj		N					
J2783	Rasburicase		K	0738		$144.43		$28.89
J2788	Rho d immune globulin 50 mcg		K	9023		$26.41		$5.28
J2790	Rho d immune globulin inj		K	0884		$80.79		$16.16
J2791	Rhophylac injection	NI	K	0945		$5.29		$1.06
J2792	Rho(D) immune globulin h, sd		K	1609		$15.62		$3.12
J2794	Risperidone, long acting		K	9125		$4.86		$0.97
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		$24.86		$4.97
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		$168.90		$33.78
J2941	Somatropin injection		K	7034		$48.52		$9.70
J2950	Promazine hcl injection		N					
J2993	Reteplase injection		K	9005		$841.28		$168.26
J2995	Inj streptokinase /250000 IU		K	0911		$129.75		$25.95
J2997	Alteplase recombinant		K	7048		$33.39		$6.68
J3000	Streptomycin injection		N					
J3010	Fentanyl citrate injeciton		N					
J3030	Sumatriptan succinate / 6 MG		K	3030		$61.27		$12.25
J3070	Pentazocine injection		N					
J3100	Tenecteplase injection		K	9002		$2,034.65		$406.93
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		$834.18		$166.84
J3243	Tigecycline injection		G	9228		$0.96		$0.19
J3246	Tirofiban HCl		K	7041		$7.56		$1.51
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		$148.30		$29.66
J3310	Perphenazine injeciton		N					
J3315	Triptorelin pamoate		K	9122		$159.38		$31.88
J3320	Spectinomycn di-hcl inj	CH	N					
J3350	Urea injection		K	9051		$74.16		$14.83
J3355	Urofollitropin, 75 iu		K	1741		$50.22		$10.04
J3360	Diazepam injection		N					
J3364	Urokinase 5000 IU injection		N					
J3365	Urokinase 250,000 IU inj		K	7036		$453.41		$90.68
J3370	Vancomycin hcl injection		N					
J3396	Verteporfin injection		K	1203		$8.99		$1.80
J3400	Triflupromazine hcl inj		N					
J3410	Hydroxyzine hcl injection		N					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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		$4.93		$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		$205.76		$41.15
J3488	Reclast injection	NI	G	0951		$220.81		$44.16
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	Humate-P, inj		K	1704		$0.88		$0.18
J7189	Factor viia		K	1705		$1.15		$0.23
J7190	Factor viii		K	0925		$0.75		$0.15
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		$0.80		$0.16
J7195	Factor IX recombinant		K	0932		$0.99		$0.20
J7197	Antithrombin iii injection		K	0930		$1.82		$0.36
J7198	Anti-inhibitor		K	0929		$1.42		$0.28
J7199	Hemophilia clot factor noc		B					
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					
J7307	Etonogestrel implant system	NI	E					
J7308	Aminolevulinic acid hcl top		K	7308		$109.92		$21.98
J7310	Ganciclovir long act implant		K	0913		$4,707.90		$941.58
J7311	Fluocinolone acetonide implt	CH	K	9225		$19,162.50		$3,832.50
J7321	Hyalgan/supartz inj per dose	NI	K	0873		$101.81		$20.36
J7322	Synvisc inj per dose	NI	K	0874		$178.11		$35.62
J7323	Euflexxa inj per dose	NI	K	0875		$110.95		$22.19
J7324	Orthovisc inj per dose	NI	K	0877		$174.50		$34.90
J7330	Cultured chondrocytes implnt		B					
J7340	Metabolic active D/E tissue		K	1632		$28.45		$5.69
J7341	Non-human, metabolic tissue	CH	N					
J7342	Metabolically active tissue		K	9054		$36.40		$7.28
J7343	Nonmetabolic act d/e tissue		K	1629		$20.22		$4.04
J7344	Nonmetabolic active tissue		K	9156		$94.53		$18.91
J7345	Non-human, non-metab tissue	CH	D					
J7346	Injectable human tissue		K	9222		$774.46		$154.89
J7347	Integra matrix tissue	NI	K	1140		$33.14		$6.63
J7348	Tissuemend tissue	NI	G	9351		$67.96		$13.59
J7349	Primatrix tissue	NI	G	1141		$67.96		$13.59
J7500	Azathioprine oral 50mg		N					
J7501	Azathioprine parenteral		K	0887		$47.88		$9.58
J7502	Cyclosporine oral 100 mg		K	0888		$3.52		$0.70
J7504	Lymphocyte immune globulin		K	0890		$336.10		$67.22
J7505	Monoclonal antibodies		K	7038		$977.75		$195.55
J7506	Prednisone oral		N					
J7507	Tacrolimus oral per 1 MG		K	0891		$3.69		$0.74
J7509	Methylprednisolone oral		N					
J7510	Prednisolone oral per 5 mg		N					
J7511	Antithymocyte globuln rabbit		K	9104		$337.82		$67.56
J7513	Daclizumab, parenteral		K	1612		$322.28		$64.46
J7515	Cyclosporine oral 25 mg		N					
J7516	Cyclosporin parenteral 250mg		N					
J7517	Mycophenolate mofetil oral		K	9015		$2.66		$0.53

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J7518	Mycophenolic acid		K	9219		$2.41		$0.48
J7520	Sirolimus, oral		K	9020		$7.50		$1.50
J7525	Tacrolimus injection		K	9006		$138.64		$27.73
J7599	Immunosuppressive drug noc		N					
J7602	Albuterol inh non-comp con	NI	M					
J7603	Albuterol inh non-comp u d	NI	M					
J7604	Acetylcysteine comp unit	NI	M					
J7605	Arformoterol non-comp unit	NI	M					
J7607	Levalbuterol comp con	CH	M					
J7608	Acetylcysteine non-comp unit	CH	M					
J7609	Albuterol comp unit	CH	M					
J7610	Albuterol comp con	CH	M					
J7611	Albuterol non-comp con	CH	D					
J7612	Levalbuterol non-comp con	CH	D					
J7613	Albuterol non-comp unit	CH	D					
J7614	Levalbuterol non-comp unit	CH	D					
J7615	Levalbuterol comp unit	CH	M					
J7620	Albuterol ipratrop non-comp	CH	M					
J7622	Beclomethasone comp unit	CH	M					
J7624	Betamethasone comp unit	CH	M					
J7626	Budesonide non-comp unit	CH	M					
J7627	Budesonide comp unit	CH	M					
J7628	Bitolterol mesylate comp con	CH	M					
J7629	Bitolterol mesylate comp unt	CH	M					
J7631	Cromolyn sodium noncomp unit	CH	M					
J7632	Cromolyn sodium comp unit	NI	M					
J7633	Budesonide non-comp con	CH	M					
J7634	Budesonide comp con	CH	M					
J7635	Atropine comp con	CH	M					
J7636	Atropine comp unit	CH	M					
J7637	Dexamethasone comp con	CH	M					
J7638	Dexamethasone comp unit	CH	M					
J7639	Dornase alpha non-comp unit	CH	M					
J7640	Formoterol comp unit		E					
J7641	Flunisolide comp unit	CH	M					
J7642	Glycopyrrolate comp con	CH	M					
J7643	Glycopyrrolate comp unit	CH	M					
J7644	Ipratropium bromide non-comp	CH	M					
J7645	Ipratropium bromide comp	CH	M					
J7647	Isoetharine comp con	CH	M					
J7648	Isoetharine non-comp con	CH	M					
J7649	Isoetharine non-comp unit	CH	M					
J7650	Isoetharine comp unit	CH	M					
J7657	Isoproterenol comp con	CH	M					
J7658	Isoproterenol non-comp con	CH	M					
J7659	Isoproterenol non-comp unit	CH	M					
J7660	Isoproterenol comp unit	CH	M					
J7667	Metaproterenol comp con	CH	M					
J7668	Metaproterenol non-comp con	CH	M					
J7669	Metaproterenol non-comp unit	CH	M					
J7670	Metaproterenol comp unit	CH	M					
J7674	Methacholine chloride, neb		N					
J7676	Pentamidine comp unit dose	NI	M					
J7680	Terbutaline sulf comp con	CH	M					
J7681	Terbutaline sulf comp unit	CH	M					
J7682	Tobramycin non-comp unit	CH	M					
J7683	Triamcinolone comp con	CH	M					
J7684	Triamcinolone comp unit	CH	M					
J7685	Tobramycin comp unit	CH	M					
J7699	Inhalation solution for DME	CH	M					
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		$4.99		$1.00
J8510	Oral busulfan		K	7015		$2.26		$0.45
J8515	Cabergoline, oral 0.25mg		E					
J8520	Capecitabine, oral, 150 mg		K	7042		$4.28		$0.86
J8521	Capecitabine, oral, 500 mg	CH	K	0934		$14.19		$2.84
J8530	Cyclophosphamide oral 25 MG		N					
J8540	Oral dexamethasone		N					
J8560	Etoposide oral 50 MG		K	0802		$29.46		$5.89
J8565	Gefitinib oral		E					
J8597	Antiemetic drug oral NOS		N					
J8600	Melphalan oral 2 MG	CH	K	0882		$4.14		$0.83
J8610	Methotrexate oral 2.5 MG		N					
J8650	Nabilone oral		K	0808		$16.80		$3.36
J8700	Temozolomide		K	1086		$7.49		$1.50
J8999	Oral prescription drug chemo		B					
J9000	Doxorubic hcl 10 MG vl chemo	CH	N					
J9001	Doxorubicin hcl liposome inj		K	7046		$396.15		$79.23

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J9010	Alemtuzumab injection		K	9110		$549.77		$109.95
J9015	Aldesleukin/single use vial		K	0807		$788.84		$157.77
J9017	Arsenic trioxide		K	9012		$34.44		$6.89
J9020	Asparaginase injection		K	0814		$54.26		$10.85
J9025	Azacitidine injection		K	1709		$4.35		$0.87
J9027	Clofarabine injection	CH	K	1710		$114.41		$22.88
J9031	Bcg live intravesical vac		K	0809		$113.75		$22.75
J9035	Bevacizumab injection		K	9214		$56.93		$11.39
J9040	Bleomycin sulfate injection		K	0748		$42.93		$8.59
J9041	Bortezomib injection		K	9207		$33.20		$6.64
J9045	Carboplatin injection		K	0811		$7.44		$1.49
J9050	Carmus bischl nitro inj		K	0812		$152.24		$30.45
J9055	Cetuximab injection		K	9215		$49.43		$9.89
J9060	Cisplatin 10 MG injection		N					
J9062	Cisplatin 50 MG injection	CH	N					
J9065	Inj cladribine per 1 MG		K	0858		$32.04		$6.41
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		$412.21		$82.44
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		$19.33		$3.87
J9151	Daunorubicin citrate liposom		K	0821		$55.23		$11.05
J9160	Denileukin diftitox, 300 mcg		K	1084		$1,386.59		$277.32
J9165	Diethylstilbestrol injection		N					
J9170	Docetaxel		K	0823		$310.85		$62.17
J9175	Elliotts b solution per ml		N					
J9178	Inj, epirubicin hcl, 2 mg		K	1167		$19.79		$3.96
J9181	Etoposide 10 MG inj		N					
J9182	Etoposide 100 MG inj	CH	N					
J9185	Fludarabine phosphate inj		K	0842		$226.67		$45.33
J9190	Fluorouracil injection		N					
J9200	Floxuridine injection		K	0827		$54.63		$10.93
J9201	Gemcitabine HCl		K	0828		$127.31		$25.46
J9202	Goserelin acetate implant		K	0810		$192.29		$38.46
J9206	Irinotecan injection		K	0830		$124.61		$24.92
J9208	Ifosfomide injection		K	0831		$38.13		$7.63
J9209	Mesna injection		K	0732		$7.97		$1.59
J9211	Idarubicin hcl injection		K	0832		$302.42		$60.48
J9212	Interferon alfacon-1		K	0912		$4.62		$0.92
J9213	Interferon alfa-2a inj		K	0834		$41.37		$8.27
J9214	Interferon alfa-2b inj		K	0836		$13.92		$2.78
J9215	Interferon alfa-n3 inj		K	0865		$9.03		$1.81
J9216	Interferon gamma 1-b inj		K	0838		$306.66		$61.33
J9217	Leuprolide acetate suspnsion		K	9217		$236.06		$47.21
J9218	Leuprolide acetate injeciton		K	0861		$7.98		$1.60
J9219	Leuprolide acetate implant		K	7051		$1,648.41		$329.68
J9225	Vantas implant		K	1711		$1,412.46		$282.49
J9226	Supprelin LA implant	NI	K	1142		$14,700.00		$2,940.00
J9230	Mechlorethamine hcl inj		K	0751		$143.08		$28.62
J9245	Inj melphalan hydrochl 50 MG		K	0840		$1,548.88		$309.78
J9250	Methotrexate sodium inj		N					
J9260	Methotrexate sodium inj	CH	N					
J9261	Nelarabine injection		G	0825		$86.84		$17.37
J9263	Oxaliplatin		K	1738		$9.15		$1.83
J9264	Paclitaxel protein bound	CH	K	1712		$8.79		$1.76
J9265	Paclitaxel injection		K	0863		$14.57		$2.91
J9266	Pegaspargase/singl dose vial		K	0843		$2,080.19		$416.04
J9268	Pentostatin injection		K	0844		$2,051.68		$410.34
J9270	Plicamycin (mithramycin) inj	CH	K	1041		$172.41		$34.48
J9280	Mitomycin 5 MG inj		K	0862		$14.39		$2.88
J9290	Mitomycin 20 MG inj	CH	K	0941		$57.56		$11.51
J9291	Mitomycin 40 MG inj	CH	K	0942		$115.11		$23.02
J9293	Mitoxantrone hydrochl / 5 MG		K	0864		$107.96		$21.59
J9300	Gemtuzumab ozogamicin		K	9004		$2,411.98		$482.40
J9303	Panitumumab injection	NI	G	9235		$83.15		$16.63
J9305	Pemetrexed injection		K	9213		$44.49		$8.90
J9310	Rituximab cancer treatment		K	0849		$504.40		$100.88
J9320	Streptozocin injection		K	0850		$146.93		$29.39

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J9340	Thiotepa injection		K	0851		$41.12		$8.22
J9350	Topotecan		K	0852		$859.62		$171.92
J9355	Trastuzumab		K	1613		$58.51		$11.70
J9357	Valrubicin, 200 mg		K	9167		$77.96		$15.59
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		$21.41		$4.28
J9395	Injection, Fulvestrant		K	9120		$80.60		$16.12
J9600	Porfimer sodium		K	0856		$2,532.53		$506.51
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					
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					
K0553	Combination oral/nasal mask	CH	D					
K0554	Repl oral cushion combo mask	CH	D					
K0555	Repl nasal pillow comb mask	CH	D					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	CH	D					
L0970	Tlso corset front		A					
L0972	Lso corset front		A					
L0974	Tlso full corset		A					
L0976	Lso full corset		A					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	CH	D					
L1858	Ko polycentric pneumatic pad	CH	D					
L1860	Ko supracondylar socket mold		A					
L1870	Ko doub upright lacers molde	CH	D					
L1880	Ko doub upright cuffs/lacers	CH	D					
L1900	Afo sprng wir drsflx calf bd		A					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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		E					
L3216	Orthoped ladies shoes dpth i	CH	E					
L3217	Ladies shoes hightop depth i	CH	E					
L3219	Orthopedic mens shoes oxford		E					
L3221	Orthopedic mens shoes dpth i	CH	E					
L3222	Mens shoes hightop depth inl	CH	E					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
L3765	EWHFO rigid w/o jnts CF		A					
L3766	EWHFO w/joint(s) CF		A					
L3800	Whfo short opponen no attach	CH	D					
L3805	Whfo long opponens no attach	CH	D					
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	CH	D					
L3815	Whfo second m.p. abduction a	CH	D					
L3820	Whfo ip ext asst w/ mp ext s	CH	D					
L3825	Whfo m.p. extension stop	CH	D					
L3830	Whfo m.p. extension assist	CH	D					
L3835	Whfo m.p. spring extension a	CH	D					
L3840	Whfo spring swivel thumb	CH	D					
L3845	Whfo thumb ip ext ass w/ mp	CH	D					
L3850	Action wrist w/ dorsiflex as	CH	D					
L3855	Whfo adj m.p. flexion contro	CH	D					
L3860	Whfo adj m.p. flex ctrl & i	CH	D					
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	CH	D					
L3908	Wrist cock-up non-molded		A					
L3909	Prefab wrist orthosis		A					
L3910	Whfo swanson design	CH	D					
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	CH	D					
L3917	Prefab metacarpl fx orthosis		A					
L3918	HFO knuckle bender	CH	D					
L3919	HO w/o joints CF		A					
L3920	Knuckle bender with outrigge	CH	D					
L3921	HFO w/joint(s) CF		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L3922	Knuckle bend 2 seg to flex j	CH	D					
L3923	HFO w/o joints PF		A					
L3924	Oppenheimer	CH	D					
L3925	FO pip/dip with joint/spring	NI	A					
L3926	Thomas suspension	CH	D					
L3927	FO pip/dip w/o joint/spring	NI	A					
L3928	Finger extension w/ clock sp	CH	D					
L3929	HFO nontorsion joint, prefab	NI	A					
L3930	Finger extension with wrist	CH	D					
L3931	WHFO nontorsion joint prefab	NI	A					
L3932	Safety pin spring wire	CH	D					
L3933	FO w/o joints CF		A					
L3934	Safety pin modified	CH	D					
L3935	FO nontorsion joint CF		A					
L3936	Palmer	CH	D					
L3938	Dorsal wrist	CH	D					
L3940	Dorsal wrist w/ outrigger at	CH	D					
L3942	Reverse knuckle bender	CH	D					
L3944	Reverse knuckle bend w/ outr	CH	D					
L3946	HFO composite elastic	CH	D					
L3948	Finger knuckle bender	CH	D					
L3950	Oppenheimer w/ knuckle bend	CH	D					
L3952	Oppenheimer w/ rev knuckle 2	CH	D					
L3954	Spreading hand	CH	D					
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					
L3982	Upper ext fx orthosis rad/ul		A					
L3984	Upper ext fx orthosis wrist		A					
L3985	Forearm hand fx orth w/ wr h	CH	D					
L3986	Humeral rad/ulna wrist fx or	CH	D					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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		E					
L7611	Ped term dev, hook, vol open	NI	A					
L7612	Ped term dev, hook, vol clos	NI	A					
L7613	Ped term dev, hand, vol open	NI	A					
L7614	Ped term dev, hand, vol clos	NI	A					
L7621	Hook/hand, hvy dty, vol open	NI	A					
L7622	Hook/hand, hvy dty, vol clos	NI	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					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	0606	1.3226	$84.24		$16.85
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					
P9010	Whole blood for transfusion		K	0950	4.0011	$254.85		$50.97
P9011	Blood split unit		K	0967	2.3409	$149.10		$29.82
P9012	Cryoprecipitate each unit		K	0952	0.6474	$41.24		$8.25
P9016	RBC leukocytes reduced		K	0954	2.9069	$185.15		$37.03
P9017	Plasma 1 donor frz w/in 8 hr		K	9508	1.0524	$67.03		$13.41
P9019	Platelets, each unit		K	0957	1.0911	$69.50		$13.90
P9020	Plaelet rich plasma unit		K	0958	5.7070	$363.50		$72.70
P9021	Red blood cells unit		K	0959	2.0356	$129.66		$25.93
P9022	Washed red blood cells unit		K	0960	4.3494	$277.03		$55.41
P9023	Frozen plasma, pooled, sd		K	0949	1.1598	$73.87		$14.77
P9031	Platelets leukocytes reduced		K	1013	1.6879	$107.51		$21.50
P9032	Platelets, irradiated		K	9500	1.9110	$121.72		$24.34
P9033	Platelets leukoreduced irrad		K	0968	2.1971	$139.94		$27.99
P9034	Platelets, pheresis		K	9507	6.9242	$441.03		$88.21
P9035	Platelet pheres leukoreduced		K	9501	7.8426	$499.53		$99.91
P9036	Platelet pheresis irradiated		K	9502	6.5581	$417.71		$83.54
P9037	Plate pheres leukoredu irrad		K	1019	9.8923	$630.08		$126.02
P9038	RBC irradiated		K	9505	3.0643	$195.18		$39.04
P9039	RBC deglycerolized		K	9504	5.4516	$347.23		$69.45
P9040	RBC leukoreduced irradiated		K	0969	3.7722	$240.27		$48.05
P9041	Albumin (human),5%, 50ml		K	0961	0.3413	$21.74		$4.35
P9043	Plasma protein fract,5%,50ml		K	0956	1.4739	$93.88		$18.78
P9044	Cryoprecipitatereducedplasma		K	1009	1.3139	$83.69		$16.74
P9045	Albumin (human), 5%, 250 ml		K	0963	1.0987	$69.98		$14.00
P9046	Albumin (human), 25%, 20 ml		K	0964	0.4118	$26.23		$5.25
P9047	Albumin (human), 25%, 50ml		K	0965	1.1362	$72.37		$14.47
P9048	Plasmaprotein fract,5%,250ml		K	0966	3.3792	$215.23		$43.05
P9050	Granulocytes, pheresis unit		K	9506	21.7847	$1,387.55		$277.51
P9051	Blood, l/r, cmv-neg		K	1010	2.3221	$147.90		$29.58
P9052	Platelets, hla-m, l/r, unit		K	1011	10.1413	$645.94		$129.19
P9053	Plt, pher, l/r cmv-neg, irr		K	1020	10.7787	$686.54		$137.31
P9054	Blood, l/r, froz/degly/wash		K	1016	3.4353	$218.81		$43.76
P9055	Plt, aph/pher, l/r, cmv-neg		K	1017	7.6733	$488.74		$97.75
P9056	Blood, l/r, irradiated		K	1018	2.3099	$147.13		$29.43
P9057	RBC, frz/deg/wsh, l/r, irrad		K	1021	5.8716	$373.99		$74.80
P9058	RBC, l/r, cmv-neg, irrad		K	1022	4.1363	$263.46		$52.69
P9059	Plasma, frz between 8–24hour		K	0955	1.2235	$77.93		$15.59
P9060	Fr frz plasma donor retested		K	9503	0.8264	$52.64		$10.53
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
Q0035	Cardiokymography		X	0100	2.5547	$162.72	$41.44	$32.54
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	0.1309	$8.34	$2.36	$1.67
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		$49.96		$9.99
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		$18.37		$3.67
Q0180	Dolasetron mesylate oral		K	0763		$43.77		$8.75
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					
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	CH	E					
Q1005	Ntiol category 5	CH	E					
Q2004	Bladder calculi irrig sol		N					
Q2009	Fosphenytoin, 50 mg		K	7028		$5.76		$1.15
Q2017	Teniposide, 50 mg		K	7035		$280.26		$56.05
Q3001	Brachytherapy Radioelements		B					
Q3014	Telehealth facility fee		A					
Q3025	IM inj interferon beta 1-a		K	9022		$118.84		$23.77
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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	D					
Q4080	Iloprost non-comp unit dose		Y					
Q4081	Epoetin alfa, 100 units ESRD		A					
Q4082	Drug/bio NOC part B drug CAP		B					
Q4083	Hyalgan/supartz inj per dose	CH	D					
Q4084	Synvisc inj per dose	CH	D					
Q4085	Euflexxa inj per dose	CH	D					
Q4086	Orthovisc inj per dose	CH	D					
Q4087	Octagam injection	CH	D					
Q4088	Gammagard liquid injection	CH	D					
Q4089	Rhophylac injection	CH	D					
Q4090	HepaGam B IM injection	CH	D					
Q4091	Flebogamma injection	CH	D					
Q4092	Gamunex injection	CH	D					
Q4093	Albuterol inh non-comp con	CH	D					
Q4094	Albuterol inh non-comp u d	CH	D					
Q4095	Reclast injection	CH	D					
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	D					
Q9946	LOCM 150–199mg/ml iodine,1ml	CH	D					
Q9947	LOCM 200–249mg/ml iodine,1ml	CH	D					
Q9948	LOCM 250–299mg/ml iodine,1ml	CH	D					
Q9949	LOCM 300–349mg/ml iodine,1ml	CH	D					
Q9950	LOCM 350–399mg/ml iodine,1ml	CH	D					
Q9951	LOCM >= 400 mg/ml iodine,1ml	CH	N					
Q9952	Inj Gad-base MR contrast,1ml	CH	D					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
Q9965	LOCM 100–199mg/ml iodine,1ml	NI	N					
Q9966	LOCM 200–299mg/ml iodine,1ml	NI	N					
Q9967	LOCM 300–399mg/ml iodine,1ml	NI	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					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					
V2787	Astigmatism-correct function	NI	E					
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					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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.—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	CY 2008 payment weight	CY 2008 payment
0028T	Dexa body composition study		N1		
0042T	Ct perfusion w/contrast, cbf		N1		
0054T	Bone surgery using computer	CH	D5		
0055T	Bone surgery using computer	CH	D5		
0056T	Bone surgery using computer	CH	D5		
0067T	Ct colonography;dx		Z2	3.0109	$124.65
0071T	U/s leiomyomata ablate <200		Z2	61.6965	$2,554.30
0072T	U/s leiomyomata ablate >200		Z2	61.6965	$2,554.30
0073T	Delivery, comp imrt		Z2	5.4582	$225.97
0126T	Chd risk imt study		N1		
0144T	Ct heart wo dye; qual calc		Z2	1.5839	$65.58
0145T	Ct heart w/wo dye funct		Z2	4.7005	$194.61
0146T	Ccta w/wo dye		Z2	4.7005	$194.61
0147T	Ccta w/wo, quan calcium		Z2	4.7005	$194.61
0148T	Ccta w/wo, strxr		Z2	4.7005	$194.61
0149T	Ccta w/wo, strxr quan calc		Z2	4.7005	$194.61
0150T	Ccta w/wo, disease strxr		Z2	4.7005	$194.61
0151T	Ct heart funct add-on		Z2	1.5839	$65.58
0159T	Cad breast mri		N1		

ADDENDUM BB.—ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including Ancillary Services for Which Payment Is Packaged]

HCPCS code	Short descriptor	Comment indicator	Payment indicator	CY 2008 payment weight	CY 2008 payment
0174T	Cad cxr with interp		N1		
0175T	Cad cxr remote		N1		
0182T	Hdr elect brachytherapy	CH	Z2	27.4752	$1,137.50
0185T	Comptr probability analysis	NI	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	0.3949	$16.35
70100	X-ray exam of jaw		Z3	0.4526	$18.74
70110	X-ray exam of jaw		Z3	0.5514	$22.83
70120	X-ray exam of mastoids		Z3	0.5183	$21.46
70130	X-ray exam of mastoids		Z2	0.6954	$28.79
70134	X-ray exam of middle ear		Z3	0.6253	$25.89
70140	X-ray exam of facial bones		Z3	0.4609	$19.08
70150	X-ray exam of facial bones		Z3	0.6336	$26.23
70160	X-ray exam of nasal bones		Z3	0.4773	$19.76
70170	X-ray exam of tear duct	CH	N1		
70190	X-ray exam of eye sockets		Z3	0.5183	$21.46
70200	X-ray exam of eye sockets		Z3	0.6418	$26.57
70210	X-ray exam of sinuses		Z3	0.4691	$19.42
70220	X-ray exam of sinuses		Z3	0.5925	$24.53
70240	X-ray exam, pituitary saddle		Z3	0.3949	$16.35
70250	X-ray exam of skull		Z3	0.5101	$21.12
70260	X-ray exam of skull		Z3	0.6831	$28.28
70300	X-ray exam of teeth		Z3	0.1894	$7.84
70310	X-ray exam of teeth		Z3	0.4855	$20.10
70320	Full mouth x-ray of teeth		Z2	0.5749	$23.80
70328	X-ray exam of jaw joint		Z3	0.4362	$18.06
70330	X-ray exam of jaw joints	CH	Z2	0.6954	$28.79
70332	X-ray exam of jaw joint	CH	N1		
70336	Magnetic image, jaw joint		Z2	4.883	$202.16
70350	X-ray head for orthodontia		Z3	0.2715	$11.24
70355	Panoramic x-ray of jaws		Z3	0.3292	$13.63
70360	X-ray exam of neck		Z3	0.3785	$15.67
70370	Throat x-ray & fluoroscopy		Z3	1.1768	$48.72
70371	Speech evaluation, complex		Z2	1.3271	$54.94
70373	Contrast x-ray of larynx	CH	N1		
70380	X-ray exam of salivary gland		Z3	0.5925	$24.53
70390	X-ray exam of salivary duct	CH	N1		
70450	Ct head/brain w/o dye		Z2	3.0109	$124.65
70460	Ct head/brain w/dye		Z2	4.3564	$180.36
70470	Ct head/brain w/o & w/dye		Z2	5.1125	$211.66
70480	Ct orbit/ear/fossa w/o dye		Z2	3.0109	$124.65
70481	Ct orbit/ear/fossa w/dye		Z2	4.3564	$180.36
70482	Ct orbit/ear/fossa w/o&w/dye		Z2	5.1125	$211.66
70486	Ct maxillofacial w/o dye		Z2	3.0109	$124.65
70487	Ct maxillofacial w/dye		Z2	4.3564	$180.36
70488	Ct maxillofacial w/o & w/dye		Z2	5.1125	$211.66
70490	Ct soft tissue neck w/o dye		Z2	3.0109	$124.65
70491	Ct soft tissue neck w/dye		Z2	4.3564	$180.36
70492	Ct sft tsue nck w/o & w/dye		Z2	5.1125	$211.66
70496	Ct angiography, head		Z2	5.1641	$213.80
70498	Ct angiography, neck		Z2	5.1641	$213.80
70540	Mri orbit/face/neck w/o dye		Z2	5.3933	$223.29
70542	Mri orbit/face/neck w/dye		Z2	6.235	$258.14
70543	Mri orbt/fac/nck w/o & w/dye		Z2	8.2463	$341.41
70544	Mr angiography head w/o dye		Z2	5.3933	$223.29
70545	Mr angiography head w/dye		Z2	6.235	$258.14
70546	Mr angiograph head w/o&w/dye		Z2	8.2463	$341.41
70547	Mr angiography neck w/o dye		Z2	5.3933	$223.29
70548	Mr angiography neck w/dye		Z2	6.235	$258.14
70549	Mr angiograph neck w/o&w/dye		Z2	8.2463	$341.41
70551	Mri brain w/o dye		Z2	5.3933	$223.29
70552	Mri brain w/dye		Z2	6.235	$258.14
70553	Mri brain w/o & w/dye		Z2	8.2463	$341.41
70554	Fmri brain by tech		Z2	5.3933	$223.29
70555	Fmri brain by phys/psych		Z2	5.3933	$223.29
70557	Mri brain w/o dye		Z2	5.3933	$223.29
70558	Mri brain w/dye		Z2	6.235	$258.14

ADDENDUM BB.—ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including Ancillary Services for Which Payment Is Packaged]

HCPCS code	Short descriptor	Comment indicator	Payment indicator	CY 2008 payment weight	CY 2008 payment
70559	Mri brain w/o & w/dye		Z2	8.2463	$341.41
71010	Chest x-ray		Z3	0.3456	$14.31
71015	Chest x-ray		Z3	0.4196	$17.37
71020	Chest x-ray		Z3	0.4609	$19.08
71021	Chest x-ray		Z3	0.5514	$22.83
71022	Chest x-ray		Z3	0.6253	$25.89
71023	Chest x-ray and fluoroscopy		Z3	0.8968	$37.13
71030	Chest x-ray		Z3	0.6582	$27.25
71034	Chest x-ray and fluoroscopy		Z2	1.3271	$54.94
71035	Chest x-ray		Z3	0.5101	$21.12
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	0.4609	$19.08
71101	X-ray exam of ribs/chest		Z3	0.5514	$22.83
71110	X-ray exam of ribs		Z3	0.6007	$24.87
71111	X-ray exam of ribs/chest		Z3	0.757	$31.34
71120	X-ray exam of breastbone		Z3	0.4937	$20.44
71130	X-ray exam of breastbone		Z3	0.5679	$23.51
71250	Ct thorax w/o dye		Z2	3.0109	$124.65
71260	Ct thorax w/dye		Z2	4.3564	$180.36
71270	Ct thorax w/o & w/dye		Z2	5.1125	$211.66
71275	Ct angiography, chest		Z2	5.1641	$213.80
71550	Mri chest w/o dye		Z2	5.3933	$223.29
71551	Mri chest w/dye		Z2	6.235	$258.14
71552	Mri chest w/o & w/dye		Z2	8.2463	$341.41
72010	X-ray exam of spine		Z2	0.6954	$28.79
72020	X-ray exam of spine		Z3	0.3456	$14.31
72040	X-ray exam of neck spine		Z3	0.5348	$22.14
72050	X-ray exam of neck spine		Z3	0.7652	$31.68
72052	X-ray exam of neck spine		Z3	0.9874	$40.88
72069	X-ray exam of trunk spine		Z3	0.4773	$19.76
72070	X-ray exam of thoracic spine		Z3	0.5019	$20.78
72072	X-ray exam of thoracic spine		Z3	0.5843	$24.19
72074	X-ray exam of thoracic spine	CH	Z2	0.6954	$28.79
72080	X-ray exam of trunk spine		Z3	0.5266	$21.80
72090	X-ray exam of trunk spine		Z3	0.6418	$26.57
72100	X-ray exam of lower spine		Z3	0.5761	$23.85
72110	X-ray exam of lower spine		Z3	0.7983	$33.05
72114	X-ray exam of lower spine		Z3	1.078	$44.63
72120	X-ray exam of lower spine		Z3	0.7734	$32.02
72125	Ct neck spine w/o dye		Z2	3.0109	$124.65
72126	Ct neck spine w/dye		Z2	4.3564	$180.36
72127	Ct neck spine w/o & w/dye		Z2	5.1125	$211.66
72128	Ct chest spine w/o dye		Z2	3.0109	$124.65
72129	Ct chest spine w/dye		Z2	4.3564	$180.36
72130	Ct chest spine w/o & w/dye		Z2	5.1125	$211.66
72131	Ct lumbar spine w/o dye		Z2	3.0109	$124.65
72132	Ct lumbar spine w/dye		Z2	4.3564	$180.36
72133	Ct lumbar spine w/o & w/dye		Z2	5.1125	$211.66
72141	Mri neck spine w/o dye		Z2	5.3933	$223.29
72142	Mri neck spine w/dye		Z2	6.235	$258.14
72146	Mri chest spine w/o dye		Z2	5.3933	$223.29
72147	Mri chest spine w/dye		Z2	6.235	$258.14
72148	Mri lumbar spine w/o dye		Z2	5.3933	$223.29
72149	Mri lumbar spine w/dye		Z2	6.235	$258.14
72156	Mri neck spine w/o & w/dye		Z2	8.2463	$341.41
72157	Mri chest spine w/o & w/dye		Z2	8.2463	$341.41
72158	Mri lumbar spine w/o & w/dye		Z2	8.2463	$341.41
72170	X-ray exam of pelvis		Z3	0.3949	$16.35
72190	X-ray exam of pelvis		Z3	0.5925	$24.53
72191	Ct angiograph pelv w/o&w/dye		Z2	5.1641	$213.80
72192	Ct pelvis w/o dye		Z2	3.0109	$124.65
72193	Ct pelvis w/dye		Z2	4.3564	$180.36
72194	Ct pelvis w/o & w/dye		Z2	5.1125	$211.66
72195	Mri pelvis w/o dye		Z2	5.3933	$223.29
72196	Mri pelvis w/dye		Z2	6.235	$258.14
72197	Mri pelvis w/o & w/dye		Z2	8.2463	$341.41

ADDENDUM BB.—ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including Ancillary Services for Which Payment Is Packaged]

HCPCS code	Short descriptor	Comment indicator	Payment indicator	CY 2008 payment weight	CY 2008 payment
72200	X-ray exam sacroiliac joints		Z3	0.4362	$18.06
72202	X-ray exam sacroiliac joints		Z3	0.5348	$22.14
72220	X-ray exam of tailbone		Z3	0.4526	$18.74
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	0.4196	$17.37
73010	X-ray exam of shoulder blade		Z3	0.428	$17.72
73020	X-ray exam of shoulder		Z3	0.3539	$14.65
73030	X-ray exam of shoulder		Z3	0.4444	$18.40
73040	Contrast x-ray of shoulder	CH	N1		
73050	X-ray exam of shoulders		Z3	0.5432	$22.49
73060	X-ray exam of humerus		Z3	0.4444	$18.40
73070	X-ray exam of elbow		Z3	0.4196	$17.37
73080	X-ray exam of elbow		Z3	0.5183	$21.46
73085	Contrast x-ray of elbow	CH	N1		
73090	X-ray exam of forearm		Z3	0.4196	$17.37
73092	X-ray exam of arm, infant		Z3	0.4196	$17.37
73100	X-ray exam of wrist		Z3	0.428	$17.72
73110	X-ray exam of wrist		Z3	0.5101	$21.12
73115	Contrast x-ray of wrist	CH	N1		
73120	X-ray exam of hand		Z3	0.4113	$17.03
73130	X-ray exam of hand		Z3	0.4609	$19.08
73140	X-ray exam of finger(s)		Z3	0.4362	$18.06
73200	Ct upper extremity w/o dye		Z2	3.0109	$124.65
73201	Ct upper extremity w/dye		Z2	4.3564	$180.36
73202	Ct uppr extremity w/o&w/dye		Z2	5.1125	$211.66
73206	Ct angio upr extrm w/o&w/dye		Z2	5.1641	$213.80
73218	Mri upper extremity w/o dye		Z2	5.3933	$223.29
73219	Mri upper extremity w/dye		Z2	6.235	$258.14
73220	Mri uppr extremity w/o&w/dye		Z2	8.2463	$341.41
73221	Mri joint upr extrem w/o dye		Z2	5.3933	$223.29
73222	Mri joint upr extrem w/dye		Z2	6.235	$258.14
73223	Mri joint upr extr w/o&w/dye		Z2	8.2463	$341.41
73500	X-ray exam of hip		Z3	0.3703	$15.33
73510	X-ray exam of hip		Z3	0.5266	$21.80
73520	X-ray exam of hips		Z3	0.5596	$23.17
73525	Contrast x-ray of hip	CH	N1		
73530	X-ray exam of hip	CH	N1		
73540	X-ray exam of pelvis & hips		Z3	0.5348	$22.14
73542	X-ray exam, sacroiliac joint	CH	N1		
73550	X-ray exam of thigh		Z3	0.4362	$18.06
73560	X-ray exam of knee, 1 or 2		Z3	0.428	$17.72
73562	X-ray exam of knee, 3		Z3	0.5101	$21.12
73564	X-ray exam, knee, 4 or more		Z3	0.5761	$23.85
73565	X-ray exam of knees		Z3	0.4444	$18.40
73580	Contrast x-ray of knee joint	CH	N1		
73590	X-ray exam of lower leg		Z3	0.4113	$17.03
73592	X-ray exam of leg, infant		Z3	0.4196	$17.37
73600	X-ray exam of ankle		Z3	0.4113	$17.03
73610	X-ray exam of ankle		Z3	0.4691	$19.42
73615	Contrast x-ray of ankle	CH	N1		
73620	X-ray exam of foot		Z3	0.4031	$16.69
73630	X-ray exam of foot		Z3	0.4609	$19.08
73650	X-ray exam of heel		Z3	0.3949	$16.35
73660	X-ray exam of toe(s)		Z3	0.4196	$17.37
73700	Ct lower extremity w/o dye		Z2	3.0109	$124.65
73701	Ct lower extremity w/dye		Z2	4.3564	$180.36
73702	Ct lwr extremity w/o&w/dye		Z2	5.1125	$211.66
73706	Ct angio lwr extr w/o&w/dye		Z2	5.1641	$213.80
73718	Mri lower extremity w/o dye		Z2	5.3933	$223.29
73719	Mri lower extremity w/dye		Z2	6.235	$258.14

ADDENDUM BB.—ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including Ancillary Services for Which Payment Is Packaged]

HCPCS code	Short descriptor	Comment indicator	Payment indicator	CY 2008 payment weight	CY 2008 payment
73720	Mri lwr extremity w/o&w/dye		Z2	8.2463	$341.41
73721	Mri jnt of lwr extre w/o dye		Z2	5.3933	$223.29
73722	Mri joint of lwr extr w/dye		Z2	6.235	$258.14
73723	Mri joint lwr extr w/o&w/dye		Z2	8.2463	$341.41
74000	X-ray exam of abdomen		Z3	0.3785	$15.67
74010	X-ray exam of abdomen		Z3	0.5266	$21.80
74020	X-ray exam of abdomen		Z3	0.5514	$22.83
74022	X-ray exam series, abdomen		Z3	0.6582	$27.25
74150	Ct abdomen w/o dye		Z2	3.0109	$124.65
74160	Ct abdomen w/dye		Z2	4.3564	$180.36
74170	Ct abdomen w/o & w/dye		Z2	5.1125	$211.66
74175	Ct angio abdom w/o & w/dye		Z2	5.1641	$213.80
74181	Mri abdomen w/o dye		Z2	5.3933	$223.29
74182	Mri abdomen w/dye		Z2	6.235	$258.14
74183	Mri abdomen w/o & w/dye		Z2	8.2463	$341.41
74190	X-ray exam of peritoneum	CH	N1		
74210	Contrst x-ray exam of throat		Z3	1.1604	$48.04
74220	Contrast x-ray, esophagus		Z3	1.2507	$51.78
74230	Cine/vid x-ray, throat/esoph		Z3	1.2589	$52.12
74235	Remove esophagus obstruction	CH	N1		
74240	X-ray exam, upper gi tract	CH	Z2	1.3834	$57.27
74241	X-ray exam, upper gi tract		Z2	1.3834	$57.27
74245	X-ray exam, upper gi tract		Z2	2.2222	$92.00
74246	Contrst x-ray uppr gi tract		Z2	1.3834	$57.27
74247	Contrst x-ray uppr gi tract		Z2	1.3834	$57.27
74249	Contrst x-ray uppr gi tract		Z2	2.2222	$92.00
74250	X-ray exam of small bowel	CH	Z2	1.3834	$57.27
74251	X-ray exam of small bowel		Z2	2.2222	$92.00
74260	X-ray exam of small bowel		Z2	1.3834	$57.27
74270	Contrast x-ray exam of colon		Z2	1.3834	$57.27
74280	Contrast x-ray exam of colon		Z2	2.2222	$92.00
74283	Contrast x-ray exam of colon		Z2	1.3834	$57.27
74290	Contrast x-ray, gallbladder		Z3	0.9053	$37.48
74291	Contrast x-rays, gallbladder		Z3	0.7816	$32.36
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	D5		
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	1.6869	$69.84
74410	Contrst x-ray, urinary tract		Z3	1.835	$75.97
74415	Contrst x-ray, urinary tract		Z3	2.1478	$88.92
74420	Contrst x-ray, urinary tract		Z2	2.6121	$108.14
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	0.65	$26.91
74740	X-ray, female genital tract	CH	N1		
74742	X-ray, fallopian tube	CH	N1		
74775	X-ray exam of perineum		Z2	2.6121	$108.14
75552	Heart mri for morph w/o dye	CH	D5		
75553	Heart mri for morph w/dye	CH	D5		
75554	Cardiac MRI/function	CH	D5		

ADDENDUM BB.—ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including Ancillary Services for Which Payment Is Packaged]

HCPCS code	Short descriptor	Comment indicator	Payment indicator	CY 2008 payment weight	CY 2008 payment
75555	Cardiac MRI/limited study	CH	D5		
75557	Cardiac mri for morph	NI	Z2	5.3933	$223.29
75559	Cardiac mri w/stress img	NI	Z2	5.3933	$223.29
75561	Cardiac mri for morph w/dye	NI	Z2	8.2463	$341.41
75563	Card mri w/stress img & dye	NI	Z2	8.2463	$341.41
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		
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		

ADDENDUM BB.—ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including Ancillary Services for Which Payment Is Packaged]

HCPCS code	Short descriptor	Comment indicator	Payment indicator	CY 2008 payment weight	CY 2008 payment
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	0.4113	$17.03
76080	X-ray exam of fistula	CH	N1		
76098	X-ray exam, breast specimen		Z3	0.2797	$11.58
76100	X-ray exam of body section		Z2	1.157	$47.90
76101	Complex body section x-ray	CH	Z3	2.7485	$113.79
76102	Complex body section x-rays		Z2	2.6838	$111.11
76120	Cine/video x-rays		Z3	1.1437	$47.35
76125	Cine/video x-rays add-on	CH	N1		
76150	X-ray exam, dry process		Z3	0.4526	$18.74
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	1.5839	$65.58
76496	Fluoroscopic procedure		Z2	1.3271	$54.94
76497	Ct procedure		Z2	1.5839	$65.58
76498	Mri procedure		Z2	4.883	$202.16
76499	Radiographic procedure		Z2	0.6954	$28.79
76506	Echo exam of head		Z2	0.957	$39.62
76510	Ophth us, b & quant a	CH	Z3	1.5963	$66.09
76511	Ophth us, quant a only		Z3	1.2507	$51.78
76512	Ophth us, b w/non-quant a		Z3	1.0862	$44.97
76513	Echo exam of eye, water bath		Z3	1.1521	$47.70
76514	Echo exam of eye, thickness		Z3	0.0659	$2.73
76516	Echo exam of eye		Z3	0.8968	$37.13
76519	Echo exam of eye		Z3	0.9874	$40.88
76529	Echo exam of eye		Z3	0.8558	$35.43
76536	Us exam of head and neck	CH	Z2	1.5094	$62.49
76604	Us exam, chest		Z2	0.957	$39.62
76645	Us exam, breast(s)		Z2	0.957	$39.62
76700	Us exam, abdom, complete		Z2	1.5094	$62.49
76705	Echo exam of abdomen		Z3	1.4647	$60.64
76770	Us exam abdo back wall, comp		Z2	1.5094	$62.49
76775	Us exam abdo back wall, lim		Z3	1.4893	$61.66
76776	Us exam k transpl w/doppler		Z2	1.5094	$62.49
76800	Us exam, spinal canal		Z3	1.4154	$58.60
76801	Ob us < 14 wks, single fetus		Z2	1.5094	$62.49
76802	Ob us < 14 wks, add'l fetus		Z3	0.7241	$29.98
76805	Ob us >/= 14 wks, sngl fetus		Z2	1.5094	$62.49
76810	Ob us >/= 14 wks, addl fetus		Z3	0.9874	$40.88
76811	Ob us, detailed, sngl fetus	CH	Z2	2.3792	$98.50
76812	Ob us, detailed, addl fetus		Z2	0.957	$39.62
76813	Ob us nuchal meas, 1 gest		Z3	1.4893	$61.66
76814	Ob us nuchal meas, add-on		Z3	0.7077	$29.30
76815	Ob us, limited, fetus(s)		Z2	0.957	$39.62
76816	Ob us, follow-up, per fetus		Z2	0.957	$39.62
76817	Transvaginal us, obstetric		Z2	0.957	$39.62
76818	Fetal biophys profile w/nst		Z3	1.4483	$59.96
76819	Fetal biophys profil w/o nst		Z3	1.2343	$51.10
76820	Umbilical artery echo		Z3	0.8311	$34.41
76821	Middle cerebral artery echo		Z3	1.3413	$55.53
76825	Echo exam of fetal heart		Z2	1.5094	$62.49
76826	Echo exam of fetal heart	CH	Z2	0.957	$39.62

ADDENDUM BB.—ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including Ancillary Services for Which Payment Is Packaged]

HCPCS code	Short descriptor	Comment indicator	Payment indicator	CY 2008 payment weight	CY 2008 payment
76827	Echo exam of fetal heart	CH	Z2	0.957	$39.62
76828	Echo exam of fetal heart		Z3	0.65	$26.91
76830	Transvaginal us, non-ob		Z2	1.5094	$62.49
76831	Echo exam, uterus		Z3	1.6623	$68.82
76856	Us exam, pelvic, complete		Z2	1.5094	$62.49
76857	Us exam, pelvic, limited		Z2	0.957	$39.62
76870	Us exam, scrotum		Z2	1.5094	$62.49
76872	Us, transrectal		Z2	1.5094	$62.49
76873	Echograp trans r, pros study		Z2	1.5094	$62.49
76880	Us exam, extremity		Z2	1.5094	$62.49
76885	Us exam infant hips, dynamic		Z2	0.957	$39.62
76886	Us exam infant hips, static		Z2	0.957	$39.62
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	0.957	$39.62
76975	Gi endoscopic ultrasound	CH	N1		
76977	Us bone density measure		Z3	0.3785	$15.67
76998	Us guide, intraop	CH	N1		
76999	Echo examination procedure		Z2	0.957	$39.62
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	0.3867	$16.01
77072	X-rays for bone age		Z3	0.2961	$12.26
77073	X-rays, bone length studies		Z3	0.5514	$22.83
77074	X-rays, bone survey, limited		Z3	0.9381	$38.84
77075	X-rays, bone survey complete		Z2	1.157	$47.90
77076	X-rays, bone survey, infant		Z2	0.6954	$28.79
77077	Joint survey, single view	CH	Z2	0.6831	$28.28
77078	Ct bone density, axial		Z2	1.1384	$47.13
77079	Ct bone density, peripheral	CH	Z2	1.5224	$63.03
77080	Dxa bone density, axial		Z2	1.1384	$47.13
77081	Dxa bone density/peripheral		Z2	0.4773	$19.76
77082	Dxa bone density, vert fx		Z3	0.5019	$20.78
77083	Radiographic absorptiometry		Z3	0.4362	$18.06
77084	Magnetic image, bone marrow		Z2	4.883	$202.16
77280	Set radiation therapy field		Z2	1.5576	$64.49
77285	Set radiation therapy field		Z2	3.9276	$162.61
77290	Set radiation therapy field		Z2	3.9276	$162.61
77295	Set radiation therapy field	CH	Z2	13.5621	$561.48
77299	Radiation therapy planning		Z2	1.5576	$64.49
77300	Radiation therapy dose plan		Z3	0.9546	$39.52
77301	Radiotherapy dose plan, imrt		Z2	13.5621	$561.48
77305	Teletx isodose plan simple		Z3	1.0451	$43.27
77310	Teletx isodose plan intermed		Z3	1.3331	$55.19
77315	Teletx isodose plan complex		Z3	1.7444	$72.22
77321	Special teletx port plan		Z3	2.156	$89.26
77326	Brachytx isodose calc simp		Z2	1.5576	$64.49

ADDENDUM BB.—ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including Ancillary Services for Which Payment Is Packaged]

HCPCS code	Short descriptor	Comment indicator	Payment indicator	CY 2008 payment weight	CY 2008 payment
77327	Brachytx isodose calc interm		Z3	2.9212	$120.94
77328	Brachytx isodose plan compl		Z3	3.9168	$162.16
77331	Special radiation dosimetry		Z3	0.4196	$17.37
77332	Radiation treatment aid(s)		Z3	1.1108	$45.99
77333	Radiation treatment aid(s)		Z3	0.8804	$36.45
77334	Radiation treatment aid(s)		Z3	2.2876	$94.71
77336	Radiation physics consult		Z2	1.5576	$64.49
77370	Radiation physics consult		Z2	1.5576	$64.49
77371	Srs, multisource		Z3	24.7441	$1,024.43
77399	External radiation dosimetry		Z2	1.5576	$64.49
77401	Radiation treatment delivery		Z3	0.9217	$38.16
77402	Radiation treatment delivery		Z2	1.4229	$58.91
77403	Radiation treatment delivery		Z2	1.4229	$58.91
77404	Radiation treatment delivery		Z2	1.4229	$58.91
77406	Radiation treatment delivery		Z2	1.4229	$58.91
77407	Radiation treatment delivery		Z2	1.4229	$58.91
77408	Radiation treatment delivery		Z2	1.4229	$58.91
77409	Radiation treatment delivery		Z2	1.4229	$58.91
77411	Radiation treatment delivery		Z2	2.2167	$91.77
77412	Radiation treatment delivery		Z2	2.2167	$91.77
77413	Radiation treatment delivery		Z2	2.2167	$91.77
77414	Radiation treatment delivery		Z2	2.2167	$91.77
77416	Radiation treatment delivery		Z2	2.2167	$91.77
77417	Radiology port film(s)	CH	N1		
77418	Radiation tx delivery, imrt		Z2	5.4582	$225.97
77421	Stereoscopic x-ray guidance	CH	N1		
77422	Neutron beam tx, simple		Z2	2.2167	$91.77
77423	Neutron beam tx, complex		Z2	2.2167	$91.77
77435	Sbrt management		N1		
77470	Special radiation treatment		Z3	5.0936	$210.88
77520	Proton trmt, simple w/o comp		Z2	12.8205	$530.78
77522	Proton trmt, simple w/comp		Z2	12.8205	$530.78
77523	Proton trmt, intermediate		Z2	15.3404	$635.11
77525	Proton treatment, complex		Z2	15.3404	$635.11
77600	Hyperthermia treatment	CH	Z3	5.2583	$217.70
77605	Hyperthermia treatment		Z2	5.7996	$240.11
77610	Hyperthermia treatment		Z2	5.7996	$240.11
77615	Hyperthermia treatment		Z2	5.7996	$240.11
77620	Hyperthermia treatment	CH	Z3	5.4064	$223.83
77750	Infuse radioactive materials		Z3	1.7529	$72.57
77761	Apply intrcav radiat simple		Z3	3.127	$129.46
77762	Apply intrcav radiat interm		Z3	3.8511	$159.44
77763	Apply intrcav radiat compl		Z3	4.9373	$204.41
77776	Apply interstit radiat simpl		Z3	3.275	$135.59
77777	Apply interstit radiat inter		Z3	3.991	$165.23
77778	Apply interstit radiat compl		Z3	5.2417	$217.01
77781	High intensity brachytherapy		Z3	9.9981	$413.93
77782	High intensity brachytherapy		Z2	11.6779	$483.48
77783	High intensity brachytherapy		Z2	11.6779	$483.48
77784	High intensity brachytherapy		Z2	11.6779	$483.48
77789	Apply surface radiation		Z3	0.8558	$35.43
77790	Radiation handling		N1		
77799	Radium/radioisotope therapy		Z2	8.514	$352.49
78000	Thyroid, single uptake		Z3	1.1355	$47.01
78001	Thyroid, multiple uptakes		Z3	1.4483	$59.96
78003	Thyroid suppress/stimul		Z3	1.1437	$47.35
78006	Thyroid imaging with uptake	CH	Z3	3.4726	$143.77
78007	Thyroid image, mult uptakes		Z3	2.2466	$93.01
78010	Thyroid imaging	CH	Z2	2.0471	$84.75
78011	Thyroid imaging with flow		Z2	2.0471	$84.75
78015	Thyroid met imaging		Z3	3.1598	$130.82
78016	Thyroid met imaging/studies	CH	Z3	4.8221	$199.64
78018	Thyroid met imaging, body		Z2	5.0681	$209.82
78020	Thyroid met uptake	CH	N1		
78070	Parathyroid nuclear imaging	CH	Z3	3.0692	$127.07
78075	Adrenal nuclear imaging	CH	Z3	6.9039	$285.83
78099	Endocrine nuclear procedure		Z2	2.0471	$84.75
78102	Bone marrow imaging, ltd		Z3	2.477	$102.55

ADDENDUM BB.—ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including Ancillary Services for Which Payment Is Packaged]

HCPCS code	Short descriptor	Comment indicator	Payment indicator	CY 2008 payment weight	CY 2008 payment
78103	Bone marrow imaging, mult		Z3	3.4313	$142.06
78104	Bone marrow imaging, body		Z2	3.9293	$162.68
78110	Plasma volume, single		Z3	1.2343	$51.10
78111	Plasma volume, multiple		Z3	1.9091	$79.04
78120	Red cell mass, single		Z3	1.5471	$64.05
78121	Red cell mass, multiple		Z3	2.0572	$85.17
78122	Blood volume		Z3	2.7567	$114.13
78130	Red cell survival study		Z3	2.5263	$104.59
78135	Red cell survival kinetics	CH	Z3	5.4803	$226.89
78140	Red cell sequestration		Z3	2.7321	$113.11
78185	Spleen imaging		Z3	3.0528	$126.39
78190	Platelet survival, kinetics		Z2	2.9022	$120.15
78191	Platelet survival		Z2	2.9022	$120.15
78195	Lymph system imaging		Z2	3.9293	$162.68
78199	Blood/lymph nuclear exam		Z2	3.9293	$162.68
78201	Liver imaging		Z3	2.806	$116.17
78202	Liver imaging with flow		Z3	3.3161	$137.29
78205	Liver imaging (3d)		Z3	4.4929	$186.01
78206	Liver image (3d) with flow		Z2	4.4603	$184.66
78215	Liver and spleen imaging		Z3	3.1188	$129.12
78216	Liver & spleen image/flow		Z3	2.5263	$104.59
78220	Liver function study		Z3	2.7238	$112.77
78223	Hepatobiliary imaging		Z2	4.4603	$184.66
78230	Salivary gland imaging		Z3	2.5509	$105.61
78231	Serial salivary imaging		Z3	2.3864	$98.80
78232	Salivary gland function exam		Z3	2.5345	$104.93
78258	Esophageal motility study		Z3	3.341	$138.32
78261	Gastric mucosa imaging		Z2	3.7911	$156.96
78262	Gastroesophageal reflux exam		Z2	3.7911	$156.96
78264	Gastric emptying study		Z2	3.7911	$156.96
78270	Vit b-12 absorption exam		Z3	1.4072	$58.26
78271	Vit b-12 absrp exam, int fac		Z3	1.4236	$58.94
78272	Vit b-12 absorp, combined		Z3	1.7693	$73.25
78278	Acute gi blood loss imaging		Z2	3.7911	$156.96
78282	Gi protein loss exam		Z2	3.7911	$156.96
78290	Meckels divert exam		Z2	3.7911	$156.96
78291	Leveen/shunt patency exam		Z3	3.6617	$151.60
78299	Gi nuclear procedure		Z2	3.7911	$156.96
78300	Bone imaging, limited area		Z3	2.6743	$110.72
78305	Bone imaging, multiple areas		Z3	3.6371	$150.58
78306	Bone imaging, whole body	CH	Z2	3.8039	$157.49
78315	Bone imaging, 3 phase		Z2	3.8039	$157.49
78320	Bone imaging (3d)		Z2	3.8039	$157.49
78399	Musculoskeletal nuclear exam		Z2	3.8039	$157.49
78414	Non-imaging heart function		Z2	4.862	$201.29
78428	Cardiac shunt imaging		Z3	2.9458	$121.96
78445	Vascular flow imaging	CH	Z3	2.5427	$105.27
78456	Acute venous thrombus image		Z2	3.1433	$130.14
78457	Venous thrombosis imaging	CH	Z3	2.9048	$120.26
78458	Ven thrombosis images, bilat		Z2	3.1433	$130.14
78459	Heart muscle imaging (pet)		Z2	21.9955	$910.64
78460	Heart muscle blood, single		Z3	2.7567	$114.13
78461	Heart muscle blood, multiple		Z3	3.4231	$141.72
78464	Heart image (3d), single	CH	Z3	5.11	$211.56
78465	Heart image (3d), multiple	CH	Z3	9.2657	$383.61
78466	Heart infarct image		Z3	2.8391	$117.54
78468	Heart infarct image (ef)		Z3	3.7523	$155.35
78469	Heart infarct image (3d)	CH	Z3	4.5506	$188.40
78472	Gated heart, planar, single	CH	Z3	4.5753	$189.42
78473	Gated heart, multiple		Z2	4.862	$201.29
78478	Heart wall motion add-on	CH	N1		
78480	Heart function add-on	CH	N1		
78481	Heart first pass, single		Z3	4.032	$166.93
78483	Heart first pass, multiple		Z2	4.862	$201.29
78491	Heart image (pet), single		Z2	21.9955	$910.64
78492	Heart image (pet), multiple		Z2	21.9955	$910.64
78494	Heart image, spect		Z2	4.862	$201.29
78496	Heart first pass add-on	CH	N1		

ADDENDUM BB.—ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including Ancillary Services for Which Payment Is Packaged]

HCPCS code	Short descriptor	Comment indicator	Payment indicator	CY 2008 payment weight	CY 2008 payment
78499	Cardiovascular nuclear exam		Z2	4.862	$201.29
78580	Lung perfusion imaging	CH	Z3	3.4149	$141.38
78584	Lung v/q image single breath		Z3	2.4111	$99.82
78585	Lung v/q imaging		Z2	4.9509	$204.97
78586	Aerosol lung image, single		Z3	2.7238	$112.77
78587	Aerosol lung image, multiple		Z3	3.3161	$137.29
78588	Perfusion lung image		Z3	4.7233	$195.55
78591	Vent image, 1 breath, 1 proj		Z3	2.8306	$117.19
78593	Vent image, 1 proj, gas		Z3	3.3328	$137.98
78594	Vent image, mult proj, gas		Z2	3.3954	$140.57
78596	Lung differential function		Z2	4.9509	$204.97
78599	Respiratory nuclear exam		Z2	3.3954	$140.57
78600	Brain image < 4 views		Z3	2.9294	$121.28
78601	Brain image w/flow < 4 views	CH	Z2	3.2295	$133.70
78605	Brain image 4+ views		Z3	3.3161	$137.29
78606	Brain image w/flow 4 + views	CH	Z3	5.0115	$207.48
78607	Brain imaging (3d)	CH	Z3	6.0728	$251.42
78608	Brain imaging (pet)		Z2	16.6001	$687.26
78610	Brain flow imaging only		Z3	3.3738	$139.68
78615	Cerebral vascular flow image	CH	D5		
78630	Cerebrospinal fluid scan	CH	Z3	5.5298	$228.94
78635	Csf ventriculography	CH	Z3	4.5753	$189.42
78645	Csf shunt evaluation		Z2	3.2295	$133.70
78647	Cerebrospinal fluid scan	CH	Z3	5.8177	$240.86
78650	Csf leakage imaging	CH	Z3	5.3405	$221.10
78660	Nuclear exam of tear flow		Z3	2.5509	$105.61
78699	Nervous system nuclear exam		Z2	3.2295	$133.70
78700	Kidney imaging, morphol		Z3	2.9953	$124.01
78701	Kidney imaging with flow		Z3	3.6043	$149.22
78707	K flow/funct image w/o drug	CH	Z3	3.9581	$163.87
78708	K flow/funct image w/drug		Z3	3.0941	$128.10
78709	K flow/funct image, multiple		Z2	5.0824	$210.42
78710	Kidney imaging (3d)	CH	Z3	4.5093	$186.69
78725	Kidney function study	CH	Z3	1.6541	$68.48
78730	Urinary bladder retention	CH	Z3	1.3908	$57.58
78740	Ureteral reflux study		Z3	3.1188	$129.12
78761	Testicular imaging w/flow		Z3	3.2915	$136.27
78799	Genitourinary nuclear exam		Z2	5.0824	$210.42
78800	Tumor imaging, limited area		Z3	3.0941	$128.10
78801	Tumor imaging, mult areas		Z3	4.1144	$170.34
78802	Tumor imaging, whole body	CH	Z3	5.5052	$227.92
78803	Tumor imaging (3d)	CH	Z3	6.0564	$250.74
78804	Tumor imaging, whole body	CH	Z3	10.5	$434.71
78805	Abscess imaging, ltd area		Z3	3.0364	$125.71
78806	Abscess imaging, whole body	CH	Z3	5.9576	$246.65
78807	Nuclear localization/abscess	CH	Z3	6.0482	$250.40
78811	Pet image, ltd area		Z2	16.6001	$687.26
78812	Pet image, skull-thigh		Z2	16.6001	$687.26
78813	Pet image, full body		Z2	16.6001	$687.26
78814	Pet image w/ct, lmtd		Z2	16.6001	$687.26
78815	Pet image w/ct, skull-thigh		Z2	16.6001	$687.26
78816	Pet image w/ct, full body		Z2	16.6001	$687.26
78890	Nuclear medicine data proc		N1		
78891	Nuclear med data proc		N1		
78999	Nuclear diagnostic exam		Z2	1.819	$75.31
79005	Nuclear rx, oral admin		Z3	1.5963	$66.09
79101	Nuclear rx, iv admin		Z3	1.6623	$68.82
79200	Nuclear rx, intracav admin		Z3	1.728	$71.54
79300	Nuclr rx, interstit colloid		Z2	3.302	$136.71
79403	Hematopoietic nuclear tx		Z3	2.6497	$109.70
79440	Nuclear rx, intra-articular		Z3	1.5553	$64.39
79445	Nuclear rx, intra-arterial		Z2	3.302	$136.71
79999	Nuclear medicine therapy		Z2	3.302	$136.71
90296	Diphtheria antitoxin	CH	N1		
90371	Hep b ig, im		K2		$122.02
90375	Rabies ig, im/sc		K2		$68.22
90376	Rabies ig, heat treated		K2		$71.69
90385	Rh ig, minidose, im	CH	N1		

ADDENDUM BB.—ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including Ancillary Services for Which Payment Is Packaged]

HCPCS code	Short descriptor	Comment indicator	Payment indicator	CY 2008 payment weight	CY 2008 payment
90393	Vaccina ig, im	CH	N1		
90396	Varicella-zoster ig, im		K2		$122.74
90476	Adenovirus vaccine, type 4	CH	N1		
90477	Adenovirus vaccine, type 7	CH	N1		
90581	Anthrax vaccine, sc	CH	N1		
90585	Bcg vaccine, percut		K2		$118.98
90632	Hep a vaccine, adult im	CH	N1		
90633	Hep a vacc, ped/adol, 2 dose	CH	N1		
90634	Hep a vacc, ped/adol, 3 dose	CH	N1		
90636	Hep a/hep b vacc, adult im	CH	N1		
90645	Hib vaccine, hboc, im	CH	N1		
90646	Hib vaccine, prp-d, im	CH	N1		
90647	Hib vaccine, prp-omp, im	CH	N1		
90648	Hib vaccine, prp-t, im	CH	N1		
90665	Lyme disease vaccine, im	CH	N1		
90675	Rabies vaccine, im		K2		$150.80
90676	Rabies vaccine, id		K2		$119.86
90680	Rotovirus vacc 3 dose, oral	CH	N1		
90690	Typhoid vaccine, oral	CH	N1		
90691	Typhoid vaccine, im	CH	N1		
90692	Typhoid vaccine, h-p, sc/id	CH	N1		
90698	Dtap-hib-ip vaccine, im	CH	N1		
90700	Dtap vaccine, < 7 yrs, im	CH	N1		
90701	Dtp vaccine, im	CH	N1		
90702	Dt vaccine < 7, im	CH	N1		
90703	Tetanus vaccine, im	CH	N1		
90704	Mumps vaccine, sc	CH	N1		
90705	Measles vaccine, sc	CH	N1		
90706	Rubella vaccine, sc	CH	N1		
90707	Mmr vaccine, sc	CH	N1		
90708	Measles-rubella vaccine, sc		K2		$45.53
90710	Mmrv vaccine, sc	CH	N1		
90712	Oral poliovirus vaccine	CH	N1		
90713	Poliovirus, ipv, sc/im	CH	N1		
90714	Td vaccine no prsrv >/= 7 im	CH	N1		
90715	Tdap vaccine >7 im	CH	N1		
90717	Yellow fever vaccine, sc	CH	N1		
90718	Td vaccine > 7, im	CH	N1		
90719	Diphtheria vaccine, im	CH	N1		
90720	Dtp/hib vaccine, im	CH	N1		
90721	Dtap/hib vaccine, im	CH	N1		
90725	Cholera vaccine, injectable	CH	N1		
90727	Plague vaccine, im	CH	N1		
90733	Meningococcal vaccine, sc		K2		$85.29
90734	Meningococcal vaccine, im		K2		$82.00
90735	Encephalitis vaccine, sc		K2		$98.17
90749	Vaccine toxoid	CH	N1		
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		
A4648	Implantable tissue marker	NI	N1		
A4650	Implant radiation dosimeter	NI	N1		
A9527	Iodine I-125 sodium iodide	CH	H2	0.4325	$27.55
A9535	Injection, methylene blue	CH	N1		
A9576	Inj prohance multipack	NI	N1		
A9577	Inj multihance	NI	N1		
A9578	Inj multihance multipack	NI	N1		
A9579	Gad-base MR contrast NOS,1ml	NI	N1		
A9698	Non-rad contrast materialNOC		N1		
C1713	Anchor/screw bn/bn,tis/bn		N1		
C1714	Cath, trans atherectomy, dir		N1		

ADDENDUM BB.—ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including Ancillary Services for Which Payment Is Packaged]

HCPCS code	Short descriptor	Comment indicator	Payment indicator	CY 2008 payment weight	CY 2008 payment
C1715	Brachytherapy needle		N1		
C1716	Brachytx, non-str, Gold-198	CH	H2	0.5228	$33.30
C1717	Brachytx, non-str,HDR Ir-192	CH	H2	2.7505	$175.19
C1719	Brachytx, NS, Non-HDRIr-192	CH	H2	1.0226	$65.13
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		
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		

ADDENDUM BB.—ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including Ancillary Services for Which Payment Is Packaged]

HCPCS code	Short descriptor	Comment indicator	Payment indicator	CY 2008 payment weight	CY 2008 payment
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, non-str,Yttrium-90	CH	H2	184.7105	$11,764.95
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		
C2634	Brachytx, non-str, HA, I-125	CH	H2	0.4858	$30.94
C2635	Brachytx, non-str, HA, P-103	CH	H2	0.7366	$46.92
C2636	Brachy linear, non-str,P-103	CH	H2	0.66	$42.04
C2638	Brachytx, stranded, I-125	CH	H2	0.7113	$45.31
C2639	Brachytx, non-stranded,I-125	CH	H2	0.5039	$32.10
C2640	Brachytx, stranded, P-103	CH	H2	1.0308	$65.66
C2641	Brachytx, non-stranded,P-103	CH	H2	0.8077	$51.45
C2642	Brachytx, stranded, C-131	CH	H2	1.5342	$97.72
C2643	Brachytx, non-stranded,C-131	CH	H2	1.006	$64.08
C2698	Brachytx, stranded, NOS	CH	H2	0.7113	$45.31
C2699	Brachytx, non-stranded, NOS	CH	H2	0.4858	$30.94
C8900	MRA w/cont, abd		Z2	6.235	$258.14
C8901	MRA w/o cont, abd		Z2	5.3933	$223.29
C8902	MRA w/o fol w/cont, abd		Z2	8.2463	$341.41
C8903	MRI w/cont, breast, uni		Z2	6.235	$258.14
C8904	MRI w/o cont, breast, uni		Z2	5.3933	$223.29
C8905	MRI w/o fol w/cont, brst, un		Z2	8.2463	$341.41
C8906	MRI w/cont, breast, bi		Z2	6.235	$258.14
C8907	MRI w/o cont, breast, bi		Z2	5.3933	$223.29
C8908	MRI w/o fol w/cont, breast,		Z2	8.2463	$341.41
C8909	MRA w/cont, chest		Z2	6.235	$258.14
C8910	MRA w/o cont, chest		Z2	5.3933	$223.29
C8911	MRA w/o fol w/cont, chest		Z2	8.2463	$341.41
C8912	MRA w/cont, lwr ext		Z2	6.235	$258.14
C8913	MRA w/o cont, lwr ext		Z2	5.3933	$223.29
C8914	MRA w/o fol w/cont, lwr ext		Z2	8.2463	$341.41
C8918	MRA w/cont, pelvis		Z2	6.235	$258.14
C8919	MRA w/o cont, pelvis		Z2	5.3933	$223.29
C8920	MRA w/o fol w/cont, pelvis		Z2	8.2463	$341.41
C9003	Palivizumab, per 50 mg		K2		$810.67
C9113	Inj pantoprazole sodium, via		N1		
C9121	Injection, argatroban		K2		$18.96
C9232	Injection, idursulfase	CH	D5		
C9233	Injection, ranibizumab	CH	D5		

ADDENDUM BB.—ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including Ancillary Services for Which Payment Is Packaged]

HCPCS code	Short descriptor	Comment indicator	Payment indicator	CY 2008 payment weight	CY 2008 payment
C9234	Inj, alglucosidase alfa	CH	D5		
C9235	Injection, panitumumab	CH	D5		
C9238	Inj, levetiracetam	NI	K2		$6.30
C9239	Inj, temsirolimus	NI	K2		$48.41
C9350	Porous collagen tube per cm	CH	D5		
C9351	Acellular derm tissue percm2	CH	D5		
C9352	Neuragen nerve guide, per cm	NI	K2		$482.56
C9353	Neurawrap nerve protector,cm	NI	K2		$482.56
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	0.5266	$21.80
G0173	Linear acc stereo radsur com		Z2	61.6965	$2,554.30
G0251	Linear acc based stero radio		Z2	16.5911	$686.89
G0288	Recon, CTA for surg plan	CH	N1		
G0339	Robot lin-radsurg com, first		Z2	61.6965	$2,554.30
G0340	Robt lin-radsurg fractx 2-5		Z2	45.0693	$1,865.91
J0120	Tetracyclin injection		N1		
J0128	Abarelix injection		K2		$67.97
J0129	Abatacept injection		K2		$18.69
J0130	Abciximab injection		K2		$420.17
J0132	Acetylcysteine injection	CH	N1		
J0133	Acyclovir injection		N1		
J0135	Adalimumab injection		K2		$329.58
J0150	Injection adenosine 6 MG		K2		$25.10
J0152	Adenosine injection		K2		$67.89
J0170	Adrenalin epinephrin inject		N1		
J0180	Agalsidase beta injection		K2		$126.00
J0190	Inj biperiden lactate/5 mg		K2		$88.15
J0200	Alatrofloxacin mesylate		N1		
J0205	Alglucerase injection		K2		$38.85
J0207	Amifostine		K2		$490.93
J0210	Methyldopate hcl injection		K2		$13.04
J0215	Alefacept		K2		$26.47
J0220	Aglucosidase alfa injection	NI	K2		$126.00
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		$10.40
J0288	Ampho b cholesteryl sulfate		K2		$11.89
J0289	Amphotericin b liposome inj		K2		$16.21
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		$2.66
J0380	Inj metaraminol bitartrate	CH	N1		
J0390	Chloroquine injection		N1		
J0395	Arbutamine HCl injection	CH	N1		
J0400	Aripiprazole injection	NI	K2		$0.28
J0456	Azithromycin		N1		
J0460	Atropine sulfate injection		N1		
J0470	Dimecaprol injection		N1		
J0475	Baclofen 10 MG injection		K2		$193.29
J0476	Baclofen intrathecal trial		K2		$69.73
J0480	Basiliximab		K2		$1,541.03
J0500	Dicyclomine injection		N1		
J0515	Inj benztropine mesylate		N1		

ADDENDUM BB.—ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including Ancillary Services for Which Payment Is Packaged]

HCPCS code	Short descriptor	Comment indicator	Payment indicator	CY 2008 payment weight	CY 2008 payment
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		$1.84
J0585	Botulinum toxin a per unit		K2		$5.21
J0587	Botulinum toxin type B		K2		$8.63
J0592	Buprenorphine hydrochloride		N1		
J0594	Busulfan injection		K2		$9.17
J0595	Butorphanol tartrate 1 mg		N1		
J0600	Edetate calcium disodium inj		K2		$49.64
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		$24.05
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		$62.78
J0740	Cidofovir injection		K2		$754.39
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		$4.43
J0800	Corticotropin injection		K2		$169.77
J0835	Inj cosyntropin per 0.25 MG		K2		$64.01
J0850	Cytomegalovirus imm IV /vial		K2		$870.53
J0878	Daptomycin injection		K2		$0.35
J0881	Darbepoetin alfa, non-esrd		K2		$2.88
J0885	Epoetin alfa, non-esrd		K2		$8.97
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		

ADDENDUM BB.—ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including Ancillary Services for Which Payment Is Packaged]

HCPCS code	Short descriptor	Comment indicator	Payment indicator	CY 2008 payment weight	CY 2008 payment
J1162	Digoxin immune fab (ovine)		K2		$478.88
J1165	Phenytoin sodium injection		N1		
J1170	Hydromorphone injection		N1		
J1180	Dyphylline injection		N1		
J1190	Dexrazoxane HCl injection		K2		$162.11
J1200	Diphenhydramine hcl injectio		N1		
J1205	Chlorothiazide sodium inj		K2		$141.07
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		$4.66
J1265	Dopamine injection		N1		
J1270	Injection, doxercalciferol		N1		
J1300	Eculizumab injection	NI	K2		$176.38
J1320	Amitriptyline injection		N1		
J1324	Enfuvirtide injection		K2		$0.40
J1325	Epoprostenol injection		N1		
J1327	Eptifibatide injection		K2		$17.67
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		$66.64
J1430	Ethanolamine oleate 100 mg		K2		$79.23
J1435	Injection estrone per 1 MG		N1		
J1436	Etidronate disodium inj		K2		$70.73
J1438	Etanercept injection		K2		$167.12
J1440	Filgrastim 300 mcg injection		K2		$193.79
J1441	Filgrastim 480 mcg injection		K2		$298.39
J1450	Fluconazole		N1		
J1451	Fomepizole, 15 mg		K2		$12.80
J1452	Intraocular Fomivirsen na	CH	N1		
J1455	Foscarnet sodium injection	CH	N1		
J1457	Gallium nitrate injection	CH	K2		$1.61
J1458	Galsulfase injection		K2		$306.88
J1460	Gamma globulin 1 CC inj		K2		$11.91
J1470	Gamma globulin 2 CC inj	CH	K2		$23.82
J1480	Gamma globulin 3 CC inj	CH	K2		$35.72
J1490	Gamma globulin 4 CC inj	CH	K2		$47.64
J1500	Gamma globulin 5 CC inj	CH	K2		$59.54
J1510	Gamma globulin 6 CC inj	CH	K2		$71.50
J1520	Gamma globulin 7 CC inj	CH	K2		$83.30
J1530	Gamma globulin 8 CC inj	CH	K2		$95.27
J1540	Gamma globulin 9 CC inj	CH	K2		$107.25
J1550	Gamma globulin 10 CC inj	CH	K2		$119.09
J1560	Gamma globulin > 10 CC inj	CH	K2		$119.09
J1561	Gamunex injection	NI	K2		$32.06
J1562	Vivaglobin, inj		K2		$7.01
J1565	RSV-ivig		K2		$16.02
J1566	Immune globulin, powder		K2		$26.89
J1567	Immune globulin, liquid	CH	D5		
J1568	Octagam injection	NI	K2		$33.19
J1569	Gammagard liquid injection	NI	K2		$31.06
J1570	Ganciclovir sodium injection		N1		
J1571	Hepagam B IM injection	NI	K2		$63.51
J1572	Flebogamma injection	NI	K2		$32.27
J1573	Hepagam B intravenous, inj	NI	K2		$63.51
J1580	Garamycin gentamicin inj		N1		
J1590	Gatifloxacin injection		N1		
J1595	Injection glatiramer acetate	CH	K2		$52.04
J1600	Gold sodium thiomaleate inj		N1		
J1610	Glucagon hydrochloride/1 MG		K2		$68.84
J1620	Gonadorelin hydroch/ 100 mcg		K2		$178.59
J1626	Granisetron HCl injection		K2		$5.74
J1630	Haloperidol injection		N1		

ADDENDUM BB.—ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including Ancillary Services for Which Payment Is Packaged]

HCPCS code	Short descriptor	Comment indicator	Payment indicator	CY 2008 payment weight	CY 2008 payment
J1631	Haloperidol decanoate inj		N1		
J1640	Hemin, 1 mg		K2		$7.08
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		$5.92
J1655	Tinzaparin sodium injection	CH	N1		
J1670	Tetanus immune globulin inj		K2		$103.46
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		$138.96
J1742	Ibutilide fumarate injection		K2		$287.15
J1743	Idursulfase injection	NI	K2		$455.03
J1745	Infliximab injection		K2		$54.42
J1751	Iron dextran 165 injection		K2		$11.82
J1752	Iron dextran 267 injection		K2		$10.30
J1756	Iron sucrose injection		K2		$0.36
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		$106.57
J1835	Itraconazole injection		K2		$39.68
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		$159.44
J1950	Leuprolide acetate /3.75 MG		K2		$452.58
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		$15.62
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		$1.44
J2250	Inj midazolam hydrochloride		N1		
J2260	Inj milrinone lactate / 5 MG		N1		
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		$1.87
J2320	Nandrolone decanoate 50 MG		N1		
J2321	Nandrolone decanoate 100 MG		N1		
J2322	Nandrolone decanoate 200 MG		N1		
J2323	Natalizumab injection	NI	K2		$7.51
J2325	Nesiritide injection		K2		$32.95
J2353	Octreotide injection, depot		K2		$99.04
J2354	Octreotide inj, non-depot		N1		
J2355	Oprelvekin injection		K2		$247.02

ADDENDUM BB.—ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including Ancillary Services for Which Payment Is Packaged]

HCPCS code	Short descriptor	Comment indicator	Payment indicator	CY 2008 payment weight	CY 2008 payment
J2357	Omalizumab injection		K2		$17.12
J2360	Orphenadrine injection		N1		
J2370	Phenylephrine hcl injection		N1		
J2400	Chloroprocaine hcl injection		N1		
J2405	Ondansetron hcl injection		K2		$0.26
J2410	Oxymorphone hcl injection		N1		
J2425	Palifermin injection		K2		$11.24
J2430	Pamidronate disodium /30 MG		K2		$28.31
J2440	Papaverin hcl injection		N1		
J2460	Oxytetracycline injection		N1		
J2469	Palonosetron HCl		K2		$16.45
J2501	Paricalcitol		N1		
J2503	Pegaptanib sodium injection		K2		$1,035.69
J2504	Pegademase bovine, 25 iu		K2		$197.51
J2505	Injection, pegfilgrastim 6mg		K2		$2,145.12
J2510	Penicillin g procaine inj		N1		
J2513	Pentastarch 10% solution	CH	K2		$21.98
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		
J2724	Protein C concentrate	NI	K2		$12.08
J2725	Inj protirelin per 250 mcg		N1		
J2730	Pralidoxime chloride inj	CH	K2		$35.20
J2760	Phentolaine mesylate inj		N1		
J2765	Metoclopramide hcl injection		N1		
J2770	Quinupristin/dalfopristin		K2		$126.44
J2778	Ranibizumab injection	NI	K2		$2,030.23
J2780	Ranitidine hydrochloride inj		N1		
J2783	Rasburicase		K2		$144.43
J2788	Rho d immune globulin 50 mcg		K2		$26.41
J2790	Rho d immune globulin inj		K2		$80.79
J2791	Rhophylac injection	NI	K2		$5.29
J2792	Rho(D) immune globulin h, sd		K2		$15.62
J2794	Risperidone, long acting		K2		$4.86
J2795	Ropivacaine HCl injection		N1		
J2800	Methocarbamol injection		N1		
J2805	Sincalide injection		N1		
J2810	Inj theophylline per 40 MG		N1		
J2820	Sargramostim injection		K2		$24.86
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		
J2940	Somatrem injection		K2		$168.90
J2941	Somatropin injection		K2		$48.52
J2950	Promazine hcl injection		N1		
J2993	Reteplase injection		K2		$841.28
J2995	Inj streptokinase /250000 IU		K2		$129.75
J2997	Alteplase recombinant		K2		$33.39
J3000	Streptomycin injection		N1		
J3010	Fentanyl citrate injeciton		N1		
J3030	Sumatriptan succinate / 6 MG		K2		$61.27
J3070	Pentazocine injection		N1		
J3100	Tenecteplase injection		K2		$2,034.65
J3105	Terbutaline sulfate inj		N1		

ADDENDUM BB.—ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including Ancillary Services for Which Payment Is Packaged]

HCPCS code	Short descriptor	Comment indicator	Payment indicator	CY 2008 payment weight	CY 2008 payment
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		$834.18
J3243	Tigecycline injection		K2		$0.96
J3246	Tirofiban HCl		K2		$7.56
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		$148.30
J3310	Perphenazine injeciton		N1		
J3315	Triptorelin pamoate		K2		$159.38
J3320	Spectinomycn di-hcl inj	CH	N1		
J3350	Urea injection		K2		$74.16
J3355	Urofollitropin, 75 iu		K2		$50.22
J3360	Diazepam injection		N1		
J3364	Urokinase 5000 IU injection		N1		
J3365	Urokinase 250,000 IU inj		K2		$453.41
J3370	Vancomycin hcl injection		N1		
J3396	Verteporfin injection		K2		$8.99
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		$4.93
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		$205.76
J3488	Reclast injection	NI	K2		$220.81
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	Humate-P, inj		K2		$0.88
J7189	Factor viia		K2		$1.15
J7190	Factor viii		K2		$0.75
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		$0.80
J7195	Factor IX recombinant		K2		$0.99
J7197	Antithrombin iii injection		K2		$1.82
J7198	Anti-inhibitor		K2		$1.42
J7308	Aminolevulinic acid hcl top		K2		$109.92

ADDENDUM BB.—ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including Ancillary Services for Which Payment Is Packaged]

HCPCS code	Short descriptor	Comment indicator	Payment indicator	CY 2008 payment weight	CY 2008 payment
J7310	Ganciclovir long act implant		K2		$4,707.90
J7311	Fluocinolone acetonide implt		K2		$19,162.50
J7321	Hyalgan/supartz inj per dose	NI	K2		$101.81
J7322	Synvisc inj per dose	NI	K2		$178.11
J7323	Euflexxa inj per dose	NI	K2		$110.95
J7324	Orthovisc inj per dose	NI	K2		$174.50
J7340	Metabolic active D/E tissue		K2		$28.45
J7341	Non-human, metabolic tissue	CH	N1		
J7342	Metabolically active tissue		K2		$36.40
J7343	Nonmetabolic act d/e tissue		K2		$20.22
J7344	Nonmetabolic active tissue		K2		$94.53
J7345	Non-human, non-metab tissue	CH	D5		
J7346	Injectable human tissue		K2		$774.46
J7347	Integra matrix tissue	NI	K2		$33.14
J7348	Tissuemend tissue	NI	K2		$67.96
J7349	Primatrix tissue	NI	K2		$67.96
J7500	Azathioprine oral 50mg		N1		
J7501	Azathioprine parenteral		K2		$47.88
J7502	Cyclosporine oral 100 mg		K2		$3.52
J7504	Lymphocyte immune globulin		K2		$336.10
J7505	Monoclonal antibodies		K2		$977.75
J7506	Prednisone oral		N1		
J7507	Tacrolimus oral per 1 MG		K2		$3.69
J7509	Methylprednisolone oral		N1		
J7510	Prednisolone oral per 5 mg		N1		
J7511	Antithymocyte globuln rabbit		K2		$337.82
J7513	Daclizumab, parenteral		K2		$322.28
J7515	Cyclosporine oral 25 mg		N1		
J7516	Cyclosporin parenteral 250mg		N1		
J7517	Mycophenolate mofetil oral		K2		$2.66
J7518	Mycophenolic acid		K2		$2.41
J7520	Sirolimus, oral		K2		$7.50
J7525	Tacrolimus injection		K2		$138.64
J7599	Immunosuppressive drug noc		N1		
J7674	Methacholine chloride, neb		N1		
J7799	Non-inhalation drug for DME		N1		
J8501	Oral aprepitant		K2		$4.99
J8510	Oral busulfan		K2		$2.26
J8520	Capecitabine, oral, 150 mg		K2		$4.28
J8521	Capecitabine, oral, 500 mg	CH	K2		$14.19
J8530	Cyclophosphamide oral 25 MG		N1		
J8540	Oral dexamethasone		N1		
J8560	Etoposide oral 50 MG		K2		$29.46
J8597	Antiemetic drug oral NOS		N1		
J8600	Melphalan oral 2 MG	CH	K2		$4.14
J8610	Methotrexate oral 2.5 MG		N1		
J8650	Nabilone oral		K2		$16.80
J8700	Temozolomide		K2		$7.49
J9000	Doxorubic hcl 10 MG vl chemo	CH	N1		
J9001	Doxorubicin hcl liposome inj		K2		$396.15
J9010	Alemtuzumab injection		K2		$549.77
J9015	Aldesleukin/single use vial		K2		$788.84
J9017	Arsenic trioxide		K2		$34.44
J9020	Asparaginase injection		K2		$54.26
J9025	Azacitidine injection		K2		$4.35
J9027	Clofarabine injection		K2		$114.41
J9031	Bcg live intravesical vac		K2		$113.75
J9035	Bevacizumab injection		K2		$56.93
J9040	Bleomycin sulfate injection		K2		$42.93
J9041	Bortezomib injection		K2		$33.20
J9045	Carboplatin injection		K2		$7.44
J9050	Carmus bischl nitro inj		K2		$152.24
J9055	Cetuximab injection		K2		$49.43
J9060	Cisplatin 10 MG injection		N1		
J9062	Cisplatin 50 MG injection	CH	N1		
J9065	Inj cladribine per 1 MG		K2		$32.04
J9070	Cyclophosphamide 100 MG inj		N1		
J9080	Cyclophosphamide 200 MG inj	CH	N1		

ADDENDUM BB.—ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including Ancillary Services for Which Payment Is Packaged]

HCPCS code	Short descriptor	Comment indicator	Payment indicator	CY 2008 payment weight	CY 2008 payment
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		$412.21
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		$19.33
J9151	Daunorubicin citrate liposom		K2		$55.23
J9160	Denileukin diftitox, 300 mcg		K2		$1,386.59
J9165	Diethylstilbestrol injection		N1		
J9170	Docetaxel		K2		$310.85
J9175	Elliotts b solution per ml		N1		
J9178	Inj, epirubicin hcl, 2 mg		K2		$19.79
J9181	Etoposide 10 MG inj		N1		
J9182	Etoposide 100 MG inj	CH	N1		
J9185	Fludarabine phosphate inj		K2		$226.67
J9190	Fluorouracil injection		N1		
J9200	Floxuridine injection		K2		$54.63
J9201	Gemcitabine HCl		K2		$127.31
J9202	Goserelin acetate implant		K2		$192.29
J9206	Irinotecan injection		K2		$124.61
J9208	Ifosfomide injection		K2		$38.13
J9209	Mesna injection		K2		$7.97
J9211	Idarubicin hcl injection		K2		$302.42
J9212	Interferon alfacon-1		K2		$4.62
J9213	Interferon alfa-2a inj		K2		$41.37
J9214	Interferon alfa-2b inj		K2		$13.92
J9215	Interferon alfa-n3 inj		K2		$9.03
J9216	Interferon gamma 1-b inj		K2		$306.66
J9217	Leuprolide acetate suspnsion		K2		$236.06
J9218	Leuprolide acetate injeciton		K2		$7.98
J9219	Leuprolide acetate implant		K2		$1,648.41
J9225	Vantas implant		K2		$1,412.46
J9226	Supprelin LA implant	NI	K2		$14,700.00
J9230	Mechlorethamine hcl inj		K2		$143.08
J9245	Inj melphalan hydrochl 50 MG		K2		$1,548.88
J9250	Methotrexate sodium inj		N1		
J9260	Methotrexate sodium inj	CH	N1		
J9261	Nelarabine injection		K2		$86.84
J9263	Oxaliplatin		K2		$9.15
J9264	Paclitaxel protein bound		K2		$8.79
J9265	Paclitaxel injection		K2		$14.57
J9266	Pegaspargase/singl dose vial		K2		$2,080.19
J9268	Pentostatin injection		K2		$2,051.68
J9270	Plicamycin (mithramycin) inj		K2		$172.41
J9280	Mitomycin 5 MG inj		K2		$14.39
J9290	Mitomycin 20 MG inj	CH	K2		$57.56
J9291	Mitomycin 40 MG inj	CH	K2		$115.11
J9293	Mitoxantrone hydrochl / 5 MG		K2		$107.96
J9300	Gemtuzumab ozogamicin		K2		$2,411.98
J9303	Panitumumab injection	NI	K2		$83.15
J9305	Pemetrexed injection		K2		$44.49
J9310	Rituximab cancer treatment		K2		$504.40
J9320	Streptozocin injection		K2		$146.93
J9340	Thiotepa injection		K2		$41.12
J9350	Topotecan		K2		$859.62
J9355	Trastuzumab		K2		$58.51
J9357	Valrubicin, 200 mg		K2		$77.96
J9360	Vinblastine sulfate inj		N1		
J9370	Vincristine sulfate 1 MG inj		N1		

ADDENDUM BB.—ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including Ancillary Services for Which Payment Is Packaged]

HCPCS code	Short descriptor	Comment indicator	Payment indicator	CY 2008 payment weight	CY 2008 payment
J9375	Vincristine sulfate 2 MG inj	CH	N1		
J9380	Vincristine sulfate 5 MG inj	CH	N1		
J9390	Vinorelbine tartrate/10 mg		K2		$21.41
J9395	Injection, Fulvestrant		K2		$80.60
J9600	Porfimer sodium		K2		$2,532.53
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		
P9041	Albumin (human),5%, 50ml	CH	K2	0.3413	$21.74
P9045	Albumin (human), 5%, 250 ml	CH	K2	1.0987	$69.98
P9046	Albumin (human), 25%, 20 ml	CH	K2	0.4118	$26.23
P9047	Albumin (human), 25%, 50ml	CH	K2	1.1362	$72.37
Q0163	Diphenhydramine HCl 50mg		N1		
Q0164	Prochlorperazine maleate 5mg		N1		
Q0166	Granisetron HCl 1 mg oral		K2		$49.96
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		$18.37
Q0180	Dolasetron mesylate oral		K2		$43.77
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		$5.76
Q2017	Teniposide, 50 mg		K2		$280.26
Q3025	IM inj interferon beta 1-a		K2		$118.84
Q4079	Natalizumab injection	CH	D5		
Q4083	Hyalgan/supartz inj per dose	CH	D5		
Q4084	Synvisc inj per dose	CH	D5		
Q4085	Euflexxa inj per dose	CH	D5		
Q4086	Orthovisc inj per dose	CH	D5		
Q4087	Octagam injection	CH	D5		
Q4088	Gammagard liquid injection	CH	D5		
Q4089	Rhophylac injection	CH	D5		
Q4090	Hepagam B IM injection	CH	D5		
Q4091	Flebogamma injection	CH	D5		
Q4092	Gamunex injection	CH	D5		
Q4095	Reclast injection	CH	D5		
Q9945	LOCM <=149 mg/ml iodine, 1ml	CH	D5		
Q9946	LOCM 150-199mg/ml iodine,1ml	CH	D5		
Q9947	LOCM 200-249mg/ml iodine,1ml	CH	D5		
Q9948	LOCM 250-299mg/ml iodine,1ml	CH	D5		
Q9949	LOCM 300-349mg/ml iodine,1ml	CH	D5		
Q9950	LOCM 350-399mg/ml iodine,1ml	CH	D5		
Q9951	LOCM >= 400 mg/ml iodine,1ml	CH	N1		
Q9952	Inj Gad-base MR contrast,1ml	CH	D5		
Q9953	Inj Fe-based MR contrast,1ml	CH	N1		
Q9954	Oral MR contrast,100 ml	CH	N1		

ADDENDUM BB.—ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including Ancillary Services for Which Payment Is Packaged]

HCPCS code	Short descriptor	Comment indicator	Payment indicator	CY 2008 payment weight	CY 2008 payment
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		
Q9964	HOCM>= 400mg/ml iodine,1ml		N1		
Q9965	LOCM 100-199mg/ml iodine,1ml	NI	N1		
Q9966	LOCM 200-299mg/ml iodine,1ml	NI	N1		
Q9967	LOCM 300-399mg/ml iodine,1ml	NI	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.—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/MACs under a fee schedule or payment system other than OPPS. Not subject to deductible or coinsurance. Not subject to deductible.
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 fiscal intermediaries/MACs 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.

ADDENDUM D1.—OPPS PAYMENT STATUS INDICATORS—Continued

Indicator	Item/code/service	OPPS payment status
H	Pass-Through Device Categories	Separate cost-based pass-through payment; not subject to copayment.
K	(1) Nonpass-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/MAC.	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.
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.
Y	Non-Implantable Durable Medical Equipment	Not paid under OPPS. All institutional providers other than home health agencies bill to DMERC.

ADDENDUM DD1.—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 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.

ADDENDUM DD2.—OPPS COMMENT INDICATORS

Comment indicator	Descriptor
CH	Active HCPCS code in current year and next calendar year, status indicator and/or APC assignment has changed; or active HCPCS code that will be discontinued at the end of the current calendar year.
NI	New code, interim APC assignment; comments will be accepted on the interim APC assignment for the new code.

ADDENDUM DD2.—ASC COMMENT INDICATORS

Comment indicator	Descriptor
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 will be 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.—HCPCS CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2008

HCPCS code	Short descriptor	SI	CI
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	

ADDENDUM E.—HCPCS CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI	CI
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	
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	Sp bone algrft morsel add-on	C	
20931	Sp bone algrft struct add-on	C	
20936	Sp bone agrft local add-on	C	
20937	Sp bone agrft morsel add-on	C	
20938	Sp bone agrft struct add-on	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	

ADDENDUM E.—HCPCS CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI	CI
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	
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	
22206	Cut spine 3 col, thor	C	NI
22207	Cut spine 3 col, lumb	C	NI
22208	Cut spine 3 col, addl seg	C	NI
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, 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	
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	

ADDENDUM E.—HCPCS CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI	CI
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	
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	

ADDENDUM E.—HCPCS CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI	CI
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	
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	
27268	Cltx thigh fx w/mnpj	C	NI
27269	Optx thigh fx	C	NI
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	

ADDENDUM E.—HCPCS CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI	CI
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	
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	

ADDENDUM E.—HCPCS CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI	CI
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	
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	
33257	Ablate atria, lmtd, add-on	C	NI
33258	Ablate atria, x10sv, add-on	C	NI
33259	Ablate atria w/bypass add-on	C	NI
33261	Ablate heart dysrhythm focus	C	
33265	Ablate atria, lmtd, endo	C	
33266	Ablate atria, x10sv, endo	C	
33300	Repair of heart wound	C	
33305	Repair of heart wound	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI	CI
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	
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	

ADDENDUM E.—HCPCS CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI	CI
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	
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	

ADDENDUM E.—HCPCS CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI	CI
33864	Ascending aortic graft	C	NI
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	
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	
34806	Aneurysm press sensor add-on	C	NI
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	

ADDENDUM E.—HCPCS CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI	CI
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	
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	
35523	Artery bypass graft	C	NI
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	

ADDENDUM E.—HCPCS CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI	CI
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 art for cabg add-on	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	
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	

ADDENDUM E.—HCPCS CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI	CI
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	
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	

ADDENDUM E.—HCPCS CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI	CI
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	
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 adj device	C	
43771	Lap revise gastr adj device	C	
43772	Lap rmvl gastr adj device	C	
43773	Lap replace gastr adj device	C	
43774	Lap rmvl gastr adj all parts	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	

ADDENDUM E.—HCPCS CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI	CI
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, cadavel 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	lleostomy/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	
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	

ADDENDUM E.—HCPCS CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI	CI
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	
47720	Fuse gallbladder & bowel	C	
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	

ADDENDUM E.—HCPCS CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI	CI
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	
49203	Exc abd tum 5 cm or less	C	NI
49204	Exc abd tum over 5 cm	C	NI
49205	Exc abd tum over 10 cm	C	NI
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	
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	

ADDENDUM E.—HCPCS CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI	CI
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	
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	

ADDENDUM E.—HCPCS CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI	CI
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	
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	

ADDENDUM E.—HCPCS CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI	CI
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	
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	

ADDENDUM E.—HCPCS CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI	CI
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	
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	

ADDENDUM E.—HCPCS CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI	CI
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	
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	

ADDENDUM E.—HCPCS CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI	CI
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	
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	

ADDENDUM E.—HCPCS CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI	CI
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	
99477	Init day hosp neonate care	C	NI
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	

ADDENDUM E.—HCPCS CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2008—Continued

HCPCS code	Short descriptor	SI	CI
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	
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	
0184T	Exc rectal tumor endoscopic	C	NI
G0341	Percutaneous islet celltrans	C	
G0342	Laparoscopy islet cell trans	C	
G0343	Laparotomy islet cell transp	C	

ADDENDUM L.—OUT-MIGRATION ADJUSTMENT

Provider No.	Reclassified for FY 2008	Out-migration adjustment	Qualifying county name	County code
010005	*	0.0296	MARSHALL	01470
010008		0.0174	CRENSHAW	01200
010009	*	0.0092	MORGAN	01510
010010	*	0.0296	MARSHALL	01470
010012	*	0.0186	DE KALB	01240
010015		0.0046	CLARKE	01120
010022	*	0.1128	CHEROKEE	01090
010025	*	0.0235	CHAMBERS	01080
010029	*	0.0289	LEE	01400
010032		0.0325	RANDOLPH	01550
010035	*	0.0254	CULLMAN	01210
010038		0.0047	CALHOUN	01070
010045	*	0.0222	FAYETTE	01280
010047		0.0127	BUTLER	01060
010052		0.0103	TALLAPOOSA	01610
010054	*	0.0092	MORGAN	01510
010061		0.0542	JACKSON	01350
010065	*	0.0103	TALLAPOOSA	01610
010078		0.0047	CALHOUN	01070
010083	*	0.0134	BALDWIN	01010
010085	*	0.0092	MORGAN	01510
010091		0.0046	CLARKE	01120
010100	*	0.0134	BALDWIN	01010
010101	*	0.0211	TALLADEGA	01600
010109		0.0451	PICKENS	01530
010110		0.0215	BULLOCK	01050
010125		0.0476	WINSTON	01660
010128		0.0046	CLARKE	01120
010129		0.0134	BALDWIN	01010
010138		0.0066	SUMTER	01590
010143	*	0.0254	CULLMAN	01210
010146		0.0047	CALHOUN	01070
010150	*	0.0127	BUTLER	01060
010158	*	0.0023	FRANKLIN	01290
010164	*	0.0211	TALLADEGA	01600
013027		0.0134	BALDWIN	01010
014009		0.0092	MORGAN	01510
030067		0.0298	LAPAZ	03055
040014	*	0.0199	WHITE	04720
040019	*	0.0258	ST. FRANCIS	04610
040039	*	0.0172	GREENE	04270
040047		0.0117	RANDOLPH	04600
040067		0.0007	COLUMBIA	04130
040071	*	0.0149	JEFFERSON	04340
040076	*	0.1000	HOT SPRING	04290
040081		0.0357	PIKE	04540

ADDENDUM L.—OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Reclassified for FY 2008	Out-migration adjustment	Qualifying county name	County code
040100	*	0.0199	WHITE	04720
042007		0.0149	JEFFERSON	04340
043034		0.0036	CHICOT	04080
050002		0.0010	ALAMEDA	05000
050007		0.0146	SAN MATEO	05510
050008		0.0026	SAN FRANCISCO	05480
050009	*	0.0180	NAPA	05380
050013	*	0.0180	NAPA	05380
050014	*	0.0139	AMADOR	05020
050016		0.0103	SAN LUIS OBISPO	05500
050042	*	0.0162	TEHAMA	05620
050043		0.0010	ALAMEDA	05000
050047		0.0026	SAN FRANCISCO	05480
050055		0.0026	SAN FRANCISCO	05480
050070		0.0146	SAN MATEO	05510
050073	*	0.0171	SOLANO	05580
050075		0.0010	ALAMEDA	05000
050076	*	0.0026	SAN FRANCISCO	05480
050084		0.0132	SAN JOAQUIN	05490
050090	*	0.0058	SONOMA	05590
050101	*	0.0171	SOLANO	05580
050113		0.0146	SAN MATEO	05510
050118	*	0.0132	SAN JOAQUIN	05490
050122		0.0132	SAN JOAQUIN	05490
050133	*	0.0178	YUBA	05680
050136	*	0.0058	SONOMA	05590
050150	*	0.0342	NEVADA	05390
050152		0.0026	SAN FRANCISCO	05480
050167		0.0132	SAN JOAQUIN	05490
050174	*	0.0058	SONOMA	05590
050194		0.0052	SANTA CRUZ	05540
050195		0.0010	ALAMEDA	05000
050197	*	0.0146	SAN MATEO	05510
050211		0.0010	ALAMEDA	05000
050228		0.0026	SAN FRANCISCO	05480
050232		0.0103	SAN LUIS OBISPO	05500
050242		0.0052	SANTA CRUZ	05540
050264		0.0010	ALAMEDA	05000
050283		0.0010	ALAMEDA	05000
050289		0.0146	SAN MATEO	05510
050291	*	0.0058	SONOMA	05590
050305		0.0010	ALAMEDA	05000
050313		0.0132	SAN JOAQUIN	05490
050320		0.0010	ALAMEDA	05000
050325		0.0033	TUOLUMNE	05650
050335		0.0033	TUOLUMNE	05650
050336		0.0132	SAN JOAQUIN	05490
050366		0.0015	CALAVERAS	05040
050367	*	0.0171	SOLANO	05580
050385	*	0.0058	SONOMA	05590
050407		0.0026	SAN FRANCISCO	05480
050444		0.0233	MERCED	05340
050454		0.0026	SAN FRANCISCO	05480
050457		0.0026	SAN FRANCISCO	05480
050476	*	0.0278	LAKE	05160
050488		0.0010	ALAMEDA	05000
050494	*	0.0342	NEVADA	05390
050506		0.0103	SAN LUIS OBISPO	05500
050512		0.0010	ALAMEDA	05000
050528	*	0.0233	MERCED	05340
050541	*	0.0146	SAN MATEO	05510
050547	*	0.0058	SONOMA	05590
050633		0.0103	SAN LUIS OBISPO	05500
050667	*	0.0180	NAPA	05380
050668		0.0026	SAN FRANCISCO	05480
050680	*	0.0171	SOLANO	05580
050690	*	0.0058	SONOMA	05590
050707		0.0146	SAN MATEO	05510
050714		0.0052	SANTA CRUZ	05540
050748		0.0132	SAN JOAQUIN	05490
050754		0.0146	SAN MATEO	05510

ADDENDUM L.—OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Reclassified for FY 2008	Out-migration adjustment	Qualifying county name	County code
052034		0.0010	ALAMEDA	05000
053301		0.0010	ALAMEDA	05000
054003		0.0146	SAN MATEO	05510
054020		0.0026	SAN FRANCISCO	05480
054074		0.0171	SOLANO	05580
054089		0.0026	SAN FRANCISCO	05480
054110		0.0010	ALAMEDA	05000
054122		0.0180	NAPA	05380
054123		0.0132	SAN JOAQUIN	05490
054141		0.0171	SOLANO	05580
054144		0.0026	SAN FRANCISCO	05480
060001	*	0.0042	WELD	06610
060003	*	0.0069	BOULDER	06060
060010		0.0153	LARIMER	06340
060027	*	0.0069	BOULDER	06060
060030		0.0153	LARIMER	06340
060103	*	0.0069	BOULDER	06060
060116	*	0.0069	BOULDER	06060
063033		0.0153	LARIMER	06340
064007		0.0069	BOULDER	06060
064016		0.0153	LARIMER	06340
070006	*	0.0045	FAIRFIELD	07000
070010	*	0.0045	FAIRFIELD	07000
070018	*	0.0045	FAIRFIELD	07000
070028	*	0.0045	FAIRFIELD	07000
070033	*	0.0045	FAIRFIELD	07000
070034	*	0.0045	FAIRFIELD	07000
074000		0.0045	FAIRFIELD	07000
074012		0.0045	FAIRFIELD	07000
074014		0.0045	FAIRFIELD	07000
080001	*	0.0063	NEW CASTLE	08010
080003	*	0.0063	NEW CASTLE	08010
082000		0.0063	NEW CASTLE	08010
083300		0.0063	NEW CASTLE	08010
084001		0.0063	NEW CASTLE	08010
084002		0.0063	NEW CASTLE	08010
084003		0.0063	NEW CASTLE	08010
100014	*	0.0047	VOLUSIA	10630
100017	*	0.0047	VOLUSIA	10630
100045	*	0.0047	VOLUSIA	10630
100047	*	0.0028	CHARLOTTE	10070
100068	*	0.0047	VOLUSIA	10630
100072	*	0.0047	VOLUSIA	10630
100077	*	0.0028	CHARLOTTE	10070
100102		0.0125	COLUMBIA	10110
100118	*	0.0177	FLAGLER	10170
100156	*	0.0125	COLUMBIA	10110
100232	*	0.0054	PUTNAM	10530
100236	*	0.0028	CHARLOTTE	10070
100252	*	0.0151	OKEECHOBEE	10460
100290		0.0582	SUMTER	10590
110023	*	0.0416	GORDON	11500
110029	*	0.0052	HALL	11550
110040	*	0.1455	JACKSON	11610
110041	*	0.0623	HABERSHAM	11540
110100		0.0790	JEFFERSON	11620
110101		0.0067	COOK	11311
110142		0.0185	EVANS	11441
110146	*	0.0805	CAMDEN	11170
110150	*	0.0227	BALDWIN	11030
110187	*	0.0643	LUMPKIN	11701
110189	*	0.0066	FANNIN	11450
110190		0.0241	MACON	11710
110205		0.0507	GILMER	11471
114018		0.0227	BALDWIN	11030
130003	*	0.0235	NEZ PERCE	13340
130024		0.0675	BONNER	13080
130049	*	0.0319	KOOTENAI	13270
130066		0.0319	KOOTENAI	13270
130067	*	0.0725	BINGHAM	13050
130068		0.0319	KOOTENAI	13270

ADDENDUM L.—OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Reclassified for FY 2008	Out-migration adjustment	Qualifying county name	County code
132001		0.0319	KOOTENAI	13270
134010		0.0725	BINGHAM	13050
140001		0.0369	FULTON	14370
140026		0.0315	LA SALLE	14580
140043	*	0.0056	WHITESIDE	14988
140058	*	0.0126	MORGAN	14770
140110	*	0.0315	LA SALLE	14580
140160	*	0.0332	STEPHENSON	14970
140161	*	0.0168	LIVINGSTON	14610
140167	*	0.0632	IROQUOIS	14460
140234		0.0315	LA SALLE	14580
150006	*	0.0113	LA PORTE	15450
150015		0.0113	LA PORTE	15450
150022		0.0158	MONTGOMERY	15530
150030	*	0.0192	HENRY	15320
150072		0.0105	CASS	15080
150076	*	0.0215	MARSHALL	15490
150088	*	0.0111	MADISON	15470
150091	*	0.0050	HUNTINGTON	15340
150102	*	0.0108	STARKE	15740
150113	*	0.0111	MADISON	15470
150133	*	0.0193	KOSCIUSKO	15420
150146	*	0.0319	NOBLE	15560
153040		0.0215	MARSHALL	15490
154014		0.0193	KOSCIUSKO	15420
154035		0.0105	CASS	15080
154047		0.0215	MARSHALL	15490
160013		0.0179	MUSCATINE	16690
160030		0.0040	STORY	16840
160032		0.0235	JASPER	16490
160080	*	0.0066	CLINTON	16220
170137	*	0.0336	DOUGLAS	17220
170150		0.0166	COWLEY	17170
180012	*	0.0080	HARDIN	18460
180017	*	0.0035	BARREN	18040
180049	*	0.0488	MADISON	18750
180064		0.0314	MONTGOMERY	18860
180066	*	0.0439	LOGAN	18700
180070		0.0240	GRAYSON	18420
180079		0.0259	HARRISON	18480
183028		0.0080	HARDIN	18460
184012		0.0080	HARDIN	18460
190003	*	0.0085	IBERIA	19220
190015	*	0.0243	TANGIPAHOA	19520
190017		0.0187	ST. LANDRY	19480
190034		0.0189	VERMILION	19560
190044		0.0261	ACADIA	19000
190050		0.0044	BEAUREGARD	19050
190053		0.0101	JEFFRSON DAVIS	19260
190054		0.0085	IBERIA	19220
190078		0.0187	ST. LANDRY	19480
190086	*	0.0061	LINCOLN	19300
190088	*	0.0387	WEBSTER	19590
190099	*	0.0189	AVOYELLES	19040
190106	*	0.0102	ALLEN	19010
190116		0.0085	MOREHOUSE	19330
190133		0.0102	ALLEN	19010
190140		0.0035	FRANKLIN	19200
190144	*	0.0387	WEBSTER	19590
190145		0.0090	LA SALLE	19290
190184	*	0.0161	CALDWELL	19100
190190		0.0161	CALDWELL	19100
190191	*	0.0187	ST. LANDRY	19480
190246		0.0161	CALDWELL	19100
190257		0.0061	LINCOLN	19300
192022		0.0061	LINCOLN	19300
192026		0.0387	WEBSTER	19590
192034		0.0187	ST. LANDRY	19480
192036		0.0243	TANGIPAHOA	19520
192040		0.0243	TANGIPAHOA	19520
192050		0.0261	ACADIA	19000

ADDENDUM L.—OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Reclassified for FY 2008	Out-migration adjustment	Qualifying county name	County code
193036		0.0187	ST. LANDRY	19480
193044		0.0243	TANGIPAHOA	19520
193047		0.0189	VERMILION	19560
193049		0.0189	VERMILION	19560
193055		0.0161	CALDWELL	19100
193058		0.0085	MOREHOUSE	19330
193063		0.0243	TANGIPAHOA	19520
193067		0.0101	JEFFRSON DAVIS	19260
193068		0.0243	TANGIPAHOA	19520
193069		0.0085	MOREHOUSE	19330
193073		0.0187	ST. LANDRY	19480
193079		0.0243	TANGIPAHOA	19520
193081		0.0261	ACADIA	19000
193088		0.0261	ACADIA	19000
193091		0.0085	IBERIA	19220
194047		0.0387	WEBSTER	19590
194065		0.0061	LINCOLN	19300
194075		0.0101	JEFFRSON DAVIS	19260
194077		0.0061	LINCOLN	19300
194081		0.0044	BEAUREGARD	19050
194082		0.0101	JEFFRSON DAVIS	19260
194083		0.0085	MOREHOUSE	19330
194085		0.0261	ACADIA	19000
194087		0.0061	LINCOLN	19300
200024	*	0.0094	ANDROSCOGGIN	20000
200032		0.0466	OXFORD	20080
200034	*	0.0094	ANDROSCOGGIN	20000
200050	*	0.0227	HANCOCK	20040
210001		0.0187	WASHINGTON	21210
210023		0.0079	ANNE ARUNDEL	21010
210028		0.0512	ST. MARYS	21180
210043		0.0079	ANNE ARUNDEL	21010
212002		0.0187	WASHINGTON	21210
214001		0.0079	ANNE ARUNDEL	21010
214003		0.0187	WASHINGTON	21210
220002		0.0271	MIDDLESEX	22090
220010	*	0.0355	ESSEX	22040
220011		0.0271	MIDDLESEX	22090
220029	*	0.0355	ESSEX	22040
220033	*	0.0355	ESSEX	22040
220035	*	0.0355	ESSEX	22040
220049		0.0271	MIDDLESEX	22090
220063		0.0271	MIDDLESEX	22090
220070		0.0271	MIDDLESEX	22090
220080	*	0.0355	ESSEX	22040
220082		0.0271	MIDDLESEX	22090
220084		0.0271	MIDDLESEX	22090
220098		0.0271	MIDDLESEX	22090
220101		0.0271	MIDDLESEX	22090
220105		0.0271	MIDDLESEX	22090
220171		0.0271	MIDDLESEX	22090
220174	*	0.0355	ESSEX	22040
222000		0.0271	MIDDLESEX	22090
222003		0.0271	MIDDLESEX	22090
222024		0.0271	MIDDLESEX	22090
222026		0.0355	ESSEX	22040
222044		0.0355	ESSEX	22040
222047		0.0355	ESSEX	22040
223026		0.0271	MIDDLESEX	22090
223028		0.0355	ESSEX	22040
224007		0.0271	MIDDLESEX	22090
224022		0.0271	MIDDLESEX	22090
224033		0.0355	ESSEX	22040
224038		0.0271	MIDDLESEX	22090
230003	*	0.0220	OTTAWA	23690
230005		0.0473	LENAWEE	23450
230013	*	0.0025	OAKLAND	23620
230015		0.0295	ST. JOSEPH	23740
230019	*	0.0025	OAKLAND	23620
230021	*	0.0101	BERRIEN	23100
230022	*	0.0212	BRANCH	23110

ADDENDUM L.—OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Reclassified for FY 2008	Out-migration adjustment	Qualifying county name	County code
230029	*	0.0025	OAKLAND	23620
230035	*	0.0095	MONTCALM	23580
230037	*	0.0210	HILLSDALE	23290
230047	*	0.0021	MACOMB	23490
230069	*	0.0210	LIVINGSTON	23460
230071	*	0.0025	OAKLAND	23620
230072	*	0.0220	OTTAWA	23690
230075		0.0047	CALHOUN	23120
230078	*	0.0101	BERRIEN	23100
230092	*	0.0223	JACKSON	23370
230093		0.0058	MECOSTA	23530
230096	*	0.0295	ST. JOSEPH	23740
230099	*	0.0231	MONROE	23570
230121	*	0.0678	SHIAWASSEE	23770
230130	*	0.0025	OAKLAND	23620
230151	*	0.0025	OAKLAND	23620
230174	*	0.0220	OTTAWA	23690
230195	*	0.0021	MACOMB	23490
230204	*	0.0021	MACOMB	23490
230207	*	0.0025	OAKLAND	23620
230208	*	0.0095	MONTCALM	23580
230217		0.0047	CALHOUN	23120
230222	*	0.0035	MIDLAND	23550
230223	*	0.0025	OAKLAND	23620
230227	*	0.0021	MACOMB	23490
230254	*	0.0025	OAKLAND	23620
230257	*	0.0021	MACOMB	23490
230264	*	0.0021	MACOMB	23490
230269	*	0.0025	OAKLAND	23620
230277	*	0.0025	OAKLAND	23620
230279	*	0.0210	LIVINGSTON	23460
232023		0.0021	MACOMB	23490
232025		0.0101	BERRIEN	23100
232028		0.0047	CALHOUN	23120
232030		0.0025	OAKLAND	23620
232034		0.0435	ALLEGAN	23020
232036		0.0223	JACKSON	23370
233025		0.0047	CALHOUN	23120
233028		0.0025	OAKLAND	23620
233031		0.0021	MACOMB	23490
234011		0.0025	OAKLAND	23620
234021		0.0021	MACOMB	23490
234023		0.0025	OAKLAND	23620
234024		0.0021	MACOMB	23490
234025		0.0276	TUSCOLA	23780
234037		0.0047	CALHOUN	23120
234039		0.0021	MACOMB	23490
240018		0.0805	GOODHUE	24240
240044		0.0625	WINONA	24840
240064	*	0.0134	ITASCA	24300
240069	*	0.0267	STEELE	24730
240071	*	0.0385	RICE	24650
240117		0.0527	MOWER	24490
240211		0.0812	PINE	24570
250023	*	0.0541	PEARL RIVER	25540
250040	*	0.0021	JACKSON	25290
250117	*	0.0541	PEARL RIVER	25540
250128		0.0446	PANOLA	25530
250160		0.0446	PANOLA	25530
252011		0.0446	PANOLA	25530
260059		0.0077	LACLEDE	26520
260064	*	0.0089	AUDRAIN	26030
260097		0.0300	JOHNSON	26500
260116		0.0087	ST. FRANCOIS	26930
260163		0.0087	ST. FRANCOIS	26930
264005		0.0087	ST. FRANCOIS	26930
264027		0.0087	CEDAR	26190
270081		0.0234	MUSSELSHELL	27320
280077		0.0080	DODGE	28260
280123		0.0123	GAGE	28330
290002	*	0.0277	LYON	29090

ADDENDUM L.—OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Reclassified for FY 2008	Out-migration adjustment	Qualifying county name	County code
300011		0.0069	HILLSBOROUGH	30050
300012		0.0069	HILLSBOROUGH	30050
300020		0.0069	HILLSBOROUGH	30050
300034		0.0069	HILLSBOROUGH	30050
310002	*	0.0268	ESSEX	31200
310009	*	0.0268	ESSEX	31200
310010		0.0092	MERCER	31260
310011		0.0115	CAPE MAY	31180
310013	*	0.0268	ESSEX	31200
310018	*	0.0268	ESSEX	31200
310021	*	0.0092	MERCER	31260
310038	*	0.0209	MIDDLESEX	31270
310039	*	0.0209	MIDDLESEX	31270
310044		0.0092	MERCER	31260
310054	*	0.0268	ESSEX	31200
310070	*	0.0209	MIDDLESEX	31270
310076	*	0.0268	ESSEX	31200
310083	*	0.0268	ESSEX	31200
310092		0.0092	MERCER	31260
310093	*	0.0268	ESSEX	31200
310096	*	0.0268	ESSEX	31200
310108	*	0.0209	MIDDLESEX	31270
310110		0.0092	MERCER	31260
310119	*	0.0268	ESSEX	31200
312018		0.0209	MIDDLESEX	31270
313025		0.0268	ESSEX	31200
313027		0.0092	MERCER	31260
314010		0.0268	ESSEX	31200
314011		0.0209	MIDDLESEX	31270
314013		0.0092	MERCER	31260
314020		0.0268	ESSEX	31200
314025		0.0092	MERCER	31260
320003	*	0.0629	SAN MIGUEL	32230
320011		0.0442	RIO ARRIBA	32190
320018		0.0024	DONA ANA	32060
320085		0.0024	DONA ANA	32060
322001		0.0629	SAN MIGUEL	32230
323025		0.0629	SAN MIGUEL	32230
323032		0.0024	DONA ANA	32060
324007		0.0024	DONA ANA	32060
324009		0.0024	DONA ANA	32060
324010		0.0024	DONA ANA	32060
324011		0.0442	RIO ARRIBA	32190
324012		0.0024	DONA ANA	32060
330004	*	0.0633	ULSTER	33740
330008	*	0.0126	WYOMING	33900
330010		0.0067	MONTGOMERY	33380
330027	*	0.0123	NASSAU	33400
330033		0.0223	CHENANGO	33080
330047		0.0067	MONTGOMERY	33380
330073	*	0.0151	GENESEE	33290
330094	*	0.0503	COLUMBIA	33200
330103	*	0.0131	CATTARAUGUS	33040
330106	*	0.0123	NASSAU	33400
330126	*	0.0642	ORANGE	33540
330132		0.0131	CATTARAUGUS	33040
330135		0.0642	ORANGE	33540
330167	*	0.0123	NASSAU	33400
330175		0.0260	CORTLAND	33210
330181	*	0.0123	NASSAU	33400
330182	*	0.0123	NASSAU	33400
330191	*	0.0017	WARREN	33750
330198	*	0.0123	NASSAU	33400
330205		0.0642	ORANGE	33540
330224	*	0.0633	ULSTER	33740
330225	*	0.0123	NASSAU	33400
330235	*	0.0306	CAYUGA	33050
330259	*	0.0123	NASSAU	33400
330264		0.0642	ORANGE	33540
330276		0.0036	FULTON	33280
330331	*	0.0123	NASSAU	33400

ADDENDUM L.—OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Reclassified for FY 2008	Out-migration adjustment	Qualifying county name	County code
330332	*	0.0123	NASSAU	33400
330372	*	0.0123	NASSAU	33400
330386	*	0.0745	SULLIVAN	33710
334017		0.0642	ORANGE	33540
334061		0.0642	ORANGE	33540
340020		0.0156	LEE	34520
340021	*	0.0162	CLEVELAND	34220
340024		0.0177	SAMPSON	34810
340027	*	0.0128	LENOIR	34530
340037		0.0162	CLEVELAND	34220
340038		0.0253	BEAUFORT	34060
340039	*	0.0101	IREDELL	34480
340068	*	0.0087	COLUMBUS	34230
340069	*	0.0015	WAKE	34910
340070	*	0.0395	ALAMANCE	34000
340071	*	0.0226	HARNETT	34420
340073	*	0.0015	WAKE	34910
340085	*	0.0250	DAVIDSON	34280
340096	*	0.0250	DAVIDSON	34280
340104		0.0162	CLEVELAND	34220
340114	*	0.0015	WAKE	34910
340124	*	0.0226	HARNETT	34420
340126	*	0.0100	WILSON	34970
340129	*	0.0101	IREDELL	34480
340133		0.0308	MARTIN	34580
340138	*	0.0015	WAKE	34910
340144	*	0.0101	IREDELL	34480
340145	*	0.0336	LINCOLN	34540
340151		0.0052	HALIFAX	34410
340173	*	0.0015	WAKE	34910
344001		0.0015	WAKE	34910
344011		0.0015	WAKE	34910
344014		0.0015	WAKE	34910
360002		0.0141	ASHLAND	36020
360010	*	0.0074	TUSCARAWAS	36800
360013	*	0.0135	SHELBY	36760
360025	*	0.0077	ERIE	36220
360036	*	0.0126	WAYNE	36860
360040		0.0387	KNOX	36430
360044		0.0127	DARKE	36190
360065	*	0.0075	HURON	36400
360071		0.0035	VAN WERT	36820
360086	*	0.0186	CLARK	36110
360096	*	0.0071	COLUMBIANA	36140
360107	*	0.0119	SANDUSKY	36730
360125	*	0.0133	ASHTABULA	36030
360156		0.0119	SANDUSKY	36730
360175	*	0.0183	CLINTON	36130
360185	*	0.0071	COLUMBIANA	36140
360187	*	0.0186	CLARK	36110
360245	*	0.0133	ASHTABULA	36030
362007		0.0119	SANDUSKY	36730
364040		0.0186	CLARK	36110
370014	*	0.0361	BRYAN	37060
370015	*	0.0366	MAYES	37480
370023		0.0090	STEPHENS	37680
370065		0.0096	CRAIG	37170
370072		0.0258	LATIMER	37380
370083		0.0051	PUSHMATAHA	37630
370100		0.0100	CHOCTAW	37110
370149	*	0.0302	POTTAWATOMIE	37620
370156		0.0121	GARVIN	37240
370169		0.0163	MCINTOSH	37450
370172		0.0258	LATIMER	37380
370214		0.0121	GARVIN	37240
372017		0.0100	CHOCTAW	37110
372019		0.0302	POTTAWATOMIE	37620
373032		0.0100	CHOCTAW	37110
380022	*	0.0067	LINN	38210
380029		0.0075	MARION	38230
380051		0.0075	MARION	38230

ADDENDUM L.—OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Reclassified for FY 2008	Out-migration adjustment	Qualifying county name	County code
380056		0.0075	MARION	38230
384008		0.0075	MARION	38230
384011		0.0107	UMATILLA	38290
390008		0.0060	LAWRENCE	39450
390016	*	0.0060	LAWRENCE	39450
390030	*	0.0284	SCHUYLKILL	39650
390031	*	0.0284	SCHUYLKILL	39650
390044	*	0.0191	BERKS	39110
390052		0.0047	CLEARFIELD	39230
390056		0.0036	HUNTINGDON	39380
390065	*	0.0532	ADAMS	39000
390066	*	0.0372	LEBANON	39460
390079	*	0.0003	BRADFORD	39130
390086	*	0.0047	CLEARFIELD	39230
390096	*	0.0191	BERKS	39110
390110	*	0.0003	CAMBRIA	39160
390113	*	0.0053	CRAWFORD	39260
390117		0.0002	BEDFORD	39100
390122		0.0053	CRAWFORD	39260
390125		0.0022	WAYNE	39760
390130	*	0.0003	CAMBRIA	39160
390138	*	0.0218	FRANKLIN	39350
390146		0.0022	WARREN	39740
390150		0.0031	GREENE	39370
390151	*	0.0218	FRANKLIN	39350
390162	*	0.0200	NORTHAMPTON	39590
390181		0.0284	SCHUYLKILL	39650
390183	*	0.0284	SCHUYLKILL	39650
390201		0.1170	MONROE	39550
390236		0.0003	BRADFORD	39130
390313	*	0.0284	SCHUYLKILL	39650
392030		0.0532	ADAMS	39000
392031		0.0003	CAMBRIA	39160
392034		0.0200	NORTHAMPTON	39590
393026		0.0191	BERKS	39110
393050		0.0200	NORTHAMPTON	39590
394014		0.0191	BERKS	39110
394016		0.0022	WARREN	39740
394020		0.0372	LEBANON	39460
420007	*	0.0027	SPARTANBURG	42410
420009	*	0.0113	OCONEE	42360
420019		0.0158	CHESTER	42110
420027	*	0.0108	ANDERSON	42030
420030	*	0.0069	COLLETON	42140
420036	*	0.0064	LANCASTER	42280
420039	*	0.0153	UNION	42430
420043		0.0157	CHEROKEE	42100
420053		0.0035	NEWBERRY	42350
420062	*	0.0109	CHESTERFIELD	42120
420068	*	0.0027	ORANGEBURG	42370
420069	*	0.0052	CLARENDON	42130
420083	*	0.0027	SPARTANBURG	42410
422004		0.0158	CHESTER	42110
423029		0.0108	ANDERSON	42030
424011		0.0108	ANDERSON	42030
430008		0.0535	BROOKINGS	43050
430048		0.0129	LAWRENCE	43400
430094		0.0129	LAWRENCE	43400
440007		0.0219	COFFEE	44150
440008	*	0.0449	HENDERSON	44380
440016		0.0144	CARROLL	44080
440024	*	0.0230	BRADLEY	44050
440030		0.0056	HAMBLEN	44310
440031		0.0019	ROANE	44720
440033		0.0027	CAMPBELL	44060
440035	*	0.0301	MONTGOMERY	44620
440047		0.0338	GIBSON	44260
440051		0.0082	MC NAIRY	44540
440057		0.0021	CLAIBORNE	44120
440060	*	0.0338	GIBSON	44260
440067		0.0056	HAMBLEN	44310

ADDENDUM L.—OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Reclassified for FY 2008	Out-migration adjustment	Qualifying county name	County code
440070		0.0109	DECATUR	44190
440081		0.0052	SEVIER	44770
440084		0.0025	MONROE	44610
440109		0.0070	HARDIN	44350
440115		0.0338	GIBSON	44260
440137		0.0738	BEDFORD	44010
440144	*	0.0219	COFFEE	44150
440148	*	0.0296	DE KALB	44200
440153		0.0007	COCKE	44140
440174		0.0312	HAYWOOD	44370
440180		0.0027	CAMPBELL	44060
440181		0.0365	HARDEMAN	44340
440182		0.0144	CARROLL	44080
440185	*	0.0230	BRADLEY	44050
444008		0.0365	HARDEMAN	44340
450032	*	0.0254	HARRISON	45620
450039	*	0.0024	TARRANT	45910
450052	*	0.0276	BOSQUE	45160
450059	*	0.0075	COMAL	45320
450064	*	0.0024	TARRANT	45910
450087	*	0.0024	TARRANT	45910
450090		0.0650	COOKE	45340
450099	*	0.0145	GRAY	45563
450135	*	0.0024	TARRANT	45910
450137	*	0.0024	TARRANT	45910
450144		0.0559	ANDREWS	45010
450163		0.0054	KLEBERG	45743
450192		0.0271	HILL	45651
450194		0.0213	CHEROKEE	45281
450210		0.0151	PANOLA	45842
450224	*	0.0195	WOOD	45974
450236		0.0389	HOPKINS	45654
450270		0.0271	HILL	45651
450283	*	0.0653	VAN ZANDT	45947
450324	*	0.0132	GRAYSON	45564
450347	*	0.0370	WALKER	45949
450348	*	0.0059	FALLS	45500
450370		0.0235	COLORADO	45312
450389	*	0.0618	HENDERSON	45640
450393	*	0.0132	GRAYSON	45564
450395	*	0.0441	POLK	45850
450419	*	0.0024	TARRANT	45910
450438	*	0.0235	COLORADO	45312
450451		0.0536	SOMERVELL	45893
450460		0.0053	TYLER	45942
450469	*	0.0132	GRAYSON	45564
450497		0.0375	MONTAGUE	45800
450539		0.0067	HALE	45582
450547		0.0195	WOOD	45974
450563	*	0.0024	TARRANT	45910
450565		0.0486	PALO PINTO	45841
450573		0.0126	JASPER	45690
450596	*	0.0743	HOOD	45653
450639	*	0.0024	TARRANT	45910
450641		0.0375	MONTAGUE	45800
450672	*	0.0024	TARRANT	45910
450675	*	0.0024	TARRANT	45910
450677	*	0.0024	TARRANT	45910
450698		0.0127	LAMB	45751
450747	*	0.0126	ANDERSON	45000
450755		0.0276	HOCKLEY	45652
450770	*	0.0182	MILAM	45795
450779	*	0.0024	TARRANT	45910
450813	*	0.0126	ANDERSON	45000
450838		0.0126	JASPER	45690
450872	*	0.0024	TARRANT	45910
450880	*	0.0024	TARRANT	45910
450884		0.0049	UPSHUR	45943
450886		0.0024	TARRANT	45910
450888		0.0024	TARRANT	45910
452018		0.0024	TARRANT	45910

ADDENDUM L.—OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Reclassified for FY 2008	Out-migration adjustment	Qualifying county name	County code
452019		0.0024	TARRANT	45910
452028		0.0024	TARRANT	45910
452041		0.0132	GRAYSON	45564
452088		0.0024	TARRANT	45910
453040		0.0024	TARRANT	45910
453041		0.0024	TARRANT	45910
453042		0.0024	TARRANT	45910
453089		0.0126	ANDERSON	45000
453094		0.0024	TARRANT	45910
453300		0.0024	TARRANT	45910
453303		0.0024	TARRANT	45910
454009		0.0213	CHEROKEE	45281
454012		0.0024	TARRANT	45910
454019		0.0024	TARRANT	45910
454051		0.0024	TARRANT	45910
454052		0.0024	TARRANT	45910
454061		0.0024	TARRANT	45910
454072		0.0024	TARRANT	45910
454086		0.0024	TARRANT	45910
454101		0.0067	HALE	45582
460017		0.0383	BOX ELDER	46010
460039	*	0.0383	BOX ELDER	46010
490019	*	0.1088	CULPEPER	49230
490084		0.0187	ESSEX	49280
490110		0.0185	MONTGOMERY	49600
500003	*	0.0166	SKAGIT	50280
500007	*	0.0166	SKAGIT	50280
500019		0.0131	LEWIS	50200
500039	*	0.0094	KITSAP	50170
500041	*	0.0020	COWLITZ	50070
510012		0.0124	MASON	51260
510018	*	0.0188	JACKSON	51170
510047	*	0.0269	MARION	51240
510077	*	0.0021	MINGO	51290
520028	*	0.0286	GREEN	52220
520035		0.0076	SHEBOYGAN	52580
520044		0.0076	SHEBOYGAN	52580
520057		0.0193	SAUK	52550
520059	*	0.0195	RACINE	52500
520071	*	0.0161	JEFFERSON	52270
520076	*	0.0146	DODGE	52130
520095	*	0.0193	SAUK	52550
520096		0.0195	RACINE	52500
520102	*	0.0242	WALWORTH	52630
520116	*	0.0161	JEFFERSON	52270
522005		0.0195	RACINE	52500
523026		0.0195	RACINE	52500
524020		0.0193	SAUK	52550
524021		0.0242	WALWORTH	52630
524022		0.0146	DODGE	52130

ADDENDUM M.—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 min	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

ADDENDUM M.—HCPCS CODES FOR ASSIGNMENT TO COMPOSITE APCS FOR CY 2008—Continued

HCPCS code	Short descriptor	CI	SI	Single code APC assignment	Composite APC assignment
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	Psytx, 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	Neuropsych 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
99205	Office/outpatient visit, new	CH	Q	0608	8002
99215	Office/outpatient visit, est	CH	Q	0607	8002
G0379	Direct admit hospital observ	CH	Q	0604	8002
99284	Emergency dept visit	CH	Q	0615	8003
99285	Emergency dept visit	CH	Q	0616	8003
99291	Critical care, first hour	CH	Q	0617	8003

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