

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.

Table of Contents

- I. Background for the OPPS
 - A. Legislative and Regulatory Authority for the Hospital Outpatient Prospective Payment System
 - B. Excluded OPPS Services and Hospitals
 - C. Prior Rulemaking
 - D. APC Advisory Panel
 1. Authority of the APC Panel
 2. Establishment of the APC Panel
 3. APC Panel Meetings and Organizational Structure
 - E. Provisions of the Medicare Improvements and Extension Act under

- Division B, Title I of the Tax Relief and Health Care Act of 2006
- F. Summary of the Major Contents of the CY 2008 OPPS/ASC Proposed Rule
 1. Updates Affecting OPPS Payments
 2. OPPS Ambulatory Payment Classification (APC) Group Policies
 3. OPPS Payment for Devices
 4. OPPS Payment for Drugs, Biologicals, and Radiopharmaceuticals
 5. Estimate of OPPS Transitional Pass-Through Spending for Drugs, Biologicals, and Devices
 6. OPPS Payment for Brachytherapy Sources
 7. OPPS Coding and Payment for Drug Administration Services
 8. OPPS Hospital Coding and Payment for Visits
 9. OPPS Payment for Blood and Blood Products
 10. OPPS Payment for Observation Services
 11. Procedures That Will Be Paid Only as Inpatient Services
 12. Nonrecurring Technical and Policy Changes
 13. OPPS Payment Status and Comment Indicators
 14. OPPS Policy and Payment Recommendations
 15. Update of the Revised ASC Payment System
 16. Quality Data for Annual Payment Updates
 17. Changes Affecting Necessary Provider Critical Access Hospitals (CAHs) and Hospital Conditions of Participation (CoPs)
 18. Regulatory Impact Analysis
- G. Public Comments Received in Response to the CY 2008 OPPS/ASC Proposed Rule
- H. Public Comments Received on the November 24, 2006 OPPS/ASC Final Rule with Comment Period
- II. Updates Affecting OPPS Payments
 - A. Recalibration of APC Relative Weights
 1. Database Construction
 - a. Database Source and Methodology
 - b. Use of Single and Multiple Procedure Claims
 - (1) Use of Date of Service Stratification and a Bypass List to Increase the Amount of Data Used to Determine Medians
 - (2) Exploration of Allocation of Packaged Costs to Separately Paid Procedure Codes
 - c. Calculation of CCRs
 2. Calculation of Median Costs
 3. Calculation of OPPS Scaled Payment Weights
 4. Changes to Packaged Services
 - a. Background
 - b. Addressing Growth in OPPS Volume and Spending
 - c. Packaging Approach
 - (1) Guidance Services
 - (2) Image Processing Services
 - (3) Intraoperative Services
 - (4) Imaging Supervision and Interpretation Services
 - (5) Diagnostic Radiopharmaceuticals
 - (6) Contrast Agents
 - (7) Observation Services
 - d. Development of Composite APCs

- (1) Background
- (2) Low Dose Rate (LDR) Prostate Brachytherapy Composite APC
 - (a) Background
 - (b) Payment for LDR Prostate Brachytherapy
- (3) Cardiac Electrophysiologic Evaluation and Ablation Composite APC
 - (a) Background
 - (b) Payment for Cardiac Electrophysiologic Evaluation and Ablation
- e. Service-Specific Packaging Issues
- B. Payment for Partial Hospitalization
 1. Background
 2. PHP APC Update
 3. Separate Threshold for Outlier Payments to CMHCs
- C. Conversion Factor Update
- D. Wage Index Changes
- E. Statewide Average Default CCRs
- F. OPPS Payments to Certain Rural Hospitals
 1. Hold Harmless Transitional Payment Changes Made by Pub. L. 109–171 (DRA)
 2. Adjustment for Rural SCHs Implemented in CY 2006 Related to Pub. L. 108–173 (MMA)
- G. Hospital Outpatient Outlier Payments
- H. Calculation of an Adjusted Medicare Payment from the National Unadjusted Medicare Payment
- I. Beneficiary Copayments
 1. Background
 2. Copayment
 3. Calculation of an Adjusted Copayment Amount for an APC Group
- 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
 - b. Implantation of Interstitial Devices (APC 0156)
 - c. Other New HCPCS Codes Implemented in April or July 2007
 2. Treatment of New Category I and III CPT Codes and Level II HCPCS Codes
 - a. Establishment and Assignment of New Codes
 - b. Electronic Brachytherapy (New Technology APC 1519)
 - c. Other Mid-Year CPT Codes
 - B. Variations within APCs
 1. Background
 2. Application of the 2 Times Rule
 3. Exceptions to the 2 Times Rule
 - C. New Technology APCs
 1. Introduction
 2. Movement of Procedures from New Technology APCs to Clinical APCs
 - a. Positron Emission Tomography (PET)/Computed Tomography (CT) Scans (APC 0308)
 - b. IVIG Preadministration-Related Services (APC 0430)
 - c. Other Services in New Technology APCs
 - (1) Breast Brachytherapy Catheter Implantation (APC 0648)
 - (2) Preoperative Services for Lung Volume Reduction Surgery (LVRS) (APCs 0209 and 0213)
 - D. APC Specific Policies
 1. Cardiac Procedures

- a. Cardiac Computed Tomography and Computed Tomographic Angiography (APCs 0282 and 0383)
- b. Coronary and Non-Coronary Angioplasty (PTCA/PTA)(APCs 0082, 0083, and 0103)
- c. Implantation of Cardioverter-Defibrillators (APCs 0107 and 0108)
- d. Removal of Patient-Activated Cardiac Event Recorder (APC 0109)
- e. Stress Echocardiography (APC 0697)
2. Gastrointestinal Procedures
 - a. Computed Tomographic Colonography (APC 0332)
 - b. Laparoscopic Neurostimulator Electrode Implantation (APC 0130)
 - c. Screening Colonoscopies and Screening Flexible Sigmoidoscopies (APCs 0158 and 0159)
3. Genitourinary Procedures
 - a. Cystoscopy with Stent (APC 0163)
 - b. Percutaneous Renal Cryoablation (APC 0423)
 - c. Prostatic Thermotherapy (APC 0163)
 - d. Radiofrequency Ablation of Prostate (APC 0163)
 - e. Ultrasound Ablation of Uterine Fibroids with Magnetic Resonance Guidance (MRgFUS) (APC 0067)
 - f. Uterine Fibroid Embolization (APC 0202)
4. Nervous System Procedures
 - a. Chemodenervation (APC 0206)
 - b. Implantation of Intrathecal or Epidural Catheter (APC 0224)
 - c. Implantation of Spinal Neurostimulators (APC 0222)
5. Nuclear Medicine and Radiation Oncology Procedures
 - a. Adrenal Imaging (APC 0391)
 - b. Injection for Sentinel Node Identification (APC 0389)
 - c. Myocardial Positron Emission Tomography (PET) Scans (APC 0307)
 - d. Nonmyocardial Positron Emission Tomography (PET) Scans (APC 0308)
 - e. Proton Beam Therapy (APCs 0664 and 0667)
6. Ocular and Ear, Nose and Throat Procedures
 - a. Amniotic Membrane for Ocular Surface Reconstruction (APC 0244)
 - b. Keratoprosthesis (APC 0293)
 - c. Palatal Implant (New Technology APC 1510)
7. Orthopedic Procedures
 - a. Arthroscopic Procedures (APCs 0041 and 0042)
 - b. Closed Fracture Treatment (APC 0043)
 - c. Insertion of Posterior Spinous Process Distraction Device (APC 0050)
 - d. Intradiscal Annuloplasty (APC 0050)
 - e. Kyphoplasty Procedures (APC 0052)
8. Vascular Procedures
 - a. Blood Transfusion (APC 0110)
 - b. Endovenous Ablation (APC 0092)
 - c. Insertion of Central Venous Access Device (APC 0625)
 - d. Noninvasive Vascular Studies (APC 0267)
9. Other Procedures
 - a. Hyperbaric Oxygen Therapy (APC 0659)
 - b. Skin Repair Procedures (APCs 0133, 0134, 0135, 0136, and 0137)
 - c. Stereotactic Radiosurgery (SRS) Treatment Delivery Services (APCs 0065, 0066, and 0067)
10. Medical Services
 - a. Single Allergy Tests (APC 0381)
 - b. Continuous Glucose Monitoring (APC 0097)
 - c. Home International Normalized Ratio (INR) Monitoring (APC 0097)
 - d. Mental Health Services (APC 0322, 0323, 0324, 0325)
- IV. OPPS Payment for Devices
 - A. Treatment of Device Dependent APCs
 1. Background
 2. Payment under the OPPS
 3. Payment When Devices Are Replaced with Partial Credit to the Hospital
 - B. Pass-Through Payments for Devices
 1. Expiration of Transitional Pass Through Payments for Certain Devices
 - a. Background
 - b. Final Policy
 2. Provisions for Reducing Transitional Pass Through Payments to Offset Costs Packaged into APC Groups
 - a. Background
 - b. Final Policy
- V. OPPS Payment Changes for Drugs, Biologicals, and Radiopharmaceuticals
 - A. Transitional Pass-Through Payment for Additional Costs of Drugs and Biologicals
 1. Background
 2. Drugs and Biologicals with Expiring Pass-Through Status in CY 2007
 3. Drugs and Biologicals with Pass-Through Status in CY 2008
 - B. Payment for Drugs, Biologicals, and Radiopharmaceuticals without Pass Through Status
 1. Background
 2. Criteria for Packaging Payment for Drugs and Biologicals
 3. Payment for Drugs and Biologicals without Pass Through Status That Are Not Packaged
 - a. Payment for Specified Covered Outpatient Drugs
 - (1) Background
 - (2) Payment Policy
 - (3) Payment for Blood Clotting Factors
 - (a) Background
 - (b) Payment for Diagnostic Radiopharmaceuticals
 - (c) Payment for Therapeutic Radiopharmaceuticals
 - b. Payment for Nonpass-Through Drugs, Biologicals, and Radiopharmaceuticals with HCPCS Codes, But without OPPS Hospital Claims Data
- VI. Estimate of OPPS Transitional Pass Through Spending for Drugs, Biologicals, Radiopharmaceuticals, and Devices
 - A. Total Allowed Pass Through Spending
 - B. Estimate of Pass Through Spending
- VII. OPPS Payment for Brachytherapy Sources
 - A. Background
 - B. Payment for Brachytherapy Sources
- VIII. OPPS Drug Administration Coding and Payment
 - A. Background
 - B. Coding and Payment for Drug Administration Services
- IX. Hospital Coding and Payments for Visits
 - A. Background
 - B. Policies for Hospital Outpatient Visits
 1. Clinic Visits: New and Established Patient Visits and Consultations
 2. Emergency Department Visits
 - C. Visit Reporting Guidelines
 1. Background
 2. CY 2007 Work on Visit Guidelines
 3. Visit Guidelines
- X. OPPS Payment for Blood and Blood Products
 - A. Background
 - B. Payment for Blood and Blood Products
- XI. OPPS Payment for Observation Services
 - A. Observation Services (HCPCS Code G0378)
 - B. Direct Admission to Observation (HCPCS Code G0379)
- XII. Procedures That Will Be Paid Only as Inpatient Procedures
 - A. Background
 - B. Changes to the Inpatient List
- XIII. Nonrecurring Technical and Policy Changes
 - A. Outpatient Hospital Services and Supplies Incident to a Physician Service
 - B. Interrupted Procedures
 - C. Transitional Adjustments—Hold Harmless Provisions
 - D. Reporting of Wound Care Services
 - E. Reporting of Cardiac Rehabilitation Services
 - F. Reporting of Bone Marrow and Stem Cell Processing Services
 - G. Reporting of Alcohol and/or Substance Abuse Assessment and Intervention Services
- XIV. OPPS Payment Status and Comment Indicators
 - A. Payment Status Indicator Definitions
 1. Payment Status Indicators to Designate Services That Are Paid under the OPPS
 2. Payment Status Indicators to Designate Services That Are Paid under a Payment System Other Than the OPPS
 3. Payment Status Indicators to Designate Services That Are Not Recognized under the OPPS But That May Be Recognized by Other Institutional Providers
 4. Payment Status Indicators to Designate Services That Are Not Payable by Medicare
 - B. Comment Indicator Definitions
- XV. OPPS Policy and Payment Recommendations
 - A. MedPAC Recommendations
 - B. APC Panel Recommendations
- XVI. Update of the Revised Ambulatory Surgical Center Payment System
 - A. Legislative and Regulatory Authority for the ASC Payment System
 - B. Rulemaking for the Revised ASC Payment System
 - 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
 - b. Identification of Surgical Procedures Eligible for Payment under the Revised ASC Payment System
 - c. Payment for Covered Surgical Procedures under the Revised ASC Payment System
 - (1) General Policies
 - (2) Office-Based Procedures
 - (3) Device-Intensive Procedures
 - (4) Multiple and Interrupted Procedure Discounting
 - (5) Transition to Revised ASC Payment Rates

2. Covered Ancillary Services under the Revised ASC Payment System
 - a. General Policies
 - b. Payment Policies for Specific Items and Services
 - (1) Radiology Services
 - (2) Brachytherapy Sources
 3. General Payment Policies
 - a. Adjustment for Geographic Wage Differences
 - b. Beneficiary Coinsurance
 - D. Treatment of New HCPCS Codes
 1. Treatment of New CY 2008 Category I and III CPT Codes and Level II HCPCS Codes
 2. Treatment of New Mid-Year Category III CPT Codes
 3. Treatment of Level II HCPCS Codes Released on a Quarterly Basis
 - E. Updates to Covered Surgical Procedures and Covered Ancillary Services
 1. Identification of Covered Surgical Procedures
 - a. General Policies
 - b. Changes in Designation of Covered Surgical Procedures as Office-Based
 - c. Changes in Designation of Covered Surgical Procedures as Device Intensive
 2. Changes in Identification 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
 - 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
 - (2) Policy When Implantable Devices Are Replaced with Partial Credit
 2. Payment for Covered Ancillary Services
 - G. Physician Payment for Procedures and Services Provided in ASC
 - H. Changes to Definitions of "Radiology and Certain Other Imaging Services" and "Outpatient Prescription Drugs"
 - I. New Technology Intraocular Lenses (NTIOLs)
 1. Background
 2. Changes to the NTIOL Determination Process Finalized for CY 2008
 3. NTIOL Application Process for CY 2008 Payment Adjustment
 4. Classes of NTIOLs Approved for Payment Adjustment
 5. Payment Adjustment
 6. CY 2008 ASC Payment for Insertion of IOLs
 - J. ASC Payment and Comment Indicators
 - K. ASC Policy and Payment Recommendations
 - L. Calculation of the ASC Conversion Factor and ASC Payment Rates
- XVII. Reporting Quality Data for Annual Payment Rate Updates
 - A. Background
 1. Reporting Hospital Outpatient Quality Data for Annual Payment Update
 2. Reporting ASC Quality Data for Annual Payment Increase
 3. Reporting Hospital Inpatient Quality Data for Annual Payment Update
 - B. Hospital Outpatient Measures
 - C. Other Hospital Outpatient Measures
 - D. Implementation of the HOP QDRP and Request for Additional Suggested Measures
 - E. Requirements for HOP Quality Data Reporting for CY 2009 and Subsequent Calendar Years
 1. Administrative Requirements
 2. Data Collection and Submission Requirements
 3. HOP QDRP Validation Requirements
 - F. Publication of HOP QDRP Data Collected
 - G. Attestation Requirement for Future Payment Years
 - H. HOP QDRP Reconsiderations
 - I. Reporting of ASC Quality Data
 - J. FY 2009 IPPS Quality Measures under the RHQDAPU Program
- XVIII. Changes Affecting Critical Access Hospitals (CAHs) and Hospital Conditions of Participation (CoPs)
 - A. Changes Affecting CAHs
 1. Background
 2. Co-Location of Necessary Provider CAHs
 3. Provider-Based Facilities of CAHs
 4. Termination of Provider Agreement
 5. Regulation Changes
 - B. Revisions to Hospital CoPs
 1. Background
 2. Provisions of the Final Regulation
 - a. Timeframes for Completion of the Medical History and Physical Examination
 - b. Requirements for Preanesthesia and Postanesthesia Evaluations
 - c. Technical Amendment to Nursing Services CoP
- XIX. Changes to the FY 2008 Hospital Inpatient Prospective Payment System (IPPS) Payment Rates
 - A. Background
 - B. Revised IPPS Payment Rates
 1. MS-DRG Documentation and Coding Adjustment
 2. Application of the Documentation and Coding Adjustment to the Hospital Specific Rates
- XX. Medicare Graduate Medical Education Affiliation Provisions for Teaching Hospitals in Certain Emergency Situations
 - A. Background
 1. Legislative Authority
 2. Existing Medicare Direct GME and Indirect GME Policies
 3. Regulatory Changes Issued in 2006 to Address Certain Emergency Situations
 - B. Additional Changes in This Interim Final Rule with Comment Period
 1. Summary of Regulatory Changes
 2. Discussion of Training in Nonhospital Settings
 - C. Responses to Comments on the April 12, 2006 Interim Final Rule with Comment Period and This Interim Final Rule with Comment Period
- XXI. Files Available to the Public Via the Internet
 - A. Information in Addenda Related to the Revised CY 2008 Hospital OPPS
 - B. Information in Addenda Related to the Revised CY 2008 ASC Payment System
- XXII. Collection of Information Requirements
- XXIII. Response to Comments
- XXIV. Regulatory Impact Analysis
 - A. Overall Impact of Changes to the OPPS and ASC Payment Systems
1. Executive Order 12866
2. Regulatory Flexibility Act (RFA)
3. Small Rural Hospitals
4. Unfunded Mandates
5. Federalism
- B. Effects of OPPS Changes in This Final Rule with Comment Period
 1. Alternatives Considered
 2. Limitation of Our Analysis
 3. Estimated Impact of This Final Rule with Comment Period on Hospitals and CMHCs
 4. Estimated Effect of This Final Rule with Comment Period on Beneficiaries
 5. Conclusion
 6. Accounting Statement
- C. Effects of ASC Payment System Changes in This Final Rule with Comment Period
 1. Alternatives Considered
 2. Limitations on Our Analysis
 3. Estimated Effects of This Final Rule with Comment Period on ASCs
 4. Estimated Effects of This Final Rule with Comment Period on Beneficiaries
 5. Conclusion
 6. Accounting Statement
- D. Effects of the Requirements for Reporting of Quality Data for Hospital Outpatient Settings
- E. Effects of the Policy on CAH Off-Campus and Co-Location Requirements
- F. Effects of the Policy Revisions to the Hospital CoPs
- G. Effects of the Changes to the Hospital Inpatient Prospective Payment System (IPPS) Payment Rates
 1. Overall Impact
 2. Objectives
 3. Limitations of Our Analysis
 4. Quantitative Effects of the IPPS Policy Changes on Operating Costs
 5. Analysis of Table I
 - a. Effects of All Changes with CMI Adjustment Prior to Estimated Growth (Columns 2a and 2b)
 - b. Effects of All Changes with CMI Adjustment and Estimated Growth (Column 3)
 6. Overall Conclusion
 7. Accounting Statement
 8. Executive order 12866
 - H. Impact of the Policy Revisions to the Emergency Medicare GME Affiliated Groups for Hospitals in Certain Declared Emergency Areas
 1. Overall Impact
 2. RFA
 3. Small Rural Hospitals
 4. Unfunded Mandates
 5. Federalism
 6. Anticipated Effects
 7. Alternatives Considered
 8. Conclusion
 9. Executive Order 12866
- XXV. Waiver of Proposed Rulemaking, Waiver of Delay in Effective Date, and Retroactive Effective Date
 - A. Requirements for Waivers and Retroactive Rulemaking
 - B. IPPS Payment Rate Policies
 - C. Medicare GME Affiliation Agreement Provisions

Regulation Text

Addenda

Addendum A—OPPS APCs for CY 2008

Addendum AA—ASC Covered Surgical Procedures for CY 2008 (Including Surgical Procedures for Which Payment is Packaged)
 Addendum B—OPPS Payment By HCPCS Code for CY 2008
 Addendum BB—ASC Covered Ancillary Services Integral to Covered Surgical Procedures for CY 2008 (Including Ancillary Services for Which Payment Is Packaged)
 Addendum D1—OPPS Payment Status Indicators
 Addendum DD1—ASC Payment Indicators
 Addendum D2—OPPS Comment Indicators
 Addendum DD2—ASC Comment Indicators
 Addendum E—HCPCS Codes That Would Be Paid Only as Inpatient Procedures for CY 2008
 Addendum L—Out-Migration Adjustment
 Addendum M—HCPCS Codes for Assignment to Composite APCs for CY 2008

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 OPSS 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 OPSS, 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 OPSS, 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 OPSS/ASC final rule with comment period (71 FR 67960). In that final rule with comment period, we revised the OPSS to update the payment weights and conversion factor for services payable under the CY 2007 OPSS 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 OPSS/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 OPSS/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 OPSS. 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 OPSS (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 OPSS (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 OPSS, 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 OPSS 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 OPSS:

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 OPSS. Section 107(b)(2) of the MIEA TRHCA 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 OPSS full annual update by 2.0 percentage points if a hospital paid under the OPSS 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 OPSS 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 OPSS/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 OPSS 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 OPSS/ASC proposed rule:

1. Updates Affecting OPSS 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 OPSS.
- The proposed retention of our current policy to use the IPPS wage indices to adjust, for geographic wage differences, the portion of the OPSS 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 OPSS payment.

- The proposed beneficiary copayments for OPSS services.

2. OPSS 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. OPSS 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. OPSS Payment for Drugs, Biologicals, and Radiopharmaceuticals

In section V. of the proposed rule, we discussed the proposed CY 2008 OPSS payment for drugs, biologicals, and radiopharmaceuticals, including the proposed payment for drugs, biologicals, and radiopharmaceuticals with and without pass-through status.

5. Estimate of OPSS Transitional Pass-Through Spending for Drugs, Biologicals, and Devices

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

6. OPSS Payment for Brachytherapy Sources

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

7. OPSS 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. OPSS 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 OPPI.

9. OPPI 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 OPPI 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. OPPI 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 OPPI/ASC final rule with comment period.

14. OPPI 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 OPPI 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 OPPI/ASC Proposed Rule

We received approximately 2,180 timely pieces of correspondence containing multiple comments on the CY 2008 OPPI/ASC proposed rule. We note that we received some comments that were outside the scope of the CY 2008 OPPI/ASC proposed rule. These comments are not addressed in this CY 2008 OPPI/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 OPPI/ASC Final Rule with Comment Period

We received approximately 21 timely items of correspondence on the CY 2007 OPPI/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 OPPI 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 OPPI 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 OPPI/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 percent 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 premalignant lesions, 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

| HCPSC 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

| HCPSC 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

| HCPSC 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, snl fetus. | |
| 76811 | Ob us, detailed, snl 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

| HCPSC 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

| HCPSC 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

| HCPSC 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

| HCPSC 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

| HCPSC 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 pace-maker system. | |
| 93732 | Analyze pace-maker system. | |
| 93733 | Telephone analy, pacemaker. | |
| 93734 | Analyze pace-maker system. | |
| 93735 | Analyze pace-maker system. | |
| 93736 | Telephonic analy, pacemaker. | |
| 93741 | Analyze ht pace device snl. | |
| 93742 | Analyze ht pace device snl. | |
| 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

| HCPSC 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

| HCPSCS 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 w/ 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). | |

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

| HCPSCS code | Short description | Added for this final rule |
|-------------|--------------------------------|---------------------------|
| 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 OPPTS/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 OPPTS 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 OPPTS/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 OPPTS 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 OPPTS 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 OPPTS. The OPPTS 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 OPPTS claims in developing median costs, then all packaged costs on claims would also be incorporated in ratesetting under the OPPTS. 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, OPPTS, 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 OPPTS 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 OPPTS 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 OPPTS 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 OPPTS 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 OPPTS, 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 OPPTS policy. We discussed each recommendation within the context of the OPPTS and provided our assessment of its application to the OPPTS in the CY 2008 OPPTS/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 OPSS (RTI study, pages 11 and 86). Moreover, with regard to radiology services, the OPSS already has partially implemented RTI's recommendation to use lower CCRs to estimate costs for those OPSS 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 OPSS 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 OPSS and to assess the impact of any such changes on payment under the OPSS (HHS 500–2005–000291 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 OPSS by comparing revenue code and cost center charges, make recommendations for changes to the crosswalk, and assess the OPSS 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 OPSS 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 OPSS (RTI study, pages 34 and 35). While RTI recommends that the model be recalibrated for outpatient charges before it is applied to the OPSS, 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 OPSS 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 OPSS.

Moreover, we were concerned that implementing the regression-based IPPS related CCRs in the OPSS 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 OPSS. 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 OPSS after we received RTI's comprehensive review of the OPSS 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 OPSS. A summary of the public comments and our responses follow.

Comment: The commenters made a number of requests for the CY 2008 OPSS. 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 OPSS. 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 OPSS 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 OPSS for CY 2009 through a joint IPPS/OPSS 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 OPSS 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 impact 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 redistributive 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 redistributive 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 OPPTS 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 OPPTS 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 OPPTS.

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 OPPTS, 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 OPPTS, 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 OPPTS 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 OPPTS/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 OPPTS, 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 OPPTS 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 OPPTS 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 OPPTS 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 FR 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 public 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 OPPI.

Response: Unlike payment under the IPPS, the law does not provide for payment for indirect medical education costs to be made through the OPPI. 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 OPPI payment to teaching hospitals for the CY 2008 OPPI.

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 OPPI. The concern, therefore, is partially mitigated by our final CY 2008 packaging policies. Commenters responding to the CY 2006 proposal OPPI 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 OPPI 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 OPPI 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 OPSS 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 OPSS 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 OPSS. We did not receive any public comments on the methodology for calculating scaled weights from the median costs for the CY 2008 OPSS. 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 OPSS 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 OPSS, 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 OPSS, greater unpackaging of payment has occurred simultaneously with continued tremendous growth in OPSS 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 OPSS/ASC proposed rule and in the context of this rapid spending growth, MedPAC encouraged CMS to broaden the payment bundles under the OPSS to encourage providers to use resources efficiently.

As permitted under section 1833(t)(2)(B) of the Act, the OPSS establishes groups of covered HOPD services, namely APC groups, and uses them as the basic unit of payment. During the evolution of the OPSS 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 OPSS, 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 OPSS 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 OPSS 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 OPSS. As illustrated in Table 3 below, total spending has been growing at a rate of roughly 10 percent per year under the OPSS, and the Medicare Trustees project that total spending under the OPSS will increase by more than \$3 billion from CY 2007 through CY 2008 to nearly \$35 billion. Implementation of the OPSS 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 OPSS.

TABLE 3.—GROWTH IN EXPENDITURES UNDER OPSS FROM CY 2001–CY 2008

[Projected expenditures for CY 2006–CY 2008 in billions]

| OPSS 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 OPSS, 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 OPSS. 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 OPSS is likewise fully appropriate. We have used this packaging approach for ratesetting throughout the history of the OPSS, 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 OPSS 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 OPSS, 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 OPSS 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 OPSS. We note that we pay hospitals under the OPSS, 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 OPSS.

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 OPSS. 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 OPSS after RTI reviews the OPSS 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 OPSS 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 OPSS 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 OPSS costs, although CMS estimated that the packaging proposal would redistribute 1.2 percent of the CY 2008 expenditures under the OPSS. 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 OPSS to other OPSS 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 OPSS spending on services addressed by the policy. We understand, and intended, that the packaging proposal affect services responsible for significant OPSS 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 OPPTS. 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, OPPTS, 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 OPPTS.

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 OPSS services that are paid separately under the MPFS.

Response: Our general process for developing the OPSS, 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 OPSS 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 OPSS 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 OPSS. 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 OPSS payment policy in its deliberations, nor should it be influenced by OPSS 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 OPSS 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 OPSS through the budget neutral weight scaler. Any reduction in the growth of OPSS 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 OPSS. 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 OPSS 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 OPSS 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 OPSS and that could inadvertently result in actually increasing the volume of services. We prefer to establish larger packages of services on which to base OPSS 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 intra-procedural 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 OPPIs 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 OPPIs 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 OPPIs 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

| HCPSC 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 | 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 HCPSC 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 HCPSC 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 OPPTS/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 OPPTS 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 OPPTS/ASC proposed rule is that hospitals may have included the charges for radiopharmaceuticals on an uncoded revenue code line.

In the CY 2007 OPPTS/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 OPPTS 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 OPPTS update, as we indicated in the CY 2008 OPPTS/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 OPPTS 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 OPPTS. 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 OPPTS 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 radiopharmaceutical 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)(I) 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)(I) 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 OPPI 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 OPPI 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 OPPI 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 OPPI, we have determined that, approximately 60 percent of the cost of an OPPI 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 OPPI 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, OPPI

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 millicuries) 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 MEDIAN

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

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 OPPI claim for echocardiography procedures performed with contrast.

For CY 2008, we are finalizing our proposal to unconditionally package 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 OPPI 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 OPPI 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 OPPI 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 OPPI, meaning that the OPPI 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 OPPI 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 composite 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 be provided under the OPSS.

Consistent with our statutory flexibility to define what constitutes a service under the OPSS, 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 OPSS 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 OPPTS, 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 OPPTS proposed rule and CY 2007 OPPTS/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 use 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 | HPCS 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 | HPCS 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 final rule with comment period 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 OPPIs. 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-pack- aged" | 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-pack- aged” | 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-pack- aged” | 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-pack- aged” | 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 | lo 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 Radio- pharmaceutical. |
| A4642 | In111 satumomab | H | 0704 | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9500 | Tc99m sestamibi | H | 1600 | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9501 | Technetium TC-99m teboroxime | n/a | n/a | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9502 | Tc99m tetrofosmin | H | 0705 | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9503 | Tc99m medronate | N | n/a | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9504 | Tc99m apcitide | N | n/a | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9505 | TL201 thallium | H | 1603 | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9507 | In111 capromab | H | 1604 | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9508 | I131 iodobenguante, dx | H | 1045 | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9509 | Iodine I-123 sod iodide mil | n/a | n/a | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9510 | Tc99m disofenin | N | n/a | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9512 | Tc99m pertechnetate | N | n/a | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9516 | I123 iodide cap, dx | H | 9148 | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9521 | Tc99m exametazime | H | 1096 | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9524 | I131 serum albumin, dx | H | 9100 | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9526 | Nitrogen N-13 ammonia | H | 0737 | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9528 | Iodine I-131 iodide cap, dx | H | 1088 | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9529 | I131 iodide sol, dx | N | n/a | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9531 | I131 max 100uCi | N | n/a | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9532 | I125 serum albumin, dx | N | n/a | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9536 | Tc99m depreotide | H | 0739 | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9537 | Tc99m mebrofenin | N | n/a | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9538 | Tc99m pyrophosphate | N | n/a | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |

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|-----------------------|-------------------------------------|------------------|-------------------|---------------------------|---|----------------------|--------------------------------------|
| (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) |
| A9539 | Tc99m pentetate | H | 0722 | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9540 | Tc99m MAA | N | n/a | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9541 | Tc99m sulfur colloid | N | n/a | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9542 | In111 ibritumomab, dx | H | 1642 | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9544 | I131 tositumomab, dx | H | 1644 | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9546 | Co57/58 | H | 0723 | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9547 | In111 oxyquinoline | H | 1646 | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9548 | In111 pentetate | H | 1647 | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9550 | Tc99m gluceptate | H | 0740 | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9551 | Tc99m succimer | H | 1650 | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9552 | F18 fdg | H | 1651 | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9553 | Cr51 chromate | H | 0741 | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9554 | I125 iothalamate, dx | N | n/a | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9555 | Rb82 rubidium | H | 1654 | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9556 | Ga67 gallium | H | 1671 | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9557 | Tc99m bismate | H | 1672 | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9558 | Xe133 xenon 10mci | N | n/a | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9559 | Co57 cyano | H | 0724 | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9560 | Tc99m labeled rbc | H | 0742 | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9561 | Tc99m oxidronate | N | n/a | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9562 | Tc99m mertiatide | H | 0743 | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9566 | Tc99m fanolesomab | H | 1678 | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9567 | Technetium TC-99m aerosol | H | 0829 | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9568 | Tc99m arcitumomab | H | 1648 | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9569 | Technetium TC-99m auto WBC | n/a | n/a | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9570 | Indium In-111 auto WBC | n/a | n/a | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9571 | Indium In-111 auto platelet | n/a | n/a | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| A9572 | Indium In-111 pentetreotide | n/a | n/a | N | n/a | n/a | Diagnostic Radio- pharmaceutical. |
| 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-pack- aged” | 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 perflerane 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 OPSS. 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 OPSS. The Medicare regulations at § 419.21 that implement this provision specify that payments under the OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS update, the CY 2006 OPSS 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 OPSS 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 OPSS 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 OPSS 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. |

| Revenue center code | Revenue center description |
|---------------------|---|
| 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 OPPOS 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 OPPOS 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 OPPTS 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 OPSS for individual mental health services that are otherwise covered and billable under the OPSS.

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 OPSS/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 OPSS. The Medicare regulations at 42 CFR 419.21 that implement this provision specify that payments under the OPSS 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 OPSS. However, it would require a statutory change to establish an independent payment system for partial hospitalization programs outside the OPSS. 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 OPSS

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 OPSS rate year). In addition, the statutory authority for the OPSS 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 OPPTS, 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 OPPTS 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 OPPTS 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 OPPTS 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 OPPTS purposes, we proposed to continue our

policy in CY 2008 to allow non-IPPS hospitals paid under the OPPTS 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 OPPTS/ASC proposed rule (72 FR 42695), we also wish to clarify that the IPPS policy for multicampus wage index payments also applies to the OPPTS. 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 OPPTS, we proposed to continue our policy to allow non-IPPS hospitals paid under the OPPTS 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 OPPTS 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 OPPTS, we proposed to use the final FY 2008 IPPS

wage indices, including the budget neutrality adjustment for the rural floor, for calculating OPSS payment in CY 2008. We discuss how the OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS estimates a labor-related share that is specific to outpatient services. The OPSS labor-related share was determined through regression analyses conducted for the initial OPSS 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 OPSS 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 OPSS 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 OPSS standard payment amounts for labor market differences under the CY 2008 OPSS.

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 OPSS. 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 OPSS/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 OPSS, 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 OPSS 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 OPSS, 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, OPSS 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. OPSS Payments to Certain Rural Hospitals

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

When the OPSS 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 OPSS 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 OPSS 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 OPSS payment. In the final CY 2006 claims, aggregated outlier payments were 1.1 percent of aggregated total OPSS payments. For CY 2006, the estimated outlier payments were set at 1.0 percent of the total aggregated OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS, 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 OPSS/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 (OPSS) 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 OPSS/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 OPSS update lag by 2 years. For the proposed rule, we used CY 2006 claims to model the CY 2008 OPSS. 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 OPSS final rule with comment period, we believe that the use of this charge inflation factor is appropriate for the OPSS 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 OPSS/ASC proposed rule, a commenter asked that CMS modify the charge methodology used to set the OPSS 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 OPSS outlier payments would more closely reflect the CCRs that would be used in CY 2007 to determine actual outlier payment. In the CY 2007 OPSS/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 OPSS, we determined that we could not calculate an OPSS-specific reliable cost per unit, comparable to the cost per discharge component of the IPPS calculation, because of variability in definition of an OPSS 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 OPSS 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 OPSS 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 OPSS than a higher fixed-dollar threshold, given the current size of the OPSS 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 OPSS 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 OPSS 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 OPSS/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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS, 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 OPSS

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 OPSS. 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)
 $x_a = 60 * (\text{national unadjusted payment rate}) * \text{applicable wage index}$.

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
 $y = .40 * (\text{national unadjusted payment rate})$
 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
 $b = \text{national unadjusted copayment for APC} / \text{national unadjusted payment rate for APC}$

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 OPPI 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, (Octagam), 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 OPPI for the following calendar year. These codes are flagged with comment indicator “NI” in Addendum B to the OPPI/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 OPPI 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 OPPI/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 OPPI/ASC proposed rule, we will respond to all comments received

concerning these codes in a subsequent final rule for the next calendar year’s OPPI/ASC update.

We did not receive any public comments on our proposal to assign a comment indicator of “NI” in Addendum B of the OPPI 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 OPPI. 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 OPPTS/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 OPPTS quarterly update process. Therefore, for CY 2008, we proposed to include in Addendum B to the CY 2008 OPPTS/ASC final rule with comment period the new Category III CPT codes released in January 2007 for implementation on July 1, 2007 (through the OPPTS 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 OPPTS practice for Category III CPT codes that are implemented mid-year by the AMA, we recognized CPT code 0182T under the OPPTS 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 OPPTS, which generally pays for services based on estimated hospital resources. In the absence of cost data from hospital claims, we believe that comparisons of OPPTS 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. |

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

| APC | APC title |
|------------|--|
| 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 HCPCS 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 OPPI 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 OPPI/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 APC assignments, which we addressed in the CY 2007 OPPI/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, the 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

| HCPSC 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

| HCPSCS 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 OPSS 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 OPSS/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 OPSS, when possible, to minimize the administrative coding burden on hospitals.

In the CY 2008 OPSS/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 OPSS.

We received a number of public comments on our CY 2008 proposal for reporting ICD implantation procedures under the OPSS. 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 OPSS 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 OPSS 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 recording; 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 noncontrast 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 contrast 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 OPPTS 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

| HCPSC 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 0202 (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 recanalization/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 64653 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 | HPCS codes included in CY 2008 median cost | HPCS 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 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 65570 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 65570. 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 65570 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

| HCPSC 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 OPFS. 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 OPFS 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 OPFS 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 OPFS, 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 subscribed 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 subscribed 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 OPPI/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 HCPCS 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, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children); CPT code 15171 (Acellular dermal replacement, 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)); 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 | Apply 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. | 0135 | 285 |
| 12020 | Closure of split wound | | |
| 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. | 0136 | 947 |
| 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 epiderm 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 skinalogrft, 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 xgrft, f/n/hf/g. | | |
| 15421 | Apply skn xgrft f/n/hf/g add. | | |
| 15430 | Apply acellular xenograft. | | |
| 15431 | Apply acellular xgrft add. | | |
| 20926 | Removal of tissue for graft. | | |
| 43887 | Remove gastric port, open. | | |
| 11762 | Reconstruction of nail bed | | |
| 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. | 0137 | 1,271 |
| 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 spl't grft, trnk/arm/leg. | | |
| 15101 | Skin spl't grft t/a/l, add-on. | | |
| 15120 | Skn spl't a-grft fac/nck/hf/g. | | |
| 15121 | Skn spl't 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 OPFS 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 OPPTS, 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 OPPTS.

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 OPPTS 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 OPPTS 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 OPPTS. 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. OPPTS 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 OPPTS, 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 OPPTS, 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 OPPTS, 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 OPPTS 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 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 rule 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, Ex- cluding 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 Elec- trodes. | \$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 pace- maker. | \$6,891 | \$6,876 | 1,896 | 634 |
| 0655 | T | Insertion/Replacement/Conversion of a permanent dual cham- ber 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 2008 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 OPPI/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 OPPI 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 OPSS 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 OPSS 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 OPSS, 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 OPSS 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 OPSS/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 OPSS/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 OPSS 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 OPSS only).

b. Final Policy

In the CY 2008 OPSS/ASC proposed rule, we stated that we were implementing in CY 2008 the final decision that we discussed in the CY 2007 OPSS/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 OPSS 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.

b. Final Policy

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 voluntarily 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 OPSS.

3. Drugs and Biologicals With Pass-Through Status in CY 2008

In the CY 2008 OPSS/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 OPSS/ASC proposed rule, we proposed to continue pass-through status for 13 drugs and biologicals. As stated previously, it is standard OPSS practice to delete temporary C-codes if an alternate permanent HCPCS code becomes available for purposes of OPSS 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 | Ecuzumab 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 OPSPS.

B. Payment for Drugs, Biologicals, and Radiopharmaceuticals Without Pass Through Status

1. Background

Under the CY 2007 OPSPS, 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 OPSPS 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 OPSPS 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 OPSPS/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 OPSPS/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 OPSPS/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 regimen. 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 OPSS and the MPFS that apply to physician's office services are fundamentally different payment systems with essential differences in their payment policies. Specifically, the OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS. 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 OPSS/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 OPSS 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 OPSS, 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

| HCPSC 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 HCPSC code in CY 2006 and were paid (via packaged or separate payment) under the OPSS 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 OPSS proposed rule (70 FR 42723 through 42724) and finalized in the CY 2006 OPSS 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 OPSS/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 OPSS claims data from the CY 2006 HCPSC codes that were reported to the CY 2007 HCPSC codes that we displayed in Addendum B to the proposed rule for payment in CY 2008.

Our policy during previous cycles of the OPSS 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 OPSS/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

| HCPSCS | 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 OPSS 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 OPSS 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 OPSS 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 OPSS final rule with comment period (70 FR 68639 through 68644).

As we noted in the CY 2006 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS. 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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS provides payment for both the drugs and the associated pharmacy overhead costs through the applicable procedural APC payments.

As noted in the CY 2007 OPSS 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 OPSS 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 regimen. We do not make separate payment for supplies used in services provided under the OPSS. 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 OPPTS 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 OPPTS 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 OPPTS, 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 OPPTS/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 OPPTS 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 OPPTS 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 OPPTS 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 OPPTS final rule with comment period, we have exempted radiopharmaceutical manufacturers from reporting ASP data for payment purposes under the OPPTS (for more information, we refer readers to the CY 2005 OPPTS final rule with comment period and the CY 2006 OPPTS 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 OPPTS ratesetting. In accordance with section 1833(t)(14)(B)(i)(I) of the Act, we have classified radiopharmaceuticals under the OPPTS 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 OPPTS 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 OPPTS 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 OPPTS/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 OPPTS. 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 OPPTS/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 OPPTS 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 OPSPS 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 OPSPS 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 OPSPS 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 OPSPS 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 OPSPS, 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 HCPCS 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 OPPI. 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 OPPI (71 FR 68095). In the CY 2008 OPPI/ASC proposed rule, we again noted our intent to move to a prospective payment for therapeutic radiopharmaceuticals under the OPPI 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 OPPI 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-through drugs, biologicals, 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 AWP. 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 AWP) 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 OPPTS/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 OPPTS/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 OPPTS 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 OPPTS. Indeed, section 1833(t)(2)(C) of the Act requires us to establish prospective payment rates for the OPPTS 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 OPPIs 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 OPPTS 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 OPPTS 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 OPPTS 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 OPPTS 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 OPPTS, 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 OPPTS 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 OPPTS 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 OPPTS 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 OPPTS, rather than a separate cost-based payment methodology within the OPPTS. We believe that consistent and predictable prospectively established payment rates under the OPPTS 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 OPPTS payment methodology as proposed. We particularly note that, under the final CY 2008 payment policies for all OPPTS 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 OPPTS, 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 OPPTS 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 OPPTS. 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 from 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 OPPI/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 OPPI 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 OPPI 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

| HCPSC 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 OPPI 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 HCPSC 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 OPPI/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 HCPSC 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 ytterbium-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 OPSS 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 OPSS. 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. OPSS Drug Administration Coding and Payment

A. Background

From the start of the OPSS 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 OPSS drug administration HCPCS code, Q0085 (Administration of chemotherapy by both infusion and another route, per visit), was active from the beginning of the OPSS 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 OPSS payment rates.

In CY 2005, in response to the recommendations made by commenters and the hospital industry, OPSS 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 OPSS 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 OPSS/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 OPSS/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 OPSS 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 OPSS and the MPFS are fundamentally different payment systems with essential differences in their payment policies. Specifically, the OPSS 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 OPSS 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 OPSS 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 OPSS 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

OPSS-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 OPSS, 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 OPSS 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 OPSS. 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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS/ASC proposed rule, we did not propose to change our OPSS 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 OPSS/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 OPSS/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 OPSS 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 OPSS, 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 OPSS, 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 99201 99211 99241 G0101 G0245 G0379 | Eye exam established pat. Office/outpatient visit, new (Level 1). Office/outpatient visit, est (Level 1). Office consultation (Level 1). CA screen; pelvic/breast exam. Initial foot exam pt lops. Direct admit hospital observ. |
| Level 2 Hospital Clinic Visits | 0605 | 63.01 | 7.3 | 90862 92002 92014 99202 99212 99213 99242 99243 99431 G0246 G0344 M0064 | Medication management. Eye exam, new patient Eye exam and treatment. Office/outpatient visit, new (Level 2). Office/outpatient visit, est (Level 2). Office/outpatient visit, est (Level 3). Office Consultation (Level 2). Office Consultation (Level 3). Initial care, normal newborn. Followup eval of foot pt lop. Initial preventive exam. Visit for drug monitoring. |
| Level 3 Hospital Clinic Visits | 0606 | 85.96 | 2.9 | 92004 99203 99214 99244 | Eye exam, new patient. Office/outpatient visit, new (Level 3). Office/outpatient visit, est (Level 4). Office consultation (Level 4). |
| Level 4 Hospital Clinic Visits | 0607 | 108.08 | .8 | 99204 99215 99245 | Office/outpatient visit, new (Level 4). Office/outpatient visit, est (Level 5). Office consultation (Level 5). |
| Level 5 Hospital Clinic Visits | 0608 | 138.88 | .08 | 99205 G0175 | Office/outpatient visit, new (Level 5). 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 OPPTS/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 OPPTS/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 OPPTS/ASC proposed rule and even fewer comments in response to the CY

2007 OPPTS/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 OPPTS, 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 OPPTS/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 OPPTS 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 OPPTS, 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 OPPTS/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 OPPTS, 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 OPPTS 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 OPPTS. As we observed in the CY 2008 OPPTS/ASC proposed rule, the differentiation of consultations from new and established patient clinic visits would appear to be clinically unnecessary under the OPPTS in order to provide proper OPPTS payment for hospital outpatient visits.

In the CY 2007 OPPTS/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 OPPTS, 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 out-patient 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 out-patient 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 out-patient 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 OPSS 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 OPSS 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 OPSS. 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 OPSS 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 OPSS 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 OPSS 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 OPSS, 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

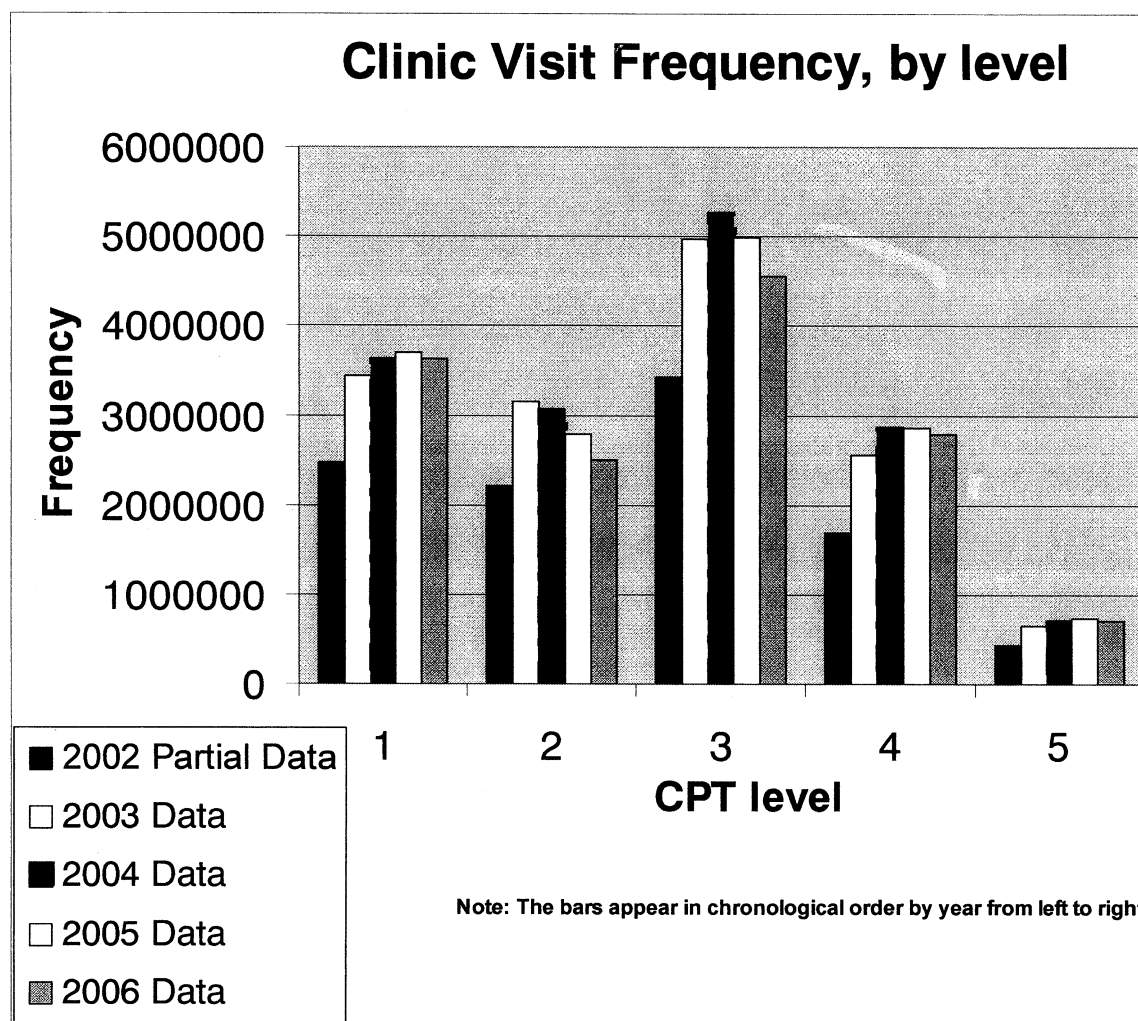
In preparation for the CY 2008 OPPS/ASC proposed rule, we performed data analyses with the goal of studying the current and historical distribution of each level of clinic and emergency department visit codes billed nationally, as well as the distribution among

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 OPPI/ASC proposed rule were single claims.

In the CY 2008 OPPI/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

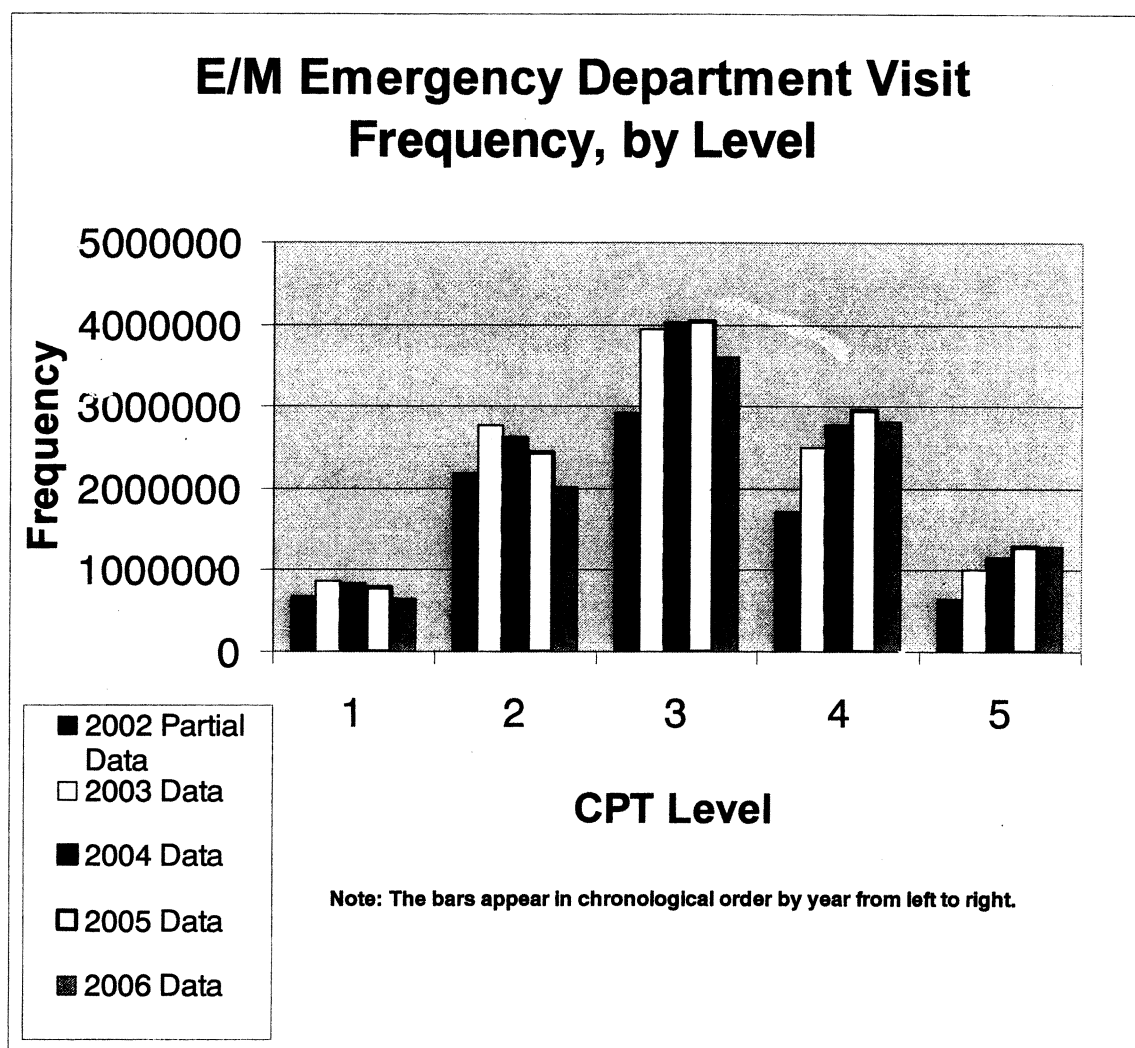
national distribution of established patient visits. Nonteaching hospitals tended to bill a greater proportion of Level 1 and 2 patient visits as compared to major teaching hospitals, as would be expected if their general patient acuity was slightly lower. Nonteaching hospitals include many community 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 OPPTS, 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 OPPTS/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 OPPTS, 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 OPPTS 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 OPPTS/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 OPPTS/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 OPPTS/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 OPPTS/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 OPPTS 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 OPSS 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 OPSS payments for the efficient and effective provision of visits in hospital outpatient settings.

X. OPSS Payment for Blood and Blood Products

A. Background

Since the implementation of the OPSS 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 OPSS 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 OPSS, 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 OPSS to the CY 2002 OPSS, payment rates for blood and blood products were updated for inflation. For the CY 2003 OPSS, 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 OPSS to the CY 2003 OPSS, 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 OPSS, 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 OPSS, 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 OPSS 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 OPSS, 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 OPSS payment rate on a 50/50 blend of the CY 2004 OPSS product-specific OPSS median costs and the CY 2005 OPSS 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* | Platelet 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 irradiated | 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 irradiated | 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* | Plasma protein 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, irradiated | 156 | 493 | 369 |
| P9058 | RBC, l/r, cmv-neg, irradiated | 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. OPPTS 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 OPPTS 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 OPPTS 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 OPPTS 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 OPPTS, meaning that the OPPTS 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 OPSS 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 OPSS.

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 OPSS/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 OPSS/ASC proposed rule, we stated in the CY 2007 OPSS/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 OPPTS/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 OPPTS/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 OPPTS. Before implementation of the OPPTS 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 OPPTS (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 OPPTS:

- 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 OPPTS:

- 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 OPPTS, 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 OPPTS inpatient list at its March 2007 meeting. Prior to publishing the CY 2008 OPPTS/ASC proposed rule, we received one other candidate HCPCS code for removal from the OPPTS 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 OPPTS inpatient list. It also recommended that CMS obtain additional utilization data about 1 of the 14 procedures identified for possible removal from the OPPTS inpatient list, specifically CPT code 64818 (Sympathectomy, lumbar); and for another procedure presented for possible removal from the OPPTS 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 dietitians, 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 dietitians. 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. OPPTS Payment Status and Comment Indicators**A. Payment Status Indicator Definitions**

The OPPTS payment status indicators (SIs) that we assign to HCPCS codes and APCs play an important role in determining payment for services under the OPPTS. They indicate whether a

service represented by a HCPCS code is payable under the OPPTS or another payment system and also whether particular OPPTS 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 OPPTS/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 OPPTS

| Indicator | Item/code/service | OPPTS payment status |
|-----------|---|--|
| G | Pass-Through Drugs and Biologicals | (1) Paid under OPPTS; 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 OPPTS; separate APC payment. |
| | (2) Therapeutic Radiopharmaceuticals | (2) Paid under OPPTS; separate APC payment. |
| | (3) Brachytherapy Sources | (3) Paid under OPPTS; separate APC payment. |
| | (4) Blood and Blood Products | (4) Paid under OPPTS; separate APC payment. |
| N | Items and Services Packaged into APC Rates | Paid under OPPTS; payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment. |
| P | Partial Hospitalization | Paid under OPPTS; per diem APC payment. |
| Q | Packaged Services Subject to Separate Payment under OPPTS Payment Criteria. | Paid under OPPTS; Addendum B displays APC assignments when services are separately payable. (1) Separate APC payment based on OPPTS 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 OPPTS; separate APC payment. |
| T | Significant Procedure, Multiple Reduction Applies | Paid under OPPTS; separate APC payment. |
| V | Clinic or Emergency Department Visit | Paid under OPPTS; separate APC payment. |
| X | Ancillary Services | Paid under OPPTS; 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 OPPTS/ASC final rule with comment period, section 107(a) of the MIEA–TRHCA extended the payment period for brachytherapy sources paid under the OPPTS 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 OPPTS 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 OPPTS 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 OPPTS.

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 OPPTS 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 OPPTS.

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 OPPTS. 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 OPPTS, we will consider how to further refine the OPPTS status indicators to provide the most relevant information concerning payment of OPPTS services.

After considering the public comments received concerning the proposed use of status indicators for services that are paid under the OPPTS, 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: <ul style="list-style-type: none"> 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. |
| C | Inpatient Procedures | Not subject to deductible. |
| F | Corneal Tissue Acquisition; Certain CRNA Services; and Hepatitis B Vaccines. | Not paid under OPPS. Admit patient. Bill as inpatient. |
| L | Influenza Vaccine; Pneumococcal Pneumonia Vaccine | Not paid under OPPS. Paid at reasonable cost. |
| 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 and 13x). | Not paid under OPPS. <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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 OPSS; (2) paid under a payment system other than the OPSS; (3) not recognized under the OPSS 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 OPSS 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 OPSS/ASC proposed rule, for CY 2008, we proposed to continue that policy which we are now adopting in this CY 2008 OPSS/ASC final rule with comment period. When used in this OPSS/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 OPSS/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 OPSS comment indicators. Therefore, we are finalizing our proposed use of comment indicators for the CY 2008 OPSS/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. OPSS 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 OPSS:

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 OPSS/ASC proposed rule, in this final rule with comment period, we are increasing the payment rates for the CY 2008 OPSS 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 OPSS 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 OPSS 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 OPSS as the IPPS, and, therefore, such analysis and recommendations may have possible implications for the CY 2009 OPSS. 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–TRHCA requires that certain quality of care reporting requirements mandated for hospitals paid under the OPPS by section 109(a) of the MIEA–TRHCA 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 OPPTS/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 OPPTS/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 OPPTS inpatient list, procedures that are packaged under the OPPTS, CPT unlisted surgical procedure codes, and surgical procedures that are not recognized for payment under the OPPTS. 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 OPPTS 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 OPPTS APCs as a “groupier” 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 OPPTS 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 OPPTS

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 OPPTS relative payment weights each year to ensure that the OPPTS 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 OPPTS 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 OPPTS and MPFS rates, along with updated utilization data. The ASC CY 2008 budget neutrality adjustment is multiplied by the OPPTS 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 OPPTS 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); anesthesiologists' 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-HDR Ir-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 OPPIs. 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 OPPIs 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 OPPIs because most of the ASC rates are lower than OPPI rates and because beneficiary copayments vary from 20 to 40 percent under the OPPIs. We note that, just like under the OPPIs, 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 OPPIs/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 OPPIs/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 OPPIs/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 OPPIs/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 OPPIs/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 OPPIs update final rule for the year following publication of the code's interim OPPIs 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 OPPIs/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 OPPIs 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 OPPIs 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 OPPIs 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 OPPTS IN JULY 2007 THAT WILL BE PAID IN CY 2008 IN ASCS

| CY 2007 HCPCS code | CY 2008 HCPCS code | Descriptor | CY 2008 ASC pay- ment indi- cator |
|-----------------------|-----------------------|---|--|
| 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 OPPTS 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 OPPTS for the recognition of those codes. Also, consistent with the MPFS and OPPTS 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 OPPTS/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 OPPTS 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 OPPTS/ASC proposed rule, we proposed to remove 13 procedures from the OPPTS 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 OPPTS/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

| HCPSC 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

| HCPSC 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

| HCPSC 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

| HCPSC 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 I 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 OPPTS/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 OPPTS/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 OPPTS/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 OPPTS 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 juxtasccleral 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., fiducial 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 OPPTS/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

| HCPSC 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 juxtasceral 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

| HCPSC 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

| HCPSC 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 de- vice-depend- ent 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 \times \$139 = \104.25 . |
| Step 2 | Calculate CY 2008 fully implemented ASC rate by multiplying ASC relative weight by ASC conversion factor. | $7.1370 \times \$41.400 = \295.4718 . |
| Step 3 | Multiply transition year one CY 2008 portion of blended rate by the fully implemented ASC rate. | $0.25 \times \$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, Exclud- ing 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 Pace- maker 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 Elec- trodes, 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

| HCPSC 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 HCPSC 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 biologics, 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 OPSS, 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 OPSS 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 OPSS-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 OPSS, while the OPSS-to-APC cost ratio is a comparison of the median cost of each of those same procedures under the OPSS 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 OPSS. 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 OPSS 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 OPSS, 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 OPSS 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 OPSS/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 OPSS/ASC proposed rule, it reflects several changes, including: (1) Use of the final OPSS 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 MPFS 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 OPFS payment rates.

To estimate the aggregate amount of expenditures that would be made in CY 2008, we use CY 2008 OPFS 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 OPFS 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 OPFS/ASC proposed rule for the revised ASC payment system that was based on partial year CY 2006 utilization and proposed CY 2008 OPFS 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 OPFS/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 OPFS 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 OPFS conversion factor by the ASC budget neutrality adjustment. The final CY 2008 OPFS 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 OPFS 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 OPPI. The CY 2008 ASC payment rates of covered ancillary drugs and biologicals and brachytherapy sources are set equal to their final CY 2008 OPPI 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 OPPI 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 OPPI 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 OPPI 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 OPPI relative payment weights) such as drugs and biologicals that are separately paid under the OPPI. 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 OPPI 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 OPPI 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 OPPI/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 OPPI 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 OPPI. We believe that including the ASC update as part of the OPPI 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 OPPI 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 OP/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 OP/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 OP/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 OP/ASC 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 OP/ASC final rule with comment period (71 FR 68189), we indicated our intent to establish, in CY 2009, an OP/ASC 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 OP/ASC 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 OP/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 OP/ASC 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. The 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-community 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 OPSPS. 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 OPSPS 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 OPSPS 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 OPSPS 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 OPSPS, so a reduction in the OPSPS 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 OPSPS 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 HCA 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 OPPI/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 OPPI. 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 OPSS 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 OPSS/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 OPSS 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 OPSS Clinical Warehouse will submit the data to CMS on behalf of the hospitals. While the CMS contract for managing the OPSS 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 OPSS Clinical Warehouse. Because the information in the OPSS 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 OPSS/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 OPSS 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 QDRP. 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-abtract 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 QDRP 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 they 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) | <ul style="list-style-type: none"> • 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) | <ul style="list-style-type: none"> • 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) | <ul style="list-style-type: none"> • 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). | <ul style="list-style-type: none"> • 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) | <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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 OPPI/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 OPPTS/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 OPPTS/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 OPPIs proposed rule because they believed that many CAHs will not evaluate, pay attention to, or read the OPPIs 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 OPPTS 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 OPPTS rulemaking. We point out that the subject of the CAH proposed changes was included in the title of the OPPTS 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 OPPI/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 OPPI/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 OPPTS/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 2007¹

| 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 2007¹—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 2007¹—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 |

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 (\$) |
|-----------|-----------------|----------------|
| 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 |

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 (\$) |
|-----------|-----------------|----------------|
| 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 OPPI. 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 OPPI 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 OPPI 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 OPPI 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 OPPI/ASC final rule with comment period, and related data files are included on the CMS Web site as noted above. MPFS data files are located at <http://www.cms.hhs.gov/PhysicianFeeSched/>.

The links to all of the FY 2008 IPPI wage index related tables (that are used for the CY 2008 OPPI) from the FY 2008 IPPI final rule with comment period (72 FR 47436 through 47539) as corrected in the October 10, 2007 **Federal Register** notice to the FY 2008 IPPI 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 OPPI/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 forward 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 OPSS, we classify these hospitals as urban hospitals. We believe that the changes to the OPSS in this final rule with comment period 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 OPSS 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 OPSS Changes in This Final Rule With Comment Period

We are making several changes to the OPSS 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 OPSS 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 OPSS payments because these changes to the OPSS 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 OPSS

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 OPPTS 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 OPPTS. 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 OPPTS 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 OPPTS. 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 OPPTS, meaning that the OPPTS 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 OPPTS 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 OPPIs.

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 OPPI/ASC proposed rule, for several reasons. We note it would not be consistent with the FY 2008 IPPIs 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 OPPIs, 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 OPPTS 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 OPPTS, 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 OPPTS/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 OPPTS 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 OPPTS/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 OPPTS, 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 OPPTS 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 OPPTS rates for CY 2008 will have a positive effect for providers paid under the OPPTS,

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 | APC changes | New wage index and rural adjust- ment | Combined (cols 2,3) with market basket up- date | All changes |
|--|------------------------|----------------|--|---|-------------|
| | (1) | (2) | (3) | (4) | (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 | APC changes | New wage index and rural adjust- ment | Combined (cols 2,3) with market basket up- date | All changes |
|----------------------------|------------------------|----------------|--|---|-------------|
| | (1) | (2) | (3) | (4) | (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 OPPI/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 OPPI 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 OPPI. (The only possible instance in which an ASC coinsurance amount could exceed the OPPI 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 OPPI 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 OPPI/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 OPPI 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 | 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) |
| 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 risk 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 than 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 OPPTS, so the beneficiary coinsurance amount under the ASC payment system almost always will be less than the OPPTS 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 OPPTS 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.whitehouse.gov/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 OPPI 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 health 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/sizestandardstocps/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 MGRB for FY 2008. The second grouping shows the MGRB 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.whitehouse.gov/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 of -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 Dilatation 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 | Transcatheter 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 | Phlebectomy 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 | S | 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 | Mecasmerin 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 irradiated | 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 | Cryoprecipitated reduced plasma | 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 irradiated | 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, irradiated | K | 5.8716 | \$373.99 | | \$74.80 |
| 1022 | RBC, l/r, cmv-neg, irradiated | 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 difitox | 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 XIX (\$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 | Corticotrelin ovine triflural | 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-HDR Ir-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 glucuronate | 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 globulin 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]

| HCPSC 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 |

Note: The Medicare program payment is 80 percent of the total payment amount and beneficiary coinsurance is 20 percent of the total payment amount, except for screening flexible sigmoidoscopies and screening colonoscopies for which the program payment is 75 percent and the beneficiary coinsurance is 25 percent.

* Refers to HCPSC codes designated as "office-based," whose designation as office-based is temporary because we have insufficient claims data. We will reconsider this designation when new claims data become available.

ADDENDUM AA.—ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued
 [Including surgical procedures for which payment is packaged]

| HCPSC 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+marg > 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 malig+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]

| HCPSC 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 |
|-------------|--------------------------------------|---|-------------------|-------------------|--------------------------|--|-----------------------------------|---------------------------------------|
| 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/leg | 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 addl | 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 spl't grft, trnk/arm/leg | Y ..... | ..... | A2 | \$446.00 | 20.2069 | \$836.59 | \$543.65 |
| 15101 | Skin spl't 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 spl't a-grft fac/nck/hf/g | Y ..... | ..... | A2 | \$446.00 | 20.2069 | \$836.59 | \$543.65 |
| 15121 | Skn spl't 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]

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|------------|-------------------------------|---|-------------------|-------------------|--------------------------|--|-----------------------------------|---------------------------------------|
| 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 epiderm 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 scip/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/leg | Y | | A2 | \$323.28 | 4.5263 | \$187.39 | \$289.31 |
| 15301 | Apply skinallogrft 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 skinallogrft 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 xgrft, 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 xgrft 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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 [Including surgical procedures for which payment is packaged]

| HCPSC 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 premalg 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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 [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 | Partial mastectomy | Y | | A2 | \$510.00 | 20.6417 | \$854.59 | \$596.15 |
| 19302 | P-mastectomy w/in 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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| 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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| 21150 | Reconstruct midface, left | 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 nasosethmoid fracture | Y ..... | ..... | A2 | \$630.00 | 23.9765 | \$992.65 | \$720.66 |
| 21339 | Treat nasosethmoid 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 |

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]

| HCPSC 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]

| HCPSC 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]

| HCPSC 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/attach 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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 [Including surgical procedures for which payment is packaged]

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|-------------|------------------------------------|---|-------------------|-------------------|--------------------------|--|-----------------------------------|---------------------------------------|
| 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/anesthet | 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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|-------------|------------------------------------|---|-------------------|-------------------|--------------------------|--|-----------------------------------|---------------------------------------|
| 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]

| HCPSC 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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 [Including surgical procedures for which payment is packaged]

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|------------|------------------------------|---|-------------------|-------------------|--------------------------|--|-----------------------------------|---------------------------------------|
| 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 |

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[Including surgical procedures for which payment is packaged]

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|------------|------------------------------|---|-------------------|-------------------|--------------------------|--|-----------------------------------|---------------------------------------|
| 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 |

Note: The Medicare program payment is 80 percent of the total payment amount and beneficiary coinsurance is 20 percent of the total payment amount, except for screening flexible sigmoidoscopies and screening colonoscopies for which the program payment is 75 percent and the beneficiary coinsurance is 25 percent.

* Refers to HCPSC codes designated as "office-based," whose designation as office-based is temporary because we have insufficient claims data. We will reconsider this designation when new claims data become available.

ADDENDUM AA.—ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued
 [Including surgical procedures for which payment is packaged]

| HCPSC 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 |

Note: The Medicare program payment is 80 percent of the total payment amount and beneficiary coinsurance is 20 percent of the total payment amount, except for screening flexible sigmoidoscopies and screening colonoscopies for which the program payment is 75 percent and the beneficiary coinsurance is 25 percent.

* Refers to HCPSC codes designated as "office-based," whose designation as office-based is temporary because we have insufficient claims data. We will reconsider this designation when new claims data become available.

ADDENDUM AA.—ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued
 [Including surgical procedures for which payment is packaged]

| HCPSC 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]

| HCPSC 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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 [Including surgical procedures for which payment is packaged]

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|-------------|------------------------------------|---|-------------------|-------------------|--------------------------|--|-----------------------------------|---------------------------------------|
| 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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|------------|-------------------------------|---|-------------------|-------------------|--------------------------|--|-----------------------------------|---------------------------------------|
| 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 | 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 autograft | 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]

| HCPSC 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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 [Including surgical procedures for which payment is packaged]

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|------------|------------------------------|---|-------------------|-------------------|--------------------------|--|-----------------------------------|---------------------------------------|
| 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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|------------|------------------------------|---|-------------------|-------------------|--------------------------|--|-----------------------------------|---------------------------------------|
| 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 epiglottitis | 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]

| HCPSC 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 | Larynsco 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 | Laryngoscopy w/arytenoidectomy | Y | | A2 | \$717.00 | 22.7191 | \$940.59 | \$772.90 |
| 31561 | Larynsco, remove 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 | Laryngoscopy 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?! | Y | | G2 | | 9.9575 | \$412.25 | \$412.25 |
| 31633 | Bronchoscopy/needle bx add?! | 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]

| HCPSC 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 I 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 | BI draw < 3 yrs fem/jugular | N | | N1 | | | | |
| 36405 | BI draw < 3 yrs scalp vein | N | | N1 | | | | |
| 36406 | BI draw < 3 yrs other vein | N | | N1 | | | | |
| 36410 | Non-routine bi 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 | BI push transfuse, 2 yr or < | N | | R2 | | 3.3967 | \$140.63 | \$140.63 |
| 36450 | BI 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]

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|------------|------------------------------|---|-------------------|-------------------|--------------------------|--|-----------------------------------|---------------------------------------|
| 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 add-on | 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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 [Including surgical procedures for which payment is packaged]

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| 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 | BI 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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| 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 |

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 [Including surgical procedures for which payment is packaged]

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|------------|------------------------------|---|-------------------|-------------------|--------------------------|--|-----------------------------------|---------------------------------------|
| 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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 [Including surgical procedures for which payment is packaged]

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| 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 strict | 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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| 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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 [Including surgical procedures for which payment is packaged]

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|------------|------------------------------|---|-------------------|-------------------|--------------------------|--|-----------------------------------|---------------------------------------|
| 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 | | P2 | | 2.7895 | \$115.49 | \$115.49 |
| 46916 | Cryosurgery, anal lesion(s) | Y | | P3 | | 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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[Including surgical procedures for which payment is packaged]

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|------------|-------------------------------|---|-------------------|-------------------|--------------------------|--|-----------------------------------|---------------------------------------|
| 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/explor | 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, abdomen | Y | | A2 | \$446.00 | 25.6947 | \$1,063.79 | \$600.45 |
| 49419 | Insert 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 mal 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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| 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 |

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]

| HCPSC 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 |

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]

| HCPSC 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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 [Including surgical procedures for which payment is packaged]

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|------------|------------------------------|---|-------------------|-------------------|--------------------------|--|-----------------------------------|---------------------------------------|
| 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 multi-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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| 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 | Transperineal 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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| 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 hystero-graphy | 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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| 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 thyroid 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 | Instl/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 discectomy | 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 | Instl/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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| 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, sphenopalatine 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 paravertebrl 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 paravertebrl 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]

| HCPSC 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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 [Including surgical procedures for which payment is packaged]

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|------------|------------------------------|---|-------------------|-------------------|--------------------------|--|-----------------------------------|---------------------------------------|
| 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/ol, 1 stage | Y | | A2 | \$973.00 | 23.8649 | \$988.03 | \$976.76 |
| 66984 | Cataract surg w/ol, 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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 [Including surgical procedures for which payment is packaged]

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|------------|------------------------------|---|-------------------|-------------------|--------------------------|--|-----------------------------------|---------------------------------------|
| 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 |

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| 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, allograft | 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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| 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 bone implant 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 sigmoidoscope | 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 risk 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 ansth | 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 |

Note: The Medicare program payment is 80 percent of the total payment amount and beneficiary coinsurance is 20 percent of the total payment amount, except for screening flexible sigmoidoscopies and screening colonoscopies for which the program payment is 75 percent and the beneficiary coinsurance is 25 percent.

* Refers to HCPSC codes designated as "office-based," whose designation as office-based is temporary because we have insufficient claims data. We will reconsider this designation when new claims data become available.

ADDENDUM AA.—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 |

Note: The Medicare program payment is 80 percent of the total payment amount and beneficiary coinsurance is 20 percent of the total payment amount, except for screening flexible sigmoidoscopies and screening colonoscopies for which the program payment is 75 percent and the beneficiary coinsurance is 25 percent.

* Refers to HCPCS codes designated as "office-based," whose designation as office-based is temporary because we have insufficient claims data. We will reconsider this designation when new claims data become available.

ADDENDUM 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, intrcnr 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 | Antiprotease 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/atrukn ..... | ..... | 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) | | T | | | | | |
| 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 tranthor 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 | | N | | | | | |
| 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 int 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 w/o dye; qual calc | CH | S | 0282 | 1.5839 | \$100.88 | \$37.81 | \$20.18 |
| 0145T | CT heart w/o 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/o 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/o, 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/o, strxr | CH | S | 0383 | 4.7005 | \$299.39 | \$117.06 | \$59.88 |
| 01490 | Anesth, lower leg casting | | N | | | | | |
| 0149T | CCTA w/o, 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/o, 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 disectomy 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 | lop 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 hysterisis | 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 ovrlid 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/leg | 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 spl t grft, trnk/arm/leg | CH | T | 0137 | 20.2069 | \$1,287.06 | | \$257.41 |
| 15101 | Skin spl t 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 spl t a-grft fac/nck/hf/g | CH | T | 0137 | 20.2069 | \$1,287.06 | | \$257.41 |
| 15121 | Skn spl t a-grft f/n/hf/g add | CH | T | 0137 | 20.2069 | \$1,287.06 | | \$257.41 |
| 15130 | Derm autogrft, trnk/arm/leg | CH | T | 0136 | 15.0458 | \$958.33 | | \$191.67 |
| 15131 | Derm autogrft t/a/l add-on | CH | T | 0136 | 15.0458 | \$958.33 | | \$191.67 |
| 15135 | Derm autogrft face/nck/hf/g | CH | T | 0136 | 15.0458 | \$958.33 | | \$191.67 |
| 15136 | Derm autogrft, 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 grft t/a/l +% | CH | T | 0135 | 4.5263 | \$288.30 | | \$57.66 |
| 15155 | Cult epiderm grft, 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 scpl/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/leg | CH | T | 0135 | 4.5263 | \$288.30 | | \$57.66 |
| 15301 | Apply skinallogrft 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 skinallogrft 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 t/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 xgrft, 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 premalg 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 | Partial mastectomy | | T | 0028 | 20.6417 | \$1,314.75 | \$303.74 | \$262.95 |
| 19302 | P-mastectomy w/lv 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 ovrd 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 lo 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 | Mnjp 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 sternum/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/l | | 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 disectomy | | 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 elbow 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/attach 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/mnjp | 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 |
| 27444 | Revision of knee joint | C | | | | | | |
| 27445 | Revision of knee joint | T | | | | | | |
| 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 autograft | 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 | Arthroscopy 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 hmrg/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 | | T | | | | | |
| 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 | Larynsco 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 | Laryngoscopy w/arytenoidectomy | | T | 0075 | 22.7191 | \$1,447.07 | \$445.92 | \$289.41 |
| 31561 | Larynsco, remove 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 | Laryngoscopy 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 Cnrc 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/Ultrasound 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 I 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, lmt'd | | C | | | | | |
| 33255 | Ablate atria w/o bypass, ext | | C | | | | | |
| 33256 | Ablate atria w/bypass, exten | | C | | | | | |
| 33257 | Ablate atria, lmt'd, 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, lmt'd, 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 | C | | | | | |
| 33406 | Replacement of aortic valve | C | C | | | | | |
| 33410 | Replacement of aortic valve | C | C | | | | | |
| 33411 | Replacement of aortic valve | C | C | | | | | |
| 33412 | Replacement of aortic valve | C | C | | | | | |
| 33413 | Replacement of aortic valve | C | C | | | | | |
| 33414 | Repair of aortic valve | C | C | | | | | |
| 33415 | Revision, subvalvular tissue | C | C | | | | | |
| 33416 | Revise ventricle muscle | C | C | | | | | |
| 33417 | Repair of aortic valve | C | C | | | | | |
| 33420 | Revision of mitral valve | C | C | | | | | |
| 33422 | Revision of mitral valve | C | C | | | | | |
| 33425 | Repair of mitral valve | C | C | | | | | |
| 33426 | Repair of mitral valve | C | C | | | | | |
| 33427 | Repair of mitral valve | C | C | | | | | |
| 33430 | Replacement of mitral valve | C | C | | | | | |
| 33460 | Revision of tricuspid valve | C | C | | | | | |
| 33463 | Valvuloplasty, tricuspid | C | C | | | | | |
| 33464 | Valvuloplasty, tricuspid | C | C | | | | | |
| 33465 | Replace tricuspid valve | C | C | | | | | |
| 33468 | Revision of tricuspid valve | C | C | | | | | |
| 33470 | Revision of pulmonary valve | C | C | | | | | |
| 33471 | Valvotomy, pulmonary valve | C | C | | | | | |
| 33472 | Revision of pulmonary valve | C | C | | | | | |
| 33474 | Revision of pulmonary valve | C | C | | | | | |
| 33475 | Replacement, pulmonary valve | C | C | | | | | |
| 33476 | Revision of heart chamber | C | C | | | | | |
| 33478 | Revision of heart chamber | C | C | | | | | |
| 33496 | Repair, prosth valve clot | C | C | | | | | |
| 33500 | Repair heart vessel fistula | C | C | | | | | |
| 33501 | Repair heart vessel fistula | C | C | | | | | |
| 33502 | Coronary artery correction | C | C | | | | | |
| 33503 | Coronary artery graft | C | C | | | | | |
| 33504 | Coronary artery graft | C | C | | | | | |
| 33505 | Repair artery w/tunnel | C | C | | | | | |
| 33506 | Repair artery, translocation | C | C | | | | | |
| 33507 | Repair art, intramural | C | C | | | | | |
| 33508 | Endoscopic vein harvest | N | C | | | | | |
| 33510 | CABG, vein, single | C | C | | | | | |
| 33511 | CABG, vein, two | C | C | | | | | |
| 33512 | CABG, vein, three | C | C | | | | | |
| 33513 | CABG, vein, four | C | C | | | | | |
| 33514 | CABG, vein, five | C | C | | | | | |
| 33516 | Cabg, vein, six or more | C | C | | | | | |
| 33517 | CABG, artery-vein, single | C | C | | | | | |
| 33518 | CABG, artery-vein, two | C | C | | | | | |
| 33519 | CABG, artery-vein, three | C | C | | | | | |
| 33521 | CABG, artery-vein, four | C | C | | | | | |
| 33522 | CABG, artery-vein, five | C | C | | | | | |
| 33523 | Cabg, art-vein, six or more | C | C | | | | | |
| 33530 | Coronary artery, bypass/reop | C | C | | | | | |
| 33533 | CABG, arterial, single | C | C | | | | | |
| 33534 | CABG, arterial, two | C | C | | | | | |
| 33535 | CABG, arterial, three | C | C | | | | | |
| 33536 | Cabg, arterial, four or more | C | C | | | | | |
| 33542 | Removal of heart lesion | C | C | | | | | |
| 33545 | Repair of heart damage | C | C | | | | | |
| 33548 | Restore/remodel, ventricle | C | C | | | | | |
| 33572 | Open coronary endarterectomy | C | C | | | | | |
| 33600 | Closure of valve | C | C | | | | | |
| 33602 | Closure of valve | C | C | | | | | |
| 33606 | Anastomosis/artery-aorta | C | C | | | | | |
| 33608 | Repair anomaly w/conduit | C | C | | | | | |
| 33610 | Repair by enlargement | C | C | | | | | |
| 33611 | Repair double ventricle | C | C | | | | | |
| 33612 | Repair double ventricle | C | C | | | | | |
| 33615 | Repair, modified fontan | C | C | | | | | |
| 33617 | Repair single ventricle | C | C | | | | | |
| 33619 | Repair single ventricle | C | C | | | | | |
| 33641 | Repair heart septum defect | C | C | | | | | |
| 33645 | Revision of heart veins | C | C | | | | | |
| 33647 | Repair heart septum defects | C | C | | | | | |
| 33660 | Repair of heart defects | C | C | | | | | |
| 33665 | Repair of heart defects | C | C | | | | | |
| 33670 | Repair of heart chambers | C | C | | | | | |
| 33675 | Close mult vsd | C | C | | | | | |
| 33676 | Close mult vsd w/resection | C | C | | | | | |
| 33677 | CI mult vsd w/rem pul band | C | C | | | | | |
| 33681 | Repair heart septum defect | C | C | | | | | |
| 33684 | Repair heart septum defect | C | 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 add-on | | C | | | | | |
| 34812 | Xpose for endoprosth, femoral | | 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 | | E | | | | | |
| 37216 | Transcath stent, cca w/o eps | | C | | | | | |
| 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 | Laparoscopy proc, spleen | | T | 0130 | 34.3958 | \$2,190.81 | \$659.53 | \$438.16 |
| 38200 | Injection for spleen x-ray | | N | | | | | |
| 38204 | BI 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 | Laparoscopy 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 | CH | 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 | | 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 reapt 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 dischrq | | M | | | | | |
| 4075F | Anticoag thx rx at dischrq | | 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 rcvng antivir txmnt hepc | | M | | | | | |
| 41510 | Tongue to lip surgery | | T | 0253 | 16.3288 | \$1,040.05 | \$282.29 | \$208.01 |
| 4151F | Pt not rcvng 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 rcvcd | | M | | | | | |
| 4156F | Hep B vac series recommended | | M | | | | | |
| 4157F | Hep B vac series prev rcvcd | | M | | | | | |
| 4158F | Pt edu re: alcoh drnkng done | | M | | | | | |
| 41599 | Tongue and mouth surgery | | T | 0251 | 2.5002 | \$159.25 | | \$31.85 |
| 4159F | Conttcp talk b/4 antiv txmnt | | M | | | | | |
| 4163F | Pt couns. 4 txmnt opt, prost | NI | M | | | | | |
| 4164F | Adjv hrml 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. Glauclmpt | 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 gbln 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 | Extrl 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 | Uppr 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 | Laparoscopy 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 small 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 | Laparoscopy 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 | Laparoscopy 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 reservoir | | 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 snl 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, retroper 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, abdomen | | 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 counslid 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+ findngs 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 | Instill rx agnt into renal 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 | Laparoscopy 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 | Laparoscopy 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/replic 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 | Urethrllys, 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/regional 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 penile circumc 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 multi-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 | Cryoblate 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 incl 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 hystero-graphy | | 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 amniocentesis 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 thyroid 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 | | 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 angioplasty 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/reduo 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 discectomy | | 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 | Inst/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, sphenopalatine 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 ..... | ..... | ..... | 0687 | 22.4734 | \$1,431.42 | \$438.47 | \$286.28 |
| 64590 | Inst/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 | Neurography 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 transscleral 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, allograft | | 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 bone implant 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 orbit/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 or w/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 | C | 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, snl 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, snl 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, lmrt | | 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 test 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 absorp 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, ltd | 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 | Nucl 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 | A | | | | | |
| 80190 | Assay of procainamide | A | A | | | | | |
| 80192 | Assay of procainamide | A | A | | | | | |
| 80194 | Assay of quinidine | A | A | | | | | |
| 80195 | Assay of sirolimus | A | A | | | | | |
| 80196 | Assay of salicylate | A | A | | | | | |
| 80197 | Assay of tacrolimus | A | A | | | | | |
| 80198 | Assay of theophylline | A | A | | | | | |
| 80200 | Assay of tobramycin | A | A | | | | | |
| 80201 | Assay of topiramate | A | A | | | | | |
| 80202 | Assay of vancomycin | A | A | | | | | |
| 80299 | Quantitative assay, drug | A | A | | | | | |
| 80400 | Acth stimulation panel | A | A | | | | | |
| 80402 | Acth stimulation panel | A | A | | | | | |
| 80406 | Acth stimulation panel | A | A | | | | | |
| 80408 | Aldosterone suppression eval | A | A | | | | | |
| 80410 | Calcitonin stimulat panel | A | A | | | | | |
| 80412 | CRH stimulation panel | A | A | | | | | |
| 80414 | Testosterone response | A | A | | | | | |
| 80415 | Estradiol response panel | A | A | | | | | |
| 80416 | Renin stimulation panel | A | A | | | | | |
| 80417 | Renin stimulation panel | A | A | | | | | |
| 80418 | Pituitary evaluation panel | A | A | | | | | |
| 80420 | Dexamethasone panel | A | A | | | | | |
| 80422 | Glucagon tolerance panel | A | A | | | | | |
| 80424 | Glucagon tolerance panel | A | A | | | | | |
| 80426 | Gonadotropin hormone panel | A | A | | | | | |
| 80428 | Growth hormone panel | A | A | | | | | |
| 80430 | Growth hormone panel | A | A | | | | | |
| 80432 | Insulin suppression panel | A | A | | | | | |
| 80434 | Insulin tolerance panel | A | A | | | | | |
| 80435 | Insulin tolerance panel | A | A | | | | | |
| 80436 | Metyrapone panel | A | A | | | | | |
| 80438 | TRH stimulation panel | A | A | | | | | |
| 80439 | TRH stimulation panel | A | A | | | | | |
| 80440 | TRH stimulation panel | A | A | | | | | |
| 80500 | Lab pathology consultation | X | X | 0433 | 0.2397 | \$15.27 | \$5.17 | \$3.05 |
| 80502 | Lab pathology consultation | X | X | 0342 | 0.0969 | \$6.17 | \$2.02 | \$1.23 |
| 81000 | Urinalysis, nonauto w/scope | A | A | | | | | |
| 81001 | Urinalysis, auto w/scope | A | A | | | | | |
| 81002 | Urinalysis nonauto w/o scope | A | A | | | | | |
| 81003 | Urinalysis, auto, w/o scope | A | A | | | | | |
| 81005 | Urinalysis | A | A | | | | | |
| 81007 | Urine screen for bacteria | A | A | | | | | |
| 81015 | Microscopic exam of urine | A | A | | | | | |
| 81020 | Urinalysis, glass test | A | A | | | | | |
| 81025 | Urine pregnancy test | A | A | | | | | |
| 81050 | Urinalysis, volume measure | A | A | | | | | |
| 81099 | Urinalysis test procedure | A | A | | | | | |
| 82000 | Assay of blood acetaldehyde | A | A | | | | | |
| 82003 | Assay of acetaminophen | A | A | | | | | |
| 82009 | Test for acetone/ketones | A | A | | | | | |
| 82010 | Acetone assay | A | A | | | | | |
| 82013 | Acetylcholinesterase assay | A | A | | | | | |
| 82016 | Acylcarnitines, qual | A | A | | | | | |
| 82017 | Acylcarnitines, quant | A | A | | | | | |
| 82024 | Assay of acth | A | A | | | | | |
| 82030 | Assay of adp & amp | A | A | | | | | |
| 82040 | Assay of serum albumin | A | A | | | | | |
| 82042 | Assay of urine albumin | A | A | | | | | |
| 82043 | Microalbumin, quantitative | A | A | | | | | |
| 82044 | Microalbumin, semiquant | A | A | | | | | |
| 82045 | Albumin, ischemia modified | A | A | | | | | |
| 82055 | Assay of ethanol | A | A | | | | | |
| 82075 | Assay of breath ethanol | A | A | | | | | |
| 82085 | Assay of aldolase | A | A | | | | | |
| 82088 | Assay of aldosterone | A | A | | | | | |
| 82101 | Assay of urine alkaloids | A | A | | | | | |
| 82103 | Alpha-1-antitrypsin, total | A | A | | | | | |
| 82104 | Alpha-1-antitrypsin, pheno | A | A | | | | | |
| 82105 | Alpha-fetoprotein, serum | A | A | | | | | |
| 82106 | Alpha-fetoprotein, amniotic | A | A | | | | | |
| 82107 | Alpha-fetoprotein I3 | A | A | | | | | |
| 82108 | Assay of aluminum | A | A | | | | | |
| 82120 | Amines, vaginal fluid qual | A | A | | | | | |
| 82127 | Amino acid, single qual | A | A | | | | | |
| 82128 | Amino acids, mult qual | A | A | | | | | |
| 82131 | Amino acids, single quant | A | A | | | | | |
| 82135 | Assay, aminolevulinic acid | A | A | | | | | |
| 82136 | Amino acids, quant, 2–5 | A | 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 | A | | | | | |
| 82140 | Assay of ammonia | A | A | | | | | |
| 82143 | Amniotic fluid scan | A | A | | | | | |
| 82145 | Assay of amphetamines | A | A | | | | | |
| 82150 | Assay of amylase | A | A | | | | | |
| 82154 | Androstenediol glucuronide | A | A | | | | | |
| 82157 | Assay of androstenedione | A | A | | | | | |
| 82160 | Assay of androsterone | A | A | | | | | |
| 82163 | Assay of angiotensin II | A | A | | | | | |
| 82164 | Angiotensin I enzyme test | A | A | | | | | |
| 82172 | Assay of apolipoprotein | A | A | | | | | |
| 82175 | Assay of arsenic | A | A | | | | | |
| 82180 | Assay of ascorbic acid | A | A | | | | | |
| 82190 | Atomic absorption | A | A | | | | | |
| 82205 | Assay of barbiturates | A | A | | | | | |
| 82232 | Assay of beta-2 protein | A | A | | | | | |
| 82239 | Bile acids, total | A | A | | | | | |
| 82240 | Bile acids, cholyglycine | A | A | | | | | |
| 82247 | Bilirubin, total | A | A | | | | | |
| 82248 | Bilirubin, direct | A | A | | | | | |
| 82252 | Fecal bilirubin test | A | A | | | | | |
| 82261 | Assay of biotinidase | A | A | | | | | |
| 82270 | Occult blood, feces | A | A | | | | | |
| 82271 | Occult blood, other sources | A | A | | | | | |
| 82272 | Occult bld feces, 1–3 tests | A | A | | | | | |
| 82274 | Assay test for blood, fecal | A | A | | | | | |
| 82286 | Assay of bradykinin | A | A | | | | | |
| 82300 | Assay of cadmium | A | A | | | | | |
| 82306 | Assay of vitamin D | A | A | | | | | |
| 82307 | Assay of vitamin D | A | A | | | | | |
| 82308 | Assay of calcitonin | A | A | | | | | |
| 82310 | Assay of calcium | A | A | | | | | |
| 82330 | Assay of calcium | A | A | | | | | |
| 82331 | Calcium infusion test | A | A | | | | | |
| 82340 | Assay of calcium in urine | A | A | | | | | |
| 82355 | Calculus analysis, qual | A | A | | | | | |
| 82360 | Calculus assay, quant | A | A | | | | | |
| 82365 | Calculus spectroscopy | A | A | | | | | |
| 82370 | X-ray assay, calculus | A | A | | | | | |
| 82373 | Assay, c-d transfer measure | A | A | | | | | |
| 82374 | Assay, blood carbon dioxide | A | A | | | | | |
| 82375 | Assay, blood carbon monoxide | A | A | | | | | |
| 82376 | Test for carbon monoxide | A | A | | | | | |
| 82378 | Carcinoembryonic antigen | A | A | | | | | |
| 82379 | Assay of carnitine | A | A | | | | | |
| 82380 | Assay of carotene | A | A | | | | | |
| 82382 | Assay, urine catecholamines | A | A | | | | | |
| 82383 | Assay, blood catecholamines | A | A | | | | | |
| 82384 | Assay, three catecholamines | A | A | | | | | |
| 82387 | Assay of cathepsin-d | A | A | | | | | |
| 82390 | Assay of ceruloplasmin | A | A | | | | | |
| 82397 | Chemiluminescent assay | A | A | | | | | |
| 82415 | Assay of chloramphenicol | A | A | | | | | |
| 82435 | Assay of blood chloride | A | A | | | | | |
| 82436 | Assay of urine chloride | A | A | | | | | |
| 82438 | Assay, other fluid chlorides | A | A | | | | | |
| 82441 | Test for chlorohydrocarbons | A | A | | | | | |
| 82465 | Assay, bld/serum cholesterol | A | A | | | | | |
| 82480 | Assay, serum cholinesterase | A | A | | | | | |
| 82482 | Assay, rbc cholinesterase | A | A | | | | | |
| 82485 | Assay, chondroitin sulfate | A | A | | | | | |
| 82486 | Gas/liquid chromatography | A | A | | | | | |
| 82487 | Paper chromatography | A | A | | | | | |
| 82488 | Paper chromatography | A | A | | | | | |
| 82489 | Thin layer chromatography | A | A | | | | | |
| 82491 | Chromotography, quant, sing | A | A | | | | | |
| 82492 | Chromotography, quant, mult | A | A | | | | | |
| 82495 | Assay of chromium | A | A | | | | | |
| 82507 | Assay of citrate | A | A | | | | | |
| 82520 | Assay of cocaine | A | A | | | | | |
| 82523 | Collagen crosslinks | A | A | | | | | |
| 82525 | Assay of copper | A | A | | | | | |
| 82528 | Assay of corticosterone | A | A | | | | | |
| 82530 | Cortisol, free | A | A | | | | | |
| 82533 | Total cortisol | A | A | | | | | |
| 82540 | Assay of creatine | A | A | | | | | |
| 82541 | Column chromatography, qual | A | A | | | | | |
| 82542 | Column chromatography, quant | A | A | | | | | |
| 82543 | Column chromatograph/isotope | A | A | | | | | |
| 82544 | Column chromatograph/isotope | A | 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 chromatography | | 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 metanephries | | 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 | A | | | | | |
| 84138 | Assay of pregnanetriol | A | A | | | | | |
| 84140 | Assay of pregnenolone | A | A | | | | | |
| 84143 | Assay of 17-hydroxypregнено | A | A | | | | | |
| 84144 | Assay of progesterone | A | A | | | | | |
| 84146 | Assay of prolactin | A | A | | | | | |
| 84150 | Assay of prostaglandin | A | A | | | | | |
| 84152 | Assay of psa, complexed | A | A | | | | | |
| 84153 | Assay of psa, total | A | A | | | | | |
| 84154 | Assay of psa, free | A | A | | | | | |
| 84155 | Assay of protein, serum | A | A | | | | | |
| 84156 | Assay of protein, urine | A | A | | | | | |
| 84157 | Assay of protein, other | A | A | | | | | |
| 84160 | Assay of protein, any source | A | A | | | | | |
| 84163 | Pappa, serum | A | A | | | | | |
| 84165 | Protein e-phoresis, serum | A | A | | | | | |
| 84166 | Protein e-phoresis/urine/csf | A | A | | | | | |
| 84181 | Western blot test | A | A | | | | | |
| 84182 | Protein, western blot test | A | A | | | | | |
| 84202 | Assay RBC protoporphyrin | A | A | | | | | |
| 84203 | Test RBC protoporphyrin | A | A | | | | | |
| 84206 | Assay of proinsulin | A | A | | | | | |
| 84207 | Assay of vitamin b-6 | A | A | | | | | |
| 84210 | Assay of pyruvate | A | A | | | | | |
| 84220 | Assay of pyruvate kinase | A | A | | | | | |
| 84228 | Assay of quinine | A | A | | | | | |
| 84233 | Assay of estrogen | A | A | | | | | |
| 84234 | Assay of progesterone | A | A | | | | | |
| 84235 | Assay of endocrine hormone | A | A | | | | | |
| 84238 | Assay, nonendocrine receptor | A | A | | | | | |
| 84244 | Assay of renin | A | A | | | | | |
| 84252 | Assay of vitamin b-2 | A | A | | | | | |
| 84255 | Assay of selenium | A | A | | | | | |
| 84260 | Assay of serotonin | A | A | | | | | |
| 84270 | Assay of sex hormone globul | A | A | | | | | |
| 84275 | Assay of sialic acid | A | A | | | | | |
| 84285 | Assay of silica | A | A | | | | | |
| 84295 | Assay of serum sodium | A | A | | | | | |
| 84300 | Assay of urine sodium | A | A | | | | | |
| 84302 | Assay of sweat sodium | A | A | | | | | |
| 84305 | Assay of somatomedin | A | A | | | | | |
| 84307 | Assay of somatostatin | A | A | | | | | |
| 84311 | Spectrophotometry | A | A | | | | | |
| 84315 | Body fluid specific gravity | A | A | | | | | |
| 84375 | Chromatogram assay, sugars | A | A | | | | | |
| 84376 | Sugars, single, qual | A | A | | | | | |
| 84377 | Sugars, multiple, qual | A | A | | | | | |
| 84378 | Sugars, single, quant | A | A | | | | | |
| 84379 | Sugars multiple quant | A | A | | | | | |
| 84392 | Assay of urine sulfate | A | A | | | | | |
| 84402 | Assay of testosterone | A | A | | | | | |
| 84403 | Assay of total testosterone | A | A | | | | | |
| 84425 | Assay of vitamin b-1 | A | A | | | | | |
| 84430 | Assay of thiocyanate | A | A | | | | | |
| 84432 | Assay of thyroglobulin | A | A | | | | | |
| 84436 | Assay of total thyroxine | A | A | | | | | |
| 84437 | Assay of neonatal thyroxine | A | A | | | | | |
| 84439 | Assay of free thyroxine | A | A | | | | | |
| 84442 | Assay of thyroid activity | A | A | | | | | |
| 84443 | Assay thyroid stim hormone | A | A | | | | | |
| 84445 | Assay of tsi | A | A | | | | | |
| 84446 | Assay of vitamin e | A | A | | | | | |
| 84449 | Assay of transcortin | A | A | | | | | |
| 84450 | Transferase (AST) (SGOT) | A | A | | | | | |
| 84460 | Alanine amino (ALT) (SGPT) | A | A | | | | | |
| 84466 | Assay of transferrin | A | A | | | | | |
| 84478 | Assay of triglycerides | A | A | | | | | |
| 84479 | Assay of thyroid (t3 or t4) | A | A | | | | | |
| 84480 | Assay, triiodothyronine (t3) | A | A | | | | | |
| 84481 | Free assay (FT-3) | A | A | | | | | |
| 84482 | T3 reverse | A | A | | | | | |
| 84484 | Assay of troponin, quant | A | A | | | | | |
| 84485 | Assay duodenal fluid trypsin | A | A | | | | | |
| 84488 | Test feces for trypsin | A | A | | | | | |
| 84490 | Assay of feces for trypsin | A | A | | | | | |
| 84510 | Assay of tyrosine | A | A | | | | | |
| 84512 | Assay of troponin, qual | A | A | | | | | |
| 84520 | Assay of urea nitrogen | A | A | | | | | |
| 84525 | Urea nitrogen semi-quant | A | A | | | | | |
| 84540 | Assay of urine/urea-n | A | 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 | A | | | | | |
| 85385 | Fibrinogen | A | A | | | | | |
| 85390 | Fibrinolysis screen | A | A | | | | | |
| 85396 | Clotting assay, whole blood | N | A | | | | | |
| 85400 | Fibrinolytic plasmin | A | A | | | | | |
| 85410 | Fibrinolytic antiplasmin | A | A | | | | | |
| 85415 | Fibrinolytic plasminogen | A | A | | | | | |
| 85420 | Fibrinolytic plasminogen | A | A | | | | | |
| 85421 | Fibrinolytic plasminogen | A | A | | | | | |
| 85441 | Heinz bodies, direct | A | A | | | | | |
| 85445 | Heinz bodies, induced | A | A | | | | | |
| 85460 | Hemoglobin, fetal | A | A | | | | | |
| 85461 | Hemoglobin, fetal | A | A | | | | | |
| 85475 | Hemolysis | A | A | | | | | |
| 85520 | Heparin assay | A | A | | | | | |
| 85525 | Heparin neutralization | A | A | | | | | |
| 85530 | Heparin-protamine tolerance | A | A | | | | | |
| 85536 | Iron stain peripheral blood | A | A | | | | | |
| 85540 | Wbc alkaline phosphatase | A | A | | | | | |
| 85547 | RBC mechanical fragility | A | A | | | | | |
| 85549 | Muramidase | A | A | | | | | |
| 85555 | RBC osmotic fragility | A | A | | | | | |
| 85557 | RBC osmotic fragility | A | A | | | | | |
| 85576 | Blood platelet aggregation | A | A | | | | | |
| 85597 | Platelet neutralization | A | A | | | | | |
| 85610 | Prothrombin time | A | A | | | | | |
| 85611 | Prothrombin test | A | A | | | | | |
| 85612 | Viper venom prothrombin time | A | A | | | | | |
| 85613 | Russell viper venom, diluted | A | A | | | | | |
| 85635 | Reptilase test | A | A | | | | | |
| 85651 | Rbc sed rate, nonautomated | A | A | | | | | |
| 85652 | Rbc sed rate, automated | A | A | | | | | |
| 85660 | RBC sickle cell test | A | A | | | | | |
| 85670 | Thrombin time, plasma | A | A | | | | | |
| 85675 | Thrombin time, titer | A | A | | | | | |
| 85705 | Thromboplastin inhibition | A | A | | | | | |
| 85730 | Thromboplastin time, partial | A | A | | | | | |
| 85732 | Thromboplastin time, partial | A | A | | | | | |
| 85810 | Blood viscosity examination | A | A | | | | | |
| 85999 | Hematology procedure | A | A | | | | | |
| 86000 | Agglutinins, febrile | A | A | | | | | |
| 86001 | Allergen specific igg | A | A | | | | | |
| 86003 | Allergen specific IgE | A | A | | | | | |
| 86005 | Allergen specific IgE | A | A | | | | | |
| 86021 | WBC antibody identification | A | A | | | | | |
| 86022 | Platelet antibodies | A | A | | | | | |
| 86023 | Immunoglobulin assay | A | A | | | | | |
| 86038 | Antinuclear antibodies | A | A | | | | | |
| 86039 | Antinuclear antibodies (ANA) | A | A | | | | | |
| 86060 | Antistreptolysin o, titer | A | A | | | | | |
| 86063 | Antistreptolysin o, screen | A | 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 | A | | | | | |
| 86141 | C-reactive protein, hs | A | A | | | | | |
| 86146 | Glycoprotein antibody | A | A | | | | | |
| 86147 | Cardiolipin antibody | A | A | | | | | |
| 86148 | Phospholipid antibody | A | A | | | | | |
| 86155 | Chemotaxis assay | A | A | | | | | |
| 86156 | Cold agglutinin, screen | A | A | | | | | |
| 86157 | Cold agglutinin, titer | A | A | | | | | |
| 86160 | Complement, antigen | A | A | | | | | |
| 86161 | Complement/function activity | A | A | | | | | |
| 86162 | Complement, total (CH50) | A | A | | | | | |
| 86171 | Complement fixation, each | A | A | | | | | |
| 86185 | Counterimmunoelectrophoresis | A | A | | | | | |
| 86200 | Ccp antibody | A | A | | | | | |
| 86215 | Deoxyribonuclease, antibody | A | A | | | | | |
| 86225 | DNA antibody | A | A | | | | | |
| 86226 | DNA antibody, single strand | A | A | | | | | |
| 86235 | Nuclear antigen antibody | A | A | | | | | |
| 86243 | Fc receptor | A | A | | | | | |
| 86255 | Fluorescent antibody, screen | A | A | | | | | |
| 86256 | Fluorescent antibody, titer | A | A | | | | | |
| 86277 | Growth hormone antibody | A | A | | | | | |
| 86280 | Hemagglutination inhibition | A | A | | | | | |
| 86294 | Immunoassay, tumor, qual | A | A | | | | | |
| 86300 | Immunoassay, tumor, ca 15-3 | A | A | | | | | |
| 86301 | Immunoassay, tumor, ca 19-9 | A | 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 | Immunifix 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 | Leukocyte 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 cult, bacteria, each | | A | | | | | |
| 87070 | Culture, bacteria, other | | A | | | | | |
| 87071 | Culture bacteri aerobic othr | | A | | | | | |
| 87073 | Culture bacteria anaerobic | | A | | | | | |
| 87075 | Cult, 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, cult | | 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 pneumophila 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, ma, 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/fitr | 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 molecu probes, 51–250 | | X | 0343 | 0.5142 | \$32.75 | \$10.84 | \$6.55 |
| 88386 | Eval molecu 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 cryopresrvd; 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 cryopreserved; sperm | CH | X | 0344 | 0.8167 | \$52.02 | \$15.66 | \$10.40 |
| 89354 | Thaw cryoprsrd; reprod tiss | CH | X | 0344 | 0.8167 | \$52.02 | \$15.66 | \$10.40 |
| 89356 | Thawing cryopreserved; 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 | Rotavirus 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 | Mmr vaccine, sc | | N | | | | | |
| 90712 | Oral poliovirus vaccine | | N | | | | | |
| 90713 | Poliovirus, ipv, sc/im | | N | | | | | |
| 90714 | Td vaccine no prsv >= 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 addon | NI | N | | | | | |
| 90779 | Ther/proph/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 impeded function test | | X | 0361 | 3.9276 | \$250.16 | \$83.23 | \$50.03 |
| 91038 | Esoph impeded 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 hearing aid test, one | | E | | | | | |
| 92595 | Electro hearing 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 program | | 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, It 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 & I heart cath, congenital | | T | 0080 | 38.9204 | \$2,479.00 | \$838.92 | \$495.80 |
| 93532 | R & I heart cath, congenital | | T | 0080 | 38.9204 | \$2,479.00 | \$838.92 | \$495.80 |
| 93533 | R & I 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 snl | | S | 0689 | 0.5946 | \$37.87 | | \$7.57 |
| 93742 | Analyze ht pace device snl | | 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 | 2.7500 | \$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 | 2.7500 | \$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 | lo anal gast n-stim init | NI | N | | | | | |
| 95981 | lo anal gast n-stim subsq | NI | S | 0218 | 1.1550 | \$73.57 | | \$14.71 |
| 95982 | lo ga n-stim subsq w/reprog | NI | S | 0692 | 1.8376 | \$117.04 | \$29.72 | \$23.41 |
| 95990 | Spin/brain pump refill & main | | T | 0125 | 2.3544 | \$149.96 | | \$29.99 |
| 95991 | Spin/brain pump refill & 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/behav, init | CH | Q | 0432 | 0.3128 | \$19.92 | | \$3.98 |
| 96151 | Assess hlth/behav, subseq | CH | Q | 0432 | 0.3128 | \$19.92 | | \$3.98 |
| 96152 | Intervene hlth/behav, indiv | CH | Q | 0432 | 0.3128 | \$19.92 | | \$3.98 |
| 96153 | Intervene hlth/behav, 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, snl 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 technique | | 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 mngmt training | | A | | | | | |
| 97537 | Community/work reintegration | | A | | | | | |
| 97542 | Wheelchair mngmt 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 | lc for lbw infant < 1500 gm | | C | | | | | |
| 99299 | lc, lbw infant 1500–2500 gm | | C | | | | | |
| 99300 | lc, 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 | | B | | | | | |
| 99435 | Newborn discharge day hosp | | C | | | | | |
| 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 suppl | | 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 suppl | | A | | | | | |
| A0398 | Als routine dispoible suppl | | 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 | Alkaline 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 attachmnt | | 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 fcpl | | 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 fcpl | | 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/filtr | | 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/filtr | | 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 | | Y | | | | | |
| A4608 | Transracheal oxygen cath | | A | | | | | |
| 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 replmnt 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 dsq 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/bodr | | 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 dsq<=16 sq in | | A | | | | | |
| A6232 | Hydrogel dsq>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/yd | | 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 thighlngh 18-30 | | E | | | | | |
| A6534 | Gc stocking thighlngh 30-40 | | E | | | | | |
| A6535 | Gc stocking thighlngh 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 waistlngh 18-30 | | E | | | | | |
| A6540 | Gc stocking waistlngh 30-40 | | E | | | | | |
| A6541 | Gc stocking waistlngh 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 cmprrs 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 iodobenguante, 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 biccisate | 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/jeuno tube, std | NI | A | | | | | |
| B4088 | Gastro/jeuno 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-amirosoy | | 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 probm focus | | E | | | | | |
| D0145 | Oral evaluation, pt < 3yrs | | E | | | | | |
| D0150 | Comprehensive 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 salinography | | 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 elsewhere | | 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 prophyl chi | | E | | | | | |
| D1204 | Topical fluor w/o prophyl 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 metallic 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 th&acrlc on mtl frmwk | | E | | | | | |
| D5671 | Replc th&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 conditn 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 suprd fixd dent | | E | | | | | |
| D6079 | Implnt/abut suprd 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 >=3srf | | 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 addtl 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 | E | | | | | |
| D7490 | Maxilla or mandible resectio | E | E | | | | | |
| D7510 | I&d absc intraoral soft tiss | E | E | | | | | |
| D7511 | Incision/drain abscess intra | B | E | | | | | |
| D7520 | I&d abscess extraoral | E | E | | | | | |
| D7521 | Incision/drain abscess extra | B | E | | | | | |
| D7530 | Removal fb skin/areolar tiss | E | E | | | | | |
| D7540 | Removal of fb reaction | E | E | | | | | |
| D7550 | Removal of sloughed off bone | E | E | | | | | |
| D7560 | Maxillary sinusotomy | E | E | | | | | |
| D7610 | Maxilla open reduct simple | E | E | | | | | |
| D7620 | Clsd reduct simpl maxilla fx | E | E | | | | | |
| D7630 | Open red simpl mandible fx | E | E | | | | | |
| D7640 | Clsd red simpl mandible fx | E | E | | | | | |
| D7650 | Open red simp malar/zygom fx | E | E | | | | | |
| D7660 | Clsd red simp malar/zygom fx | E | E | | | | | |
| D7670 | Closd rductn splint alveolus | E | E | | | | | |
| D7671 | Alveolus open reduction | E | E | | | | | |
| D7680 | Reduct simple facial bone fx | E | E | | | | | |
| D7710 | Maxilla open reduct compound | E | E | | | | | |
| D7720 | Clsd reduct compd maxilla fx | E | E | | | | | |
| D7730 | Open reduct compd mandible fx | E | E | | | | | |
| D7740 | Clsd reduct compd mandible fx | E | E | | | | | |
| D7750 | Open red comp malar/zygma fx | E | E | | | | | |
| D7760 | Clsd red comp malar/zygma fx | E | E | | | | | |
| D7770 | Open reduc compd alveolus fx | E | E | | | | | |
| D7771 | Alveolus clsd reduc stblz te | E | E | | | | | |
| D7780 | Reduct compnd facial bone fx | E | E | | | | | |
| D7810 | Tmj open reduct-dislocation | E | E | | | | | |
| D7820 | Closed tmp manipulation | E | E | | | | | |
| D7830 | Tmj manipulation under anest | E | E | | | | | |
| D7840 | Removal of tmj condyle | E | E | | | | | |
| D7850 | Tmj meniscectomy | E | E | | | | | |
| D7852 | Tmj repair of joint disc | E | E | | | | | |
| D7854 | Tmj excisn of joint membrane | E | E | | | | | |
| D7856 | Tmj cutting of a muscle | E | E | | | | | |
| D7858 | Tmj reconstruction | E | E | | | | | |
| D7860 | Tmj cutting into joint | E | E | | | | | |
| D7865 | Tmj reshaping components | E | E | | | | | |
| D7870 | Tmj aspiration joint fluid | E | E | | | | | |
| D7871 | Lysis + lavage w catheters | E | E | | | | | |
| D7872 | Tmj diagnostic arthroscopy | E | E | | | | | |
| D7873 | Tmj arthroscopy lysis adhesn | E | E | | | | | |
| D7874 | Tmj arthroscopy disc reposit | E | E | | | | | |
| D7875 | Tmj arthroscopy synovectomy | E | E | | | | | |
| D7876 | Tmj arthroscopy discectomy | E | E | | | | | |
| D7877 | Tmj arthroscopy debridement | E | E | | | | | |
| D7880 | Occlusal orthotic appliance | E | E | | | | | |
| D7899 | Tmj unspecified therapy | E | E | | | | | |
| D7910 | Dent sutur recent wnd to 5cm | E | E | | | | | |
| D7911 | Dental suture wound to 5 cm | E | E | | | | | |
| D7912 | Suture complicate wnd > 5 cm | E | E | | | | | |
| D7920 | Dental skin graft | E | E | | | | | |
| D7940 | Reshaping bone orthognathic | S | E | 0330 | 9.1677 | \$583.93 | | \$116.79 |
| D7941 | Bone cutting ramus closed | E | E | | | | | |
| D7943 | Cutting ramus open w/graft | E | E | | | | | |
| D7944 | Bone cutting segmented | E | E | | | | | |
| D7945 | Bone cutting body mandible | E | E | | | | | |
| D7946 | Reconstruction maxilla total | E | E | | | | | |
| D7947 | Reconstruct maxilla segment | E | E | | | | | |
| D7948 | Reconstruct midface no graft | E | E | | | | | |
| D7949 | Reconstruct midface w/graft | E | E | | | | | |
| D7950 | Mandible graft | E | E | | | | | |
| D7951 | Sinus aug w bone/bone sup | E | E | | | | | |
| D7953 | Bone replacement graft | E | E | | | | | |
| D7955 | Repair maxillofacial defects | E | E | | | | | |
| D7960 | Frenulectomy/frenulotomy | E | E | | | | | |
| D7963 | Frenuloplasty | E | E | | | | | |
| D7970 | Excision hyperplastic tissue | E | E | | | | | |
| D7971 | Excision pericoronal gingiva | E | E | | | | | |
| D7972 | Surg reduct fibrous tuberosit | E | E | | | | | |
| D7980 | Sialolithotomy | E | E | | | | | |
| D7981 | Excision of salivary gland | E | E | | | | | |
| D7982 | Sialodochoplasty | E | E | | | | | |
| D7983 | Closure of salivary fistula | E | E | | | | | |
| D7990 | Emergency tracheotomy | E | E | | | | | |
| D7991 | Dental coronoidectomy | E | E | | | | | |
| D7995 | Synthetic graft facial bones | E | E | | | | | |
| D7996 | Implant mandible for augment | E | E | | | | | |
| D7997 | Appliance removal | E | 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 transiti | | 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 orthodontic 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 of 4 | | 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 detach arm | | Y | | | | | |
| E0167 | Commode chair pail or pan | | Y | | | | | |
| E0168 | Heavy duty/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/ pump | | 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 mattress | | Y | | | | | |
| E0198 | Water pressure pad for mattress | | Y | | | | | |
| E0199 | Dry pressure pad for mattress | | Y | | | | | |
| E0200 | Heat lamp without stand | | Y | | | | | |
| E0202 | Phototherapy light w/ photom | | Y | | | | | |
| E0203 | Therapeutic lightbox tabletop | 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/ mattress | | E | | | | | |
| E0251 | Hosp bed fixed ht w/o mattress | | E | | | | | |
| E0255 | Hospital bed var ht w/ mattress | | E | | | | | |
| E0256 | Hospital bed var ht w/o mattress | | E | | | | | |
| E0260 | Hosp bed semi-electric w/ mattress | | E | | | | | |
| E0261 | Hosp bed semi-electric w/o mattress | | E | | | | | |
| E0265 | Hosp bed total electric w/ mattress | | E | | | | | |
| E0266 | Hosp bed total electric w/o mattress | | E | | | | | |
| E0270 | Hospital bed institutional type | | 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 pressure-reducing air mattress | | 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/ matr | | E | | | | | |
| E0295 | Hosp bed semi-elect w/o matt | | Y | | | | | |
| E0296 | Hosp bed total elect w/ matr | | 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 O2 | | Y | | | | | |
| E0425 | Gas system stationary compre | | E | | | | | |
| E0430 | Oxygen system gas portable | | E | | | | | |
| E0431 | Portable gaseous O2 | | Y | | | | | |
| E0434 | Portable liquid O2 | | Y | | | | | |
| E0435 | Oxygen system liquid portabl | | E | | | | | |
| E0439 | Stationary liquid O2 | | Y | | | | | |
| E0440 | Oxygen system liquid station | | E | | | | | |
| E0441 | Oxygen contents, gaseous | | Y | | | | | |
| E0442 | Oxygen contents, liquid | | Y | | | | | |
| E0443 | Portable O2 contents, gas | | Y | | | | | |
| E0444 | Portable O2 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 intrfc | | Y | | | | | |
| E0471 | RAD w/backup non inv intrfc | | Y | | | | | |
| E0472 | RAD w backup invasive intrfc | | Y | | | | | |
| E0480 | Percussor elect/pneum home m | | Y | | | | | |
| E0481 | Intrpnlmry 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 suppl 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 stdnd fram sys | | E | | | | | |
| E0642 | Dynamic standing frame | | E | | | | | |
| E0650 | Pneuma compressor 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-programable 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 absbr for hd man wc | | Y | | | | | |
| E1018 | HD shck absbr 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 tiltspac | | 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 titnspc w/o seat | | Y | | | | | |
| E1234 | Fld ped wc titnspc 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 | Adjust 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 SPSPD | | 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 endolymph 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 scrm; 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 scrm hgh risk direc | CH | S | 0698 | 0.8696 | \$55.39 | | \$11.08 |
| G0118 | Glaucoma scrm hgh risk direc | | S | 0230 | 0.5903 | \$37.60 | | \$7.52 |
| G0120 | Colon ca scrm; barium enema | | S | 0157 | 2.0651 | \$131.53 | | \$26.31 |
| G0121 | Colon ca scrm not hi rsk ind | | T | 0158 | 7.8504 | \$500.02 | | \$125.01 |
| G0122 | Colon ca scrm; 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 | | P | | | | | |
| G0129 | Partial hosp prog service | | B | 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 m,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,fdv vsst 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 endure | 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 | Electromagnetic 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 antiplatelet | | 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/antidepress12w | | M | | | | | |
| G8128 | Pt inelig for antidepress med | | M | | | | | |
| G8129 | Pt treat w/antidepress for 6m | | M | | | | | |
| G8130 | Pt not treat w/antidepress 6m | | M | | | | | |
| G8131 | Pt inelig for antidepress 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/prolong intub | | M | | | | | |
| G8165 | Iso CABG pt w/o prolong intub | | M | | | | | |
| G8166 | Iso CABG req surg reexpo | | 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 calculate w/followup | NI | M | | | | | |
| G8418 | BMI < 22 calculate 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 & couns | 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 antivir tx | NI | M | | | | | |
| G8459 | Doc pt rec antivir treat | NI | M | | | | | |
| G8460 | Pt inelig RNA no antivir tx | NI | M | | | | | |
| G8461 | Pt rec antivir treat hep c | NI | M | | | | | |
| G8462 | Pt inelig couns no antivir 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 rehabilitate 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 stg1 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 metastatic/ recur | | M | | | | | |
| G9077 | Onc dx prostate T1no progres | | M | | | | | |
| G9078 | Onc dx prostate T2no progres | | M | | | | | |
| G9079 | Onc dx prostate T3b-T4noprogr | | 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,N1-2nprg | | 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 unknown 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 | Succinylcholine 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 benzotropine 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 phosph | | N | | | | | |
| J0704 | Betamethasone sod phosph/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 | Corticotropin injection | | 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 | Medroxyprogester acetate inj | | E | | | | | |
| J1056 | MA/EC contraceptive injection | | 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 | Mecaserin injection | | K | 0805 | | \$15.62 | | \$3.12 |
| J2175 | Meperidine hydrochl /100 MG | | N | | | | | |
| J2180 | Meperidine/promethazine inj | | N | | | | | |
| J2185 | Meropenem | CH | N | | | | | |
| J2210 | Methylegonovin 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 injecton | | N | | | | | |
| J2710 | Neostigmine methylsflte 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 | Sinacalide 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 injecton | | 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 | Retepase 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 injecton | | 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 acetoneide inj | | N | | | | | |
| J3302 | Triamcinolone diacetate inj | | N | | | | | |
| J3303 | Triamcinolone hexacetoln inj | | N | | | | | |
| J3305 | Inj trimetrexate glucuronate | | K | 7045 | | \$148.30 | | \$29.66 |
| J3310 | Perphenazine injecton | | N | | | | | |
| J3315 | Triptorelin pamoate | | K | 9122 | | \$159.38 | | \$31.88 |
| J3320 | Spectinomycin 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 | Intrauterine copper contraceptive | | E | | | | | |
| J7302 | Levonorgestrel iu contraceptive | | 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 acetone 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 | | | | | | |
| 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 globulin 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 unit | 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 | Glycopyrrrolate comp con | CH | M | | | | | |
| J7643 | Glycopyrrrolate 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 | N | | | | | |
| 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 injection | | 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 frst/igrst | | 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 | Y | | | | | |
| K0802 | POV group 1 vhd 451–600 lbs | Y | Y | | | | | |
| K0806 | POV group 2 std up to 300lbs | Y | Y | | | | | |
| K0807 | POV group 2 hd 301–450 lbs | Y | Y | | | | | |
| K0808 | POV group 2 vhd 451–600 lbs | Y | Y | | | | | |
| K0812 | Power operated vehicle NOC | Y | Y | | | | | |
| K0813 | PWC gp 1 std port seat/back | Y | Y | | | | | |
| K0814 | PWC gp 1 std port cap chair | Y | Y | | | | | |
| K0815 | PWC gp 1 std seat/back | Y | Y | | | | | |
| K0816 | PWC gp 1 std cap chair | Y | Y | | | | | |
| K0820 | PWC gp 2 std port seat/back | Y | Y | | | | | |
| K0821 | PWC gp 2 std port cap chair | Y | Y | | | | | |
| K0822 | PWC gp 2 std seat/back | Y | Y | | | | | |
| K0823 | PWC gp 2 std cap chair | Y | Y | | | | | |
| K0824 | PWC gp 2 hd seat/back | Y | Y | | | | | |
| K0825 | PWC gp 2 hd cap chair | Y | Y | | | | | |
| K0826 | PWC gp 2 vhd seat/back | Y | Y | | | | | |
| K0827 | PWC gp vhd cap chair | Y | Y | | | | | |
| K0828 | PWC gp 2 xtra hd seat/back | Y | Y | | | | | |
| K0829 | PWC gp 2 xtra hd cap chair | Y | Y | | | | | |
| K0830 | PWC gp2 std seat elevate s/b | Y | Y | | | | | |
| K0831 | PWC gp2 std seat elevate cap | Y | Y | | | | | |
| K0835 | PWC gp2 std sing pow opt s/b | Y | Y | | | | | |
| K0836 | PWC gp2 std sing pow opt cap | Y | Y | | | | | |
| K0837 | PWC gp 2 hd sing pow opt s/b | Y | Y | | | | | |
| K0838 | PWC gp 2 hd sing pow opt cap | Y | Y | | | | | |
| K0839 | PWC gp2 vhd sing pow opt s/b | Y | Y | | | | | |
| K0840 | PWC gp2 xhd sing pow opt s/b | Y | Y | | | | | |
| K0841 | PWC gp2 std mult pow opt s/b | Y | Y | | | | | |
| K0842 | PWC gp2 std mult pow opt cap | Y | Y | | | | | |
| K0843 | PWC gp2 hd mult pow opt s/b | Y | Y | | | | | |
| K0848 | PWC gp 3 std seat/back | Y | Y | | | | | |
| K0849 | PWC gp 3 std cap chair | Y | Y | | | | | |
| K0850 | PWC gp 3 hd seat/back | Y | Y | | | | | |
| K0851 | PWC gp 3 hd cap chair | Y | Y | | | | | |
| K0852 | PWC gp 3 vhd seat/back | Y | Y | | | | | |
| K0853 | PWC gp 3 vhd cap chair | Y | Y | | | | | |
| K0854 | PWC gp 3 xhd seat/back | Y | Y | | | | | |
| K0855 | PWC gp 3 xhd cap chair | Y | Y | | | | | |
| K0856 | PWC gp3 std sing pow opt s/b | Y | Y | | | | | |
| K0857 | PWC gp3 std sing pow opt cap | Y | Y | | | | | |
| K0858 | PWC gp3 hd sing pow opt s/b | Y | Y | | | | | |
| K0859 | PWC gp3 hd sing pow opt cap | Y | Y | | | | | |
| K0860 | PWC gp3 vhd sing pow opt s/b | Y | Y | | | | | |
| K0861 | PWC gp3 std mult pow opt s/b | Y | Y | | | | | |
| K0862 | PWC gp3 hd mult pow opt s/b | Y | Y | | | | | |
| K0863 | PWC gp3 vhd mult pow opt s/b | Y | Y | | | | | |
| K0864 | PWC gp3 xhd mult pow opt s/b | Y | Y | | | | | |
| K0868 | PWC gp 4 std seat/back | Y | Y | | | | | |
| K0869 | PWC gp 4 std cap chair | Y | Y | | | | | |
| K0870 | PWC gp 4 hd seat/back | Y | Y | | | | | |
| K0871 | PWC gp 4 vhd seat/back | Y | Y | | | | | |
| K0877 | PWC gp4 std sing pow opt s/b | Y | Y | | | | | |
| K0878 | PWC gp4 std sing pow opt cap | Y | Y | | | | | |
| K0879 | PWC gp4 hd sing pow opt s/b | Y | Y | | | | | |
| K0880 | PWC gp4 vhd sing pow opt s/b | Y | Y | | | | | |
| K0884 | PWC gp4 std mult pow opt s/b | Y | Y | | | | | |
| K0885 | PWC gp4 std mult pow opt cap | Y | Y | | | | | |
| K0886 | PWC gp4 hd mult pow s/b | Y | Y | | | | | |
| K0890 | PWC gp5 ped sing pow opt s/b | Y | Y | | | | | |
| K0891 | PWC gp5 ped mult pow opt s/b | Y | Y | | | | | |
| K0898 | Power wheelchair NOC | Y | Y | | | | | |
| K0899 | Pow mobil dev no SADMERC | Y | Y | | | | | |
| L0112 | Cranial cervical orthosis | A | A | | | | | |
| L0120 | Cerv flexible non-adjustable | A | A | | | | | |
| L0130 | Flex thermoplastic collar mo | A | A | | | | | |
| L0140 | Cervical semi-rigid adjustab | A | A | | | | | |
| L0150 | Cerv semi-rig adj molded chn | A | A | | | | | |
| L0160 | Cerv semi-rig wire occ/mand | A | A | | | | | |
| L0170 | Cervical collar molded to pt | A | A | | | | | |
| L0172 | Cerv col thermplas foam 2 pi | A | A | | | | | |
| L0174 | Cerv col foam 2 piece w thor | A | A | | | | | |
| L0180 | Cer post col occ/man sup adj | A | A | | | | | |
| L0190 | Cerv collar supp adj cerv ba | A | A | | | | | |
| L0200 | Cerv col supp adj bar & thor | A | A | | | | | |
| L0210 | Thoracic rib belt | A | A | | | | | |
| L0220 | Thor rib belt custom fabrica | A | A | | | | | |
| L0430 | Dewall posture protector | A | A | | | | | |
| L0450 | TLSO flex prefab thoracic | A | A | | | | | |
| L0452 | tiso flex custom fab thoraci | A | 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 symphysis-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 sagitt 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 | Ctiso a-p-l control molded | | A | | | | | |
| L0710 | Ctiso 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 | Ctiso milwauke initial model | | A | | | | | |
| L1001 | CTLISO infant immobilizer | | A | | | | | |
| L1005 | Tension based scoliosis orth | | A | | | | | |
| L1010 | Ctiso 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/o 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/pronator 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-stdnd 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 gauntlth 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 metacarpal 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 dsq bk ea add cast ch | A | | | | | | |
| L5420 | Postop dsq & 1 cast chg ak/d | A | | | | | | |
| L5430 | Postop dsq ak ea add cast ch | A | | | | | | |
| L5450 | Postop app non-wgt bear dsq | A | | | | | | |
| L5460 | Postop app non-wgt bear dsq | 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 articulac | 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 | Knee-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 hydal 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 split 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 pwrld 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/shldr 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 chgr six volt otto | | A | | | | | |
| L7364 | Twelve volt battery utah/equ | | A | | | | | |
| L7366 | Battery chgr 12 volt utah/e | | A | | | | | |
| L7367 | Replacmnt 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 utlitle mat | | A | | | | | |
| L7402 | Add UE prost s/d utlitle 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 | Radiofq trsmtr implt scr1 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 flocculation 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 | 0958 | 1.0524 | \$67.03 | | \$13.41 |
| P9019 | Platelets, each unit | | K | 0957 | 1.0911 | \$69.50 | | \$13.90 |
| P9020 | Platelet 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 | 0950 | 1.9110 | \$121.72 | | \$24.34 |
| P9033 | Platelets leukoreduced irradi | | K | 0968 | 2.1971 | \$139.94 | | \$27.99 |
| P9034 | Platelets, pheresis | | K | 0957 | 6.9242 | \$441.03 | | \$88.21 |
| P9035 | Platelet pheres leukoreduced | | K | 0951 | 7.8426 | \$499.53 | | \$99.91 |
| P9036 | Platelet pheresis irradiated | | K | 0952 | 6.5581 | \$417.71 | | \$83.54 |
| P9037 | Plate pheres leukoredu irradi | | K | 1019 | 9.8923 | \$630.08 | | \$126.02 |
| P9038 | RBC irradiated | | K | 0950 | 3.0643 | \$195.18 | | \$39.04 |
| P9039 | RBC deglycerolized | | K | 0954 | 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 | 0956 | 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, irradi | | K | 1021 | 5.8716 | \$373.99 | | \$74.80 |
| P9058 | RBC, l/r, cmv-neg, irradi | | 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 | 0953 | 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 clips 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 | Misc supply/accessory vad | | A | | | | | |
| Q0510 | Dispens fee immunosuppressive | | 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 fiberglass | | B | | | | | |
| Q4003 | Cast sup shoulder cast plstr | | B | | | | | |
| Q4004 | Cast sup shoulder cast fbgrl | | 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 fiberglass | | 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 cylindr ped p | | B | | | | | |
| Q4036 | Cast sup lngleg cylindr 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 perflerane 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 sphcyl bifocal 4.00d/2.1 | | A | | | | | |
| V2205 | Lens sphcyl bifocal 4.00d/4.2 | | A | | | | | |
| V2206 | Lens sphcyl bifocal 4.00d/ove | | A | | | | | |
| V2207 | Lens sphcyl bifocal 4.25–7d/ | | A | | | | | |
| V2208 | Lens sphcyl bifocal 4.25–7/2 | | A | | | | | |
| V2209 | Lens sphcyl bifocal 4.25–7/4 | | A | | | | | |
| V2210 | Lens sphcyl bifocal 4.25–7/ov | | A | | | | | |
| V2211 | Lens sphcyl 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 sphcyl trifocal 4.0/12- | | A | | | | | |
| V2304 | Lens sphcyl trifocal 4.0/2.25 | | A | | | | | |
| V2305 | Lens sphcyl trifocal 4.0/4.25 | | A | | | | | |
| V2306 | Lens sphcyl trifocal 4.00/>6 | | A | | | | | |
| V2307 | Lens sphcyl 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 artificial 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 | | E | | | | | |
| 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]

| HCPSC 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 orb/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]

| HCPSC 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]

| HCPSC 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]

| HCPSC 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]

| HCPSC 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 | CH | 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]

| HCPSC 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, snl fetus ..... | ..... | Z2 | 1.5094 | \$62.49 |
| 76810 | Ob us >= 14 wks, addl fetus ..... | ..... | Z3 | 0.9874 | \$40.88 |
| 76811 | Ob us, detailed, snl 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]

| HCPSC 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]

| HCPSC 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]

| HCPSC 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]

| HCPSC 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, ltd ..... | ..... | 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]

| HCPSC 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 | Rotavirus 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 | Mmr 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]

| HCPSC 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 | Matri 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]

| HCPSC 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]

| HCPSC 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-programable 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 | Alefaccept | | 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 | Succinylcholine 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 benztrapine 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]

| HCPSC 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 | Corticotropin 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]

| HCPSC 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]

| HCPSC 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]

| HCPSC 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 injection ..... | ..... | N1 ..... | ..... | ..... |
| J2710 | Neostigmine methylsulfate 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 | Phentolamine 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 | Sinacalide 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 injection ..... | ..... | N1 ..... | ..... | ..... |
| J2916 | Na ferric gluconate complex ..... | ..... | N1 ..... | ..... | ..... |
| J2920 | Methylprednisolone injection ..... | ..... | N1 ..... | ..... | ..... |
| J2930 | Methylprednisolone injection ..... | ..... | N1 ..... | ..... | ..... |
| J2940 | Somatrem injection ..... | ..... | K2 ..... | ..... | \$168.90 |
| J2941 | Somatropin injection ..... | ..... | K2 ..... | ..... | \$48.52 |
| J2950 | Promazine hcl injection ..... | ..... | N1 ..... | ..... | ..... |
| J2993 | Retepase 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 injection ..... | ..... | 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]

| HCPSC 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 hexacetoni inj ..... | ..... | N1 ..... | ..... | ..... |
| J3305 | Inj trimetrexate glucuronate ..... | ..... | K2 ..... | ..... | \$148.30 |
| J3310 | Perphenazine injecton ..... | ..... | N1 ..... | ..... | ..... |
| J3315 | Triptorelin pamoate ..... | ..... | K2 ..... | ..... | \$159.38 |
| J3320 | Spectinomycin 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 | Trifluoperazine 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]

| HCPSC 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 acetoneide 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 globulin 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 | Carbus bischi 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]

| HCPSC 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 injection ..... | ..... | 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]

| HCPSC 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]

| HCPSC 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: <ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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/l | 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 disectomy | 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, lmted | C ..... | ..... |
| 33255 | Ablate atria w/o bypass, ext | C ..... | ..... |
| 33256 | Ablate atria w/bypass, exten | C ..... | ..... |
| 33257 | Ablate atria, lmted, 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, lmted, 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 | CI 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 small 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 | Ileostomy/jejunostomy | C ..... | ..... |
| 44314 | Revision of ileostomy | C ..... | ..... |
| 44316 | Devise bowel pouch | C ..... | ..... |
| 44320 | Colostomy | C ..... | ..... |
| 44322 | Colostomy with biopsies | C ..... | ..... |
| 44345 | Revision of colostomy | C ..... | ..... |
| 44346 | Revision of colostomy | C ..... | ..... |
| 44602 | Suture, small intestine | C ..... | ..... |
| 44603 | Suture, small intestine | C ..... | ..... |
| 44604 | Suture, large intestine | C ..... | ..... |
| 44605 | Repair of bowel lesion | C ..... | ..... |
| 44615 | Intestinal stricturoplasty | C ..... | ..... |
| 44620 | Repair bowel opening | C ..... | ..... |
| 44625 | Repair bowel opening | C ..... | ..... |
| 44626 | Repair bowel opening | C ..... | ..... |
| 44640 | Repair bowel-skin fistula | C ..... | ..... |
| 44650 | Repair bowel fistula | C ..... | ..... |
| 44660 | Repair bowel-bladder fistula | C ..... | ..... |
| 44661 | Repair bowel-bladder fistula | C ..... | ..... |
| 44680 | Surgical revision, intestine | C ..... | ..... |
| 44700 | Suspend bowel w/prosthesis | C ..... | ..... |
| 44715 | Prepare donor intestine | C ..... | ..... |
| 44720 | Prep donor intestine/venous | C ..... | ..... |
| 44721 | Prep donor intestine/artery | C ..... | ..... |
| 44800 | Excision of bowel pouch | C ..... | ..... |
| 44820 | Excision of mesentery lesion | C ..... | ..... |
| 44850 | Repair of mesentery | C ..... | ..... |
| 44899 | Bowel surgery procedure | C ..... | ..... |
| 44900 | Drain app abscess, open | C ..... | ..... |
| 44950 | Appendectomy | C ..... | ..... |
| 44955 | Appendectomy add-on | C ..... | ..... |
| 44960 | Appendectomy | C ..... | ..... |
| 45110 | Removal of rectum | C ..... | ..... |
| 45111 | Partial removal of rectum | C ..... | ..... |
| 45112 | Removal of rectum | C ..... | ..... |
| 45113 | Partial proctectomy | C ..... | ..... |
| 45114 | Partial removal of rectum | C ..... | ..... |
| 45116 | Partial removal of rectum | C ..... | ..... |
| 45119 | Remove rectum w/reservoir | C ..... | ..... |
| 45120 | Removal of rectum | C ..... | ..... |
| 45121 | Removal of rectum and colon | C ..... | ..... |
| 45123 | Partial proctectomy | C ..... | ..... |
| 45126 | Pelvic exenteration | C ..... | ..... |
| 45130 | Excision of rectal prolapse | C ..... | ..... |
| 45135 | Excision of rectal prolapse | C ..... | ..... |
| 45136 | Excise ileoanal reservior | C ..... | ..... |
| 45395 | Lap, removal of rectum | C ..... | ..... |
| 45397 | Lap, remove rectum w/pouch | C ..... | ..... |
| 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 snl 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 | Lc for lbw infant < 1500 gm | C ..... | ..... |
| 99299 | Lc, 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 disectomy | C ..... | ..... |
| 0095T | Artific disectomy 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 disectomy 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 | JEFFERSON 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 | JEFFERSON 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 | JEFFERSON DAVIS | 19260 |
| 194077 | | 0.0061 | LINCOLN | 19300 |
| 194081 | | 0.0044 | BEAUREGARD | 19050 |
| 194082 | | 0.0101 | JEFFERSON 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 pscy/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 | Intevne 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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